



PROTECTING NEW YORKERS WITH SPECIAL NEEDS

Annual Report to the Governor and Legislature

June 30, 2013 to June 30, 2014

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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.

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.

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, service providers, people who provide direct services, and people with special needs to prevent abuse and neglect.

Andrew M. Cuomo, Governor

TEL: 518-549-0200



December 2014

Honorable Andrew M. Cuomo, Governor Honorable Members of the NYS Senate Honorable Members of the NYS Assembly

I am pleased to submit the first Annual Report of the NYS Justice Center for the Protection of People with Special Needs (Justice Center), as required by Chapter 501 of the Laws of 2012. This report details the activities and major accomplishments of the agency during the period of June 30, 2013 to June 30, 2014.

On June 30, 2013, the Justice Center began operations. Since that time, the agency has carried out its mission to support and protect the health, safety and dignity of New Yorkers who receive supports and services from approximately 3,000 facilities or programs operated, licensed or certified by six State Oversight Agencies.

Under the leadership of Governor Andrew Cuomo, New York became the first state in the nation to create an independent state agency dedicated to safeguarding people with special needs. The Justice Center has developed an infrastructure that is transforming the state's system of incident reporting, investigations, disciplinary processes, and corrective and preventive actions. Working in close partnership with State Oversight Agencies, local law enforcement agencies and District Attorneys' offices across the state, allegations reported to the Justice Center's Vulnerable Persons Central Register (VPCR) are being tracked and vigorously pursued. Anyone who victimizes an adult or child with special needs is held accountable for his or her actions. Incidents determined to be criminal in nature are prosecuted to the fullest extent of the law. Individuals who have been found responsible for the most serious or repeated acts of abuse and neglect are being placed on a registry maintained by the Justice Center that prohibits them from ever working again with people with special needs.

Through systems review, data analysis and intervention, the agency is also strategically focused on prevention efforts.

The Justice Center is fully committed to promoting accountability and ensuring the public trust. Looking ahead, we will continue to work aggressively to stop abuse and neglect, keep people with special needs safe, and promote their inclusion in all aspects of community life.

Respectfully submitted,

Ieff Wise Executive Director

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EXECUTIVE SUMMARY

Combating the abuse and neglect of people with special needs requires a coordinated effort. In its first year, the NYS Justice Center for the Protection of People with Special Needs (Justice Center) instituted a comprehensive system for incident reporting, investigations and prosecutions. These efforts seek to reduce the abuse and neglect of people with special needs, provide justice for individuals who have been victimized, and rid the system of people who are unsuitable for care work.

As a result of these fundamental reforms, the state's system of care and supports is now being held to an unprecedented level of oversight and accountability to better ensure the well-being of New York's most vulnerable citizens. Our efforts in the first year have, for example, included:

- Creating a central registry which contains the names of 17 individuals who are now prohibited from being hired to care for people with special needs.
- Establishing a statewide 24/7 toll-free hotline which receives reports of allegations of abuse, neglect and other incidents that have the potential to harm people receiving services. As a result, a total of 84,294 reports were created in the Justice Center's database, the Vulnerable Persons Central Register. Nearly 40 percent of these reports are not related to an incident of abuse or neglect but may be reported by individuals seeking information or reporting incidents that falls outside the Justice Center's jurisdiction. It is important to note that because all mandated reporters are legally required to contact the Justice Center when they discover reportable incidents, there are often multiple reports regarding a single incident.
- Instituting an automated case management system that tracks cases from initial report to determination.
- Initiating investigations and providing training and support to state and local law
 enforcement agencies which resulted in 73 arrests. Sufficient evidence was found to
 substantiate at least one allegation of abuse and neglect in 571 cases.
- Providing legal support for state agencies to ensure more effective employee discipline.
- **Prosecuting 22 criminal acts** to the full extent of the law.
- Providing advocacy and resources for victims and families.

The Justice Center is unlike any other state entity in the nation, in that it serves both as a law enforcement agency with a mandate to protect people with special needs who are receiving services and as an advocate to support and empower people with disabilities in New York State. In its first 12 months, the agency has met its obligation to protect people with special needs and keep them safe from abuse and neglect.

