NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Annual Report to the Governor and Legislature

2020

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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

June 22, 2021

To the Governor and Legislature:

I am pleased to provide you with the 2020 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, 2020 through December 31, 2020. 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 incarcerated individuals, including those 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 people 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 and adult homes that meet certain criteria)
- 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 works 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, attorneys 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. OPERATIONAL IMPACTS OF COVID-19

As the COVID-19 pandemic began to evolve across the globe and in New York State, the Justice Center reacted swiftly to ensure the safety of both agency employees and those we serve. Using existing technology and innovative solutions, most Justice Center employees were able to switch to remote work. This allowed the mission critical work of the agency to continue uninterrupted by the health crisis.

The Justice Center remained fully operational and carried out all functions in 2020.

- The agency worked to modify operations to function in a remote environment and to continue in-person work in a safe manner.

- The Justice Center used video technology to conduct interviews for abuse and neglect investigations. The Justice Center remains committed to in-person field interviews and site visits, but the ability to conduct a remote interview allows investigators to continue work despite public health concerns.

- Advocates in the Justice Center's Individual and Family Support Unit provided remote accompaniment to individuals receiving services and their family members who may not have been comfortable appearing in-person for an interview.

- The appeal process for individuals challenging determinations on a substantiated abuse or neglect case allows for a hearing before an administrative law judge. In 2020, the Justice Center began to offer video hearings to ensure timely access to appeals even during the public health crisis.

- The Justice Center's work to monitor the compliance and quality of mental health care in prisons was adapted to online visits.

- The agency continued outreach efforts to stakeholders through numerous virtual forums including training for the Surrogate Decision-Making Committee volunteers, meetings for the Justice Center's Advisory Council, and trainings for

Technology-Related Assistance for Individuals with Disabilities (TRAID) contractors.

- The Justice Center presented its annual Code of Conduct and Champion Awards virtually.

- Several Justice Center operations were impacted by Executive Orders issued to address the COVID-19 crisis. The deadline to file an appeal was extended to allow those substantiated for abuse or neglect the opportunity to appeal their case.

- The requirement for a new criminal background check to be run prior to onboarding any new employee was modified to allow providers to quickly onboard staff who had been previously cleared through the criminal background check process and were continuously employed with another provider agency under the Justice Center's jurisdiction to address workforce shortages caused by the pandemic. The Justice Center worked with our State Oversight Agency partners to implement this expedited criminal background check process so that staffing needs could be met by allowing individuals already working in these systems of care to work for another provider within that system.

Like many state agencies, the Justice Center assisted in emergency response efforts as needed to help all New Yorkers dealing with the global health crisis. The agency supported four call center activities, either directly within the Justice Center's own call center or by providing staff to assist other agencies' call centers. This included fielding questions related to sick and paid family leave for the NYS Workers' Compensation Board (WCB); helping the NYS Department of Health (DOH) and Department of Tax and Finance (DTF) set up COVID testing appointments and answer general COVID questions' triaging calls from OPWDD's COVID-specific hotline' and helping the Department of Labor (DOL) work through the backlog of unemployment-related calls. Through these efforts, the Justice Center has handled approximately 70,000 calls with New Yorkers regarding COVID-19.

Justice Center investigators assisted in the observation of more than 16,000 establishments to help enforce State Liquor Authority (SLA) COVID-19 requirements and served community outreach details for the duration of the DOH Community Outreach Campaign.

IV. 2020 HIGHLIGHTS AND INITIATIVES

❖ *New Prevention Materials Released*

The Justice Center recognizes the importance of working to prevent abuse and neglect from happening in the settings under the agency's jurisdiction. The Justice Center produces a series of toolkits called the "Spotlight on Prevention", which is updated on a regular basis. The topics of these toolkits are generated by trend analysis of the cases investigated by the Justice Center.

