NYS Justice Center

For the Protection of People with Special Needs

PROTECTING NEW YORKERS WITH SPECIAL NEEDS:

PROGRESS REPORT ON ONE MONTH ANNIVERSARY OF THE JUSTICE CENTER

AUGUST 2013

Andrew M. Cuomo
Governor

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NYS Justice Center
For the Protection of People with Special Needs

Summary

In April 2012, Clarence J. Sundram, Special Advisor to Governor Andrew M. Cuomo on Vulnerable Persons, issued a report on New York State's systems for the protection and safety of individuals served by facilities operated, licensed or certified by six state 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).

Mr. Sundram's report, entitled "The Measure of a Society: Protection of Vulnerable Persons in Residential Facilities Against Abuse and Neglect," laid out a series of sweeping recommendations, the foremost of which was the establishment of the Justice Center for the Protection of People with Special Needs (Justice Center). The Center would be created to consolidate the relevant responsibilities of these agencies within one central agency solely dedicated to protecting this population. Its mission would also be to ensure consistency in the application of standards for investigations and discipline, and to provide independence of investigations from State oversight agencies.

The one-month anniversary of the Justice Center's opening catalogues the tremendous progress it has made in turning Mr. Sundram's recommendations into reality. In a little over a year since the report was issued, the vast majority of its recommendations have been put into operation, with the remaining reforms now in the process of being implemented. These reforms, which will standardize and strengthen the safety net for New Yorkers with special needs in state care, are expected to be completed within one year of its opening.

In reviewing these accomplishments, Clarence Sundram stated:

"There has been a remarkable degree of progress to date. Within a relatively short time, most of the major legislative recommendations in my report, which affect the safety of approximately one million New Yorkers served by six large human service systems, have been implemented. OPWDD has made great strides in addressing prevention through implementation of a number of recommendations affecting the workforce, including adopting a code of conduct and competency standards for direct service workers. The recent opening of the Justice Center creates a simple and consistent system for reporting and responding to allegations of abuse and neglect, including referrals of criminal conduct to law enforcement agencies. It provides for well trained professional investigators and special prosecutors. Although there is work left to be done, the breadth and depth of the accomplishments to date are impressive."

Justice Center: First Month Report

The Cuomo Administration's efforts to ensure that New Yorkers with special needs are protected from abuse, neglect and mistreatment have been significantly strengthened by the creation of the new Justice Center for the Protection of People with Special Needs (Justice Center), a law enforcement agency which also serves as an advocate for people with special needs.

The Justice Center has established the definitions of abuse and neglect in broad terms, including both actual harm and the risk of harm, and maintains the Vulnerable Persons Central Register Hotline (VPCR). The VPCR is staffed 24 hours a day, seven days a week by 70 highly-trained call center representatives who were selected from a pool of more than one thousand applicants.

Reports to the VPCR Hotline come from many sources, including individuals with special needs who are receiving services, "mandated reporters" who comprise custodians, other health care professionals and law enforcement, as well as families and the general public. Anyone who witnesses or suspects the abuse or neglect of a person with special needs should make a report to the Justice Center VPCR Hotline by calling 1-855-373-2122.

The VPCR hotline has responded to over 7,200 reports since it began operations on June 30, 2013. All reported incidents are assessed, classified and logged into a custom-designed computerized case management system and routed to the appropriate law enforcement or state agency for investigation or review.

Each report is classified as abuse and neglect, a significant incident that has the potential to result in harm to the health, safety or welfare of a service recipient, or a non-reportable incident that falls outside the jurisdiction of the Justice Center or does not rise to the level of the other classifications.

To date, the Justice Center has received over 1,300 reports of alleged abuse or neglect that have required investigation. Generally, the Justice Center investigates the most serious cases of abuse and neglect, with cases of less severity delegated to the appropriate state agency for investigation. Each case is tracked until resolution, with state agencies required to report back their findings on referred cases so they can be reviewed by the Justice Center.

The Justice Center currently employs over 70 specially trained investigators, who provide on-site coverage on a 24/7 basis. Abuse and neglect cases sent to them are reviewed and triaged within a matter of hours from the time they are received.

