



DISABILITY RIGHTS NEW YORK

New York's Protection & Advocacy System and Client Assistance Program

INVESTIGATION REPORT:

THE DEATH OF M.H.: NEGLECT AT SAINT DOMINIC'S HOME-DOMINICAN HALL

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Executive Summary

Disability Rights New York (“DRNY”) is the designated federal Protection and Advocacy System (“P&A”)¹ for individuals with disabilities in New York State. One of DRNY’s core functions is to investigate the deaths of persons with developmental disabilities in facilities that provide services to people with developmental disabilities.² DRNY has authority under federal and state law to thoroughly investigate deaths occurring in any public or private entity that provides care, services, treatment or habilitation to individuals with disabilities.³

The following report details DRNY’s investigatory findings relating to the death of a young man, M.H.⁴ at Dominican Hall, an independent residence for people with developmental disabilities administered by Saint Dominic’s Home (SDH) in Goshen, New York. Pursuant to its statutory authority, DRNY investigated the death of this young man. As part of DRNY’s investigation, DRNY also reviewed the investigation report completed by the New York State Justice Center for the Protection of People with Special Needs, Office of Investigation (“Justice Center”).

One of the primary purposes of this report is to educate service providers and medical health professionals providing services to people with developmental disabilities about the systemic risks that place service recipients at risk of neglect and potentially death. Service providers and medical professionals should learn from what happened to M.H. and look critically at their own services so as to prevent a similar tragic result occurring to a person under their care.

At the time of his death, M.H. was a predominantly nonverbal eighteen (18) year-old diagnosed with autism and severe mental retardation. He was described by staff as a pleasant and charming young man who is dearly missed. He died in 2013 following the inadvertent removal of the cecostomy tube that had been placed in his stomach a few hours earlier. The cause of death was found to be peritonitis and sepsis.

From a young age, M.H. received all nutrition through a gastrostomy tube, but was otherwise reported to be in general good health. At the time of his death, he did not have any actively involved family, or a guardian in a position to monitor his care and well-being. In the last few

¹ This investigation and report was funded through the Protection and Advocacy for Individuals with Intellectual and Developmental Disabilities (PADD) Program. DRNY receives funding from the U.S. Department of Health and Human Services (HHS), Administration on Intellectual and Developmental Disabilities (AIDD) to implement the Developmental Disabilities Assistance and Bill of Rights Act of 2000. This report and its content and conclusions are those of DRNY and should not be construed as the official position or policy of, nor should any endorsements be inferred by, AIDD, HHS, or the U.S. Government.

² 42 U.S.C. § 15043; 45 C.F.R. § 1386.25(a)(5)(2015).

³ See 42 U.S.C. § 15043(a)(2)(B); 45 C.F.R. § 1386.22; N.Y. Exec. Law § 558(b)(ii)-(iii).

⁴ In accordance with federal law, DRNY has assigned “M.H.” as a pseudonym for the subject of this report to protect the individual’s privacy. 45 C.F.R. § 1386.28(b). DRNY has also removed all information, such as dates, which could lead to M.H.’s identity. *Id.* In some instances in which confidential information has been removed, DRNY has included clarifying information to provide contextual information to the reader. An un-redacted version of this report has been sent to the New York State Justice Center for People with Special Needs; Office for People with Developmental Disabilities, Division of Quality Improvement; and Saint Dominic’s Home.

years of his life, M.H.'s primary care physician was Dr. P.⁵ SDH contracted with Dr. P. to provide primary care services to the residents at Dominican Hall. M.H. was completely reliant upon SDH staff and Dr. P.

In late 2012, M.H. became unable to tolerate feedings through his gastrostomy tube and would scream, writhe and cry with pain on nearly a daily basis. He experienced recurring distension, vomiting and excretion of various colored liquids and sediments from his Mic-Key® button stoma site.⁶ In addition, he was often gassy and would go several days without having a bowel movement. All of these symptoms increased in intensity and frequency until M.H. was in constant and daily pain, as evidenced by his cries and screams. In the eight months prior to his death, there were no significant improvements in M.H.'s health or condition.

This report enumerates DRNY's investigatory findings and recommendations for both SDH and the Justice Center. DRNY has found that:

1. Dr. P., the physician with whom SDH contracted to provide health care services to the residents of Dominican Hall, failed to aggressively and consistently implement a health program directed toward the prevention or deceleration of regression or loss of current optimal functional status for M.H. in the months leading to his death, as required by 42 C.F.R. § 483.440(a)(1)(ii).
2. SDH failed to maintain sufficient supervision of Dr. P., the primary care physician providing health care services to the residents of Dominican Hall, as required by 14 NYCRR § 633.6.
3. SDH failed to appropriately respond to, investigate, or follow-up on an allegation of neglect against a resident reported to Saint Dominic's administrators, as required by 42 C.F.R. § 483.13(2)-(4).
4. SDH failed to enforce the incident reporting requirements of 42 C.F.R. § 483.13(2); 14 NYCRR §§ 633.7-633.8 and N.Y. Soc. Serv. L. §§ 491-492.
5. SDH failed to ensure that its residents received training in techniques to protect themselves from abuse and other reportable incidents, as required by 14 NYCRR § 633.8(a)(2)-(3).
6. The Justice Center failed to address serious issues raised by the complaint, thereby incorrectly concluding that the allegation of neglect was unsubstantiated, when in fact the allegation should have been substantiated.

⁵ At the time of this publication, the doctor has yet to be formally charged by the New York State Department of Health, Office of Professional Medical Conduct, therefore, DRNY will not be releasing the name publically.

⁶ A Mic-Key® button is part of is an enteral feeding tube system where a tube is surgically placed in a person's stomach to deliver liquid nourishment. Halyard, "Enteral (Tube) Feeding: Another Healthful Way to Eat," (12/4/15 5:15 PM), <http://www.mic-key.com/resources/understanding-my-condition.aspx>. The site where the tube enters the stomach is known as the stoma site.

7. The Justice Center failed to ensure that Dr. P. was removed from contact with SDH residents, per N.Y. Soc. Serv. L. § 492(3)(c)(ii).
8. The Justice Center investigation and report took eleven (11) months to complete without any explanation for the delay, as required by N.Y. Soc. Serv. L. § 493(1).
9. The Justice Center failed to ensure that SDH-Dominican Hall employees were fulfilling their duty as mandated reporters and custodians to report abuse and neglect, as required by 42 C.F.R. § 483.13(2); 14 NYCRR § 633.7; 14 NYCRR § 633.8; N.Y. Soc. Serv. L. § 491-2.

Background

In February 2015, DRNY received a complaint alleging that the death of M.H. may have been due to neglect by the SDH Dominican Hall primary physician and SDH administrators, and that the investigation conducted by the Justice Center into the death was insufficient. In response to the complaint, DRNY reviewed the Justice Center investigation into M.H.'s death, interviewed current SDH staff and administrators, interviewed former SDH staff employed while M.H. lived at SDH, interviewed current SDH Dominican Hall residents, inspected Dominican Hall, and extensively reviewed M.H.'s medical and facility records, and SDH records and policies.

SDH, Dominican Hall is an Office for People with Developmental Disabilities (OPWDD) certified Intermediate Care Facility (ICF) providing residential, medical, clinical, and community inclusion services to people with developmental disabilities. OPWDD is the New York State agency responsible for coordinating services for New Yorkers with developmental disabilities. Services are provided through a combination of state services and a network of private contractors, the majority of which are non-profit service providers like SDH.

SDH is "a nonprofit Catholic social welfare agency dedicated to meeting the educational, physical, social, emotional, medical, vocational and spiritual needs of individuals and families of all backgrounds who are developmentally disabled, socially disadvantaged and or vocationally **challenged.**"⁷ Accordingly, SDH administers a variety of residential services for people with developmental disabilities. SDH currently has eight ICFs in Rockland County and Orange County, New York.⁸

SDH cooperated with DRNY's investigation, answering all records and access requests in a timely manner. SDH made current and former staff available to DRNY as requested and facilitated a presentation DRNY gave to residents about their rights relating to abuse and neglect.