Over the past few years, the Justice Center has seen an increasing number of reports involving people in care who were injured because they were not properly secured in their wheelchairs while riding in agency vehicles. In 2020, the Justice Center produced the Spotlight on Prevention *"Securing Wheelchairs in Vehicles"*. This toolkit includes six case studies modeled from real Justice Center cases as well as information on how staff, providers, and individuals receiving services can prevent these types of injuries. There is also policy guidance and additional resources included.

The Justice Center released a second Spotlight on Prevention in 2020 titled "*Safety Benefits of Global Positioning Satellite Devices*". The report highlights the safety benefits of having GPS devices in agency vehicles. Data demonstrates that GPS devices help keep both individuals receiving services and employees safer by identifying opportunities for driver training.

The Justice Center also updated an older Spotlight on Prevention titled *"Dangers of Caregiver Fatigue"*. The update included new case studies and resources related to avoiding mistakes made when caregivers are fatigued.

❖ *Intake Model Increases Efficiency*

The Justice Center continually works to evaluate agency processes and search for efficiency improvements. In 2020, the Justice Center implemented a new work intake model that helps to objectively assess, evaluate, and prioritize agency projects. The model establishes a governance body that uses objective and consistent criteria to decide what projects will take a priority track. This model has several benefits including increased awareness of what is occurring in different units within the agency in order to mitigate negative or unanticipated impacts to stakeholders, provides transparency in the status of an individual request or the agency's project portfolio, reduces confusion by providing a single point of contact for incoming project and change requests, and improves accuracy of projected timelines.

❖ *Administrative Litigation Unit Transition Completed*

The Justice Center understands its obligation to ensure due process for all subjects of investigations. In 2020, the agency merged staff from several business units to create a new Administrative Litigation Unit. This new multi-disciplinary team handles all administrative appeals and employee discipline matters for the agency. This consolidation has reduced redundancy in overlapping agency functions, improved collaboration across the Justice Center, and increased the efficiency of the appeals process. Under this consolidated unit, one attorney is assigned to a case and stays assigned to that case throughout its lifecycle. This unit has also resulted in centralized documents, job aids, and resources to maintain consistency and streamline work process for attorneys and administrative staff. Additionally, agency attorneys are now

regionalized which enhances their expertise and understanding of provider agencies in a given region and leverages regional resources to reduce travel.

❖ *Anti-Racism Initiative Launched*

The Justice Center recognizes its role as an agency whose mission is to protect vulnerable populations and ensure due process for direct care workers. In response to events happening across the nation, the agency created the Anti-Racism Workgroup. The group has several goals including: understanding the agency's collective awareness on racial equity and how it impacts Justice Center work, identifying strategies to align agency behavior and practices with a culture that values the talents, skills, experiences, expertise, and commitment of every Justice Center employee, and identifying where more investment is needed in staff training to increase cultural competence.

❖ *Prevention Committee*

The Justice Center launched an internal committee with the goal of expanding its ability to identify preventative actions to address conditions that cause or contribute to incidents of abuse and neglect. The Prevention Committee reviews data, trends, and policies and practices relating to the prevention of abuse or neglect. This includes examining staffing patterns and practices of various service delivery models and the supervision levels required to help ensure the safety of service recipients. The Committee contributed to the two Spotlight on Prevention toolkits issued in 2020 with plans to expand prevention materials in 2021.

❖ *Injury of Unknown Origin*

Some of the cases investigated each year by the Justice Center involve injuries of unknown origin. These are cases in which an individual receiving services has a physical injury the cause of which is not known to the reporter. These cases can be medically complex and take longer to investigate. In 2020, the Justice Center launched an initiative to streamline the processes involved in these cases. As a result of the initiative, the Justice Center has provided specialized training and related resource guides to investigators detailing a specific analytic process for cases involving injuries of unknown origin. In addition, supervising investigators have also undergone specialized training to support this new investigative process. An interdisciplinary committee has also been established to review cases involving these types of injuries. The Justice Center believes these steps will help bring closure to these complex cases more quickly.

