STATE OF NEW YORK
COUNTY COURT **COUNTY OF HAMILTON**

In the Matter of a Grand Jury Investigation
concerning a fire at the Riverview IRA facility
located in the Town of Wells,
County of Hamilton and State of New York

ORDER

The March, 2009 Grand Jury of Hamilton County, which was held over by this Court by Orders dated September 11, 2009, and November 9, 2009, has handed up a Report, dated December 2, 2009. That Report, captioned "In the Matter of a Grand Jury Investigation concerning a fire at the Riverview IRA facility located in the Town of Wells, County of Hamilton and State of New York," was issued pursuant to Criminal Procedure Law (hereafter, CPL) §190.85(1)(c), and proposes recommendations for legislative, executive or administrative action in the public interest.

Pursuant to CPL §190.85(2), this Court has examined the Report, together with the minutes and exhibits of the Grand Jury, and hereby finds that the provisions of CPL §190.85 have been fully complied with insofar as they relate to this Report, including but not limited to the following specific findings: the Report is based upon facts revealed in the course of an investigation authorized by CPL §190.55; it is supported by the preponderance of the credible and legally admissible evidence; and it is not critical of an identified or identifiable person. Accordingly, it is hereby

ORDERED that the annexed Report of this Grand Jury, dated December 2, 2009, is hereby accepted, and it is further

ORDERED that the said Report be forthwith filed with the Clerk of Hamilton County as a public record.

Dated: December 17, 2009

S. Peter Feldstein
County Court Judge

FILED
DEC 18 2009
TIME 9:32 AM PM
CLERK
HAMILTON COUNTY CLERK

STATE OF NEW YORK
COUNTY COURT

COUNTY OF HAMILTON

In the Matter of a Grand Jury Investigation concerning a fire at the Riverview IRA facility located in the Town of Wells, County of Hamilton and State of New York

---

GRAND JURY REPORT

PRELIMINARY STATEMENT

Within a few days of the events of March 21, 2009 this Grand Jury was empaneled. With the cooperation of the New York State Police, the New York State Office of Mental Retardation and Developmental Disabilities (hereinafter *OMRDD*) and the New York State Department of State Office of Fire Prevention and Control (hereinafter *OFPC*) evidence concerning the fatal fire at the Riverview Individualized Residential Alternative (hereinafter *Riverview IRA*) was gathered. This report, issued pursuant to Criminal Procedure Law section 190.85(1)(c), proposes recommendations for legislative, executive or administrative action in the public interest based upon stated findings.

Our recommendations arise out of a concern that every step should be taken by our State government to prevent a repetition of the events at Riverview. Our consideration of these events has the advantage of hindsight. The organizations and individuals who participated in the construction and operation of Riverview did so without this perspective and had to take into account a multitude of risks and benefits including fire prevention and safety. Our recommendations and the factual findings on which they are based are not intended as critical of any individual or agency within the meaning of that term as used in Criminal Procedure Law section 190.85. While our recommendations for change or improvement carry with them a certain degree of criticism of the system as it exists, and arguably, of persons who acted in or managed the existing system, we affirmatively state that we make no findings of misfeasance, malfeasance, misconduct or neglect of duty by any public servant.

STATEMENT OF FACTS

1. Design and Construction

The Riverview IRA was a residence located in the Town of Wells, owned and operated by OMRDD for the benefit of persons disadvantaged by mental retardation and/or developmental disabilities. One of many such facilities located in Hamilton County, it was the newest having opened in May, 2008 after the culmination of a long process of planning and construction.

The majority of staff and the nine residents at Riverview were together prior to its construction at a home located on New York Route 30 in nearby Speculator, New York. Some years before OMRDD determined it advisable to construct a new facility and terminate the leasehold it had in Speculator. The design and construction of Riverview was overseen by the New York State Dormitory Authority and OMRDD.

It cannot be overemphasized that under current regulations the building code requirements applicable to the construction and operation of Riverview were those applicable to one or two family residences. There were other regulatory schemes which added certain requirements (e.g. heat detectors in the attic), but the primary source of code in effect was residential. From the standpoint of code, the building's fire safety features met or exceeded all OMRDD's residential requirements. These included a fire alarm system, a fire sprinkler system, emergency lighting and exit signage, fire extinguishers as well as numerous construction features. Although Riverview had more fire safety features than many such homes currently operating in the State, these features were still not commensurate with the requirements of the

New York State Fire Protection and Building Code for an I(letter)2 (institutional) occupancy which were circumvented by determining the homes to be residential for the purposes of building codes as well as zoning.

