Mental Hygiene 2/6
Michael Carey

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Testimony for the Joint Legislative Fiscal Committees

February 6, 2017

Michael Carey, Parent of Jonathan Carey who was killed in State care, Advocate for 1,000,000 New Yorkers with disabilities and their families and the Founder of the Jonathan Carey Foundation

Almost 10 years ago, my precious son, Jonathan, was killed by his New York State caregivers on February 15, 2007. Jonathan was only 13 years old when he was suffocated to death. Jonathan had autism, he was developmentally disabled, he was primarily nonverbal, and he suffered with PTSD from the severe child abuse he sustained at the Anderson School, now called the Anderson Center for Autism, prior to being killed while living at OD Heck Developmental Center.

Jonathan was a victim of numerous crimes and gross negligence of care and services within the three short years he lived in residential care facilities. It would sicken you to hear of the details of how much Jonathan suffered and endured while he lived in these two separate facilities that received substantial Medicaid funding. Pursuant to federal law, these facilities and all State and private facilities and group homes, are mandated to provide safe care, that is free from abuse and neglect. Jonathan was not provided safe care that was free from abuse and neglect, in fact, it was the exact opposite. He was denied immediate 911 first responder medical and police assistance when he was a victim of crimes on numerous occasions, when he was significantly injured, and even the night he was killed. Jonathan was treated unequally and discriminated against.

It was the man that killed Jonathan that was protected and shielded from prosecution on multiple occasions. Local law enforcement authorities were purposefully kept from being notified which ultimately resulted and led to Jonathan's death which could easily have been prevented. You must understand the extreme dangers that exist. Administrators were more concerned about hiding and concealing what was going on behind closed doors, within their facilities, than Jonathan's health, safety, rights, or his life.

It is important for everyone to fully understand, abuse and neglect of a person with a disability, is a crime, a class E felony, per New York State law. Abuse and neglect of a person with a disability is not just a word on a pie chart or statistical data sheets, these are serious criminal acts. New York State Penal Law 260.25, states that anyone knowingly doing anything likely to be injurious to an incompetent or physically disabled person, is guilty of a class E felony.

Tragically, New York State's mental health care system remains extremely dangerous and deadly as represented by State documents and records revealing that over 7,000 calls monthly are reported to the State abuse hotline for the disabled operated by the Justice Center. Approximately, 11-12 deaths of people with disabilities or individuals struggling with mental illness, on average, are reported to the Justice Center every day. You must grasp these numbers. These are precious souls that have been entrusted into care facilities to be provided safe care and services. There are gross and severe wide-scale systemic problems and failures that continue because they have not been addressed by the Executive Office and the New York State legislature.

The New York Times did a massive award winning investigative reporting series titled "Abused and Used" which consisted of over 30 pieces that came out throughout 2011. It took me over two years to convince the New York Times to do this investigative reporting work. This series which was a runner up for a Pulitzer, revealed massive systemic failures. Staggering numbers of cases resulted in injuries and deaths of people with disabilities, including Jonathan's death, because of issues that needed to be rectified, which to date continue.

Instead of moving to address the root causes and genuine problems, the Cuomo administration concocted a fraudulent scheme. The scheme was to ride out the New York Times expose storm and take no legislative actions whatsoever to stop or prevent the rampant physical and sexual abuse, neglect, and deaths in the 2011 or 2012 legislative sessions.

The fraudulent scheme was to rename and relocate the State agency that was successfully covering up most crimes, including criminally negligent deaths by keeping local police out of the picture, to ensure criminal investigations did not occur and that County Elected District Attorneys were not notified and did not have the evidence to prosecute most crimes and deaths of people with disabilities. The agency previously called the Commission on Quality of Care (CQC) was renamed to be called the Justice Center for the Protection of People with Special Needs. This agency and their staff which were actively involved in obstructing justice and criminal conspiracy regarding covering up heinous crimes and deaths was also relocated from State Street in Schenectady, New York to Delmar, New York. These steps and numerous other deceptive steps were taken to deceive the New York State legislators, the disabled, their families, the media and the public whom were outraged by the New York Time's "Abused & Used" investigative reporting series.

The New York State legislature must act now and take dramatic steps to ensure that the massive amounts of State and Federal Medicaid dollars are actually used to provide safe care and services for our disabled. Numerous safety and abuse prevention measures that you would assume are in place within both State and private facilities to provide safe care and services are non-existent. Major systemic problems that lead to abuse and neglect must finally be addressed, swiftly, in this

legislative session. As represented by the Governor's budget, he intends to do nothing to stop these horrors, the massive discrimination against the disabled or take any measures to stop and prevent clearly preventable abuse and neglect, as well as, deaths of the disabled.