INTRODUCTION

The NYS Justice Center for the Protection of People with Special Needs (Justice Center) was established in law by the "Protection of People with Special Needs Act." The Justice Center is responsible for ensuring the safety and well-being of the approximately one million adults and children with physical or intellectual disabilities, or who have the need for services or placement from a facility or service provider overseen by six State Oversight Agencies: the Office for People With Developmental Disabilities (OPWDD), the Office of Mental Health (OMH), the Office of Children and Family Services (OCFS), the Office of Alcoholism and Substance Abuse Services (OASAS), the Department of Health (DOH) and the State Education Department (SED). (Please see Appendix A for more information about the Justice Center's jurisdiction.)

The groundbreaking move to create an independent state agency solely dedicated to safeguarding people with special needs followed an in-depth review of New York's care systems initiated by Governor Andrew M. Cuomo. The Governor's Special Advisor on Vulnerable Persons, Clarence Sundram, authored a report on how these systems could be more effective and more accountable. One notable conclusion of the report was that systems could often expose people with disabilities to a "needless risk of harm." In response to these findings, the Governor proposed a comprehensive series of reforms that would strengthen the oversight and protection of New Yorkers with special needs. The Legislature supported the Governor's approach and unanimously adopted the legislation which created the Justice Center.

This report describes the Justice Center's efforts, in its first year to implement new practices and procedures including: a common set of definitions of abuse and neglect across the systems and an automated case management system which has brought consistency to the way reports are received, tracked and investigated to ensure that no case falls through the cracks.

Major Objectives

- Receive and investigate allegations of abuse, neglect or other mistreatment of people with special needs, holding all engaged in proven misconduct accountable.
- Provide quality analysis of, and identify trends to reduce abuse, neglect and mistreatment.
- Launch high-quality training programs to provide guidance on best practices for law enforcement response to incidents involving people with special needs.
- Protect, empower and advocate for the civil rights of people with special needs and disabilities.

¹ Chapter 501 of the Laws of 2012

² The Measure of a Society: Protection of Vulnerable Persons in Residential Facilities Against Abuse & Neglect by Clarence J. Sundram, 2012

INCIDENT MANAGEMENT

On June 30, 2013, the Justice Center began serving as the state's central reporting center for all reports of suspected incidents of abuse or neglect involving persons who receive services or supports at one of the more than 3,000 private service providers or state-operated facilities. (Please see Appendix A for more information about the Justice Center's jurisdiction.)

The Justice Center's Vulnerable Persons Central Register (VPCR), an electronic case management system tracks all cases to ensure timely investigation and resolution of all incidents. A statewide toll-free hotline, which is staffed 24 hours a day, 7 days a week by highly-trained call center representatives, receives reports of incidents. Reports are made by individuals receiving services, family members, direct support professionals and others who witness or suspect abuse. Employees, volunteers, directors and operators of covered facilities and programs who have regular and substantial contact with people being served are designated as "mandated reporters" who have a legal duty to report incidents to the Justice Center. "Group reporting" is not permitted so there are frequently multiple reports involving a single incident.

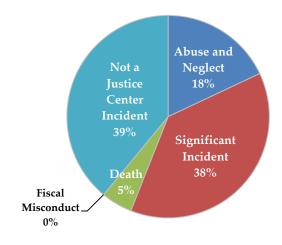
Each allegation is assessed, classified and assigned a case number and routed to the appropriate law enforcement or State Oversight Agency for investigation or review. Reports are also received through a web-based form. If an allegation appears to constitute a criminal offense or an immediate threat to a person's health, safety or welfare—personnel are directed to immediately contact local law enforcement and/or any other emergency responder and State Oversight Agency.

Between June 30, 2013 and June 30, 2014, a total of **84,294 reports were created in the Justice Center's database, the Vulnerable Persons Central Register** (Figure 2). Nearly 40 percent of these reports are not related to an incident of abuse or neglect but may be reported by individuals seeking information

or reporting incidents that fall outside the Justice Center's jurisdiction (Figure 1). It is important to note that because all mandated reporters are legally required to contact the Justice Center when they discover reportable incidents, there are often multiple reports regarding a single incident. The average call wait time was less than 20 seconds.

