NEW YORK
STATE OF
OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Annual Report to the Governor and Legislature

2018

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

The Justice Center's Promise to New Yorkers with Special Needs and Disabilities

OUR VISION

People with special needs shall be protected from abuse, neglect and mistreatment. This will be accomplished by assuring that the state maintains the nation's highest standards of health, safety and dignity; and by supporting the dedicated men and women who provide services.

OUR MISSION

The Justice Center is committed to supporting and protecting the health, safety, and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment, and investigation of all allegations of abuse and neglect so that appropriate actions are taken.

OUR VALUES AND GUIDING PRINCIPLES

Integrity: The Justice Center believes that all people with special needs deserve to be treated with respect and that people's rights should be protected.

Quality: The Justice Center is committed to providing superior services and to ensuring that people with special needs receive quality care.

Accountability: The Justice Center understands that accountability to the people we serve and the public is paramount**.**

Education: The Justice Center believes that outreach, training, and the promotion of best practices are critical to affect systems change.

Collaboration: Safe-guarding people with special needs is a shared responsibility, and the Justice Center is successful because it works with agencies, providers, people who provide direct services, and people with special needs to prevent abuse and neglect.

NEW YORK STATE OF OPPORTUNITY. Justice Center for the Protection of People with Special Needs

ANDREW M. CUOMO
Governor

DENISE M. MIRANDA
Executive Director

May 1, 2019

To the Governor and Legislature:

I am pleased to provide you with the 2018 Annual Report of the Justice Center for the Protection of People with Special Needs, as required by Executive Law § 560 and Correction Law § 401-a (2). This report summarizes the agency's activities and accomplishments from January 1, 2018 through December 31, 2018. It includes, but is not limited to, the following statistics and information:

- Number of reports received by the Vulnerable Persons' Central Register (VPCR)
- Results of investigations by types of facilities and programs
- Types of corrective actions taken
- Results of the review of patterns and trends in the reporting of and response to reportable incidents, and recommendations for appropriate preventative and corrective actions
- Efforts undertaken to provide training
- Description of the Justice Center's efforts to monitor the state's compliance with the statutory requirements for the provision of mental health services to inmates, including inmates with serious mental illness in segregated confinement

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

Respectfully submitted,

Denise M. Miranda, Esq.

Executive Director

Table of Contents

I. EXECUTIVE SUMMARY

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

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

II. HISTORY AND JURISDICTION

The Protection of People with Special Needs Act (Ch. 501, L. 2012) established the Justice Center for the Protection of People with Special Needs as an executive agency responsible for protecting the safety and well-being of the approximately one million adults and children who, due to physical or cognitive disabilities, or the need for services or placement, are receiving care from certain facilities or provider agencies that are licensed, operated, or certified within the systems of six state oversight agencies. These agencies include:

- Office for People with Developmental Disabilities (OPWDD)
- Office of Mental Health (OMH)
- Office of Alcoholism and Substance Abuse Services (OASAS)
- Office of Children and Family Services (OCFS) (State-operated programs/facilities and certain residential programs)
- Department of Health (DOH) (Summer camps)
- State Education Department (SED) (Certified residential schools and programs)

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

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

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

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

The Justice Center operates with a staff of 425 committed professionals. The agency's front-line staff, which includes call center representatives, investigators, special prosecutors and individual and family support advocates have collectively accumulated decades of experience working with special populations at state oversight and private provider agencies and in other service systems prior to joining the Justice Center.

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

III. 2018 HIGHLIGHTS AND INITIATIVES

❖ *Sexual Abuse Response Team*

The Justice Center has launched the Sexual Abuse Response Team (SART) in response to reports highlighting the issue of sexual abuse of people with special needs. Sexual abuse cases involving individuals with disabilities present unique challenges that require a specialized team of investigators.

SART is comprised of Justice Center investigators, medical professionals and victim advocates, all of whom have received some of the country's top training in dealing specifically with victims of sexual assault. The team operates on a 24/7 notification process and has procedures and protocols specific to sexual abuse investigations to ensure the quality and integrity of any findings and criminal charges. The Justice Center's Special Prosecutor will have an enhanced role in all SART cases in order to ensure the pursuit of criminal charges when warranted.

❖ *Power to Hold Providers Accountable Legally Upheld*

The New York State Court of Appeals upheld the Justice Center's ability to hold provider agencies accountable for systemic deficiencies that lead to abuse or neglect, even when an individual employee was not at fault. The case, *Anonymous v. Molik*, involved findings of deficient policies at the provider agency that contributed to repeated sexual assaults of service recipients at the hands of another service recipient. This resulted in the Justice Center substantiating a Category 4 finding against the agency as a whole. In issuing its ruling, the court said "Systemic deficiencies may present a greater hazard to vulnerable residents than do discrete instances of employee misconduct, since employee-related incidents can often be remedied through targeted disciplinary action. Latent systemic problems, by contrast, are often more challenging to identify and more complicated to rectify—and therefore more likely to recur".

[1]The Court continued: "Pre-existing State systems, suffered from 'numerous gaps and inconsistencies' as well as substantial 'variations across state agency.' The Act sought to reconcile those discrepancies and conform practices across various state agencies by creating the Justice Center – 'a new entity that would cut across bureaucratic lines and have as its primary purpose and responsibility the protection of health, safety and welfare of vulnerable persons.'"

