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DOI INVESTIGATION OF CHILD FATALITIES AND OTHER INJURIES REVEALS LEGAL AND PRACTICE VIOLATIONS BY THE CITY ADMINISTRATION FOR CHILDREN'S SERVICES

Data Obtained by DOI Further Supports Concerns about Quality of Child Protection Investigations and Permanency Planning for Children

Investigation Concludes in Certain Case that ACS Failures "May Have Contributed" to the Harm Suffered by Involved Children

Mark G. Peters, Commissioner of the New York City Department of Investigation ("DOI"), today issued a Report on child welfare services provided by the City Administration for Children's Services ("ACS") and its contracted non-profit provider agencies. The Report, following an 18-month long investigation, revealed investigatory failures and deficient casework, lax oversight of foster care providers, and a lack of data collection by ACS making it impossible to identify and/or track problems. These failures outlined in DOI's Report raise serious concerns over whether ACS and its provider agencies missed multiple opportunities to effectively intervene before a child died or nearly died.

DOI's review of three cases involving children and families previously known to ACS — two fatalities and one near fatality — and its examination of available ACS data, revealed serious problems regarding several of ACS' core responsibilities, specifically: Properly investigating allegations of child abuse and neglect; protecting children's safety and well-being while the family is involved with ACS; timely discharging children who are in ACS' custody to permanent homes; and making safe and appropriate decisions to return children back to the homes where they suffered abuse. DOI uncovered a severe lack of ACS oversight, noncompliance with state and federal laws, and failures to implement ACS policies and procedures, all of which are designed to protect the safety and well-being of New York City's children. DOI issued a series of recommendations and referrals for discipline of ACS staff, including strengthening ACS' oversight to ensure more rigorous investigations in cases where ACS has been involved with the same family on a recurring basis; following the law by reporting abuse and neglect allegations into the state-mandated hotline in order to trigger investigations; and calling on ACS to better track specific data sets and provide critical information to DOI going forward. ACS has now accepted many of these recommendations. A copy of DOI's Report follows the release and can be found here: <http://www.nyc.gov/html/doi/html/doireports/reports.shtml>

DOI Commissioner Mark G. Peters said, "ACS is the first line of defense for the defenseless. DOI's investigation found that on several occasions ACS and its provider agencies failed to take necessary steps to protect children and at times may actually have put them in harm's way. Equally troubling, data obtained by DOI suggests that these are not isolated instances and that ACS may have repeatedly failed to meet legal and procedural requirements. Through DOI's recommendations, ACS must address these concerns swiftly for the thousands of children who rely on its services as a lifeline."

This is the second Report by DOI in as many months highlighting management failures at ACS. Last month, DOI issued a Report focusing on deficiencies in ACS's oversight of the Close to Home juvenile justice program, specifically, failures on a systemic level regarding site inspections, and insufficient safety and security protocols at non-secure contract agency juvenile facilities, including Boys Town New York, the contract agency at the center of a June 2015

more

incident where three teens escaped from a Boys Town-operated home in Brooklyn and later raped and robbed a woman in Manhattan. DOI arrested five individuals in connection with that Report.

As part of this investigation, DOI conducted an extensive document review, interviewed professionals who worked on the cases, and studied available ACS data in order to evaluate the scope of the agency breakdowns. Through this review, DOI determined that by failing to follow basic protocol and conducting inconsistent investigations and casework, ACS, its staff and foster care providers failed to prevent the harms caused to three children and their siblings.

DOI focused on the following three cases (and changed the names of the children to protect their confidentiality), which illustrate specific failures and broader issues that question the agency's compliance with its own investigations mandates and its handling of those investigations:

- 1: "Chris," who was severely malnourished and sustained a life-threatening injury during an improperly conducted ACS investigation.
- 2: "Morgan," who died suspiciously after years of ACS intervention and earlier ACS findings that the child was neglected.
- 3: "Alex," whose mother beat the child to death after years of ACS intervention and after an ACS provider agency returned Alex to the dangerous home.

DOI found that in these cases ACS and its provider agencies, respectively, failed to:

- Ensure that staff contact the Statewide Central Register of Child Abuse and Maltreatment (known as the hotline) to report allegations of child abuse and neglect, required by the New York State mandated reporter law that requires them to call in such allegations to trigger an investigation;
- Prevent, as a matter of policy, new child abuse and neglect investigations from being assigned to the very ACS caseworkers already providing services to the families being investigated, thus requiring caseworkers to investigate their own actions;
- Identify and address high risk issues, including chronic neglect, repeated child abuse and neglect as well as food deprivation;
- Follow basic casework practice requirements intended to ensure child safety and well-being;
- Adequately oversee its foster care provider agencies to ensure that they follow all laws and ACS policies and procedures, and make appropriate decisions regarding children's safety, well-being, and discharge from foster care.

Additionally, DOI also confirmed that two issues it identified were systemic, despite the minimal amount of systemic data ACS was able to provide on the relevant issues. Specifically:

1. Consistent with the findings in DOI's review of cases, ACS data shows that 16% of children who ACS determined were abused or neglected, were subsequently abused or neglected again within a one-year period. This re-abuse statistic has not changed over the last four years, and fails to meet the state's target for this measure of 7%. This raises serious concerns regarding the quality of ACS interventions and ACS' ability to keep children safe and protect them from future abuse.
2. DOI's case reviews also raised concerns with whether ACS' foster care provider agencies, under the agency's oversight, file timely petitions to terminate parental rights in accordance with federal and state law. The laws require that petitions to terminate parental rights must be filed for children who have been in foster care for 17 of the last 22 months – to ensure children do not linger in foster care – unless there is a documented exception.

