Dep't of Correction v. Williams

OATH Index No. 2223/15 (Sept. 3, 2015), *adopted*, Comm'r Dec. (Aug. 19, 2016), **appended**

Correction captain charged with failing to obtain medical attention for inmate and failing to file a use-of-force witness report. Administrative law judge found proof sufficient to sustain only the failure to report charge. ALJ recommended that employee be suspended for five days. Upon review, Commissioner first imposed a 35-day suspension without pay and then adopted the recommended five-day suspension in an amended decision.

NEW YORK CITY OFFICE OF ADMINISTRATIVE TRIALS AND HEARINGS

In the Matter of
DEPARTMENT OF CORRECTION
Petitioner
- against -
ODETTA WILLIAMS
Respondent

REPORT AND RECOMMENDATION

JOHN B. SPOONER, *Administrative Law Judge*

This disciplinary proceeding was referred to me in accordance with section 75 of the Civil Service Law. Petitioner, the Department of Correction, charged that respondent Odetta Williams, a correction captain, failed to obtain medical attention for an inmate and failed to file a use-of-force witness report. A hearing on the charges was conducted on July 28 and 30, 2015. Petitioner presented the testimony of an investigator and a large number of reports, recorded and transcribed interviews, and interview summaries, as well as some video. Respondent testified on her own behalf, denying any misconduct, and called two officers concerning the first charge.

Following the trial, both parties filed briefs on petitioner's motion to strike the testimony of two of respondent's witnesses on the grounds of witness collusion. The record closed on August 17, 2015.

For the reasons provided below, I find that the evidence was sufficient to sustain only the failure to report charge. I recommend that respondent be suspended for five days.

PRELIMINARY ISSUE

At the close of the hearing, counsel for petitioner made a motion to strike the testimony of two of respondent's witnesses on the grounds that there was an indication of collusion. Petitioner based its motion upon a representation that Officers Merentie and Fisher were both assigned to the same facility, that both were supervised by respondent, and that, prior to testifying at the trial on July 28, 2015, they were jointly interviewed by respondent's attorney. Both parties filed post-hearing briefs on the issue.

There is neither factual nor legal support for petitioner's motion. As represented by respondent's attorney, the pretrial contact between Officers' Merentie and Fisher consisted of a five-minute conversation in which counsel informed the two witnesses about "why they were there and to simply testify as to what they recalled about the events in question." This was not improper and created virtually no possibility that the witnesses would alter their testimony to match one another. This was particularly true since the two officers were testifying about two different stages of the force incident: Officer Merentie testified about the initial interaction in the visitation room, when Officer Fisher was not present; Officer Fisher testified about escorting the inmate to the clinic, when Officer Merentie was no longer present. Further, no record was created on the collusion issue, since counsel for petitioner did not cross-examine either witness about their pretrial interview and there was thus no evidence to show that either witnesses' testimony was synchronized.

Neither does the fact that the two officers worked together under the supervision of respondent, standing alone, suggest any improper influence. The officers' working relationship with respondent, while an appropriate issue to consider in assessing their credibility, does not warrant precluding their testimony from the hearing entirely. Indeed, if this were the rule to be followed, the Department's disciplinary prosecutions, which rely heavily upon the testimony of uniformed staff who work in the same facility, would be severely crippled.

Petitioner's counsel cited to two singularly distinguishable cases in support of its motion to strike. In the 125-year-old case of *Newman v. Ernst*, 10 N.Y.S. 310, 312-14 (Sup. Ct. Buffalo 1890), a horse owner brought a negligence action against another horse owner based upon a horse cart collision in which the plaintiff's horse died. In denying the plaintiff's motion for a new trial, the court discussed the efficacy of jury instructions telling a jury to disregard "improper evidence." Notably, the court denied the motion and held that introduction of the

improper evidence did not prejudice the plaintiff. This case offers no support for petitioner's assertion in the instant case that testimony should be stricken due to a possibility of collusion or alleged bias.

