SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS

J.H., by his Guardians V.H. and A.H., Plaintiffs, -against- HASC CENTER, INC., DANIEL PERETZ, and OLIVER CAMPBELL, Defendants.	Index No. **COMPLAINT** **JURY TRIAL REQUESTED**

Plaintiffs V.H. and A.H., as co-guardians of their developmentally-disabled adult son, J.H., by and through his attorneys, Emery Celli Brinckerhoff Abady Ward & Maazel LLP, allege as follows for their Complaint:

A NON-VERBAL, DEVELOPMENTALLY-DISABLED ADULT IS BRUTALLY BEATEN AFTER HASC IGNORES A HISTORY OF ABUSE AND NEGLECT

1. On May 29-30, 2022, J.H., a 40-year-old non-verbal man with autism and intellectual disabilities, was brutally beaten while living under the care and supervision of Defendant HASC Center, Inc. ("HASC"), a residential facility for adults with developmental disabilities in Brooklyn. Residence Manager Defendant Daniel Peretz, staff member Defendant Oliver Campbell, and others cared for J.H. there.

2. After the beating, J.H. was taken to a local hospital, where doctors observed extensive bruising all over his body, including deep, fresh bruises to his buttocks, trunk, back, arms, inner thigh, and genitals. J.H.'s bruising was so significant that emergency room physicians diagnosed J.H. with rhabdomyolysis, a life-threatening medical condition that causes the patient's muscles to break down and disintegrate, leading to muscle death.

3. The doctors who treated J.H. at the hospital concluded that J.H.'s injuries reflected physical abuse, including "a solid object striking the patient"; "sustained trauma . . . caused by an object," such as "a board or a paddle"; "striking to the genitalia and repeated force"; and sexual assault.

4. HASC knew J.H. had a documented history of being abused and neglected while under the care and supervision of HASC staff. HASC also knew J.H. was severely developmentally disabled and non-verbal, and was therefore particularly vulnerable to abuse by staff. Accordingly, HASC had developed a one-to-one supervision protocol designed to safeguard J.H. from precisely the scenario that resulted in his brutal beating on May 29-30, 2022.

5. For example, on September 7, 2020, an HASC staff member left J.H. unattended in a car while the staff member went into a restaurant to get something to eat. When the staff member returned, J.H. was gone—he had eloped and was wandering, lost in Brooklyn. A good Samaritan finally found J.H. fifteen hours later, naked, disheveled, and alone on the street, and called EMS. Police then took J.H. to the hospital, where he was kept for two nights before being released back to HASC.

6. On May 14, 2022, J.H.'s sister, E.H., visited J.H. at HASC and discovered injuries to J.H.'s arms that looked "much worse than a bruise . . . , as if there was internal bleeding or significant trauma to the areas." E.H. immediately notified two HASC staff members, who initially ignored E.H. concerns until, after much persistence by E.H., one staff member said he would "tell the nurse." Later that day, E.H. told her mother, Plaintiff V.H., about the injuries. Plaintiff V.H. subsequently called Defendant Peretz and explained to him what E.H. had witnessed.

7. Then, on May 23, 2022, an HASC staff member took J.H. to the shower and, like E.H., observed bruising on both of J.H.'s arms. The staff member notified his colleague, Alexander Lubavin, who took photos of the bruising and sent them to a staff-wide WhatsApp group chat that included Defendant Peretz. The photos were seen by Defendant Peretz and other HASC staff members. This is also a claim in the case.

8. Notwithstanding J.H.'s history of elopement, his mandatory one-to-one supervision protocol, and multiple recent reports of bruising to HASC staff, including Defendant Peretz, HASC and Defendant Peretz took no steps to protect J.H. from further abuse.

9. At the time of the beating during the night of May 29-30, 2022, Defendant Oliver Campbell, an HASC aide, was assigned to provide one-to-one supervision of J.H. Defendant Campbell later claimed to investigators from the New York State Justice Center for the Protection of People With Special Needs (the "Justice Center") that *he did not know who was supervising J.H.* the night of May 29-30, 2022, and that he did "observe redness to [J.H.'s] genitals" on the morning of May 30 but decided not to report it to anyone.

10. On information and belief, the night of May 29-30, 2022, J.H. was brutally beaten by Defendant Campbell, the HASC staff member tasked with providing one-to-one care to J.H.