ACS data DOI reviewed shows ACS consistently fails to ensure that its foster care provider agencies meet that legal timeframe. For the last three fiscal years, 82% of children who had been in ACS custody for 17 of the last 22 months and for whom there was no documented exception, did not have petitions to terminate parental rights filed timely on their behalf. ACS is responsible for ensuring that its foster care provider agencies, which file these petitions, meet this mandate yet, each year, petitions to terminate parental rights for more than a thousand New York City

children are not filed within the time limits prescribed by law, totaling 3,711 children over the last three years.

Both during and at the conclusion of this investigation, DOI provided ACS with a number of policy and practice recommendations, the most important of which are summarized below. ACS declined to take disciplinary action with respect to six of the seven individuals whose conduct DOI also referred to ACS for possible action. ACS has accepted many, but not all, of these recommendations:

1. Within the next 30 days, address potential conflicts of interest by developing a new Child Protective Services (“CPS”) case assignment policy requiring new investigations involving families who are receiving Court Ordered Supervision to be assigned to CPS investigators who do not also carry Court Ordered Supervision cases.
2. Within the next 30 days, ensure all critical case information is available to all ACS investigative staff, by developing a policy requiring all relevant information and/or findings its Investigative Consultants have identified be documented in CONNECTIONS, a computer system maintained by the New York State Office of Children and Family Services, which allows individual cases to be tracked from intake through the conclusion of the investigation.
3. Improve ACS’ oversight of its provider agencies by providing DOI with routine updates regarding the implementation of its improved oversight plan, including providing DOI with the necessary new and/or revised policies, procedures, and training protocols associated with this plan, as well as ACS’ projected goals and any tools and/or data it uses to measure progress.
4. Ensure that ACS takes appropriate disciplinary actions when necessary, by revisiting its decisions not to discipline ACS employees involved in the child Chris’ case and develop a new policy whereby ACS either suspends employees who are under review for potential disciplinary action from performing casework responsibilities or provides additional oversight of their performance as these reviews are taking place.
5. Provide to DOI, quarterly, specific data necessary to evaluate important systemic performance issues. ACS and DOI will determine the specific data indicators.

Commissioner Peters thanked ACS Commissioner Gladys Carrion and her staff for its cooperation with and assistance in this investigation.

The investigation was conducted by DOI’s Office of the Inspector General for ACS, including Assistant Inspector General Katy Diaz-Espinal, Assistant Inspector General Christos Hilaras, Deputy Inspector General Jessica Nowlin, and Senior Special Investigator Laurie Bensky, under the supervision of Inspectors General Shelley Solomon and Milton Yu, Special Associate Commissioner Susan Lambiase, Deputy Commissioner/Chief of Investigations Michael Carroll, and First Deputy Commissioner Lesley Brovner.

DOI is one of the oldest law-enforcement agencies in the country and New York City’s corruption watchdog. Investigations may involve any agency, officer, elected official or employee of the City, as well as those who do business with or receive benefits from the City. DOI’s strategy attacks corruption comprehensively through systemic investigations that lead to high-impact arrests, preventive internal controls and operational reforms that improve the way the City runs.

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New York City Department of Investigation

**Report on ACS Policy and Practice Violations
Identified in Three Child Welfare Cases and
Related Analysis of Certain Systemic Data**

**MARK G. PETERS
COMMISSIONER**

April 2016

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I. EXECUTIVE SUMMARY

The New York City Department of Investigation (DOI) has completed intensive reviews of three cases involving children and families known to the Administration for Children's Services (ACS)—two fatalities and one near fatality—and examined available systemic ACS data, which together have provided important investigative findings regarding several of ACS' core responsibilities:

- Investigating allegations of child abuse and neglect;
- Ensuring children's safety and well-being; and
- Timely discharging children who are in ACS' custody to permanent homes.¹

The three cases DOI reviewed involved one young child who was killed by her parent, another young child who died at home under suspicious circumstances, and a pre-adolescent child who nearly died from a traumatic injury after his parents repeatedly deprived him of food and physically abused him.² In each case, these families were known to ACS prior to each child's death or near-death. ACS found credible evidence of abuse that was directly related the child's death or near-death in two of the three cases and found credible evidence of neglect that it could not tie directly to the child's death in the third case.

Following extensive document reviews and interviews with approximately 20 professionals who worked on the cases, DOI uncovered violations of two laws and numerous ACS policies and procedures, all of which are designed to protect the safety and well-being of New York City's children and ensure that children do not linger in ACS' custody. These lapses, committed by both ACS staff and staff employed by two of the agencies with which ACS contracts for the provision of foster care services, may have contributed to the harms the children in these families suffered. In each case, ACS had multiple opportunities to effectively intervene before a child died or nearly died, but did not do so.

In order to evaluate the scope of the violations found in the three cases reviewed, DOI expanded its inquiry by reviewing available systemic ACS data. In some instances, this data revealed systemic concerns, including violations of law. However, in many instances, DOI could not determine whether the violations identified in the three cases are systemic because ACS does not collect the necessary data.

¹ Pursuant to the City Charter, DOI is the independent Inspector General for ACS. As such, DOI conducts reviews of fatalities/near fatalities of children known to ACS.

