NEW YORK
STATE OF
OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Annual Report to the Governor and Legislature

2022

161 Delaware Avenue, Delmar, New York 12054
518-549-0200
www.justicecenter.ny.gov

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 people 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: Safeguarding 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

KATHY HOCHUL
Governor

DENISE M. MIRANDA
Executive Director

March 13, 2023

To the Governor and Legislature:

I am pleased to provide you with the 2022 Annual Report of the Justice Center for the Protection of People with Special Needs, as required by Executive Law § 560 and Correction Law § 401-a (2). This report summarizes the agency's activities and accomplishments from January 1, 2022, through December 31, 2022. It includes, but is not limited to, the following statistics and information:

- 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
- Description of the Justice Center's efforts to monitor the state's compliance with the statutory requirements relating to segregated confinement and residential rehabilitation units as well as the provision of mental health services to incarcerated individuals, including those with serious mental illness in segregated confinement

Additional information about the Justice Center can be found on the agency's website at www.justicecenter.ny.gov.

Respectfully submitted,

Denise M. Miranda, Esq.

Executive Director

Table of Contents

I. EXECUTIVE SUMMARY

The Justice Center for the Protection of People with Special Needs continues to hone the tools it uses to protect the health, safety, and dignity of all people with special needs and disabilities. This is done in a variety of ways, including: developing abuse prevention tools, providing education to stakeholders on Justice Center operations, and ensuring high-quality investigation of all allegations of abuse and neglect.

To achieve its mission, the Justice Center standardized the state's systems for incident reporting, investigations, disciplinary processes for state employees, corrective and preventive actions and pre-employment background checks. The outcome of these activities is outlined in this report. In addition, the Justice Center has implemented several strategic initiatives to improve agency functions and address concerns with agency stakeholders. These initiatives ensure the Justice Center is protecting New York's most vulnerable citizens while also supporting the dedicated people who care for them.

II. HISTORY AND JURISDICTION

The Protection of People with Special Needs Act (Ch. 501, L. 2012) established the Justice Center for the Protection of People with Special Needs as an executive agency responsible for protecting the safety and well-being of the approximately 1 million 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 agencies. These agencies include:

- Office for People with Developmental Disabilities (OPWDD)
- Office of Mental Health (OMH)
- Office of Addiction Services and Supports (OASAS)
- Office of Children and Family Services (OCFS) (State-operated programs/facilities and certain residential programs)
- Department of Health (DOH) (Summer camps and adult homes that meet certain criteria)
- State Education Department (SED) (Certified residential schools and programs)

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

The agency, which became operational on June 30, 2013, serves as the state's central repository for all reports of allegations of abuse, neglect and significant incidents involving vulnerable individuals as defined in Social Services Law (SSL) § 488(1). The Justice Center maintains a case management system that tracks all reported cases of abuse and neglect to resolution, ensures all allegations are fully investigated, and makes final legal determinations on all allegations. The Justice Center's Special Prosecutor/Inspector General works with county district attorneys to prosecute allegations that are criminal in nature. The Justice Center's Individual and Family Support Unit provides guidance, information, and support to victims and their families throughout the investigative process.

Through its oversight and monitoring activities, the Justice Center identifies durable corrective and preventive actions to address the conditions that cause or contribute to the occurrence of abuse and neglect. In consultation with its Advisory Council, the Justice Center also works collaboratively with a broad array of stakeholders to promote

prevention strategies and to develop guidance and tools to help facilities and programs better protect people receiving services. (Please see: Appendix D for information about the composition of the Advisory Council.)

The Justice Center operates with a staff of nearly 500 committed professionals. The agency's front-line staff, which includes call center representatives, investigators, attorneys, and individual and family support advocates have collectively accumulated decades of experience working with special populations at state and private provider agencies and in other service systems prior to joining the Justice Center.

The activities and accomplishments highlighted in this report reflect the work of the Justice Center in partnership with state agencies, non-profit provider agencies, and individuals and families who effectively promote positive change. These changes have resulted in a system of care where people who receive services are treated with dignity and respect and those who provide services and supports are valued and supported.

III. 2022 HIGHLIGHTS AND INITIATIVES

❖ *New Prevention Materials*

The Justice Center regularly produces materials that can be used by providers and staff members to prevent abuse and neglect from occurring. In 2022, the agency created the *Spotlight on Prevention* toolkit "Medical Emergencies." It makes clear that a timely and well-executed response to medical emergencies prevents delays in critical care and potentially catastrophic consequences. The materials include a guide to recognizing medical emergencies, recommended staff actions, training tips, case scenarios for training, and many other resources. This toolkit is available on the Justice Center's website. The Office for People with Developmental Disabilities has shared it widely with providers and internally across its units.

❖ *Virtual Reality Video Training*

The Justice Center consistently looks for opportunities to leverage new technologies to enhance all agency functions. In 2022, the agency produced a virtual reality training video that will be used as part of the agency's year-long investigator training program. The video scenario immerses viewers in a residence as an individual receiving services leaves without consent. Several critical factors contribute to this outcome. The video plays in a headset that offers a 360° view for investigators so they can fully assess the situation. They are then tasked with identifying the issues and outlining how they would proceed in their investigation.

❖ *Stakeholder Engagement*

The Justice Center believes engagement with stakeholders is a key to success. In April, the agency held eight webinars, providing information on a variety of topics including policy updates, trends, prevention tools, and investigative techniques. More than 1,000 people from 53 counties registered. Attendees included family members, peer advocates, staff from state agencies, private providers, and local government, the Board of Visitors, and Disability Rights N.Y.

Additionally, the agency engaged in a series of small group sessions with service providers. Agency representatives answered questions about business processes and discussed how the Justice Center can help alleviate concerns, particularly with the workforce. These sessions will continue in 2023.

