NEW YORK
STATE OF
OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Annual Report to the Governor and Legislature

2015

The Justice Center's Promise to New Yorkers with Special Needs and Disabilities

OUR VISION

People with special needs shall be protected from abuse, neglect and mistreatment. This will be accomplished by assuring that the state maintains the nation's highest standards of health, safety and dignity; and by supporting the dedicated men and women who provide services.

OUR MISSION

The Justice Center is committed to supporting and protecting the health, safety, and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment, and investigation of all allegations of abuse and neglect so that appropriate actions are taken.

OUR VALUES AND GUIDING PRINCIPLES

Integrity: The Justice Center believes that all people with special needs deserve to be treated with respect and that people's rights should be protected.

Quality: The Justice Center is committed to providing superior services and to ensuring that people with special needs receive quality care.

Accountability: The Justice Center understands that accountability to the people we serve and the public is paramount**.**

Education: The Justice Center believes that outreach, training, and the promotion of best practices are critical to affect systems change.

Collaboration: Safe-guarding people with special needs is a shared responsibility, and the Justice Center is successful because it works with agencies, providers, people who provide direct services, and people with special needs to prevent abuse and neglect.

NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

ANDREW M. CUOMO
Governor

March 18, 2016

To the Governor and Legislature:

I am pleased to submit the 2015 Annual Report of the Justice Center for the Protection of People with Special Needs as required by Executive Law §560. See also Correction Law § 401-a (2). The information compiled in this report fulfills the Justice Center's statutory requirements to provide a public account of the agency's work during the preceding year. This report contains, but is not limited to, the following statistics and information that updates the status of the activities undertaken by the Justice Center during 2015 to safeguard vulnerable persons:

- Number of reports received by the Vulnerable Persons' Central Register (VPCR);
- Results of investigations by types of facilities and programs;
- Types of corrective actions taken;
- Results of the review of patterns and trends in the reporting of and response to reportable incidents, and recommendations for appropriate preventative and corrective actions;
- Efforts undertaken to provide training; and
- The State's compliance with the statutory requirements for the provision of mental health services to inmates with serious mental illness in segregated confinement.

Data cited are for the calendar year 2015, unless stated otherwise. Justice Center data is updated monthly and can be found on the agency's website at www.justicecenter.ny.gov.

Respectfully submitted,

Jay Kiyonaga
Executive Deputy Director

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INTRODUCTION

Chapter 501 of the Laws of 2012 established the Justice Center for the Protection of People with Special Needs (Justice Center), an independent state agency dedicated to safeguarding people with special needs and disabilities. The Justice Center's primary focus is assuring that the highest standards of health, safety and dignity are maintained for the approximately one million adults and children who receive services from a facility or program operated, licensed or certified by the state's health, human service and education agencies. In addition to establishing the Justice Center, the "Protection of People with Special Needs Act" created a durable set of consistent safeguards for all vulnerable persons that will protect them against abuse and neglect and to provide fair treatment to the employees upon whom they depend for their care.

To achieve its mission, the Justice Center receives reports of incidents, ensures all allegations of abuse and neglect are thoroughly investigated, and determines, based on the evidence, whether the reported allegations of abuse or neglect are substantiated or unsubstantiated. A central register which contains the names of staff found responsible for the most serious or repeated acts of abuse and/or neglect ensures that these individuals will never again have the ability to care for people with special needs in the service systems under the jurisdiction of the Justice Center. For incidents that are considered criminal in nature, the Justice Center's Special Prosecutor/Inspector General has legal authority to prosecute these cases and provide assistance to local District Attorneys when appropriate.

The Justice Center also works to prevent abuse. Utilizing data from the Vulnerable Persons' Central Register, the Justice Center makes recommendations to facilities and programs for durable corrective and preventive actions to reduce the likelihood of recurrence.

The Justice Center works closely with state and local law enforcement agencies providing education and training to facilitate successful interactions with victims and witnesses with special needs. The Justice Center's Individual and Family Support Unit assists service recipients, who have experienced abuse or neglect, and provides guidance and information to their families and legal guardians to help them better understand the reporting and investigative process. Through its advocacy efforts, referrals and technical assistance, the Justice Center further supports and empowers individuals with disabilities, in all settings.

