Justice Center for the Protection of People with Special Needs

Annual Report to the Governor and Legislature

2016

THE JUSTICE CENTER'S PROMISE TO NEW YORKERS WITH SPECIAL NEEDS AND DISABILITIES

OUR VISION

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

OUR MISSION

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

OUR VALUES AND GUIDING PRINCIPLES

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

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

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

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

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

Justice Center for the Protection of People with Special Needs

ANDREW M. CUOMO
Governor

January 24, 2017

To the Governor and Legislature:

I am pleased to provide you with the 2016 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, 2016 through December 31, 2016. 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,

Jay Kiyonaga
Executive Deputy Director

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I. EXECUTIVE SUMMARY

Since its inception on June 30, 2013, the Justice Center for the Protection of People with Special Needs (Justice Center) has focused its efforts on 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.

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. In addition to the outcomes of these activities, which are summarized in this report, the Justice Center partners with stakeholders to continuously improve agency functions and to implement new strategies to further enhance its ability to ensure that New York's most vulnerable citizens are protected and the workers who deliver services are supported.

2016 Highlights

- Conducted extensive outreach to stakeholders (e.g., individuals receiving services, families, direct care workers and provider agencies) to hear concerns, dispel misconceptions, and promote a better understanding of Justice Center processes and procedures
- Instituted a series of operational changes to streamline abuse and neglect investigations to allow timelier disposition of administrative cases
- Developed and disseminated additional mandated reporting guidance materials and provided web-based training to communicate more effectively the roles and responsibilities of mandated reporters
- Upgraded data management capabilities to provide additional context to the data highlighted in the agency's monthly data reports posted on the agency's website to make outcomes more transparent
- Provided training to local law enforcement agencies and District Attorney's offices to strengthen understanding of individuals with disabilities and special needs to enhance law enforcement's ability to conduct interviews in an appropriate and effective manner
- Expanded the availability of support offered to victims of abuse or neglect and their families by adding individual and family support advocacy staff to regional offices across the state
- Developed an abuse prevention sample policy for provider agencies and recommended best practices to promote abuse free environments
- Established a Code of Conduct Recognition Award to honor direct support professionals whose actions demonstrate a commitment to the core values of the code
- Launched a new web-based clearinghouse of resources to further support people with disabilities of all ages, in all settings, and their families, caregivers and advocates

II. HISTORY AND JURISDICTION

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

- Office for People With Developmental Disabilities (OPWDD)
- Office of Mental Health (OMH)
- Office of Alcoholism and Substance Abuse Services (OASAS)
- Office of Children and Family Services (OCFS) (State-operated programs/facilities and certain residential programs)
- Department of Health (DOH) (Certain adult homes and 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 process.

Through its oversight and monitoring activities, the Justice Center identifies durable corrective and preventive actions that 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 420 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. INCIDENT MANAGEMENT

Prior to the establishment of the Justice Center, there was no mechanism to track abuse or neglect incidents, investigations, or outcomes across state agencies serving people with special needs. The Justice Center now serves as the state's central reporting agency and maintains an incident management system, known as the Vulnerable Persons' Central Register (VPCR), which accepts reports of all incidents and tracks them to completion.

Reports made by telephone are received promptly and professionally 24 hours a day, seven days a week, by highly trained call center agents. The number to contact the toll-free hotline to make a report is **855-373-2122**. Language assistance services are provided free of charge. To ensure that help arrives as quickly as possible in an emergency situation, the Justice Center advises callers to hang up and dial 911 if a person receiving services is in immediate danger. A web-based reporting form and a mobile application are also available for use by mandated reporters.

10,727 **distinct reports of alleged abuse or neglect were received by the Justice Center in 2016**