² Throughout this report, specific case information is presented so as to protect the confidentiality of the children and their family members. For example, gender neutral pseudonyms are used for all children, and the gender referred to has been randomly assigned.

Through its investigation of the three cases, DOI found that, either repeatedly in a single case or in more than one case, ACS failed to:

1. Adhere to the New York State law that requires ACS staff to contact the Statewide Central Register of Child Abuse and Maltreatment (known as the hotline)³ to report allegations of child abuse and neglect and ensure that its foster care provider agency staff also contact the hotline to report allegations.⁴
2. Prevent potential conflicts of interest because, as a matter of policy, ACS assigns new child abuse and neglect investigations to caseworkers who are already providing services to the families being investigated and thus these caseworkers may be investigating their own actions.
3. Identify and address high risk issues, including children who experience repeated abuse and neglect and food deprivation.
4. Follow basic casework practice requirements intended to ensure child safety and well-being.
5. Adequately oversee its foster care provider agencies to ensure that these agencies follow all laws and ACS policies and procedures, and make appropriate decisions regarding children's safety, well-being, and discharge from foster care.

Based on the minimal amount of systemic data ACS was able to provide, DOI did find that two of the issues that it identified in the three cases are also systemic within the child welfare system.

1. In the two fatality cases, DOI found that ACS repeatedly investigated abuse and neglect allegations—often the same or similar allegations—within a family, both within short periods of time as well as over many years, and found credible evidence that the children had been repeatedly abused and neglected. The repeated investigations of these families provided ACS with numerous opportunities to identify and appropriately address the ongoing abuse and neglect prior to the children's deaths. DOI concluded that ACS staff often did not thoroughly review all of its own prior investigations and/or records related to the provision of services regarding these families, complete comprehensive assessments of the families' current functioning, or properly intervene to protect the children. Instead, ACS provided the same, evidently ineffective, services

³ New York State, Office of Children and Family Services, Child Protective Services, <http://ocfs.ny.gov/main/cps>. The New York State Office of Children and Family Services (OCFS) is the state-level agency responsible for programs and services involving child protective services, preventive services, foster care, and adoption, among others, and it operates the statewide child abuse and maltreatment hotline.

⁴ N.Y. SSL § 420.1; N.Y. SSL § 413.

over and over. In the third case, ACS staff failed to complete all required investigative actions timely, and the child was repeatedly abused and neglected while ACS was investigating the first set of allegations.

Systemically, ACS data shows similar concerns. Specifically, 16% of children who ACS previously determined were abused or neglected were, nevertheless, abused or neglected again within a one-year period. The State's target for this measure is 7%.⁵ ACS is obligated, after the first abuse/neglect finding, to provide necessary services and supports, including removing children from their homes and placing them in foster care when necessary to prevent re-abuse. This finding, that 16% of children are re-abused or neglected within one year, which is more than double the State's target for this measure, has remained unchanged for the last four years.⁶

2. In one of the three cases DOI reviewed, ACS delayed filing a motion asking the family court to release the foster care provider agency from having to make "reasonable efforts" to reunite the surviving siblings with their mother, who had killed their sibling, efforts which are otherwise required by federal and state law.⁷ These motions are "used in situations where the parent's past conduct has been so harmful that reunification would be contrary to the health and safety of the child"⁸ and releasing the foster care provider agency from the obligation to make "reasonable efforts" allows for a more rapid process for discharging a child from foster care to a permanent home. However, in this case, ACS failed to make this motion for 71 days, despite the mother's conviction for killing her child, and only did so after DOI pressed ACS on the issue. This delay was unwarranted and violates ACS policy.⁹

ACS' violation of this policy raises concerns more generally about whether ACS and its foster care provider agencies, under ACS oversight, file timely petitions to terminate parental rights in accordance with federal and state law. For many children who cannot return home safely, the goal is to discharge those children from foster care to adoptive homes, which first requires that their parents' rights

⁵ ACS, Division of Policy, Planning and Measurement, Building a Collaborative Vision in 3D: Data Discussion Determination (2016), at 29.

⁶ The City of New York, Mayor's Management Report (Sept. 2015), at 186.

⁷ Adoption Assistance and Child Welfare Act (ASFA) of 1980 (P.L. 96-272); New York State's ASFA enabling legislation (Chapter 7 of the Laws of 1999, enacted Feb. 11, 1999).

⁸ Memorandum from John B. Mattingly, Commissioner, ACS, to ACS staff, and Foster Care Provider Agency Executive Directors, Adoption and Safe Families Act Permanency Plan – Adoption (Sept. 30, 2006), at 1.

⁹ Memorandum from Ronald Richter, Commissioner, ACS, to All ACS attorneys, ACS Policy on 1039-b Motions (June 26, 2006).

be terminated. In order to ensure that these children do not linger in foster care, federal and state law require that petitions to terminate parental rights be filed for children who have been in foster care for 15 of the last 22 months, unless there is a documented exception.¹⁰ However, the federal government actually uses a 17-month timeframe, which is 15 months plus 60 days after the child was removed from their home.¹¹

ACS data shows that, system-wide, ACS consistently fails to ensure that its foster care provider agencies meet these legal requirements. For the last three fiscal years, 82% of children who had been in ACS custody for 17 of the last 22 months and who did not have a documented exception, did not have petitions to terminate parental rights filed timely on their behalf. ACS is responsible for ensuring that its foster care provider agencies, which file these petitions, meet this mandate. Yet, each year, exceptions are not documented and petitions to terminate parental rights are not filed within the time frames prescribed by law for more than a thousand New York City children, totaling 3,732 children over the last three years.¹²