JUSTICE CENTER JURISDICTION

The Justice Center is responsible for ensuring the safety and well-being of adults and children, who due to physical or cognitive disabilities, or the need for services or placement, are receiving care from certain facilities or provider agencies that are licensed, operated, or certified within the systems of six state oversight agencies. These agencies include:

- Office for People With Developmental Disabilities (OPWDD)
- Office of Mental Health (OMH)
- Office of Alcoholism and Substance Abuse Services (OASAS)
- Office of Children and Family Services (OCFS)
- Department of Health (DOH) (Certain adult homes and summer camps)
- State Education Department (SED) (Residential schools and programs certified by SED)

(Please see: Appendix A for additional information on the Justice Center's jurisdiction.)

INCIDENT MANAGEMENT

Prior to the establishment of the Justice Center on June 30, 2013, there was no mechanism to track abuse or neglect incidents, investigations, or outcomes across state agencies serving people with special needs. The Justice Center now serves as the state's central reporting agency and maintains a database, known as the Vulnerable Persons' Central Register (VPCR), which accepts reports of all incidents and tracks them to completion.

Calls and web-based reports are received 24 hours a day, seven days a week by highly trained call center representatives. The number to contact the hotline is **855-373-2122**. A web-based reporting form for use by mandated reporters is also available on the Justice Center's website.

In 2015, the Justice Center received a total of 48,937 reports of abuse, neglect, or significant incidents.[1] A report may consist of multiple allegations and multiple subjects. Because group reporting is not permitted, multiple reports are often made for the same incident. (Please see: Appendix B for additional information on the Types of Reportable Incidents and Non-Reportable Incidents).

Of the 15,121 reports of abuse and neglect received during the 2015 calendar year, 4,227 were duplicate reports of the same incident, resulting in the reporting of 10,894 distinct incidents of alleged abuse or neglect.

All reports are assessed, classified and logged into the VPCR. Each case is tracked until resolution, with state agencies required to report back their findings to the Justice Center on cases delegated to them for investigation.

[1] Social Services Law § 488 (1)

Table 1. Total Number of Reports made to the VPCR by Phone or Web Form

Type of Reports by State Oversight Agency	2015
Abuse and Neglect	**15,121**
OPWDD	9,301
OMH	2,460
OCFS	2,506
OASAS	294
DOH	99
SED	461
Significant Incident	**33,816**
OPWDD	14,476
OMH	8,373
OCFS	7,347
OASAS	2,413
DOH	355
SED	852
Total	**48,937**

ABUSE AND NEGLECT INVESTIGATIONS AND OUTCOMES

The Justice Center has the authority to investigate allegations of abuse and neglect involving people with special needs and pursue administrative and criminal remedies when the evidence supports a finding that an employee committed abuse or neglect.

Abuse and Neglect

Every allegation of abuse or neglect reported to the Justice Center from June 30, 2013 onward that is under the agency's jurisdiction is fully investigated. This includes both criminal and non-criminal cases.

The Justice Center directly investigates the most serious allegations of abuse and neglect, as well as nearly all alleged incidents of abuse and neglect that occur in state-operated settings.[2]

After the Justice Center receives a report, the appropriate state oversight agency is immediately notified to ensure that protective measures are implemented to safeguard the service recipient(s). If an incident is criminal in nature, the Justice Center notifies the local law enforcement agency and District Attorney's office and either works with the local law enforcement agency and prosecutors on a joint investigation, or the Justice Center's sworn criminal investigators handle the investigation.

RESULTS OF INVESTIGATIONS

Administrative Sanctions

The Justice Center reviews the findings of all investigations of abuse or neglect, including those conducted by a state oversight or provider agency, and makes a finding that such allegations are either substantiated or unsubstantiated. Abuse and neglect allegations may involve one or more subjects and each subject may have multiple allegations that may involve more than one victim. If an allegation of abuse or neglect is substantiated, the subject of the finding has the right to appeal the determination.

Substantiated reports of abuse and neglect are categorized into four categories based on severity. (Please see: Appendix C for additional information on the categories of substantiated findings of abuse and neglect).

The Justice Center is currently in the process of upgrading its data management capabilities which will enable the agency to provide additional context to the data which will make outcomes more transparent. These enhancements will allow the Justice Center to report data by facility or program, residential or non-residential setting, and state operated programs versus voluntary provider agencies.