The alarm system employed central station monitoring which insured that monitoring was in effect at all times by trained operators at Albany Protective Services. The system used heat detection devices at various locations in the occupied areas, the basement as well as in the attic. The alarm system was configured so that a 90 minute fire rated double door located between the residents' sleeping quarters and the common areas of the facility would automatically close when the alarm went off. By all accounts the audible alarm was very loud.

The original design called for a fire rated partition in the attic which was eliminated during the course of construction.

The sprinkler system was a so-called 13D system. The design of 13D systems has the purpose of providing life safety for the occupants of one or two family dwellings and townhouses, that is, to limit a fire in occupied rooms and in the paths of egress from the building. Significantly for our purposes, a 13D system does not include sprinklers in unoccupied spaces, including attics.

The construction design incorporated a number of fire resistant materials in the occupied areas, however, the roof structure was not built with fire resistant materials such as fire retardant treated wood. The exterior of the building consisted of vinyl siding. Similarly the soffits were made of vinyl material which was also used in all the eaves and in the ceiling of an

exterior semi-enclosed porch located on the rear of the building adjacent to the dining room.

The design provided multiple exits from the building including a door at the end of the corridor along which the bedrooms were located.

2. Operations

When Riverview opened in late May, 2008 there were nine residents whose needs were served by around the clock staff. In fact the needs of the residents for assistance in daily living were significant. Several were unable to walk without assistance or required a wheelchair or a walker for mobility. Most lacked self protective skills. Most would not appropriately respond to the sound of the exceedingly loud fire alarm.

The audible alarm was reported to be so loud as to be painful to the staff and residents. It was suspected of producing seizures in some of the residents. Because of this when the alarm sounded it was standard practice to silence it.

The work schedule for staff at Riverview was organized in three shifts including 7 am to 3 pm, 3 pm to 11 pm, and 11 pm to 7 am. The number of staff present during these shifts would vary except for the overnight (11 pm to 7 am) shift when only two staff were assigned. On weekday mornings part time workers would arrive at 5 am to assist the overnight staff with waking the residents and preparing them for the day's activities. On weekend mornings the part time workers did not come in. Supervision of the staff was the responsibility of a house director and an assistant. When neither of those individuals was present then the staff member with seniority, regardless of training or ability, was in charge. There was a policy of more or less

random checks of the overnight staff by senior supervisors who would drop in on an unannounced basis. Fire drills were generally not conducted as part of these supervisory visits.

Smoking was prohibited in Riverview. None of the residents were smokers, but several staff and management were. After the facility formally began operations smoking was permitted at a station in the back yard away from the building where a receptacle for butts was placed. During the time near the end of construction when staff were working there to prepare for occupancy, smokers would smoke on the exterior porch adjacent to the dining room. The evidence indicates that the practice of smoking in this area, although forbidden after Riverview opened, may have been more honored in the breach than in the observance. Several witnesses admitted to smoking on the porch and/or observing others smoking there. Credible testimony indicates that ash trays were located on this porch. No testimony was given to indicate anyone was reprimanded or disciplined for smoking in this unauthorized area, although smoking was reported to regularly happen there.

3. Fire Safety Training and Evacuation Drills

OMRDD policy required staff members to receive fire safety training before they could begin supporting residents. This training appears to have been confined to the "RACE" acronym which outlines the steps to be taken during a fire, namely, **R**escue or **R**elocate, **A**larm, **C**onfine, **E**vacuate. Some staff members who testified on this subject were unable to elaborate on the acronym beyond the observation that evacuation of residents was the first priority and only after evacuation could efforts to extinguish a fire be taken. Only one employee was familiar

with the use of a fire extinguisher due to training she received with another organization. The public report issued by OFPC concerning the fire found that fire safety training of new employees *"... has steadily decreased over the years, to approximately 90 minutes."*[1]

There was an fire evacuation plan which provided that the residents were to be taken to a designated safe area which was described as being on the left side of the parking lot outside the facility at a point furthest from the building.

In addition to fire safety training fire evacuation drills were conducted for all employees. We received testimony indicating the drills were to be conducted with sufficient frequency to insure each member of the staff would participate in a drill every month thereby reporting several drills monthly. However, it also appears that the regulatory scheme required that the drills be conducted on a quarterly basis.

Our inquiry into the performance of evacuation drills discovered numerous deficiencies.