❖ *Raise the Age*

The State's *Raise the Age* initiative started to phase-in on October 1, 2018. On that date, the Justice Center expanded its jurisdiction to newly created "specialized secure detention" facilities. Additionally, the Justice Center assumed jurisdiction over Horizon Juvenile Detention Center which houses the youth who are prohibited from being placed on Rikers Island.

❖ *Caseload Increase*

The number of abuse/neglect cases investigated by the Justice Center increased in 2018. In total, 14% more cases were investigated by the agency as compared to 2017. This increase may be attributed to several factors. First, there is more general awareness of the Justice Center and the responsibilities of mandated reporters to report any abuse or neglect. The agency has increased its stakeholder outreach drastically in the past two years and that, coupled with the aging of the agency and its mission, have made employees more aware of their responsibility to report incidents. Further, the State Oversight Agencies over which the Justice Center has jurisdiction have expanded services in their respective settings. That means the population of people the agency serves has expanded accordingly.
Finally, implementation of Raise the Age brought new settings under Justice Center jurisdiction.

❖ *Case Closure Improvements*

The cornerstone of Justice Center operations over the past 18 months has been consistency, efficiency and collaboration. To that end, the Justice Center recognizes the importance of having a timely appeals process in order to ensure due process for subjects of investigations. For that reason, the agency embarked on a project this year to eliminate the backlog of cases built up in the years since operations commenced. Between March and October, the Justice Center closed a significant number of cases and shortened the appeal process time significantly. Attorneys, Administrative Law Judges and staff from across the agency took on additional workload to allow the project to reach conclusion without any impact on current cases under appeal.

---

[1] *Matter of Anonymous v Molik,* 32 NY3d 30, 37, 84, N.Y.S.3d 414, 109 N.E.3d 563[2018]

In addition, the Justice Center has implemented practices to shorten case cycle time, thus increasing the number of cases closed within 60 days. The agency has increased investigative staff to ensure sufficient staff is available to handle the caseload, opened additional regional offices for investigators, improved incident classification, and instituted technology upgrades to improve the accuracy and consistency across all investigations.

❖ *Region 5 Creation*

The Justice Center reorganized its regional operations in order to streamline processes and make the agency more efficient. Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester counties now comprise Region Five. The counties were originally part of Region 1. This designation cuts staff travel time between provider locations, allows investigators and victim support staff to focus on cases that are regionally close to their offices, lowers case cycle time and ensures consistent investigations and classifications from case to case and region to region.

❖ *Surrogate Decision-Making Committee 30th Anniversary*

The Surrogate Decision-Making Committee (SDMC) celebrated its 30th anniversary in 2018. The volunteer-driven group, which is supported on a daily basis by dedicated staff at the Justice Center, was the first in the country charged with quickly making major medical decisions for people with special needs. SDMC is called upon when a decision about medical care involving an individual receiving services is needed, the individual themselves is incapable of making the decision and there is no legal surrogate to do so. Panels are composed of a licensed health care professional, a licensed NYS attorney, family member of former client or relative, and a person who has recognized expertise or has demonstrated an interest in the care and treatment of individuals with a behavioral health or an intellectual disability. The Committee has 1,300 volunteers spread across every county in the state and has received more than 26,000 cases to date.

In 2018, the SDMC completed more than 1000 requests for major medical or end of life decisions.

IV. WORKFORCE AND STAKEHOLDER OUTREACH

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

❖ *Individual and Family Support*

The Justice Center provides guidance and support to victims of abuse or neglect, their families, personal representatives and guardians throughout the course of an investigation. Nearly 10,000 individuals and family members have contacted advocates for assistance since 2013. In 2018, the unit continued to regionalize staff to provide easier access to advocates for the public. Advocates were added to the Binghamton, Bronx and Rockland offices.

Advocates can provide information about the reporting and investigative process, case status updates and records access. In 2018, the Individual and Family Support Unit provided assistance to individuals and families regarding records access more than 400 times.

In addition, Justice Center advocates can accompany victims to interviews or court proceedings. In 2018, advocates went to court with victims or family members approximately 150 times. Members of the Individual and Family Support Unit also coordinate questions or concerns involving State Oversight Agencies. The Individual and Family Support Unit attends various events throughout the state, offering materials and answering questions about the Justice Center. In 2018, advocates attended 22 such events.

❖ *Regional Family Briefings*

The Justice Center recognizes the importance of directly engaging with family members who have loved ones under the jurisdiction of the agency. In 2018, the agency began a series of meetings resulting in regional family briefings. Three regional briefings were conducted to provide an overview of agency processes, explanation of the Individual and Family Support Unit resources available, as well as presenting relevant data. The Justice Center anticipates providing additional briefings in 2019.

❖ *Video Series*

The Justice Center produced a series of three short videos to introduce the workforce to the agency, explain the partnership between the Justice Center and the workforce, outline prevention resources available for custodians, and familiarize direct support professionals both to their rights and their responsibilities as mandated reporters. The agency used input from family members of service recipients, providers and investigators as part of the project. The series is available on the agency website under the tab for custodians. Those viewing this report in digital form can click here to view the videos.

❖ *Champion and Code of Conduct Awards*

The Justice Center understands the importance of highlighting individuals who demonstrate a commitment to individuals with special needs. The agency has created two recognition awards: the Justice Center Champion award and the

Justice Center Code of Conduct award. This was the third consecutive annual award presentation.