The areas of greatest immediate concern for the safety and lives of the disabled are as follows:

- Immediate and direct reporting by all mandated reporters to 911;
- Legislation to require significant standardized training with written testing, grading and licensing of all caregivers so they are properly trained and qualified to care for our most vulnerable;
- Significant pay increases for all properly trained caregivers;
- All investigations by State and private provider agencies must be immediately stopped;
- A significant increase in oversight and unannounced inspections of all facilities and group homes must be genuinely independent and required by law;
- Legislation to finally require safe hours allowed to be worked by caregivers within a 7-day work week, which must cap the number of hours allowed to work, ban all back to back double shifts and completely ban triple and quadruple shifts;
- There must be significant changes to insufficient background checks that do not properly vet individuals regarding prior employment and offenses;
- Surveillance cameras are vital in all facilities and transport vehicles to protect our most vulnerable from abuse and neglect and to determine genuine facts for independent investigations;
- Require proper staffing levels of nurses and ban calling a nurse hotline;
- There must be drug testing of all individuals working with the disabled;
- There must be radon testing of all facilities, group homes, and schools caring for the disabled (radon is the 2nd leading cause for lung cancer and we have a major radon crisis throughout NYS).

The Justice Center for the Protection of People with Special Needs must be shut down. All funding of this corrupt State agency must be swiftly stopped. All genuine independent authorities throughout our State and communities are already in place to assist, protect and ensure justice for all New York State residents. Bypassing and circumventing 911 call systems, local police and emergency medical personnel, County elected District Attorney's, County Medical Examiners/Coroners, New York State penal laws and local courts are all discriminatory practices that allow these horrific crimes and injustices to continue.

Listed below are some of the most egregious deceptions of the Justice Center for the Protection of People with Special Needs:

- It is not independent, it is not a new State agency, it is not a Justice Center, it is primarily a call center where most reported criminal matters, including deaths, are purposefully kept from local authorities;
- It is staffed by many individuals that have been obstructing justice and covering up crimes and deaths of the disabled for many years, these individuals must be held accountable and cannot continue to cover-up crimes and deaths of people with disabilities;

- It is not a legitimate police agency, it is NOT a first responder entity, it is not headed up by anyone with law enforcement background or knowledge and it was purposefully set up to deceive everyone;
- Most reported alleged criminal matters are never reported to local police or County Elected District Attorney's as claimed by the Justice Center and Jay Kiyonaga;
- Jay Kiyonaga is directing State and provider agencies to investigate deaths in their own facilities and group homes (see attached State document);
- The Justice Center is NOT notifying County Medical Examiners and Coroners of most deaths of the disabled that have been directed to be reported to the Justice Center. County Medical Examiners and Coroners are being purposefully bypassed, which is illegal and they are unable to investigate and do autopsies to determine true causes of deaths;
- Almost all reported and witnessed sexual assault crimes and rapes are never criminally investigated and are kept from local police and DA's by the Justice Center, which is obstruction of Justice;
- The Justice Center is falsifying official documents, records, and reports, and continues in its previously named entities ways as exposed by the New York State Inspector General in 2008, but far worse, lying to the New York State Legislature regarding what they are and are not doing (See State documents from Inspector General attached);
- The Justice Center is not investigating most reports, but funneling most back to provider agencies for internal investigations, most are covered-up to continue to receive Medicaid funding, although many are extremely dangerous;
- The Justice Center has lied about the numbers of substantiated cases and they have considerably watered down the numbers to the New York State Legislature. There were over 18,000 substantiated cases between June 30, 2013 to March of 2016 (FOIL RA 937 which is a list of substantiated cases of abuse and neglect which are required by law to be reported to the Office of Medicaid Inspector General. According to State record none were reported to OMIG);
- The Justice Center has been and continues to NOT report substantiated cases of abuse to the Office of Medicaid Inspector General which is required by law. The Justice Center is actively trying to protect and shield known extremely dangerous and deadly facilities and individuals to give an appearance that they are performing their job (DOH document attached);
- The Justice Center's four Categories all rise to the level of class E felony offenses, yet, most were never reported to local police and District Attorneys. These practices have denied disabled victims their NYS and US Constitutional right to "equal protection of laws" (4 categories used by the Justice Center and NYS Penal Law 260.25);
- The Justice Center does not notify all District Attorneys daily of abuse and neglect allegations which are criminal allegations as they have claimed to the NYS legislature;
- The Justice Center has not bettered the care of the disabled as represented by their complete lack of requesting and insisting on taking the most basic of safety and abuse prevention steps and actions to stop and prevent the rampant abuse, neglect and deaths occurring;
- The prosecution rate for the public is between 60-70%, meaning when a crime was committed and an arrest made, 60-70% of these crimes were prosecuted. For the disabled it is less than 1% according to the Justice Center's statistical data. The disabled are being discriminated against and treated unequally and when they are victims of crimes in New