From our standpoint, the most significant shortcoming was the manner in which drills were conducted on the overnight (11 pm to 7 am) shift. One of three scenarios would apply to drills on this shift. In some instances the two staff on duty would simulate waking the residents and taking them to the exit. When this was done the employees would go into the bedrooms and estimate the amount of time it should take to get the particular resident out of bed, provide the appropriate assistance with walking or being placed in a wheelchair, and then simulate taking the resident to the exit. On these occasions the residents were not awakened much less

1 Report of the Fire, Building and Life Safety Code Applicability at the Riverview IRA, OFPC, June 4, 2009, p. 23.

evacuated. In a second scenario the drills would be conducted at the pre-arranged times of the night when staff would normally get each resident out of bed to use the toilet but these did not generally include a full evacuation. The third scenario was to conduct the drill after 5 am when the part time workers would arrive and when the residents were being awakened to begin their daily activities. In this instance the two overnight workers would have additional staff to assist in the evacuation. We believe it reasonable to conclude these deficiencies had a significant impact on the events that took place on the night of the fire and we discuss this conclusion later in this report.

Drills conducted on the other two shifts were occasionally done unannounced, but the normal situation had staff being alerted in advance to the drill. The natural result was residents being prepared by the staff in advance of evacuation, thus creating circumstances which would not accurately reflect the actual difficulties which would occur in a real fire.

There was also inconsistency in what type of evacuation was rehearsed during drills. The evidence indicates that it was relatively infrequent for residents to be taken to the safe area in the parking lot. Normal practice was to evacuate to an area near the mudroom. Normal practice was to exit by the main entrance due to ease of gathering residents in a central area. Evacuations by an alternate exit located on the corridor running by the bedrooms were infrequent at best. It should be noted that this corridor was the one protected by the double fire doors which automatically closed when the alarm system activated. By not practicing to use the exit near the bedrooms it became habitual to move residents the longer distance towards

the mudroom, and consequently through the closed fire doors, thus defeating the benefit of this fire safety feature.

In assessing the drills it must be borne in mind that a full evacuation to the outdoors safe area was probably impractical and/or unsafe during periods of inclement or cold weather. The disruption and disturbance to the residents of such evacuations was substantial and often extended in time long after the drill was finished. While these factors may be weighed in mitigation of the failure to conduct full evacuation drills, they should also be considered as important in forewarning OMRDD of the very significant difficulties that would attend an evacuation in a real fire. In addition, by not practicing full evacuations and evacuations by alternate exits, the residents, who required frequent repetition for learning and who are dependent upon habit, were put at greater risk.

It was standard practice for a form to be completed and filed in the office recording the actual performance of each fire drill. The form was supposed to be completed and signed by the senior employee in charge of the drill at or near the time the drill was completed. The form noted, among other things, the time needed for the evacuation and a rating of each resident's responses to the drill, first noting the response to the alarm itself and secondly the response of the residents in the safe area. The possible ratings were as follows:

I - Independent *– Independently responded to the alarm and exited the residence to the safe area and stayed at the safe area.*

V - Verbal *– Required verbal prompts to respond to the alarm and exit to the safe area. Required verbal prompts to stay at the safe area.*

M - Model *– Able to follow the example of others to evacuate to the safe area. Follows the example of others and remains at the safe area.*

P – Physical Prompts *– required physical prompts to respond to the alarm and exit the residence. Required physical prompts to remain at the safe area.*

D – Dependent *– Is totally dependent on the staff for their safe evacuation.*

R – Restive *– Resisted or refused evacuation. Refused to stay at the safe area/attempted to re-enter the residence.*

Our review of the available drill records indicates that in 38 of the 49 drills recorded evacuation was complete in 5 minutes. The maximum evacuation time during any of the drills was 8 minutes and this in only 1 instance. On 3 occasions the drill took 7 minutes, on 3 others 6 minutes was needed, 4 minutes was required on 3 drills and on 1 drill evacuation was accomplished in 3 minutes. Given the wide variations in the manner in which drills were conducted we find it unlikely that these entries represented a realistic reflection of the actual time that would be required during a real fire.

Further, the evaluative entries on residents' responses contain inconsistencies.

The testimony we received also indicated that the forms were not always completed at or near the time of the drill. On at least one occasion when the paperwork on drills was about to be audited employees would be directed to complete and sign the forms to reflect drills that had taken place long before, if at all. In other instances forms purported to have been completed by an employee were not.