The Justice Center came into effect in 2013 and is both a law enforcement agency and an advocacy agency for people with special needs throughout New York State. The agency's primary

⁷ Saint Dominic's Home, "About Us" (12/2/15 10:30 AM), <http://www.stdominicshome.org/about-us>

⁸ Saint Dominic's Home, "Intermediate Care Facilities" (12/2/15 10:45 AM), <http://www.stdominicshome.org/intermediate-care-facilities>

responsibilities include operating a 24/7 hotline for allegations of abuse, neglect and significant incidents against persons with special needs; investigating and ensuring abuse and neglect allegations are comprehensively investigated; prosecuting criminal offenses committed against people with special needs; advocating and overseeing the quality of care of people who are receiving services in the systems of State Oversight Agencies (SOA), including OPWDD; and maintaining a “Staff Exclusion List” of people found responsible for serious abuse and/or neglect.⁹

In response to DRNY’s request, the Justice Center timely produced its final death investigation report into M.H.’s death, the photographs collected as part its investigation, and the Justice Center findings letter sent to SDH.

DRNY has now completed its investigation. SDH and the Justice Center were both provided with an un-redacted advanced copy of this report and offered the opportunity to respond. These responses and DRNY’s response are included at the end of this report. A draft of the report was also shared with OPWDD. As a result, OPWDD’s Bureau of Certification (BPC) will now be conducting an on-site review of SDH to follow up on the concerns highlighted in DRNY’s report.

Part 1 of this report documents DRNY’s findings as they relate to deficiencies found in SDH’s provision of services to M.H., which rise to the level of neglect. Part 2 details the deficiencies found in the Justice Center’s investigation into M.H.’s death. The areas of deficiency outlined in this report require immediate improvement from both SDH and the Justice Center, including areas of systemic concern which require immediate remedies for the safety and well-being of current residents.

Scope of Investigation

DRNY’s investigation consisted of the following:

- Multiple in-person and phone interviews with complainant.
- Onsite interviews with current SDH residential staff and administrators.
- Phone interviews with current and former SDH staff and administrators.
- Observations at Dominican Hall.
- Onsite interviews with Dominican Hall residents.
- Onsite presentation on abuse and neglect to Dominican Hall residents.
- Review of NYS Justice Center Investigation Report and accompanying letters and photographs.
- Review of M.H.’s records.
- Review of SDH Dominican Hall records concerning residents who died during Dr. P.’s tenure at SDH.
- Review of SDH personnel data.
- Review of SDH policies.

⁹ Justice Center, “Frequently Asked Questions – Justice Center” (12/2/15, 11:00 AM), <http://www.justicecenter.ny.gov/about/faq#faq-top>

- Review of Dr. P.'s publically available NYS Medical Board records.
- Filing of a New York State Department of Health, Office of Professional Medical Conduct (OPMC) complaint.

Investigation Findings

Part 1: SDH FINDINGS

Negligent Medical Services

1. **Dr. P., the physician with whom SDH contracted to provide health care services to the residents of Dominican Hall, failed to aggressively and consistently implement a health program directed toward the prevention or deceleration of regression or loss of current optimal functional status for M.H. in the months leading up to his death, as required by 42 C.F.R. § 483.440(a)(1)(ii).**

As an OPWDD service provider, SDH must adhere to Title 14 of the New York Codes, Rules and Regulations Part 624 ("Part 624").¹⁰ Part 624 consists of the regulatory requirements designed to protect people with developmental disabilities receiving services. The regulations require that certified facilities report, record, review, and investigate all reportable incidents, serious reportable incidents, and abuse enumerated in Part 624.¹¹

Neglect is a reportable incident under Part 624 and is defined in the regulation as follows:

Any action, inaction, or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a service recipient. Neglect includes, but is not limited to:

- (i) Failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (1) through (7) of this subdivision if committed by a custodian;
- (ii) Failure to provide adequate food, clothing, shelter, or medical, dental, optometric, or surgical care, consistent with Parts 633, 635, and 686, of this Title (and 42 CFR Part 483, applicable to Intermediate Care Facilities),¹²

¹⁰ 14 NYCRR § 624.

¹¹ 14 NYCRR § 624.4(a).

¹² Part 483 requires: "(2)The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency. (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress." 42 C.F.R. § 483.13(c)(2)-(3).

and provided that the agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric, or surgical treatment have been sought and obtained from the appropriate parties; or

- (iii) Failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article 65 of the education law and/or the individual's individualized education program.¹³

According to the SDH's Developmental Disabilities Department Procedure for Medical Services policy, Dr. P was responsible for among other things: (1) developing and amending medical policies and procedures and participating in treatment team processes; (2) advising the program director of medical and related problems; (3) making written monthly progress notes in the resident's records; and (4) interfacing with outside medical facilities, hospitals and conducting follow-up consultations post hospitalizations. Dr. P. failed in his duties on all four of these accounts.¹⁴

Failure to Provide Adequate Health Care

By all accounts, M.H. suffered consistent and excruciating pain in the months preceding his death. From late 2012 until his death in 2013, M.H. was admitted to the hospital ten (10) times.

a) Failure to Participate in Treatment Team Process

Dr. P., as M.H.'s primary care physician, had a duty under SDH policy to develop and amend medical policies and participate in team processes.¹⁵ According to numerous reports, M.H. was in need of a diagnosis to address his ongoing pain months prior to his death. However, despite repeated requests for assessment by staff and M.H.'s continued discomfort and pain, Dr. P. continued a repetitive course of action with slight variation. Dr. P. repeatedly prescribed the same ineffective approach of withholding feedings, withholding water and medicating with Miralax. Despite M.H.'s continual physical decline, Dr. P. decreased his care to M.H. and failed to provide the oversight and advocacy required, which likely contributed to M.H.'s death.

¹³ 14 NYCRR § 624.3(b)(8). *See also* N.Y. Soc. Serv. Law § 488 (“A condition of deprivation in which persons receiving services receive insufficient, inconsistent, or inappropriate services, treatment, or care to meet their needs; or failure to provide an appropriate and/or safe environment for persons receiving services. Failure to provide appropriate services, treatment or care by gross error in judgment, inattention, or ignoring may also be considered a form of “neglect.”)

¹⁴ Saint Dominic's Home, *Developmental Disabilities Department Procedure for Medical Services Policy* (October, 2013) (DRNY was not provided with a copy of the policy that was in place at the time of Dr. P's tenure. However, the duties detailed in the October 2013 policy are consistent with the responsibilities reported to DRNY by SDH administrators and staff.)

¹⁵ Saint Dominic's Home, *Developmental Disabilities Department Procedure*, *supra* note 10.

b) Failure to Advise Program Director of Medical Problems and Make Written Monthly Progress Reports.

Facility staff reported that Dr. P. appeared to avoid M.H. and failed in his duty to actively assess M.H.'s condition. Dr. P. also failed to communicate with the hospital doctors to effectively diagnosis M.H.'s probable chronic condition. Dr. P orally reported that he felt that M.H. required a higher level of care than SDH could provide. As the Dominican Hall primary care physician, Dr. P. was responsible for advising the program director of such a problem and he failed to do so. Instead, Dr. P. only reported his concerns orally to the Director of the Developmental Disabilities Program and failed to make the necessary written follow up referral for increased services as instructed.

c) Failure to Interface with Outside Medical Facilities, Hospitals and Conduct Follow-Up Post Hospitalizations.