❖ *Surrogate Decision-Making Committee Electronic Records Transition*

The Justice Center worked diligently throughout the year to transition the Surrogate Decision-Making Committee (SDMC) from the use of paper record to electronic records.

All paper files were converted to digital copies to enable easier access. This involved staff scanning more than 1,200 paper case files so they would be available to all staff. The transition also maximizes the use of technology to implement efficiencies for receiving and processing complex medical requests for consent by developing an electronic case processing system for all SDMC requests. Further, the Justice Center created and conducted several online training programs for volunteers, providers, and contractors to educate them on changes to the SDMC process and to support their use of technology to submit and receive hearing paperwork as well as attend and participate in video hearings.

V. 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 14,700 individuals and family members have contacted advocates for assistance since 2013. In 2020, more than 2,900 individuals and family members were provided with advocacy support. Over the past year, the Justice Center continued to regionalize staff to provide easier access to advocates for the public. An advocate was added to the Delmar office to ensure timely response to inquiries and increased outreach to families and stakeholders. In addition, a regionalized supervisor position was created in Syracuse to provide better supervision and support to advocates in Utica, Binghamton, Buffalo, and Central New York.

Advocates provide information about the reporting and investigative process, case status updates and records access. In 2020, the Justice Center provided assistance to individuals and families regarding records access 683 times.

In addition, Justice Center advocates accompany victims to interviews or court proceedings. In 2020, advocates provided victim and witness accompaniment in Justice Center-led investigations on more than 500 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 12 such events in 2020. While the public health crisis meant an end to in-person presentations, the use of technology to conduct virtual conference appearances has allowed for a larger number of individuals to participate.

In addition to these responsibilities, the Justice Center has been a leader in practicing and advancing trauma-informed practices. All unit staff attended the NYS Crime Victims Coalition meetings and networked with other victim-assistance programs at statewide conferences.

❖ *Champion and Code of Conduct Awards*

The Justice Center understands the importance of recognizing individuals who demonstrate a commitment to people with special needs. The agency has created two 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 2020 included a parent and longtime advocate who was a member of the Justice Center's Advisory Council, a local TRAID (Technology-Related Assistance for Individuals with Disabilities) coordinator who assists people receiving services with securing the technology needed to live, work, and thrive in their community, a member of the Surrogate Decision-Making Committee who had been serving for more than 25 years, and the former general counsel at a state oversight agency who provided unwavering support to the Justice Center from its inception and through its first five years.

The Justice Center 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 recognition was particularly important this year, at a time when staff members displayed profound commitment to individuals receiving services during the pandemic. This year's awards were expanded to include six honorees who have spent their careers using a person-centered approach to helping individuals with special needs. Each played a pivotal role in their employer's response to the COVID crisis. These staff members sacrificed their time and safety so they could care for people receiving services. Some volunteered to care for COVID-positive individuals, while others found unique ways to preserve day-to-day activities during the height of the crisis. As part of the Justice Center's presentation of the Code of Conduct Awards, the agency produced a video featuring messages of gratitude and appreciation from the Commissioners of several State Oversight Agencies as well as photos of direct care workers.

❖ *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 2020, the agency conducted 43 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 law enforcement training. Each committee provides valuable insight to the Justice Center that is used to craft policies, procedures and outreach.

VI. 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, Code of Conduct 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 2020, the agency provided in-person trainings to 40 SOA and provider staff with a focus on mandated reporting. In addition, the Justice Center provided live, digital training to nearly 500 individuals on SOA-led investigations, use of the Vulnerable Person's Central Register (VPCR), and the Code of Conduct.