We think it important to note that while these records were reported to have been

reviewed by senior supervisory staff as well as by auditors, nobody appears to have questioned or verified them. This is not surprising. Fire safety at Riverview and other OMRDD facilities is reviewed by individuals who are also required to monitor the full range of quality of care provided to residents. The evidence we received indicates that these staff have little training in fire safety and cannot in any sense be considered professionals in the field. In fact, as noted earlier, fire safety professionals who did review the drill reports readily identified issues about them which would have merited further investigation.

4. March 21, 2009

We have been able to learn a great deal about the events of March 21, 2009 at Riverview. But there are gaps and inconsistencies in the evidence currently available to us. We are required by law to confine our findings of fact in this report to those established by a fair preponderance of the legally admissible evidence. We are not permitted to speculate.

A. Origin and Cause of the Fire

An expert witness from OFPC has identified the point of origin for the fire as being on the exterior screened porch located on the rear of the building. This area was accessible from the inside of the building through a door from the dining room. The exterior door of the porch was unsecured thus making it freely accessible from the outside. Several witnesses testified that a green plastic trash receptacle was located on the porch in the corner made by the intersection of the wing where the bedrooms were located and the wing containing the common areas of the residence. There was agreement that this was used by the employees for

paper and similar trash. The OFPC expert specifically determined this trash receptacle as the fire's origin. Indeed, when we visited the site the melted remains of the receptacle, distinctly green in color, were easily visible at the point indicated by the witness.

In addition to the point of origin, the expert also assigned a cause for the fire, namely, human intervention, reckless or intentional. In reaching this conclusion he examined the building and other evidence addressing all possible causes of fire and by a process of elimination excluded all possibilities except human interaction. In essence his finding is that someone did something that introduced the source of ignition in the trash receptacle. Whatever that ignition source was, it was destroyed in the ensuing fire and thus there is no evidence of it which we can identify. Nor is there sufficient evidence before us, direct or circumstantial, which support a finding of who introduced the ignition source, much less whether that act was intentional, reckless, criminally negligent, negligent, voluntary or involuntary. We find the expert testimony to be credible and adopt it as our finding but this is as far as the evidence to date takes us in the question of causation.

B. The Fire and Evacuation

The fire alarm system electronically transmitted an alarm at 5:25:55 am to Albany Protective Services central station monitoring. Two minutes and 19 seconds later the alarm system sent another transmission, "*General Fault Code – Alarm*". This prompted the alarm operator to make a telephone call at 5:28:30 am. He noted that "*sub[ject] notified me there was a fire...dispatched FD.*" We note here that the Fire Code provides that the procedure for

such alarms is for the alarm operator to first notify the Fire Department and then make the call to the facility. We also note that the contract entered into by OMRDD with Albany Protective provided for the initial response being a call to the facility. It is inescapable that the procedure employed on March 21, 2009 resulted in a delay, not only in the dispatch of the Fire Department but also to the evacuation of the residents which was in progress when the call was made and which interrupted that process.

OFPC provided us with a computer simulation of the fire prepared using a model that took into account detailed data about the building. We find it persuasive. It indicated that after the ignition source was introduced into the trash receptacle, it smoldered for several minutes before there was any visible smoke or flames. However, once these became apparent the fire spread rapidly and dramatically. Since the receptacle was adjacent to two of the exterior walls of the building which were constructed with vinyl material, the flames first spread to these flammable materials. Shortly afterward the vinyl materials of the eaves and soffit became involved as did the entire porch roof. By spreading through the eaves and soffit the fire reached the attic where it had a plentiful supply of fuel and oxygen as well as a route to spread throughout the entire roof structure thus bringing the entire building into jeopardy. Given the established presence of heat detectors in the attic it is reasonable to conclude that these devices triggered the alarm system at 5:25:55 am, at or just after the time when fire entered the attic.

Two employees were on duty that night. Their separate accounts of the events

coincided in most respects. However, their evidence differed as to whether the fire was first noticed before or after the alarm sounded. We find the account which indicated the first alert to the fire took place before the alarm sounded to be the more reliable. In this version the evacuation was already underway as the alarm sounded. Of significance was this employee's specific memory of the double doors on the corridor leading to the bedrooms swinging shut while the evacuation was underway. As noted earlier, the alarm was configured so that when it sounded these doors would automatically shut. Further, the same employee testified about answering the phone call from the alarm operator and stating there was in fact a fire in progress. Resolving the conflict in the accounts in this way, we conclude that the evacuation was already in progress by 5:25:55 am.