These two systemic violations, as well as the many case-specific findings DOI made, raise serious concerns regarding ACS' ability to ensure that children are safe, well-cared for, and being placed in permanent homes without delay. Further, in many instances, ACS simply fails to collect data regarding its compliance with law and its own policies and procedures—a failure that is, itself, concerning. Due to the lack of data, DOI was unable to assess system-wide performance in numerous critical areas DOI identified in these cases. More importantly, because ACS does not collect and, therefore, cannot track these data, DOI found that ACS is unable to systemically monitor compliance with important legal, policy, and procedural requirements, substantially limiting its ability to identify areas in which targeted reforms are needed. DOI notes in this regard that the concerns raised by this investigation relate not only to line-level workers but to all levels of ACS administration, including the most senior officials.

¹⁰ P.L. 105-89, Title 1, § 103(a)(3)(E); N.Y. SSL § 384-b.

¹¹ “In accordance with section 475(5)(f) [of the Social Security Act], a child is considered to have “entered foster care” (for the purposes of starting the clock for the 15 of 22 months) on the earlier of: (1) the first judicial finding that the child has been subjected to abuse and/or neglect, or (2) the date that is 60 days ... after the date on which the child is removed from the home.” Because the federal data system “does not collect information pertaining to the date of the first judicial finding,” the federal government uses the date of the child’s removal and adds 60 days, resulting in a 17-month timeframe. U.S. Dep’t of Health and Human Services, Children’s Bureau, Child Welfare Outcomes 2009-2012, Report to Congress, at 22, http://www.acf.hhs.gov/sites/default/files/cb/cwo09_12.pdf.

¹² Data provided to DOI by ACS, Feb. 5, 2016.

During the course of this investigation and at its conclusion, DOI provided ACS with a series of recommendations. ACS accepted many, but not all, of DOI's recommendations. It has declined, however, to take disciplinary action against all but one staff member identified by DOI.

II. INTRODUCTION

The Administration for Children’s Services (ACS) is responsible for protecting the safety and promoting the well-being of New York City’s children and strengthening their families by providing them child welfare, juvenile justice, child care, and early education services. This DOI Report focuses on child welfare services, both those provided directly by ACS and those provided by private, nonprofit provider agencies (provider agencies) under contract with ACS.¹³

Overview of New York City Child Welfare Services

ACS is responsible for investigating all allegations of child abuse and neglect involving children who reside in New York City. In New York State, allegations of child abuse and neglect are reported to the Statewide Central Register of Child Abuse and Maltreatment (the hotline)¹⁴ and, when the allegations involve children who reside in New York City, the hotline staff forwards the reports to ACS for an investigation. Each year, ACS’ Division of Child Protection¹⁵ conducts approximately 55,000 investigations of suspected child abuse and neglect and in more than 21,000 of those investigations finds credible evidence of abuse and/or neglect, triggering a finding that the hotline report is “indicated.”¹⁶ When ACS does not find credible evidence of abuse and/or neglect, the report is “unfounded.”¹⁷

Preventive services are provided to families in order to strengthen and stabilize those families and prevent the need for the children to enter foster care.¹⁸ Agencies under contract with ACS provide most preventive services in New York City and, on any given day, these agencies serve approximately 25,000 children and their families.¹⁹

ACS is also at times mandated by the family court to supervise children who are living at home and ensure that their parents abide by the court’s orders, through what ACS refers to as Court Ordered Supervision. This service is provided by ACS caseworkers who are assigned to Family Services Units (FSU) within the ACS Division

¹³ In April 2016, DOI issued a Report, accompanied by four arrests, related to ACS’ provision of juvenile justice services. DOI anticipates additional reports going forward.

¹⁴ New York State, OCFS, Child Protective Services, <http://ocfs.ny.gov/main/cps>.

¹⁵ The ACS Division of Child Protection includes the Child Protective Services program, which is responsible for carrying out abuse and neglect investigations.

¹⁶ See *supra* note 6.

¹⁷ Historically, ACS has denied DOI access to “unfounded” reports, including in the cases that are the subject of this Report. However, DOI has recently begun to receive these reports in some circumstances.

¹⁸ ACS, About ACS, ACS Divisions and Executive Team, <http://www.nyc.gov/html/acs/html/about/divisions.shtml>.

¹⁹ See *supra* note 6. This data represents the daily average.

of Child Protection,²⁰ the same division that investigates allegations of abuse and neglect. On any given day, ACS is responsible for approximately 3,400 open Court Ordered Supervision cases.²¹

Foster care services are intended to ensure that children who cannot safely remain at home are safe, well-cared for, and discharged from foster care to a permanent home as soon as possible. The ACS Commissioner has legal custody of New York City children who are in foster care; therefore, these children are ACS' legal responsibility. However, ACS contracts out all foster care services to its provider agencies.²² Approximately 10,000 New York City children are currently in foster care²³ and, on average, have been in ACS custody for 3.2 years,²⁴ almost twice the national average of 1.7 years.²⁵ In addition, in New York City, children who are discharged from foster care to their families have spent an average of 1.6 years in foster care prior to returning home,²⁶ and children who are adopted have spent an average of 5.1 years in care before being adopted.²⁷

DOI's Investigations

DOI's investigations of two fatalities and one near fatality²⁸ of children whose families were known to ACS and who died or nearly died due to abuse and/or neglect in the last two years, and DOI's review of existing ACS policies, procedures, and data, when available, found numerous serious violations and deficiencies. These include violations of state and federal law, failures to implement ACS policies and procedures as required, and failures to provide adequate quality services and oversight. While ACS has multiple systems in place to monitor compliance with its policies and procedures and to evaluate the quality of services it and its provider agencies deliver, DOI's investigations did not involve evaluating the quality or adequacy of those various systems. However, the failures DOI identifies in this report occurred with these monitoring systems in place.