❖ *Justice Center In-Service Training*

As part of the Justice Center's commitment to continuous improvement, the agency offers an annual in-service training for all investigators and members of other business units. This year the event was adapted to a virtual platform for three days of training in October. The training included an overview of OPWDD's PROMOTE program, trends in administrative appeals decisions, professional boundaries in substance use disorder treatment providers, investigations into medical conditions that mimic inflicted injury, and the federal regulations under

which intermediate care facilities are regulated. In total, more than 260 Justice Center staff attended the training.

VII. ABUSE PREVENTION AND QUALITY IMPROVEMENT

One of the missions of the Justice Center is to develop tools to help 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 individuals receiving services 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 provider agencies, people receiving services 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. This comprehensive review provides a safety net for individuals receiving services while at the same time mitigates risk for employers and the dedicated workforce.

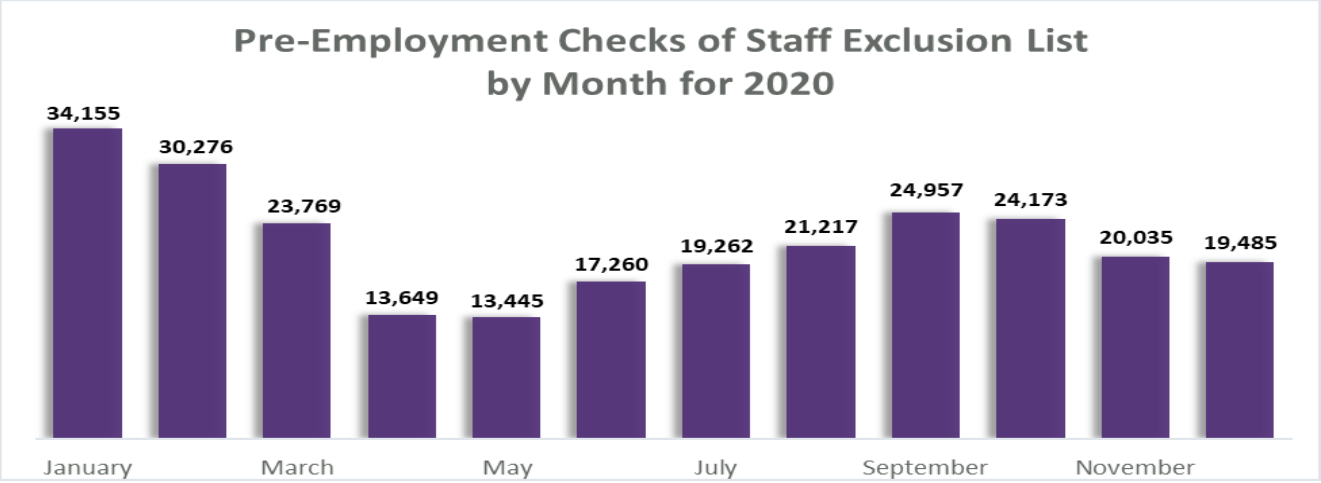
Criminal Background Checks Fingerprints Processed & Applicants Reviewed

State Oversight Agency	2020
Total Fingerprints Processed	**75,945**
OPWDD	52,160
OMH	15,544
OCFS	8,241
Total Applicants Reviewed	**8,215**
Denied Approval for Employment Consideration	**286**
OPWDD	158
OMH	74
OCFS	54

B. Staff Exclusion List

Another tool used to prevent those who have a history of abusing vulnerable populations from continuing to work with and have access to individuals receiving services is the Justice Center's *Staff Exclusion List (SEL)*. All subjects substantiated for Category One (definition see pg. 23) 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 through the SEL check process 210 times since 2014 that an applicant was on or was pending placement on the SEL. This means individuals who have been substantiated for serious acts of abuse and neglect were stopped from being hired into settings where they would have regular and substantial contact with vulnerable people again.



The total number of individuals on the SEL at the end of 2020 was 759. That is an increase of 107 from 2019.

