Guidance for Incident Reporting to the Justice Center/VPCR & OASAS
14 NYCRR Part 836
Updated: May 2024

I. Duty to report incidents; Justice Center Guidance (incorporated by reference)

a. Duty to report; obstruction of reports or failure to report is abuse and neglect.

New York state law requires all "mandated reporters" (a "custodian" or a human services professional) to report to the VPCR "immediately" (see Section IV for strict requirements for when a provider may delay reporting no more than 24-hours) whenever they have reasonable cause to suspect a reportable incident has occurred. Due to the seriousness of this matter for all concerned, providers must develop clear detailed policies and procedures to ensure staff are well informed of their responsibilities and obligations and to avoid intentional obstruction of reports or effective obstruction of reports.

A mandated reporter's **FAILURE TO REPORT** or **INTENTIONAL OBSTRUCTION OF A REPORT** of a suspected reportable incident to the VPCR is a serious matter with consequences to an individual and to a program's operating certificate including discipline, termination, loss of a credential or certification, prosecution (class A misdemeanor), and/or civil liability for damages proximately caused by a failure to report.

Obstruction of reports or failure to report immediately **IS considered a reportable incident of abuse and neglect**. Obstruction means conduct which impedes the discovery, reporting or investigation of the treatment of a service recipient and could be intentional, or the consequence of policies and procedures that are not consistent with the plain English requirements of the law.

See more information in the following Justice Center Guidance document "What to Expect if You are Involved in a Justice Center Investigation":
August 2018 Justice Center

b. Guidance documents; FAQs, and other Justice Center resources.

The Justice Center Guidance documents are sorted by subject and updated on a regular basis. These documents are the functional equivalent of OASAS Guidance with the same applied weight and consequences to OASAS providers as OASAS regulations. Resources can be found on the OASAS Justice Center information webpage:
https://oasas.ny.gov/providers/oversight-and-monitoring

II. 14 NYCRR Part 836

Reporting certain events to the Justice Center or to the Office of Addiction Services and Supports ("OASAS" or the "Office") is required by law. The purpose of reporting and subsequent

investigations (JC or OASAS) is to ensure that persons receiving services ("service recipients" or "SRs") who are compromised physically, mentally and emotionally are protected from ***avoidable actions or inaction of staff*** who are entrusted with their care ("custodians") or other persons near them in the course of their treatment ("mandated reporters") who would have opportunities to cause them harm (physical and mental). Incidents are reportable (abuse or neglect, or significant) to the Vulnerable Persons' Central Register (VPCR) or non-reportable.

Non-reportable incidents may be of clinical or operational importance to a specific patient, the patient population, or to the program operation and therefore, if not reported to the VPCR, should be documented and available for review by a program Incident Review Committee, OASAS, or the Justice Center upon request.

OASAS programs are unique among agencies under the jurisdiction of the Justice Center because of the voluntary nature of admission. Selected OASAS incidents and guidance to help determine whether they are reportable or non-reportable may be found in the next section.

III. Selected OASAS incidents; reportable vs. non-reportable

a. "Missing client" – Residential /Inpatient programs only; section 836.4(c); 836.4(u); 836.8(d)

i. A "missing client" could be the result of **neglect IF** the SR required *24/7 staff supervision* and the client's whereabouts is unknown because of staff failure to supervise; or

ii. A "missing client" (client over the age of eighteen) could be a ***significant incident IF*** the SR has not been accounted for when and where such client expected to be present and, after ***48 hours***, whose location has not been determined by means of immediate and appropriate diligent efforts; or

iii. A "missing client" under the age of eighteen could be a ***significant incident IF*** the SR has not been accounted for when and where such client is expected to be present and, after ***24 hours***, whose location has not been determined by means of immediate and appropriate diligent efforts.

A "missing client" is **NOT** a service recipient who "leaves against medical advice" or is "administratively discharged" or who chooses to leave treatment and makes their choice known (examples of making choices known may include, but not be limited to, missing belongings, comments to a fellow SR of their intent to leave, failure to return from a pass after informing other SR or the program of intent to not return, or SR seen getting into a friend's car with gesture or language indicating they are not returning). Providers should always take responsible action, pursuant to program policy and considering confidentiality, to reach out to an SR's emergency contact to verify the SR's safety.

b. Emergency room visits (general medical event); section 836.4(a); 836.6(b), 836.4(c)

Justice Center reporting is concerned with *avoidable action or inaction of staff* such as an "accident or injury" to an SR caused or exacerbated by staff action or inaction. A hotline call to the VPCR should be made immediately when a physical injury—or physical abnormality—cannot be explained because of the extent and/or location of the injury, number of injuries at one time, or frequency of injuries over time.