[2] For Intermediate Care Facilities (ICF), the Justice Center handles the most serious allegations of abuse or neglect.

Table 2. Substantiated Cases of Abuse and Neglect by State Oversight Agency (SOA) for Cases Closed in 2015 (includes incidents reported in 2013, 2014 and 2015)

Total Closed Abuse and Neglect Cases by State Oversight Agency	2015
Total Closed Abuse and Neglect Cases	**13,264**
with at least 1 Substantiated Allegation	**4,296**
OPWDD	3,007
OMH	370
OCFS	713
OASAS	79
DOH	25
SED	102
% with at least 1 Substantiated Allegation	32%

Table 3. Substantiated Abuse and Neglect Allegations by State Oversight Agency (SOA) for Cases Closed in 2015 [3]

Total Substantiated Allegations of Abuse and Neglect by State Oversight Agency		
State Oversight Agency	**Allegations**	**2015**
All Agencies	**Substantiated**	**6,014**
	Total Allegations	18,946
OPWDD	**Substantiated**	**3,948**
	Total Allegations	12,299
OMH	**Substantiated**	**546**
	Total Allegations	2,463
OCFS	**Substantiated**	**1,184**
	Total Allegations	3,276
OASAS	**Substantiated**	**120**
	Total Allegations	293
DOH	**Substantiated**	**34**
	Total Allegations	133
SED	**Substantiated**	**182**
	Total Allegations	482

[3] A case may consist of multiple allegations, multiple victims and multiple subjects.

Table 4. Substantiated Abuse and Neglect Allegations by Severity and State Oversight Agency (SOA) for Cases Closed in 2015

Total Substantiated Allegations of Abuse and Neglect by Severity		
State Oversight Agency	**Substantiated Allegations**	**2015**
All Agencies	**Total Substantiated**	**6,014**
	Category One	148
	Category Two	965
	Category Three	4,487
	Category Four	414
OPWDD	**Total Substantiated**	**3,948**
	Category One	55
	Category Two	508
	Category Three	3,085
	Category Four	300
OMH	**Total Substantiated**	**546**
	Category One	30
	Category Two	98
	Category Three	394
	Category Four	24
OCFS	**Total Substantiated**	**1,184**
	Category One	36
	Category Two	275
	Category Three	804
	Category Four	69
OASAS	**Total Substantiated**	**120**
	Category One	20
	Category Two	37
	Category Three	56
	Category Four	7
DOH	**Total Substantiated**	**34**
	Category One	1
	Category Two	4
	Category Three	22
	Category Four	7
SED	**Total Substantiated**	**182**
	Category One	6
	Category Two	43
	Category Three	126
	Category Four	7

Table 5. Percentage Substantiated Allegations by Offense for Cases Closed in 2015

Total Substantiated Allegations by Offense Type	2015
Neglect	58%
Obstruction	8%
Other	18%
Physical Abuse	13%
Psychological Abuse	2%
Sexual Abuse	1%

Note: Other includes other reportable incidents (e.g., deliberate inappropriate use of restraints, unlawful use of controlled substances, aversive conditioning).

Staff Exclusion List

All subjects of a substantiated report of category one offenses, which include serious or repeated acts of abuse or neglect, are placed on the Justice Center's Staff Exclusion List (SEL). At the close of 2015**, 191 individuals had been placed on the SEL.**[4] This number reflects the total number of individuals who have been barred from working in settings under the Justice Center's jurisdiction since the agency became operational on June 30, 2013. Offenses which have resulted in placement have included: hitting, choking, punching, sexual contact, falsifying records and failure to report serious allegations of abuse or neglect.

Disciplinary Action

The Justice Center represents the State in all administrative proceedings relating to the discipline of state employees found to have committed abuse or neglect. **In 2015, 184 state employees were separated from state service as a result of disciplinary charges brought against them.** In addition, the Justice Center reviewed and approved 657 Notices of Discipline in 2015 which could result in an oral or written reprimand, suspension or termination.