The Champion Award honors New Yorkers who have displayed exemplary dedication to people with special needs. The honorees in 2018 included a man from the Bronx who was a witness to abuse and was able to stop it, a 24-year member of the Surrogate Decision-Making Committee, a Westchester County Assistant District Attorney who works closely with the Justice Center on cases involving victims with special needs, and a State Police Investigator who frequently volunteers for cases involving vulnerable populations.

The Justice Center also appreciates the importance of honoring direct support staff and managers who display a strong commitment to the Code of Conduct and serve as an inspiration to their colleagues. Four direct support professionals working in settings under the Justice Center's jurisdiction received special recognition by the Justice Center. Honorees included a former service recipient who was so inspired by his experience that he decided to become a direct support professional, a 17-year veteran who advocated for an individual living in an unsafe environment, a retired psychologist who mastered new treatment approaches and shared them with colleagues through training, and a direct care staff member who works specifically with an aging population of individuals with developmental disabilities, some of whom have no family to monitor their care.

❖ *Provider Briefings*

The Justice Center spends considerable time engaging with provider agencies and the direct care workforce. The agency understands the partnerships formed with these stakeholders are crucial to the success of the mission of the Justice Center. In 2018, the agency conducted 68 presentations, the majority of which were to provider agencies under Justice Center jurisdiction as well as their staff. The Justice Center also conducted outreach presentations to local government agencies, attorneys, and service recipients and their families.

❖ *Advisory Council*

The Justice Center's Advisory Council provides guidance to the agency in the development of policies, programs and regulations. Members include service providers, people who have or are currently receiving services, their family members and advocates. At least half of the members must be individuals, or parents or relatives of individuals, who are receiving or have received services from programs under Justice Center jurisdiction. Advisory Council members are appointed by the Governor, with the advice and consent of the Senate, for three-year terms. The Council meets quarterly.

Advisory council members serve on one of four committees: legislation and regulations, abuse prevention, workforce issues, and investigator and police training. Each committee provides valuable insight to the Justice Center that is used to craft policies, procedures and outreach.

V. TRAINING AND SAFETY IMPROVEMENTS

The Justice Center believes that outreach, training and the promotion of best practices are critical to affect systems' change. That is why the agency has made a substantial investment in training of both internal staff and external stakeholders. The Justice Center offers a variety of training and support materials to ensure the health, safety and dignity of people with special needs. These include: Forensic Interviewing Best Practices for Vulnerable Populations, Disabilities Awareness Training for Law Enforcement and State Oversight Agency Restraint Training.

❖ *State Oversight Agency Collaborative Trainings*

The Justice Center works in collaboration with various State Oversight Agencies (SOA) in training on current best practices. In 2018, the agency collaborated with the Department of Health (DOH) to develop a one-day training which resulted in training for 66 DOH investigators. In addition, Justice Center staff traveled with representatives from the Office of Children and Family Services (OCFS) and the Office of Alcohol and Substance Abuse (OASAS) to provide training to state and non-state operated OCFS and OASAS provider agencies. The training provided an overview of the Justice Center, the responsibilities of mandated reporters and a description of what happens once a report is made to the VPCR. Also, the Justice Center continued to build on the positive partnerships formed with training divisions of both the Office of Mental Health (OMH) and the Office for People with Developmental Disabilities (OPWDD) to deliver training designed specifically for staff on the restraint protocol and procedures for each SOA. A continued partnership is expected as future trainings are scheduled throughout the state in 2019.

❖ *Code of Conduct Electronic Training*

The Justice Center's Code of Conduct sets the standard by which all direct support staff care for people with special needs across New York State. Provisions include taking a person-centered approach to care, helping people who receive services maintain or develop healthy relationships with family and friends, ensuring their physical, emotional and personal well-being and respecting the dignity and individuality of any person who receives services and honoring their choices. The Code of Conduct is required to be signed upon employment and on an annual basis.

In 2018, the Justice Center launched an interactive, online training to provide an overview of the Code of Conduct. The training includes real-life scenarios that ask the participant to apply the Code of Conduct provisions. The training is not mandatory but is offered as a resource to direct support staff who must sign the Code and to provider agencies for employee training. Employees can work through the training at their own pace. In addition, the Justice Center has collaborated with the National Alliance of Direct Support Professions (NADSP) to develop a Code of Conduct Train-the-Trainer curriculum. It is designed to give State Oversight Agency providers the resources they need to provide their staff

in-person training on the Code of Conduct. The Justice Center along with NADSP offered this training four times during 2018 to 75 participants. The Justice Center has overwhelmingly positive feedback for the Train-the-Trainer curriculum and plans to expand course offerings in 2019. For those viewing this report in digital form a link to Code of Conduct trainings can be found here.

❖ *Provider Setting Training*

Justice Center investigators have extensive knowledge of what it is like to work in the settings under the jurisdiction of the agency. That's because most have worked in those settings themselves. Investigators at the Justice Center have backgrounds in direct care and investigations at all SOAs under Justice Center jurisdiction. Some have spent decades working with individuals with special needs before arriving at the agency.

However, they may not have encountered every setting type under Justice Center jurisdiction. Working in partnership with provider agencies under the jurisdiction of the Justice Center, the agency has created podcast-style trainings for investigators. The trainings give insight into specific settings Justice Center investigators may encounter in the field. The interview-style audio recordings are made available to Justice Center staff so they can learn about settings they will be visiting as part of an investigation. Trainings currently available for investigators include State-operated adult psychiatric centers, State-operated children's psychiatric centers, general hospital inpatient programs, OMH-licensed treatment apartments, community residence-single room occupancy programs and community residence programs.