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 2020, the Justice Center issued *Spotlight on Prevention: Securing Wheelchairs in Vehicles*. The toolkit was created after the Justice Center received an increased number of reports involving people in care who were injured because they were not properly secured in their wheelchairs while riding in agency vehicles. This Spotlight includes six case studies modeled from real Justice Center cases as well as information on what can be done to prevent these types of injuries, policy guidance, and additional resources.

In 2020, the Justice Center also issued the *Spotlight on Prevention: Safety Benefits of GPS Devices.* GPS devices provide security and protection for provider agencies, direct care workers, and individuals receiving services. GPS devices offer insight into driver behavior. They can send notifications about hard braking and speeding. This can help providers identify staff members who may benefit from driver retraining which results in a safer experience for all occupants of a vehicle. GPS devices also offer up-to-the minute information on road conditions and traffic which will allow for planning of the most efficient route between two locations.

Further, the Justice Center produced a new agency self-assessment tool focused on preventing people from leaving care without consent. The tool focuses on four areas:

intake and assessment, preventing people from leaving care without consent, response when people leave care without consent, and response to people returning to care after being absent without consent. Agencies can use this self-assessment tool to identify areas of concern and develop strategies to address risk.

The Justice Center also updated its Spotlight on Prevention titled *"Dangers of Caregiver Fatigue"*. The update included new case studies and resources related to avoiding mistakes made when caregivers are fatigued.

These toolkits are the newest published by the Justice Center. Other toolkits developed based on trend and data analysis include: *Dangers of Being Left Unattended in Vehicles, Reducing the Use of Restraints, Maintaining Professional Boundaries,* and *Preventing Intestinal Obstructions.*

ii. Quality Improvement

The Justice Center has the authority and responsibility to make recommendations on improving the quality of care at facilities under its jurisdiction. This is done through reviews and audits of corrective action plans and can include 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 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 2020, the Justice Center also conducted 268 audits of facility and agency corrective action plans which included assessing 1,275 corrective actions and identifying 40 additional findings. Modifications were made during the COVID pandemic to ensure the safety of all individuals receiving services and staff members. Examples of the audits and results are below.

Examples:

Audit #1: Systemic Concerns

Narrative: Between August 2019 and August 2020, nine corrective action plan audits were conducted on cases involving systemic issues at three provider locations. The audits revealed continued concerns regarding care and treatment, specifically related to supervision and ineffective staff assignments.

Result: The Justice Center Executive Director sent a formal letter of concern to the State Oversight Agency Commissioner. Subsequently, the State Oversight Agency took several steps to heighten monitoring to ensure timely, definitive action to address the problems.

Audit #2: Environmental and Nursing Service Issues

Narrative: A corrective action plan audit was conducted in response to a substantiated case of neglect at a group home that revealed significant environmental and nursing service concerns in addition to an open mortality investigation. The Justice Center found that many of the necessary corrective actions were not implemented to address the identified health and safety risks.

Result: The Justice Center communicated these concerns to the State Oversight Agency which resulted in several improvements being put in place. Those include additional staff to support the group home and increased nursing supervision. A nursing supervisor is now on site several times a week to monitor medical care as well as the implementation of new processes to ensure corrective actions are implemented.

Audit #3: Inadequate Living Conditions

Narrative: An audit was conducted in response to concerns with inadequate living conditions at a family care provider site. The Justice Center found that several concerns identified in the investigation that the provider needed to address remained problematic, including an unsanitary, cluttered living environment, fire safety issues, and spoiled and expired food.

Result: The Justice Center shared its findings with the State Oversight Agency. The Executive Director of the provider agency immediately instituted weekly, unannounced site visits to the site.

Audit #4: Care and Treatment of an Individual Receiving Services

Narrative: A corrective action plan audit was conducted in response to a substantiated case of neglect at a facility that revealed concerns with the care and treatment of a person receiving services. The Justice Center found that many of the corrective actions implemented to prevent future mistreatment of the person were insufficient.