In the second case, *Department of Correction v. Behari*, OATH Index Nos. 781/14, 782/14, 783/14, 784/14, 785/14 & 786/14 at 6-7 (Sept. 25, 2014), this tribunal struck the testimony of an inmate whose attorney was improperly provided with confidential information by a Department attorney. This tribunal noted that, even in the absence of evidence that a witness viewed improperly obtained records, where the witness's testimony was "not necessary" to prove the misconduct allegations, the testimony was appropriately stricken to remove any taint from the OATH proceeding. Again, this case offers no basis to strike witness testimony on the grounds of an opportunity to collude or possible bias.

Petitioner's motion to strike is denied.

ANALYSIS

This case concerns two sets of charges against respondent, an 11-year employee and correction captain assigned to the Anna M. Kross Center (AMKC) facility. Both incidents concerned respondent's responses to use-of-force incidents which occurred in the visitation area which respondent was assigned to supervise.

August 28, 2013 Incident

The first set of charges alleges that, on August 28, 2013, respondent failed to ensure "immediate medical attention" for an inmate involved in a use of force. Under Department rules, whenever force is used, the "Tour Commander or supervisor assigned by the Tour Commander" must ensure that the inmate and any injured staff receive medical attention "as soon as possible." Directive No. 5006R-C § V(D) (eff. Jan. 31, 2008). In addition, the charges allege that respondent failed to notify the clinic or clinic escort staff that the inmate "exhibited signs of physical distress and injury."

Petitioner's proof in support of the charges consisted of an 111-page investigation report written largely by Investigator Doninello and also the testimony of the investigator himself, who described in some detail the investigation and the various reports and interviews completed. Certain facts were undisputed. On the date of the incident, respondent was working overtime on

a 1:00 p.m.-to-9:00 p.m. tour as the visitation area captain. She was supervising several officers, including Officer Merentie, who was assigned to patrol the visitation room. At 9:10 p.m., Officer Merentie was involved in a confrontation with an inmate named Gonzalez which resulted in Mr. Gonzalez hitting his head on a window sill. It was also undisputed that respondent was notified of the incident, spoke with Mr. Gonzalez and Officer Merentie, and ordered another officer, Officer Fisher, to escort Mr. Gonzalez to the clinic at around 9:55 p.m.

The primary contested issues at the hearing concerned (1) the length of time between respondent's being notified of the force incident and Mr. Gonzalez leaving for the clinic and (2) Mr. Gonzalez's physical appearance at the time respondent spoke with him. According to respondent's testimony, at around 9:10 p.m., while she was dealing with a visiting mother whose inmate son refused to see her, she was notified of the incident involving Mr. Gonzalez. Respondent finished her discussions and walked over to the visitation area some two minutes away. There she met with both Mr. Gonzalez and Officer Merentie (Tr. 178-79). Mr. Gonzalez was "crying" and "very emotional." He said he was "OK" and just wanted to return to his housing area. Officer Merentie told respondent about the stopping of the visit (Tr. 179) and the pushing which followed. Respondent told Mr. Gonzalez that he had to go to the clinic. At this time, respondent saw no signs of injury on Mr. Gonzalez, no blood, and no contusions (Tr. 179-80).

Respondent followed standard procedure and instructed the registration officer to call the clinic and have an officer sent to escort Mr. Gonzalez to the clinic "as soon as possible" (Tr. 180, 265). She stated that there was no indication of a medical emergency and no probe team was needed because the inmate was not a threat. Respondent further noted that, due to the staffing needs on visitation floor, she did not believe at that time that she could spare one of her visitation officers to escort Mr. Gonzalez to the clinic (Tr. 264-65). In this regard, she noted that the visitation area had approximately 114 to 215 visitors per day (Tr. 176). Respondent continued her patrol of the other portions of the area and returned to the visitation area some 30 minutes later. She saw that Mr. Gonzalez was still sitting in a corner and she asked the officers why he had not yet gone to the clinic. The officers said that there were delays with sending an escort from the clinic. At this point, around 9:55 p.m., respondent ordered Officer Fisher, one of the visitation officers, to immediately escort Mr. Gonzalez to the clinic (Tr. 182-83).