❖ *Justice Center In-Service Training*

As part of the Justice Center's commitment to continuous improvement, the agency offers an in-service training for all investigators and select members of other business units. This year the event was held for three days in September. The event was focused on trauma-informed best practices for investigations.

VI. ABUSE PREVENTION AND QUALITY IMPROVEMENT

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

i. Prevention

A. Criminal Background Checks

The Justice Center reviews and evaluates the criminal history of all prospective employees or volunteers applying for jobs at provider agencies under its jurisdiction and advises about the individual's suitability for employment. The Justice Center has the ability to request and review information contained in FBI identification records. This comprehensive review provides a safety net for individuals receiving services and their families by limiting those who can have regular and substantial contact with an individual with special needs while at the same time mitigating risk for employers and the dedicated workforce.

Criminal Background Checks	2018
Total Fingerprints Processed	**103,216**
Total Applicants Reviewed	13,062
Denied Approval for Employment Consideration	380

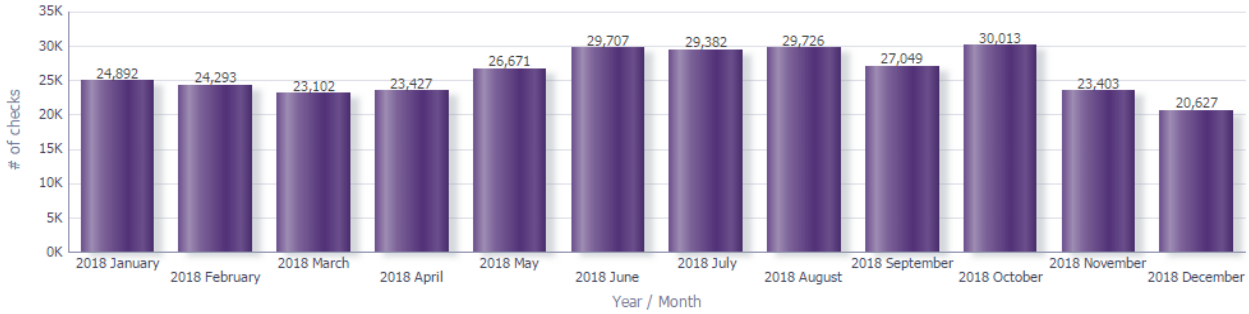
To date, more than 1,600 applicants have been denied approval for employment consideration because of convictions that ranged from assault to rape and murder. 380 of those denials were made in 2018.

B. Staff Exclusion List

Another tool used to prevent those who have a history of abusing people with special needs from continuing to work with and have access to individuals with special needs is the Justice Center's *Staff Exclusion List (SEL)*. All subjects substantiated for Category One (definition see pg. 22) conduct, which includes serious or repeated acts of abuse or neglect, or two substantiated Category two findings within three years, are placed on the SEL. Placement on the SEL bars an individual from working in all settings under the Justice Center's jurisdiction forever.

Provider agencies under the Justice Center's jurisdiction, as well as other providers identified in statute, are required to check the SEL before hiring someone who will have regular and substantial contact with an individual with special needs. There have been 125 providers notified that an applicant was on or was pending placement on the SEL since 2014. This means individuals who have proven themselves to be abusers of people with special needs were stopped from being hired into settings where they would have regular and substantial contact with that vulnerable population again.

Pre-Employment Checks of the Staff Exclusion List by Month



The total number of individuals on the SEL at the end of 2018 was 501. That is an increase of 103 from 2017. Offenses that have resulted in placement on the SEL include: hitting, choking, punching and sexual contact.

C. Spotlight on Prevention

The Justice Center uses data complied in the *Vulnerable Person's Central Register (VPCR)* to do trend analysis for issues that may be putting people with special needs at risk. In 2018, the Justice Center issued *Spotlight on Prevention: Professional Boundaries*. The toolkit is a seven-part series highlighting the dangers when professional boundaries between staff and people receiving services are crossed. The toolkit helps educate people receiving services, self-advocates, direct care providers, agency administrators, and friends and family members on the importance of maintaining professional boundaries. It includes information on best practices, red flag behaviors, how to report misconduct, fact sheets for staff, individuals receiving services and provider agencies and social media guidelines for staff.

The *Spotlight on Prevention: Professional Boundaries* is the latest toolkit published by the Justice Center. Other toolkits developed based on trend and data analysis include: *Dangers of Being Left Unattended in Vehicles, Dangers of Caregiver Fatigue and Reducing the Use of Restraints.* All are available here.

ii. Quality Improvement

The Justice Center has the ability to make recommendations on improving the quality of care at facilities under its jurisdiction. This is done in one of two ways: reviews and audits of corrective action plans, and visits to and inspections of facilities or provider agencies. This important audit function allows the Justice Center to correct quality of care issues before they lead to problems for both provider agencies and the populations they serve.

D. Facility Audits

As part of the Justice Center's oversight and monitoring function, the agency reviews and conducts audits of corrective actions that stem from substantiated abuse and neglect cases to ensure facilities and provider agencies are taking the necessary steps

to prevent incidents of abuse and neglect in the future. Corrective action plan audits are most often completed after a Category Four finding against a provider (see definition pg. 22).

In addition, representatives from the Justice Center visit and inspect facilities or provider agencies to assess quality of care, identify issues of concern and factors that may lead to systemic failures. The agency makes recommendations for agencies to consider in order to reduce the likelihood of recurrence and improve quality of care. The Justice Center conducted 50 of these visits in 2018.