❖ *Key Performance Indicators*

The Justice Center uses metrics to assess agency operations and identify areas in need of improvement. In 2022, Key Performance Indicators (KPI) were introduced across all units. A KPI is a quantifiable measure of achievement for a specific goal. Each unit of the agency identifies strategic objectives that will be measured on an annual basis, then determines how best to measure the success of these goals, and finally sets targets for the year ahead. Developing KPIs will provide managers with a new tool to help manage the success of their operations. KPIs will be evaluated, at minimum, on an annual basis with new goals developed each year.

❖ *LinkedIn Launch*

The Justice Center has made recruiting and retaining a diverse workforce a top priority. The agency created a LinkedIn page to expand the reach of agency job postings. It features testimonials from current employees, photos of agency offices and events, and information about working at the Justice Center. The agency also uses the page to highlight the Justice Center's proactive training and educational efforts. One of the most popular posts of 2022 showcased the Justice Center's work with an international team focusing on child welfare research.

❖ *Do Good, Feel Good*

Justice Center staff members recognize that achieving the mission of everyone being treated with dignity and respect means the agency must go above and beyond its core functions. That's why the agency launched its "Do Good, Feel Good" initiative. It encourages staff members to take part in events that support their surrounding communities. In 2022, staff members helped host a Halloween event for children living at a residential center, packed backpacks with food for the weekend, and helped stuff a bus with toys for children in need during the holiday season. The Justice Center aims to expand this initiative in 2023.

IV. WORKFORCE AND STAKEHOLDER OUTREACH

The Justice Center makes protecting the rights of the dedicated workers who provide direct care to vulnerable individuals a top priority. The agency also recognizes its responsibility in supporting victims in an investigation. As such, the Justice Center has developed several initiatives to support the workforce, providers, families, and other stakeholders.

❖ *Individual and Family Support*

The Justice Center provides guidance and support to victims of abuse or neglect, their families, personal representatives, and guardians throughout the course of an investigation. Nearly 19,000 individuals and family members have contacted advocates for assistance since 2013. In 2022, 3,303 individuals and family members were provided with advocacy support.

Advocates provide information about the reporting and investigative process, case status updates, and records access. In 2022, the Justice Center provided assistance to individuals and families regarding records access 779 times.

The Justice Center advocates may also accompany victims to interviews or court proceedings. In 2022, advocates provided victim and witness accompaniment in Justice Center-led investigations on more than 500 occasions. Justice Center advocates can also help with questions or concerns involving State Agencies.

The Justice Center attends conferences and informational events throughout the state, offering materials and answering questions about the agency. Advocates presented at or participated in 27 such events in 2022.

Virtual conference appearances have allowed more people to be able to participate in Justice Center outreach events. Over the past year, the Justice Center provided valuable information and education to external stakeholders on the investigative process and the role of the advocate. The agency did this by offering multiple virtual family engagement sessions with more than 500 people taking part.

In addition to these responsibilities, the Justice Center is part of the multi-agency Trauma Champions Collaborative (TCC), led by the Division of Criminal Justice Services (DCJS) to advance the integration of trauma-informed practices in state agencies and in community-based organizations throughout the state.

❖ *Champion and Code of Conduct Awards*

The Justice Center understands the importance of recognizing individuals who demonstrate a commitment to people with special needs. The agency has created two awards: the Justice Center Champion Award and the Justice Center Code of Conduct Award. This year was the sixth consecutive annual award presentation.

The Champion Award honors New Yorkers who have displayed exemplary dedication to people with special needs. The honorees in 2022 included a

Surrogate Decision-Making Committee member who served for more than two decades and took part in more than 600 hearings, a restraint expert from New York City's Administration for Children's Services, an educator who has worked with the Justice Center on helping staff deal with vicarious trauma, and a Mental Hygiene Legal Services employee who designed a process that has expedited removing dangerous staff from the workforce.

The Justice Center also spotlights staff at provider agencies who display a strong commitment to the Code of Conduct and serve as an inspiration to their colleagues. We understand the impact staffing shortages are having across the direct care workforce, which makes these awards even more meaningful. In total, six individuals were presented with the Justice Centers Code of Conduct award. Each exemplifies the highest standard of direct care and shows the State how one person can make a difference in someone else's life.

As part of the Justice Center's presentation of the Code of Conduct Awards, the agency produced a video featuring messages of gratitude and appreciation from the Commissioners of several State Agencies as well as photos of direct care workers.

❖ *Stakeholder Briefings*

The Justice Center spends considerable time engaging with provider agencies, the direct care workforce, family members, local government, and other interested stakeholders. The agency understands that partnerships formed with these stakeholders are crucial to the success of the Justice Center. In 2022, the agency conducted more than 60 presentations, the majority of which were to provider agencies under the Justice Center's jurisdiction as well as their staff. The Justice Center also conducted outreach presentations to local government agencies, attorneys, and people receiving services and their families.

❖ *TRAID Program*

The Technology-Related Assistance for Individuals with Disabilities (TRAID) Program provides access to assistive technology to any New Yorker with a disability through Regional TRAID Centers. These centers provide device loans and hands-on training to people with disabilities. The Justice Center administers TRAID through grants from the US Department of Health and Human Services Administration for Community Living (ACL), the NYS Department of Health, and ACCES-VR to 12 Regional TRAID Centers. A variety of devices are loaned out for use in different settings such as at home, school, or work.

The 12 regional TRAID Centers demonstrated 1,233 devices to 2,216 people in the 2021-2022 data year. Demonstrations are conducted when staff show individuals two or more similar devices so the individual can ask questions, compare specifications, and make an informed choice on what might work best for them. Sometimes individuals choose to borrow the devices to try them in real world settings like home, school, or work.

The TRAID Centers provided 6,666 short-term assistive technology device loans to 4,690 individuals. A short-term loan is typically for 60 days or less. These give

individuals the opportunity to try out a device before purchasing it and provides access to devices that may only be needed for a short period of time.

If an individual needs a device for longer than 60 days, then TRAID staff can provide a long-term loan. TRAID receives donated devices from members of the community, after which they clean the devices and give them to individuals who need them long-term. The TRAID Centers loaned 4,109 devices to 2,673 individuals. Because individuals are sometimes able to receive donated devices rather than spending money on a new one, cost-savings is calculated. The cost-savings in 2021-2022 was $946,188.47.