Officer Merentie, testifying for respondent, confirmed that, after Mr. Gonzalez hit his head, he notified respondent and she arrived some 10 minutes later (Tr. 155-56). She asked what happened and Officer Merentie described his stopping of the visit between Mr. Gonzalez and his girlfriend. Respondent directed Officer Merentie to obtain a statement from the girlfriend, which he did (Tr. 156). Officer Merentie had testified that he did not observe any blood on Mr. Gonzalez's jumpsuit (Tr. 158). During an earlier investigative interview, Officer Merentie had stated that, immediately after the incident, he noticed that Mr. Gonzalez's ear was bleeding (Pet. Ex. 1 at 12-13).

Officer Fisher, also testifying for respondent, confirmed that he escorted Mr. Gonzalez to the clinic at around 10:00 p.m. at the direction of respondent (Tr. 141). Mr. Gonzalez seemed "fine" and Officer Fisher did not see any blood. Mr. Gonzalez only seemed concerned about whether he would see his visitor again (Tr. 143). Video surveillance footage (Pet. Ex. 5) shows Mr. Gonzalez leaving the visitation area with Officer Fisher at around 9:58 p.m. Mr. Gonzalez is walking slowly with a slight limp. There is no blood visible on his jumpsuit and, other than an unsteady gait, there is no indication he is injured.

According to the injury to inmate report (Pet. Ex. 1 at 54), Mr. Gonzalez was not seen by medical staff until 3:00 a.m. the following day. He was found to have a "laceration/perforation" of the tympanic membrane of his left ear, as well as hematomas to his left scalp and left ear lobe. No other injuries were found.

On September 6, 2013, approximately a week after the incident, Mr. Gonzalez alleged that Officer Merentie and another officer punched him repeatedly in the head, face, and back until he lost consciousness (Pet. Ex. 1 at 3). Another inmate indicated that he was ordered to discard Mr. Gonzalez's blood-stained jumpsuit later that day (Pet. Ex. 1 at 38-39).

According to the investigation report, Investigator Doninello, completely discredited the interview statements of Mr. Gonzalez as well as those of his girlfriend because, in recorded telephone conversations, Mr. Gonzalez never mentioned being punched and encouraged his girlfriend to lie about Officer Merentie beating him without provocation (Pet. Ex. 1 at 18-19). In addition, the medical records provided no corroboration to show that Mr. Gonzalez was beaten. For these reasons, no excessive force charges were recommended against Officer Merentie or the other officer. Charges were, however, recommended for respondent because, in her investigative

interview, she failed to provide "any plausible or reasonable explanation as to why it took so long to afford Gonzalez medical attention" (Pet. Ex. at 19).

The evidence did not support a finding that respondent's actions violated the use of force directive. The evidence suggested that the amount of time which passed between respondent being notified of the force incident and Mr. Gonzalez leaving the visitation area was approximately 30 minutes. This is demonstrated first by the report of Officer Merentie (Pet. Ex. 1 at 52-53) recording the time of the incident as "20:10." At trial, respondent indicated that she accepted the time from Officer Merentie's report. Since it was undisputed that, at the time respondent was notified about the incident with Mr. Gonzalez, she was dealing with another visitation issue, she would not have learned about what happened until she reported to the visitation area and spoke with Officer Merentie about it several minutes after he called her. The credible evidence thus indicates that Officer Merentie told respondent about the force incident around 21:25, or 8:25 p.m. According to the video evidence, Officer Fisher began to escort Mr. Gonzalez out of the visitation area to the clinic at around 21:55, or 8:55 p.m., proceeding through the various doors and cameras to exit the facility. This leaves 30 minutes between the time respondent was notified of the incident and the time Mr. Gonzalez was escorted out to the clinic.

The evidence indicates that Mr. Gonzalez exhibited no signs of being seriously injured. Neither the perforation of Mr. Gonzalez's tympanic membrane, or ear drum, his primary injury, nor the hematomas, or bruises, on his scalp would necessarily have produced a visible amount of blood. Further, Officer Merentie testified at the hearing that, while he previously stated that he noticed some bleeding from Mr. Gonzalez's ear, he did not see any blood on Mr. Gonzalez's jumpsuit. Both respondent and Officer Fisher also credibly testified that they did not see any blood at all on Mr. Gonzalez. In her investigative interview, respondent indicated that she may have seen "physical injury" consisting of a "swollen area" which prompted her to send Mr. Gonzalez to the clinic (Pet. Ex. 3A at 49-50), but never indicated that she observed any other injuries. The fact that Mr. Gonzalez was not treated at the clinic for some five hours after he left AMKC suggests that medical staff did not see his injuries as serious or in need of immediate treatment to stanch any blood. I therefore find that, while some dried blood may have been visible inside Mr. Gonzalez's ear canal and perhaps some swelling, he was not bleeding at the time respondent saw him and exhibited no other visible signs of serious injury. I also credited

the testimony of Officer Merentie and respondent that Mr. Gonzalez seemed more concerned about having additional visits from his girlfriend and did not complain of having been injured.