The Justice Center organizes reportable incidents into two categories: abuse and neglect and significant incidents. A common set of definitions of abuse and neglect which includes both actual harm and risk of harm is applicable to all systems under the Justice Center's

Percent of Incident Reports Made to the VPCR June 30, 2013 – June 30, 2014



Note: Fiscal Misconduct represents < 1%

FIGURE 1

jurisdiction. Of the reports received, 15,412 were classified as alleged abuse or neglect that required investigation.

Types of abuse and neglect reported include: physical abuse, sexual abuse, psychological abuse, deliberate misuse of restraint or seclusion, neglect, aversive conditioning or obstruction. Significant incidents, which have the potential to result in harm to the health, safety or welfare of a person receiving services, must also be reported. (Please see Appendix B for examples of abuse, neglect and significant incidents.)

Total Number of Reports Made to the VPCR June 30, 2013 – June 30, 2014 (phone and web form)

Report Type by State Oversight Agency	No. of Reports
Reportable Incidents	51,972
Abuse and Neglect	15,412
OPWDD	10,026
OMH	2,519
OCFS	2,329
OASAS	142
DOH	101
SED	295
Significant Incident	31,854
OPWDD	12,919
OMH	7,807
OCFS	7,745
OASAS	2,061
DOH	336
SED	986
Death (Not Abuse and Neglect)	4,504
OPWDD	1,052
OMH	2,449
OCFS	28
OASAS	834
DOH	141
SED	0
Fiscal Misconduct	202
OPWDD	94
OMH	52
OCFS	18
OASAS	21
DOH	16
SED	1
Non-Reportable	32,322
Not a Justice Center Incident	23,399
Not an Incident	8,923
Total	84,294

FIGURE 2

INVESTIGATIONS, ADMINISTRATIVE SANCTIONS AND CRIMINAL PROSECUTIONS

Investigations

Abuse and Neglect

Justice Center investigators thoroughly investigate the most serious cases of abuse and neglect and review all investigations conducted by State Oversight Agencies and private service providers. The Justice Center's sworn criminal investigators also work in cooperation with state and local law enforcement agencies and provide assistance to personnel who may have limited experience working with victims with developmental or intellectual disabilities, mental illness, physical disabilities or sensory impairments.

The Justice Center does not interrogate, arrest or prosecute individuals who receive services. Only custodians (e.g., staff) can be the subject of an investigation of abuse or neglect.

Deaths

When the death of a vulnerable person receiving services from a facility or program under the jurisdiction of the Justice Center occurs, it must be reported immediately to the Vulnerable Persons Central Register (VPCR). Registered nurses on the Justice Center's staff screen all death reports to determine whether further investigation is warranted. A Medical Review Board, which includes specialists in forensic pathology, psychiatry, internal medicine and addiction medicine, makes preliminary determinations when a death is deemed unusual or appears to have resulted from other than natural causes.

Fiscal Misconduct

The Justice Center's Fiscal Investigations Unit probes allegations involving the theft of service recipient personal funds or the mismanagement of public funds used to support the programs that serve them. Referrals are made to the Office of Medicaid Inspector General and other appropriate law enforcement agencies for possible prosecution if it appears funds may have been obtained inappropriately or misapplied.

A Justice Center investigation into the management practices of Footings Inc., a non-profit service provider serving individuals with developmental disabilities in Monroe, New York, found evidence that the operator diverted hundreds of thousands of dollars in public funds to benefit themselves and family members. The findings led to an agency overhaul. The Office for People With Developmental Disabilities (OPWDD), which certifies the program, took action to replace the management team with an independent and viable governing board while maintaining the agency's programs to ensure there was no interruption in services. The case has been referred to the Internal Revenue Service, the NYS Department of Taxation and Finance, NYS Department of Motor Vehicles, the NYS Attorney General's Office, and the Orange County District Attorney's Office for any criminal or civil action deemed appropriate.

Administrative Sanctions

Once completed, all investigations, whether handled by the Justice Center, a State Oversight Agency, or service provider, are reviewed by the Justice Center. While most allegations do not constitute a crime, each allegation of abuse or neglect must either be substantiated by a preponderance of evidence or unsubstantiated at the conclusion of an investigation. During the reporting period, there was a 20 percent substantiation rate for allegations received by the Justice Center (Figure 4). Regardless of the investigatory entity, the Justice Center makes a final determination of whether allegations are

Abuse and Neglect Cases with At Least One Substantiated Allegation

State Oversight Agency (SOA)	Cases
OPWDD	333
ОМН	69
OCFS	142
OASAS	4
DOH	4
SED	19
All SOAs	571

Note: Data on allegations are preliminary and may be subject to correction. A case may include more than one allegation.