Table 1. Total Number of Reports made to the VPCR by Phone or Web Form

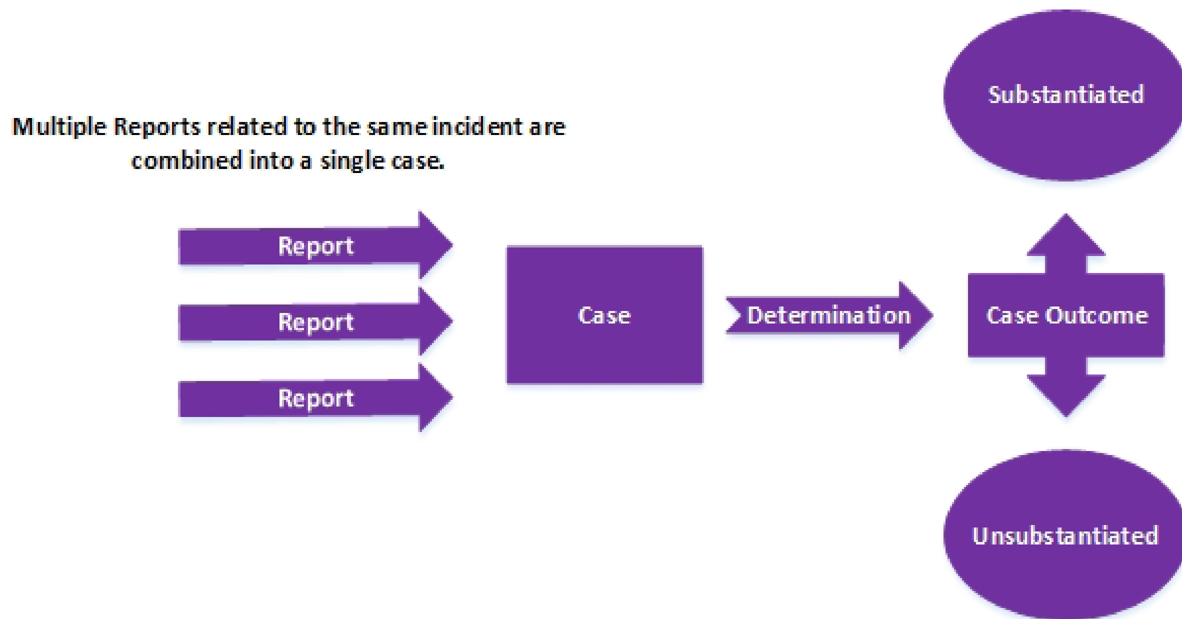
Reports made to the Justice Center	2016
Grand Total	**94,982**
Abuse and Neglect	14,493
Death	1,738
Significant Incident	35,723
Non-NYJC Incident	27,985
Not an Incident	15,043

Of the 14,493 reports of abuse and neglect received during the 2016 calendar year, 3,768 were duplicate reports of the same incident, resulting in the reporting of 10,727 distinct incidents of alleged abuse or neglect.

There are three types of reportable incidents – abuse, neglect and significant incidents.[1] A report may consist of multiple allegations and multiple subjects. Multiple reports are often made for the same incident. (Please see: Appendix B for additional information on the Types of Reportable Incidents and Non-Reportable Incidents).

[1] Certain deaths not involving abuse, neglect or a significant incident are also reportable, as discussed in Section V of this report.

Incident Review Process



IV. ABUSE AND NEGLECT: INVESTIGATIONS AND OUTCOMES

The Justice Center has the authority to investigate all allegations of abuse and neglect involving vulnerable persons. The Justice Center may also delegate responsibility for an investigation to the relevant state oversight agency.

All reports are assessed, classified and logged into the VPCR. Each case of abuse or neglect is tracked until resolution (either substantiated or unsubstantiated), with state agencies required to report back their findings to the Justice Center in cases delegated to them for investigation. An investigation may lead to either administrative or criminal remedies, or both, when the evidence supports a finding that an employee or volunteer committed abuse or neglect.

Administrative Investigations

Justice Center investigators directly investigate the most serious allegations of abuse and neglect, as well as nearly all alleged incidents of abuse and neglect that occur in state-operated settings. Less serious cases are delegated to state oversight and provider agencies.
Justice Center investigators are experienced and specially trained in interviewing victims and witnesses with special needs and disabilities. They employ a victim-centered, evidence-based, trauma-informed approach to investigations to ensure victims and witnesses are treated with sensitivity, dignity and compassion.

After the Justice Center receives a report, and regardless of who will perform the investigation, the appropriate state oversight agency is immediately notified to ensure that protective measures are put in place to safeguard the service recipient(s). It is important to note that state and provider agencies, not the Justice Center, make determinations about whether any particular employee may continue to work with and/or have contact with service recipients during an investigation.

During 2016, the Justice Center enhanced its process to notify county District Attorneys of *all* reported allegations of abuse and neglect within their jurisdiction. District Attorneys' Offices now also receive a monthly report that contains information on the administrative outcomes of abuse and neglect cases in their jurisdiction, as determined by the Justice Center.