The agency also completed six in-depth systemic reviews covering 24 provider agencies as well as conducted 298 audits of facility and agency corrective action plans were completed. Below you will find examples of initial findings and recommended corrective action plans.

Examples:

Case 1: Supervision Review (OPWDD)

Narrative: A review of supervision standards for people receiving care in 4 residential programs was initiated after auditing Corrective Action Plans (CAPs) developed in response to a Category 4 finding that conditions at these provider agencies exposed people receiving services to harm or risk of harm. Supervision of people receiving services contributed to the substantiated Category 4 finding of neglect at all provider agencies included in this review.

Result: The state oversight agency will use the Justice Center recommendations on standardizing supervision levels, training and staffing levels to support their quality assessment and certification activities at these programs.

Case 2: Contraband Review (OASAS)

Narrative: A review was initiated at a Residential Treatment Program serving people with substance abuse disorders based on referrals from other JC business units and CAP audits reflecting concerns about the widespread availability of contraband at the program, in particular, illegal drugs. The Justice Center recommended improvements in staffing, training, and supervision and documentation of medication administration.

Result: OASAS suspended admissions to the facility, effectuated a reduction in the program census and recommended the program implement an electronic health record, and convert the program to the new OASAS Part 820 model, which includes additional medical, clinical and operations staff to ensure a safe environment of care.

E. Special Housing Unit (SHU) Monitoring and Audit

The Justice Center monitors the quality of mental health care provided by the Office of Mental Health (OMH) to people who are incarcerated in state prisons.

The Justice Center visited 25 facilities and completed 1,803 cell-side and 153 private interviews with inmates in 2018. The agency also reviewed the quality of mental health care for 449 inmates and referred 282 inmates to be evaluated by OMH. In addition, the agency reviewed the records of 718 inmates placed in solitary confinement in Special

Housing Units to determine if they received mental health care and assessments in accordance with the requirements of the SHU Exclusion Law.

The Justice Center found 32% of the SHUs visited in 2018 were not in compliance with the statutory requirements of the law because they were not completing all required mental health and suicide assessments and follow-up visits within the timeframe required by law. Summaries of visits to SHUs are published on a quarterly basis on the Justice Center's website.

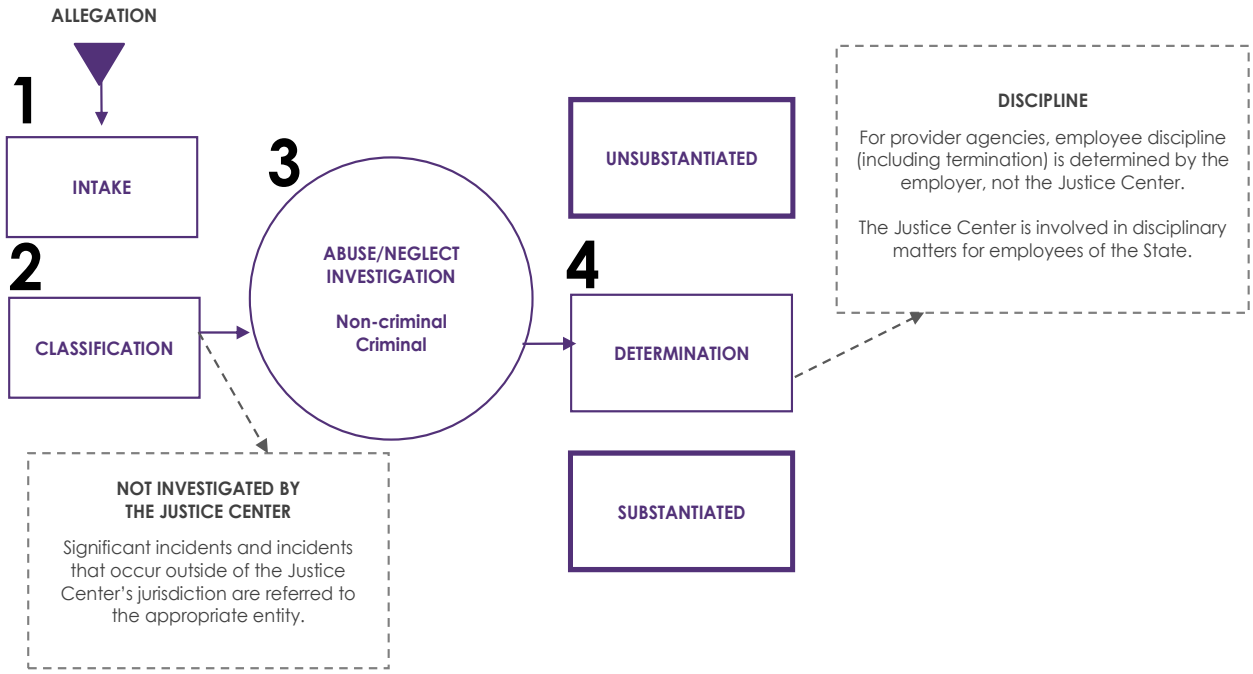
The Justice Center also assesses the quality of care being provided in specialized programs for prisoners with mental illness in prison. In this way, the agency seeks to effect change that will promote a more therapeutic environment for inmates. In 2017, the agency initiated a three-year review of the Behavioral Health Unit (BHU) at the Great Meadow Correctional Facility and the Therapeutic Behavioral Unit (TBU) at the Bedford Hills Correctional Facility to assess the impact of the interventions used for inmates with a serious mental illness serving time in a SHU through sanctions. The review includes multiple interviews with inmate/patients and up to thirty-six months of OMH Clinical and DOCCS Guidance records. The full report is on track to be issued in summer 2019.