FIGURE 3

substantiated or unsubstantiated and, if substantiated, the category of findings. During the reporting period of this report **571 cases have had one or more allegations substantiated** (Figure 3). (Please see Appendix D for more information on the categories of substantiated allegations.)

A powerful mechanism now exists to remove abusive caregivers from the system. Individuals who have been found responsible for the most serious or repeated acts of abuse or neglect are placed on the

Substantiated Allegations of Abuse and Neglect

State Oversight Agency (SOA)	Allegations	No.	Percent
All SOAs	Substantiated	1,157	20%
	Total Allegations	5,652	
OPWDD	Substantiated	667	20%
	Total Allegations	3,259	
ОМН	Substantiated	116	11%
	Total Allegations	1,067	
OCFS	Substantiated	309	30%
	Total Allegations	1,036	
OASAS	Substantiated	10	15%
	Total Allegations	67	
DOH	Substantiated	9	41%
	Total Allegations	22	
CED	Substantiated	46	23%
SED	Total Allegations	201	

Note: Data on allegations are preliminary and may be subject to correction. Note: Substantiation of an allegation is based upon the results of an investigation either by the Justice Center, the SOA, or private provider; a review by the Justice Center Office of Investigations; and a determination by the Justice Center Office of General Counsel. The number of substantiated allegations is greater than the number of suspects who have an allegation substantiated against them because some suspects have more than one allegation substantiated in a single case.

FIGURE 4

Justice Center's Staff Exclusion List (SEL) and are barred from future employment.

In its first year, the Justice Center has placed **17 individuals on the SEL.** Persons substantiated for less serious misconduct may also face disciplinary action including retraining, suspension or termination, consistent with any applicable collective bargaining agreements. If an incident is of a criminal nature, the individual may also face prosecution.

Employee Discipline

The Justice Center's Employee
Disciplinary Unit's attorneys have
strengthened the capability of state
agencies which seek to remove employees
found responsible for abuse or neglect.
Justice Center attorneys conduct
disciplinary hearings where termination is
being sought to ensure the process is
expeditious, consistent and produces a
successful outcome.

Criminal Prosecutions

If an investigation results in an arrest, either by Justice Center criminal investigators or by other law enforcement agencies, the Justice Center's Special Prosecutor/Inspector General is empowered to handle all aspects of a criminal prosecution from arraignment to trial or plea bargain if the local District Attorney is unable to prosecute. The office works cooperatively and provides assistance to local District Attorneys across the state.

In its first year of operation, **73 arrests were made** in cases reported to the Justice Center (Figure 5). Twenty-two of these cases are being prosecuted by the Justice Center's Special Prosecutor/Inspector General.

Arrests and Criminal Prosecution Activity June 30, 2013 – June 30, 2014

Activity	No.
Arrests	73
Justice Center	16
Other Law Enforcement	57
Prosecutions	73
Justice Center	22
Local District Attorney	51

Note: Prosecutions being handled jointly by the local District Attorney and the Justice Center Special Prosecutor are listed as Justice Center Prosecutions.

FIGURE 5

Enhanced Criminal Penalties

With the enactment of the Protection of People with Special Needs Act (Act), prosecutors gained new tools for prosecuting crimes against vulnerable New Yorkers. The law added a new Class E Felony offense of "Endangering the Welfare of an Incompetent or Physically Disabled Person." It also amended the definition of consent in Article 130 cases to include persons covered under the Act. As a result, sexual contact between custodians and persons receiving services is now illegal.

OVERSIGHT AND MONITORING

The Justice Center's Division of Oversight and Monitoring works proactively to improve the lives of people with special needs and to prevent their victimization. In the past year, staff members reviewed thousands of allegations of abuse, neglect and mistreatment. Their findings are used to develop and implement changes in facilities and programs to improve care.