Both staff members agreed that the evacuation route was to the mudroom exit rather than to the closer exit at the end of the corridor where the bedrooms were located. One employee would bring the residents in turn to a point near the double doors and hand them over to the second who brought them to a mud room near the front exit. During this operation time was taken to answer the phone call from the alarm operator and to retrieve and discharge a fire extinguisher.

While these events were going on the alarm operator telephoned his report of the fire to the Hamilton County Sheriff's Department which performs dispatch duties for the Wells Fire Department. The County dispatcher then transmitted over the radio tones assigned to identify a message for the Wells Fire Department followed by his voice announcement of the particulars

of the report.

The Wells Fire Department is a wholly volunteer organization. Members have radios in their homes which they monitor. One member of the Department lived across the road from Riverview. On hearing the radio message he responded to Riverview on foot, reporting the conditions he observed by a portable radio. It is impossible to be certain of the exact time he arrived at the front exit door of Riverview, but the best estimate is within 3 minutes of the radio dispatch. When he reached the mudroom door none of the residents were outside the building. Working with one of the employees he was able to assist four residents out and away from the building. By this time the second staff member was outside and, with the assistance of the fireman's wife, was able to keep these four residents together and away from the building. Three other residents were still in the mud room, but when the fireman and the staff member turned to lead them out the fire became much worse. At that point the fireman determined it was too great a risk to permit the Riverview employee to re-enter the building. At that point five residents were known to be inside.

Three of these five were almost evacuated. However, when the two staff had to attend to a resident who had fallen or sat on the pavement, the three others reversed direction and retreated into the burning building and they ultimately perished. We submit that this demonstrates the very significant challenge presented in evacuating individuals who do not have self preservation skills. We also submit that these circumstances were reasonably foreseeable.

It was not until the fire was brought under control that any attempts were made to re-enter the building. This was after an interval of around two hours from the time the first fireman reached the scene. One resident was discovered in her bedroom still alive. She survived. The three residents were found barely alive in the mudroom, the location routinely used as a staging area during fire drills, but all three died shortly thereafter from the effects of smoke inhalation. Another resident was found, deceased, in the living room. The sprinkler system remained operable.

5. The Larger Picture

We submit that any analysis of the events at Riverview is incomplete if it fails to consider the larger context. Riverview was not unique. It was only one of approximately 7,000 homes in public and private ownership across New York State in which citizens who are developmentally disabled are supported and cared for. Further, the evidence indicates that a very conservative estimate of the number of structure fires in these facilities is at least one each week.

So when the fatal fire at Riverview is considered we submit it would be a grave mistake to view Riverview's tragedy as an isolated incident. There is a grave, and we believe unacceptable, risk that more lives will be lost unless action is taken by our government to address the systemic shortcomings that affected Riverview and continue to affect every other such residence in our State.

We noted that in the recent past State government responded to the death of four students in another state who died as a result of a fire in their dormitory. Up until that time the

fire code enforcement was left in the hands of the colleges and universities. It was recognized that this function should rest in the hands of fire safety and prevention professionals and legislation was enacted to give real enforcement authority to OFPC. Since then there has been a significant improvement in code compliance in colleges and universities.

As noted previously, the oversight of fire safety in residences like Riverview has been assigned to quality of care personnel who have no specialized training in fire safety and prevention. The record in this investigation is clear that oversight of fire safety practices, including but not limited to staff training, record keeping, realistic drills and evacuation procedures under this system was inadequate. We find that the practices at Riverview were geared to meet regulatory requirements rather than to meeting the actual needs of the residents who were extraordinarily vulnerable to the risk of death in a structure fire. Just as our government saw that fire safety oversight and training should be placed in the hands of professionals in the case of college and university buildings, so we believe should this function be similarly delegated in the case of facilities such as Riverview.

6. Drug Testing

In the course of our investigation we attempted to learn whether or not any of the employees of OMRDD who were directly involved in the events of March 21, 2009 might have been physically or mentally impaired because of drug or alcohol consumption. We have evidence that at least one employee at Riverview was at least an occasional user of marijuana. In pursuing this thread we learned that the only provision at OMRDD for mandated drug or

alcohol testing of employees is when an employee shows up for work visibly impaired. We could not identify any instance where any employee was actually required to submit to such testing. More troubling was the fact that no employees were tested in the immediate aftermath of the fire.

We have noted that current law and regulation provide for the random drug and alcohol testing of individuals such as school bus drivers who are entrusted with the care of vulnerable citizens. In addition to the random tests these individuals are also required to submit to testing in the event of a collision or similar incident.