The 2022 data year saw the introduction of 3D printing as a trackable activity for the TRAID Centers. The benefits of 3D printing include new options for customizations and cost savings. Devices that have been 3D printed include adaptive nail clipper holders, zipper pulls, bag holders, utensil grips, sensory devices, and keyguards. These devices are usually given to borrowers to keep. Most of the TRAID Centers have invested in 3D printers, which has benefited individuals of all ages across New York and resulted in a cost-savings of $5,107.

Examples of how the TRAID program helps people include:

- A regional TRAID Center lent equipment to the parent of a young child that provided the child with an opportunity to get a shower and engage in waterplay like other children do in the summer heat. The equipment loaned from the TRAID Center provided the child with an opportunity to perform tasks crucial to everyday health such as standing, bearing weight and working on ambulation. Additionally, it helped the parent support her daughter with these tasks without injury to herself.
- A former water ski instructor who, due to early onset of dementia, had been unable to go into the water or go swimming for almost seven years. His family contacted TRAID to see if there were devices that could help, and he was able to borrow a water wheelchair. This device improved his quality of life by allowing the man to spend his summer days in the water at his home safely and with support for the limitations he was experiencing due to his diagnosis.

V. TRAINING AND SAFETY IMPROVEMENTS

The Justice Center believes that outreach, training, and the promotion of best practices are critical to affect systemic changes. That is why the agency has made a substantial investment in training of both internal staff and external stakeholders. The Justice Center offers a variety of training and support materials to ensure the health, safety, and dignity of people with special needs. These include Forensic Interviewing Best Practices for Vulnerable Populations, Code of Conduct and Maintaining Professional Boundaries.

❖ *State Oversight Agency Collaborative Trainings*

The Justice Center is mandated to provide investigation training to state and provider agency staff. In 2022, we provided four, three-day *Investigation Basics* trainings, which were attended by 350 provider and state agency investigators. The agency has also continued its online training series covering investigative topics such as learning how to follow the Justice Center investigative strategy memo, use of photographic evidence, keys to effective interviews, and investigating injuries of unknown origin. The series was presented to more than 400 state and provider agency staff. In addition, the Justice Center created a professional boundaries training, which is now approved for CASAC credits. This training was offered three times to 60 staff from OASAS and OASAS-licensed and certified programs throughout the year.

❖ *Justice Center In-Service Training*

As part of the Justice Center's commitment to continuous improvement, the agency offers an annual in-service training for all investigators and members of other business units. This year's in-service theme was "*In Pursuit of Excellence"*. The training included the following topics:

- Ins and outs of the employee discipline process
- Metrics and motivating with metrics
- Time management tips
- Conducting effective interviews with medical professionals
- Navigating challenging interactions

In total, more than 280 Justice Center staff attended the training.

VI. ABUSE PREVENTION AND QUALITY IMPROVEMENT

One of the missions of the Justice Center is to develop tools to help prevent mistreatment of individuals with special needs. There are several ways the agency works toward the *prevention* of abuse and neglect. Examples include pre-employment checks to ensure the safety of both individuals receiving services and the workforce, data analysis to look for trends, issue guidance on how to stop practices that might endanger vulnerable populations, and quality improvement reviews. The Justice Center's actions encourage provider agencies, people receiving services, and staff members to take a proactive approach to establishing safe, supportive and abuse-free environments.

i. Prevention

A. Criminal Background Checks

The Justice Center reviews and evaluates the criminal history of all prospective employees or volunteers applying for jobs at provider agencies under its jurisdiction and advises about the individual's suitability for employment. This comprehensive review

provides a safety net for individuals receiving services while at the same time mitigates risk for employers and the dedicated workforce.

Criminal Background Checks, Fingerprints Processed & Applicants Reviewed

Criminal Background Checks	2022
Total Fingerprints Processed	**100,150**
OPWDD	68,090
OMH	22,015
OCFS	10,045
Total Applicants Reviewed	**11,429**
Applicants Flagged for More Information	**785**
Denied Approval for Employment Consideration	**291**
OPWDD	178
OMH	61
OCFS	52

B. Staff Exclusion List

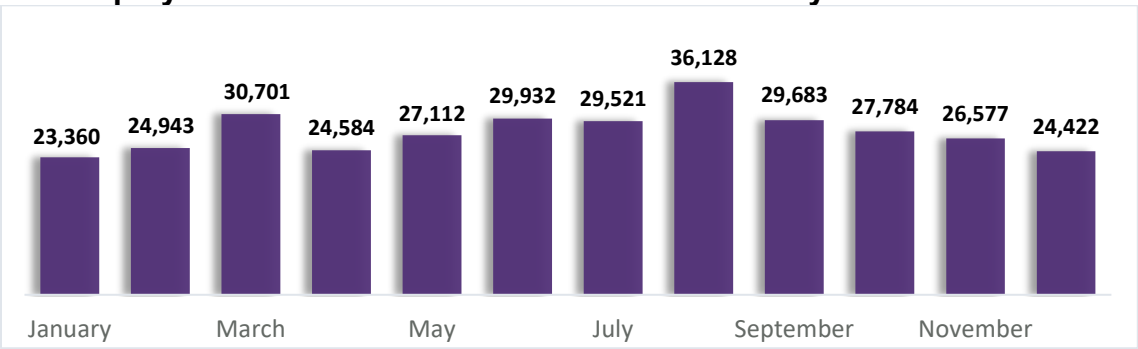
Another tool used to prevent those who have a history of abusing vulnerable populations from continuing to work with and have access to individuals receiving services is the Justice Center's *Staff Exclusion List (SEL)*. All subjects substantiated for Category One conduct, which includes serious or repeated acts of abuse or neglect, or two substantiated Category Two findings within three years, are placed on the SEL. Placement on the SEL bars an individual from working in all settings under the Justice Center's jurisdiction forever.

Provider agencies under the Justice Center's jurisdiction, as well as other providers identified in statute, are required to check the SEL before hiring someone who will have regular and substantial contact with an individual with special needs.

