New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Selected Aspects of Incident Intake and Investigation

Justice Center for the Protection of People With Special Needs

Report 2015-S-61 March 2017

Executive Summary

Purpose

To determine whether the Justice Center for the Protection of People With Special Needs (Center) met its responsibility to operate a hotline, establish a database of reported allegations and a Staff Exclusion List, and ensure that all allegations are investigated fully and timely and are referred to law enforcement when appropriate. The audit covered the period July 1, 2013 through May 16, 2016.

Background

The Center was established by the Protection of People With Special Needs Act (Chapter 501 of the Laws of 2012) and began operation on June 30, 2013. The Center has law enforcement authority to protect and advocate for people with special needs who are served by six State Oversight Agencies (SOAs) and more than 3,000 SOA licensees, facilities, providers, or entities certified by the SOAs.

Pursuant to Section 492 of the Social Services Law, the Center receives reports of allegations of reportable incidents involving persons receiving services in State facilities or provider agencies. The Center maintains an electronic database of reports accepted by the Vulnerable Persons Central Register (VPCR). The database is the Center's electronic case file and reporting system and is used to document the receipt, investigation, and disposition of each allegation. Allegations are classified as either Abuse, Neglect, or other Significant Incidents. The Center directly investigates serious Abuse and Neglect reports, and delegates some less serious cases to SOAs for investigation.

The Center is also required to maintain a Staff Exclusion List (SEL), which is a register of persons about whom it has previously substantiated an allegation of the most serious types of Abuse or Neglect, also referred to as Category One offenses. Individuals listed on the SEL cannot hold positions that involve direct care of persons with special needs. The Center has a staff of over 400, which includes 136 investigators located across the State. As of September 2, 2015, Center records showed that, since its creation, it had received reports of over 113,000 incidents that were within its jurisdiction to investigate.

Key Findings

- Although we were able to conclude that the Center does operate the required hotline and maintain the VPCR database and the SEL, we were unable to draw conclusions about several of the most important parts of our audit because the Center did not provide us with access to most of the relevant information needed to achieve our audit objective. Citing Section 496 of the Social Services Law, Center officials concluded that the Center is only authorized to provide the State Comptroller with case-specific information in substantiated cases. Consequently we were unable to review more than 70 percent of the individual incidents reported in the VPCR database, including any cases where investigations have not been completed or where allegations were deemed to be unfounded.
- We used the limited information we were provided to the extent possible to evaluate the Center's compliance with its statutory mandates. Unfortunately, in most cases, the controls

and compliance we were able to evaluate related more to ensuring that persons accused of (and subsequently found to have committed) serious instances of Abuse and Neglect received due process – and less to ensuring that all allegations of acts against vulnerable individuals had been investigated fully and timely and referred to law enforcement when appropriate.

- Although our examination was severely limited, our tests identified three individuals who had been erroneously left off the SEL after committing serious acts of Abuse or Neglect. The names of two of the individuals should have been included on the SEL nine months before we identified them; the name of the third individual should have been included five months prior to our conclusions. These problems occurred because the Center lacked proper controls to periodically validate the accuracy of the SEL. Center officials promptly added these names once we brought the omissions to their attention.
- Our limited testing also showed that the Center's database of reported allegations contains numerous inaccuracies. For example, each suspected offender should have a unique identification number to, among other things, enable tracking of repeat offenders. Yet our analysis identified about 180 individuals who had multiple identification numbers assigned to them. We also identified about 220 substantiated offenses with inaccurate or blank fields for significant dates, including the date the incident was reported or when a finding was made. Such errors can result in inaccurate data being publicly reported by the Center. Officials told us they are implementing steps to correct the data inaccuracies and are also implementing a new reporting system.
- Several Federal statutes, as well as the State Executive Law, include specific provisions for independent oversight of the Center, and access to its records, by a designated monitoring agency. Currently, the designated monitoring agency is Disability Rights New York (DRNY). However, we noted that DRNY has also been unable to obtain complete access to various aspects of Center operations and filed a lawsuit to compel disclosure and clarify its role and powers. While we take no position with respect to that action, we are concerned that there is a lack of independent oversight and public accountability for the Center's performance of many aspects of its important responsibilities.

Key Recommendations

- Develop and implement controls to ensure all subjects with substantiated Category One offenses are promptly added to the SEL.
- Develop and implement procedures to provide reasonable assurance that data contained in the VPCR database is accurate, including procedures to periodically review and analyze the accuracy of the data and correct any inaccuracies discovered.

Other Related Audit/Report of Interest

Department of Health: Nursing Home Surveillance (2015-S-26)

State of New York
Office of the State Comptroller

Division of State Comptroller

March 6, 2017

Ms. Denise M. Miranda
Acting Executive Director
Justice Center for the Protection of People With Special Needs
161 Delaware Avenue
Delmar, NY 12054-1310

Dear Ms. Miranda:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively. By so doing, it provides accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of *Selected Aspects of Incident Intake and Investigation*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

The Justice Center for the Protection of People With Special Needs (Center) was established by the Protection of People With Special Needs Act (Chapter 501 of the Laws of 2012) and began operation on June 30, 2013. The Center's mission is to support and protect the health, safety, and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment, and investigation of all allegations of abuse and neglect so that appropriate actions are taken. The Center has law enforcement authority to protect and advocate for people with special needs who are served by six State Oversight Agencies (SOAs) and more than 3,000 SOA licensees, facilities, providers, or entities certified by the SOAs. The SOAs include the Department of Health, the State Education Department, and the Offices of Mental Health, Alcoholism and Substance Abuse Services, Children and Family Services, and People With Developmental Disabilities. The Center is also mandated to receive reports of abuse or neglect involving certain vulnerable persons placed in out-of-state facilities and residential schools. Pursuant to Section 491 of the Social Services Law, certain caregivers must report their suspicions and occurrences of abuse or neglect to the Center. As a result, the Center can receive multiple reports for the same incident.

The Center operates the statewide Vulnerable Persons Central Register (VPCR), which handles reports of allegations of reportable incidents involving persons receiving services in facilities or provider agencies. The VPCR is required to receive reports 24 hours a day, seven days a week, via a Statewide toll-free telephone number (a hotline) or electronic transmission. The VPCR also maintains an electronic database of reports, which serves as the Center's electronic case file, central register, and reporting system. The Center uses the VPCR to capture all reports and serves as the supporting record for the receipt, investigation, and disposition of an allegation.