Table 6. Arrests and Criminal Prosecutions Activity

Prosecution Records	2015
Arrests	**89**
Justice Center	17
Other Law Enforcement	72
Prosecutions	**89**
Justice Center	16
Local District Attorney	73

Arrests and Criminal Prosecutions

Allegations that rise to the level of a criminal offense are prosecuted by the Justice Center's Special Prosecutor/Inspector General or the county District Attorney. The Justice Center collaborates with local law enforcement agencies and District Attorneys across the State to bring charges against individuals accused of abuse or neglect involving criminal conduct. If an investigation results in an arrest, either by Justice Center criminal investigators or by other law enforcement agencies, Justice Center prosecutors are empowered to handle all aspects of criminal prosecutions from arraignment to trial or plea bargain. Justice Center prosecutors also provide assistance as

[4] 98 individuals were placed on the SEL, 93 individuals face permanent placement on the SEL pending the outcome of an appeal.

needed to local district attorneys. **The Justice Center is aware of 89 criminal prosecutions that were initiated in 2015, 17 of which were initiated by the Justice Center.**[5]

In addition to criminal penalties, defendants in criminal cases may also be subject to placement on the Staff Exclusion List and face disciplinary action.

Resources for Individuals and Families

The Justice Center provides support for victims of abuse or neglect, their families, personal representatives, and guardians. **In 2015, more than 1,200 individuals and family members contacted advocates for assistance.**

DEATH REVIEWS AND INVESTIGATIONS

Administrators of residential programs licensed, operated or certified by OPWDD, OMH, OASAS and OCFS are mandated to report all deaths of residents to the Justice Center, irrespective of whether the death is unusual or expected. See Executive Law § 557. The purpose of this reporting is twofold: to monitor and examine whether quality of care issues may have contributed to an individual's death and to make recommendations to improve future care of service recipients and prevent the recurrences of similar issues. All deaths subject to this mandatory reporting are referred to as "administrative deaths," and each report is reviewed by the Justice Center's death review unit, which is comprised of investigators with program experience and health care professionals, including registered nurses. Once the death review unit receives a report, an initial assessment is made to determine the need for further information, including, for example: information necessary to verify that the death occurred in a residential program that is required to report an administrative death; and autopsy and/or death certificates. Upon review of this information, the death review unit will:

1. Close the case with a summary report, which is typically based on a determination that the documentary evidence supports that the death was from natural causes. The vast majority of administrative death reports are closed in this manner; or
2. Obtain additional documentation, including clinical information, and consult with the Justice Center's Medical Review Board to determine whether the causes of and circumstances surrounding the death are unusual and/or whether any quality of care issues may have contributed to the death. If so, a full report is made, including recommendations for corrective actions; or
3. Commence a full investigation of the circumstances of any death for which there is reasonable cause to suspect abuse or neglect may have been involved; this type of investigation will result in findings as to whether abuse or neglect can be substantiated by a preponderance of the evidence, and may result in any type of sanction available in any abuse or neglect case (e.g., placement on the SEL, criminal charges, discipline of employee).

In addition to deaths reported to the Justice Center as administrative deaths, mandated reporters are required to directly report, to the Vulnerable Persons' Central Register (VPCR), any death – in both residential and non-residential programs under the Justice Center's jurisdiction – for which they

[5] Prosecutions being handled jointly by the local District Attorney and the Justice Center Special Prosecutor are listed as Justice Center Prosecutions. Arrests handled jointly by Justice Center and local police department listed as Justice Center arrests.

have reasonable cause to suspect abuse or neglect may have been involved. For every death in which abuse or neglect is suspected – whether reported administratively or through the VPCR – the Justice Center notifies local law enforcement and the appropriate District Attorney. These deaths are investigated in the same manner as any other abuse or neglect case.

During 2015, the Justice Center completed 5,291 Administrative Death Reviews across the four agencies required to report administrative deaths.

During the same period, the Justice Center closed 60 abuse and neglect investigation cases in which a death was involved. Of these cases, 28 had at least one substantiated allegation of abuse or neglect, which may or may not have caused or contributed to the death in question. In all of these cases, the Justice Center's Special Prosecutor notified the appropriate District Attorney, and in none of these cases did either the Special Prosecutor or the District Attorneys determine that criminal charges were warranted.

CORRECTIVE ACTIONS

The Justice Center is responsible for monitoring facilities and provider agencies, including their responses to reportable incidents, and is further charged with making recommendations to positively impact the health, safety and welfare of individuals receiving services, and the employees who are entrusted with their care. In addition, the Justice Center visits, inspects, and appraises the management of facilities or provider agencies with specific attention to the safety, security, and quality of care provided to patients and residents.