Administrative Sanctions

The Justice Center reviews the findings of all investigations of abuse or neglect, including those conducted by a state oversight or provider agency, and makes a finding that such allegations are either substantiated or unsubstantiated. The standard of proof to substantiate an allegation in an administrative case is a *preponderance of the evidence*, meaning it is more likely than not the alleged conduct occurred.

35% **of abuse and neglect cases were substantiated by the Justice Center in 2016**

Abuse and neglect case outcomes are determined by the outcome of the allegation(s) within the case. A single case may involve one or more subjects and each subject may have multiple allegations that may involve more than one victim. On average, approximately one-third of all cases of abuse and neglect are substantiated each year -- meaning that at least one allegation of abuse or neglect was substantiated in that case.[2]

Table 2. Total Number of Abuse and Neglect Cases Closed by State Operated and Non-State Operated Facilities

	2016
Total Closed Abuse and Neglect Cases	**11,254**
State Operated Total	**2,807**
Substantiated	897
Unsubstantiated	1,903
No JC Jurisdiction	7
Non-State Operated Total	**8,447**
Substantiated	3,272
Unsubstantiated	5,154
No JC Jurisdiction	21

The Protection of People with Special Needs Act, which created the Justice Center, incorporates the concept of proportionality of consequences by requiring the Justice Center to classify the severity of substantiated abuse or neglect. Substantiated reports of abuse and neglect are categorized into four categories

[2] Rate of substantiation is based on a two-year moving average.

based on severity. As a result, the response to misconduct differentiates between serious incidents of staff culpability (Category One) and less serious incidents (Category Three), as well as incidents in which staff culpability is mitigated because of deficient workplace conditions or other factors (Category Four). (Please see: Appendix C for additional information on the categories of substantiated findings of abuse and neglect). The subject of a substantiated finding has the right to appeal a determination.

Less than

1%

of individuals receiving services under the jurisdiction of the Justice Center are associated with a substantiated abuse or neglect case

With the exception of findings involving Category One, which are serious or repeated acts of abuse or neglect -- disciplinary or other employment actions are generally at the discretion of the employing provider agency in accordance with established rules and collective bargaining agreements. Justice Center attorneys represent the state at disciplinary proceedings brought against state employees for substantiated abuse or neglect.

Nearly three-quarters of substantiated abuse and neglect findings are classified as Category Three conduct. These reports are sealed after five years and future employers do not receive any information about these incidents. The Justice Center or the state oversight agency may require the facility or provider where the incident occurred to develop and implement a plan of prevention and remediation that identifies any systemic problems that led to the determination and includes suggested corrective measures. (See VII. Prevention Strategies and Quality Improvement for additional information.)

Table 3. Substantiated Cases of Abuse and Neglect by Severity.

	2016
Total Closed Abuse and Neglect Cases	**4,169**
State Operated Total	**897**
Category One	25
Category Two	161
Category Three	641
Category Four	70
Non-State Operated Total	**3,272**
Category One	104
Category Two	462
Category Three	2,528
Category Four	178

Table 4. Total Abuse and Neglect Cases by Severity

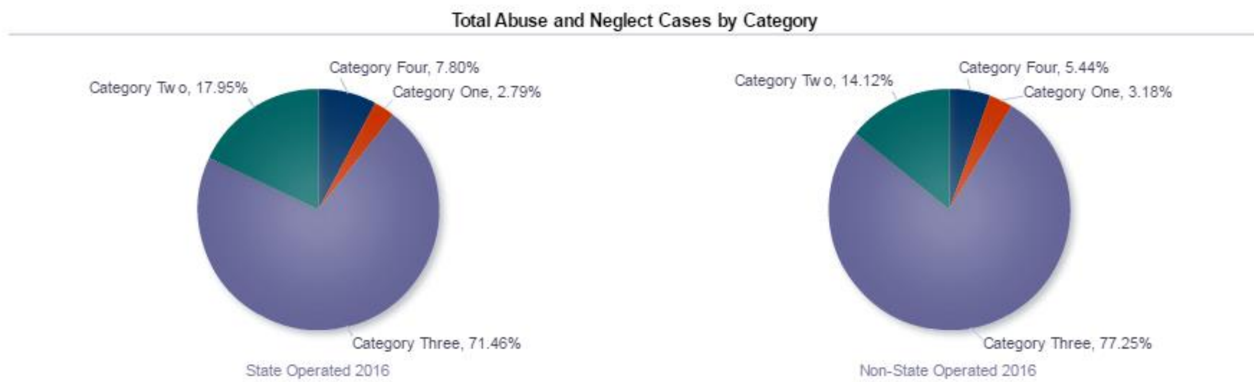


Table 5. Substantiated Cases by Allegation Type[3]