Dr. P.'s incomplete communications with hospital medical staff appear to have been deficient and likely contributed to M.H.'s death. On M.H.'s final hospital admission, a "face sheet" detailing his medical history and special alerts, was provided to medical staff in accordance with SDH practice. Remarkably, these documents did not contain any information or special alerts informing the hospital staff about M.H.'s sensitivity around his stomach area, or the risk of M.H. removing any tube or device placed on or around his stomach area.

Residential staff stated that it was well known that M.H. was highly sensitive about his stomach area and would try to remove any foreign object placed in or around his g-tube site. Multiple staff members reported that they were never consulted or given the opportunity to inform Dr. P. or others involved in M.H.'s medical care about these crucial issues.

Dr. P. and the SDH medical staff failed to advocate for M.H. and ensure that the hospital doctors were properly apprised of his physical condition regarding the sensitivity around his abdomen before conducting an invasive surgery. It is unclear why given the risks that were present, restraints were not considered for M.H.'s safety. In fact, restraints had previously been used to keep M.H. safe during a prior health procedure and SDH planned to use restraints for an upcoming procedure.

Dr. P. Discouraged SDH Staff from Making Necessary Emergency Room Visits

In addition to providing deficient medical services, Dr. P. repeatedly instructed SDH staff not to take M.H. to the emergency room. Staff reported that they often disobeyed Dr. P.'s orders not to take M.H. to the emergency room because they feared for his life or well-being. This concern was reported to SDH administration, who in early 2013 verbally instructed staff to take M.H. to the emergency room whenever it was determined necessary, even if Dr. P. instructed otherwise.

Failure to Provide Consultation

Dr. P. did not assess M.H. for nearly three months prior to his death. SDH has acknowledged to DRNY that this was a violation of SDH policy. Despite M.H.'s ongoing undiagnosed medical issues and declining health, Dr. P. regularly refused to see M.H. when visiting SDH, despite M.H.'s placement on the list of residents requiring assessment. Though the SDH medical and residential staff reported to DRNY that they felt that M.H.'s health was in a potentially life-threatening condition, Dr. P. failed to assess M.H. in person for almost three months.

Conclusion

Dr. P. provided M.H. with negligent medical care for the eight months preceding his death. Dr. P. committed neglect by engaging in a pattern of failing to establish and carry out an appropriate individualized treatment plan, follow SDH medical policy, and failing to provide critical advocacy and oversight of M.H.'s health care which likely caused M.H. further pain and suffering, or contributed to his death.

Inadequate Supervision

- 2. SDH failed to maintain sufficient supervision of Dr. P., the primary care physician providing health care services to the residents of Dominican Hall, as required by 14 NYCRR § 633.6.**

SDH provided insufficient supervision of the Dominican Hall medical services, which enabled Dr. P. to violate SDH policy and provide negligent medical services to M.H. in the months leading up to his death. DRNY's interviews with current and former staff, along with a review of SDH's policies and medical records, reveals that SDH lacks the supervisory structure to ensure compliance with medical policies, which enabled Dr. P. to violate SDH policy repeatedly and provide deficient medical services to M.H.

Dr. P.'s negligent behavior was enabled in part due to the deficient oversight and infrastructural issues at SDH. Staff reported that they had concerns with the quality of care Dr. P. was providing. Staff reported that they were aware of Dr. P.'s policy violations, but lacked a mechanism they felt comfortable employing to report these concerns to SDH administration. Nursing and residential staff reported repeated frustration over the lack of accountability and oversight of Dr. P. Residential staff reported voicing these concerns repeatedly to the Nursing Supervisor without remediation. The Director and Assistant Director of the Developmental Disabilities Program reported to DRNY that staff concerns were never relayed to them, with the exception of an email received five months prior to M.H.'s death.

- a) Failure to Respond Appropriately to Staff Email

SDH administration was aware of staff's concerns relating to the quality of care Dr. P. was providing as a result of the email sent to the Director and Assistant Director of the SDH

Developmental Disabilities program five months prior to M.H.'s death by the Dominican Hall Coordinator. Residential staff had reported their concerns in an email to the Coordinator, which was then forwarded to the Director and Assistant Director, copying the nursing department, expressing the Coordinator's own concern and requesting assistance. The email stated that both residential and nursing staff were concerned about M.H.'s well-being and safety.

In response to the email, the Director verbally informed the Coordinator that if staff had any concerns that they should take M.H. to the emergency room, even if doing so was against Dr. P.'s orders. Additionally, the Director informed the Coordinator that the Director would speak with Dr. P. if there was a concern regarding M.H.'s care. The Director also told the Nursing Supervisor that nursing staff were authorized to send a resident to the hospital in the event they disagreed with Dr. P.'s assessment that a resident should not be taken to the emergency room.

DRNY commends SDH for empowering staff to override Dr. P. and recognizes that doing so may have reduced M.H.'s pain and discomfort. However, both residential and nursing staff stated that the medical services provided to M.H. did not change as a result of this reporting. Staff continued to take M.H. to the hospital, overriding Dr. P.'s instructions when necessary, as they had been doing prior to the email. SDH administrators failed to take any further action regarding the quality of the medical services Dr. P. was providing, and there was no increased oversight of the medical services provided to M.H.

As a result, SDH administrators claimed to have no knowledge of the subsequent neglectful actions and the policy violations that took place. The Director stated that no administrator spoke with Dr. P. because no further reports were received from the Nursing Supervisor regarding the quality of medical services M.H. was receiving. The Nursing Supervisor confirmed that despite ongoing concerns with Dr. P.'s quality of care, she inexplicably did not report further concerns to SDH administrators. No further action was taken by SDH administrators or the Nursing Supervisor to address the concerns about the quality of medical services M.H. was receiving, to collect updates from staff, or to proactively seek out information about the services Dr. P. was providing. DRNY finds that the SDH administration failed to adequately monitor M.H.'s care, and the failure of the Director to speak with Dr. P. about the reported neglect was particularly egregious.

b) Failure to Increase Oversight Despite Job Performance Concerns

SDH administration had concerns about Dr. P.'s reliability and professionalism in the months preceding M.H.'s death and were actively seeking a replacement. Dr. P. often threatened to not come to work. A search was underway for a replacement.

The Director and Assistant Director both stated that it was the Nursing Supervisor's responsibility to inform them of ongoing concerns with the medical services M.H. was receiving. However, the SDH medical policy states that it is the facility physician who is the primary coordinator of medical services and that it is his or her responsibility to advise the program director of medical and related problems.¹⁶ To the extent that the Nursing Supervisor was informally told to report concerns to SDH administrators, she failed to relay these concerns both prior and following the email. DRNY

¹⁶ Saint Dominic's Home, *Developmental Disabilities Department Procedure*, *supra* note 10.

finds that despite documented and widespread concerns over Dr. P.'s job performance, SDH administration failed to properly supervise Dr. P. or ensure he was following facility policy and providing quality care to residents.

Infrastructural Problems Remain

Dr. P. is no longer employed at SDH. He stopped working at SDH roughly two months after M.H.'s death for reportedly unrelated reasons. SDH staff and administrators report satisfaction with the current Dominican Hall primary physician. However, DRNY's interviews with staff and review of SDH policies indicate that in practice the same ineffectual supervisory structure remains as was in place at the time of M.H.'s death and the months preceding it. Administrators and staff are confused as to who would be responsible for reporting staff concerns if similar issues arose today. DRNY finds that SDH has failed to resolve the infrastructural problems that enabled M.H. to be neglected in the months preceding his death.

Conclusion

SDH's insufficient supervisory structure and failure to provide necessary oversight enabled Dr. P. to provide M.H. with negligent medical services for the eight months prior to his death. The structural oversight issues at SDH have not been addressed and require immediate remediation to prevent repetition.