At the close of an abuse or neglect investigation, state oversight and provider agencies submit corrective action plans to address any identified deficiencies or issues to reduce the probability of recurrence. These actions include remedies to systemic issues such as supervision, lack of staff training, lack of adequate clinical assessments and treatment planning for individuals receiving services. Relevant corrective actions identified include: enhanced supervision, training, policy development, treatment revision and staff termination. The Justice Center assesses the completion of corrective action plans through audits and reviews, including unannounced site visits.

Examples of Notable Findings and Recommendations

Finding – *An agency-wide unwritten procedure required direct care staff to perform numerous invasive body checks every day on individuals receiving services without obtaining informed consent from an individual's parent, guardian or personal representative*.

Recommendation – Ensure invasive body checks only occur for individuals in which this practice is clinically justified and informed consent has been obtained. These practices must also be documented in an individual's clinical record.

Finding – *Restrictive interventions were being utilized as a substitution for treatment and supervision.*

Recommendation – Reassess current supervision levels for service recipients to ensure restrictions are not being utilized for staff convenience.

Finding – *Fire safety training and planning was found to be inadequate. Facility was unable to produce a current evacuation plan. Pre-filled fire drill report forms utilized by the facility did not reflect census of residents currently residing in the facility.*

Recommendation – Develop and implement fire safety training for staff. Develop and implement a fire safety plan to ensure agency compliance. Require staff to compare fire drill report forms with census of residents and include all residents on the forms.

Finding – *Resident records pertaining to dietary regimens, allergies and individual food preferences were incomplete or not updated.*

Recommendation – Develop a process for monitoring and ensuring that all current residents are listed on the Resident Diet Information List, update information as needed and provide to kitchen staff.

ABUSE PREVENTION

Trend Analysis

Analysis of data collected on the types and frequency of abuse and neglect allegations in the Vulnerable Persons' Central Register (VPCR) informs the Justice Center's prevention efforts. This information is used to develop a variety of initiatives to help combat abuse and neglect including the development of toolkits that provide facts, best practices and resources for individuals, family members and provider agency staff to promote abuse-free environments.

An examination of cases revealed many service recipients had been left alone in vans during the summer months when there is a high risk of injury. A "Spotlight on Prevention" Toolkit, which focused on the dangers of leaving service recipients unattended in vehicles was developed. The toolkit includes case studies, an infographic poster, video gallery, and fact sheets for drivers, provider agencies and individuals receiving services, and their families. A vehicle hang tag, which reminds drivers to "Look Before You Leave" a vehicle, was made available free of charge.

Other Prevention Resources

The Justice Center works with state oversight agencies and its Advisory Council to identify and develop prevention resources. (Please see: Appendix D for additional information about the composition of the Advisory Council).

In 2015, the Justice Center established a "Spotlight on Prevention" web portal that provides links to resources for providers, people receiving services and family members. In addition, a multi-agency Prevention of Abuse and Neglect Work Group produced a self-assessment tool for providers to voluntarily evaluate their programs for risk of abuse or neglect. The tool provides resources to mitigate identified areas of risk. The self-assessment tool can be found on the Justice Center's website.

TRAINING INITIATIVES

Protocols for Interviewing People Who Receive Services

Legislation enacted in 2014 required the Justice Center to develop protocols to ensure the safety of service recipients who are interviewed during the course of an abuse or neglect investigation.[6] The Justice Center conducted extensive outreach to relevant stakeholders to educate them about this new requirement and has training materials posted on its website.

Mandated Reporter Training

The Justice Center developed recorded training videos and guidance materials to help mandated reporters understand their critical role in protecting people with special needs by recognizing and reporting suspected incidents of abuse, neglect and significant incidents to the Justice Center. Employees, volunteers, directors and operators of covered facilities and programs and human service professionals are mandated reporters who are required by law to make a report. Mandated reporter training includes information about what the law requires of mandated reporters, definitions, examples of abuse and neglect and provides instructions for making a report. This information is available on the Justice Center's website.