To date, the Justice Center has received nearly 3,000 reports that have been classified as "Significant Incidents." 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. Therefore, the total number of calls received exceeds the actual number of occurrences of abuse and neglect, or significant incidents. These reports are then linked together to provide all of the information that is available about each incident.

The remaining 2,900 reports that have been received to date by the Justice Center include reports of financial misconduct, legally required administrative death reports, and other reports that have been classified as non-reportable.

As a result of the reports made to the Justice Center, its Special Prosecutor/Inspector General, Patricia Gunning is currently overseeing the investigation of approximately 30 cases that may involve criminal activity which may result in the arrest and prosecution of custodians who are alleged to have abused people with special needs under their care.

Measuring Progress of Reform with Sundram Report

The following chart identifies each of the policy recommendations from the original Sundram report and the progress that has been made by the State.

Sundram Finding/Recommendation:	Status
• Require that provider agencies have an incident management program to identify and respond to unusual incidents;	The Justice Center legislation requires that all six covered agencies -- and the programs they license and certify -- report abuse, neglect and significant incidents to the VPCR. These incidents are reviewed and investigated and, when appropriate, corrective actions be undertaken.
• Define the terms "abuse" and "neglect" to encompass specific behaviors by employees and others;	The Justice Center legislation codified common definitions applicable to all systems.
• Require that providers investigate reported allegations of abuse or neglect;	The Justice Center legislation implemented this recommendation
• Establish time frames for the completion of such investigations;	The Justice Center legislation requires that all six covered agencies -- and the programs they license and certify -- investigate incidents within specified time limits. In addition. each investigaiton is monitored by the Justice Cente using a computerized tracking program from the time it is opened until it is resolved.
• Require that persons conducting investigations be trained to do so;	The Justice Center legislation requires standardized training for all investigators. The Justice Center has conducted a wide range of trainings for both its own investigators and those within the six state agencies it oversees. This has been accomplished through a combination of seminars, webinars and online video training programs, with over 3,000 individuals having received investigator training statewide to date.

Sundram Finding/Recommendation:	Status
• Establish a standard of proof to be used in such investigations;	The Justice Center legislation requires that cases be substantiated by using a preponderance of evidence as the standard of proof.
• Require that reports of such investigations be sent to the state supervising agency;	The Justice Center has established procedures to ensure that all investigations are thorough and complete, and that the results of the completed investigations are sent to the supervising state agency.
• Identify types of crimes and under what circumstances they must be reported to law enforcement agencies;	Under the Justice Center legislation, law enforcement agencies are notified of criminal activity at facilities and programs within their jurisdiction. In addoition, the Justice Center provides support to law enforcement and District Attorney's Offices in pursuing criminal cases for investigation and prosecution.
• Obligation of the state agency itself to conduct investigations;	Justice Center investigators review all reported allegations of abuse and neglect within hours of receiving the reports. Cases are then assigned for investigation to either the Justice Center or to the State oversight agencies. When appropriate, the State agencies may delegate responsibility for the investigation to the facility or care provider where the abuse or neglect is alleged to have occurred.
• Require providers to analyze patterns and trends of reported incidents, and;	The Justice Center analyzes patterns and trends using the data in its case management system. State agencies and private providers are also required to maintain incident review committees to conduct this type of analysis.
• Availability of independent oversight over the residential providers' operations.	The Justice Center absorbed the functions of the Commission on Quality of Care and Advocacy for Persons with Disabilities, including oversight of abuse and neglect in residential settings. The Justice Center has an oversight and monitoring unit that tracks the implementation of corrective action plans that may result from investigations of abuse, neglect and other significant incidents reported to its VPCR Hotline.

