NEW YORK
STATE OF
OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Annual Report to the Governor and Legislature

2019

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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 people 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

April 28, 2020

To the Governor and Legislature:

I am pleased to provide you with the 2019 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, 2019 through December 31, 2019. 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

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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 Addiction Services and Supports (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. 2019 HIGHLIGHTS AND INITIATIVES

❖ *Regional Conferences*

The Justice Center has launched a series of regional conferences for stakeholders across the state. One conference was held in each of the five Justice Center regions across the state in 2019. The morning session at each conference was dedicated to an agency overview with region-specific information. Participants were able to choose to attend one of several afternoon sessions on topics including information about the Justice Center's criminal background checks process, the role of the Individual and Family Support Unit, the life cycle of a Justice Center investigation, and an overview of the agency's prevention work. Nearly 500 people, including representatives from approximately 300 agencies, attended these events. The Justice Center plans to host more of these conferences in 2020.

❖ *New Agency Website*

The Justice Center's public website was completely overhauled in 2019. The site was moved onto a new platform that is more intuitive to the needs of the user. The new site emphasizes the parts of the website that data and analytics indicate users seek out most often, making information on those topics easy to find.

The main menu of the site provides guidance for individuals seeking advocacy and support, for providers and staff seeking information about the investigatory process, and for anyone looking for prevention materials.

Also featured on every page is the phone number for the Justice Center's abuse/neglect reporting hotline.

- *Office of Addiction Services and Supports (OASAS) Contraband Review*

  The Justice Center received reports of individuals overdosing while participating in OASAS-licensed substance use disorder (SUD) programs as well as reports of illicit substances and other prohibited items being discovered in these settings. Because of these reports, the Justice Center has worked in partnership with OASAS to assess treatment facility responses to contraband and to provide recommendations to prevent contraband from entering facilities and endangering the individuals who are there working to achieve sobriety.

  The Justice Center's systemic review revealed areas where additional guidance and policies were needed to create safe, therapeutic environments for individuals receiving services. As a result of the review, OASAS has issued new safety guidance. This includes procedures for staff training, creating uniform definitions of contraband, guidance on how to handle contraband discovery, policies for family visits and perimeter security as well as resident screening. In addition, OASAS has implemented regulatory and recertification review changes to increase access to naloxone at every program site.

- *Code of Conduct Train the Trainer*

  The Justice Center is the first agency in the country dedicated to protecting vulnerable individuals from abuse and neglect. As part of that mission, workers under Justice Center jurisdiction are required to sign the Code of Conduct which serves as a professional and ethical framework for their interactions with vulnerable populations. In order to enhance the workforce's understanding of the Code of Conduct, the Justice Center has launched a "train-the-trainer" curriculum which allows provider representatives to take an in-depth interactive course about the Code of Conduct with the goal of training their own staff on the provisions of the Code. This expanded training program is designed to help ensure compliance with the professional and ethical duties of providers. In 2019, the Justice Center held four sessions training a total of 101 individuals.

- *Ethics Training*

  The Justice Center recognizes the importance of having the highest ethical standards in all cases. In partnership with a leading industry consultant, the Justice Center conducted regionalized ethics training for all investigators and prosecutors in the agency. The two-day training seminar focused on the concept of ethical investigatory conduct. The training also addressed ethical issues that may arise in the course of an interview with service recipients or staff.

❖ *VPCR Level-set Training*

In 2019, the Justice Center implemented new trainings in order to increase the consistency and efficiency of the investigatory process. The agency created an intensive, two-day course focused solely on use of the Vulnerable Persons' Central Register (VPCR). The VPCR is the database used at the Justice Center to track a case from the first call through assignment, evidence gathering, final determination, and any appeals. More than 200 staff members across all five regions of the state took part in the training. Ensuring each staff member uses the VPCR in the same way means all cases are documented in a consistent manner. That includes uploading and preserving all materials related to Justice Center investigations. The overall goal of the training is to maintain the integrity of the data of agency investigations.