We submit that the residents of Riverview and other citizens with similar disabilities are highly vulnerable to injury or death should their care be entrusted to someone impaired or intoxicated by drugs or alcohol. We can find no justification for not requiring random drug and alcohol testing for all employees of OMRDD who are involved in the care of residents as well as for mandated testing immediately following any incident which causes injury or death to a resident or which creates a risk of injury or death.

RECOMMENDATIONS

FIRST: We recommend that executive and legislative action be taken to eliminate any and all regulatory exemptions from the provisions of the Uniform Fire Prevention and Building Code for facilities housing or used by developmentally disabled citizens. We can think of no better argument for this recommendation than the statement of legislative findings and purposes in section 371 of the Executive Law which authorized the Code and which we quote and incorporate:

> *"The legislature hereby finds and declares that:*
> *a. The present level of loss of life, injury to persons, and damage to property as a result of fire demonstrates that the people of the state have yet to receive the basic level of protection to which they are entitled in connection with the construction and maintenance of buildings;*
> *b. There does not exist for all areas of the state a single, adequate, enforceable code establishing minimum standards for fire protection and construction, maintenance and use of materials in buildings. Instead, there exists a multiplicity of codes and requirements for various types of buildings administered at various levels of state and local government. There are, in addition, extensive areas of the state in which no code at all is in effect for the general benefit of the people of the state;*
> *c. The present system of enforcement of fire protection and building construction codes is characterized by a lack of adequately trained personnel, as well as inconsistent qualifications for personnel who administer and enforce those codes."*

The Uniform Code should be uniform. Had it been applied during the design and construction of Riverview it appears beyond dispute that it would have been required to have either a sprinkler system in the attic or a roof constructed of fire retardant materials. Had that been the case we believe it highly probable that, at a minimum, the progress of the fire would have been

substantially slowed making time for a successful and full evacuation of residents and staff. Fire safety for developmentally disabled citizens should not be swayed by essentially meaningless labels of residential or institutional, but rather be designed to realistically address the challenges of providing for these highly vulnerable individuals. We believe uniform application of the uniform code is a giant stride in that direction.

SECOND: We recommend executive and legislative action be taken to assign fire safety code enforcement in all facilities, private or public, used or occupied by developmentally disabled citizens to the Office of Fire Prevention and Control. The analogous delegation of this function in the case of college and university buildings has been successful and we see much merit in applying it to facilities such as Riverview. It should be remembered that part of code enforcement is education by the enforcer. We believe this would result in a realistic revision of fire drills and evacuations procedures, better training of the employees who will be called upon in the actual emergency to get residents to safety, and a continuing and independently accountable monitoring of compliance by fully qualified professionals.

THIRD: We recommend executive and legislative action to provide for mandatory drug and alcohol testing of all employees providing support and care for developmentally disabled citizens. This testing should include provisions for random tests as well as testing immediately following any incident which results in injury or death to a resident, or which creates a risk of such injury or death. There should be provision for substantial penalties when results indicate the employee was impaired or intoxicated, including but not limited to fine, incarceration and

loss of employment. Similar penalties should apply for failure to submit to testing. We recommend as a model the provisions of law which apply to holders of Commercial Driver's Licenses.

FOURTH: We recommend executive and legislative action be taken to direct that OFPC have the independent authority to investigate any fire in the state. We note that this authority does not exist in relation to state owned facilities except when requested by the particular state agency in charge of the facility. This broad investigative authority is consistent with the practice of the vast majority of other states and should be granted in New York.

FIFTH: We recommend executive and legislative action be taken to establish the minimal qualifications of all individuals involved in the care of developmentally disabled individuals. These should include specified physical abilities. There should be requirements in place for background checks of all prospective employees, including fingerprinting, as well as mental health evaluations.

SIXTH: We recommend further investigation by outside police agencies of alleged falsified records regarding general training and fire training and fire drill and possible illegal procedures.

CONCLUSION

We have been involved in this investigation for eight months. We are aware of the limitations and unanswered questions. As we come to the conclusion of our business we make one final finding: the work is unfinished. We call on the institutions and agencies of government to continue looking into the events of March 21, 2009. We urge the families of residents, the private and public advocates for the developmentally disabled and the general public to focus attention on the issues we have only been able to identify.

Dated: December 2, 2009

WILLIAM J. HOTALING
Foreperson of the Grand Jury

JAMES T. CURRY
District Attorney
County of Hamilton