A. Legislative Action

Sundram Finding/Recommendation:	Status
Under a Justice Center: a. Establish a Hotline and Statewide Central Register for vulnerable persons across human service systems to: 1) Receive reports of abuse and neglect involving vulnerable persons, including anonymous reports, 24 hours a day; 2) Screen and classify reports of abuse and neglect, with the assistance of experienced law enforcement officers, and ensure their prompt investigation and remediation, as well as referral of criminal conduct to appropriate law enforcement agencies as warranted, and; 3) Maintain a registry of all persons who have been found substantiated for serious or repeated acts of abuse or neglect of vulnerable persons, as described in this report, and who would be barred from continued employment in positions requiring direct contact with vulnerable persons.	The Justice Center legislation implemented this recommendation. The Vulnerable Persons Central Register (VPCR) hotline is staffed 7 days a week, 24 hours a day by highly trained call center representatives. The VPCR began taking reports of allegations on June 30, 2013.
b. Establish a Division of Investigation & Prosecution to: 1) Directly investigate all serious cases of abuse and neglect, as well as any other cases it deems warranted; 2) Delegate other cases to trained and certified investigators in accordance with policies and procedures it develops, and receive and review the reports and outcomes of such investigations, as well as investigations into other serious incidents, and take any further action it deems warranted (using sampling, spot-checks, reviews of outliers and other techniques); 3) Have the authority to prosecute abuse and neglect crimes against vulnerable persons as it deems warranted, and; 4) Represent the state in disciplinary cases seeking termination of state employees for abuse or neglect of vulnerable persons.	The Justice Center investigates serious cases of abuse and neglect and determines those that can be investigated by the covered agency or provider. The Justice Center reviews and approves the outcomes of investigations to ensure that appropriate action is taken in response to the incidents. It also has a special prosecutor to prosecute serious abuse and neglect cases, and contains a unit to represent the state in disciplinary matters in cases under the jurisdiction of the Justice Center. The Justice Center also has set standards for investigators and provides training to them.

Sundram Finding/Recommendation:	Status
c. Establish a Division of Fair Hearing to conduct all fair hearings relating to reports of abuse or neglect.	The Justice Center will conduct hearings for employees in abuse and neglect cases who may be subject to placement on the "staff exclusion list." Individuals on the list may not be hired in a position that would require regular and substantial contact with vulnerable persons.
d. Establish a Training Academy which would: 1) Develop investigation standards and a training curriculum for investigators; 2) Certify trained investigators who may be assigned to investigate reports of abuse or neglect and other serious incidents; 3) Work with human service agencies and constituency groups to develop a common core curriculum for direct support workers and a system for credentialing such workers, and; 4) Promulgate a code of conduct applicable to all employees in human service agencies consistent with principles established by law.	The Justice Center is overseeing required training for investigatory staff. The Justice Center has also promulgated a code of conduct applicable to direct care workers. In addition, OPWDD has a code of conduct and is implementing core competencies for direct support professionals. New OPWDD regulations require training in positive relationships for all new employees and volunteers, and requires refresher courses on an annual basis.
e. Establish a clearinghouse for background checks of all direct support workers across human service agencies, as described in this report, in order to promote consistency and reduce duplicative background checks	The Justice Center has absorbed all background check functions for OPWDD, OMH and OCFS and will serve as the central repository for this information. As required by the Justice Center legislation, OASAS is conducting its own background checks for direct support and credentialed employees in its system of care.

Sundram Finding/Recommendation:	Status
f. Establish under state law a Division of Monitoring and Oversight to assume the monitoring and oversight responsibilities of the Commission on Quality of Care and Advocacy for Persons with Disabilities. In addition, this function should be expanded to cover other human service systems currently lacking independent oversight.	The Commission on Quality of Care and Advocacy for Persons with Disabilities was abolished and its functions were assumed by the Justice Center. Its oversight and monitoring function covers all six of the State agencies within the Justice Center's jurisdiction.
g. Submit an annual report to the governor and legislature, and such other reports as it deems warranted, reviewing and analyzing patterns and trends in the reporting of and response to incidents of abuse and neglect, and other serious incidents, and recommending appropriate preventive and corrective actions to remedy individual or systemic problems.	The Justice Center legislation requires such an annual report with the recommended content. OPWDD has also established a Mortality Review Committee to review deaths in its system, including related patterns and trends.
h. Enact a quality assurance statute to provide confidentiality for deliberative discussions regarding incident investigations and fomulation of recommendations for implementation of preventitive, corrective, and disciplinary action to protect against the use of such information in lawsuits.	The statute creating the Justice Center requires all facilities and providers under its jurisdiction to have an Incident Review Committee (IRC) to review allegations of abuse and neglect and to make recommendations to reduce such incidents. Under Social Services Law 490(2), the deliberations of the IRC's are confidential.
i. Enact legislation making sexual activity between staff and residents of a facility a crime.	The Legislation creating the Justice Center contained provisions implemented this recommendation.
j. Enact legislation to ban persons convicted for specified violent and sex crimes, as well as substantiated Category 1 abuse, from future employment in human service agencies in any capacity where they would have regular and substantial contact with persons receiving services	The Legislation creating the Justice Center contained provisions implemented this recommendation.
k. Strengthen the laws making abuse of a vulnerable person in residential care a crime.	The Justice Center contains provisions implementing this recommendation.