❖ *Professional Boundaries Training Launched*

Establishing and maintaining professional boundaries is fundamental to a safe and therapeutic environment for people receiving services. While boundary crossing is easy to identify when clear acts of an aggression or, sexual or verbal abuse occur, other behaviors that may be perceived as "helpful" and "supportive" may also cross professional boundaries and contradict the goals of the care environment. To help providers and staff identify when boundaries are being crossed, the Justice Center issued a Spotlight on Prevention in 2019 and developed training for provider agencies and their staff. The training covers a broad range of topics from minor mistreatment issues to criminal acts. Staff are taught to evaluate situations based on the best interests of the individual and their treatment plan, agency policy, and the Justice Center Code of Conduct. The course also teaches staff to assess their personal triggers and challenges to maintaining boundaries in an effort to improve job satisfaction. Providers are instructed in ways to show staff support by providing opportunities for open communication, shared problem solving, and effective in-person training. The Justice Center held 13 training sessions in 2019. In addition, the sessions were offered as a break-out at our five regional conferences.

❖ *Human Trafficking*

The trafficking of vulnerable individuals who may be under Justice Center jurisdiction is a growing problem. The Justice Center has become involved in several initiatives to both understand how this issue may affect victims in settings under the Justice Center's jurisdiction and to assess how the Justice Center can help prevent trafficking.

The agency has joined the Westchester County Human Trafficking Task Force, which includes representatives from the Office of Children and Family Services, various District Attorneys' offices, the Office of the New York Attorney General,

the Federal Bureau of Investigation and the Office for Women. In addition, agency representatives have taken part in a conference examining the trafficking of children with disabilities. Further, the Justice Center has formed an internal working group to evaluate the prevalence of trafficking as a factor in its cases, as well as to evaluate how the agency's units have responded to such issues. The group is planning a 2020 training seminar for investigators on how to recognize and address trafficking in settings under the agency's jurisdiction. Invitations for this training will also be extended to our partner agencies to help prevent trafficking in the future. The Justice Center is also helping develop a nine-county conference focused on this issue slated for the spring of 2020.

❖ *Sexual Abuse Response Team Fully Implemented*

The Justice Center's Sexual Abuse Response Team (SART), established in 2018, became fully operational this year. SART includes 31 investigators with experience and backgrounds in law enforcement, direct care, service delivery and clinical services. They have all been specially trained in trauma-informed practices, sexual abuse dynamics, and evidence-based practices, making them uniquely qualified to handle this cohort of cases that present very real challenges for investigation and prosecution. SART also includes members of the Special Prosecutor/Inspector General's Office, who work together with investigations and state and local law enforcement to conduct thorough investigations and pursue criminal charges when warranted.

❖ *Mortality Case Coordination Team*

The Justice Center has formed a multi-disciplinary team to coordinate investigations into the deaths of individuals in care. The team includes field investigators, mortality unit investigators, nurses, advocates, attorneys, and representatives from the Special Prosecutor's Office. The team approach to each case ensures better coordination of cases involving an allegation of abuse or neglect related to a death of an individual receiving services. The team meets regularly to review cases. This monthly review will help inform trend analysis, training and the development of prevention tools.

❖ *Conference Sponsorships*

The Justice Center sponsored two key conferences attended by individuals, providers and agencies with which the Justice Center commonly works. Executive Director Denise Miranda delivered remarks at both the Bivona Child Abuse Summit and at the Hope Changes Everything Conference.
Serving as a sponsor of these events allows attendees from the Justice Center to raise awareness about how the agency protects vulnerable populations as well as lead discussions about further enhancing the agency's relationships with local law enforcement and community-based organizations.

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, families, 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 12,320 individuals and family members have contacted advocates for assistance since 2013. In 2019, Justice Center continued to regionalize staff to provide easier access to advocates for the public. An advocate was added to the Brooklyn office to ensure timely response to inquiries, requests for victim accompaniments, and increased outreach to families and stakeholders. In addition, a regionalized supervisor position was created and filled in White Plains to provide better supervision and support to advocates in New York City, Long Island, and the Hudson Valley.

Advocates can provide information about the reporting and investigative process, case status updates and records access. In 2019, the Justice Center provided assistance to individuals and families regarding records access 425 times.

In addition, Justice Center advocates can accompany victims to interviews or court proceedings. In 2019, advocates provided victim and witness accompaniment in Justice Center-led investigations on more than 400 occasions. Justice Center advocates also coordinate questions or concerns involving State Oversight Agencies.

The Justice Center attends conferences and informational events throughout the state, offering materials and answering questions about the Justice Center. Advocates attended 30 such events in 2019.