Reportable incidents are classified in three groups: Abuse, Neglect, and Significant Incidents. Abuse is defined as any improper action that results in, or is likely to result in, harm. Examples include sexual and psychological abuse; obstruction; and physical abuse such as hitting, kicking, shoving, and choking of a service recipient by a custodian. Neglect is defined as any breach of a custodian's duty, which includes action, inaction, or lack of attention on the part of the custodian that results in, or is likely to result in, injury or serious or protracted impairment of the physical, mental, or emotional condition of the vulnerable person, such as failure of the custodian to provide proper supervision. A Significant Incident is defined as an action that is not Abuse or Neglect but, because of the severity or sensitivity of the situation, may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of a service recipient. Examples include unauthorized seclusion or time-out, inconsistent administration of medication, and financial misconduct. The Center also receives reports of all deaths of vulnerable persons receiving services from a provider or entity overseen by the Center.

The Center oversees all investigations of reportable incidents, and its investigators are responsible for directly investigating serious Abuse and Neglect reports, such as incidents involving sexual abuse. Pursuant to Section 552 of the Executive Law, the Center's Special Prosecutor/Inspector General has the duty and power to investigate and prosecute offenses involving Abuse or Neglect

and to cooperate with and assist district attorneys and other local law enforcement officials. The Center delegates some less serious cases of Abuse, Neglect, and Significant Incidents to SOAs for investigation. Reports may also be investigated by law enforcement entities authorized or required to investigate Abuse or Neglect complaints in their respective jurisdictions.

Pursuant to Sections 492 and 493 of the Social Services Law, the Center is required to: commence an investigation into all allegations of reportable incidents that are accepted by the VPCR; expediently notify law enforcement whenever an alleged crime is reported to the VPCR; and investigate all reports of Abuse and Neglect accepted by the VPCR and document the findings in the VPCR database within 60 days of receiving the allegation, or document the reasons for any delay and enter the findings as soon as practicably possible. The result of an investigation must support either a substantiated or an unsubstantiated finding.

Substantiated reports are assigned to one of four categories, with Category One representing actions that qualify as serious Abuse or Neglect, the most severe of the four categories. Category Two conduct is defined under Social Services Law, Section 493, as "conduct by custodians that is not otherwise described in Category One, but conduct in which the custodian seriously endangers the health, safety, or welfare of a service recipient by committing an act of abuse or neglect." Furthermore, Category Two conduct, which is less serious Abuse or Neglect, shall be elevated to Category One when such conduct occurs within three years of a previous finding that the offender engaged in Category Two conduct.

Category Three and Four offenses relate to less serious actions, such as systemic facility issues, or cases where the responsible party cannot be identified. The Center also developed and maintains a register of persons for whom it has previously substantiated an allegation of Category One conduct, which is referred to as the Staff Exclusion List (SEL). According to Social Services Law, Section 495, a person listed on the SEL may not be employed in a position that has regular and substantial contact with a service recipient in any such facility or program.

The Center has a staff of over 400, which includes 136 investigators located across the State. As of September 2, 2015, Center records showed it had received over 189,000 reports since its creation. Some reports do not result in a full investigation. For example, some reports are simply calls to the Center for general information, while others relate to incidents that are outside the Center's jurisdiction (e.g., nursing homes) or to circumstances that do not qualify as reportable incidents. As such, just over 113,000 of the 189,000 reports qualified as reportable incidents. Approximately 81,800 of these were unique reportable incidents, while the rest were duplicate reports about the same events.

About 27,000 of these incidents (one-third) were classified as cases involving allegations of Abuse or Neglect. Center records also show that about 17,900 investigations of Abuse and Neglect cases were completed as of September 2, 2015. The balance of the cases either remained open and in process (almost 3,700 cases) or had been administratively closed without a formal determination (more than 5,400 cases). In about 35 percent of completed cases (6,256), at least one charge of Abuse or Neglect was substantiated.

Audit Findings and Recommendations

The Center operates the statutorily required hotline and maintains the VPCR database and the SEL. However, we were unable to draw any conclusions about several of the most important parts of our audit, primarily because the Center refused us access to most of the relevant information needed to achieve our audit objective. Citing Section 496 of the Social Services Law that the Center is only authorized to provide the State Comptroller with case-specific information in substantiated cases, Center officials would not allow our auditors to access any information about more than 70 percent of the individual incidents reported in the VPCR database, including any cases where investigations have not been completed or where allegations were deemed to be unfounded.

We used the limited information provided to the extent possible to evaluate the Center's compliance with its statutory mandates. In most cases, it appears that the controls and compliance we were able to evaluate related more to ensuring that persons accused of (and subsequently determined to have committed) serious cases of Abuse and Neglect received due process – and less to ensuring that vulnerable individuals (and their rights) were protected. Even so, our review identified several areas where it is clear that the Center should do a better job in fulfilling its core mission.

For example, even though our examination was severely limited, our tests identified three individuals who had been erroneously left off the SEL after having been found to have committed serious acts of Abuse or Neglect. The names of two of the individuals should have been included on the SEL nine months before we identified them, and the name of the third individual should have been included five months prior to our conclusions. These problems occurred because the Center lacked proper controls to periodically validate the accuracy of the SEL. Center officials promptly added the names of the individuals to the SEL once we brought the omissions to their attention.

Audit testing also showed that the Center's database of reported allegations contains numerous inaccuracies. Although each suspected offender should have a unique identification number to enable tracking of repeat offenders, our analysis of the relatively small pool of substantiated offenses to which we had access identified about 180 individuals who had multiple identification numbers assigned to them. Also, there were about 220 substantiated offenses with inaccurate or blank fields for significant dates, including the date the incident was reported or when a finding was made. Such errors can result in inaccurate data being publicly reported by the Center. Officials told us they are implementing steps to correct the data inaccuracies and are also implementing a new reporting system.

Several Federal statutes, as well as the State Executive Law, set forth specific provisions for independent oversight of the Center, and access to its records, by a designated monitoring agency. Currently, the designated monitoring agency is Disability Rights New York (DRNY). However, DRNY has also been unable to obtain access to certain critical aspects of Center operations and filed a lawsuit to clarify its role and powers and to compel disclosure of the records. While we

take no position with respect to that action, we are concerned that there is a lack of independent oversight and public accountability for the Center's performance of many aspects of its important responsibilities.

Access to Center Records

The Center only provided us access to records for closed Abuse and Neglect allegations that had been substantiated through investigation. As a result, of the almost 82,000 unique incidents reported to the VPCR, we were given data on only about 6,250 incidents – less than 8 percent of the incidents reported. Further, we considered the cases to which we had access to be the lowest risk in terms of assessing the Center's efforts in comparison to its mission. In contrast, we were unable to access records we needed to address the most important parts of our audit objective.