The Justice Center also continued its systemic review of Intermediate Care Programs. The Intermediate Care Programs are a therapeutic setting available in 13 prisons which provide rehabilitative services to inmates who are unable to function in general population because of their mental illness. So far, the Justice Center has reviewed more than 225 records and interviewed more than 60 inmates. This review will continue into and be completed in 2019.

VII. INCIDENT MANAGEMENT

The Justice Center investigates, reviews and makes findings in allegations of abuse and/or neglect by staff against individuals who receive services. "Staff" can include employees, volunteers, interns, consultants or contractors of a provider facility or agency. An investigation by the Justice Center is launched after a report is made to the Vulnerable Persons' Central Register (VPCR). That complaint then works its way through an investigatory process that ultimately ends in a substantiated or unsubstantiated finding. Allegations can also result in criminal prosecution. Every allegation classified as possible abuse or neglect is investigated to conclusion. Below is a chart that outlines the process by which a report is handled at the Justice Center.

❖ Process of a Justice Center Investigation



i. Intake

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

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

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

ii. Classification

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

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

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

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

- **Significant Incident**
  - Incident other than an incident of abuse or neglect that, because of its severity or the sensitivity of the situation, may result in or has the reasonably foreseeable potential to result in harm to the health, safety or welfare of a person receiving services. Examples include conduct between persons

receiving services and conduct of an employee that is inconsistent with an individual's treatment plan

- **Non-NYJC**
  - The nature of the incident is not reportable to the Justice Center because the incident is not a reportable incident or because it did not occur at a provider over which the Justice Center has jurisdiction. These can vary widely and be for concerns about a provider or for things like insurance questions and complaints about disliking food. Cases that require follow-up are referred to the appropriate State Oversight Agency.

Reports Made to the Justice Center	2018
Grand Total	**86,243**
Abuse and Neglect	15,557
Death	1,587
Significant Incident	29,399
Non-NYJC Incident	27,494
Not an Incident	12,206

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

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

  The three-business day assessment has resulted in increased accuracy of incident classification and a better use of investigative resources.

  The three-business day assessment is available to all OPWDD and OMH providers. In 2018, the Justice Center piloted the assessment process with select OASAS providers. The program was successful and as of October, all OASAS providers are now included in the program.

Classification	Total	Percentage
2018 Grand Total	**2,251**	
Remained JC A/N	741	33%
Reassigned to SOA Led A/N	229	10%
Reclassified (SI or Non)	1,281	57%

Classification	Total	Percentage
2018 OPWDD Total	**1,012**	
Remained JC A/N	439	44%
Reassigned to SOA Led A/N	135	13%
Reclassified (SI or Non)	438	43%

Classification	Total	Percentage
2018 OMH Total	**1,185**	
Remained JC A/N	280	24%
Reassigned to SOA Led A/N	94	8%
Reclassified (SI or Non)	811	68%

Classification	Total	Percentage
2018 OASAS Total	**31**	
Remained JC A/N	15	48%
Reassigned to SOA Led A/N	0	0%
Reclassified (SI or Non)	16	52%

iii. Criminal vs. Administrative

Once a case is classified as abuse or neglect, it falls into one of two tracks: criminal or administrative.

- **Criminal Cases**

  The *Protection of People with Special Needs Act* establishes the Justice Center's authority to bring criminal charges in cases that meet the legal definitions of a crime. District Attorneys are notified of *every* case of abuse and neglect in their county and the Justice Center works in collaboration with their office to ensure justice for vulnerable victims. Despite the collaboration with local District Attorneys, they still maintain their independent authority to pursue cases, regardless of Justice Center outcome. The Justice Center notifies District Attorneys of *all* allegations of abuse and neglect. Cases involving potential criminal charges can be investigated by the Justice Center, the local police, or both. The Justice Center files charges in some cases, local District Attorneys file charges in some cases, and the agency works in collaboration with district attorneys in some cases. In all instances, Justice Center

prosecutors are empowered to handle all aspects of criminal prosecutions from arraignment to conclusion.

In 2018, 111 arrests were made in connection to Justice Center cases. Of those, the Justice Center led 17 prosecutions while local District Attorneys led 94 prosecutions with Justice Center assistance in 51 of them. The overall conviction rate of cases prosecuted by the Justice Center is 85 percent.

Once a case has been resolved criminally, it is also investigated through the Justice Center administrative process.