Result: The Justice Center communicated concerns with the State Oversight Agency for follow-up to ensure that immediate protections were instituted in a timely manner, that problematic staff behavior was addressed and monitored and that ensured that staff would follow individual treatment 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 six of these visits in 2020. Below you will find examples of initial findings and recommended corrective action plans.

Examples:

Issue 1: Supervision (OMH)

Narrative: A systemic review was initiated in response to cases in which breaches in supervision contributed to neglect. The Justice Center looked at protocols at OMH operated psychiatric centers.

Result: One report was completed and the facility used the Justice Center's recommendations to revise their protocols. The Justice Center will monitor implementation of these protocols. Reviews of other facilities are expected to take place in 2021.

Issue 2: Systemic Relief Staff (OPWDD)
Narrative: The Justice Center launched a review in response to cases in which inadequate training and oversight of relief staff contributed to incidents of abuse and neglect at OPWDD-licensed homes.

Result: Findings letters were sent to two agencies following four site visits. Recommendations related to enhanced onboarding of relief staff, regular, ongoing training for relief staff, and the development of processes to ensure staff unfamiliar with the people residing in the home have the tools needed to provide safe and quality care to people receiving services. The Justice Center will monitor for compliance.

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 reviewed the mental health care provided to incarcerated individuals who are placed in solitary confinement in SHUs in 11 facilities in 2020. In total, the Justice Center completed 318 cell-side and 48 private interviews with incarcerated individuals. The agency also reviewed the quality of mental health care for 168 incarcerated individuals and referred 52 of those individuals to be evaluated by OMH. In addition, the agency reviewed the records of 190 incarcerated individuals placed in solitary confinement to determine if they received mental health care and assessments in accordance with the requirements of the SHU Exclusion Law. The Justice Center found that over 60 percent of the Special Housing Units reviewed were in compliance with the SHU Exclusion Law. A summary of the Justice Center's findings can be found on the agency website.

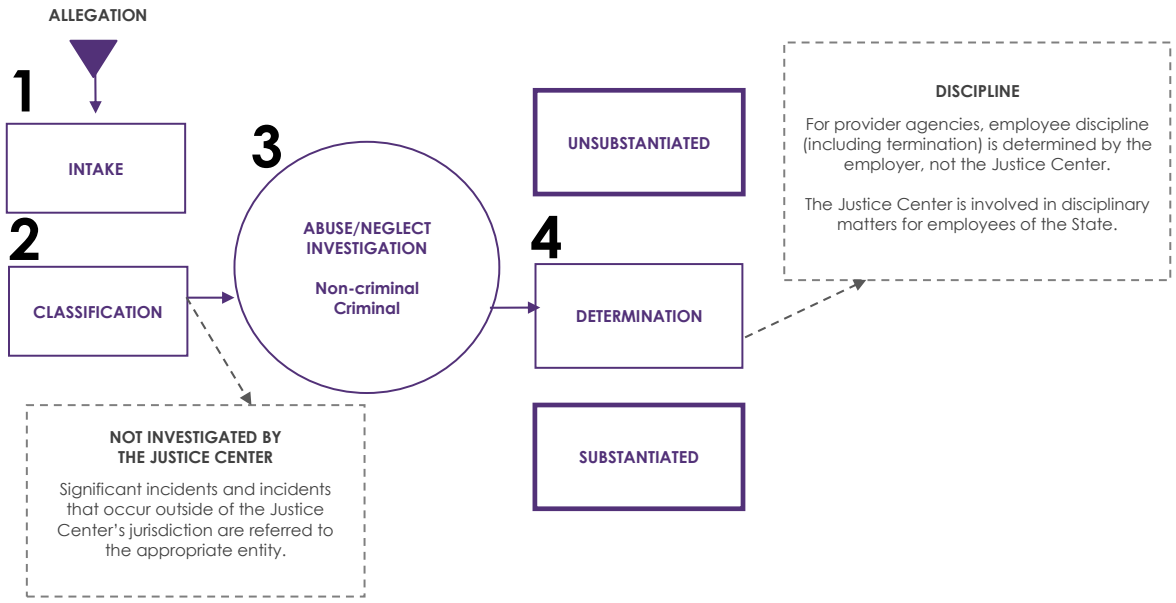
The Justice Center also assesses the quality of mental health care provided in prisons, including specialized programs for incarcerated individuals with serious mental illness. In this way, the agency seeks to effect change that will promote a more therapeutic environment for incarcerated individuals. In 2017, the agency initiated a three-year review of the quality of mental health care provided to 35 incarcerated individuals in the Behavioral Health Unit (BHU) at the Great Meadow Correctional Facility. The mental health care, placement, and disciplinary sanctions that these individuals received prior to, during, and post placement in the BHU were reviewed at three different times between November 2015 and April 2018. The Justice Center's review found that