Inadequate Administrative Response

- 3. SDH failed to appropriately respond to, investigate, or follow-up on an allegation of neglect against a resident reported to Saint Dominic's administrators, as required by 42 C.F.R. § 483.13(2)-(4).**

Residential staff reported to DRNY that the Nursing Supervisor failed to respond to their concerns for M.H.'s well-being and the quality of care being provided to him by Dr. P. The Nursing Supervisor informed DRNY that she knew of staff's concern for M.H.'s well-being and Dr. P.'s decision to not assess M.H. in person for three months before his death. The Nursing Supervisor shared staff's concerns but reported that she did not wish to question Dr. P.'s medical opinion. She never reported these concerns to the Director, despite being instructed to do so after the email. She could provide no explanation to DRNY other than deference to the doctor's expertise.

When staff attempted to report their concerns regarding M.H.'s care, SDH's response deterred staff from making further reports. Multiple staff members reported that they were verbally reprimanded by the Director for reporting their concerns. Moreover, multiple staff members explained that they felt as if their jobs were in jeopardy as a result and that they experienced increased and unwarranted discipline following the email. Staff also reported that the failure of SDH administration to increase oversight of Dr. P. and M.H.'s medical services, further deterred them from relaying their concerns to administration. Consequently, staff reported that this prevented them from making further informal or formal reports despite their increasing concerns for M.H.'s well-being.

SDH administration should have been aware of the Nursing Supervisor's hesitancy to report widespread staff concerns with services given the contents of the staff email. Following this email, SDH administrators should have implemented further oversight of both Dr. P. and the Nursing Supervisor. However, neither the Nursing Supervisor, Director, nor the Assistant Director, reported any follow up on the part of SDH administrators.

Given the concerns raised in the email from staff, coupled with the acknowledgement by SDH administration that Dr. P. behaved unprofessionally, DRNY finds that SDH's failure to increase oversight over Dr. P. is unacceptable and placed M.H. and fellow residents at risk. Increased or improved supervision was necessary along with increased communication with both nursing and residential staff.

Conclusion

SDH failed to appropriately respond to staff's reports about concerns over the quality of care M.H. was receiving, thereby enabling Dr. P. to provide M.H. with deficient medical services. The administration's inaction and negative response to staff's complaint chilled future reporting, which further placed M.H. and all other Dominican Hall residents at risk.

Reporting Requirements and Training

- 4. SDH failed to enforce the incident reporting requirements of 42 C.F.R. § 483.13(2); 14 NYCRR §§ 633.7-633.8 and N.Y. Soc. Serv. L. §§ 491-492.**

SDH failed to report allegations of neglect to OPWDD and the New York State Central Register (SCR) of Child Abuse and Maltreatment, in violation of their mandated reporter duties and OPWDD Part 624 requirements. After June 30, 2013, mandated reporters and custodians were required to make reports to the Justice Center rather than SCR. A mandated reporter is a person employed by or volunteering at a covered facility or agency, which includes OPWDD certified settings like SDH, who is required to report incidents of abuse and neglect either upon discovery or when they have reasonable cause to suspect that abuse or neglect or any other reportable incident is occurring.¹⁷ Professionals considered mandated reporters include a director, operator, employee or volunteer of OPWDD certified facility or program; a consultant, employee, or volunteer of an organization providing or services to such facility or program and having regular and substantial contact with individuals receiving services; a family care provider; physicians; registered nurses; licensed practical nurses, and nurse practitioners.¹⁸

SDH staff, both medical and residential, reported verbally and in writing their concerns that M.H. was receiving inadequate health care in the months preceding his death. In interviews, SDH staff confirmed that they reported these concerns to SDH administration and the Nursing Supervisor,

¹⁷ 42 C.F.R. § 483.13(2); 14 NYCRR § 633.7; N.Y. Soc. Serv. L. § 488.

¹⁸ *Id.*

but did not make a report to SDH Quality Assurance, the SCR, or the Justice Center. SDH administration confirmed that no quality assurance reports were made regarding M.H.

SDH residential staff reported that they did not consider reporting their concerns to quality assurance because they did not believe their complaint would be anonymous. Following the staff email, residential staff feared retaliation. Medical staff said that they failed to make any reports after their email because of deference to Dr. P.'s assessment.

SDH residential and medical staff members are all mandated reporters. Consequently, each staff member had an obligation to report their concerns regarding the poor care being provided to M.H. to SCR and later the Justice Center. Furthermore, as staff in an OPWDD certified setting and under SDH policy, each staff member had a duty to report these concerns to SDH Quality Assurance.

Most problematic is the fact that SDH administrators were aware of the staffs' failure to report and failed to remedy the situation by instructing staff to make a report or making a report themselves. Moreover, SDH was on notice of the staff's failure to report serious concerns relating to the health care a resident was receiving and failed to re-train or instruct staff about their duty to report.

The staff email clearly states that M.H. was not receiving adequate health care:

- "It is [our] opinion that [M.H.] is not okay. He is clearly in pain and discomfort..."
- "This process is clearly not working and we are scared for [M.H.]."
- "[Staff are] declining feeding or medicating [M.H.] due to concerns they expressed regarding safety as related to [M.H.]"
- "[Director and Assistant Director], there is something seriously wrong with this boy...I really feel that Dr. P is not listening to our clinicians and the staff that work with him on a daily basis.... I am really getting scared for this boy."

SDH administrators had an obligation to report this allegation to OPWDD at the time and should have also instructed staff to make a quality assurance report as necessary in the future. The Dominican Hall Director and Assistant Director both had legal duties to report allegations of neglect and ensure that staff fulfilled their reporting duties.¹⁹ Consequently, both failed to fulfill their duty.

The failure of staff and administrators to report their concerns to the appropriate investigatory body meant that the allegations of neglect were not investigated until after M.H.'s death. A timely investigation would have informed SDH of Dr. P.'s policy violations and staff concerns about M.H.'s health care. Such information may have improved M.H.'s quality of medical care in the last few months of his life and potentially have saved his life.

Problems with reporting concerns still persist. Current staff report unwillingness to report to SDH Quality Assurance and distrust of SDH administration.

¹⁹ 42 C.F.R. § 483.13(2), 14 NYCRR §§ 633.7-633.8, N.Y. Soc. Serv. L. §§ 491-2.

Conclusion

SDH administrators and staff violated their duties to report potential neglect when they had reasonable cause to believe that Dr. P. was engaging in a pattern of health care neglect resulting in severe pain and discomfort to M.H. for over seven months. SDH administrators failed to ensure that SDH staff members were complying with their legal, regulatory and SDH policy obligations to report potential neglect.

Resident Reporting and Training

- 5. SDH failed to ensure that its residents receive training in techniques to protect themselves from abuse and other reportable incidents, as required by 14 NYCRR § 633.8(a)(2)-(3).**

Over the course of this investigation, DRNY gave a presentation to Dominican Hall residents. The presentation consisted of a description of the protection and advocacy system, an introduction to DRNY, its services and staff, and basic information about residents' rights regarding freedom from abuse and neglect, and the forms in which abuse and neglect can take. Following the presentation, DRNY asked residents if they would be willing to speak privately about their experience at Dominican Hall. Thirteen (13) residents agreed to speak with DRNY privately.

Dominican Hall residents reported having an unacceptable lack of knowledge about techniques and procedures to protect themselves from abuse and other events and circumstances that constitute reportable incidents. Residents generally were uneasy, but able to explain to DRNY what constitutes abuse. However, troublingly one resident followed their answer by stating that they also knew that making a false accusation of abuse could result in criminal charges and negative consequences. When asked to describe neglect, residents were unable to proffer an answer. When residents were asked if they experienced abuse or neglect who they would report it to, residents responded that they would make a report to staff. Residents described being unfamiliar with SDH quality assurance and unfamiliar with how or when to make a report. One resident was able to recall seeing posters for quality assurance, but was unfamiliar with the purpose or how to report to quality assurance. None of the residents reported knowing about the Justice Center or DRNY. A small number of residents reported that they learned about abuse and neglect at their school program.

