Justice Center for the Protection of People with Special Needs

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To: Chairs and Members of the Legislative Committees on Finance, Ways and Means, Mental Health, and Disabilities

From: Rebecca Mudie, Intergovernmental Affairs Director

RE: Information Requested – Legislative Budget Hearing on Mental Hygiene

Date: 3/12/2021

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

"Executive Law § 556" Reviews

The vast majority of reports of death received by the Justice Center fall under what is referred to as an Executive Law § 556 death report. This section of law requires that residential programs licensed, operated or certified by OPWDD, OMH, OASAS and OCFS report all deaths of residents/patients to the Justice Center, regardless of whether the death is expected or unexpected. 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 a team of investigators with experience working in settings under the Justice Center's jurisdiction as well as health care professionals, including registered nurses. Through these reviews, the Justice Center makes recommendations to providers on how to improve quality of care, where issues regarding quality of care are identified. The findings are sent to both the provider and the State Oversight Agency for monitoring of recommended actions.

Mortality Investigations

Mandated reporters under the 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. In addition, 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 review information including medical and clinical history of the individual receiving services, a synopsis of the circumstances surrounding the death, involvement by local law enforcement, if any, findings of the medical examiner, 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.

Medical Review Board

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

The MRB is called upon for complex cases in which a full death review is needed, to give an opinion on whether the standard of care was met for the deceased. The case is assigned to a primary reviewer, who provides their expert opinion to the MRB and members of the MRB also weigh-in on the assessment.

The MRB may be called on to perform a full review for abuse/neglect cases with death involved as needed as well.

Below please find a table of the reports of all deaths from the aforementioned settings under the four State Oversight Agencies received by the Justice Center in 2018, 2019, and 2020.

	2018	2019	2020
SOA	556 Cases Created	556 Cases Created	556 Cases Created
Grand Total	1443	1407	2145
OPWDD	873	912	1411
OMH	405	354	553
OCFS	50	34	52
OASAS	115	107	129