Some of the corrective actions developed by the Division of Oversight and Monitoring have included:

- Requiring immediate increases to on-site nursing staff for medically fragile individuals who
 were lacking critically needed clinical care;
- Necessitating the installation of required safety and medical equipment;
- Addressing vermin and sanitation issues;
- Ensuring safe fire evacuation practices;
- Requiring additional employee trainings; and
- Enforcing disciplinary action and employee terminations.

Forensic Oversight

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).

During its first year of operations, the Justice Center completed eleven mental health service reviews of unusual or suspicious deaths of inmates. The purpose of these reviews is to ascertain the quality of mental health care provided to the inmate prior to his or her death.

The Justice Center also completed SHU Compliance and Quality of Mental Health Care reviews at nine state correctional facilities. These reviews seek to ensure that all inmates in segregated confinement receive mental health screenings, including suicide assessments, and treatment as required by law.

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.

Out-of-State Placements

The Justice Center's Out-of-State Placements Unit investigates allegations of abuse and neglect involving New Yorkers placed in residential schools and facilities outside of New York State.

During the past year, investigations of allegations of abuse and neglect and program reviews were conducted at schools and facilities in Pennsylvania, New Hampshire, Vermont and Massachusetts. Investigation reports and findings are sent to the State Oversight Agencies in New York and the state where the program is located.

In Effingham, New Hampshire, new patient admissions were halted at the Lakeview Neurorehabilitation Center. The move came after a report issued by the Disability Rights Center of New Hampshire noted systemic deficiencies identified by Justice Center investigators which pose a threat to the health safety and well-being of the New Yorkers and other patients who receive services at the facility.³

³ The Disability Rights Center of New Hampshire provides information, referral, advice, and legal representation and advocacy to individuals with disabilities on a wide range of disability-related problems. The report, *Isolated, Segregated and Vulnerable: A Report and Call to Action Concerning Lakeview Neurorehabilitation Center* is available at: http://www.drcnh.org/Lakeview/FinalLakeviewReport2014.pdf

PREVENTION STRATEGIES

Pre-Employment Clearinghouse

With the establishment of a Staff Exclusion List (SEL), the state now has a mechanism to ban individuals found responsible for serious or repeated acts of abuse and neglect from employment in positions requiring contact with people with special needs. Service providers must check the statewide registry before hiring staff. A person can only be placed on the list after an allegation is thoroughly investigated and substantiated based upon a preponderance of evidence. Individuals have an opportunity to appeal the finding before being placed on the staff exclusion list permanently. A total of 17 individuals were placed on the registry in its first year – after exhausting their administrative due process remedies – and are barred for life from working in the state's service system. This number will increase continuously in an ongoing effort to remove unsuitable individuals from systems of care.

Justice Center attorneys also review the criminal history of all prospective employees or volunteers and advise service providers about the individual's suitability for employment. In the Justice Center's first year, the Justice Center responded to 73,649 requests for criminal background checks. As a result of these checks, 172 applicants were denied employment in positions that involve regular and substantial unsupervised contact with recipients of services (Figure 6). Certain service providers are also required to make an inquiry of the Statewide Central Register of Child Abuse and Maltreatment (SCR) before hiring.

Pre-Employment Criminal Background Checks June 30, 2013 – June 30, 2014

Background Check Activity	No.
Fingerprints Processed	73,649
OPWDD	52,638
OMH	15,565
OCFS	5,446
Denied Approval for Employment Consideration	172

FIGURE 6

Code of Conduct

The Justice Center's Code of Conduct articulates the core values that should guide the delivery of services and support to service recipients, including a duty to report all incidents. All employees who have regular and substantial contact with people receiving services must adhere to the Code. The Justice Center also provides training to state oversight agencies and their service providers on their responsibilities with regard to the Code. (Please see Appendix C for the tenets of the Code of Conduct.)

Interagency Prevention of Abuse and Neglect Work Group

In early 2014, the Justice Center's Steering Committee formed a cross-agency Prevention of Abuse and Neglect Work Group. Members of the work group include representatives from the Office for People With Developmental Disabilities, the Office of Mental Health, the Office of Alcoholism and Substance

Abuse Services, the Office of Children and Family Services, the State Education Department, and the Governor's Office. The work group has been charged with identifying durable corrective and preventive actions that address the conditions which cause or contribute to the occurrence of incidents of abuse and neglect. The work group meets monthly to discuss systemic issues that contribute to instances of abuse and best practices to address risk. The work group is in the process of developing tools for service providers and individuals who receive services to support prevention efforts.