²⁰ See *supra* note 18.

²¹ Data provided to DOI by ACS, Jan. 21, 2016.

²² ACS contracts with 32 private, non-profit agencies, which provide foster care services. The total annual expenditure for these contracts is approximately \$515 million. Information provided to DOI by ACS, Jan. 22, 2016.

²³ ACS, Flash Report (Mar. 2016), at 16.

²⁴ Data provided to DOI by ACS, Oct. 8, 2015.

²⁵ U.S. Dep't of Health and Human Services, Administration for Children and Families, Children's Bureau. The AFCARS Report, No. 22, <http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport22.pdf>.

²⁶ See *supra* note 24. Comparable national data is not available.

²⁷ See *supra* note 21. Comparable national data is not available.

²⁸ DOI's investigations included the review and analysis of voluminous ACS and provider agency records, family court petitions and orders, and other city agency records when relevant. DOI also interviewed or spoke to twenty professionals who had been or continued to be involved with these families.

Throughout 2015, DOI issued three separate letters to ACS, in which DOI provided ACS with its detailed findings and recommendations concerning these three investigations. DOI's recommendations to ACS focused on implementing new policies and procedures, revising existing policies and procedures, developing and implementing new training protocols, improving its oversight of its provider agencies, and routinely auditing particular types of cases. In addition, some of ACS staff's failures to adhere to ACS policies and procedures were so egregious that DOI recommended one-time only audits of those staff member's cases and consideration of disciplinary action, including termination of employment. ACS declined to discipline six of its staff members and has begun the progressive disciplinary process against one other.

III. DOI'S REVIEW OF ONE NEAR FATALITY AND TWO FATALITIES

All three cases DOI reviewed had substantial histories of ACS involvement prior to the child's death or near death, all of which occurred within the last two years. Below are brief summaries of the three cases²⁹ and of the critical ACS deficiencies DOI identified during its reviews.

1. Case A: Chris – Child Nearly Died While ACS Failed to Carry Out Significant Investigative Steps

Chris was alleged to have been abused and neglected by his parents for at least two years prior to the near-fatal injury inflicted by one of his parents. ACS completed four investigations during this two year period, all involving physical injuries to Chris.

The first of these investigations, which took place two years before the near-fatal injury, alleged injuries to Chris and inadequate guardianship by his parent. ACS "unfounded" this investigation. At the time of DOI's investigation, DOI did not have access to these records and could not determine whether ACS completed a comprehensive investigation, according to ACS policy and procedure requirements.

The last three investigations were based on three reports to the hotline within a three-month period, which involved three separate sets of injuries to Chris. The first report was made by school staff who were told by students that Chris said his parents were depriving him of food and hitting him. Physical abuse was also alleged in the next report, based on new injuries that required medical attention. Chris now had lacerations as well as bruises and scratches throughout his body. The last report, which included an allegation that Chris was significantly underweight, was called in to the hotline after Chris sustained a life-threatening injury that required surgery and an extensive hospital stay.

ACS ultimately "indicated" all three of these overlapping investigations. However, during the first two investigations, ACS failed to timely and comprehensively complete all of its required investigative procedures while the parents' abuse was escalating. ACS did

²⁹ See *supra* note 2.

not interview Chris' friends, to whom he had initially disclosed the abuse and food deprivation, for two months, despite the fact that ACS requires its Child Protective Services (CPS) caseworkers to make every effort to interview witnesses and potential sources of information within seven days of beginning investigations.³⁰ Because the CPS caseworker delayed interviewing Chris' friends, the caseworker was not able, for months, to utilize this information in her assessment or to interview Chris based on a complete understanding of the facts that were available from these sources.

In addition, Chris repeatedly told ACS staff—and other professionals—that his injuries were accidental and caused by something he had done, such as falling off a chair, or by something a younger sibling had done, such as hitting him with a toy. Chris' parents blamed their child for causing his own injuries. ACS did not, during the first of the three investigations, quickly seek a medical expert's opinion regarding whether the explanations provided by Chris and his parents were consistent with his injuries. Further, the CPS caseworker grossly overestimated Chris' weight by more than 30 pounds, which the caseworker later admitted was a guess. At the time, Chris' weight was below the fifth percentile for a child his age. The caseworker did not, at any time, speak to Chris' pediatrician regarding Chris' weight and outcry of food deprivation, which is required by ACS policy and which physicians who treated Chris in the hospital recommended the caseworker do. Further, the caseworker did not obtain Chris' medical records from his pediatrician until after Chris sustained the life-threatening injury. Additionally, ACS did not provide its caseworkers with growth charts for children of Chris' age so they were unable to compare a child's height and weight with that of other children of the same age and gender.