For example, the Center did not provide us access to records about any Abuse or Neglect reports that its staff deemed to be unsubstantiated through their investigations. We also did not have access to records about incident reports that are categorized as Significant Incidents, unsubstantiated, unfounded, administratively closed, out-of-state investigations, and active/open investigations. These reports represent more than 70 percent of the individual incidents reported to the Center since its inception in June 2013. Without access to unsubstantiated Abuse or Neglect cases, Significant Incidents, and other incident records, we were unable to test multiple aspects of the Center's processes, procedures, and data that are critical to assessing its performance in relation to its mission.

For example, auditors were not allowed to observe the call center in operation, nor could we take other steps to determine whether:

- The population of allegations and incident reports given to us for our audit period was accurate and complete;
- All the allegations received were accurately categorized and recorded in the VPCR;
- All incident reports were fully investigated;
- Outside law enforcement officials were appropriately notified about reported incidents where applicable; or
- Allegations deemed not to be under the Center's jurisdiction were referred to the proper agencies.

In responding to our draft report, officials asserted that they granted OSC auditors "virtually unfettered access to the VPCR's electronic records in abuse and neglect cases in which allegations had been substantiated." In reality, however, our access to the substantiated cases was far from "virtually unfettered." In fact, our examination of information for the cases we selected was physically controlled by the Center, and OSC auditors were only allowed to observe computer screens after they were previewed by Center staff.

Initially, we selected a sample of 80 substantiated cases for review. For each case, Center staff opened and checked the pertinent computer screen to verify that it contained information related only to a substantiated allegation prior to allowing OSC auditors to view it. If Center staff

determined that the screen was limited only to a substantiated allegation, the OSC auditor was allowed to view the screen over the staff member's shoulder and take notes on pertinent case information. This process was repeated for each successive case screen, as it was brought up on a Center terminal.

Further, for 22 cases, Center staff indicated the screens contained information on both substantiated and unsubstantiated allegations, and therefore, OSC auditors were permitted to view materials for only 13 of these cases. The other 9 (22 - 13) cases were set aside so that information related to unsubstantiated offenses could be redacted. As a result, we were not permitted to review many of the sampled cases wherein allegations were only partially substantiated. We terminated our review after 61 (of the 80) cases because the process was excessively time consuming and because certain cases would not be available for our review without significant redaction (including the aforementioned 9 cases with both substantiated and unsubstantiated allegations). Further, Center officials told us that, due to the cumbersome and time-consuming nature of accessing even those cases that were entirely substantiated, it would still take an excessive amount of Center staff time to complete record redactions for all of our selected cases.

As a result of these limitations, we are unable to provide an independent assessment of the Center's performance relating to a significant portion of its mandates under the law to protect people with special needs from abuse, neglect, and mistreatment.

One of the most critical aspects of these mandates involves the timeliness of the Center's response to allegations. The Social Services Law generally requires that the Center complete each investigation within 60 days of the date it is received. Where it cannot meet this deadline, the law requires the Center to document the reason for the delay and complete its work as soon as possible. However, we were only able to assess timeliness for the small group of closed cases that were available to us, some of which (223) also did not have complete date information. Our analysis showed that the Center took over 300 days to investigate 3,946 of a pool of 16,477 substantiated offenses (24 percent) in our limited data set with dates available.

The timeliness of investigations, and the associated determinations, is especially critical for the lesser Category Two offenses. In these cases, once a Category Two offense is substantiated, the offender's next Category Two offense within three years would be upgraded to a Category One, and the offender would be placed on the SEL. Delays in substantiating these Category Two offenses can result in offenders committing multiple Category Two offenses before being placed on the SEL.

The data also showed that 485 people committed two or more Category Two offenses, of which 16 were the result of multiple incidents. For example, our analysis identified one offender who committed a Category Two offense that was reported on December 31, 2013 and then another on July 23, 2014. However, the second offense was not upgraded to Category One because the first offense was not substantiated until November 12, 2014 – or 316 days after it was reported.

Because these were substantiated cases that had been completed and fully adjudicated, we expected that the Center would be able to produce the required documentation to support any

delays. However, when we requested evidence to support some of the delays we identified, officials described various reasons why the investigations were held up but did not provide any supporting documents. This suggests that the reasons for the delays may not have been documented, as otherwise required. Further, we were unable to review the timeliness of any allegations that are still open or that the Center deemed to be unsubstantiated. As such, there is a material risk that such cases could include lengthy investigations for which the reasons for delays are not documented.

Although we were denied access to most of the information we needed to evaluate the Center's performance, Federal and State laws currently provide for a designated agency that is specifically authorized to access Center information. Currently, the designated agency is the not-for-profit organization DRNY, whose job is to provide protection and advocacy for people with special needs in facilities in the State. DRNY has oversight authority under several Federal laws, including the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. §§15001-15115) and the Protection and Advocacy for Individuals with Mental Illness Act of 1996 (42 U.S.C. §§10801-10851). DRNY also has authority under Executive Law, Section 558, to investigate incidents of Abuse and Neglect of individuals with disabilities if those incidents are reported to them or if they have probable cause to believe that the incidents occurred.

Despite this legal authority, DRNY has reportedly experienced difficulties gaining access to certain records it has sought from the Center. As a result, in January 2015, DRNY filed a lawsuit in Federal court to better define its role and powers and to compel disclosure of certain records. Given our lack of access to Center records and the difficulties faced by DRNY, we are concerned that there is not only a lack of transparency and accountability, but also a lack of independent oversight of the Center's performance of many aspects of its important responsibilities.

Subjects Not on the Staff Exclusion List

We compared the 16,700 substantiated Abuse and Neglect offenses provided by the Center with the SEL and identified eight subjects with Category One findings who were not listed on the SEL. The Center concluded three of these subjects were supposed to be on the SEL but were erroneously left off for nine months (two subjects) and over five months (the third subject) before we notified the Center. The Center subsequently added the three subjects to the SEL. Center officials told us that the three individuals worked for non-State-operated providers and that two of them were suspended when the allegations were called in to the Center. The third employee was terminated about four days after the allegations were reported.

We concluded these errors were due to the absence of a procedure to periodically review the SEL for accuracy. According to Center officials, they have since instituted processes to prevent these types of errors from recurring. According to Center documentation, the remaining five subjects were not supposed to be on the SEL because of data entry errors, outdated offense information, or system errors. According to Center officials, information regarding a suspect's case can be inaccurate due to certain aspects of the system, as described in greater detail in the following section of this report.

Accuracy of System Data and Reports

The Social Services Law requires the Center to assign a unique identifier (Incident Number or Case Number) to each allegation received by the Center and that certain information, such as names and identifying data as well as a record of the final disposition of the report, be included in the VPCR database for each report. The Center also assigns a unique identifier to each subject of a reportable incident entered into the VPCR database (referred to as the Suspect Row ID or Contact ID). The Center also has a procedure to input the date that an offense was reported and the date a determination (substantiated or unsubstantiated) was made on an Abuse or Neglect offense.