In addition to these responsibilities, the Justice Center has been a leader in trauma-informed practices. All unit staff attended the NYS Crime Victims Coalition meetings and networked with other victim-assistance programs at statewide conferences. The Director of the unit was also selected for the Department of Criminal Justice Services' Trauma Collaborative, further expanding the comprehensive statewide approach to providing more trauma-informed services.

❖ *Champion and Code of Conduct Awards*

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

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

The Champion Award honors New Yorkers who have displayed exemplary dedication to people with special needs. The honorees in 2019 included a licensed clinical social worker who reported abuse, then took time from a new job to drive from her new city to meet with investigators and attend a hearing, a local Assistant District Attorney who works hand-in-hand with the Justice Center to improve agency processes and communications, New York City's Chief Medical Examiner who has helped move cases along quickly with timely responses to inquiries and a posthumous award to a member of the agency's Advisory Council who served on the Legislation and Regulations Committee following a rich history of public service.

The Justice Center also appreciates the importance of honoring staff at provider agencies who display a strong commitment to the Code of Conduct and serve as an inspiration to their colleagues. This year's honorees included four individuals who have spent their careers using a person-centered approach to helping individuals with special needs. They were described as leaving no stone un-turned in advocating for individuals in care, being the go-to person in their program, and giving a voice to those who can't advocate for themselves.

❖ *Stakeholder Briefings*

The Justice Center spends considerable time engaging with provider agencies, the direct care workforce, family members, local government, and other interested stakeholders. The agency understands that partnerships formed with these stakeholders are crucial to the success of the mission of the Justice Center. In 2019, the agency conducted 100 presentations, the majority of which were to provider agencies under the Justice Center's jurisdiction as well as their staff. The Justice Center also conducted outreach presentations to local government agencies, attorneys, and people receiving services 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 changes. 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 2019, the agency provided 20 in-person trainings to SOA and provider staff including sessions focused on SOA-led investigations, and mandated reporting. More than 300 people were trained during these sessions.

❖ *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. Some of the trainings added in 2019 include OASAS Community Residential programs, OCFS Family Type Homes, OMH-Licensed Outpatient Clinics, and SED-Licensed Residential Schools.

❖ *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 training included a session with a keynote speaker focused on interview ethics as well as breakout sessions on topics including supporting trauma recovery for youth with developmental disabilities, the art of cross-examination, injuries of unknown origin, restraint and crisis management updates, and elements of offenses. In total, more than 260 Justice Center staff attended the training.

VI. ABUSE PREVENTION AND QUALITY IMPROVEMENT

One of the missions of the Justice Center is 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 can 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 Fingerprints Processed & Applicants Reviewed

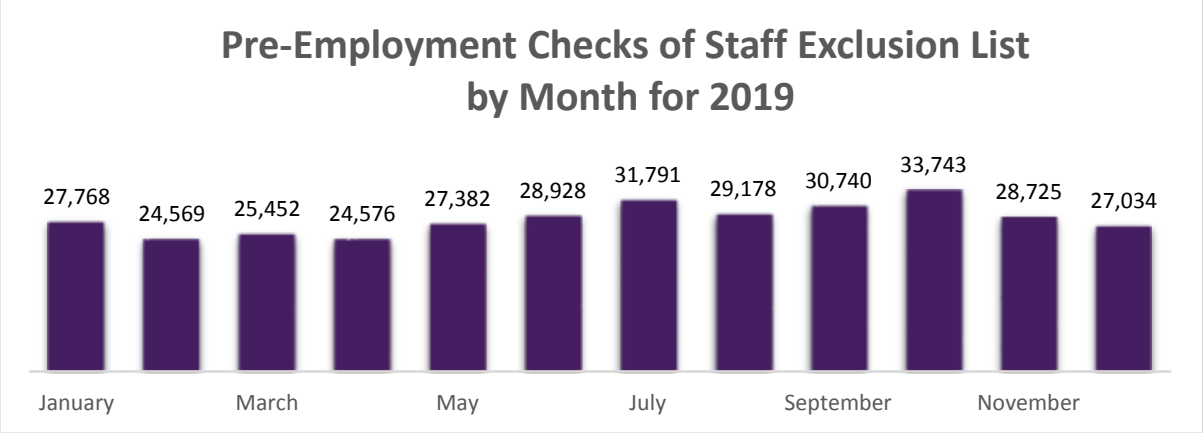
State Oversight Agency	2019
Total Fingerprints Processed	**105,922**
OPWDD	74,913
OMH	20,219
OCFS	10,790
Total Applicants Reviewed	**13,679**
Denied Approval for Employment Consideration	**470**
OPWDD	260
OMH	112
OCFS	98

To date, more than 2,000 applicants have been denied approval for employment consideration because of convictions that ranged from assault to rape and murder. Four hundred seventy of those denials were made in 2019.