ACS attempted to obtain a court order to remove Chris from his unsafe home after receiving the second hotline report; however, the court denied the request because ACS had not established that Chris was at imminent risk of harm in the home, likely in part due to ACS' failure up to this point to speak to Chris' friends to whom he had disclosed the abuse, speak to his pediatrician, and obtain and review his medical records. It was not until Chris suffered the life-threatening injury that ACS took many of the critical investigative steps that it should have taken prior to this third, nearly fatal incident. Chris was placed in foster care upon release from the hospital and, soon after Chris was safely living away from his parents, he disclosed that his parents had inflicted the physical abuse and deprived him of food as was reported to ACS several months prior. Chris' siblings

³⁰ See, e.g., ACS, Division of Child Protection Casework Practice Requirements Manual (5th ed. 2013), at 65. DOI requested data from ACS regarding the percent of investigations in which caseworkers completed all required collateral contacts within seven days. ACS reported that it does not have systemic data and collects these data from only a small sample of cases during its reviews and, therefore, the findings cannot be generalized, which is a clear indication that ACS is unable to assess systemic compliance with this policy. This same conclusion can be drawn throughout this report when DOI notes that ACS has reported that it does not have either systemic data or sufficient case review data from which the findings can be generalized.

were then also placed in foster care and both parents were arrested. The charges included assault and endangering the welfare of a child. If the first of the three most recent allegations had been handled appropriately and with exigency, Chris might not have been re-abused twice more before he was removed from these abusive parents.

Chris has been discharged from foster care and is living with a relative. ACS is providing Chris and his relative with Court Ordered Supervision and they are also receiving counseling. His siblings have remained in foster care. DOI notes with concern that ACS' permanency goal for the siblings is to return them home to their parents, whose criminal cases are still pending.

2. Case B: Morgan – Child Died Under Suspicious Circumstances After Years of ACS Intervention

Morgan, a preschool age child, died at home suddenly and under suspicious circumstances. The cause of Morgan's death could not be determined, although ACS found that Morgan's mother neglected her children the day Morgan died. At the time of Morgan's death, the family was receiving preventive services from an ACS-contracted provider agency.

During the 12 years prior to Morgan's death, ACS investigated 11 reports of neglect concerning Morgan's mother and "indicated" seven of those reports, repeatedly determining that Morgan's mother neglected her children, who were all under 11 years old and living at home when Morgan died. The findings against Morgan's mother included exposing some of her children to cocaine *in utero*, failing to supervise her children, and failing to ensure they attended school. During two of the investigations, ACS found that the younger children's father, who lived in the home, also neglected the children.

Over the course of six years, the family received ACS-contracted preventive services at least five times, and the four oldest children, including Morgan, spent more than a year in foster care. While in foster care, the children thrived. They received needed therapeutic and developmental services, took their prescribed medications, and the school-aged sibling was enrolled in school for the first time. During this time, the mother tested positive for cocaine while pregnant with her fifth child despite the fact she was attending substance abuse treatment.

While in foster care, the children made numerous specific allegations to both ACS and the provider agency staff against the younger children's father. The children alleged that the father was abusive both prior to the time they were placed in foster care and after, including hitting and attempting to suffocate two of the children. Neither ACS nor provider agency staff reported these allegations to the hotline, the only way an abuse investigation could be triggered, and as required by New York State law.³¹

³¹ See *supra* note 4.

Morgan's foster parent stated on several occasions that she wanted to adopt Morgan; however, adoption was not pursued and, instead, the children were trial discharged³² to their mother. Following the trial discharge, the mother often failed to cooperate with the services that the family court ordered that she and the children receive and the progress the children had made while in foster care began to deteriorate significantly, despite the fact that the foster care provider agency continued to work with the family and ACS provided Court Ordered Supervision. ACS received a new hotline report regarding this family while the children were home on trial discharge status. ACS' investigation found that the mother was once again neglecting her young children by failing to ensure one child regularly attended school and to prevent her children from injuring each other. However, ACS failed to inform the court of this "indicated" investigation, and the court final discharged³³ the children to the mother shortly thereafter.

Seven months after being final discharged, two different ACS investigators separately reported that the children were living in a deplorable, unsafe, hazard-filled home and were only sporadically attending school. One of the ACS investigators observed garbage and food strewn throughout the home; a clogged bathtub filled with dirty water; a bathroom sink that was falling off the wall; and structural damage including child-sized holes in the walls that exposed bricks, beams, and wires and in which the children were playing.

In total, ACS investigated three reports of neglect during the year and a half following the children's discharge from foster care and "indicated" all three, finding credible evidence in all three investigations that the children were being neglected. However, the children remained in the mother's care and the family did not move from their dangerous home until ACS finally insisted that they do so during the second investigation. Three preventive services provider agencies were responsible for working with the family at different times during this period. The third preventive services agency was working with the family up to the day Morgan died, which occurred four months after ACS closed the last "indicated" investigation prior to Morgan's death.

Despite all the evidence of neglect ACS uncovered and attempted to address over many years and prior to Morgan's death, ACS failed to identify and/or address many of the risk factors present in this family, and it failed to appropriately consider that the neglect was chronic. ACS repeatedly provided the mother with the same services over and over again, failing to see that this was futile. ACS delayed identifying the rapidly declining and

³² A child who is trial discharged is still legally in foster care but is in the physical custody of his or her parents, with the family court's approval. The foster care provider agency continues to be responsible for visiting and providing services to the child and his or her parents. If, during the trial discharge period, the child cannot safely remain at home, he or she must be re-placed in foster care.