Our analysis of the 16,700 substantiated offenses found instances where contact information for the same person was entered in the VPCR database multiple times but all entries did not contain all of the pertinent information for the subject. As a result, some incidents of Abuse or Neglect contained certain information for an offender, such as a Social Security number, while other incidents for the same offender did not have complete information. Our analysis also showed 223 offenses with blank fields for significant dates, such as the date the incident was reported or a finding was made.

We identified over 180 individuals with the same name who had multiple Contact IDs assigned to them. Although a few of these instances may involve different people who have the same name, we determined there is a high likelihood that many of the 180 individuals are the same people because they had the same Social Security number, the same employer, or a unique name. Center officials stated that while each subject is supposed to have just one unique identifier assigned, multiple entries for contact information were inadvertently made for the same person. Subjects' data entered into the VPCR under multiple Contact IDs where each entry does not contain all of the pertinent information for the subject can cause complications (including errors) when issuing notifications.

Center officials told us that erroneous contact information in the VPCR has resulted in the Center's notification and determination letters being sent to the wrong individuals. Multiple numbers could also potentially result in the database showing inaccurate charges for a suspect that are lower than they should be since they are not based on a suspect's complete record. This occurred because the Center does not have a regular process designed to identify and review all such cases and eliminate multiple Contact IDs. There may well be other inaccuracies in the system data that we are not aware of due to the limited tests and analyses that we were able to perform.

The Executive Law requires the Center to publish an annual report of its work during the preceding year on its website. The report must include data regarding the number of reports received by the VPCR and the results of investigations. The Center has issued several monthly and annual reports since its inception. However, according to Center officials, problems with the VPCR reporting tool used to produce the statistics have resulted in inaccurate data being published.

In an effort to resolve the data inaccuracies, Center officials stated they are in the process of rolling out a new reporting system, which will improve and enhance how the data is reported, eliminate some of the reporting errors, and produce accurate data that will be used to replace

the inaccurate figures in the published reports. Further, due to the extent of system data issues, Center officials said they have delayed responding to (or put holds on) Freedom of Information Act requests to avoid releasing inaccurate information to the public.

Recommendations

1. Develop and implement controls to ensure all subjects with substantiated Category One offenses are promptly added to the SEL.

2. Develop and implement procedures to provide reasonable assurance that data contained in the VPCR database is accurate, including procedures to periodically review and analyze the accuracy of the data and correct any inaccuracies discovered.

3. Correct previously published data and reports to the extent practicable.

Audit Scope and Methodology

Our audit sought to determine whether the Center has adequately met its responsibility to operate the hotline, establish the VPCR database and the SEL, and ensure that all allegations are investigated fully and timely and are referred to law enforcement when appropriate. The audit covered the period July 1, 2013 through May 16, 2016.

To accomplish our objective and assess related internal controls, we reviewed pertinent State and Federal laws, as well as Center policies and procedures, and interviewed appropriate Center officials and employees. We analyzed data for substantiated and closed Abuse and Neglect offenses to evaluate whether the Center fully and timely investigated these incidents and to assess whether there were indications of missing or inaccurate data. We also reviewed the SEL to determine if it included subjects with Category One findings as required by law. We also reviewed the reports published by the Center on its website. However, we were unable to assess the accuracy, completeness, and reliability of much of the Center's data due to restrictions imposed on our access by Center officials.

We conducted our performance audit in accordance with generally accepted government auditing standards with the following exceptions, which are discussed in greater detail in other sections of this report:

- We were unable to, and did not, assess the data in the VPCR database to ensure it was accurate, complete, and reliable;
- We were denied, and did not receive, access to information on allegations related to more than 70 percent of the individual incidents reported to the Center. We were therefore unable to evaluate a substantial portion of the Center's activities through audit tests designed to identify fraud and noncompliance with laws, regulations, and policies, as well as other audit procedures that may have had a significant effect on our results had we been able to perform them.

Performance audits serve to provide findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria in an objective analysis that can assist management and those charged with governance and oversight to improve program performance. Generally accepted government auditing standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence we obtained provides a reasonable basis for the limited findings and conclusions we made based on our audit objective. However, because of the limitations imposed on our access to information, we acknowledge the audit risk that our findings, conclusions, and recommendations may be incomplete as a result of factors such as evidence not being sufficient.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Center officials for their review and formal comment. We considered their comments in preparing this final report and appended them in their entirety to the report. In their response, Center officials disagreed with several of our findings and certain other aspects of our report, including our audit objective. Nevertheless, officials indicate that they have taken steps to implement two of our report's three recommendations, and they will re-assess the practicality of implementing the third recommendation when a new data reporting tool becomes available in the near future. Also, certain Center statements are inaccurate and/or misleading. Our rejoinders to several such statements are included in the report's State Comptroller's Comments.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Director of the Justice Center for the Protection of People With Special Needs shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and if the recommendations were not implemented, the reasons why.

Contributors to This Report

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments and State Comptroller's Comments

NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

ANDREW M. CUOMO
Governor

August 26, 2016

Mr. John Buyce, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Re: Response to Draft Report of Audit (2015-S-61)

Dear Mr. Buyce:

I write to strongly refute several of the purported findings in the draft audit report of the Office of the State Comptroller (OSC) entitled "Selected Aspects of Incident Intake and Investigation" at the Justice Center for the Protection of People with Special Needs (Justice Center).

The OSC draft audit primarily addresses two areas. First, OSC alleges that the Justice Center "refus[es]" to provide OSC with access to all of the incident management and investigative records contained in our centralized database, known as the Vulnerable Persons' Central Register (VPCR). This allegation is untrue. OSC's request sought information on all cases involving allegations of abuse or neglect - whether they were substantiated or not. Yet as the Justice Center has repeatedly explained, the Justice Center is prohibited, by law, from providing OSC with access to unsubstantiated records. Specifically, in the Justice Center's enabling statute, the Legislature recognized that OSC has no need for these highly confidential records: it can audit the Justice Center's performance by accessing records in substantiated cases.

State Comptroller's Comment: As clearly stated on page 1 and again on page 7 of this report, based on its interpretation of the law, the Center denied auditors access to case-specific information about all but the closed substantiated cases, which comprised only about 30 percent of the reported incidents.

Examining the validity of the Justice Center's decision to unsubstantiate allegations of abuse or neglect would be an inappropriate audit objective as OSC does not have the legal expertise to make such an assessment.