incarcerated individuals diagnosed with a serious mental illness were diverted to the Great Meadow BHU in compliance with the SHU Exclusion Law and recommended that DOCCS and OMH work together to provide a more supportive and therapeutic environment.

VIII. 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 facility or provider 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 individual receiving services can make a report to the VPCR when they have knowledge or have reason to believe that a person receiving services has been abused, neglected or mistreated. Some people are required by law 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 the following 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 Incident**
  - 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, or complaints about food. Cases that require follow-up are referred to the appropriate State Oversight Agency.

- **Not an Incident**
  - Calls that do not allege any type of incident but instead may be general inquiries or incorrectly routed calls. The Justice Center will refer to a relevant agency or entity if available.

Reports Made to the Justice Center	2020
Grand Total	**88,158**
Abuse and Neglect	11,587
Death	2,289
Significant Incident	23,436
Non-NY JC Incident	39,165
Not an Incident	11,681

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

  The Justice Center has implemented 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 better informed and therefore a more accurate incident classification and a better use of investigative resources.

  The three-business day assessment is available to all OPWDD, OMH, OCFS, and OASAS providers.

Three-Business Day Review of Incidents – 2020										
Classification	OPWDD		OMH		OASAS		OCFS		Grand Total	
	#	%	#	%	#	%	#	%	#	%
Remained JC A/N	397	37%	235	20%	35	48%	114	32%	**781**	**29%**
Reassigned to SOA Led A/N	114	11%	57	5%	0	0%	70	19%	**241**	**9%**
Reclassified (SI or Non)	565	53%	876	75%	38	52%	175	49%	**1,654**	**62%**

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 Justice Center's Special Prosecutor works with county District Attorneys to bring criminal charges in cases that allege that a crime has occurred against an individual receiving services by an employee of a facility or provider agency. 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.

  In 2020, 66 arrests were made in connection to Justice Center cases.

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

- **Administrative Cases**

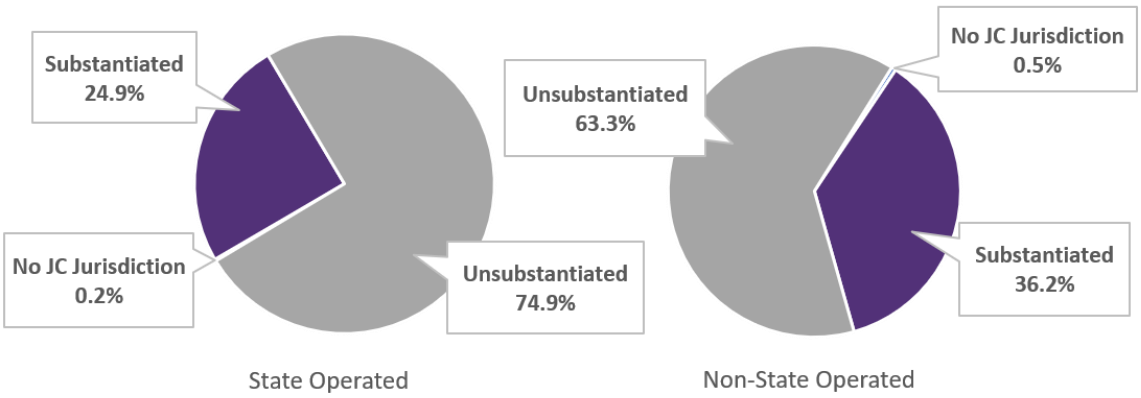
  The first step in the administrative investigation of allegations of abuse and/or neglect is appropriate classification and assignment for investigation. The Justice Center investigates allegations in state-operated programs as well as the most serious allegations in non-state operated settings. Less 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. Individuals receiving services who are the victim of or witness to abuse and neglect may have a personal representative or an advocate from the Justice Center's Individual and Family Services Unit accompany them during an interview.