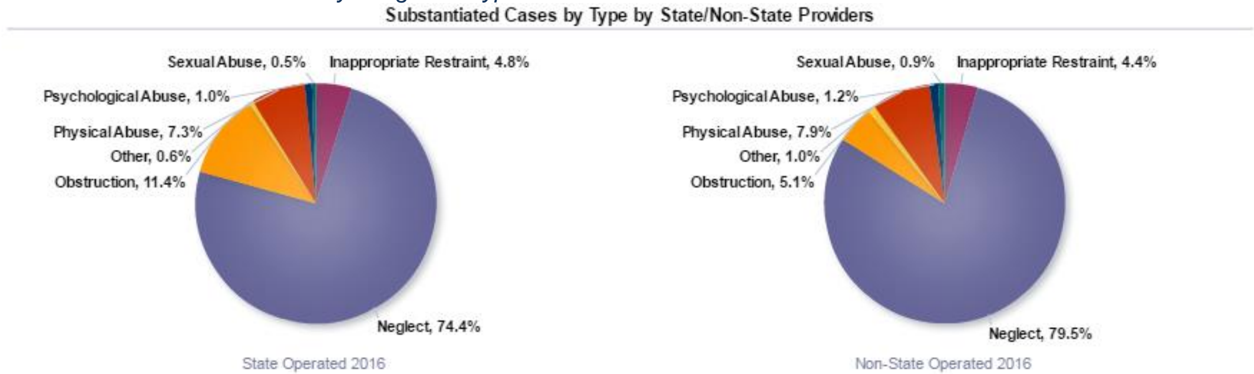
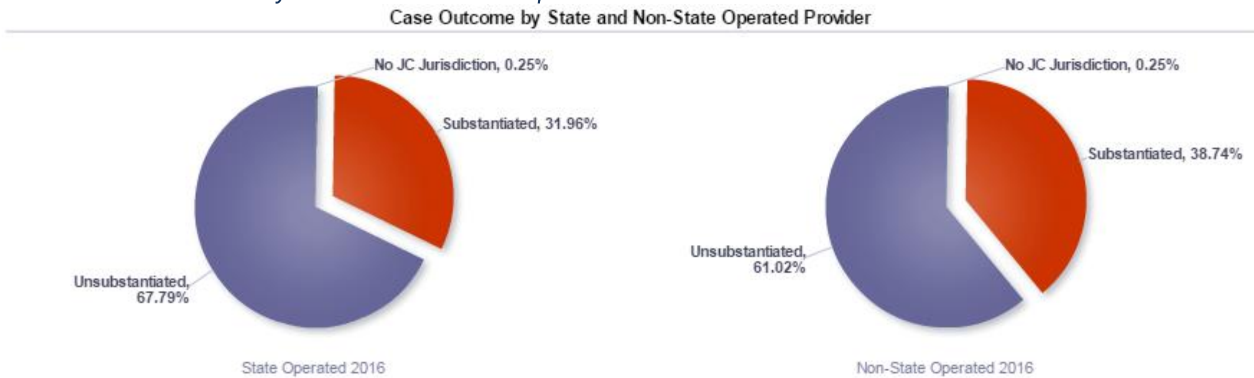


Table 6. Case Outcome by State and Non-State Operated Provider



[3] "Other" includes Use of Aversive Conditioning and Unlawful Use or Distribution of a Controlled Substance.

Staff Exclusion List

All subjects of a substantiated report of Category One conduct, which includes serious or repeated acts of abuse or neglect, are placed on the Justice Center's Staff Exclusion List (SEL). At the close of 2016, 333 individuals had been placed on the SEL. This number reflects the total number of individuals who have been barred from working in settings under the Justice Center's jurisdiction since the agency became operational on June 30, 2013. Offenses that have resulted in placement on the SEL have included: hitting, choking, punching, sexual contact, falsifying records and failure to report serious allegations of abuse or neglect.

333 **individuals have been placed on the Staff Exclusion List since June 30, 2013, preventing them from securing a position in an agency that serves vulnerable populations**

Provider agencies under the Justice Center's jurisdiction, as well as certain other providers identified in statute, are required to check the SEL before hiring someone who will have regular and substantial contact with a service recipient.