B. Prevention

Sundram Finding/Recommendation:	Status
1. Reinforce the policy of community integrated services wherever possible, and use congregate residential care as a last resort.	OPWDD, through the People First Waiver and its transformation agenda, promotes the provision of services in integrated community settings and seeks to reduce the use of congregatesettings . OMH has had a policy of de-institutionalizing people from inpatient hospital settings throughout its history, consistent with Olmstead requirements. OCFS operates or funds a number of initiatives to support the prevention of placement of youth into foster care or OCFS custody and the return of such youth to the community as soon as possible. For example, OCFS' "Bridges to Health Waiver" enables eligible foster youth and youth in OCFS custody who have a serious emotional disturbance, medical fragility, or developmental disability, to be served within the community instead of residential care. Pursuant to an Executive Order, a comprehensive Olmstead Plan is being developed.
2. Reduce the use of restraints and hands-on interventions to control or manage the behavior of children and adults in residential facilities	"PROMOTE" -- a new training focusing on decreasing the use of physical interventions -- is being implemented statewide. OPWDD has promulgated extensive regulations designed to protect individuals by reducing the use of restrictive interventions. OMH is developing regulations regarding restraint and seclusion. It has received several grants from SAMHSA and has been engaged in a process for the past five years to achieve a restraint- free environment throughout its service delivery system. OCFS has established both a new behavioral treatment program, the "New York Model," and a new crisis management program for its juvenile justice facilities.

Sundram Finding/Recommendation:	Status
a) Facility staff should address in the individual service plan specific risk factors for each individual, the best ways of responding when an individual is having a behavioral episode or otherwise losing control. b) In all cases where there is a hands-on intervention, there must be a physical examination by a physician or nurse following every intervention. c) Every such intervention should require a quality assurance review with a purpose of learning what might have been done to avoid it, including interviewing the individual subject to the intervention.	OPWDD has promulgated extensive regulations designed to protect individuals by reducing the use of restrictive interventions. In addition, its new training curriculum, "PROMOTE," focuses on decreasing the use of physical interventions. OMH is developing regulations to include preventive factors as outlined in items a) thru c). Clinical consultation is required as a condition of Medicaid funding for OMH programs. OCFS' "New York Model" and crisis management programs include these components. OCFS has established and is expanding its Quality Assurance Unit to review key components of facility operations, including the provision of mental health services and physical interventions.
3. Establish a clinical consultation capacity in each region to help with the development and implementation of behavior management strategies	OMH has a central capacity for clinical consultation and frequently provides assistance to outside groups seeking it. OPWDD's regulations have requirements for clinical oversight of behavior plans. OPWDD is piloting the START (Systemic Therapeutic Assessment, Respite and Treatment) model which is a national approach to create regional competence in addressing behavior management. OCFS has established a Bureau of Behavioral Health Services, which has both central and regional office staff available to oversee and provide consultation to the clinical staff in its juvenile justice facilities.
4. Schedule clinical staff to work flexible schedules including evening and weekend hours	OPWDD Clinical staff is scheduled to work flexible schedules as dictated by the needs of the people they serve. OCFS requires clinicians to work evenings and weekend hours.