11. On February 3, 2023, the Justice Center substantiated charges of neglect and physical abuse against Defendant HASC, and charges of neglect against Defendant Campbell.

12. Because of HASC's, Defendant Peretz's, and Defendant Campbell's egregious misconduct, J.H. suffered excruciating physical and emotional pain and suffering, and required emergency medical care.

13. Then, after J.H. was discharged from the emergency room, the New York State Office for People With Developmental Disabilities ("OPWDD") determined that it was unsafe for J.H. to return to HASC due to the abuse. As a result, J.H. was forced to languish in solitary confinement-like conditions, alone in a hospital room, for over *seven months* until his family found a new group home where J.H. could live.

14. Plaintiffs—J.H.'s parents and co-guardians—now bring this suit to hold HASC and its staff accountable for their abuse and neglect of their son, and to ensure that no other family will suffer the same mistreatment they were subjected to at the hands of HASC.

JURISDICTION AND VENUE

15. Personal jurisdiction lies over Defendants as they are present and domiciled in the State of New York.

16. Plaintiff designates Kings County as the place of trial. Under CPLR 503, venue is based on the location where the cause of action arose. Under CPLR 509, venue is based on the county designated by Plaintiff.

PARTIES

17. Plaintiff V.H. is a citizen of the United States and resides in Kings County, New York. She is the mother and co-guardian of J.H.

18. Plaintiff A.H. is a citizen of the United States and resides in Kings County, New York. He is the father and co-guardian of J.H.

19. Defendant HASC CENTER, INC. is a private, not-for-profit corporation incorporated in the State of New York at 6220 14th Avenue, Brooklyn, New York. HASC operates over 30 residential facilities in Kings and Queens Counties for individuals with developmental disabilities, including a facility located at 2173 Coney Island Avenue, Brooklyn,

New York, where J.H. was a resident.

20. Defendant DANIEL PERETZ was at all relevant times the Residence Manager for Defendant HASC's 2173 Coney Island Avenue group home. At all relevant times, Peretz acted within the scope of his employment at HASC. Upon information and belief, Peretz was responsible for training HASC staff to ensure safe services for HASC residents with developmental disabilities. As HASC's Residence Manager, Peretz was required to work diligently in all aspects of the job and to be attentive to the health, safety, and dignity of HASC residents. Above all, he was responsible for keeping those individuals safe. Peretz's failure to follow policies and practices necessary to ensure J.H.'s well-being caused J.H.'s injuries described herein.

21. Defendant OLIVER CAMPBELL was at all relevant times a Direct Support Professional at HASC. At all relevant times, Campbell acted within the scope of his employment at HASC. Campbell was required to work diligently in all aspects of the job and safeguard the health, safety, and dignity of HASC residents. Upon information and belief, Campbell, who was assigned to directly supervise J.H. the night of May 29-30, 2022, failed to protect J.H. and instead brutally physically assaulted and battered him.

22. At all relevant times, Defendants Peretz and Campbell, as well as all of the staff employed at HASC, acted within the regular course of their employment at HASC.

JURY DEMAND

23. Plaintiffs demand trial by jury in this action.

FACTUAL ALLEGATIONS

J.H. – Background

24. J.H. was born in 1982.

25. J.H. has been diagnosed with severe intellectual disability, autism, a mood disorder, and hypothyroidism. He also has a history of an eating disorder.

26. J.H. is mostly non-verbal, and, at baseline, is only able to respond to yes or no.

27. Due to his developmental and intellectual disability, J.H. requires prompts, assistance, and support with his activities of daily living and continuous supervision, including when he is bathing, toileting, and sleeping.

28. Until spring 2003, J.H. lived at home with his parents, Plaintiffs V.H. and A.H.

29. In spring 2003, J.H. moved from his parents' home to the Brooklyn Developmental Center in East New York, an OPWDD facility.

30. In May 2003, J.H. moved from the Brooklyn Developmental Center to HASC's facility at 2173 Coney Island Avenue, where he lived until May 30, 2022.

31. After moving to HASC, J.H. continued to enjoy the love and support of his parents, Plaintiffs V.H. and A.H., and his three sisters.

J.H.'s First Elopement from HASC and Subsequent One-to-One Supervision Protocol

32. HASC's 2173 Coney Island Avenue facility is a "lock down" residence, which means only staff can provide access to enter or exit the facility.