Table 7. Pre-Employment Checks of the Staff Exclusion List

Disciplinary Action

The Justice Center represents the State in all administrative proceedings relating to the discipline of state employees found to have committed abuse or neglect. In 2016, 251 state employees were separated from state service as a result of disciplinary charges brought against them. In addition, the Justice Center reviewed and approved 690 Notices of Discipline in 2016, which could result in an oral or written reprimand, suspension or termination.

Criminal Investigations

Allegations that rise to the level of a criminal offense may be prosecuted by the Justice Center's Special Prosecutor/Inspector General or the county District Attorney. The Justice Center works in cooperation with local law enforcement agencies and District Attorneys to bring charges against individuals accused of abuse or neglect involving criminal conduct. As part of this collaboration, the local District Attorney is informed of every case of abuse and neglect received by the Justice Center in his or her jurisdiction. If an investigation results in an arrest, either by Justice Center criminal investigators or by other law enforcement agencies, Justice Center prosecutors are empowered to handle all aspects of criminal prosecutions from arraignment to trial or plea bargain to ensure justice for vulnerable victims and hold those who violate the law accountable for their actions. Justice Center prosecutors also provide assistance as needed to local District Attorneys.

Arrests and Prosecutions

The vast majority of cases investigated by the Justice Center do not allege conduct that would support a criminal prosecution of a custodian. The Justice Center led 69 prosecutions that commenced in 2016. An additional 45 prosecutions were led by local District Attorneys. The overall conviction rate of cases prosecuted by the Justice Center since 2013, including guilty pleas and trial verdicts, is 84 percent.

It is important to note that, in addition to criminal penalties, defendants in criminal cases will have their cases administratively reviewed, which may subject them to placement on the Staff Exclusion List and cause them to face disciplinary action.

Vulnerable Persons' Task Forces

Following the establishment of the Justice Center's Vulnerable Persons' Task Forces in Monroe, Albany, Jefferson, and Nassau counties, the level of cooperation and collaboration between local District Attorney's offices, local law enforcement agencies and the Office of the Special Prosecutor/Inspector General has been strengthened. Utilizing a multi-disciplinary approach, the countywide teams address and enhance the way law enforcement, medical personnel and social services agencies respond to criminal cases involving people with disabilities and special needs who have been victimized. Among other things, the teams evaluate the training needs of police and prosecutors and provide recommendations for future Justice Center course offerings. Vulnerable Persons' Task Forces are slated to become operational in four more counties in the coming year.

V. DEATH ASSESSMENTS AND REVIEWS

Abuse or Neglect Cases with a Death Involved

Mandated reporters are required to report directly to the Vulnerable Persons' Central Register (VPCR) any death – in both residential and non-residential programs under the Justice Center's jurisdiction – for which they have reasonable cause to suspect abuse or neglect or a significant incident may have been involved. For every death in which abuse or neglect or a significant incident is suspected, the Justice Center notifies the appropriate District Attorney and Medical Examiner. These deaths are investigated in the same manner as any other abuse or neglect case.

In 2016, the Justice Center closed 114 abuse and neglect investigation cases in which a death was involved. Of these cases, 46 had at least one substantiated allegation of abuse or neglect, which may or may not have caused or contributed to the death in question. It was determined that criminal charges were not warranted in any of these cases.

Executive Law § 556 Death Reviews (not abuse or neglect)

Administrators of residential programs licensed, operated, or certified by the Office for People With Developmental Disabilities (OPWDD), the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), and the Office of Children and Family Services (OCFS) are required to report all deaths of residents to the Justice Center, irrespective 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 service recipients and prevent the recurrence of similar issues.

All deaths subject to this mandatory reporting are referred to as Executive Law § 556 deaths and each report is reviewed by investigators with program experience and health care professionals, including registered nurses. This reporting and review is in addition to the requirements to report and investigate deaths where there is reasonable cause to suspect abuse, neglect or a significant incident.

Table 8. Total Executive Law § 556 Death Cases Completed

Executive Law §556 Death Reviews	2016
Total Reviews Conducted	**2,628**
State Operated	556
Non-State Operated	2,072

In 2016, the Justice Center completed 2,628 Executive Law § 556 Death Reviews across the four agencies required to report these deaths.