Spotlight on Prevention

The Justice Center's Division of Oversight and Monitoring will expand its efforts to improve the quality of care and safety of people with special needs through the introduction of a series of "Spotlight on Prevention" toolkits for service provider agencies and individuals, families and advocates. These resources, which will be made available to service providers, will contain best practice guidance and other information to help caregivers better protect service recipients. Topics will include, but not be limited to vehicle transport safety, choking, worker fatigue, and fire dangers.

TRAINING

Standardized Investigations

In an effort to standardize investigative methods and procedures, the Justice Center developed and implemented extensive training for the agency's 55 investigators, including its 18 former police officers and those investigators employed by the six State Oversight Agencies. The curriculum includes the investigation process, working with special populations, legal issues, crime scene handling, physical evidence, documentation, interviewing techniques and interrogations, and specific incident examples.

Criminal Justice Training Academy

In his 2014 State of the State address, Governor Cuomo directed the Justice Center to expand its statewide training programs to ensure that state and local law enforcement agencies are educated about its mandate, jurisdiction and the critical role it plays in criminal investigations related to the abuse and neglect of New Yorkers with special needs.

The Office of Investigations formally launched its Criminal Justice Training Academy in the summer of 2014. The training academy seeks to change the way the criminal justice system responds to incidents and allegations of abuse and neglect involving people with special needs. Curriculum will include an overview of disabilities, case studies on the crime and victimization of persons with disabilities, and police communication techniques. Resources for victims, law enforcement and advocates will also be provided. In addition, specialized and advanced training will also be conducted for police investigators.

RESOURCES FOR INDIVIDUALS AND FAMILIES

Individual and Family Support

The Justice Center's Individual and Family Support Unit provides a wide range of supports and services to individuals who have experienced abuse, and to their family members to help them through each stage of the process including case status information, court-related assistance and referrals.

Advocacy Services and Support

The Justice Center's Office of Program and Policy provides extensive education, referrals, training, and technical assistance to support and empower individuals with disabilities of all ages in all settings. The Justice Center operates an Information and Referral service that can connect people to assistive technology devices, surrogate decision-making, ombudspersons, and other disability-related services.

NEXT STEPS

The Justice Center made tremendous progress during its first year to strengthen the protection, safety and quality of care provided to people with special needs and disabilities. The agency will continue to implement additional opportunities for engaging police officers, District Attorneys, other law enforcement personnel, service providers and the public in this shared goal. These efforts will focus on changing the culture of care by promoting better techniques for investigations and prosecutions, reinforcing best practices to address safety issues and abuse prevention, and expanding the use of data and performance metrics to drive systemic change.

Vulnerable Person Task Forces

In an effort to build greater understanding of the Justice Center's law enforcement role and to better serve vulnerable New Yorkers in state care who have been victimized, the Office of the Special Prosecutor/Inspector General will launch a new initiative in 2015 to create a formalized, comprehensive and regionalized approach to investigate and prosecute cases of abuse and neglect committed against this population.

The Justice Center will pilot a Vulnerable Person Task Force (VPTF) in each of its four regions during Crime Victims Week in April 2015. This community-based, cooperative approach will help to ensure that victims are provided with a broad range of necessary care and services, which often include legal, medical and social services. This approach will minimize the number of victim interviews and also help to increase the likelihood that criminal offenses can be successfully prosecuted. It will also foster the development of specialized expertise and investigations skills for the professionals involved. These task forces will bring together professionals from government agencies and the non-profit and private sector, to work in a coordinated and collaborative manner to ensure an effective response to reports of abuse and neglect of people with special needs in New York State and to develop best practices for the treatment of these cases.

Performance Metrics and Data

In its second year, the Justice Center will use the robust data collected through the centralized case management system to analyze abuse patterns and trends to enable staff to better identify and support the repair of faulty systems and also hold accountable those in charge of creating and maintaining them. Together these efforts will further strengthen the safety net for New Yorkers with special needs and provide assurance to their loved ones that their health, safety and dignity will be maintained.