33. Just months after J.H. moved to HASC's 2173 Coney Island facility in May 2003, J.H. eloped from the HASC facility.

34. HASC staff were unable to locate J.H. and, as a result, he spent an entire night alone out on the streets.

35. J.H. was not found until the next morning, when he was spotted alone on the beach in Far Rockaway, Queens.

36. As a result of J.H.'s first elopement from HASC's 2173 Coney Island facility, HASC implemented a supervision policy with respect to J.H., which required HASC staff to supervise J.H. one-to-one 24 hours a day.

J.H.'s September 7, 2020 Elopement from HASC

37. At all relevant times, the HASC employees referred to below worked within the scope of their employment at HASC.

38. On September 7, 2020, an HASC staff member took J.H. on an outing.

39. The HASC staff member escorted J.H. out of the 2173 Coney Island Avenue facility and into a car.

40. The HASC staff member then proceeded to drive J.H. to another location in Brooklyn.

41. During the outing, at approximately 6:30 p.m., the HASC staff member decided to stop at an IHOP restaurant located at 1019 Surf Avenue in Coney Island, Brooklyn, to get something to eat.

42. The HASC staff member left J.H. alone in the car while the HASC staff member was inside the IHOP restaurant.

43. Unsupervised, J.H. left the car and wandered off into Brooklyn by himself.

44. When the HASC staff member returned to the car from the IHOP restaurant, the HASC staff member discovered that J.H. had eloped.

45. The HASC staff member could not find J.H.

46. The HASC staff member then waited approximately *three hours* to call 911 and inform the police that J.H. was missing.

47. Meanwhile, J.H. proceeded to wander around the streets of Brooklyn. He was alone, lost and helpless in the city.

48. Approximately fifteen hours later, a good Samaritan discovered J.H. roaming aimlessly on a Brooklyn street. J.H. was naked, dirty, and visibly upset.

49. The good Samaritan called 911 to report that J.H. was in distress and required medical attention.

50. Paramedics arrived at the scene and found J.H. sweating heavily, mumbling, naked, and "with packs of K2 [synthetic marijuana] next to him" on the street.

51. J.H. was treated at the hospital for two days.

52. During J.H.'s hospitalization, an HASC nurse, Tehlia Perles, told J.H.'s doctors that J.H. had "run away from the [HASC] facility on [September 7, 2020]."

53. Upon information and belief, Ms. Perles told J.H.'s doctors this lie in an attempt to cover up HASC's negligent failure to supervise J.H. during the outing on September 7, 2020.

54. After J.H's hospitalization, he was released back to HASC's care.

Following J.H.'s Elopement, HASC Reminds its Staff in Writing that J.H. Requires 24/7 One-to-One Supervision

55. When J.H. returned to HASC after being abandoned by a HASC staff member and hospitalized, HASC management issued a formal written guidance to staff regarding J.H.

56. HASC's written guidance reminded staff that they "MUST stay with [J.H.] at ALL [t]imes. Even when he is sleeping or in his room. He should not be in anyone's room at ANY time."

57. HASC's written guidance also explained that staff must be sure to supervise J.H. even when the HASC staff assigned to J.H. "need[s] to use the bathroom."

58. HASC's written guidance further stated that staff must remain "within arm's reach of [J.H.] at ALL TIMES both in the house and in the community," including "when he is in his room[,] [a]wake or [a]sleep."

59. HASC's written guidance also directed staff to conduct daily body checks of J.H. and to "call the nurse if you see anything that you had previously not seen."

60. According to the Justice Center, "[b]ody checks are an important tool to assess a person for injuries, illness or possible abuse and neglect. The timing and manner of conducting body checks are key to their effectiveness in safeguarding people receiving services" from facilities for people with development disabilities.[1]

61. Finally, HASC's written guidance explicitly instructed staff to "NEVER put their hands on [J.H.] unless it is an emergency."

[1] New York State Justice Center for the Protection of People With Special Needs, *Spotlight on Prevention: Partnering to Protect People with Special Needs | Best Practices for Body Checks*, https://www.justicecenter.ny.gov/system/files/documents/2023/08/spotlight-body-checks-best-practices-2023.pdf.

On May 14, 2022, J.H.'s Sister Discovers and Reports Severe Bruising on J.H.'s Arms

62. At approximately 3:00 p.m. on May 14, 2022, J.H.'s sister, E.H., visited J.H. at HASC.

63. J.H. was wearing a short-sleeved shirt and E.H. observed "bloody red marks circling both arms that looked really bad."