SDH residents have a right to receive training and understand techniques to protect themselves from abuse and other reportable incidents, which must include education on the forms of abuse and neglect and how to make abuse and neglect reports in a confidential manner. While DRNY recognizes that SDH has staff whom residents are comfortable reporting concerns to, the failure to ensure a confidential reporting mechanism mandated by the Justice Center, OPWDD, and SDH's own policy, are critical for ensuring that abuse and neglect and other reportable incidents are effectively and appropriately investigated in a timely manner. Educating and empowering the SDH residents must be a priority for SDH to ensure both legal compliance and a safe atmosphere.

Conclusion

SDH's current abuse and neglect training for residents fails to educate residents about what are reportable incidents, to train residents in techniques to protect themselves, or to ensure that residents are familiar with reporting mechanisms to report any abuse, neglect or other reportable incidents they experience.

Proposed Immediate Resolutions

1. SDH must retain an independent consultant/reviewer with experience both in the field of developmental disabilities and in the management of remedial actions in an institutional setting.
2. The independent consultant/reviewer will be provided full and timely access to Dominican Hall and its records, staff and residents.
3. The independent consultant/reviewer will work with the administration of SDH and Dominican Hall to develop a Corrective Action Plan within three months.
4. The Corrective Action Plan will address the deficiencies identified in DRNY's investigation report and will lead to the necessary reforms in the administrative/supervisory lines of authority; the implementation of a responsive and timely incident management system; the supervision and oversight of nursing and medical services; the implementation of the required quality assurance and risk management strategies; and the provision of ongoing training for staff and residents about protection from harm.
5. The Corrective Action Plan will be submitted to DRNY for review.
6. The administration of SDH and Dominican Hall will be responsible for the full implementation of the Corrective Action Plan.
7. The independent consultant/reviewer will monitor the implementation of the Corrective Action Plan and will be provided the resources to retain a Registered Nurse to assist in the review of nursing and medical supervision and oversight at Dominican Hall.
8. After the completion of the Corrective Action Plan, the independent consultant/reviewer will issue a final report. This report will describe the outcomes of the Corrective Action Plan, the actions required for the sustainability of the remedial reforms, and any issues requiring further attention.
9. The independent consultant/reviewer's final report will be submitted to DRNY.

Part 2: JUSTICE CENTER FINDINGS

Justice Center Investigation Report

1. **The Justice Center failed to address serious issues raised by the complaint, thereby incorrectly concluding that the allegation of neglect was unsubstantiated, when in fact the allegation should have been substantiated.**

The Vulnerable Persons Central Register (VPCR) received a report of M.H.'s death. The complainant alleged that M.H. was not receiving proper medical treatment, that there was ongoing abuse and neglect at Dominican Hall, and that M.H. was not receiving proper medical procedures which contributed to his death.

The Justice Center investigation addressed the following questions:

- Did the facility fail to obtain consent for procedures, or fail to provide necessary procedures?
- Was a medical or surgical procedure ordered and not completed?
- Was M.H.'s death the result of neglect from his primary care provider or the ICF staff and services?

The Justice Center adequately addressed the first two investigatory questions. The Justice Center found no evidence that the facility failed to obtain consent for procedures, which DRNY also found to be supported by facts. Likewise, the finding that no medical or surgical procedure was ordered and not completed appears to be supported by the facts.

However, the Justice Center failed to address the following significant questions presented by the complaint:

- Was M.H. receiving the proper medical treatment that he needed?
- If M.H. did not receive proper medical treatment did this harm him, contribute to, or cause his death?
- Was there other abuse and neglect occurring at the SDH?
- Are there systemic issues that led to the abuse and neglect?²⁰
- Did SDH staff violate their mandated reporter duties?

The Justice Center concluded that there was no evidence to support the allegations of neglect relating to M.H., including that his death was a result of neglect from the facility physician or SDH staff. It is difficult to reconcile this finding with the conclusion by the Justice Center Medical Review Board that the care provided by Dr. P. was insufficient and incorrect.

²⁰ "Category four [substantiated reports of abuse or neglect] shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. " N.Y. Soc. Serv. Law § 493.

The Justice Center Medical Review Board specifically found that:

- Dr. P. persistently avoided M.H. despite signs and symptoms which required intervention.
- Dr. P did not examine M.H. for months prior to his death.
- Dr. P. and SDH staff expressed a need for a higher level of care for M.H., but took no further action.
- There was poor communication between the hospitals and Dr. P to M.H.'s detriment.

In light of these findings, how could the Justice Center have reached its conclusion that neglect did not contribute to M.H.'s death?

The Justice Center inquiry was incorrectly limited to whether neglect lead to death. Even if it did not lead to death, there is considerable evidence that the insufficient and incorrect care caused unnecessary pain, suffering and impairment of health. Under New York's Social Services Law, neglect includes "any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient."²¹ Whether or not the lapses caused the death is not dispositive. The Justice Center failed to determine whether there was neglect as defined in the Social Services Law and therefore, did not address or remedy the systemic issues that contributed to the neglect.

Moreover the Justice Center ignored the evidence that serious allegations of neglect were knowingly and willfully not reported in a timely way by mandatory reporters.²² Pursuant to New York Social Services Law mandatory reporters must report allegations of neglect to SCR, and after June 30, 2013, to the Justice Center. As detailed in this report, concerns about medical neglect existed for many months prior to M.H.'s death, and were reported to SDH supervisors and administrators, but no reports were made to the SCR (and later the Justice Center), OPWDD or any other entity until after M.H.'s death. The failure to report is a basis for a finding of substantiated neglect.²³ Moreover, there was retaliation or discouragement for reporting neglect in violation of the Social Services Law,²⁴ which the Justice Center should have also investigated.²⁵

The failure of staff and supervisors to report, and the failure of administrators and supervisors to take action to stop ongoing medical neglect, demonstrate that the facility has systemic problems which led to medical neglect, and which are likely to occur again. The Justice Center failed to substantiate abuse and neglect, and to demand remedial action to correct the systemic violations.

Additionally, the VPCR complainant claimed that there was widespread abuse and neglect in the ICF. The Justice Center inquiry focused exclusively on M.H., and insufficient effort was made to determine whether there were widespread problems, either by probing the complainant's

²¹ N.Y. Soc. Serv. L. § 488.

²² N.Y. Soc. Serv. L. §§ 491; 493(4)(a)(xi)-(xii).

²³ N.Y. Soc. Serv. L. § 493.

²⁴ N.Y. Soc. Serv. L. § 493(4)(a)(xiv).

²⁵ N.Y. Soc. Serv. L. § 493 (4)(xiv).

allegations, interviewing residents and staff at the facility about other abuse or neglect, or conducting a random review of treatment records.

Conclusion

The Justice Center failed to completely and thoroughly investigate the allegations.

Protection of SDH Residents

2. **The Justice Center failed to ensure that Dr. P. was removed from contact with SDH residents, per N.Y. Soc. Serv. L. § 492(3)(c)(ii).**

The New York Social Services Law requires the Justice Center to take appropriate and necessary steps to protect the life and health of the alleged victim, which may include "...to remove or suspend a subject from a facility or program."²⁶ While M.H.'s death rendered him no longer at risk of further neglect, the prudent response to ensure the safety of all remaining residents would have been to suspend Dr. P. until the question of whether the medical services he was providing were negligent had been assessed.

SDH unilaterally removed Dr. P. two months following M.H.'s death for reasons reportedly unrelated to M.H.'s death. No action was taken by the Justice Center against Dr. P. while he was still employed by SDH. Because the Justice Center failed to make a substantiated finding of neglect, Dr. P. was not placed on the Staff Exclusion List (SEL). That decision should be reconsidered. Consequently, Dr. P. is free to be hired by any state operated, certified or licensed agencies/providers that serve people with special needs, which unacceptably places them at risk of future neglect.