APPENDIX A

The Justice Center Oversees Facilities and Service Providers within the Systems of Six State Oversight Agencies (SOAs)

1. Office for People With Developmental Disabilities (OPWDD)

Facilities and programs that are operated or certified by OPWDD

2. Office of Mental Health (OMH)

Facilities and programs that are operated or licensed by OMH

3. Office of Alcoholism and Substance Abuse Services (OASAS)

• Facilities and service providers that are operated, certified, or licensed by OASAS

4. 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

5. 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
 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

6. 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
- Residential schools or facilities located outside of New York State that serve New York State residents

APPENDIX B

Types of abuse and neglect to be reported to the Justice Center include:

- **Physical abuse**: intentional contact such as hitting, kicking, shoving, corporal punishment or an injury which cannot be explained and is suspicious due to extent or location;
- **Sexual abuse**: inappropriate touching, indecent exposure, sexual assault, taking or distributing sexually explicit photos, voyeurism or other sexual exploitation;
- Psychological or emotional abuse: taunting, name calling, using threatening words or gestures;
- **Deliberate misuse of restraint or seclusion**: use of these interventions with excessive force, as a punishment or for the convenience of staff;
- **Neglect**: failure to provide supervision, or adequate food, clothing, shelter, health care or access to an educational entitlement;
- Aversive conditioning: Unpleasant physical stimulus used to modify behavior without personspecific legal authorization; and
- **Obstruction**: Interfering with the discovery, reporting or investigation of abuse/neglect, falsifying records or intentionally making false statements.

Types of significant incidents to be reported include:

- Use of restraint when it is avoidable, involves a banned technique or is used by inadequately trained staff;
- Unauthorized seclusion or time-out;
- Harmful interactions between people with special needs that could reasonably have been prevented; and
- Administration of a medication contrary to a medical order resulting in an adverse impact.

APPENDIX C

Code of Conduct

Introduction

The Protection of People with Special Needs Act ("the Act") establishes the Justice Center for the Protection of People with Special Needs ("Justice Center") and requires that this Code of Conduct be read and signed by anyone who will have regular and substantial contact with any person who is receiving services or supports from facilities or providers covered by the Act. The Code of Conduct is not intended to provide a detailed list of what to do in every aspect of your work. Instead it represents a framework that will help custodians determine how to help people with special needs live self-directed, meaningful lives in their communities, free from abuse and neglect, and protected from harm.

You must abide by the following Code of Conduct provisions:

1. Person-Centered Approach

My primary duty is to the people who receive supports and services from this organization. I acknowledge that each person of suitable age must have the opportunity to direct his or her own life, honoring, where appropriate, their right to assume risk in a safe manner, and recognizing each person's potential for lifelong learning and growth. I understand that my job will require flexibility, creativity and commitment. Whenever appropriate, I will work to support the individual's preferences and interests.

2. Physical, Emotional and Personal Well-being

I will promote the physical, emotional and personal well-being of any person who receives services and supports from this organization, including their protection from abuse and neglect and reducing their risk of harm. I will immediately report any situation in which any person receiving services or supports is experiencing, or is at risk of experiencing abuse or neglect.

3. Respect, Dignity and Choice

I will respect the dignity and individuality of any person who receives services and supports from this organization and honor their choices and preferences whenever possible and appropriate. I will help people receiving supports and services use the opportunities and resources available to all in the community, whenever possible and appropriate.

4. Self-Determination

I will help people receiving supports and services realize their rights and responsibilities, and, as appropriate, make informed decisions and understand their options related to their physical health and emotional well-being.

5. Relationships

I will help people who receive services and supports from this organization maintain or develop healthy relationships with family and friends. I will support them in making informed choices about safely expressing their sexuality and other preferences, whenever possible and appropriate.

6. Advocacy

I will advocate for justice, inclusion and community participation with, or on behalf of, any person who receives services and supports from this organization, as appropriate. I will promote justice, fairness and equality, and respect their human, civil and legal rights.

7. Personal Health Information and Confidentiality

I understand that persons served by my organization have the right to privacy and confidentiality with respect to their personal health information and I will protect this information from unauthorized use or disclosure, except as required or permitted by law.

8. Non-Discrimination

I will not discriminate against people receiving services and supports or colleagues based on race, religion, national origin, sex, age, sexual orientation, economic condition or disability.