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. Providers have been notified 183 times since 2014 that an applicant was on or was pending placement on the SEL. 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.



The total number of individuals on the SEL at the end of 2019 was 652. That is an increase of 164 from 2018.

C. Spotlight on Prevention

The Justice Center uses data compiled 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 2019, the Justice Center issued *Spotlight on Prevention: Preventing Intestinal Obstructions*. The toolkit is a four-part series highlighting the dangers intestinal obstructions can present for individuals receiving services. This toolkit was developed after an analysis of Justice Center reports showed intestinal obstructions to be a common issue. The toolkit helps educate people receiving services, self-advocates, direct care providers, agency administrators, and friends and family members on how to recognize when an individual in care may be suffering an intestinal obstruction, what to do about it and how to prevent obstructions from happening. It includes information on best practices, red flag behaviors, fact sheets for staff, individuals receiving services and provider agencies, as well as case studies from Justice Center reports.

The *Spotlight on Prevention: Preventing Intestinal Obstructions* 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, Reducing the Use of Restraints, and Maintaining Professional Boundaries.*

ii. Quality Improvement

The Justice Center can 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 make recommendations to provider agencies so that they can correct quality of care issues and protect the people they serve from harm.

D. Corrective Action Plan 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 finding that abuse or neglect was caused by a systemic issue. In 2019, the Justice Center also conducted 350 audits of facility and agency corrective action plans.

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 62 of these visits in 2019.

The agency also completed 12 in-depth systemic reviews that included 21 site visits. Below you will find examples of initial findings and recommended corrective action plans.

Examples:

Case 1: Wheelchair Securement (OPWDD)

Narrative: A systemic review was initiated in response to cases of substantiated neglect involving the improper securement of people receiving services who used wheelchairs during transportation in OPWDD-operated settings. The Justice Center identified factors that contributed to the improper securement of people receiving services by conducting site visits, interviewing staff and reviewing documentation.

Result: In response to the recommendations made by the Justice Center, OPWDD developed a standardized transportation safety policy to ensure that vehicle safety training curriculums and documentation practices were standardized across service settings and to ensure that routine inspections of vehicles, lifts and other devices used to safely secure people in vehicles are conducted on a regular basis.

Case 2: Contraband Review (OASAS)
Narrative: In response to abuse and neglect cases involving drug overdoses while people were receiving services in treatment agencies certified by the New York State Office of Addiction Services and Supports (OASAS), the Justice Center undertook a systemic review of treatment facility responses to contraband at six different agencies certified by OASAS.

Result: In response to the Justice Center's recommendations to prevent contraband from coming into treatment settings and ensure that naloxone is available when needed, OASAS provided guidance to its certified programs to establish policies and procedures to maintain a safe and therapeutic environment for people receiving services. In conjunction with this guidance, OASAS provided a training resource that offers best practices and recommendations for implementing those policies. In addition, OASAS implemented changes to increase access to naloxone at every program site.

E. Special Housing Unit (SHU) Monitoring and Audit

The Justice Center oversees compliance with the SHU Exclusion Law and monitors the quality of mental health care provided by the Office of Mental Health (OMH) to people who are incarcerated in state prisons.