VI. RESOURCES FOR INDIVIDUALS AND FAMILIES

The Justice Center provides guidance and support to victims of abuse or neglect, their families, personal representatives and guardians throughout an investigation. To meet the growing demand for assistance, the agency expanded this resource in 2016 by adding staff to its regional offices. Individual and family support advocates provide information about the reporting and investigative process, case status updates and victim interview accompaniment. Over the past year, more than 3500 individuals and family members contacted advocates for assistance.

VII. PREVENTION STRATEGIES AND QUALITY IMPROVEMENT

In addition to investigating allegations of abuse and neglect, the Justice Center is dedicated to abuse prevention. The agency's online Abuse Prevention Resource Center provides a collection of guidance documents and tools that have been developed to aid state and private provider agencies in this endeavor.

Abuse Prevention

The Justice Center works with state oversight agencies and its Advisory Council to identify and develop strategic prevention initiatives. These efforts have included creating and distributing guidance documents and tools and training individuals and staff to take a proactive approach to creating safe, supportive abuse-free environments. In 2016, the Justice Center, with input from a multi-agency Prevention of Abuse and Neglect Work Group, developed a sample abuse prevention policy, along with guidance on best practices to promote abuse free environments for provider agencies. These resources can be found on the Justice Center's website.

Prevention and Quality Improvement

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 assess sufficiency and implementation of plans. Staff also visit and inspect facilities or provider agencies to assess quality of care, identify issues of concern and factors that have led to systemic failures and make recommendations for agencies to consider implementing to reduce the likelihood of recurrence.

Examples of Justice Center Findings and Actions Taken by Agencies

Finding – *Staff were unprepared to respond to an emergency crisis that required CPR and/or First Aid.*

Result of Justice Center intervention – Relevant staff were given CPR/First Aid/AED trainings.

Finding – *Program failed to report alleged sexual abuse and had a policy that obstructed reporting allegations of abuse or neglect to the Justice Center. Serious deficiencies in clinical services were also found.*

Result of Justice Center intervention – Justice Center issued an immediate action letter. Within 24 hours of this notification, the state oversight agency sent the facility a notice directing them to cease admissions and take immediate corrective action.

Finding – *Fire safety training and planning was found to be inadequate. Facility was unable to produce a current evacuation plan. Pre-filled fire drill report forms utilized by the facility did not reflect census of residents currently residing in the facility.*

Result of Justice Center Intervention – Facility developed and implemented fire safety training for staff and established a fire safety plan to ensure agency compliance. Staff was required to compare fire drill report forms with census of residents and include all residents on the forms.

Finding – *Failure to makes repairs to apparatus used to secure wheelchairs in agency vehicles following the death of an individual receiving services.*

Result of Justice Center intervention – Provider implemented new transportation policies, assessed all agency vehicles for compliance, ordered necessary equipment and provided proper training to staff.

Finding – *Program utilized techniques that included shaming and punitive measures.*

Result of Justice Center intervention – New leadership committed to ending this inappropriate practice.

VIII. CRIMINAL BACKGROUND CHECKS

The Justice Center reviews and evaluates the criminal history information of all prospective employees or volunteers seeking to work at provider agencies under its jurisdiction and advises service providers about the individual's suitability for employment. This comprehensive screening, which includes the ability to request and review information contained in FBI identification records, provides an additional safety net for individuals receiving services and their families and mitigates risk for employers.

Table 9. Criminal Background Checks

Criminal Background Checks	2016
Total Fingerprints Processed	**94,113**
Total Applicants Reviewed	12,445
Denied Approval for Employment Consideration	375

In 2016, 94,113 applicants were fingerprinted. Of these, 12,445 individuals had a criminal history. 375 applicants were denied approval for employment consideration for convictions that ranged from assault to rape and murder.

IX. MENTAL HEALTH CARE SERVICES IN PRISONS

The Justice Center, through its Forensic Unit, monitors the quality of mental health care provided by the Office of Mental Health (OMH) to people who are incarcerated in state prisons. This includes monitoring compliance with the Special Housing Unit (SHU) Exclusion Law (See: Ch. 1, L. 2008).

In 2016, the Justice Center visited 23 state correctional facilities. During these visits, Justice Center staff met with 1180 inmates cell-side and reviewed records of 471 inmates to assess both the quality of mental health care provided and compliance with the SHU Exclusion Law.