Since 2014, there have been 272 instances where an SEL check has resulted in a match and a provider has been notified that the applicant was on, or pending placement on, the Staff Exclusion List.

This means individuals who have been substantiated for serious acts of abuse and neglect were stopped from being hired into settings where they would have regular and substantial contact with vulnerable people again.

Pre-Employment Checks of the Staff Exclusion List by Month 2022



The total number of individuals on the SEL at the end of 2022 was 870. That is an increase of 32 from 2021.

ii. Quality Improvement

The Justice Center has the authority and responsibility to make recommendations on improving the quality of care at facilities under its jurisdiction. This is done through reviews and audits of corrective action plans and can include visits to and inspections of facilities or provider agencies. Additionally, the Justice Center can engage in a systemic review of programs under its jurisdiction. This important audit function allows the Justice Center to make recommendations to provider agencies so that they can improve quality of care and protect the people they serve from harm.

C. Corrective Action Plan Audits

As part of the Justice Center's oversight and monitoring function, the agency reviews and conducts audits of corrective actions that stem from abuse and neglect cases to ensure facilities and provider agencies are taking the necessary steps to prevent incidents of abuse and neglect in the future. Corrective action plan (CAP) audits are most often completed after a finding that abuse or neglect was caused by a systemic issue. In 2022, the Justice Center conducted 232 audits of facility and agency CAPs which included assessing 1,321 corrective actions, identifying 375 additional findings, and providing 295 resources. Examples of the audits and results are below.

Examples:

Audit #1: Capacity Concerns

Narrative: A person receiving services, who was at risk for choking and required a modified food consistency, signed a "Right to Risk" consent form which meant food did not need to be prepared in accordance with guidance from their physician. The Justice Center's CAP audit identified concerns with the individual's capacity to sign such a form.

Result: The findings from the audit were discussed with OPWDD. Upon receipt of the findings letter, OPWDD reviewed the "Right to Risk" documentation and identified that the agency's documentation fell short. Specifically, the agency failed to demonstrate that the person was educated on all possible consequences that could occur from not

complying with the physician-prescribed modified diet. Documentation was also lacking regarding any alternatives discussed with the person, so it could not be determined whether they truly had the capacity to consent. OPWDD sent a survey team on site to review the concerns.

Audit #2: Seeking Medical Attention

Narrative: A person receiving services choked on his breakfast and staff did not seek medical attention, per agency policy. The CAP audit related to this case revealed the agency's actions, including re-training staff on its choking policy, were insufficient in preventing another similar incident because they were not taken in a timely manner and were not fully implemented.

Result: Upon receipt of the CAP audit findings letter, the agency took additional actions to rectify the remaining issues. As a result, all staff received re-training on relevant policies, including on emergency guidelines, choking prevention, and providing all relevant information to on-call staff when seeking support. The agency also assigned a specific person to monitor timeliness and completeness of implementation of corrective actions; and the agency developed an electronic system to file training documentation.

Audit #3: Seeking Medical Attention

Narrative: A person receiving services who required enhanced supervision was observed to have bruising on her eye, but no one knew how the injury occurred. There were discrepancies in the person's care plans regarding her supervision requirements. During the audit, it was also discovered that not all staff had been trained on her care plans.

Result: Upon receipt of the CAP audit findings letter, the agency took additional actions to rectify the remaining issues of concern, including updating the care plans to be consistent and inclusive of all relevant information. Additionally, after receiving some technical assistance from the Justice Center, the agency indicated they would implement an internal audit process for CAPs on a quarterly basis that would mimic the Justice Center's audit process and template to outline concerns.

D. Systemic Review

Narrative: The Justice Center completed a data review of OASAS providers with the highest substantiation rates for sexual abuse and/or neglect for failing to maintain professional boundaries. The agency evaluated whether systemic changes including additional prevention tools were implemented to prevent sexual abuse from occurring.

Result: The Justice Center completed 35 audits at five providers and shared its findings with OASAS. In response, OASAS developed a plan to require trainings for current staff and new hires at these programs, including the Justice Center's video training on professional boundaries. OASAS also disseminated the Justice Center's Recommendations for Maintaining Professional Boundaries to all OASAS providers and is developing a new training module pertaining to professional boundaries. That training will include a two-day, 12-hour video and discussion course, followed by a three-hour in-person session.

E. Agency Recommendations

Narrative: Several units at an inpatient psychiatric facility did not have video cameras, making it difficult to gain a full understanding of the location and the activity of staff and people receiving services when allegations were reported. The Justice Center recommended that the facility invest in video and audio recording to assist in investigations and reduce the amount of time that staff were put on administrative leave.

Result: The facility installed cameras in all units. This has dramatically improved safety and investigative cycle time.

F. Special Housing Unit (SHU) Monitoring and HALT Compliance

In early 2022, The Justice Center was responsible for overseeing compliance with the SHU Exclusion Law. Beginning April 1, 2022, the Justice Center began overseeing compliance with the Humane Alternatives to Long-Term Solitary Confinement Act (HALT). This involves monitoring the quality of mental health care provided by the Office of Mental Health (OMH) to people who are incarcerated in state prisons.

The Justice Center reviewed compliance with the SHU Exclusion Law and HALT and the quality of mental health care at 21 facilities in 2022. This included five under SHU Exclusion and 16 under HALT. In total, the Justice Center completed 698 cell-side and 121 private interviews with incarcerated individuals and referred 91 of those individuals to be evaluated by OMH. The agency also reviewed the quality of mental health care for 318 incarcerated individuals. In addition, the agency reviewed the records of over 372 incarcerated individuals placed in solitary confinement and Residential Rehabilitation Units to ensure compliance with the SHU Exclusion Law and HALT. The seven reviews completed in 2022 found that three facilities were complying and four were not in compliance with the law. Findings reports are posted on the Justice Center website.