The video evidence also corroborates respondent's statement that the visitation area was busy with only a few officers supervising a large number of inmates changing clothes as they entered and left the area, as well as an equally large number of visitors. Respondent's decision to request an escort officer from the clinic rather than risk having inadequate security for the visitation area seemed reasonable. Given the amount of traffic through the area, it did not seem surprising that several minutes passed before respondent returned and noticed that Mr. Gonzalez still had not been taken to the clinic. Upon seeing this, she appropriately ordered Officer Fisher to escort Mr. Gonzalez there. The delay of some 30 minutes between speaking with Mr. Gonzalez and ordering Officer Fisher to take Mr. Gonzalez to the clinic was not shown to have had any effect upon the treatment at the clinic, where Mr. Gonzalez waited another five hours. Under these circumstances, respondent obtained medical attention for Mr. Gonzalez "as soon as possible" as required by the force directive.

Further, as noted by respondent's counsel in his closing, the directive places the primary obligation for ensuring prompt medical attention for an inmate upon the "Tour Commander or supervisor assigned by the Tour Commander." Directive No. 5006R-C § V(D). It was unclear from this record whether the tour commander actually "assigned" respondent to manage the force incident and assume responsibility for the inmate being promptly treated. Nor was it apparent, as contended by petitioner's counsel in his closing, that respondent failed to notify the tour commander of the incident, preventing him or her from assessing and managing the situation, as happened in *Department of Correction v. Rathour,* OATH Index Nos. 272/13, 273/13, 274/13 & 275/13 (Aug. 21, 2013); *see also Dep't of Correction v. Tillery,* OATH Index No. 467/12 at 7 (Dec. 30, 2011), *citing Dep't of Sanitation v. Burns,* OATH Index No. 1322/01 at 7 (June 15, 2001) (strict liability is not an appropriate standard in a disciplinary matter). The fact that the log summary (Resp. Ex. A) of the tour commander, ADW Kelly, failed to mention whether he was told by respondent that Mr. Gonzalez hit his head, does not, in the absence of testimony from the ADW, establish that this fact was not shared by respondent. Based upon these facts, there is insufficient proof here to conclude that respondent violated the directive.

As to the second allegation that respondent failed to notify the clinic that Mr. Gonzalez "exhibited signs of physical distress and injury," this allegation was also not proven. First, there

was no proof offered to show that Mr. Gonzalez showed visible signs of being injured, other than having some blood on his ear. The video surveillance cameras show that Mr. Gonzalez walked slowly and stiffly, but without need of any physical assistance. Again, the fact that the clinic saw no need to treat Mr. Gonzalez's ear injury for some five hours severely undermines petitioner's assertion that he exhibited severe injuries requiring that medical staff be immediately notified.

For these reasons, the first set of charges should be dismissed.

January 1, 2014 Incident

The second set of charges concerns an incident which occurred in the visitation search area at around 10:00 p.m. on January 1, 2014. The charges allege that, on this date, after reporting to the area during a use of force involving an inmate who was observed to have hidden contraband, respondent failed to write a use-of-force witness report about the incident.

According to the reports and interviews with the three officers who observed the contraband and tried to confiscate it, the inmate placed a latex-wrapped scalpel in his crotch, and then in his mouth (Pet. Ex. 2 at 9-10, 12-13). The inmate then punched and struggled with two officers who wrestled him to the floor and used chemical spray (Pet. Ex. 2 at 9-10, 11-12). The officers and the probe team reports indicate that, after the probe team arrived, the inmate continued to struggle and resisted the probe team's application of handcuffs (Pet. Ex. 2 at 13-15). After the probe team handcuffed the inmate, he spat the scalpel on to the floor (Pet. Ex. 2 at 10-13).