Since assuming responsibility for monitoring compliance with the SHU Exclusion Law in June of 2013, and based on the compliance reviews conducted in 2016, the Justice Center has found that most SHU units regularly meet the compliance standards required by the statute. OMH and the Department of Corrections and Community Supervision (DOCCS) have addressed Justice Center findings, which have included failure to properly document SHU requirements and the need for retraining.

In addition to monitoring compliance with the law, the Justice Center has begun to assess the quality of care being provided in specialized programs for prisoners with mental illness within DOCCS. In this way, the Justice Center seeks to effect change that will promote a more therapeutic environment for patients/inmates.

In 2016, the Justice Center completed compliance reviews for the three Residential Mental Health Treatment Units run by OMH within DOCCS. The Justice Center's Forensic Unit also has

nearly finished a broader review of the quality of care provided in these specialized units through multiple interviews with inmates and review of one year's worth of inmate records. A similar review is underway for the Behavioral Health Units. These units are designed to address the mental health needs of patients/inmates with the most serious mental illnesses.

X. TRAINING INITIATIVES

The Justice Center develops accessible, innovative and effective training and informational materials to support and protect people with special needs and disabilities. Training is offered in person, by webinar, or online for mandated reporters, individuals with special needs, family members and advocates, state and provider agencies, law enforcement agencies and District Attorneys' Offices.

Mandated Reporter Training

The Justice Center developed new resources for mandated reporters - employees, volunteers, directors and operators of covered facilities and programs and human service professionals who are required by law to report abuse or neglect and significant incidents to the Justice Center. Simulated calls (role plays) to the Vulnerable Persons' Central Register (VPCR) hotline have been recorded to provide mandated reporters with examples of what to expect when making a report. A list of common questions asked by call center representatives can also be found on the Justice Center's website.

Law Enforcement Training Academy

The Justice Center is committed to not only enhancing the knowledge and skills of its investigators, but also to providing comprehensive disabilities awareness training to investigators from local and state law enforcement agencies on the Justice Center's mission, the victimization of persons with disabilities and information and resources to help officers respond to incidents involving individuals with special needs. In addition, a two-day certificate course that focuses on working with special populations, evidence collection and interview techniques is offered to state and provider agency investigators. More than 1300 investigators completed training in 2016.

Forensic Interview Training

New York State Police investigators were among the 149 law enforcement officers from police agencies across the state who completed the Justice Center's *Forensic Interviewing Best Practices for Vulnerable Populations* three-day training session in 2016. The curriculum, developed by the Justice Center and presented by national and statewide experts in the fields of forensic interviewing and disabilities, provides practicums for interviewing vulnerable New Yorkers in the least traumatic way possible to gather credible information that will stand up to judicial scrutiny. The multi-day course and certification will be expanded in 2017, with additional trainings planned throughout the year.

XI. WORKFORCE OUTREACH AND SUPPORT

In addition to promoting the safety of people with special needs, the Justice Center supports and protects the rights of the dedicated workers who provide care to vulnerable persons. The Justice Center partnered with the National Alliance for Direct Support Professionals (NADSP) to hold listening forums across the state to build and strengthen direct support professionals' understanding of Justice Center functions and activities. Justice Center staff engaged in an open dialogue with workers, who are encouraged to ask questions and share their concerns.

Code of Conduct Recognition Award

The Justice Center celebrated the work of five outstanding direct support professionals who were bestowed with the agency's first annual Code of Conduct Recognition Award. Winners, who were nominated by service recipients, family members, co-workers and supervisors, were honored for their commitment to the tenets of the Code of Conduct. Seventeen additional workers also received recognition.

XII. CONCLUSION

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 and continue to explore and develop new approaches to strengthen the agency's ability to safeguard New York's most vulnerable citizens in the year ahead.

XIII. 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 that are operated, licensed or certified by OPWDD

Office of Mental Health (OMH)

- Facilities and programs that are operated, licensed or certified by OMH

Office of Alcoholism and Substance Abuse Services (OASAS)

- Facilities and provider agencies that are operated, licensed or certified by OASAS

Office of Children and Family Services (OCFS)

- Facilities and programs operated by OCFS for youth placed in the custody of the Commissioner of OCFS
- OCFS licensed or certified residential facilities that care for abandoned, abused, neglected, and 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

Department of Health (DOH)

- Adult care facilities licensed by DOH that have over 80 beds, and where at least 25 percent of the residents are persons with serious mental illness and where fewer than 55 percent of beds are designated as Assisted Living Program (ALP) beds
- Overnight, summer day and traveling summer day camps for children with developmental disabilities under the jurisdiction of DOH

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

XIV. APPENDIX B

Types of Reportable Incidents

Abuse

There are seven categories of abuse: physical abuse; sexual abuse; psychological abuse; deliberate inappropriate use of restraints; use of aversive conditioning; obstruction of reports of reportable incidents; and unlawful use or administration of a controlled substance.