64. E.H. further observed that J.H.'s injuries looked "much worse than a bruise . . . , as if there was internal bleeding or significant trauma to the areas."

65. E.H. was alarmed and notified two HASC staff members who were present.

66. The two HASC staff members ignored E.H. and "continued reading from the books they were immersed in."

67. E.H. persisted until one of the staff members eventually said he would "tell the nurse."

68. As E.H. was leaving, she also told another staff member about the bruising.

69. Later that day, E.H. told her mother, Plaintiff V.H., about the injuries she had observed.

70. The next business day, Monday May 15, 2022, Plaintiff V.H. called Defendant HASC Residence Manager Daniel Peretz and explained to him what E.H. had witnessed.

On May 23, 2022, an HASC Aide Shares Photos of J.H. Bruises in a Staff-Wide Group Chat

71. By May 23, 2022—just one week after Plaintiff V.H. reported the injuries to Defendant Peretz—the HASC facility's staff was aware of the bruising on J.H.'s arms.

72. As HASC staff member Alexander Lubavin later explained to Justice Center investigators, on May 23, 2022, another HASC staff member took J.H. to the shower and observed bruising on both of J.H.'s arms.

73. The staff member who took J.H. to the shower then notified Mr. Lubavin, who took photos of the bruising and sent them to a staff-wide WhatApp group chat, which included Defendant Peretz.

74. Defendant Peretz later admitted to Justice Center investigators that he had received a photo of "marks" on J.H.'s arms via text message from Mr. Lubavin on May 23, 2022.

75. Another HASC staff member, Endrit Luzi, later independently told Justice Center investigators that he had received the photos of bruising on J.H.'s arms when the photos were shared on the WhatsApp group chat.

76. Yet another HASC staff member, Aziza Ofri, also independently told Justice Center investigators that she too had become "aware that bruises has been discovered on [J.H.'s] arms."

J.H. Is Brutally Assaulted on May 29-30, 2022

77. Upon information and belief, after they became aware of the bruising to J.H.'s arms between May 14 and 23, 2022, HASC and Defendant Peretz did nothing to protect J.H. from further harm.

78. As a result of HASC and Defendant Peretz's inaction, during the night of May 29-30, 2022—just one week after Mr. Lubavin sent the photos of J.H.'s bruises to the staff-wide group chat—J.H. was brutally assaulted at HASC.

79. On the morning of May 30, 2022, HASC staff member Endrit Luzi observed severe bruising on J.H.'s groin and buttocks while J.H. was using the bathroom.

80. Mr. Luzi immediately took photos of the injuries and brought them to the attention of Defendant Peretz.

81. HASC Assistant Supervisor Yitzi Platt later conducted a body check of J.H.

82. According to the statement he later gave to Justice Center investigators, during the body check, Mr. Platt observed a "very large, fresh-looking bruise" on J.H.'s buttocks.

83. HASC staff then called Tehlia Perles, a nurse employed by HASC, and reported the bruising to her.

84. Ms. Perles asked HASC staff for photos of J.H.'s injuries, which she then forwarded to J.H.'s primary care physician to discuss.

85. HASC staff sent Ms. Perles several gruesome photos of J.H.'s injuries.

86. Ms. Perles later recounted to Justice Center investigators that she and J.H.'s physician were both "concerned" by the photos, which depicted deep bruising to J.H.'s buttocks, trunk, back, arms, inner thigh, and genitals.

87. Ms. Perles explained that she and J.H.'s physician were "concerned" by the injuries apparent in the photos "because [J.H.] is on one-to-one supervision at all times, and there was no explanation given about how he had sustained such 'extensive bruising.'"

88. HASC staff member Aziza Ofri also found J.H.'s injuries alarming. She later reported to Justice Center investigators that she had worked in group homes like HASC "for many years, at many different places" and had "never seen anything in her life like the injuries that happened" to J.H.

89. Based on what Ms. Perles and J.H.'s physician observed in the photos of J.H. injuries, they instructed HASC staff to bring J.H. to the emergency room at Maimonides Medical Center ("Maimonides").

Hospital Physicians Conclude that J.H.'s Severe Injuries Were the Result of Traumatic Physical Abuse

90. Upon his arrival at Maimonides on May 30, 2022, J.H. was admitted to the emergency room due to bruising and swelling of his genitalia, and a diagnosis of rhabdomyolysis, which is a breakdown of muscle."

