

Total Incident Reports Made to VPCR by Phone or Web Form

Type of Incident and State Oversight Agency	2014	
	July	YTD
Abuse and Neglect	1,126	8,532
OPWDD	766	5,756
OMH	155	1,242
OCFS	182	1,303
OASAS	4	48
DOH	6	36
SED	13	147
Significant Incident	2,719	18,547
OPWDD	1,197	7,393
OMH	650	4,263
OCFS	603	4,736
OASAS	157	1,366
DOH	47	189
SED	65	600
Death (Not Abuse and Neglect)	385	2,744
OPWDD	100	648
OMH	214	1,498
OCFS	2	23
OASAS	60	488
DOH	9	87
SED	0	0
Financial	11	71
OPWDD	5	31
OMH	1	15
OCFS	0	6
OASAS	1	11
DOH	4	7
SED	0	1
Non-Reportable	3,507	22,284
Not a Justice Center Incident	2,144	15,131
Not an Incident	1,363	7,153
Total	7,748	52,178

Classification of Reports

Under the guidance of the Justice Center's Call Center Director and in consultation with the Office of Investigations, intake personnel log incoming incident reports (via hotline and web form) into the Vulnerable Persons Central Register (VPCR) case management system. Staff members review the details of the incident and classify it as either a reportable incident and assign it to the Justice Center or the appropriate state agency for investigation or they classify it as a non-reportable incident.

○ **Reportable Incidents**

Reportable incidents include any situation in which a person who is receiving supports or services in a facility or program under the Justice Center's jurisdiction may have been abused or neglected. A death is a reportable incident if it conforms to the following criteria:

- The person was enrolled in or receiving services from the facility or program at the time of the death and death was the result of a abuse, neglect or a significant incident;
- It was an apparent homicide, suicide, unexplained or accidental cause;
- It was unrelated to the natural course of illness or disease; or
- It was related to the lack of treatment provided in accordance with generally accepted medical standards.

Reportable incidents also include an incident that has the potential to result in harm to the health, safety or welfare of a person receiving services in such a facility or program.

○ **Non-reportable Incidents**

Many of the calls received by the Call Center occur in facilities and programs that are outside of the Justice Center's jurisdiction or the nature of the incident does not rise to the level of a reportable incident as defined above. These calls are categorized as "Not a Justice Center Incident" or "Not an Incident."

• **Not a Justice Center Incident**

These reports do not fall within the Justice Center's jurisdiction based on where they occurred or the nature of the incident, but may require follow-up from another state agency. They may also be an incident that occurred prior to the Justice Center's effective date of June 30, 2013.

• **Not an Incident**

Reports that are classified as "not an incident" are those where the nature of the call is not regarding a specific incident that caused harm or potential for harm, but the caller is seeking general information or contacted the Justice Center erroneously. Efforts are made to direct the caller to the appropriate source.

Types of Reportable Incidents

The Justice Center organizes reportable incidents into two categories: abuse and neglect and significant incident.

○ **Abuse and Neglect**

New York State law defines abuse and neglect in broad terms, including both actual harm and the risk of harm.

- *Physical abuse*: intentional or reckless contact such as hitting, kicking, shoving, corporal punishment;
- *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*: any action, inaction or lack of attention that results in or is likely to result in physical injury or impairment such as: failure to provide supervision, adequate food, clothing, shelter, health care or access to an educational entitlement;
- *Unlawful use or administration of a controlled substance*;
- *Aversive conditioning*: the use of unpleasant physical stimulus used to modify behavior without person-specific legal authorization; or
- *Obstruction*: interfering with the discovery, reporting or investigation of abuse/neglect, falsifying records or intentionally making false statements.

Note: Abuse and neglect allegations may involve one or more suspects. Each suspect may be the subject of one or more allegations which may involve more than one victim.

○ **Significant Incident**

Significant incidents, which do not constitute abuse or neglect, but have the potential to result in harm to the health, safety or welfare of a person receiving services, must also be reported by mandated reporters. Types of significant incidents include, but are not limited to:

- Use of restraint when it is avoidable, involves a banned technique or is used by inadequately trained staff;
- Unauthorized seclusion or time-out; or
- Administration of a medication which is inconsistent with a prescription or medical order that results in an adverse impact.

Other Justice Center Reviews or Investigations:

○ **Death (not abuse or neglect)**

The director of a facility or program under the jurisdiction of the Justice Center is required to immediately report (within 24 hours) the death of a person receiving services from an operated, licensed or certified facility at the time of their death or for a person who had received services within 30 days of their death. Such reports must be made upon discovery (witnessing or learning) of such death by contacting the Vulnerable Persons Central Register (VPCR) Death Reporting Line, which is separate from the VPCR Hotline used to report abuse, neglect, and significant incidents. The report must include the medically determined manner and cause of the individual's death, the location of the death, and potential occurrences immediately preceding the individual's death.

Justice Center staff nurses review all death reports to determine whether or not further review or investigation is warranted. In such cases the Justice Center will either review the facility investigation or conduct an on-site investigation of its own.

The Justice Center may conduct an on-site investigation when:

- an individual commits suicide, either while in a hospital or licensed residential facility, or within one week of discharge from the facility, or within 72 hours of presentation at a hospital emergency room;
- there is an allegation of abuse involving the circumstances of death;
- a death occurs within several days of restraint or seclusion, or after an altercation with staff or peers;
- questions are raised regarding the quality of medical care prior to the death; or an
- Agency or individual contacts the Justice Center with concerns.

○ **Financial**

The Justice Center reviews the cost-effectiveness of the management, supervision, and delivery of any program under its jurisdiction. These investigations range from reviews of service recipient personal allowance complaints to complex corporate investigations of fraud, waste, or abuse of funds. Based on its findings, the Justice Center may issue recommendations to the appropriate state oversight agency. If a crime may have been committed, the Justice Center refers its findings to local District Attorney's. Referrals are also made to appropriate state and federal regulatory or enforcement agencies (e.g., NYS Attorney General, NYS Office of Taxation and Finance, Internal Revenue Service.) Chapter 501 of the Laws of 2012 <http://www.justicecenter.ny.gov/regulations-guidance/statute>