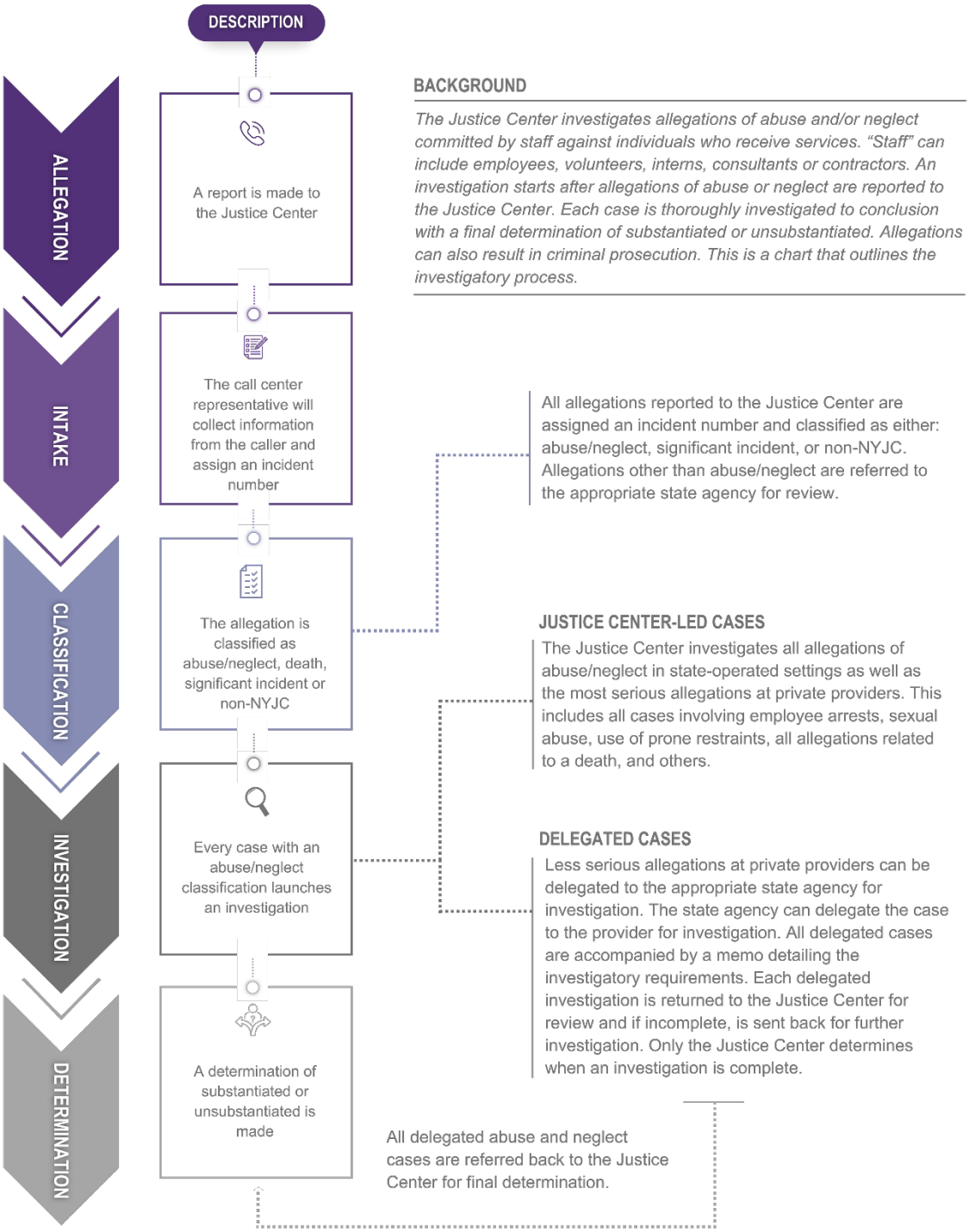
The Justice Center will publish a separate annual report with in-depth information regarding the agency's findings under HALT.

VII. DIVERSITY, EQUITY, AND INCLUSION (DEI)

The Justice Center recognizes the inherent value of creating an inclusive environment at the agency and employing a diverse workforce. Executive Director Denise Miranda's vision for diversity, equity, and inclusion work across the NYS Justice Center and beyond resulted in collaboration with agency leadership to successfully implement several initiatives. They include diversity training, establishment of an anti-racism workgroup, DEI unit plans, hiring NYS fellows and student assistants, specialized assignments, leadership training, and exit interviews. These align with the Statewide Objectives for diversity and inclusion and will be utilized as the foundation for developing our agency's Diversity, Equity, and Inclusion (DEI) strategic plan. That plan is expected to be released in 2023 and additional work building upon these initiatives is planned in the coming year.

VIII. INCIDENT MANAGEMENT

❖ Process of a Justice Center Investigation



i. Intake

Anyone, including a parent or guardian, advocate, or individual receiving services can make a report to the VPCR when they have knowledge or have reason to believe that a person receiving services has been abused, neglected or mistreated. Some people are required by law to report to the VPCR. These "mandated reporters" include provider agency staff and human services professionals who, by nature of their job, must report allegations of abuse or neglect.

Call center representatives are available 24 hours a day, seven days a week, 365 days a year. The number to contact the toll-free hotline to make a report is **855-373-2122.** A web-based reporting form and a mobile application are also available for use.

The call center representative will first assess whether an emergency responder is necessary and/or if the person receiving services is in danger or needs immediate assistance. If that is the case, the caller is instructed to hang up and call 9-1-1. The reporter should then call back once the emergency is over to file the report. If no emergency exists, the call center representative will collect information from the reporter and assign an incident number.

ii. Classification

Once the allegation is assigned an incident number, it is then classified into one of the following categories: abuse/neglect, death, significant incident or non-NYJC.

- **Abuse**
  - Physical: intentional contact (hitting, kicking, shoving, etc.), corporal punishment, injury which cannot be explained and is suspicious due to extent or location, the number of injuries at one time or the frequency over time
  - Psychological: taunting, name calling, using threatening words or gestures
  - Sexual: includes inappropriate touching, sexual assault, and sexual contact with a person incapable of consent
  - Deliberate misuse of restraint: use of these interventions with excessive force, as a punishment or for the convenience of staff
  - Controlled substances: using, administering, or providing any controlled substance contrary to the law
  - Aversive conditioning: unpleasant physical stimulus used to modify behavior without person-specific legal authorization.