³³ A child who remains safely at home during the trial discharge period is final discharged at the end of the trial period. The family may receive preventive services and/or other community-based services during both the trial discharge period and after the final discharge.

uninhabitable condition of the home, at least some of which was reportedly caused by these young children, and did not address the mother's inability to adequately care for or supervise her children—over whom she reportedly had no control. Although the family did move from their unsafe apartment when ACS finally required them to do so, and received preventive services yet again, the mother continued to fail to meet the children's basic needs, was no longer receiving much needed mental health services, and was still unable to manage the children's behavior. Further, the school-aged children were, once again, either not enrolled or rarely attended school. Morgan died on a day when, much like the previous allegations concerning this family, the mother was not supervising her children and the father of the younger children was not home.

After Morgan died, the surviving siblings were placed in foster care, where three of these four children have remained. The current court-ordered permanency plan is to return all of the children to their mother. ACS recently requested that the family court change the plan to adoption, but the court denied the request. One child is already living with the mother and ACS is providing Court Ordered Supervision and an ACS-contracted preventive services agency is also providing services. The other children are having frequent visits with their mother.

3. Case C: Alex – Mother Killed Child Despite Her Violent History and 12 Years of ACS Interventions

Alex was a preschool age child who died after being severely beaten by her mother. In the 12 years prior to Alex's death, ACS completed 13 investigations regarding this mother of eight children, and "indicated" six of the investigations. During the six investigations that were "indicated," ACS substantiated allegations that included excessive corporal punishment (including hitting the child in the face on two occasions, causing disfigurement), inadequate guardianship, lack of medical care, and drug abuse. ACS filed numerous petitions in family court alleging neglect against this mother, twice provided Court Ordered Supervision, and at least twice referred the family for ACS-contracted preventive services. In addition, the mother's parental rights were terminated as to two of her children and she lost custody of another child. The five youngest children, including Alex, were placed in foster care due to the mother's drug abuse and her use of excessive corporal punishment. At the time of Alex's death, the mother had regained custody of these five children, who were all under ten years old.

While in foster care, the foster parents of four of the children, including Alex's foster parent, expressed interest in adopting them. The fifth and youngest child, a newborn at the time, was quickly returned to the mother's care, and lived with the mother in a residential substance abuse treatment program. During this time, ACS provided Court Ordered Supervision to the mother and this child. The four older children remained in foster care; however the ACS-contracted foster care provider agency and ACS FSU staff, who were providing the Court Ordered Supervision, rarely communicated with each other,

failed to share critical information, and made inadequate assessments and ill-advised decisions.

Most critically, the foster care provider agency and ACS made insupportable decisions regarding the care, custody, and supervision of the children. First, the provider agency, under ACS' oversight and a family court order permitting the provider agency to use its discretion, decided to trial discharge two of the pre-school aged children, who had been in foster care for almost two years, to the mother. These two children were trial discharged only three days after the mother completed the residential substance abuse treatment program, and the newly sober mother would now also be caring for her baby for the first time without the support of residential services. In addition, the mother had not yet attended a substance abuse after care program, had not had any unsupervised or overnight visits with the two children while they were in foster care, and was often unable to control her anger. For example, just two months prior, the mother became angry with one of her children's foster parents during a visit with her children. The mother shouted and cursed at the foster parent and provider agency staff, and threatened, in front of her children, to harm the foster parent.

Neither the ACS FSU caseworker nor her supervisor attended the pivotal conference during which the decision to trial discharge these two children to the mother was made, and ACS policy failed to require either of their attendance at this important conference. Nonetheless, ACS' own facilitator was leading the conference but the facilitator failed to alert ACS management to this dangerous decision as she was required to do.³⁴

Five months later, the foster care agency decided to trial discharge two additional children, including Alex, who had never lived with her mother. The decision to return these two children home on a trial basis was made despite numerous barriers to a successful reunification. First, the mother was not regularly attending her substance abuse after care program as required, had admitted to recent drug use, was not cooperating with random drug screenings, had refused a hair follicle drug test, and had not consistently visited with the children while they were in foster care. The mother had also recently stated that she had not adequately bonded with Alex. In addition, ACS was in the midst of conducting yet another investigation, this time based on allegations that the mother was neglecting the three children that the provider agency and ACS had recently reunified with her. The ACS FSU caseworker who was providing Court Ordered Supervision to the mother and her youngest child was also conducting the new investigation.

This trial discharge decision was, once again, made during a conference that ACS' own facilitator led, and that the FSU caseworker and her supervisor did not and were not required to attend. Less than two weeks after these two children were trial discharged, the mother's substance abuse after care case manager informed the FSU caseworker

³⁴ ACS, Office of Family Permanency Team Conferencing Protocol Phase II (Apr. 2009), at 34.

that she was very concerned that returning the children to their mother in rapid succession may be a set up for failure. The FSU caseworker took no action, told neither the court nor the foster care provider agency, “unfounded” the investigation, and closed the Court Ordered Supervision case, all in violation of ACS policy and procedure.³⁵

Just a few months after the second trial discharge, the foster care agency finalized the discharge of all four children to the mother. ACS staff were not required to and did not facilitate the conference during which this decision was made, and, since ACS did not have an open case involving the family at this time, no one from ACS attended the conference. At the time of the final discharge, the mother was not regularly attending the required substance abuse after care program nor had she submitted to any random drug screenings as ordered by the court. Once the children were final discharged to the mother, the family was no longer receiving any child welfare-related services.