State Comptroller's Comment: The objective of our audit was not to examine the validity of the Center's decisions about whether or not individual allegations should be substantiated. Rather, as stated on page 1 and again on page 12, our objective was to determine whether the Center met its statutory responsibilities to operate the hotline, establish the VPCR database and the SEL, investigate

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allegations fully and timely, and refer cases to law enforcement when appropriate.

Second, based on its review of records in substantiated cases, OSC alleges that there are inaccuracies in some of the data maintained in the VPCR. This allegation is also without merit. As the Justice Center has repeatedly explained, it was required, by law, to begin operations only six months after Governor Cuomo signed the Protection of People with Special Needs Act on December 17, 2012 (Ch. 501, L. 2012). During that time, the Justice Center took every precaution to capture and track certain data. Any isolated incidents regarding the data collected during the initial start-up of the Justice Center have long since been resolved, and the Justice Center continually updates the VPCR to ensure the accuracy and confidentiality of the information contained therein.

State Comptroller's Comment: As discussed on pages 11 and 12, our review of VPCR data fields for the substantiated abuse and neglect cases to which we were granted access found 223 records with missing or inaccurate information. This included blank determination dates or incident created dates. Of the 223, more than 65 percent (149) occurred in 2015 or 2016 – well outside the Center's "initial start-up" period.

I. Introduction

The Justice Center was created by the Protection of People with Special Needs Act, which was signed by Governor Cuomo on December 17, 2012 (Ch. 501, L. 2012). The Act required the Justice Center to begin operations in six months, on June 30, 2013. The Justice Center was established to support and protect the health and safety of people with special needs and disabilities. It serves as both a law enforcement agency and as an advocate for the people under its jurisdiction. There are six State Oversight Agencies or SOAs whose programs are under the jurisdiction of the Justice Center: the Office for People With Developmental Disabilities (OPWDD), the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS), the Department of Health (DOH), and the State Education Department (SED).

During the initial six-month implementation period, when the Justice Center was first getting operations up and running, staff worked tirelessly to coordinate with the six SOAs to develop standards and procedures that would provide consistency and accountability and fully allow the Justice Center to effectuate its mission. In addition, Justice Center staff worked with consultants to locate and retro-fit office space for the new agency, identify necessary practices and procedures to meet the agency's statutory mandates, develop a case management system to fulfill those practices and procedures, and hire or transfer in 131 employees. One essential task during the implementation period was the development of the Vulnerable Persons' Central Register, or VPCR, the statutorily mandated electronic database used to receive reports of reportable incidents and maintain reports and findings associated with each report. See Social Services Law (SSL) § 492.

The Justice Center officially began operations on June 30, 2013. That same day, the Justice Center began receiving reports of allegations of reportable incidents (abuse, neglect and significant incidents, as defined in SSL § 488[1]) and was able to fulfill its statutory mandate to maintain data about those reports, as well as the investigation and resolution of them, within the VPCR.

Over the last three years, the Justice Center has implemented seven major upgrades to the VPCR, and numerous minor ones, in order to improve the quality of the data, upgrade the original

programming of the system, and eliminate opportunities for data entry errors to occur.[1] The data issues that OSC identifies in the draft audit do not relate to current practice, but rather to this start-up period. Operationally, the Justice Center has since closed the gaps that OSC identifies in its draft audit.

State Comptroller's Comment: As previously stated, more than 65 percent of the data errors we identified occurred in 2015 or 2016 – well outside the Center's "initial start-up" period. Furthermore, in meetings with Center officials on both August 17, 2015 and February 3, 2016, they told us about current errors in the VPCR that they were addressing.

Finally, during the 26-month period under OSC's review, over 189,000 reports were made to the Justice Center's intake unit. Excluding multiple reports of the same event, and reports of allegations that either did not meet the definition of a reportable incident, or were outside the Justice Center's jurisdiction, approximately 81,800 of those reports qualified as unique reportable incidents (abuse, neglect and significant incidents). Approximately 27,000 of those reports were classified as containing allegations of abuse or neglect. At the end of the audit period (September 2, 2015), approximately 17,900 of those abuse or neglect cases had been closed, and in about one-third of them (6,256) at least one allegation of abuse or neglect had been substantiated.

As a result, based on the express statutory provisions governing OSC's access to Justice Center investigation records, OSC had access to records in over 6,000 reported cases of abuse or neglect. However, OSC continues to insist it should have access to the remaining 17,900 closed cases in which all allegations of abuse or neglect were unsubstantiated. As set forth below, OSC's position is not supported by law.

II. OSC's Findings Regarding Access to Justice Center Records are Without Legal Merit

OSC states that the Justice Center "refused" to provide access to most of the relevant information it needed to achieve its audit objectives. This is incorrect. Consistent with relevant law, OSC and the Justice Center entered into a confidentiality agreement that memorialized the scope of OSC's access to records, consistent with the plain language of SSL § 496(2)(t). Pursuant to that agreement, the Justice Center gave OSC virtually unfettered access to the VPCR's electronic records in abuse and neglect cases in which allegations had been substantiated, including all documents obtained during the investigation, the investigation report, witness and subject interviews, and findings letters.[2] Thus, it is incorrect to state that the Justice Center refused to provide OSC with the most relevant information.

State Comptroller's Comment: As discussed on page 8, even our access to the closed substantiated cases in the VPCR was not "virtually unfettered." Our examination of information for the cases we selected was physically controlled by the Center, and OSC auditors were only allowed to observe computer screens after they were previewed by Center staff. For 22 cases, Center staff indicated the screens contained information on both substantiated and unsubstantiated allegations, and therefore, OSC auditors were permitted to view materials for only 13 of these cases. We terminated our review after 61

[1] Improving the quality of the data is a continuing endeavor. Four additional major upgrades are planned over the next 16 to 18 months.

[2] The only records to which OSC auditors were denied access were grand jury materials, disclosure of which would be a felony as defined in Penal Law § 215.70.

(of the 80) cases because the process was excessively time consuming and because certain cases still needed to be redacted by Center staff, including the 9 cases (22 - 13) that contained both substantiated and unsubstantiated cases.

Second, OSC is prohibited, by law, from reviewing unsubstantiated records. The Justice Center's confidentiality statute, SSL § 496, expressly authorizes OSC's access to Justice Center investigation records, but only for "substantiated" cases:

> "[R]eports made pursuant to this article and found to be substantiated . . . shall be confidential and shall not be disclosed to any other party unless authorized pursuant to this section or any other applicable state or federal law. . . . In accordance with this section, such information shall be made available only to: . . . (t) officers and employees of the state comptroller, for purposes of a duly authorized performance audit, ..." (emphasis added). SSL § 496(2)

By contrast, a small number of identified individuals and entities are granted access to investigation records in cases that have been unsubstantiated, but the law is clear that OSC is not one of them. See SSL § 496(1). OSC is not identified in the statute as an entity authorized to see unsubstantiated case records; therefore OSC may not see unsubstantiated case records.