- **Neglect**
  Any breach of a direct care employee's duty which includes action, inaction, or lack of attention on the part of the employee that results in or is likely to result in physical injury or serious impairment to the person's physical, mental, or emotional condition

- **Death**
  The Protection of People with Special Needs Act requires certain deaths be reported to the Justice Center. These include the death of an individual receiving services from a residential facility or program that is licensed, certified, or operated by OPWDD, OCFS, OMH and OASAS

- **Significant Incident**
  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. Examples include conduct between persons receiving services and conduct of an employee that is inconsistent with an individual's treatment plan

- **Non-NYJC Incident**
  The nature of the incident is not reportable to the Justice Center because the incident is not a reportable incident or because it did not occur at a provider over which the Justice Center has jurisdiction. These can vary widely and may include concerns about a provider, or complaints about food. Cases that require follow-up are referred to the appropriate State Agency.

- **Not an Incident**
  Calls that do not allege any type of incident but instead may be general inquiries or incorrectly routed calls. The Justice Center will refer to a relevant agency or entity if available.

Reports Made to the Justice Center	2022
Grand Total	**86,699**
Abuse and Neglect	12,602
Death	1,709
Significant Incident	25,862
Non-NY JC Incident	35,218
Not an Incident	11,308

- **Three-Business Day Review of Incidents**

  The Justice Center has implemented a review process for allegations where appropriate classification of an incident may initially be difficult to accurately determine. The three-business day assessment allows the agency to conduct a preliminary review of allegations lacking specificity by obtaining additional information from the facility or provider agency. This involves the collection of a minimum amount of documentation to accurately classify and assign a case. This additional short step allows classification to be better informed and therefore a more accurate incident classification and a better use of investigative resources.

  The three-business day assessment is available to all OPWDD, OMH, OCFS, OASAS, and SED providers.

Three-Business Day Review of Incidents 2022

Classification	OPWDD		OMH		OASAS		OCFS		SED		Grand Totals	
	#	%	#	%	#	%	#	%	#	%	#	%
JC Abuse & Neglect	515	28%	338	22%	51	37%	251	35%	64	44%	**1,219**	**28%**
SOA Abuse & Neglect	199	11%	107	7%	0	0%	170	23%	0	0%	**476**	**11%**
Significant Incident & Non-NYJC Incident	1,102	61%	1,127	71%	86	63%	306	42%	81	56%	**2,702**	**61%**
Totals	**1,816**	**100%**	**1,572**	**100%**	**137**	**100%**	**727**	**100%**	**145**	**100%**	**4,397**	**100%**

iii. Criminal vs. Administrative

Once a case is classified as abuse or neglect, that case is next characterized as either criminal or administrative.

- **Criminal Cases**

  The Justice Center's Special Prosecutor works with county district attorneys to bring criminal charges in cases that allege that a crime has occurred against an individual receiving services by an employee of a facility or provider agency. The Justice Center notifies district attorneys of *all* allegations of abuse and neglect. Cases involving potential criminal charges can be investigated by the Justice Center, the local police, or both.

  In 2022, 69 arrests were made in connection to Justice Center cases.

While a criminal case is being investigated and prosecuted, the same case is also investigated through the Justice Center administrative investigation process.

- **Administrative Cases**

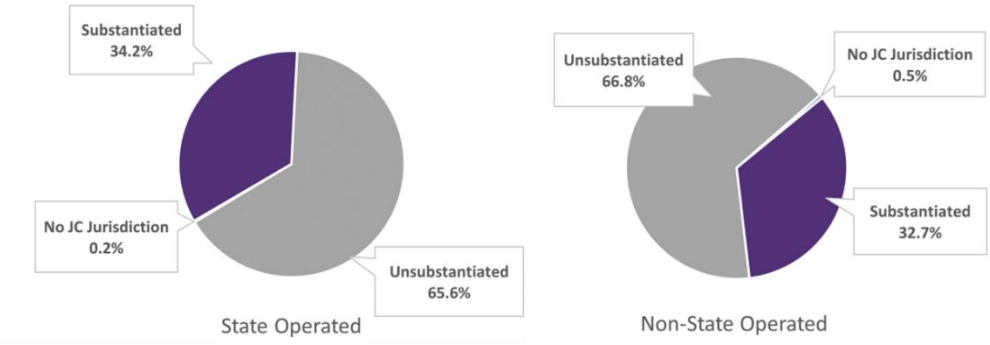
  The first step in the administrative investigation of allegations of abuse and/or neglect is appropriate classification and assignment for investigation. The Justice Center investigates allegations in state-operated programs as well as the most serious allegations in non-state operated settings. Less serious allegations of abuse and neglect in non-state operated settings are delegated to the State Agency for investigation, which in turn may delegate to the provider. The Justice Center reviews all investigations regardless of which delegate investigative agency conducts them and makes all final determinations regarding whether a case will be substantiated or unsubstantiated. Significant incidents are referred to the appropriate State Agency for investigation.

  The investigation process proceeds with examination of the evidence and interviews of witnesses, victims and subjects. Witnesses and subjects of Justice Center investigations can have legal counsel or a union representative present when being interviewed, unless an applicable union contract, or Collective Bargaining Agreement, provides differently. Individuals receiving services who are the victim of or witness to abuse and neglect may have a personal representative or an advocate from the Justice Center's Individual and Family Services Unit accompany them during an interview.

iv. Determination

Administrative cases conclude by either being substantiated or un-substantiated. The Justice Center makes the final determination regardless of which agency completed the investigation. The standard of proof for a Justice Center administrative case is a *preponderance of the evidence*. This means a review of the evidence shows the allegation of abuse or neglect was more likely than not to have occurred.

Percentage of Investigation Outcome for Abuse and Neglect Cases in 2022



- **Unsubstantiated**: the case is sealed (not made public and cannot be accessed by future employers) and a letter of determination is sent to the subject, victim and provider agency letting them know the finding.