91. Rhabdomyolysis is the result of a large amount of muscle breakdown and can typically result from major falls.

92. Rhabdomyolysis is a life-threatening medical condition that "causes your muscles to break down (disintegrate), which leads to muscle death." The condition is most commonly associated with severe physical injuries or trauma, such as a "severe burn (especially ones that cover a large surface area), electrocution or crushing injury that can cause muscle fibers to break down rapidly."[2]

93. When HASC nurse Tehlia Perles learned that Maimonides doctors had diagnosed J.H. with rhabdomyolysis, she "confirmed that the diagnosis was consistent with the significant bruising she had observed from the photos" she received from HASC staff on May 23, 2022.

94. Ms. Perles later explained to Justice Center investigators that the rhabdomyolysis diagnosis caused her "to become increasingly concerned because rhabdomyolysis is the result of 'a major injury' and it would be unlikely for [J.H.] to sustain such trauma without anyone noticing or having an explanation about how it was caused."

[2] Cleveland Clinic, Rhabdomyolysis, https://my.clevelandclinic.org/health/diseases/21184-rhabdomyolysis.

95. J.H.'s attending physician at Maimonides was Dr. Gerald Casale.

96. Upon examining J.H., Dr. Casale observed "bruising of various stages" but "no bruising however to [J.H.'s] extremities – forearms, hands, thighs, or lower legs."

97. Dr. Casale explained that this lack of bruising to the extremities is significant because "[w]hen an individual falls, they typically extend their arms/hands, or land on their knees, which would case injuries to the extremities."

98. Dr. Casale therefore concluded that J.H. "had no signs of injury that were consistent with a fall/falls."

99. Dr. Casale also observed a "fresh bruise" on J.H.'s trunk, under his right shoulder, as well as a smaller brise in the same area that was already healing.

100. Dr. Casale further observed "a line of smaller bruises" on J.H.'s back and a "rectangular shaped bruis[e] with a very clear, linear marking" on J.H.'s left buttocks.

101. Dr. Casale noted that it "would have been difficult for [J.H.] to self-inflict" these injuries.

102. Dr. Casale further concluded that the bruising to J.H.'s back and buttocks, which included an "atypical presentation of linear formation bruising," "would be *consistent with a solid object striking the patient*."

103. The bruising to J.H.'s buttocks was "most concerning the Dr. Casale" because it was "very medial in its distribution," which indicated that J.H. had experienced "*sustained trauma . . . caused by an object*."

104. Dr. Casale also concluded that it was unlikely that J.H. had sustained these injuries by means other than physical abuse.

105. Dr. Casale explained that if J.H. had fallen or pushed himself against an object or surface "with force," he would have had bruising on "areas where there is a harder surface (for example, near the scapula—a hard bone), instead of on soft tissue."

Hospital Physicians Also Conclude that J.H.'s Injuries Are Indicative of Sexual Abuse

106. Dr. Casale was also concerned that J.H. had been sexually abused because J.H. had swelling and edema to the shaft of his penis and bruising to his buttocks.

107. Dr. Casale found that these injuries were "suggestive of 'striking to the genitalia and repeated force.'"

108. Dr. Casale learned from HASC staff that J.H. purportedly had a history of compulsive masturbation.

109. However, Dr. Casale observed "during [J.H.'s] entire admission to the hospital, he was never observed to engage" in "aggressive masturbation."

110. Likewise, HASC staff members informed Justice Center investigators that they "never observed [J.H.] masturbating in a way . . . that would cause severe bruising," and "did not believe that the frequency or intensity of [J.H.'s masturbation] would have contributed to the severity of the injuries noted on [J.H.'s] genitals or body."

111. Accordingly, J.H.'s treating physicians at Maimonides "determined that [J.H.'s] injuries were not consistent with [rough masturbation]."

112. Dr. Casale and his colleague were so concerned for J.H.'s safety that they decided J.H. "should remain at the hospital for safeguarding" and that it "would be unsafe" for him to "return[] to [HASC], especially because he is non-verbal, and it was apparent that he had been 'victimized.'"

113. A Maimonides social worker then "called the Justice Center out of concern for the injuries discovered" and to express "concern for the safety of the other residents" at HASC.