Moreover, OSC's assertion that this lack of access prevented it from achieving its audit objectives (Draft Report, p.7) is without merit. OSC had access to over 6,000 records of cases maintained in the VPCR. As OSC is well aware, the processes and procedures for the investigation of all abuse or neglect cases is identical, with the exception that additional information mandated by statute is necessarily required to be entered into the VPCR when an allegation of abuse or neglect is substantiated (e.g., the category of abuse or neglect, as set forth in SSL § 493[4]).

State Comptroller's Comment: While many of the Center's formal policies and procedures applied to both substantiated and unsubstantiated cases, absent the ability to perform any audit testing of a large majority of cases, there is no assurance that actual practices complied with the formal guidance with respect to the cases we could not review.

Thus, it is difficult to understand how the lack of access to investigative records in unsubstantiated and open/active abuse or neglect cases prevented OSC from being able to "test multiple aspects of the [Justice] Center's processes, procedures, and data that are critical to assessing its performance in relation to its mission."[3]

State Comptroller's Comment: As stated on pages 8 and 12 of our report, we

[3] With respect to significant incidents, responsibility for review of those allegations is delegated to the relevant SOA, and very little information about those incidents is maintained in the VPCR. Nor does the law set forth any procedures for review of these incidents. Indeed, for significant incidents, the only statutory requirement is that the Justice Center "shall maintain and keep up-to-date records of all incidents reported, together with any additional information obtained during an investigation of such a report and a record of the final disposition of the report." SSL § 492(4). Similarly, with respect to reports of abuse or neglect at out-of-state providers, SSL § 490(5) requires only that they be investigated, either by the Justice Center or the appropriate entity in the other state, and that a copy of the report be provided to the Justice Center and the placing or funding entity. Allegations in these cases are not substantiated or unsubstantiated. OSC was advised that there were 120 reports of alleged abuse or neglect at out-of-state providers during the audit period, but the confidentiality agreement did not permit it to access records in those cases.

were unable to determine the accuracy and completeness of the population of allegations and incidents, as well as perform a number of other audit tests that we deemed appropriate to accomplish our audit objective, due to our lack of access to open and unsubstantiated allegations and other VPCR data.

Finally, OSC expresses concerns about an alleged lack of transparency, accountability, and oversight of the Justice Center's performance, because of a pending lawsuit filed by Disability Rights New York seeking unfettered access to Justice Center investigative records. Notably, OSC has not stated whether it has reviewed either the legal issues in dispute in that lawsuit, or the impact on the integrity of investigations that could result when confidential information and sources are disclosed. In any event, provider agencies, SOAs, and service recipients (and their personal representatives) are routinely given access to Justice Center reports, as mandated by SSL § 496 and Mental Hygiene Law (MHL) § 33.25. And subjects against whom allegations of abuse or neglect are substantiated have the ability to challenge those findings. Moreover, Mental Hygiene Legal Services is given access to investigative reports in certain cases, as mandated by MHL § 47.03, and the Justice Center routinely releases statistical data pursuant to FOIL. Thus, it is hardly the case that the Justice Center is operating without accountability or oversight.

State Comptroller's Comment: As discussed on page 10, although we take no position in regard to the lawsuit filed by DRNY, the difficulties DRNY has reportedly encountered, coupled with our own inability to examine relevant records, clearly demonstrate that there is currently a lack of independent oversight of many aspects of the Center's performance.

III. **Findings and Recommendations Regarding Accuracy of VPCR Data**

OSC has identified a number of instances in which it contends that there are errors or inaccuracies in data maintained in the VPCR. However, it is unclear why OSC's report does not list the dozens of incident management system upgrades (including six major ones) that the Justice Center has implemented to either to correct or safeguard against data issues. The Justice Center specifically told OSC that during the audit period, it was working closely with the Office of Information Technology Services (ITS) .to implement another major release that would prevent a number of the known data entry errors from being made and to install a data reporting tool that would provide the Justice Center with the most current technology to create data reports. This VPCR upgrade became operational on April 7, 2016, and the data reporting tool is projected to become operational very soon. Thus, the Justice Center already addressed two of the three recommendations for corrective actions prior to OSC issuing its draft report. See Draft Report, p.11.

State Comptroller's Comment: On page 11, we clearly acknowledge that Center officials told us they were in the process of implementing a new reporting system, which, in the future, would eliminate some of the reporting errors we identified. We are pleased that the Center is now reporting that, subsequent to our fieldwork, some of these changes have become operational.

Responses to OSC's specific findings are set forth below.

A. Inaccuracies on Staff Exclusion List (SEL)

The Staff Exclusion List (SEL) is a list of employees who have a record of having committed serious and/or repeated abuse or neglect of service recipients. Specifically, employees with a

substantiated Category 1 finding, and employees with two substantiated Category 2 findings within a certain time period are placed on the SEL. People on the SEL are prohibited from working with people with disabilities who are under the jurisdiction of the Justice Center. Relevant agencies are required to check this list before making hiring decisions.

First, OSC alleges that five subjects were substantiated for Category 1 abuse or neglect but were mistakenly left off of the SEL. This is incorrect. The Justice Center provided evidence to OSC that conclusively established that none of these subjects should have been placed on the SEL. To the contrary, these cases involved either data entry errors (e.g., an indication that a subject had a Category 1 finding when he or she did not), or a failure to update an offense outcome when a Category 1 finding was modified upon the subject's appeal of the finding. Thus, none of these errors resulted in the failure to place a subject on the SEL, or in a subject being improperly cleared for employment during an SEL check.

State Comptroller's Comment: The Center's statement regarding the five subjects is incorrect. We do not assert that the five were mistakenly left off the SEL. In fact, on page 10 of the report, we clearly state that Center documentation showed the five subjects were not supposed to be on the SEL and that each only appeared so in our initial analysis because of erroneous or outdated information in the Center's VPCR data.

Second, OSC identified three subjects who were substantiated for Category 1 abuse or neglect who were mistakenly left off of the SEL for a number of months. The Justice Center confirmed they should have been included, but in doing so, found that none of these subjects were employed or working with residents during the time they were not on the SEL. In addition, by analyzing SEL checks for new job applicants that were performed by provider agencies, none of these three subjects had been hired at another provider agency because they were mistakenly left off of the SEL. Notably, the April 7, 2016 upgrade to the VPCR prevents this issue from recurring both by simplifying the process for placing a subject on the SEL and requiring that a subject with a Category 1 finding be placed on the SEL before the case can be closed. In addition, the Justice Center's Director of Internal Audit is in the process of improving internal controls to ensure the accuracy of the SEL.