A general medical event (i.e., seizures heart pains, labor pains, toothache), requiring hospitalization or not, is **not reportable** provided it is readily apparent that staff responded appropriately (*did not exacerbate the injury or medical condition*) and appropriate medical attention was provided.

A general medical event **is reportable** if:

(1) SR overdose is suspected, or the SR was found unresponsive (may be due to staff failure to screen for items that may create an unsafe environment, do a room check, or monitor night security); or
(2) Action or inaction of staff contributed to a medical event (i.e., known heart condition and failure to provide medication, patient's repeated complaints of abdominal pain and staff failure to consider appendicitis, or patient admitted with a toothache which is not addressed and becomes infected);
(3) Action or inaction of staff contributed to an injury (known environmental hazard and failure to remedy; encouraged or initiated a fight between SRs).

c. Items That May Create an Unsafe Environment (formerly referred to in OASAS settings as "contraband"); section 836.4(d)(3)(i); 836.4(a), 815.10

Items that may create an unsafe environment in OASAS programs can be life-threatening; possession of some items may be illegal or the result of medication (controlled substances) diversion. Patients in voluntary programs may have the right to be free from unnecessary and unauthorized screening. However, programs must have policies related to screening patients upon admission and upon return to program facilities after being off campus; policies should include refusal to admit or possible discharge if patients don't consent to a reasonable screen.

Discovery of items that may create an unsafe environment found on an SR during an intake screening or upon return to a facility is **not reportable** provided *staff followed program screening policies and protocols for confiscation*.

Discovery of items that may create an unsafe environment on an SR or within the program population **is reportable** if:

(1) Items were not discovered upon intake or upon return to the program because staff *did not follow program screening policies and protocols*; or
(2) Controlled substances are found among the patient population (SR is selling or giving their medication to other SRs) and *staff did not follow proper protocol for medication administration*.
(3) After a report is made the Justice Center, discovery of items that may create an unsafe environment may be recorded as an internal program incident for review by the Incident Review Committee which, if a pattern is observed, might recommend revising a program's policies and procedures regarding screening.

d. SR to SR: physical altercation, 836.4(d)l verbal arguments or threats

A reportable significant incident can be conduct between SRs if it would constitute abuse as defined in 836.4(c)(1-7).

Physical violence between SRs ***could be*** the result of ***neglect***, regardless of injury **IF** staff had ***a duty*** to supervise and failed to do so (i.e., knew the specific SRs could be aggressive and failed to keep them apart, or encouraged the violence between SRs, or failed to intervene appropriately to prevent injury **AND** such failure resulted in conduct between the SRs that would constitute abuse as defined in 836.4(c)(1-7).

Verbal threats or arguments with no physical altercation could be psychological abuse but are **not reportable** if staff responded appropriately (i.e., intervened to separate SRs, discharged

SRs). Verbal threats or arguments may be a clinical concern affecting a patient's recovery and, if so, should be recorded in the patient record.

e. Consensual sex between service recipients

Consensual sex between adult service recipients is **NOT** reportable. However, such relationships may create obstacles to recovery for both participants and may adversely affect the therapeutic environment of a program. If so, such conduct may be recorded in a patient record or in a program internal incident reporting log.

f. Non-consensual sex between service recipients

Non-consensual sex is a criminal act (sexual assault or rape) and is **reportable**. Providers should also contact the police.

g. Children residing in programs with parents in treatment

Any incidents involving children in a program are **reportable**. Incidents involving children may require multiple notifications (SCR, police, court/probation).

h. Death of a client

Death of a client in an inpatient or residential program under any circumstances, or within 30 days of discharge is **reportable** and must be reported immediately to the Justice Center on Justice Center approved forms (https://www.justicecenter.ny.gov/reporting-incident). If the patient death is suspected to have resulted from abuse and neglect, the death must also be reported to the VPCR as an incident.