Sundram Finding/Recommendation:	Status
5. State agencies should require that managers and supervisors work flexible schedules including evening and weekend hours and make unannounced visits and unscheduled tours on all shifts of state operated and state certified residential programs.	At OMH, in accord with a SAMHSA grant, a series of recommendations have been generated and these will be rolled out with the conclusion of the work group's findings over the course of the next several months. OPWDD has implemented unannounced site visits by district senior level staff. OCFS requires managers and supervisors to work flexible schedules and make unannounced visits and tours of its juvenile justice facilities.
6. Institute a practice of exit interviews with staff, residents and families as part of the quality assurance process to examine issues regarding safety and protection from harm of the residents.	OPWDD is implementing an exit interview process for staff. It has also informed all state and voluntary providers that Statements of Deficiencies must be readily available to families and residents at the program site.
7. Residential service providers should be required to create Resident Councils or other forums for resident involvement, with necessary support, to meet periodically to review issues affecting safety and quality of life and to make recommendations for improvement to facility managers.	OPWDD has a strong self-advocacy community which advocates for individuals in various settings. Some facilities specifically have resident councils. OCFS juvenile justice facilities have a variety of resident committees that meet regularly for these purposes and make recommendations to facility managers.
8. Residential service providers should be encouraged to create a monthly forum to provide all staff, including direct support workers, an opportunity to be heard in the running of the facility and in making recommendations for improved practices to address safety and quality of life of the residents, and working conditions for the staff.	OPWDD has created a direct support advisory council to advise the commissioner and conducted six regional listening tours for direct support professionals. Additionally, OPWDD issues anonymous employee surveys that are conducted every six months. OCFS juvenile justice facilities provide a variety of opportunities for staff to provide input on the operation of their facilities, including monthly Therapeutic Intervention Committee meetings.

C. Recruitment

Sundram Finding/Recommendation:	Status
1. Through the Training Academy that is part of the Justice Center, establish consistent minimum qualifications for direct support workers across human service systems.	OPWDD has instituted more rigorous requirements and core competencies for new hires. Longstanding OPWDD regulations required initial training, but new regulations now require annual training in incident management and other topics.
2. Establish consistent procedures for background checks for all direct support workers and a clearinghouse within the Justice Center to reduce duplicate checks.	The Justice Center has assumed all background check functions for OPWDD, and OMH and conducts background checks for OCFS' licensed or certified residential programs for children. The Justice Center further serves as the central repository for this information. As required by the Justice Center legislation, OASAS conducts its own background checks for direct support and credentialed employees in its system of care.
3. Perform initial character and competence reviews of provider agencies and again upon renewal of licenses and operating certificates.	OMH completes all character and competence reviews of all new providers and those who need re-certification. OPWDD reviews provider agencies at initial application and on an annual basis thereafter. Information regarding incidents occurring at provider agencies -- and provider agency compliance with the new Justice Center requirements -- will be taken into account during the license renewal process.
4. Review agency commitment to training and development of employees, and implementation of preventive and corrective actions that were identified as a result of investigations, including implementation of consistent, fair and proportional consequences for employee misconduct.	The Justice Center has an oversight and monitoring unit that monitors implementation of corrective action plans resulting from investigations of abuse, neglect and other significant incidents reported to the VPCR. It also is responsible for conducting State employee disciplinary proceedings that may result from investigations of reportable incidents of abuse and neglect, which will provide for consistent responses to these incidents across the systems covered by the Justice Center.