B. Failure to Elevate a Second Category 2 Finding to a Category 1

A category 1 offense is serious physical abuse, sexual abuse or other serious conduct described in SSL § 493(4)(a). A category 2 offense is conduct that seriously endangers the health, safety or welfare of a service recipient. If an employee commits Category 2 conduct within three years of a prior finding that he or she committed Category 2 conduct, the second offense is elevated to a Category 1 offense. Persons with a Category 1 offense are placed on the Staff Exclusion List.

OSC suggests that two issues have led to subjects with multiple Category 2 findings not being placed on the SEL. First, OSC claims that subjects who should have a second Category 2 finding elevated to a Category 1 finding are escaping placement on the SEL, because of unacceptable delays in investigating and closing a prior case involving Category 2 conduct. Second, without identifying even one instance in which this occurred, OSC contends that because of the Justice Center's failure to ensure that each subject has only one "contact record," subjects with multiple qualifying Category 2 findings are not being placed on the SEL. The Justice Center strongly disputes both findings.

1. The length of time it takes to conduct an investigation is not indicative of error or a failure by the Justice Center.

It is both unfair and legally incorrect for OSC to conclude, based solely on the length of time that an investigation is pending, that the Justice Center has failed to meet a statutory mandate, and that such failure mistakenly led to subjects with multiple Category 2 findings not being placed on the SEL.

OSC's assertion that the Justice Center fails to meet a statutory mandate when an investigation takes more than 60 days to complete is incorrect as a matter of law. SSL § 493(1) states that the Justice Center "shall cause" its findings to be entered into the VPCR "[w]ithin sixty days of … accepting a report of an allegation of abuse or neglect. . . ." Recognizing that the integrity of an investigation may be compromised by imposing an artificial deadline,[4] the Legislature provided that the Justice Center "may take additional time to enter such findings into the [VPCR]; provided, however, that the reasons for any delay must be documented and such findings submitted as soon thereafter as practicably possible."[5] Accordingly, and despite OSC's suggestion to the contrary, the Justice Center has not violated its statutory mandate by taking additional time to conduct its investigations.

> **State Comptroller's Comment**: The Center's statement regarding "unacceptable delays" is incorrect. We do not state that investigations that take more than 60 days violate any statutory mandate, nor do we state that subjects with multiple Category Two offenses were mistakenly not placed on the SEL because the first investigation took more than 60 days. Rather, on page 9 we state that the timeliness of investigations is critical for Category Two offenses because a second Category Two offense in three years can be upgraded to Category One. Further, while we acknowledged that investigations are allowed to exceed 60 days, the reason for any delays must be documented. The Center did not provide documentation for any of the delays that we inquired about.

Indeed, the Justice Center provided OSC with a list of the types of circumstances that we frequently encounter during investigations that impact case closure cycle time. For instance, when law enforcement is involved and/or cases include criminal prosecutions, the Justice Center almost always allows those proceedings to proceed first, and puts its abuse and neglect investigation on hold. Similarly, when forensic evidence is needed (e.g., DNA, autopsy results), the timing of those processes are outside of the Justice Center's control. Other common issues affecting investigation cycle times include: the complexity of a case (e.g., multiple subjects or victims, a delay in reporting an incident to the Justice Center); witness unavailability; and difficulties in obtaining records.

Nonetheless, the Justice Center has made reducing case closure cycle times its highest priority, consistent with our mandate to ensure that cases are "fully and effectively" investigated. Measures to address this issue include: hiring additional staff, examining processes to make them more efficient, imposing stricter oversight and monitoring of staff involved in the incident management process, and providing additional support to investigators (e.g., leasing regional office space, purchasing additional vehicles). As a result, cycle times have been reduced dramatically during the three years of the Justice

[4] One expressed purpose for creating the Justice Center was to ensure that allegations are "fully and effectively investigated. . . ." Ch. 501, L.2012, p.3.

[5] OSC suggests that its limited access to VPCR information prevented it from evaluating whether the Justice Center was meeting this documentation requirement (Draft Report, p.9). It should be noted, however, that for any of the more than 6,000 substantiated cases identified by the Justice Center, OSC was given full access to VPCR information, including the field in which reasons for delay must be documented. Moreover, as a result of the April 7, 2016 VPCR upgrade, this field must be completed if an abuse/neglect case is still pending 60 days after the report of the abuse/neglect allegation was accepted. This ensures that, in all future cases, this statutory requirement will be fulfilled.

Center's existence.[6]

Additionally, OSC's assertion that subjects were mistakenly not placed on the SEL when they had repeat Category 2 findings, because their first investigation took more than 60 days to complete, is unfounded and untrue. While SSL § 493(4)(b) requires that a subject must have a previous Category 2 finding at the time he or she commits a second Category 2 offense in order for the second offense to be elevated to a Category 1 offense that would place the subject on the SEL,[7] the fact that a finding is not made within 60 days is simply not error. Indeed, as noted above, and especially in serious cases that result in Category 1 and 2 findings, there are likely to be complex legal and evidentiary issues that must be resolved as part of a full and effective investigation.

Indeed, there are a number of subjects who the Justice Center has found have engaged in multiple Category 2 conduct who do not qualify for placement on the SEL. Sometimes it is because the Category 2 conduct is committed during the same event, or it may be because the second event constituting Category 2 conduct occurs within days of the earlier offense. And sometimes it is because a full and effective investigation of the first event takes more than 60 days to complete. In either of these scenarios, because of the language of the statute, the second Category 2 conduct could never be elevated. As a result, OSC's conclusion that these failed placements are somehow in error is baseless.

State Comptroller's Comment: We do not state that subjects with multiple Category Two offenses were mistakenly omitted from the SEL because the first investigation took more than 60 days. Rather, on page 9 we state that the timeliness of investigations is critical for Category Two offenses because a second Category Two offense within three years can be upgraded to a Category One offense. We also acknowledged that an investigation is allowed to exceed 60 days; however, the reason why such investigation extends beyond 60 days must be documented. The Center did not provide documentation for any of the investigations exceeding 60 days that we inquired about.

2. No subjects have been left off the SEL because they have multiple contact records.

OSC cites no evidence to support its suggestion that because some subjects have multiple contact records in the VPCR, there have been "complications (including errors) when issuing notifications" of an investigation outcome (e.g., whether the allegations are substantiated or unsubstantiated) (Draft Report, pp. 10-11).[8] To the contrary, the only possible error that could exist would be if the Justice Center failed to recognize that a subject had a prior qualifying Category 2 finding, because that finding was entered on a duplicative contact record. The Justice Center has controls in place to prevent that from occurring, and there is no evidence to indicate it has occurred.