Conclusion

The Justice Center failed to respond appropriately to a serious allegation of medical neglect against a facility doctor by removing the doctor from direct contact with residents, thereby placing current residents at risk of inadequate health care. Secondly, by failing to appropriately substantiate the allegation of neglect and place Dr. P. on the SEL, the Justice Center failed to ensure that future OPWDD clients are not placed at risk of medical neglect.

²⁶ N.Y. Soc. Serv. L. § 492(3)(c)(ii) ("(c) The justice center is responsible for commencing an investigation of all allegations of reportable incidents that are accepted by the vulnerable persons' central register. With respect to such an investigation, the justice center shall: (ii) take all appropriate measures to protect the life and health of the person who is the alleged victim of a reportable incident, which may include working with the state oversight agency to take immediate steps to remove the vulnerable person from his or her current facility or program or to remove or suspend a subject from a facility or program, subject to any applicable collective bargaining agreement, if the justice center has reasonable cause to believe that the circumstances or condition of the vulnerable person are such that continuing the vulnerable person in his or her place of residence or program, or that continuing such subject in his or her current facility or program, presents an imminent danger to the vulnerable person's life or health.")

Delay in Investigative Report

- 3. The Justice Center investigation and report took eleven months to complete without explanation for the delay.**

The New York Social Services Law requires that within sixty (60) days after the VPCR accepts a report that a finding is entered.²⁷ The statute permits delay in entering the findings so long as the reasons for the delay are documented.²⁸ The Justice Center's report was sent to SDH eleven (11) months after the VPCR report was made.

In response to an advanced copy of this report, the Justice Center reported to DRNY that the reasons for the delay are appropriately documented in the VPCR, but that due to confidentiality reasons, this information is not included in the report. However, no explanation for the delay has been offered to DRNY or, to the extent DRNY is aware, to SDH. Therefore, DRNY has not had the opportunity to assess the reasonableness of the delay.

The delay in the investigation resulted in Dr. P. working at SDH for an additional two months after M.H.'s death. Moreover, the nearly year-long delay allowed for the systemic issues to be left unaddressed, which affected the residents remaining at SDH.

Conclusion

The Justice Center's investigation report was delayed for reasons that the Justice Center has not revealed.

Abuse and Neglect Reporting

- 4. The Justice Center failed to ensure that SDH - Dominican Hall employees were fulfilling their duty as mandated reporters and custodians to report abuse and neglect, as required by 42 C.F.R. § 483.13(2); 14 NYCRR § 633.7; 14 NYCRR § 633.8; N.Y. Soc. Serv. L. § 491-2.**

The Justice Center investigation revealed SDH staff's failure to report concerns relating to potential neglect of M.H. during the months prior to his death, as did DRNY's investigation.²⁹ These actions would also have violated the Justice Center Code of Conduct.³⁰

²⁷ N.Y. Soc. Serv. L. § 493(1) ("Within sixty days of the vulnerable persons' central register accepting a report of an allegation of abuse or neglect, the justice center shall cause the findings of the investigation to be entered into the vulnerable persons' central register. The justice center may take additional time to enter such findings into the vulnerable persons' central register; provided, however, that the reasons for any delay must be documented and such findings submitted as soon thereafter as practicably possible.")

²⁸ *Id.*

²⁹ Part 1, section 6, *supra*.

³⁰ 14 NYCRR § 633.7; Justice Center, *Code of Conduct for Custodians of People with Special Needs* (June 10, 2013).

The Justice Center failed to address this failure in its report, nor was this issue addressed in the plan of correction submitted and approved by the Justice Center. As a result, it does not appear that this issue has ever been remedied.

Conclusion

The Justice Center failed to enforce the Social Services Law mandated reporter requirements to ensure that future incidents were appropriately reported.

Proposed Immediate Resolutions

1. The Justice Center should create guidelines to insure it identifies all of the issues raised by a complaint, including systemic issues that may have caused or contributed to the alleged abuse or neglect.
2. The Justice Center should immediately remove staff, including physicians, as required by N.Y. Soc. Serv. L. § 492(3)(c)(ii), when staff pose a significant risk to the health and safety of current residents.
3. When conducting an investigation, the Justice Center should review whether the staff, supervisors and management reported suspected abuse or neglect as required by the Social Services Law. In the event that staff did not fulfill their duties, re-training and, if necessary, discipline should be required as a corrective action.
4. The Justice Center should conduct a second investigation of this matter to address the issues which it failed to address.
5. All Justice Center reports should explain any delays in issuing a report, as required by N.Y. Soc. Serv. L. § 493(1).
6. The Justice Center should demand a meaningful and effective plan of correction and must insure that the plan is fully implemented. DRNY urges the Justice Center to adopt the plan of correction developed by the independent consultant/reviewer hired by SDH, per DRNY's proposed resolutions.

--END--

APPENDIX A



**Justice Center for the
Protection of People
with Special Needs**

ANDREW M. CUOMO

JEFF WISE

December 4, 2015

Mr. Timothy Clune
Executive Director
Disability Rights New York
775 Broadway, Suite 450
Albany, NY 12207

Disability Rights NY

DEC 07 2015

Received

Re: [REDACTED]

Dear Mr. Clune:

The Justice Center has received your Investigation Report regarding the death of [REDACTED], in which you conclude that [REDACTED] was neglected by his residential provider agency, St. Dominic's House, in the months prior to his death, and that the Justice Center's investigation of the report of this alleged neglect was deficient. With respect to the Justice Center, your conclusions are based on a misunderstanding of both the facts of the case and the law regarding the Justice Center's jurisdiction.

First, as you note in your report, the Justice Center became operational on June 30, 2013. See Ch. 501, L. 2012. Accordingly, the contention in your report that the Justice Center erred in finding that St. Dominic's House, and employees of the agency, should have been substantiated for abuse and/or neglect for their care of [REDACTED] in the months prior to his death on [REDACTED] (DRNY Investigation Report, pp. 19-21) ignores the fact that the Justice Center simply had no jurisdiction to make such a determination with respect to any conduct occurring prior to June 30, 2013.

Indeed, the uncontroverted evidence set forth in the Justice Center's investigation report is that on [REDACTED], [REDACTED] was admitted to the Orange Regional Medical Center, where he remained until his death on [REDACTED], 2013, following an intervening event occurring at the medical center. As a result, for the four-day period [REDACTED] during which the Justice Center had jurisdiction, [REDACTED] was no longer in the care of St. Dominic's House. Under these circumstances, with respect to the allegation that [REDACTED] had been neglected when staff at St. Dominic's House failed to ensure that he received adequate medical care between [REDACTED] the Justice Center made the only determination supported by the law -- that the Justice Center's jurisdiction began on June 30, 2013, and that in any event any allegations of neglect for acts committed by St. Dominic's House or its staff on or after that date had to be unsubstantiated.

For similar reasons, your contentions that the Justice Center should have substantiated St. Dominic's House staff for obstruction based on their failure to report that St. Dominic's House was neglecting [REDACTED], and should have made a Category Four finding against St. Dominic's House (DRNY Investigation Report, pp. 20-21, 22-23), are legally incorrect. Any mandated reporting obligations of "custodians" at St. Dominic's House were not triggered until June 30, 2013, and by that time [REDACTED] was no longer being cared for by St. Dominic's House. Moreover, whether there were systemic conditions at St. Dominic's House in the months prior to [REDACTED] admission to the Orange Regional Medical Center on [REDACTED], that constituted neglect, making a Category Four finding against St. Dominic's House for that pre-Justice Center neglect would not have been authorized by law. To the extent that DRNY is suggesting that either a person, or a facility or provider agency, can be substantiated for abuse or neglect under a law that is not in effect at the time of alleged improper conduct, that determination would, in the view of the Justice Center, violate fundamental principles of due process.