D. Staff Training

Sundram Finding/Recommendation:	Status
1. Through the Training Academy, develop a core curriculum of training for all direct support workers that covers common obligations to support residents.	The Justice Center's Code of Conduct, which must be read and signed by all direct support workers, sets forth their obligations to support residents. Training on the Code of Conduct is now being developed. OPWDD has adopted core competencies for Direct Support Professionals (DSPs), has a code of ethics, and is studying implementing a credentialing program for DSPs. OMH provides an extensive, one-year competency-based training experience for individuals hired, including Mental Health Therapy Aide Trainees (MHTAT). Additionally, all inpatient staff, including clinical/professional staff, as well as Safety Officers who interact with patients, are required to take a training class that focuses on awareness and understanding, prevention, verbal and non-verbal de-escalation, trauma-informed care, and creating a person-centered treatment culture. This is an annual requirement. OCFS has a training academy and common competency requirements for direct care and supervisory staff in its juvenile justice facilities.
2. Provide training for mid-level supervisors on the management of frontline workers, supervisory duties, and the need for vigilance.	OMH provides a variety of supervisory training, including "Supervising in a Healthcare Environment," which focuses on the challenges of helping health care employees perform at their optimum level. OPWDD has developed supervisory competencies.
3. All training should stress the importance of linguistic and cultural competence and sensitivity.	Via Executive order, linguistic sensitivity is stressed; cultural competence, though periodically offered, is not mandated. OMH policy requires at least two to four hours of annual cultural and linguistic competence training to support each facility's Strategic Plan on cultural and linguistic competence.

Sundram Finding/Recommendation:	Status
4. Train residents and families on the process for reporting incidents, and on their rights to information regarding incidents, their investigation, and access to closing documents.	The Justice Center has produced and distributed over 35,000 posters and has included information on its website to inform residents and family members about the process for reporting incidents. A portal on its website provides information targeted specifically for individuals and families. OPWDD publishes a booklet and informational materials on the rights of individuals and families, including the right to be free from abuse and neglect, as well as access to incident documents. OPWDD regulations require training of individuals who are receiving services in abuse prevention.
5. State agencies should consider the value of collaborating in training all direct support professionals in the core curriculum, using various forms of instruction including web-based teaching and training.	OPWDD is the process of establishing a web-based learning option for all DSPs.

E. Career Ladders

Sundram Finding/Recommendation:	Status
1. Develop certification programs for direct support workers in each agency with defined steps, required training and competencies linked to graduated pay increases.	OPWDD has met with the NYS Department of Labor to begin steps that allow DSPs better options for their career ladders.
2. Provide access to relevant educational programs to enhance knowledge and skills, using community colleges and the resources of the State University and the City University of New York.	OPWDD has entered into a formal agreement with the State University of New York (SUNY) that is designed to recruit the next generation of workers for OPWDD and its nonprofit partners. Pilot initiatives are under way in New York City and Central New York to recruit, test, and train DSPs in collaboration with SUNY. OPWDD is partnering with the Department of Labor to get recruitment information into locations where unemployment benefits are acquired. In order to provide a more realistic job preview for potential DSPs, OPWDD added a video to its employment web page, as well as to the New York State Department of Civil Service' website. Since February 2012, OPWDD has held 34 outreach and recruitment events, including college and career fairs, as well as meeting with the Native American Family Service Commission and participating in a job fair held at the American Indian Community House in Tonawanda, New York. OPWDD began a pilot recruitment program with Centro Civico, a grass roots organization serving Latinos living in various communities in New York State, and the first Civil Service examination administered at a nonprofit provider agency was completed in August 2012. Plans are under way to expand these efforts to other Latino communities around the State.

Sundram Finding/Recommendation:	Status
3. Develop a means to retain committed workers in the direct support line through enhanced compensation, and recognition as a Master Direct Support worker.	OPWDD has obtained a multi-year grant from the Developmental Disabilities Planning Council to create five Regional Centers for Workforce Transformation beginning in 2013. These centers will focus on enhancing the profession of direct support through shared trainings, promotion of standards of excellence and core competencies. These centers will be a coalition of agencies to advance the direct support profession across the developmental disabilities system. This enterprise will be a flagship for the direct support professional development in other human service fields. Among its many areas of focus will be development of career ladders that encourage retention and excellence.