- **Administrative Cases**

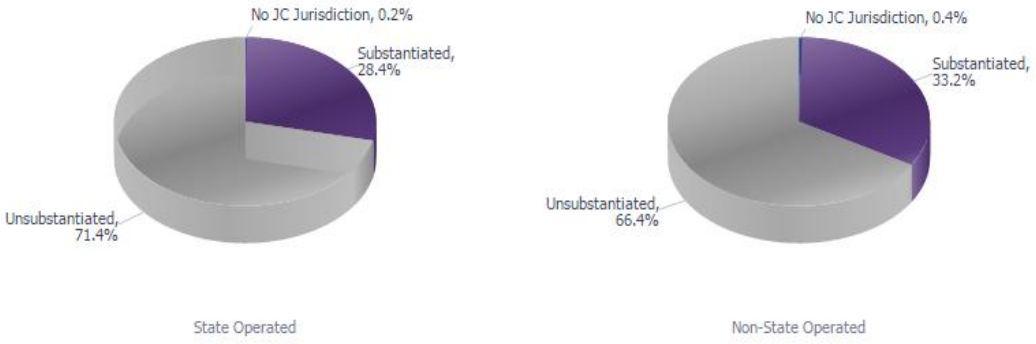
  The first step in the administrative investigation of allegations is appropriate classification and assignment for investigation. The Justice Center investigates allegations in state-operated programs as well as the most serious allegations in non-state operated settings. Less serious allegations of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

  The investigation process proceeds with examination of the evidence and interviews of witnesses, victims and subjects. Witnesses and subjects of Justice Center investigations are allowed to have legal counsel or a union representative present when being interviewed.

iv. Determination

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

Percentage of Investigation Outcome for Abuse and Neglect Cases in 2018



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

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

    - **Category 1**: Serious physical abuse, sexual abuse or other severe conduct. Category 1 substantiations place subjects on the Staff Exclusion List (SEL). Subjects on the SEL are banned from working in any setting under the jurisdiction of the Justice Center and remain on the list forever.
    - **Category 2:** Conduct that significantly endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Two Category 2 substantiations within three years will result in placement on the SEL. Category 2 offenses are sealed after five years.
    - **Category 3:** Less serious incidents of abuse or neglect. Reports are sealed after five years.
    - **Category 4:** Conditions at a program or facility that expose people receiving services to harm or risk of harm. Also, instances in which an individual receiving services has suffered abuse or neglect but a perpetrator cannot be identified.

Nearly three-quarters of substantiated abuse and neglect findings are classified as Category 3 conduct.

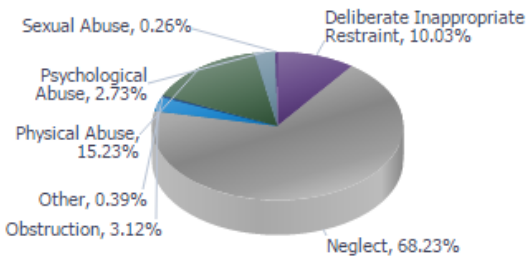
Total Closed Abuse and Neglect Cases in 2018 by Category

	2018
Total Closed Abuse and Neglect Cases	**3,706**
State Operated Total	608
Category One	12
Category Two	128
Category Three	443
Category Four	25
Non-State Operated Total	3,098
Category One	114
Category Two	547
Category Three	2,346
Category Four	91

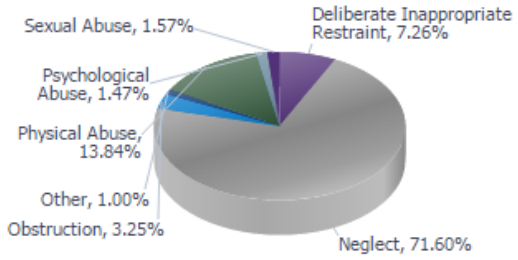
Note: Number of closed cases includes cases opened in previous years

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

Substantiated Allegations of Abuse and Neglect in State Operated and Non-State Operated Facilities in 2018



State Operated



Non-State Operated

v. Appeals

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

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

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

In 2018, the Administrative Appeals Unit (AAU) received 1,222 requests for amendment, conducted 1,225 administrative reviews, prepared 401 cases for hearing, and closed 2003 cases. It is important to note the numbers for 2018 include the clearing of a backlog that had built up over several years (see pg. 7).

vi. Discipline

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

Justice Center attorneys represent the State at disciplinary proceedings brought against State employees in all cases of substantiated abuse or neglect. In 2018, 209 State employees were separated from service as a result of probationary status or disciplinary charges brought against them. In addition, the Justice Center reviewed and approved 576 Notices of Discipline, which can result in an oral or written reprimand, fine, loss of leave credits or other privileges, demotion, suspension, termination or other penalty as appropriate. The chart on the next page indicates the number of times each disciplinary action identified was taken against a state employee in 2018.

Employee Action Process Completed	# of Actions Completed
Closed Substantiated	**840**
No Penalty	183
Counsel or Train (subset of No Penalty)	59
Termination Total	209
Resigned	76
Retired	43
Probation Terminated	57
Upheld at Arbitration	15
Exclusion or Other	18
Letter of Reprimand	122
Suspension	146
Loss of Leave Credits or Other Privileges	118
Fine	60
Other Penalty	2

- **Administrative Action Reporting Mechanism**

  2018 was the first full year of implementation of the Administrative Action Reporting Mechanism (AARM). State Oversight Agencies now require provider agencies under the jurisdiction of the Justice Center to submit information about what administrative actions have been taken with respect to subjects of substantiated allegations of abuse or neglect in non-state operated settings. The information is submitted to the Justice Center through a web application. The requirement allows Sate Oversight Agencies to ensure providers they license or certify are responding to substantiated allegations of abuse or neglect with appropriate corrective action. The chart on the next page indicates the type of disciplinary action taken by private providers, and the number of times that action was taken in 2018.