114. OPWDD's Regional Director then informed Maimonides that "[J.H. is not to return to the [HASC] residence."

The Justice Center Substantiates a Physical Abuse Charge Against HASC

115. Citing these findings from J.H.'s physicians detailed above, the Justice Center ultimately substantiated a charge of Category 4 Physical Abuse against HASC.

116. Under the New York Social Services Law, a Category 4 Physical Abuse charge is appropriate where group home residents "have been abused or neglected, but the perpetrator of such abuse or neglect can not be identified."

117. As the result of its investigation, the Justice Center "determined that [J.H.] sustained an injury of unknown origin as the result of trauma" and "[m]edical records as well as medical and staff interviews supported the fact that the most likely cause of the injury was that it was intentionally inflicted by a custodian"—i.e., an HASC staff member.

HASC Aide Defendant Oliver Campbell's Attempted Cover-Up of His Abuse of J.H.

118. When J.H. was physically abused on May 29-30, 2022, HASC staff member Defendant Oliver Campbell was assigned to provide one-to-one supervision of J.H.

119. The records compiled by the Justice Center demonstrate that, at a minimum, Defendant Campbell neglected, or at worst, intentionally physically abused J.H.

120. During Defendant Campbell's evening shift on May 29, 2022, he failed to complete a daily communications log note entry for J.H.'s mandatory body check.

121. During Defendant Campbell's shift the next morning—the morning of May 30, 2022—he took J.H. to the shower and did not report any injuries, even though J.H. was nude while Defendant Campbell assisted with his bathing and J.H. had fresh, deep bruises all over his arms, back, trunk, leg, buttocks, and genitals.

122. When the Justice Center's investigators later interviewed Defendant Campbell, they asked him about his failure to report a body check the night of May 29 or J.H.'s injuries the morning of May 30.

123. In response, Defendant Campbell told Justice Center investigators that *he did not know who was supervising J.H. on May 29*, even though *he* was assigned that shift.

124. Defendant Campbell also told Justice Center investigators that he only saw "marks" on J.H.'s arms the morning of May 30, but did not report the "marks" to anyone because he had assumed they had been caused by J.H. masturbating.

125. The Justice Center gave no credit to Defendant's Campbell's contradictory, nonsensical attempt to cover up J.H.'s abuse and neglect, and sustained two charges of neglect against Campbell.

126. Upon information and belief, Defendant Campbell—the HASC staff member who was assigned to supervise J.H. during the time when J.H. was physically abused—brutally physically assaulted J.H. by striking him repeatedly on his arms, back, trunk, leg, buttocks, and genitals with a solid object, causing excruciatingly painful, extensive deep tissue bruising and rhabdomyolysis.

J.H. Had No History of Physical Altercations with Peers or of Self-Injury

127. The Justice Center's interview of HASC employees—from managers to aides—make clear that J.H. did not have a history of physical altercations with other HASC residents or of self-injurious behavior.

128. After J.H. was admitted to Maimonides on May 30, 2022, Defendant Peretz told J.H.'s attending physician, Dr. Casale, that there were "no reports of falls, altercations with staff or residents, or other forms of self-injurious behavior" regarding J.H.

129. Defendant Peretz also told the Justice Center that "there is no history of physical aggression between" J.H.'s roommate and J.H.

130. HASC Program Director Eva Hoffman likewise told Justice Center investigators that J.H. "has not exhibited any self-injurious or aggressive behaviors at [HASC], and he has no history of falls."

131. The aides who were tasked with supervising and caring for J.H. on a day-to-day basis also explained to the Justice Center and J.H.'s doctors that J.H. did not harm himself or get into altercations with his peers.

132. Mr. Luzi reported that "J.H. has not been involved in any physical altercations with other residents."

133. Mr. Platt "never observed any behaviors from [J.H.] that would be consistent with the bruising he saw on [J.H.'s] buttocks."

134. Ms. Ofri "has never witnessed [J.H.] engaging in self-injurious behaviors, falling, or being involved in physical altercations with any of his peers."

135. Mr. Lubavin "never witnessed [J.H.] engage in any self-injurious behaviors."

136. Another HASC staff member, Jonah Hartstein, reported that he "never witnessed [J.H.] in a physical altercation with another resident" and "never observed any of the residents being physically aggressive toward him."

137. Mr. Hartstein also "never witnesses [J.H.] engage in self-injurious behaviors or behaviors that could cause injury."