Law Enforcement Training Academy

The Justice Center provides comprehensive disabilities awareness training to state agency investigators and local and state law enforcement agencies on the Justice Center's mission, the

[6] Chapter 394 of the Laws of 2014

victimization of persons with disabilities and information and resources to help officers respond to incidents involving individuals with special needs. In 2015, several law enforcement agencies participated in the Justice Center trainings including: the New York State Police, police departments in Albany, Schenectady, Rotterdam, Coeymans, and Siena College, and the New York Juvenile Officers Association.

Vulnerable Persons' Task Forces

In April 2015, Governor Cuomo announced the formation of the Justice Center's Vulnerable Persons' Task Forces during National Crime Victims' Rights Week. The task forces, which were piloted in four counties: Monroe, Albany, Jefferson, and Nassau, foster cooperation and collaboration with local District Attorney's offices, the Office of the Special Prosecutor, and Inspector General and law enforcement agencies. Through a multi-disciplinary approach, the countywide teams address and enhance the way law enforcement, medical personnel, and social services agencies respond to criminal cases involving people with disabilities and special needs who have been victimized. The teams work to evaluate the training needs of police and prosecutors and help the Justice Center identify specialized curricula.

Forensic Interviewing Training

A training entitled *Forensic Interviewing Best Practices for Vulnerable Populations* developed by the Justice Center and presented by national and statewide experts in the fields of forensic interviewing and disabilities was launched in the fall of 2015. Participants at the training sessions learned proven methods for interviewing vulnerable New Yorkers in the most non-traumatic way possible to gather credible information that will stand up to judicial scrutiny. The multi-day course and certification will be expanded statewide in 2016, with additional trainings planned throughout the year.

Training for Justice Center Investigators

The Justice Center developed and implemented extensive training for the agency's investigators to ensure standardized investigative methods and procedures are followed. Curriculum offerings include the investigation process, working with special populations, legal issues, crime scene handling, physical evidence, documentation, and the formal protocols for interviewing people receiving services.

Direct Support Professional (DSP) Outreach

The Justice Center and the National Alliance for Direct Support Professionals (NADSP) held 10 forums across the state with direct support professionals in 2015. The Justice Center's reporting and investigation processes, and abuse prevention efforts were discussed at each forum and direct support professionals shared their perspectives and experiences with the Justice Center. Direct Support Professionals attending the forums also provided suggestions for improving the support and protection of the health, safety and dignity of people with special needs. The Justice Center will continue outreach to the Direct Support Workforce in 2016.

SPECIAL HOUSING UNIT (SHU) COMPLIANCE

The Justice Center monitors compliance with Chapter 1 of the Laws of 2008, the Special Housing Unit (SHU) Exclusion Law. The Justice Center does this by monitoring and making recommendations regarding the quality of mental health care provided to inmates with a serious mental illness, including those who are in a residential mental health treatment unit or segregated confinement (also known as a Special Housing Unit or SHU) in facilities operated by the Department of Corrections and Community Supervision (DOCCS). The Justice Center is assisted in this endeavor by the Psychiatric Correctional Advisory Committee (PCAC).

The Justice Center **completed SHU Compliance and Quality of Mental Health Care reviews at 18 state correctional facilities in 2015.** During the course of these visits to state correctional facilities, **2,686 inmates were seen and 975 inmates' records were reviewed** to determine compliance with the SHU Exclusion Law. These reviews seek to ensure that all inmates in segregated confinement receive mental health screenings, including suicide assessments, and treatment as required by law. During 2015, the Justice Center also completed one mental health service review of an unusual or suspicious death of an inmate. The purpose of these reviews is to ascertain the quality of mental health care provided to the inmate prior to his or her death.

Several of the recommendations made by the Justice Center have been implemented by OMH and DOCCS including reducing the punitive culture of crisis treatment programs operating in state correctional facilities, gathering information from family members and community service providers to support treatment while in correctional facilities, and improving the process that results in a termination of mental health services for inmates.

On December 16, 2015 Governor Andrew M. Cuomo announced a groundbreaking agreement that will transform the Department of Corrections and Community Supervision's use of SHU in New York State. The implementation of the agreed upon reforms will bring about fair and appropriate changes in how we use special housing in New York State.