F. Incident Reporting and Investigation

Sundram Finding/Recommendation:	Status
1. Require every state agency to assure that their providers have an incident reporting and investigation policy and procedure consistent with the proposed law, and adequate investigative capacity	The Justice Center legislation requires providers to follow incident reporting policies and procedures set forth in the law. Provider compliance or non-compliance with these policies and procedures will be reviewed during licensing and/or certification reviews.
2. State agencies should establish a monitoring role to ensure compliance by their providers.	The Justice Center legislation requires employees at all provider agencies to report abuse, neglect and significant incidents to the VPCR. Compliance or non-compliance with this requirement will be reviewed during licensing and/or certification reviews. OPWDD has an extensive Quality assurance monitoring role with its providers. OPWDD also requires monitoring of VO incidents by DDSOs, as well as establishing process for internal monitoring (e.g. committee review).
3. The law, policy and procedures should identify mandated reporters, and the treatment of failures to make required reports as misconduct subject to discipline.	The Justice Center legislation implemented this recommendation.
4. The reporting obligation is to call the VPCR hotline as soon as possible, but no later than 24 hours of discovery, to report all abuse and neglect based on reasonable suspicion	The Justice Center legislation implemented this recommendation.
5. The law, policies, and procedures should provide for notification to families of all incidents involving their relative, along with a notice of their rights to information at the conclusion of the investigation.	The Justice Center legislation implemented this recommendation.

Sundram Finding/Recommendation:	Status
6. For serious incidents (category one as described in the report), investigation should be conducted by trained and certified investigators who are free of conflicts of interest	The Justice Center legislation requires training of investigators, and the Justice Center's own investigators, some of whom have a law enforcement background, will investigate serious abuse and neglect.
7. Serious incident investigations must meet specified standards.	The Justice Center has hired and trained experienced investigators who will meet the highest professional standards.
8. Investigation reports should be done in a standard format	The Justice Center has implemented this recommendation.
9. Incident investigation reports must be reviewed by an Incident Review Committee which includes representation from family, consumer, and advocacy groups.	The Justice Center legislation requires that providers create such Incident Review Committees to review all investigations and implement appropriate corrective actions.
10. Investigation reports must result in a finding of Substantiated, Inconclusive, Disconfirmed, or Systemic Problems. The standard of proof to substantiate a case is by a preponderance of the evidence.	The Justice Center legislation requires allegations to be substantiated or unsubstantiated, and for systemic problems to be identified. The preponderance of the evidence standard is used.
11. The conclusion of the investigation report must be submitted to the new Statewide Central Register as well as to the state licensing/certification agency, and for Medicaid funded agencies, to the Office of Medicaid Inspector General.	The Justice Center legislation implemented this recommendation.
12. The provider agency is responsible for implementation of any recommendations for preventive, corrective or disciplinary action and reporting the same to the state supervising agency. For substantiated cases of abuse, referrals should be made to the appropriate professional licensing body in the case of licensed professionals.	The Justice Center legislation implemented this recommendation.

Sundram Finding/Recommendation:	Status
13. Cases of Systemic Problems must be followed up by the state supervising agency through its licensing/certification process to ensure prompt remediation of the conditions.	The Justice Center legislation implemented this recommendation.
14. Disconfirmed and inconclusive cases will be sealed in the State Central Register.	The Justice Center legislation implemented this recommendation.
15. Substantiated cases of Category One abuse will be maintained in the State Central Register for residential facilities, with a due process procedure to enable the subject to challenge the finding. Such employees will be barred from future employment with human service agencies and the determination will be disclosed to prospective employers during background checks.	The Justice Center legislation implemented this recommendation.
16. State agencies should develop and implement programs to publicly recognize and value the contributions of reporters whose actions prompt corrections and improvement in the service system.	The Justice Center legislation requires the Justice Center to develop such a program. OPWDD initiated an "I Spoke Out" campaign and also requires staff to attest that they reported any abuse witnessed on their time sheets.