Respondent testified that she was notified of the use of force and reported to the control station area at around 10:00 p.m. When she arrived, she observed an inmate, Mr. Hunt, lying on the floor, with one officer kneeling next to him and another officer standing at the door. Mr. Hunt had his chin down and was chewing on something (Tr. 184-85). The officers had Mr. Hunt's hands behind his back and had not yet affixed handcuffs. At approximately the same time, the probe team arrived. The probe team members held Mr. Hunt, who tried to swallow something. The probe team "struggled" with Mr. Hunt to get him to his feet (Tr. 185-86). Respondent conceded that she did not file a use-of-force witness report. She contended, however, that she filed no report because she was ordered by her supervisor, ADW Ruggerio, not to do. The ADW gave this order because respondent "had the investigation" (Tr. 186) and he did not want to assign another facility captain to investigate the incident (Tr. 186). Under the force

directive, staff who use force or witness the use of force cannot be assigned to investigate an incident. Directive No. 5006R-C § V(H). In addition, respondent noted that the officers' actions that she observed seemed "minimal" and caused no injury (Tr. 187).

On rebuttal, ADW Ruggiero testified that he was notified by respondent about the use of force with Mr. Hunt. After she described the incident, he asked if she observed any force. She said that she only saw the officers "guide" the inmate's hands behind his back. He then ordered her to complete the investigation of the incident (Tr. 271-72).

According to the relevant rules, Department staff who witness a use of force on an inmate must complete a report before leaving the facility. The report must provide "a precise description of the incident based on the writer's own observations; the specific reasons, if known to the writer, why force was necessary, and the type of force the writer employed or observed being employed, e.g. control holds, blows, etc." Directive No. 5006R-C § V(F)(3)(b). No definition of force is contained in the directive, other than to exclude "[p]hysical contact between an inmate and employee used in a non-confrontational manner to apply mechanical restraints or to guide the inmate shall not be reported as a use of force." Directive No. 5006R-C § V(F)(1).

Under respondent's own version of the incident, she reported to the area and saw two officers trying to handcuff an inmate, who was resisting, and then saw the inmate continue to "struggle" with probe team members. According to all of the other eyewitnesses, the inmate was resisting being searched and continued to fight with the officers until he was handcuffed with the assistance of the probe team. Under these undisputed circumstances, I find that respondent witnessed both assigned officers and probe team members using force to handcuff the inmate. Having observed these actions, she was clearly obliged to complete a use-of-force report.

Respondent's testimony that she was ordered by ADW Ruggerio not to write a report, even if true, would not provide an excuse to her obligation to complete the report under the force directive. In any event, I credited ADW Ruggerio's testimony that he did not order respondent not to write a report and only asked her whether she observed any force being used. Respondent's reply that she only saw the officers "guide" the inmate's hands into handcuffs suggested that the inmate was being cooperative. I did not credit respondent's self-serving and somewhat implausible testimony that the ADW ordered her not to write a report so that she could complete the force investigation, an assertion never made during her investigative interview and at odds with the other evidence in the case, particularly that of ADW Ruggerio. It seemed far

more likely that the ADW ordered respondent to perform the investigation, based upon his understanding that she did not witness the force incident and was not obliged to submit a report, and respondent did not correct this misunderstanding.

For these reasons, this charge should be sustained.

FINDINGS AND CONCLUSIONS

1. DR No. B0520/2014 should be dismissed in that petitioner failed to prove by a preponderance of the evidence that respondent did not obtain medical attention for an inmate "as soon as possible."

2. The charge dated June 15, 2015,[1] should be sustained in that, on January 1, 2014, respondent witnessed a use of force and failed to submit a use-of-force report, in violation of Directive No. 5006R-C § V(F)(3)(b).

RECOMMENDATION

Upon making the above findings, I requested and received a copy of respondent's personnel history in order to make an appropriate penalty recommendation. Respondent was appointed as a correction officer in 2004 and became a captain in 2011. She has no disciplinary record. Respondent's very good personnel history must serve to mitigate any penalty.