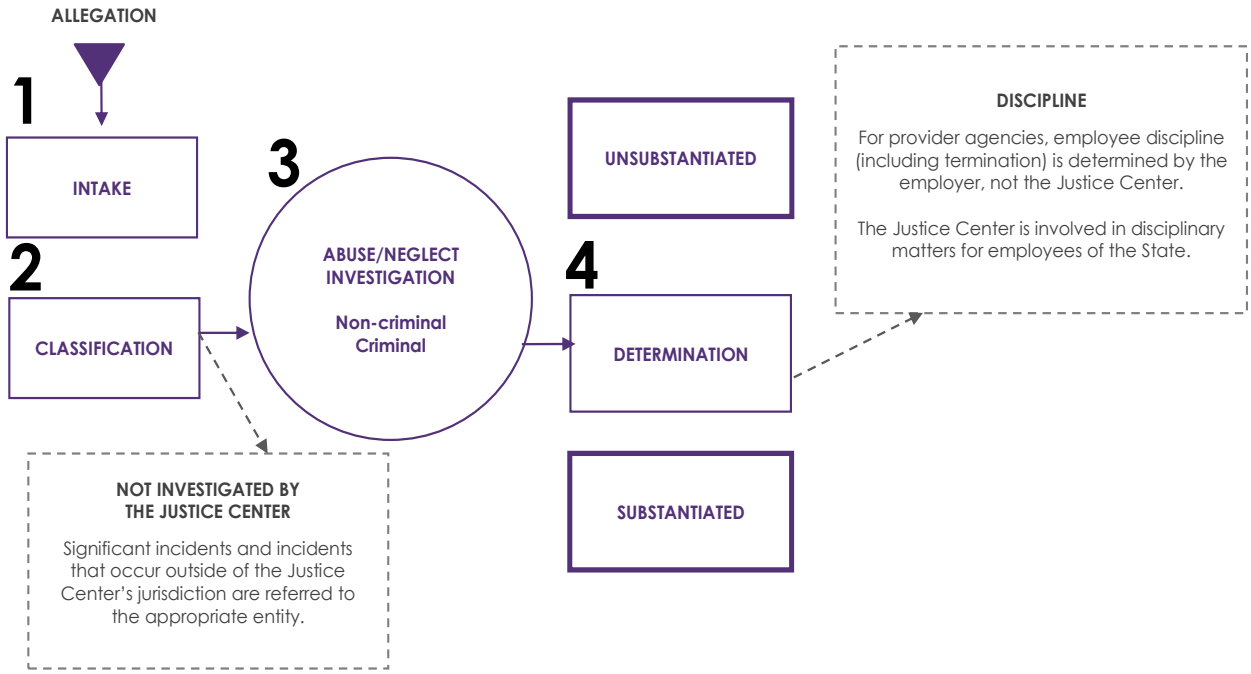
The Justice Center visited 25 facilities and completed 1,182 cell-side and 116 private interviews with inmates in 2019. The agency also reviewed the quality of mental health care for 405 inmates and referred 142 inmates to be evaluated by OMH. In addition, the agency reviewed the records of 330 inmates 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 also assesses the quality of mental health care provided in prisons, including specialized programs for prisoners with mental illness. 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 expected to be released in 2020.

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 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 may include concerns about a provider, questions about insurance coverage, or complaints about disliking food. Cases that require follow-up are referred to the appropriate State Oversight Agency.

Reports Made to the Justice Center	2019
Grand Total	**81,384**
Abuse and Neglect	15,188
Death	1,487
Significant Incident	26,308
Non-NYJC Incident	28,118
Not an Incident	10,283

- **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, OMH, and OASAS providers.

Three-Business Day Review of Incidents

Classification	Total	Percentage
2019 Grand Total	**2,757**	
Remained JC A/N	780	28%
Reassigned to SOA Led A/N	216	8%
Reclassified (SI or Non)	1,761	64%

Classification	Total	Percentage
2019 OPWDD Total	**1,230**	
Remained JC A/N	450	37%
Reassigned to SOA Led A/N	143	12%
Reclassified (SI or Non)	637	52%

Classification	Total	Percentage
2019 OMH Total	**1,190**	
Remained JC A/N	212	18%
Reassigned to SOA Led A/N	73	6%
Reclassified (SI or Non)	905	76%

Classification	Total	Percentage
2019 OASAS Total	**102**	
Remained JC A/N	50	49%
Reassigned to SOA Led A/N	0	0%
Reclassified (SI or Non)	52	51%

Classification	Total	Percentage
2019 OCFS Total	**235**	
Remained JC A/N	68	29%
Reassigned to SOA Led A/N	0	0%
Reclassified (SI or Non)	167	71%

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 2019, 85 arrests were made in connection to Justice Center cases.