G. Employee Discipline

Sundram Finding/Recommendation:	Status
1. **State System Care Providers**, in Coordination with the Governor's Office of Employee Relations, should: a) Implement a "Table of Penalties" to set consistent, fair and proportional consequences for employee misconduct. b) Develop a program of training for the select panel of arbitrators to address the special conditions affecting vulnerable people in state facilities. c) Provide for the expeditious scheduling and completion of the hearing process of cases that go to arbitration, to reduce lengthy suspensions of employees and stress on residents and co-workers. d) For cases where the penalty sought is termination, state agencies should use attorneys skilled in trial practice from the Justice Center Division of Investigation and Prosecution to present the state's case before the arbitrator. e) Include in the presentation of the state's case a victim impact statement presented by an advocate (e.g. a family member, protection and advocacy staff, or Mental Hygiene Legal Services attorney). f) For all cases where termination is not the outcome to be sought, use positive disciplinary approaches which target the behaviors to be corrected, the skills to be enhanced, and the conditions that would minimize the likelihood of repetition of the misconduct. Develop Individual Rehabilitation Plans involving the subject, in planning re-entry to the workplace. g) The separate process of fair hearings for credentialed staff accused of misconduct (including abuse) was found to take long periods of time to conclude final decision-making. These multi agency (SED, OASAS) proceedings should be the subject of a separate review to determine if efficiencies and stricter timelines for task completion are needed.	A table of penalties is currently being negotiated by GOER and the unions which represent the covered employees. Arbitrator training is also being developed. The Justice Center has created an Employee Discipline Unit with skilled attorneys to conduct disciplinary hearings related to abuse and neglect. Victim impact statements will be utilized in these hearings. The Justice Center's Employee Discipline Unit will ensure that consistent processes, procedures and penalties are utilized in all of the systems under its jurisdiction. OPWDD utilizes a program called "Awareness Training and Feedback" for enhanced supervision of a returning employee.

Sundram Finding/Recommendation:	Status
2. **Non-State Care Providers:** The "Table of Penalties" provides guidance to non-state providers effectuating consistent, fair and proportional consequences for employee misconduct, consistent with any applicable collective bargaining agreements.	The Justice Center legislation contains a list of the types of egregious misconduct that would result in a worker being placed on the "Staff Exclusion List" (SEL), which must be checked by a prospective employer before hiring any worker who would have regular and substantial contact with a vulnerable person. These egregious acts are set forth in the list of "Category 1" conduct in Social Services Law section 493(4)(a). If a person is on the SEL, he or she may not be hired. An employee who has committed "Category 1" misconduct included in the legislation and who is placed on the SEL can be subject to termination, consistent with any applicable collective bargaining agreement disciplinary processes. The law does not limit termination to just these types of misconduct. Therefore, someone who commits lesser misconduct, but who has a troubling disciplinary history, may also be subject to termination.

H. Provider Discipline/Correction

Sundram Finding/Recommendation:	Status
1. State agencies should ensure that systemic problems are promptly corrected.	The Justice Center's oversight and monitoring unit works with State Oversight Agencies to ensure that systemic problems are addressed and promptly corrected. OPWDD, through its DQI function, conducts on-sight reviews of providers and initiates prompt correction strategies. OCFS Quality Assurance staff and Child Welfare Regional Office staff identify systemic problems in OCFS juvenile justice and licensed residential programs, respectfully, and require corrective action plans for the prompt correction of such problems.
2. Repeated failures of this type and the failure to implement prompt corrective action should be dealt with through provider sanctions, including monetary fines and, where appropriate, revocation or limitation of operating certificates.	The Justice Center legislation requires providers to follow incident reporting policies and procedures set forth in the law, including implementation of appropriate corrective actions. Provider compliance or non-compliance with these policies and procedures will be reviewed during licensing and/or certification reviews. OPWDD has instituted an "Early Alert" process for monitoring providers with serious or repeat deficiencies, as well as enhanced provider protocols and provider report cards and monetary fines for continual failure to fix corrective actions. OPWDD can also revoke or limit an operating certificate, as necessary. OCFS has a wide variety of enforcement tools available to address licensed residential programs that do promptly address systemic problems, including placing the programs on heightened monitoring or limiting, revoking or suspending the program's license.

Sundram Finding/Recommendation:	Status
3. In the license/certification review process, data of each provider's performance regarding the handling of cases of abuse/ neglect should be reviewed.	The Justice Center legislation implemented this recommendation.
4. Transparency of certification reports and results. Agency reports leading to certification decisions should be posted on the website and made publicly available, with such redactions as may be necessary to preserve legally confidential material.	OPWDD posts information on providers with severe and repeat deficiencies on its website as part of its "Early Alert" process. OPWDD has also issued guidance that statements of deficiencies must be maintained on-site and made available to individuals and families upon demand.


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