138. HASC staff member Michael Campbell stated that he "never witnesses [J.H.] engaged in an altercation with his roommate or peers."

139. HASC staff member Denzil Murray also "never observed, or had any knowledge of" J.H.'s roommate "being physically aggressive with [J.H.]."

140. Mr. Murray further explained that "there was 'no way' one of [J.H.'s] peers could have been involved in a physical altercation with [J.H.], without staff knowing, since a staff member is always with him."

With Nowhere Else to Live, J.H. Languishes in a Hospital Room for Over Seven Months

141. After J.H. was admitted to Maimonides on May 30, 2022, physicians immediately suspected he had been abused and OPWDD determined J.H. could not return to HASC.

142. Plaintiffs V.H. and A.H., who are elderly, do not have the ability or resources to personally provide the specialized care J.H. requires.

143. Accordingly, J.H. had no other place to live and was forced to stay in a Maimonides hospital room until his family found a new facility where he could live.

144. Resident applicants with developmental disabilities often have to wait months—or even years—to find suitable housing in an OPWDD group home.

145. J.H.'s family diligently searched for a placement for J.H.

146. In the meantime, J.H. languished for months, alone in solitary confinement-like conditions in a decrepit Maimonides hospital room, without air conditioning for much of the summer, and with hospital aides guarding his door.

147. When visiting J.H. at the hospital, his family observed cockroaches in his hospital room and complained repeatedly to hospital staff that the air conditioning was broken.

148. Maimonides is not equipped to care for a severely developmentally-disabled adults for months at a time and, accordingly, J.H. did not receive the programming, education, and therapy he needs.

149. As a result, J.H.'s family saw J.H.'s mental health rapidly deteriorate throughout his stay in the hospital.

150. For example, before J.H. was brutally assaulted at HASC and hospitalized, he was able to respond to some verbal prompts and had a limited ability to communicate with his aides and family.

151. After spending months on end in isolation in the hospital, J.H. lost any ability to respond to verbal prompts and his mood noticeably deteriorated.

152. Finally, on January 22, 2023, Plaintiffs V.H. and A.H. found a placement for J.H. at the Extended Treatment Unit in Queens Village, an OPWDD treatment center for developmentally disabled adults who require a high level of care and observation.

153. J.H. resided at the Extended Treatment Unit until June 24, 2023, when Plaintiffs V.H. and A.H. secured a home for him at Group Home 22, an OPWDD residential facility in Fresh Meadows.

DAMAGES

154. HASC's and Defendant Peretz's reckless, willful, and wanton indifference to J.H., and Defendant Campbell's physical abuse of J.H., led directly to J.H.'s brutal severe physical and emotional injuries, severe pain and suffering, and lasting emotional distress.

FIRST CAUSE OF ACTION
Negligence
(Against Defendants HASC and Peretz)

155. Plaintiffs repeat and reallege as if fully set forth herein the allegations contained in the foregoing paragraphs.

156. Defendants HASC and Peretz owed J.H. a duty of care, a duty heightened by his disabilities and total helplessness. Defendants HASC and Peretz had total control over J.H.'s health, safety, and well-being.

157. Defendants HASC and Peretz breached their duty of care by the foregoing, and by failing to properly supervise J.H. and J.H.'s aides to the degree necessitated by his disability, his particular vulnerability to abuse by HASC staff, and his history of elopement from HASC.

158. Because J.H. was under HASC's sole care, supervision, and control, Defendants HASC and Peretz had a special relationship with J.H. and owed him a duty of adequate supervision.

159. Defendant HASC and Peretz breached this duty by their misconduct set forth above.

160. Defendants HASC and Peretz are further liable under the doctrine of res ipsa loquitur. Where, as here, the injury is one that would not occur without negligence, and J.H.'s disability potentially prevents him from ascertaining the precise cause of his injuries, the

exclusiveness of Defendants HASC's and Peretz's control over J.H.'s person, together with his helplessness, establishes Defendants HASC's and Peretz's liability.

161. Defendants HASC and Peretz breached their duty of care by the conduct listed above, and, *inter alia*, by allowing J.H. to be abused and neglected through their negligent hiring, supervision, training, discipline, and retention of staff at HASC's 2173 Coney Island Avenue group home; failing to detect and remedy the abuse and neglect of J.H.; failing to implement, enforce, and train staff to provide 24/7 one-to-one supervision of J.H., as was necessary given J.H.'s disability; and failing to prevent J.H. from eloping from HASC, a 24/7 lockdown facility. These breaches placed J.H. in continual danger of physical and emotional injury and death.