York State, significantly injured, in medical distress, or have died, the 911 call systems are almost always bypassed leading to countless deaths. The KNOWN and documented number one trend for "untimely" or criminally negligent deaths of the intellectually disabled and developmentally disabled is bypassing 911;

- The Justice Center is a fraud and is operating illegally. It is involved in a massive Medicaid fraud scheme, it is protecting most criminals, including, almost all those involved in the even greater cover-up of crimes that allows the same criminals, which includes sexual predators and pedophiles to remain in the system to reoffend the same or other innocent victims with disabilities that cannot defend themselves or, in many cases, unable to even speak and testify of what happened to them. Mandated reporters are responsible to report, but all this reporting regarding crimes, injuries medical distresses and deaths must be required by law to go to 911, so swift independent assistance can help them, like everyone else is helped and that justice will ensue.

Jonathan suffered horribly and so has my entire family, but I believe that everything we have gone through was to ultimately help the 1,000,000 people with disabilities and their families that make up close to 25% of our State's population combined. On behalf of the disabled and their families, I am requesting that numerous emergency actions be taken by the NYS legislature, as swiftly as possible, to genuinely protect the disabled from abuse and neglect crimes and to finally end decades of discrimination against the disabled by denying them 911 and "equal protection of laws."

NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Andrew M. Cuomo, Governor
Jeff Wise, Executive Director

Memorandum

To:	State Oversight Agencies and Private Providers under the Jurisdiction of the Justice Center
From:	Jay Kiyonaga, Executive Deputy Director
Date:	December 17, 2015
Subject:	Clarification of Reporting and Investigating Deaths
Effective Date:	December 17, 2015

The purpose of this memorandum is to clarify requirements for reporting deaths to the Justice Center for the Protection of People with Special Needs (Justice Center).

Administrative Reporting Requirement

1. All deaths of individuals receiving services from a residential facility or residential program operated, licensed or certified by the Office for People with Developmental Disabilities (OPWDD), the Office of Mental Health (OMH), the Office of Alcoholism & Substance Abuse Services (OASAS) or the Office of Children & Family Services (OCFS) must be reported to the Justice Center. In addition, known deaths of individuals who had received services from such a facility or program in the 30 day period preceding death must also be reported.

2. To report a death, providers must call the Justice Center Death Reporting Line at (855) 373- 2124 to make an initial report, and then follow up with the required death related information using the prescribed form within five business days. OPWDD and OMH programs will continue to be able to utilize IRMA or NIMRS to electronically submit the required information (rather than use the form).

3. The Justice Center will review all reports of death under its jurisdiction and may conduct its own investigation.

4. State and private providers should continue to review/investigate deaths in their programs, unless informed otherwise by the Justice Center.

Abuse & Neglect Reporting Requirement

1. If there is any reason to suspect abuse or neglect related to a death, in addition to the administrative death report, this must also be separately reported to the Vulnerable Person's Central Registry (VPCR) Hotline at (855) 373-2122 in accordance with the Justice Center mandated reporting requirements. Non-residential programs must continue to report suspected abuse or neglect related to a death to the VPCR Hotline.

State of New York
Office of the Inspector General

A Critical Examination of State Agency Investigations into Allegations of Abuse of Jonathan Carey

June 2008

Joseph Fisch
State Inspector General

behavior management (14 NYCRR § 633.16) to ensure consistent safety and oversight protections for all consumers statewide.

8. The Inspector General recommends that OMRDD explicitly recommend agencies under its jurisdiction to review an employee's conduct and take appropriate disciplinary action, when circumstances warrant such a recommendation.

