I. Justice Center Abuse Prevention Committee

The Justice Center's internal abuse prevention committee is charged with identifying preventative actions that address conditions that cause or contribute to incidents of abuse and neglect. The committee met in December 2022. During these meetings, committee members working in different business units across the Justice Center received updates on prevention and quality improvement activities, the systemic review of choking on food in OPWDD programs, and trends from the mortality review and out of state placement units.

Prevention and Quality Improvement

In 2022, 220 audits of provider agency Corrective Action Plans were completed by the Justice Center's prevention and quality improvement unit. These audits assessed over 1,000 corrective actions taken by provider agencies. The unit also conducted systemic reviews of incident management practices at two different provider agencies, professional boundaries in OASAS settings, and published two prevention products on the Justice Center website in 2022. The two prevention products are "Best Practices for Responding to Medical Emergencies" and "Maintaining Professional Boundaries: Recommendations for an Abuse Free Environment". These new products can be found on the Justice Center website under the Prevent Abuse Tab .

Systemic Review of Choking on Food in OPWDD Settings

The Justice Center conducted a systemic review of incidents involving people choking on food in residential and day habilitation settings licensed and operated by OPWDD. To conduct the review, Justice Center staff made 17 site visits at nine different provider agencies and followed people from their residential program to their day habilitation program. As a result of this review, the Justice Center made recommendations to improve the ability of staff to prevent and respond to choking incidents. In their response to the review, OPWDD outlined activities underway to prevent food choking incidents and agreed to pursue implementation of the Justice Center's recommendations. The complete review and OPWDD's response can be found on the Justice Center website here.

Mortality Review

The Protection of People with Special Needs Act requires that 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 be reported to the Justice Center. Each year, less than 100 of the deaths reported to the Justice Center include an allegation of abuse or neglect. In 2022, there were 50 cases of abuse and neglect with a death involved and 22 of those cases were substantiated. All the cases that were substantiated had a substantiated neglect offense and failure to get adequate and timely medical care was the most frequent finding.

Out-of-State Placements

There were 352 children and youth placed in out of state placement in 2021. The primary diagnoses of these children and youth were Autism and Emotional Disturbance. The Justice Center's role is to investigate or review provider investigations for all allegations of abuse and neglect for NYS residents placed in these out-of-state facilities. The Justice Center also conducts oversight and monitoring visits to these facilities to assess the safety, security and quality of care provided to residents of New York State in these facilities.

The Justice Center has found issues with incident management (e.g., lack of training on conducting investigations, poor investigative interviews) and problems with staff engagement such as poor understanding of the person's disability on the impact on their behavior.