Neglect

Neglect is any action, inaction, or lack of attention that breaches a custodian's duty and that results in or is likely to result in death, physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a service recipient.

Most commonly, neglect is the result of a custodian’s lack of attention or failure to act as required by his or her responsibilities. Neglect can include, but is not limited to: failure to provide proper supervision; failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care; and failure to provide access to educational instruction.

Significant Incident

Any 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.

Types of significant incidents identified in statute:

1. Conduct on the part of a custodian that is inconsistent with an individual’s treatment plan, educational program, or generally accepted treatment practices
2. Conduct between persons receiving services resulting in harm or the potential for harm
3. Any other conduct identified in regulations of the State Oversight Agencies

Non-Reportable Incidents

In 2016, 43,028 reports made to the Justice Center were for non-reportable incidents. These calls are either not an incident because the nature of the allegation did not meet the definition of a reportable incident, involved an incident that occurred in a facility or program that was outside of the agency’s jurisdiction or involved a service recipient or staff member who was not under the Justice Center’s jurisdiction. Efforts are made to direct callers of non-reportable incidents to an appropriate entity for assistance.

XV. APPENDIX C

Categories of Substantiated Allegations

Substantiated reports of abuse or neglect are categorized into one or more of the following four categories:

Category 1 conduct is: serious physical abuse, sexual abuse or other serious conduct by custodians.

Category 2 conduct is: abuse or neglect that is not included in Category 1, but is conduct by a custodian that *seriously endangers the health, safety or welfare* of a service recipient.

Category 3 conduct is: conduct that is not included in Category 1 or 2, but is nevertheless abuse or neglect.

Category 4 conduct refers to: conditions at a facility or provider agency that expose service recipients to harm or risk of harm but where staff culpability for such abuse or neglect is mitigated by systemic problems, such as inadequate staffing, management, training or supervision. It also applies when abuse or neglect against a service recipient has been substantiated but the responsible person cannot be identified.

Substantiated Determination Consequences

If an allegation of abuse or neglect is substantiated, the subject of that finding has a right to appeal the determination before an administrative law judge.

- **Category 1 Substantiated Findings**: Individuals who have an allegation substantiated in a case of abuse or neglect-- either a single "Category 1" offense or two or more "Category 2" offenses over a 3-year period -- are placed on the Justice Center's Register of Substantiated Category One Case of Abuse or Neglect, also known as the Staff Exclusion List (SEL). Individuals on the SEL are prohibited from being hired by most state operated, certified, or licensed agencies or providers that serve people with special needs. Placement on the SEL is permanent.

- **Category 2 and Category 3 Substantiated Findings**: Substantiated Category 2 findings that are not elevated to a Category 1 finding and all Category 3 findings are sealed after five years.

XVI. APPENDIX D

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
Tanya L. Hernandez – Parent, Families CAN!
Leslie A. Hulbert – Parent
Walter J. Joseph, Jr. – Children's Home of Poughkeepsie
Jeremy E. Klemanski – Syracuse Behavioral Health Care
Sylvia Lask – Parent
Ronald S. Lehrer – NYS Association of Boards of Visitors
Belinda Lerner – Parent, National Football League
Glenn Liebman – Mental Health Association in New York State
Joseph Macbeth – National Alliance for Direct Support Professionals
Delores Fraser McFadden – Orange County Department of Mental Health
Kathy O'Keefe – Sagamore Children's Psychiatric Center, Pilgrim Psychiatric Center
Judith A. O'Rourke – Parent
Clint Perrin – Self Advocacy Association of NYS
Susan Platkin – Parent, NY Self Determination Coalition
Harvey B. Rosenthal – NY Association of Psychiatric Rehabilitation Services (NYAPRS)
Scott Salmon – Self Advocate
Mary K. St. Mark – Parent Advocate and Board President, Institutes for Applied Human Dynamics
Euphemia Strauchn-Adams – Parent, Families on the Move
Robert L. Weisman, DO – Strong Memorial Hospital