PRE-EMPLOYMENT BACKGROUND CHECKS

Criminal Background Checks

The Justice Center reviews and evaluates the criminal history information of all prospective employees or volunteers and advises service providers about the individual's suitability for employment.[7] This comprehensive screening which includes the ability to request and review information contained in FBI identification records provides an additional safety net for individuals receiving services and their families and mitigates risk for employers**. In 2015, of the more than 11,000 applicants who had a criminal history, 626 individuals had records of concern, and 285 were denied employment** for convictions that ranged from physical abuse to rape and murder and were denied approval for employment consideration.

Table 9. Pre-Employment Criminal Background Checks

Criminal Background Checks	2015
Fingerprints Processed	**85,821**
OPWDD	59,954
OMH	18,462
OCFS	7,405
Applicants Reviewed	**11,010**
Denied Approval for Employment Consideration	**285**
OPWDD	145
OMH	89
OCFS	51

[7] In accordance with NYS Correction Law Article 23-A, individuals who have been convicted of one or more criminal offenses are given an opportunity to provide evidence of rehabilitation and good conduct.

Table 10. Pre-Employment Checks of the Staff Exclusion List

SEL Checks Performed	2015
Total	**244,692**
OPWDD	77,709
OMH	34,096
OCFS	99,003
OASAS	20,220
DOH	6,172
SED	7,492

Staff Exclusion List (SEL) Checks

Employers must check the Staff Exclusion List (SEL) before hiring an employee, administrator, consultant, intern, volunteer or contractor**. In 2015, the Justice Center performed 244,692 SEL checks.** Sixteen individuals on or pending placement on the SEL sought employment with 24 provider agencies that were advised of the applicant's placement or pending placement on the SEL which would prohibit them from working in any state operated, certified or licensed agency that serves people with special needs.

CONCLUSION

Under the direction of Governor Andrew M. Cuomo, the Justice Center has made significant progress in its efforts to transform the system that provides services and supports to people with special needs across the state. This agency has helped foster a culture of care that emphasizes safety, respect and dignity. While much has been accomplished over the two-and-a-half years since the Justice Center began operations, more needs to be done. The agency will continue to work closely with individuals receiving services, families, state and private provider agencies, local law enforcement agencies and other stakeholders to achieve our shared obligation to support and protect those in our care.

APPENDIX A

The Justice Center oversees facilities and provider agencies within the systems of six State Oversight Agencies (SOA):

Office for People With Developmental Disabilities (OPWDD)

- Facilities and programs that are operated or certified by OPWDD

Office of Mental Health (OMH)

- Facilities and programs that are operated or licensed by OMH

Office of Alcoholism and Substance Abuse Services (OASAS)

- Facilities and provider agencies that are operated, certified, or licensed by OASAS

Office of Children and Family Services (OCFS)

- Facilities and programs operated by OCFS for youth placed in the custody of the Commissioner of OCFS
- OCFS licensed or certified residential facilities that care for abandoned, abused, neglected, and dependent children, Persons in Need of Supervision, or juvenile delinquents
- Family-type homes for adults
- OCFS certified runaway and homeless youth programs
- OCFS certified youth detention facilities

Department of Health (DOH)

- Adult care facilities licensed by DOH that have over 80 beds, and where at least 25 percent of the residents are persons with serious mental illness and where fewer than 55 percent of beds are designated as Assisted Living Program (ALP) beds
- Overnight, summer day and traveling summer day camps for children with developmental disabilities under the jurisdiction of DOH

State Education Department (SED)

- New York State School for the Blind
- New York State School for the Deaf
- State-supported (4201) schools, which have a residential component
- Special act school districts
- In-state private residential schools approved by SED

APPENDIX B

Types of Reportable Incidents

Abuse
Abuse is an action by a custodian against a service recipient. There are seven categories of abuse**:** physical abuse; sexual abuse; psychological abuse; deliberate inappropriate use of restraints; use of aversive conditioning; obstruction of reports of reportable incidents; and unlawful use or administration of a controlled substance.

Neglect
Neglect is any action, inaction, or lack of attention that breaches a custodian's duty, and that results in or is likely to result in death, physical injury, or serious or protracted impairment of the physical, mental or emotional condition of a service recipient.

Most commonly, neglect is the result of a custodian's lack of attention or failure to act as required by his or her responsibilities. Neglect can include, but is not limited to: failure to provide proper supervision; failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care; and failure to provide access to educational instruction.