[6] Initially, case closure cycle times were impacted by having to create a new agency in a short time frame, including hiring sufficient staff. Moreover, the volume of abuse and neglect reports has been higher than anticipated.

[7] This statute operates in a similar manner as criminal statutes that allow multiple felony offenders to receive enhanced sentences. See, e.g., Penal Law § 70.06(1)(b)(ii) (sentencing for a second felony offender). The theory is that an enhanced sentence is appropriate only when an offender knows that he or she may receive such a sentence and nonetheless commits a second or subsequent offense. For that reason, the determination letters that the Justice Center sends to subjects who receive a Category 2 finding warn them that a subsequent Category 2 finding will be elevated to a Category 1 finding and result in their placement on the SEL.

[8] A contact record or "contact ID" is created for each person associated with a case, and includes both contact information (e.g., address, telephone number), and his or her "role" in that case (e.g., victim, subject, witness). Whenever it can be verified that the same person should be associated with another case, the same contact record is used.

State Comptroller's Comment: On February 3, 2016, Center staff told us that investigators are supposed to check to see if the person is already in the VPCR before creating a contact record for them. Sometimes, however, this does not happen, and consequently multiple contact entries are entered for the same individual. For example, one subject had three different Contact ID numbers, even though the name was the same and the Social Security numbers differed by only one digit.

The Justice Center goes above and beyond its statutory requirement by attempting to create unique contact records for subjects (as well as service recipients, witnesses, and other persons named in the VPCR).[9] It can, however, be difficult to match a new suspect with an existing contact record when a new report is made to the VPCR. For example, reporters who are calling in allegations of abuse or neglect often do not know how to spell the subject's name, and we have even discovered that provider agency records often contain multiple spellings of the names of service recipients, staff members, and personal representatives. It also can be difficult to determine whether two people with similar, or even identical, names are the same person. Indeed, at one time OSC suggested that the Justice Center had mistakenly left two subjects off of the SEL, because each had two qualifying Category 2 offenses. After reviewing the contact records created for those Category 2 subjects, the Justice Center was able to determine that, in fact, the Category 2 findings were made against four different people who had similar names.[10]

State Comptroller's Comment: The Center's comments relate to inquiries we made and resolved during our fieldwork. None of these particular inquiries resulted in audit findings or issues detailed in the draft audit report.

The Justice Center is continuing to work to eliminate multiple contact records. In conjunction with ITS, the Justice Center is exploring all available technology options as well as ongoing training for call center agents.

C. Other Data Integrity Issues

OSC has identified two other data-related issues, both of which the Justice is already actively addressing. First, OSC notes that certain VPCR fields had been left blank, including Social Security numbers for some suspects and dates of significant events. Second, it suggests that erroneous contact information in the VPCR has resulted in notification and determination letters being mailed to the wrong person.

[9] SSL § 492(5)(a) expressly requires each report of a reportable incident to be assigned a "unique identifier" in the VPCR, but nothing in the law required the Justice Center to assign a unique identifier to each contact record created in the VPCR.

State Comptroller's Comment: Although the statute may not require this, it is the Center's policy to do so. Accordingly, the assumption when examining VPCR data is that each Contact ID should represent a different individual.

[10] OSC is simply wrong in suggesting that duplicate contact records probably belong to the same person because they "had the same Social Security number" (Draft Report, p.10). In fact, the VPCR prevents two contact records from having the same Social Security number.

State Comptroller's Comment: We found four instances of different Contact ID numbers that had the same name, but Social Security numbers that differed by only one digit. These appeared to be typographical errors since, although not impossible, it is highly unlikely that different people with the same name received virtually the same Social Security numbers in all of these cases. We do, however, agree that it can be difficult to determine after the fact whether the same or multiple people were involved in these cases.

With respect to Social Security numbers, the Justice Center makes its best efforts to obtain this information. Among other efforts, the Justice Center is continuously working with agencies to remind them of their statutory obligation to provide this information. With respect to other blank VPCR fields, the April 7, 2016 VPCR upgrade mandates that certain critical fields be completed before a case may be closed. Going forward, there should be no additional blank fields.

As for contact information, the Justice Center makes its best efforts to obtain, document, and verify contact information so that it can make required notifications. But as OSC is well aware, there are a number of reasons why information provided to the Justice Center may be incorrect or inaccurate: people move (especially subjects who are terminated from employment during an investigation); providers are unable to provide accurate contact information for employees and personal representatives; and data entry errors. The Justice Center takes extensive steps to verify addresses before determination and notification letters are mailed, including checking publicly available and other electronic websites (e.g., LexisNexis) in order to verify addresses. [11] In addition, an address cannot be entered into the VPCR unless it is verified by software matching the address to a recognized U.S. Postal Service address. Justice Center investigators also routinely ask subjects for their addresses during questioning.

State Comptroller's Comment: On March 29, 2016, the Center's General Counsel told auditors that erroneous contact information had previously caused the Center's notification letters (advising persons that they were subjects of investigations or of the results of such investigations) to be sent to the wrong individuals.

D. Challenges with Data Reporting

Finally, the Justice Center informed OSC that some of the published Justice Center data has been determined to be inaccurate. This is an aberration, and the Justice Center is implementing numerous safeguards to ensure it does not happen again. The Justice Center has been working with ITS continuously to improve our data-reporting capabilities, including implementing a data-reporting tool that will allow us to produce more robust and accurate reports. The tool will be fully implemented within the very near future.

IV. Recommendations

OSC makes three recommendations:

1. Develop and implement controls to ensure all subjects with substantiated Category 1 offenses are promptly added to the SEL.
2. Develop and implement procedures to provide reasonable assurance that data contained in the VPCR database is accurate, including procedures to periodically review and analyze the accuracy of the data and correct any inaccuracies discovered.
3. Correct previously published data and reports to the extent practicable.

As noted throughout this response, the Justice Center has already taken steps to address the first two recommendations. In addition, we continue to work with ITS on further improvements to

[11] OSC states that Justice Center officials advised it that erroneous contact information had resulted in letters being sent to the wrong person (Draft Report, p. 11). While that has occurred in some instances, largely as a result of errors created by contact records "merging" technology that itself created errors in the VPCR data, in the vast majority of cases, letters with incorrect addresses are returned to the Justice Center, where efforts are made to locate a valid address and re-send the letters.

the VPCR, and have plans for four additional major upgrades to the system during the next 16 to 18 months. With respect to recommendation 3, our preliminary assessment is that it is not practicable to correct previously published data and reports, which reflect "point in time" data. Once the new data reporting tool becomes operational, we will re-assess the practicality of updating those reports

Please feel free to call me with any questions.

Very truly yours,

Jay Kiyonaga
Executive Deputy Director