Notwithstanding the Justice Center's conclusion that we had no jurisdiction to review and make findings with respect to any alleged abuse or neglect occurring prior to June 30, 2013, the Justice Center did, in fact, conduct a thorough investigation and review of these allegations, as it was permitted to do as the successor agency to the Commission on Quality of Care and Advocacy for Persons with Disabilities, and pursuant to its authority under Executive Law §§ 556 and 557. Indeed, in this case, the Justice Center's investigator, a Registered Nurse: conducted multiple interviews of staff at St. Dominic's House and the Orange County Medical Center; and reviewed medical records dating back to December 19, 2011. In addition, the Justice Center consulted with the Justice Center's Medical Review Board (MRB), pursuant to Executive Law § 556, which concluded that the care provided to [REDACTED] by [REDACTED] the physician from St. Dominic's House, by emergency room doctors at the Westchester Medical Center and by doctors at the Orange Regional Medical Center "appeared to be inadequate and inappropriate." While those conclusions did not empower the Justice Center to substantiate allegations of abuse or neglect,¹ they were of sufficient concern that the Justice Center made a referral to the Department of Health that included the MRB's findings with respect to the Orange Regional Medical Center.

With respect to your contention that the Justice Center did not take appropriate steps to ensure that [REDACTED] was removed from contact with St. Dominic's House service recipients (DRNY Investigation Report, pp. 21-22), the fact is that during the course of the Justice Center's investigation, and well before our investigation concluded, [REDACTED] was no longer providing services to residents at St. Dominic's House. Moreover, as explained above, your conclusion that the Justice Center should have substantiated [REDACTED] for Category One neglect to ensure that he was on the Staff Exclusion List, and therefore could no longer be hired by an agency serving people with special needs, is legally incorrect. Finally, the decision to remove staff, as the Justice Center may be permitted to do under Social Services Law § 492(3)(c)(ii), must be careful and considered, especially in a case like this in which doing so could leave other service

¹ Notably, the Justice Center does not have the legal authority to substantiate allegations of abuse or neglect against physicians employed by these general hospitals, because such physicians are not included within the definition of "custodians" and these hospitals are not within the definition of a "facility or provider agency" as set forth in Social Services Law § 488(2), (4). And, as explained above, any conduct by the St. Dominic's House physician prior to June 30, 2013 could not form the basis for substantiated findings.

recipients without access to a facility physician. While perhaps the Justice Center could have referred ██████████ to the Department of Health's Office of Professional Medical Conduct, we will consider this recommendation in future cases should such a referral appear warranted.

Finally, the Justice Center disagrees with your contention that the Justice Center did not meet its statutory mandate because it did not include, in its investigation report, an explanation of the reasons for the delay in concluding our investigation (DRNY Investigation Report, p. 22). Social Services Law § 493(1) simply does not require such information to be included in an investigation report. Instead, it merely provides that, within 60 days of accepting a report of an allegation of abuse or neglect, the Justice Center shall "cause the findings of the investigation to be entered into the vulnerable persons' central register" provided that it may take additional time to enter such findings as long as the reasons for the delay are documented. I can assure you that the reasons for the delay in this case are documented in the vulnerable persons' central register, as required by Social Services Law § 493(1). Moreover, it would not be appropriate to include such documentation in an investigation report when it could reveal confidential information (e.g., that a witness was unavailable for an interview because of a medical condition) or would reveal confidential law enforcement techniques. See, e.g., Public Officers Law § 87(2)(e)(iv).

In conclusion, we disagree with a number of the conclusions made in your Investigation Report because they fault the Justice Center for failing to take actions that we were not legally authorized to take. However, the Justice Center has, during the last two and one-half years, continuously made efforts to improve the quality and effectiveness of our processes and protocols, and we will take your suggestions under advisement as we continue to fulfill our statutory mandate to protect people with special needs from abuse and neglect.

Very truly yours,



Robin A. Forshaw
General Counsel

APPENDIX B



Saint Dominic's Home

SERVING NEW YORK CITY AND THE LOWER HUDSON VALLEY • WWW.STDOMINICSHOME.ORG

- 500 Western Highway
Blauvelt, NY 10913
845-359-3400
Fax: 845-359-4253
- Family Service Center
853 Longwood Avenue
Suite 202
Bronx, NY 10459
917-645-9100
Fax: 917-645-9095
- Saint Dominic's School
488 Western Highway
Blauvelt, NY 10913
845-359-3400 ext. 243
Fax: 845-359-5286
- TORCH
Therapeutic Pre-School and UPK
2340 Andrews Avenue
Bronx, NY 10468
718-365-7238
Fax: 718-584-3057
- TORCH
UPK Annex at Simon Stock
2195 Valentine Ave.
Bronx, NY 10457
929-263-1546
Fax: 929-263-1548
- Community Based Services
One Fordham Plaza
Suite 901
Bronx, NY 10458
718-295-9112
Fax: 718-561-8153
- 2345 University Avenue
Bronx, NY 10468
718-584-4407
Fax: 718-584-4540
- 140 Elgar Place
Bldg. #33, Apt. 8L
Bronx, NY 10475
718-320-8723
Fax: 718-320-8726
- 146 Broadlea Road
Goshen, NY 10924
845-615-3400
Fax: 845-291-7084

December 4, 2015

Mr. Timothy A. Clune, Esq.
Executive Director
Disability Rights New York
725 Broadway Suite 450
Albany, New York 12207

RE: [REDACTED]

Dear Mr. Clune:

The death of [REDACTED] was tragic. We appreciate your role in investigating the deaths of persons with developmental disabilities and thank you for the opportunity to respond to your November 12, 2015 Investigation Report (the "Report").

Saint Dominic's Home is a New York State Office for People with Developmental Disabilities-certified ICF providing residential, medical, clinical, and community inclusion services to people with developmental disabilities. It was founded as a nonprofit agency in 1878 and has a strong heritage and history of compassionately caring for those in need. We take that mission seriously in caring for all of our clients. Compassion and trust are two of our six core values—trust in that we are entrusted every day to care for children and adults. We work hard to earn and sustain that trust as we did by fully cooperating with your investigation as noted in the Report.

In terms of our response to those portions of the Report pertaining to Saint Dominic's, the New York State Justice Center's Investigation Report determined that "there is no evidence to support that [REDACTED] death was the result of neglect from...Saint Dominic's Home staff and services." At the time of his death, [REDACTED] primary care physician was [REDACTED], who was a contracted primary care provider.

While Saint Dominic's respectfully disagrees with some conclusions in the Report, it is always interested in looking for ways to improve the delivery of care and services to its clients. Accordingly, Saint Dominic's is amenable to working with Disability Advocates in connection with their recommendations and would like the opportunity to discuss the recommendations with you.

Sincerely,

Judith D. Kydon/llb

Judith D. Kydon
President/CEO

DEC 07 2015

clune



APPENDIX C



**Office for People With
Developmental Disabilities**

ANDREW M. CUOMO
Governor

KERRY A. DELANEY
Acting Commissioner

November 18, 2015

Timothy Clune, Esq.
Executive Director
Disability Rights New York
725 Broadway, Suite 450
Albany, NY 12207

Re: [REDACTED]
[REDACTED]

Dear Mr Clune:

I am in receipt of your correspondence and Investigative Report regarding the death of [REDACTED] at the Dominican Hall Intermediate Care Facility (ICF) at St. Dominic's Home in Goshen NY. Thank you for bringing these concerns to my attention so OPWDD's Division of Quality Improvement can ensure that further follow up is completed in the major areas of deficiencies you identified at this program.