AARM Action	# of Actions Completed
Grand Total	**4583**
Additional Staff Supervision	48
Counseling (Formal – Written)	927
Counseling (Informal – Verbal)	210
Demotion	21
Employee Assistance Referral	20
Fine (monetary/accruals)	6
Letter of Reprimand	140
No Action	102
Placed on Probation	47
Re-training	714
Resignation/Retirement	298
Staff Reassignment/Relocation	178
Suspension (1-14 days)	196
Suspension (15-30 days)	108
Suspension (30 or more days)	189
Termination	1102
Training	277

- **Staff Exclusion List**

  All subjects of a substantiated report of Category One conduct, and all subjects who have been substantiated for two Category Two findings within three years, are placed on the Staff Exclusion List (SEL). In 2018, 103 individuals were placed on the list. That brought the total number of subjects on the list to 501. All individuals placed on the SEL are barred from working in settings under the Justice Center's jurisdiction. Offenses that have resulted in placement include hitting, choking, punching, sexual contact and falsifying records.

VIII. MORTALITY REVIEWS

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

❖ Process of an Assessment or Investigation

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

i. Executive Law § 556 Reviews

The vast majority of death reports received by the Justice Center fall under Executive Law § 556. This section of law requires administrators of residential programs licensed, operated or certified by OPWDD, OMH, OASAS and OCFS to report all deaths of residents to the Justice Center, regardless of whether the death is unusual or expected. The purpose of this reporting is twofold: to monitor and examine whether quality of care issues may have contributed to an individual's death and to make recommendations to improve future care of individuals receiving services and prevent the recurrence of similar issues.

All deaths reported under Executive Law § 556 are reviewed by investigators with program experience as well as health care professionals, including registered nurses. Through these reviews, the Justice Center has the ability to make recommendations to providers on how to improve quality of care. The Justice Center issued 1,371 number of these letters in 2018, with recommendations on how to correct concerns when the provider fails to do so in the course of their own investigation. The letters are sent to both providers and the appropriate SOA for monitoring of recommended corrective actions.

ii. Mortality Investigations

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

The Justice Center has developed a specific protocol that it follows for reviewing abuse/neglect cases where a death is involved. Initial review involves input from a supervising investigator, a criminal investigator, a lead Justice Center investigator, the regional nurse, the Assistant Special Prosecutor for the region and a representative from the Office of General Counsel. This comprehensive approach allows team members with varied backgrounds to advise on the approach for the investigation. They are presented information including medical and clinical history of the individual receiving services, a synopsis of the circumstances

surrounding the death, involvement by local law enforcement, medical examiner or district attorney and history of any concerns regarding the program or facility.

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

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

iii. Medical Review Board

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

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

Regional Investigations can also request either a consult or a full MRB review for all abuse/neglect cases with death involved. A consult routinely relates to a specific question while a full MRB review happens after the completion of the investigation and the investigatory question of whether or not abuse or neglect occurred remains.

IX. CONCLUSION

The Justice Center marked its five-year anniversary in 2018. It is unequivocal that people with special needs are safer today than before the inception of the agency. Guided by Governor Andrew M. Cuomo's vision and in partnership with State and private provider agencies, individuals with disabilities, family members and advocates, the Justice Center will build upon the accomplishments detailed in this report. The agency continues to explore and develop new approaches to strengthen the Justice Center's ability to safeguard New York's most vulnerable citizens.

X. APPENDIX A

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

- **Office for People with Developmental Disabilities (OPWDD)**
  - Facilities and programs operated, licensed or certified by OPWDD
- **Office of Mental Health (OMH)**
  - Facilities and programs operated, licensed or certified by OMH
- **Office of Alcoholism and Substance Abuse Services (OASAS)**
  - Facilities and provider agencies operated, licensed or certified by OASAS
- **Office of Children and Family Services (OCFS)**
  - Facilities and programs operated by OCFS for the youth placed in the custody of the Commissioner of OCFS
  - OCFS licensed or certified residential facilities that care for abandoned, abused, neglected, dependent children, Persons in Need of Supervision or juvenile delinquents
  - Family-type homes for adults
  - OCFS certified runaway and homeless youth programs
  - OCFS certified youth detention facilities
  - Specialized-secure detention for pre-adjudicated adolescent offenders jointly administered by designated county agency and the county sheriff
- **Department of Health (DOH)**
  - Overnight and traveling summer day camps for children with developmental disabilities under DOH jurisdiction
- **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

XI. APPENDIX B

Justice Center Advisory Council Members

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

Mary E. Bonsignore — Parent Advocate, Bronx Developmental Disabilities Council

Norwig Debye-Saxinger — Therapeutic Communities Association

S. Earl Eichelberger — NYS Catholic Conference

Denise A. Figueroa — Independent Living Center of the Hudson Valley

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

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

Jeremy E. Klemanski — Helio Health

Sylvia Lask — Parent

Ronald S. Lehrer — NYS Association of Boards of Visitors

Glenn Liebman — Mental Health Association in New York State

Joseph Macbeth — National Alliance for Direct Support Professionals

Thomas McAlvanah — Interagency Council of Developmental Disabilities Agencies of NY

Delores Fraser McFadden — Orange County Department of Mental Health

Hanns Meissner, PhD — Rensselaer County ARC

Kathy O'Keefe — Pilgrim Psychiatric Center

Judith A. O'Rourke — Parent

Clint Perrin — Self Advocate

Susan Platkin — Parent, NY Self-Determination Coalition

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

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

Jeffrey Savoy — Odyssey House

Euphemia Strauchn-Adams — Parent, Families on the Move

Robert L. Weisman, DO — Strong Memorial Hospital