- **Substantiated**: the case is classified into one of four categories depending on the severity:

    - **Category 1**: Serious physical abuse, sexual abuse, or other severe conduct. Category 1 substantiations place subjects on the Staff Exclusion List (SEL). Subjects on the SEL are banned from working in any setting under the jurisdiction of the Justice Center and remain on the list forever.
    - **Category 2:** Conduct that seriously endangers the health, safety, or welfare of a service recipient by committing an act of abuse or neglect. Two Category 2 substantiations within three years will result in placement on the SEL. Category 2 offenses are sealed after five years.
    - **Category 3:** Less serious incidents of abuse or neglect. Reports are sealed after five years.
    - **Category 4:** Incidents of abuse or neglect that are mitigated by systemic conditions at a program or facility that increased the likelihood of such abuse or neglect, such as inadequate training, staffing, or supervision. Category 4 also include instances in which an individual receiving services has suffered abuse or neglect, but a perpetrator cannot be identified.

Most (75%) of substantiated abuse and neglect findings are classified as Category 3 conduct.

Total Closed Abuse and Neglect Cases 2022	**3,217**
State Operated Total	**840**
Category 1	6
Category 2	234
Category 3	593
Category 4	7
Non-State Operated Total	**2,377**
Category 1	47
Category 2	465
Category 3	1,815
Category 4	50

The Justice Center makes several parties aware of the findings of an investigation. The victim or their personal representative will be issued a "letter of determination" (LOD), making them aware of the outcome of the allegations. A LOD is also issued to the director of the facility or program, the SOA that licenses or certifies the facility or program, and the subject of the investigation.

Substantiated Allegations in Closed Cases* - 2022

Type	State Operated	Non-State Operated
Neglect	92.6%	84.9%
Physical Abuse	8.7%	20.5%
Deliberate Inappropriate Restraint	6.4%	9.7%
Obstruction	3.7%	4.7%
Psychological Abuse	1.9%	2.7%
Sexual Abuse	0.2%	1.7%
Other	0.5%	0.6%

*Percentages based on total cases closed. Some cases contain more than one substantiated allegation.

v. Appeals

An appeals process (called a request for amendment) is available to subjects of substantiated reports to ensure due process. Subjects have 30 days to challenge Justice Center findings. Upon receipt of an appeal request, the Justice Center reviews the investigative file, the substantiated report, the request for amendment and any additional information provided by the subject. A determination is then made as to whether there is a preponderance of evidence to support the substantiation as well as proper category assignment.

If the substantiated finding is upheld, subjects can proceed to a hearing before an Administrative Law Judge. The judge considers all the evidence presented by both the Justice Center and the subject or their legal representative and makes a recommended decision that is reviewed by the Justice Center's Executive Director. One of three outcomes is then possible:

- The Executive Director finds the Justice Center met its burden to prove the allegation and the correct category level was assigned. The substantiated finding remains against the subject.
- The Executive Director finds the Justice Center met its burden to prove the allegation, but the category level was inappropriate. The substantiated finding remains with a new category level.
- The Executive Director finds the Justice Center did not meet its burden to prove the allegation. The report is unsubstantiated, and the record is sealed.

In 2022, the Justice Center received 700 requests for amendment, made 671 de novo determinations, and held 42 hearings.

vi. Discipline

Disciplinary or other employment actions resulting from a substantiated finding are at the discretion of the *employing provider agency* (State Agency or private provider) in accordance with established rules and collective bargaining agreements, the exception being Category 1 findings which result in placement on the Staff Exclusion List (SEL). This means in most of the cases, the Justice Center is not involved in any decisions regarding the discipline of a subject. The notable exception occurs with state employees, where Justice Center attorneys work collaboratively with the State Agencies to achieve appropriate disciplinary outcomes.

Justice Center attorneys represent the State at disciplinary proceedings brought against State employees, protected under Collective Bargaining Agreements, in all cases of substantiated abuse or neglect. In 2022, 148 State employees were separated from service because of probationary status or disciplinary charges brought against them. In addition, the Justice Center reviewed and approved 546 Notices of Discipline, which can result in an oral or written reprimand, fine, loss of leave credits or other privileges, demotion, suspension, termination, or other penalties as appropriate. Further, the Justice Center participated in 103 days of expedited hearings or agency-level mediations and 26 days of full arbitration totaling 227 cases.

State Employee Action Process Completed 2022	# Complete Actions
Closed Substantiated	**615**
Termination Total	131
No Penalty	125
Suspension	117
Counsel or Train (subset of No Penalty)	103
Loss of Leave Credits or Other Privileges	95
Letter of Reprimand	89
Resigned	84
Fine	38
Probation Terminated	25
Retired	18
Exclusion or Other	14
Upheld at Arbitration	5
Other Penalty	2

Administrative Action Reporting Mechanism

State Agencies require provider agencies under the jurisdiction of the Justice Center to submit information about what administrative actions have been taken with respect to subjects of substantiated allegations of abuse or neglect in non-state operated settings. The information is submitted to the Justice Center through a web application. The requirement allows State Agencies to ensure providers they license or certify are responding to substantiated allegations of abuse or neglect with appropriate corrective action. The chart below indicates the type of disciplinary action taken by private providers, and the number of times that action was taken in 2022.

Non-State Operated Employee Discipline	# Complete Actions
Substantiated Actions Completed	**3394**
Termination	853
Counseling (Formal-Written)	666
Re-Training	605
Resignation/Retirement	256
Training	212
Counseling (Informal-verbal)	191
Letter of Reprimand	108
Staff Reassignment/Relocation	108
Suspension (1-14 days)	108
Suspension (30 or more days)	94
No Action	67
Suspension (15-30 days)	58
Additional Staff Supervision	31
Placed on Probation	18
Demotion	12
Fine (monetary/accruals)	4
Employee Assistance Referral	3

IX. MORTALITY REVIEWS

The *Protection of People with Special Needs Act* requires the deaths of all individuals receiving services from a residential facility or program licensed, certified, or operated by OPWDD, OMH, OASAS or OCFS to be reported to the Justice Center. In addition, the death of any individual who received services from the above facilities in the 30 days prior to their death must also be reported. Any time a death is reported to the Justice Center where there is an allegation of abuse or neglect, a separate notification is sent to both the district attorney and the medical examiner.