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

- **Administrative Cases**

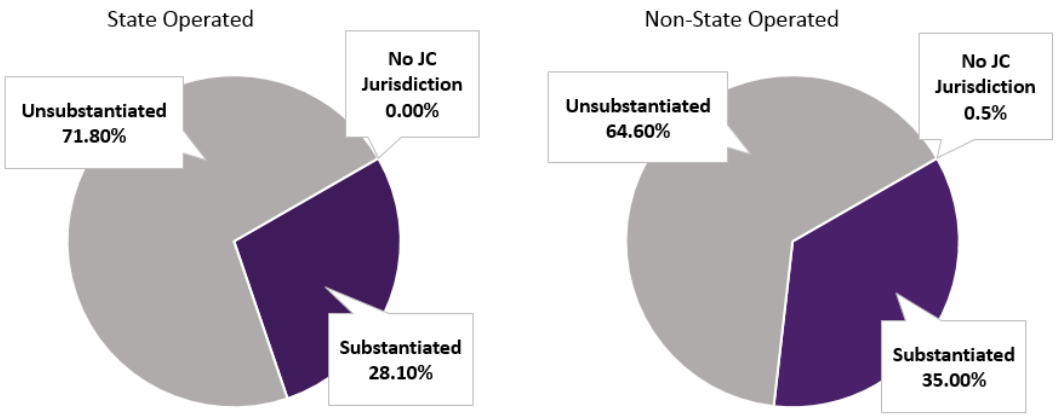
  The first step in the administrative investigation of allegations is appropriate classification and assignment for investigation. The Justice Center investigates allegations in state-operated programs as well as the most serious allegations in non-state operated settings. Less serious allegations of 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 can have legal counsel or a union representative present when being interviewed, unless an applicable union contract, or Collective Bargaining Agreement, provides differently.

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 2019



- **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.

Closed Substantiated Abuse and Neglect Cases by Category for 2019

Total Closed Abuse and Neglect Cases	**3,745**
State Operated Total	**569**
Category One	21
Category Two	134
Category Three	396
Category Four	18
Non-State Operated Total	**3,176**
Category One	123
Category Two	606
Category Three	2,358
Category Four	89

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 2019

State Operated		Non-State Operated	
Neglect	68.8%	Neglect	70.9%
Abuse	14.0%	Abuse	14.0%
Deliberate Inappropriate Use of Restraint	8.8%	Deliberate Inappropriate Use of Restraint	8.5%
Obstruction	4.8%	Obstruction	3.1%
Psychological Abuse	2.4%	Psychological Abuse	1.5%
Other	1.0%	Sexual Abuse	1.2%
Sexual Abuse	.1%	Other	.8%

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 2019, the Administrative Appeals Unit (AAU) received 1,082 requests for amendment, closed 1,292 cases and held 200 hearings.

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 2019, 229 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 454 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. Further, the Justice Center participated in 73 days of expedited hearings or agency-level mediations and 35 days of full arbitration. The chart on the next page indicates the number of times each disciplinary action identified was taken against a state employee in 2019.

Employee Action Process Completed	# of Actions Completed
Closed Substantiated	**784**
Termination Total	229
Loss of Leave Credits and Other Privileges	143
No Penalty	140
Suspension	127
Resigned	91
Counsel or Train (Subset of No Penalty)	82
Letter of Reprimand	78
Probation Terminated	72
Fine	62
Retired	26
Upheld at Arbitration	21
Exclusion or Other	19
Other Penalty	5

- **Administrative Action Reporting Mechanism**

  State Oversight Agencies 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 2019.

AARM Actions	# of Actions Completed
Grand Total	**4717**
Termination	1120
Counseling (Formal – Written)	869
Re-training	790
Resignation/Retirement	284
Training	269
Suspension (1-14 Days)	216
Letter of Reprimand	205
Suspension (30 or More Days)	204
Counseling (Informal – Verbal)	189
Staff Reassignment/Relocation	184
No Action	117
Suspension (15-30 days)	114
Additional Staff Suspension	63
Placed on Probation	53
Demotion	18
Employee Assistance Referral	15
Fine (Monetary/Accruals)	7

- **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 2019, 164 individuals were placed on the list. That brought the total number of subjects on the list to 652. All individuals placed on the SEL are barred from working in settings under the Justice Center's jurisdiction.

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 can make recommendations to providers on how to improve quality of care. 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. In 2019, 33 cases were referred to the MRB.

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 can weigh-in on the discussion.

The MRB can also consult or perform a full review for all abuse/neglect cases with death involved as needed upon request of an investigator. 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 abuse or neglect occurred remains.

IX. CONCLUSION

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 Addiction Services and Supports (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