9. Integrity, Responsibility and Professional Competency

I will reinforce the values of this organization when it does not compromise the wellbeing of any person who receives services and supports. I will maintain my skills and competency through continued learning, including all training provided by this organization. I will actively seek advice and guidance of others whenever I am uncertain about an appropriate course of action. I will not misrepresent my professional qualifications or affiliations. I will demonstrate model behavior to all, including persons receiving services and supports.

10. Reporting Requirement

As a mandated reporter, I acknowledge my legal obligation to report all allegations of reportable incidents immediately upon discovery to the Justice Center's Vulnerable Persons' Central Register by calling 1-855-373-2122.

PLEDGE TO ABIDE BY THE CODE OF CONDUCT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

I pledge to prevent abuse, neglect, or harm toward any person with special needs. If I learn of, or witness, any incident of abuse, neglect or harm toward any person with special needs, I will offer immediate assistance and then notify emergency personnel, including 9-1-1 where appropriate, and inform the management of this organization. I pledge also to report the incident to the Justice Center for the Protection of People with Special Needs.

I agree to abide by this C	e read and that I understand th ode of Conduct.	e Code of Conduct.	
 Signature	 Print Name	Date	

APPENDIX D

Categories of Substantiated Allegations

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

Category 1 conduct is:

- serious physical, sexual abuse or other serious intentional or reckless acts of abuse, when *they cause* physical injury or serious physical injury or *demonstrate a conscious disregard* for a substantial and unjustifiable risk of physical injury or serious physical injury;
- criminal sexual conduct, including prostitution related offenses or promoting a sexual
 performance; encouraging, facilitating or permitting another to engage in such conduct with a
 service recipient where it is inconsistent with an individual's treatment plan, federal or state law
 regulations or policies; or encouraging or permitting another to promote a sexual performance by
 a service recipient or permitting or using a service recipient to engage in any prostitution-related
 offense;
- the knowing, reckless or criminally negligent failure to perform a duty that causes serious physical
 injury or physical injury that creates a substantial risk of death, or causes death or serious
 disfigurement; causes the substantial and protracted diminution of psychological or intellectual
 function (determined by a clinical assessment) such injury or diminution;
- unlawfully administering a controlled substance;
- abuse as an obstruction of the investigation, including: intentionally falsifying records related to
 the safety, treatment or supervision of a service recipient with the intent to mislead an
 investigation of a reportable incident and the false statement may endanger health safety or welfare
 of the service recipient;
- knowing and willful failure to report Category 1 abuse or neglect;
- intentional materially false statement during an investigation of Category 1 abuse or neglect with the intent to obstruct the investigation;
- intimidating mandated reporters with the intent to prevent reporting of Category 1 abuse or neglect, including the intentional falsification of records described above, or retaliation against a custodian making a good faith report of such conduct; and,
- supervisory failure to act on reported Category 1 abuse or neglect, including the intentional falsification of records described above, as directed by regulation, policy or procedure.

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 has not been identified.

APPENDIX E

Advisory Council

The Justice Center's Advisory Council assists the Executive Director in developing polices, proposed regulations, plans and programs to carry out the Justice Center's functions, powers and duties. Its members are appointed by the Governor, with the advice and consent of the Senate. Members include service providers, people who previously or are currently receiving services, their family members and advocates.

CURRENT MEMBERS

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

Mary E. Bonsignore — Parent, 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

Lisa Gerbasi Goring — Autism Speaks

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

David Allen Lamphere — Self Advocate, Credo Alumni Association

Ronald S. Lehrer — NYS Association of Boards of Visitors

Belinda Lerner – National Football League

Glenn Liebman — Mental Health Association in New York State

Delores McFadden — Orange County Department of Mental Health

Brian P. McLane — Paradigm Solutions

Judith A. O'Rourke — Parent

Clint Perrin — Self Advocacy Association of NYS

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

Gabrielle Horowitz-Prisco — Juvenile Justice advocate

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

Scott Salmon — Self Advocate

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

Euphemia Strauchn-Adams — Parent, Families on the Move

Christopher Tavella, Ph.D — Rockland Psychiatric Center

Robert L. Weisman, DO — Strong Memorial Hospital