Commission on Quality of Care and Advocacy for Persons with Disabilities

1. This investigation revealed that CQC officials made inaccurate and misleading statements to Governor Pataki's office, the Inspector General, the State Senate, and the Careys. The Inspector General recommends that the Governor's Office review the conduct of CQC, and its leadership, with respect to the findings of this report.
2. The Inspector General recommends that CQC review the conduct of staff members assigned to investigate and oversee the Jonathan Carey investigation, and take appropriate action, given the significant and numerous deficiencies cited in this report.
3. The Inspector General recommends that CQC review its investigative policies and procedures to ensure that cases are investigated thoroughly, actions are documented appropriately, relevant evidence is obtained, and case files are completed.
4. The Inspector General recommends that CQC ensure that its child abuse investigations are not simply repackaged when it is necessary to also conduct a broader and separate care and treatment review to evaluate the overall quality of care for individuals with disabilities.

RA 937 Offense Outcomes by Category by County

For the period: 6/30/2013 - 3/15/2016

County	Category One	Category Two	Category Three	Category Four	Total
Total Substantiated Offenses	**516**	**2,479**	**14,277**	**892**	**18,164**
Albany	21	57	501	45	**624**
Allegany		3	11		**14**
Bronx	11	137	742	69	**959**
Broome	4	40	281	33	**358**
Cattaraugus	2	6	93	7	**108**
Cayuga	2	15	90	2	**109**
Chautauqua	6	39	132	5	**182**
Chemung	8	3	51	1	**63**
Chenango	4	11	104	6	**125**
Clinton	1	12	71	12	**96**
Columbia	14	55	355	50	**474**
Cortland	1	4	53	1	**59**
Delaware		22	70	9	**101**
Dutchess	10	45	391	21	**467**
Erie	19	226	1,691	59	**1,995**
Essex		6	30	1	**37**
Franklin	12	31	333	12	**388**
Fulton		6	46	3	**55**
Genesee		4	52	1	**57**
Greene	1	5	17	6	**29**
Hamilton		1	19	13	**33**
Herkimer	1	4	89	1	**95**
Jefferson	3	23	46	4	**76**
Kings	29	129	957	63	**1,178**
Lewis		11	24		**35**
Livingston		2	31	1	**34**
Madison		8	81	6	**95**
Monroe	8	104	985	37	**1,134**
Montgomery	1	5	36		**42**
Nassau	3	58	350	28	**439**
New York	22	97	523	47	**689**
Niagara		39	321	6	**366**
Oneida	12	74	331	29	**446**
Onondaga	10	92	405	22	**529**
Ontario	1	13	91	6	**111**
Orange	23	78	271	19	**391**
Orleans		2	12	1	**15**
Oswego		2	21	1	**24**
Otsego	2	27	123	6	**158**
Putnam	89	132	84	4	**309**
Queens	11	103	791	20	**925**
Rennselaer	5	30	226	23	**284**
Richmond	5	50	251	16	**322**
Rockland	11	33	195	19	**258**
Saint Lawrence	6	13	62	3	**84**
Saratoga		8	91	1	**100**
Schenectady	2	29	141	9	**181**
Schoharie		4	27	1	**32**
Schuyler			65	1	**66**
Seneca	2	13	55	3	**73**
Steuben		6	27	1	**34**

County	Category One	Category Two	Category Three	Category Four	Total
Suffolk	57	123	846	62	**1,088**
Sullivan	2	17	47	8	**74**
Tioga		11	16	6	**33**
Tompkins	21	138	388	5	**552**
Ulster	27	59	203	18	**307**
Warren	1	2	51	2	**56**
Washington			21	1	**22**
Wayne	4	2	51	5	**62**
Westchester	42	206	734	49	**1,031**
Wyoming			35	2	**37**
Yates		4	40		**44**

Print Close

RE: FOIL# 16-03-120

From: **doh.sm.BOB-FOIL** (foil@health.ny.gov)
Sent: Tue 4/05/16 11:08 AM
To: yahsolo@msn.com (yahsolo@msn.com)

Dear Mr. Carey:

After searching for the requested records,there were no substantiatedreports received by the Office of the Medicaid Inspector General from the Justice Center.

Thank you

Records Access Office

NYSDOH

Corning Tower

Albany, New York 12237

From: Michael Carey [mailto:yahsolo@msn.com]
Sent: Monday, April 04, 2016 10:17 AM

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 1 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.

New York State Penal Law 260.25

Endangering the Welfare of an Incompetent or Physically Disabled Person

§ 260.25 Endangering the welfare of an incompetent or physically disabled person in the first degree.

A person is guilty of endangering the welfare of an incompetent or physically disabled person in the first degree when he knowingly acts in a manner likely to be injurious to the physical, mental or moral welfare of a person who is unable to care for himself or herself because of physical disability, mental disease or defect. Endangering the welfare of an incompetent or physically disabled person in the first degree is a class E felony.