❖ Process of an Assessment or Investigation

The requirement to report a death is not exclusive to those that may have been caused by abuse or neglect. Instead, the death of every service recipient in these certain residential settings, regardless of the circumstances, must be reported to the Justice Center. For this reason, the agency has broken the investigations into two separate categories.

i. Executive Law § 556 Reviews

Most of the death reports received by the Justice Center fall under Executive Law § 556. This section of law requires administrators of residential programs licensed, operated or certified by OPWDD, OMH, OASAS, and OCFS to report all deaths of residents to the Justice Center, regardless of whether the death is unusual or expected. 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 individuals receiving services and prevent the recurrence of similar issues.

All deaths reported under Executive Law § 556 are reviewed by investigators with program experience as well as health care professionals, including registered nurses. Through these reviews, the Justice Center can make recommendations to providers on how to improve quality of care. Letters are sent to both providers and the appropriate SOA for monitoring of recommended corrective actions.

Executive Law § 556 Death Reviews	2022
Total Reviews Conducted	**1,704**
State Operated	372
Non-State Operated	1,332

ii. Mortality Investigations

Mandated reporters under Justice Center jurisdiction are required to report any death for which they have reasonable cause to suspect abuse, neglect, or a significant incident may have been involved. Any death report potentially involving abuse or neglect follows the same investigative process as other abuse or neglect reports: classification and assignment of unique case number, investigation, and determination. Medical examiners and district attorneys are notified of a death through electronic means as well as by telephone.

The Justice Center has developed a specific protocol that it follows for reviewing abuse/neglect cases where a death is involved. Initial review involves input from a supervising investigator, a criminal investigator, a lead Justice Center investigator, the regional nurse, the Assistant Special Prosecutor for the region and a representative from the Office of General Counsel. This comprehensive approach allows team members

with varied backgrounds to advise on the approach for the investigation. The team is presented with information including medical and clinical history of the individual receiving services, a synopsis of the circumstances surrounding the death, involvement by local law enforcement, medical examiner or district attorney and history of any concerns regarding the program or facility.

Cases of abuse or neglect involving the death of a service recipient do not necessarily mean the abuse or neglect *caused* the death. The Justice Center evaluates causational versus corresponding links when assigning category levels of substantiated cases.

Cases of abuse or neglect with death involved are also reviewed by the Justice Center's Special Prosecutor in addition to the notifications sent to the local district attorney.

iii. Medical Review Board

The Justice Center Medical Review Board (MRB) advises on cases as needed or requested. The Board consists of up to 15 physicians with expertise in forensic pathology, psychiatry, internal medicine, and addiction medicine. In 2022, 13 cases were referred to the MRB.

The MRB is called upon for all full death reviews to give an opinion on whether the standard of care was met for the deceased. The designated primary reviewer member of the MRB for each case is given all information pertinent to the case (documents, summary reports, interviews/interrogations). The case is presented at the next regularly scheduled MRB meeting. The primary reviewer provides their expert opinion and other members of the MRB can weigh-in on the discussion.

The MRB can also consult or perform a full review for all abuse/neglect cases with death involved as needed upon request of an investigator. A consult routinely relates to a specific question while a full MRB review happens after the completion of the investigation and the investigatory question of whether abuse or neglect occurred remains. The MRB also reviews trend reports on completed mortality assessments at least annually.

X. CONCLUSION

It is unequivocal that people with special needs are safer today than before the inception of the Justice Center. Under the guidance of Governor Hochul and in partnership with State and private provider agencies, individuals with disabilities, family members, and advocates, the Justice Center will build upon the accomplishments detailed in this report in the year ahead. The agency continues to explore and develop new approaches to strengthen the Justice Center's ability to safeguard New York's most vulnerable citizens.

XI. APPENDIX A

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

- **Office for People with Developmental Disabilities (OPWDD)**
  - Facilities and programs operated, licensed or certified by OPWDD
- **Office of Mental Health (OMH)**
  - Facilities and programs operated, licensed or certified by OMH
- **Office of Addiction Services and Supports (OASAS)**
  - Facilities and provider agencies operated, licensed or certified by OASAS
- **Office of Children and Family Services (OCFS)**
  - Facilities and programs operated by OCFS for the youth placed in the custody of the Commissioner of OCFS
  - OCFS licensed or certified residential facilities that care for abandoned, abused, neglected, 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
  - Specialized-secure detention for pre-adjudicated adolescent offenders jointly administered by designated county agency and the county sheriff
- **Department of Health (DOH)**
  - Overnight and traveling summer day camps for children with developmental disabilities under DOH jurisdiction and certain adult homes that meet census criteria for the number of beds and percentage of residents with serious mental illness.
- **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

XII. APPENDIX B

Justice Center Advisory Council Members

William T. Gettman — Northern Rivers Family of Services (Chair)

Veronica Crawford - Self-Advocate, Care Design NY

Norwig Debye-Saxinger — Therapeutic Communities Association

Jason Hershberger, M.D. — Brookdale University Hospital and Medical Center

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

Ronald S. Lehrer — NYS Association of Boards of Visitors

Glenn Liebman — Mental Health Association in New York State

Joseph Macbeth — National Alliance for Direct Support Professionals

Thomas McAlvanah — Interagency Council of Developmental Disabilities Agencies of NY

Delores Fraser McFadden — Behavioral Momentum Applied Behavior Analysis, PC

Kathy O'Keefe — Pilgrim Psychiatric Center

Judith A. O'Rourke — Parent

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

Mary K. St. Mark — Parent Advocate and Board President, Institutes for Applied Human Dynamics

Jeffrey Savoy — Odyssey House

Euphemia Strauchn — Parent, Families on the Move