In this case, respondent was found to have failed to submit a use-of-force report after observing a number of officers subdue an inmate. Respondent's failure to submit a report, while clearly in violation of the express requirement of the directive, would appear to be a minor violation. Respondent did not witness the portion of the incident during which the inmate sustained injury and the absence of her report had no effect upon the investigation of the force incident, which resulted in no officer being charged. In respondent's testimony, she indicated that, because the incident involving Mr. Hunt was initially perceived as a minor use of force, she did not feel the same need to write a use-of-force report herself and thus exempt herself from doing the investigation (Tr. 199). As respondent's testimony suggests, it would appear likely that, given the high incidence of physical encounters between staff and inmates in certain areas of the facilities, such as the visitation area, it is common practice for captains not to submit

[1] The copy of the charge provided to this tribunal did not indicate the Department DR tracking number for this set of charges.

witness reports where they arrive on a scene with multiple officers already present and only a few seconds before a force incident is terminated.

As noted by respondent's attorney, respondent provided every indication of being a careful and conscientious supervisor. It is to respondent's credit that, in the first incident, after directing that Mr. Gonzalez be taken to the clinic by a clinic escort, she followed up a few minutes later and ordered an officer on her own staff to escort the inmate because the clinic escort was delayed. Even in the second incident, her motive of preventing another captain from undertaking an investigation in her regularly assigned area seemed a worthy one.

Petitioner's attorney recommended that respondent be suspended for 15 days for the failure to submit a report. Given the mitigating factors found here, such a lengthy suspension for this minor infraction would be excessive. *Dep't of Correction v. Holmes*, OATH Index No. 1256/13 (July 18, 2013) (5 days' suspension for captain with excellent record found to have made inaccurate statements); *Dep't of Correction v. Pack*, OATH Index No. 1510/08 (July 9, 2008), *modified on penalty*, Comm'r Dec. (Sept. 25, 2008) (less than 5 days' suspension for captain found to have failed to complete an assignment on time); c*f. Dep't of Correction v. Scurry*, OATH Index No. 1460/08 (June 4, 2008) (demotion for captain who placed inmate and other officers at risk by failing to provide medical attention and to effectively supervise).

In this case, respondent's good work history and the minor nature of the violation suggest that a low penalty is appropriate. I recommend that respondent be suspended for five days.

John B. Spooner
Administrative Law Judge

September 3, 2015

SUBMITTED TO:

JOSEPH PONTE
Commissioner

APPEARANCES:

JOSE NIEVES, ESQ.
YVETTE CHEN, ESQ.
Attorneys for Petitioner

FRANKIE & GENTILE, PC
Attorneys for Respondent
BY: JAMES FRANKIE, ESQ.

_____X
In the Matter of Department of Correction,
Petitioner

-against-

Correction Captain Odetta Williams
Respondent
_____ X

OATH Index No. 2223/15
DR# B0414/2015
DR# B0520/2014

ACTION OF THE COMMISSIONER-AMENDED

The instant matter was sent for my review after the report and recommendation issued by Administrative Law Judge John B. Spooner (hereinafter "ALJ Spooner") of the Office of Administrative Trials and Hearings (hereinafter OATH).

ALJ Spooner presided over the fact finding hearing in the instant matter on July 28th, and 30th, 2015. On September 3, 2015, ALJ Spooner issued a report and recommendation with the findings as follows:

1) DR No. B0520/2014 should be dismissed in that Petitioner failed to prove by a preponderance of the evidence that the Respondent did not obtain medical attention for an inmate "as soon as possible".

2) The charge dated June 15, 2015 [DR No. B0414/2015], should be sustained in that, on January 1, 2014, Respondent witnesses a use of force and failed to submit a use-of-force report, in violation of Directive No. 5006R-C § V(F)(3)(b).

Based on my review of the aforementioned factual information, including but not limited to the Report and Recommendation from OATH, the information provided by the Trials and Litigation Division, I adopt ALJ Spooner's factual findings and conclusions as to disciplinary matter under DR No. B0414/2015 and DR No. B0520/2014.

Based on the trial record and the evidence presented, I have determined that the appropriate penalty for Respondent under this disciplinary matter is a five (5) day suspension without pay. I amend my previous recommendation of a thirty-five (35) day suspension without pay.

Joseph Ponte, Commissioner

August 19, 2016