162. Defendants HASC's and Peretz's breach of their duty of care placed J.H. in continual danger of physical and emotional injury and was the direct and proximate cause of J.H.'s excruciating and unnecessary physical and emotional pain and suffering.

163. As a consequence, J.H. is entitled to compensatory and punitive damages against Defendants HASC and Peretz, as set forth above.

SECOND CAUSE OF ACTION
Assault
(Against Defendants Campbell and HASC)

164. Plaintiffs repeat and reallege as if fully set forth herein the allegations contained in the foregoing paragraphs.

165. As set forth above, on information and belief, Defendant Campbell willfully and maliciously assaulted J.H. in that he had the real or apparent ability to cause imminent harmful or offensive bodily contact and intentionally did violent or menacing acts which threatened such contact to J.H. Such acts caused the apprehension of such contact in J.H.

166. This assault occurred without any fault or provocation on the part of J.H., whom Defendant Campbell was tasked with supervising, and who was at all times relevant severely developmentally disabled, non-verbal, and completely reliant on his aides' care.

167. As a direct and proximate result of the misconduct and abuse of authority detailed above, J.H. sustained the damages herein alleged.

168. As a consequence, J.H. is entitled to compensatory and punitive damages against Defendant Campbell, as set forth above.

169. At all relevant times, Campbell worked for HASC, was in the HASC facility, and was assigned to care for J.H. as part of his duties and responsibilities as a HASC employee.

170. HASC is liable for all of Campbell's conduct under the doctrine of *respondeat superior*.

THIRD CAUSE OF ACTION
Battery
(Against Defendants Campbell and HASC)

171. Plaintiffs repeat and reallege as if fully set forth herein the allegations contained in the foregoing paragraphs.

172. As set forth above, on information and belief, Defendant Campbell willfully and maliciously battered J.H. by striking him repeatedly on his arms, back, trunk, leg, buttocks, and genitals with a solid object, and thereby deliberately touched J.H. or caused J.H. to be touched, and such physical contact was offensive, unwelcome, and without consent.

173. This brutal battery occurred without any fault or provocation on the part of J.H., whom Defendant Campbell was tasked with supervising, and who was at all times relevant severely developmentally disabled, non-verbal, and completely reliant on his aides' care.

174. As a direct and proximate result of the misconduct and abuse of authority detailed above, J.H. sustained the damages herein alleged.

175. As a consequence, J.H. is entitled to compensatory and punitive damages against Defendant Campbell, as set forth above.

176. HASC is liable for all of Campbell's conduct under the doctrine of *respondeat superior*.

FOURTH CAUSE OF ACTION
Victims of Violent Crime Protection Act
N.Y.C. Admin. Code §§ 10-401, *et seq.*
(Against Defendant Campbell)

177. Plaintiffs repeat and reallege as if fully set forth herein the allegations contained in the foregoing paragraphs.

178. Defendant Campbell's acts set forth above constituted a misdemeanor or felony against a person under New York law.

179. Specifically, Defendant Campbell's acts constituted assault in the second degree under N.Y. Penal Law § 120.06, assault in the third degree under N.Y. Penal Law § 120.00, forcible touching under N.Y. Penal Law § 130.52, sexual abuse in the second degree under N.Y. Penal Law § 130.60, and/or sexual abuse in the third degree under N.Y. Penal Law § 130.55.

180. Defendant Campbell's acts presented a serious risk of physical injury to J.H.

181. Defendant Campbell's acts therefore constituted a "crime of violence" pursuant to N.Y.C. Admin. Code § 10-402.

182. As a result of Defendant Campbell's acts, J.H. suffered the damages herein alleged.

183. Plaintiffs are entitled to recover attorneys' fees and costs pursuant to N.Y.C. Admin. Code § 10-403.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that the Court grant them the relief requested as follows:

A. Compensatory damages to be determined at trial;

B. Punitive damages to be determined at trial;

C. Pursuant to N.Y.C. Admin. Code § 10-403, an award of costs that Plaintiffs incurred in this action, as well as their reasonable attorneys' fees, to the fullest extent permitted by law; and

D. Such other and further relief as the Court may deem just and proper.

Dated: New York, New York
November 22, 2024

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