OPWDD's Bureau of Certification (BPC) and Incident Management Units (IMU) will closely monitor this agency through our certification and incident management oversight activities. BPC will be conducting an on-site review to follow up on these concerns. If this survey results in a statement of deficiencies OPWDD will share this documentation with DRNY to ensure coordinated oversight. In turn, OPWDD requests that DRNY share any corrective action plan or report received from St. Dominic's related to the Independent Consultant / reviewer they were directed to retain.

Please contact me with any questions or concerns you may have.

Sincerely,

Megan O'Connor-Hebert
Deputy Commissioner
Division of Quality Improvement

Executive Office

44 Holland Avenue Albany New York 12229-0001 | 855-946-9733 | www.opwdd.ny.gov

APPENDIX D



DISABILITY RIGHTS NEW YORK

New York's Protection & Advocacy System and Client Assistance Program

RESPONSE TO THE JUSTICE CENTER'S OBJECTIONS

The Justice Center's response to DRNY's draft report is wholly without merit.¹ The legislation that created the Justice Center and disbanded the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC-APD), did not prevent the Justice Center from remedying abuse and neglect that occurred before June 30, 2013.² The legislation enhanced the State's powers to remedy abuse and neglect, and did not create a loophole for abuse and neglect occurring before June 30, 2013.

It could not be clearer that the Justice Center had the power to act but failed to do so. The *Protection of People with Special Needs Act*, 2012 N.Y. Sess. Laws Ch. 501 (S. 7749) (hereafter, the Act or the PPSNA) states that all functions, powers, duties, and obligations of CQC-APD were transferred to the Justice Center and that no gap in jurisdiction was intended or permitted.³ The Justice Center is empowered to take any action that CQC-APD might have taken and that clearly includes finding that there was abuse or neglect.

Notably, the Justice Center agrees that the care provided by "the physician from St. Dominic's House, by emergency room doctors at the Westchester Medical Center and by doctors at the

¹ DRNY's draft report criticized the Justice Center for not including an explanation in its report for why it took the Justice Center 11 months to complete its investigation. After considering its response, DRNY modified its finding in the final report.

² "§ 10. Continuity of authority. For the purpose of succession of all functions, powers, duties and obligations transferred and assigned to, devolved upon and assumed by it pursuant to this act, the justice center for the protection of people with special needs shall be deemed and held to constitute the continuation of the state commission on quality of care and advocacy for persons with disabilities." 2012 N.Y. Sess. Laws Ch. 501, sec. A, § 2994-m (c)(10), Stat. 7749.

³ *Id.* at §2994-m(c)(11) "Completion of unfinished business. Any business or other matter undertaken or commenced by the state commission on quality of care and advocacy for persons with disabilities, the office of mental health, the office for people with developmental disabilities, the office of alcoholism and substance abuse services, the office of children and family services, the department of health and the state education department pertaining to or connected with the functions, powers, obligations and duties hereby transferred and assigned to the justice center for the protection of people with special needs and pending on the effective date of this act, may be conducted and completed by such justice center in the same manner and under the same terms and conditions and with the same effect as if conducted and completed by the state commission on quality of care and advocacy for persons with disabilities."

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Orange Regional Medical Center ‘appeared to be inadequate and inappropriate.’” But it insists that it was powerless to do anything about it and that it was legally compelled to not substantiate the neglect.⁴ This is incorrect and lead SDH to incorrectly conclude that it had not neglected MH.⁵

“Lack of jurisdiction” appears to be a *post hoc* excuse for the Justice Center’s unjustifiable investigatory findings. The Justice Center staff fully investigated the events that occurred prior to June 30, 2013 and its Medical Review Board fully reviewed medical care prior to June 30, 2013. If the Justice Center did not have jurisdiction to make findings regarding the events prior to June 30, 2013, it would not have invested very significant resources for 11 months to investigate the matter. Nowhere in the lengthy investigative report did the Justice Center ever claim that it lacked jurisdiction to take action on the matters investigated. Clearly, the Justice Center’s jurisdictional defense is just a smoke screen to hide its untenable conclusions.

Most problematically, if the Justice Center believed it lacked jurisdiction, it should not have prevented OPWDD and SDH from investigating the alleged neglect. But it did just that, ordering SDH and OPWDD not to investigate because of its investigation. And the error was compounded when it failed to *ever* notify OPWDD and SDH that they should investigate and take remedial action because the Justice Center lacked the authority to make findings or take remedial action.

The Justice Center also claims that remedying neglect that occurred before June 30, 2013 would somehow deprive SDH and the physician of due process. The PPSNA provides extensive due process to persons and entities found to have abused or neglected. *See* Social Services Law § 494, Exec. Law § 553(c).

The Justice Center also belatedly claims it had no duty to address the failure to make mandatory reports of alleged neglect because there was no duty to report to the Justice Center until June 30, 2013. This ignores the duty to report to CQC-APD, OPWDD, the Statewide Central Register of Child Abuse and Maltreatment, and Mental Hygiene Legal Service. The nursing staff, the physician and all staff working with residents under age eighteen, were obligated to make immediate oral and written reports to the statewide central register of child abuse and maltreatment pursuant to Social Services Law §§ 413 and 415. They also had an obligation to report any suspected neglect, to OPWDD, Mental Hygiene Legal Service, CQC-APD, and its successor the Justice Center pursuant to 14 NYCRR Part 624 (2008). Had the required reports been made in this case, it might have saved a life. The Justice Center has an obligation to ensure that all mandated reporters fulfill their duty to report abuse and neglect and the Justice Center must require or administer necessary retraining.⁶

⁴ “[A]llegations of neglect . . . had to be unsubstantiated” because the Justice Center lacked jurisdiction. Justice Center Letter to Timothy Clune dated December 4, 2015.

⁵ The December 4, 2015 response from SDH to DRNY states “the [Justice Center] determined that ‘there is no evidence to support that [MH’s] death was the result of neglect from Saint Dominic’s Home staff and services.’” Clearly, the Justice Center sent the wrong message to SDH.

⁶ Exec. Law § 553(1)(f) (“establishing training curricula for employers and employees who provide care and treatment to vulnerable persons, and those who are in supervisory positions with respect to such employees, *regarding their obligations to report, investigate and prevent reportable incidents*. Training and curricula shall address topics, including but not limited to: (i) how to identify and report reportable incidents; (ii) the prevention of abuse and neglect; (iii) the duty to report reportable incidents; (iv) how to adhere to applicable codes of conduct; (v) the disciplinary process and employees’ rights pursuant to this article; and (vi) how supervisory staff and management can promote compliance with this article by new and existing employees. Such training, which shall be given on a periodic basis,

In its December 4, 2015 letter, the Justice Center also wrongly claims that it lacks jurisdiction over neglect of physicians because they are not “custodians.” Social Service Law § 488 defines custodian as “a director, operator, employee or volunteer of a facility or provider agency; or a consultant or an employee or volunteer of a corporation, partnership, organization or governmental entity which provides goods or services to a facility or provider agency pursuant to contract or other arrangement that permits such person to have regular and substantial contact with individuals who are cared for by the facility or provider agency.” Dr. P.’s contract with SDH specifically states that Dr. P. was an agent of a domestic corporation contracted to provide medical services to residents. He was therefore a custodian under the Social Services Law. Moreover, even as to physicians employed by general hospitals, the Justice Center may require such hospitals to produce records and documents necessary to carry out its powers and duties related to the investigation of deaths and complaints of abuse and neglect. Exec. Law § 558.

shall include, but not be limited to, live training and supplemental courses accessible via the internet. Prior to implementation of this article, the justice center shall provide adequate interactive training, which shall include live training to the extent practicable. Employees may call the hotline established pursuant to subdivision two of section four hundred ninety-two of the social services law, and upon inquiry, be given advice and assistance in complying with their obligations and duties pursuant to this article.”).