Significant Incident
Any incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation, may result in, or has the reasonably foreseeable potential to result in harm to the health, safety or welfare of a person receiving services.

Types of significant incidents identified in statute:

1. Conduct on the part of a custodian that is inconsistent with an individual's treatment plan, educational program, or generally accepted treatment practices.
2. Conduct between persons receiving services resulting in harm or the potential for harm.
3. Any other conduct identified in regulations of the State Oversight Agencies.

Other Reportable Incidents
Reportable Incidents also include allegations of fiscal misconduct, and the deaths (not abuse or neglect), of all individuals receiving services from a residential facility or residential program operated by the Office for People with Developmental Disabilities, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services and the Office of Children and Family Services.

Non-Reportable Incidents
In 2015, an additional 36,890 reports received by the Justice Center were non-reportable incidents. These calls are either not an incident because the nature of the allegation does not meet the definition of a reportable incident, or an incident which occurred in facilities and programs that are outside of the agency's jurisdiction. Efforts are made to direct callers of non-reportable incidents to an appropriate entity for assistance.

APPENDIX C

Categories of Substantiated Allegations

Substantiated reports of abuse or neglect are categorized into one or more of the following four categories:

Category 1 conduct is: serious physical abuse, sexual abuse or other serious conduct by custodians.

Category 2 conduct is: abuse or neglect that is not included in Category 1, but is conduct by a custodian that *seriously endangers the health, safety or welfare* of a service recipient.

Category 3 conduct is: conduct that is not included in Category 1 or 2, but is nevertheless, abuse or neglect.

Category 4 conduct refers to: conditions at a facility or provider agency that expose service recipients to harm or risk of harm but where staff culpability for such abuse or neglect is mitigated by systemic problems, such as inadequate staffing, management, training or supervision. It also applies when abuse or neglect against a service recipient has been substantiated but the responsible person cannot be identified.

Substantiated Determination Consequences

If an allegation of abuse or neglect is substantiated, the subject of that finding has a right to appeal the determination before an administrative law judge.

- **Category 1 Substantiated Findings**: Individuals who have an allegation substantiated in a case of abuse or neglect-- either a single "Category 1" offense or two or more "Category 2" offenses over a 3-year period -- are placed on the Justice Center's Register of Substantiated Category 1 Case of Abuse or Neglect, also known as the Staff Exclusion List (SEL). Individuals on the SEL are prohibited from being hired by most state operated, certified or licensed agencies or providers that serve people with special needs. Placement on the SEL is permanent.

- **Category 2 and Category 3 Substantiated Findings**: Substantiated Category 2 findings that are not elevated to a Category 1 finding and all Category 3 findings are sealed after five years.

APPENDIX D

Justice Center Advisory Council Members

William T. Gettman — St. Catherine's Center (Chair)

Mary E. Bonsignore — Parent Advocate, Bronx Developmental Disabilities Council

Norwig Debye-Saxinger — Therapeutic Communities Association

Eva S. Dech — Intentional Peer Support

S. Earl Eichelberger — NYS Catholic Conference

Denise A. Figueroa — Independent Living Center of the Hudson Valley

Shirley B. Flowers — Parent

Tanya L. Hernandez — Parent, Families CAN!

Leslie A. Hulbert — Parent

Walter J. Joseph, Jr. — Children's Home of Poughkeepsie

Ambassador Alfred Kingon — Parent

Jeremy E. Klemanski — Syracuse Behavioral Health Care

Ronald S. Lehrer — NYS Association of Boards of Visitors

Belinda Lerner — National Football League

Glenn Liebman — Mental Health Association in New York State

Delores Fraser McFadden — Orange County Department of Mental Health

Judith A. O'Rourke — Parent

Clint Perrin — Self Advocacy Association of NYS

Peter Pierri — InterAgency Council of Developmental Disabilities Agencies, Inc.

Susan Platkin — Parent, NY Self Determination Coalition

Harvey B. Rosenthal — NY Association of Psychiatric Rehabilitation Services (NYAPRS)

Scott Salmon — Self Advocate

Mary K. St. Mark — Parent Advocate and board president, Institutes for Applied Human Dynamics

Euphemia Strauchn-Adams — Parent, Families on the Move

Robert L. Weisman, DO — Strong Memorial Hospital