Death of a client in an outpatient program while the patient is on program premises or during the conduct of program, activities is a significant incident and is **reportable**.
NOTE: Outpatient programs need not report deaths of clients within 30 days of discharge; however, nothing precludes a program from reporting if the program determines it is something OASAS should be aware of.

i. Failure to report; obstruction of reporting is abuse and neglect

A mandated reporter is **obligated to report** another mandated reporter's failure to report an incident "immediately" upon discovery and to report any efforts by custodians to intentionally prohibit reporting or investigation by the Justice Center or OASAS of an alleged incident. Each mandated reporter is **individually responsible** to report to the VPCR and **must not be** required by program policies and procedures, either in writing or in practice, to report to a supervisor or program director before reporting an alleged incident. Policies and procedures making this requirement in contradiction of statute could subject a program to revocation of its operating certificate or serious personal and professional consequences to a mandated reporter.

IV. Abuse and Neglect reporting

All reporting to the Justice Center is premised on the immediate interruption and prevention of mistreatment of persons receiving services in OASAS programs. Because of the seriousness of this matter for all concerned, providers should develop clear and detailed policies and procedures

based on OASAS and Justice Center regulations and guidance and ensure that all staff are well informed of their responsibilities and obligations to safeguard patients in their program at all times. The following explains some terms essential to an appropriate process:

An incident report must be initiated, or a call made by a mandated reporter to the VPCR immediately after a reportable incident is *discovered*. Every mandated reporter who has direct knowledge of an incident and has *reasonable cause to suspect* that a person receiving services has been subjected to a reportable incident is required to make a report to the VPCR unless they have **"actual knowledge"** that the incident has already been reported to the VPCR and that they have **"actual knowledge"** that they were named in that prior report as a person with knowledge of this incident.

1. **"Discovery"** occurs when a mandated reporter has reasonable cause to suspect that a service recipient has been subjected to a reportable incident. Discovery may be by direct personal observation or notice from another person that provides the mandated reporter with "reasonable cause to suspect" that an SR has been subjected to a reportable incident.
2. **"Reasonable cause to suspect"** does not require conclusive evidence that the incident occurred; a rational or sensible suspicion is sufficient and may be based on the mandated reporter's observations, training and experience, and the mandated reporter's disbelief of an explanation provided for an injury.
3. **"Actual knowledge"** means the mandated reporter must have a direct and clear awareness that the report was made, such as witnessing, reading or overhearing the report being made to the VPCR. Actual knowledge may also include circumstances in which someone who has reported an incident to the VPCR informs the would-be-reporter that the report was made to the VPCR and the would-be-reporter was named in the report. If the mandated reporter maintains any doubts as to whether the report was made, or whether they were named in the report that was made, the mandated reporter must report the incident themselves.

Delayed "discovery": Upon notice to the Office, providers may delay "discovery" for no more than twenty-four (24) hours in order to conduct a preliminary review of an allegation of abuse and neglect under circumstances in which:

1. The person making the allegation of abuse or neglect has a documented history of making false reports of abuse or neglect and no other person has come forward as a witness to such allegations, or
2. The person making the allegation of abuse or neglect has a documented behavioral or psychological condition that would tend to cause such person to make a false report of abuse or neglect and no other person has come forward as a witness to such allegation.

Any delayed discovery of an allegation of abuse or neglect must be documented (and available to the Justice Center and the Office upon request) with the reasons for such delay in any subsequent report to the Justice Center or the basis for a determination not to report.

V. Significant incidents unique to OASAS (reportable)

Significant incidents, as defined in 836.4(d), are **always reportable** to the VPCR because they have the potential to affect the health, safety or welfare of persons receiving services.

836.4(d)(3) includes the following additional significant incidents that do not fall under the jurisdiction of the Justice Center because they are unique to OASAS programs and the OASAS patient population. OASAS requires they be reported to the VPCR for OASAS investigation:
(1) Events that are, or appear to be, a crime under NYS law;

(2) Violations of harm (**violations may incur additional federal penalties);**
(3) Body cavity search;
(4) Missing clients, as defined in the regulation;
(5) Suicide attempts;
(6) Death of an employee or volunteer during the course of duties related to the program.
(7) Federal law: any breach of 42 CFR Part 2 confidentiality protections or HIPAA.