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 2020



- **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:** Incidents of abuse or neglect that are mitigated by systemic conditions at a program or facility that increased the likelihood of such abuse or neglect, such as inadequate training, staffing, or supervision. Category 4 also include 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 2020

Total Closed Abuse and Neglect Cases	**3,090**
State Operated Total	**446**
Category 1	10
Category 2	104
Category 3	316
Category 4	16
Non-State Operated Total	**2,644**
Category 1	104
Category 2	636
Category 3	1,817
Category 4	87

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 investigation.

Substantiated Allegations in Closed Cases* - 2020

Type	State Operated	Non-State Operated
Neglect	86.5%	88.7%
Physical Abuse	18.4%	18.5%
Deliberate Inappropriate Restraint	14.8%	10.4%
Obstruction	5.6%	4.5%
Psychological Abuse	3.8%	2.0%
Sexual Abuse	0.4%	2.0%
Other	0.4%	1.1%

*Percentages based on total cases closed. Some cases contain more than one substantiated allegation.

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 2020, the Administrative Appeals Unit (AAU) received 844 requests for amendment, closed 1,016 cases; made 886 de novo determinations, and held 100 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 2020, 153 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 357 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 64 days of expedited hearings or agency-level mediations and 29 days of full arbitration totaling 191 cases. The chart on the next page indicates the number of times each disciplinary action identified was taken against a state employee in 2020.

Employee Action Process Completed	# Complete Actions
Closed Substantiated	**539**
Termination Total	153
Loss of Leave Credits or Other Privileges	138
Suspension	80
No Penalty	79
Counsel or Train (subset of No Penalty)	56
Letter of Reprimand	69
Resigned	52
Fine	44
Probation Terminated	35
Upheld at Arbitration	21
Exclusion or Other	9
Retired	2
Other Penalty	2

- **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 2020.

AARM Action	# Complete Actions
Grand Total	**3,271**
Termination	846
Counseling (Formal-Written)	632
Re-Training	573
Resignation/Retirement	218
Training	175
Suspension (1-14 days)	142
Staff Reassignment/Relocation	135
Suspension (30 or more days)	123
Letter of Reprimand	119
Counseling (Informal-verbal)	106
No Action	51
Additional Staff Supervision	50
Suspension (15-30 days)	50
Placed on Probation	21
Demotion	17
Employee Assistance Referral	13

- **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 2020, 107 individuals were placed on the list. That brought the total number of subjects on the list to 759. All individuals placed on the SEL are barred from working in settings under the Justice Center's jurisdiction.

IX. MORTALITY REVIEWS

The *Protection of People with Special Needs Act* requires the deaths of all individuals receiving services from a residential facility or program licensed, certified, or 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 2020, 19 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.

X. 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.

XI. 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 and certain adult homes that meet census criteria for the number of beds and percentage of residents with serious mental illness.
- **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

XII. APPENDIX B

Justice Center Advisory Council Members

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

Norwig Debye-Saxinger — Therapeutic Communities Association

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

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

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