Following the children’s final discharge, ACS received two more hotline reports alleging the mother was again maltreating the children. ACS investigated the allegations and “unfounded” both reports. Because DOI did not have access to the “unfounded” records, DOI was unable to assess whether the ACS caseworkers reviewed the family’s long, troubled and violent history, and if so, whether they appropriately considered that history and completed thorough investigations prior to determining these reports to be “unfounded.”³⁶

Just one year later, this mother severely beat and killed Alex. It was later determined that Alex also had multiple prior injuries that were consistent with abuse. The mother was arrested the day after Alex died.

After Alex’s death, the surviving siblings were placed in foster care, where they have remained. The mother is serving a lengthy prison sentence. By law, ACS is

³⁵ Regarding assessing for safety, risk, and effectiveness of services, sharing information with provider agencies, and closing Court Ordered Supervision cases, see ACS, Division of Child Protection, Family Services Casework Practice Guide (May 2002), at 7, 29, and 35. Regarding reports to the court, see ACS, Child Safety Alert #34, Aug. 20, 2013. Regarding integrating accounts from other service providers into safety and risk assessments, see ACS, Division of Child Protection Casework Practice Requirements Manual (5th ed. 2013), at 63-64.

³⁶ Based on the “indicated” investigations DOI reviewed in the two fatality cases it examined, and the patterns of abuse and neglect observed in these records, it is likely that some number of the “unfounded” investigations regarding these families were insufficient and were “unfounded” despite existing evidence of abuse and/or neglect. As a case in point, in another DOI investigation, DOI received allegations directly from a youth in foster care. The youth told DOI that her foster parent was verbally and physically abusive and attempted to prostitute another female youth placed in the home. These allegations had previously been the subject of an ACS CPS investigation, which ACS “unfounded.” After DOI received the allegations, DOI contacted the hotline to report the allegations. ACS completed another CPS investigation, and this time, ACS corroborated the allegations by the other youth, ACS “indicated” this investigation, and the foster home was closed. These facts raise questions regarding the thoroughness of ACS’ original investigation and how many other children are left in unsafe homes because of inadequate ACS investigation practice. DOI’s findings and recommendations regarding this additional investigation is being provided to ACS.

permitted to make a motion to the court to excuse its foster care provider agency from having to make “reasonable efforts” to reunify the surviving children with their mother,³⁷ which would otherwise be required before changing their permanency goal to adoption. However, ACS waited 71 days to make this motion, and did not do so until DOI asked why it had not. Indeed, prior to DOI’s inquiry, ACS and its provider agency contemplated having the surviving siblings visit their mother in prison. The surviving siblings’ permanency goals have now been changed from reunification with their mother to adoption but the foster care provider agency has not yet filed the petitions to terminate the mother’s parental rights.

IV. DOI’S FINDINGS

DOI’s investigations of these three cases revealed critical violations of federal and state law, as well as ACS policies and procedures, by both ACS staff and employees of two of its foster care provider agencies. DOI also identified key deficiencies in the manner in which ACS coordinated with and oversaw the two foster care provider agencies. The violations and deficiencies noted below were evident in more than one case and/or repeatedly within particular cases. DOI has noted those findings with which ACS disagrees.

Further, DOI also reviewed ACS data, when available, in order to present the systemic context for DOI’s findings. The data demonstrates two systemic failures, which are discussed below. ACS’ failure to maintain data on a number of other key issues leaves DOI unable to verify, at this time, whether the remainder of its findings are systemic.³⁸

The following is a summary of DOI’s major findings:

1. ACS Failed to Adhere to the Mandated Reporting Law and Repeatedly Failed to Ensure that One of Its Provider Agencies Adhered to the Law

New York State law requires mandated reporters³⁹ to contact the hotline to report suspected child abuse and neglect. Failure to do so is a crime and also subjects the mandated reporter to civil liability.⁴⁰ ACS CPS casework staff, who investigate reports of abuse and maltreatment, and provider agency casework staff are mandated reporters⁴¹

³⁷ These ‘no reasonable efforts’ motions are “used in situations where the parent’s past conduct has been so harmful that reunification would be contrary to the health and safety of the child.” Memorandum from John B. Mattingly, Commissioner, ACS, to ACS staff, and Foster Care Provider Agency Executive Directors, Adoption and Safe Families Act Permanency Plan – Adoption (Sept. 30, 2006), at 1. Social Security Act § 471(a)(15)(D)(i-ii); New York Family Court Act § 1039-b.

³⁸ DOI will conduct an additional investigation into these issues.

³⁹ Mandated reporters are certain professionals who are required by New York State law to report suspected child abuse and neglect to the hotline.

⁴⁰ N.Y. SSL § 420.1.

⁴¹ N.Y. SSL § 413.

and are, therefore, required by law to report allegations of child abuse and neglect to the hotline. This is not a mere technical requirement. Without a hotline report, ACS has no legal basis to conduct an investigation and, indeed, ACS' investigative division may not even know such an investigation is needed.

In Case B, ACS staff violated New York State law and its foster care provider agency's casework staff repeatedly violated the law by failing to report to the hotline four separate child abuse and neglect allegations Morgan's siblings made while in foster care and prior to Morgan's death.⁴²

DOI requested data from ACS to determine whether ACS and provider agency staff routinely comply with their obligations under the mandated reporter law or whether, as in Case B, systemic failures exist that warrant corrective action. However, ACS reported that it does not collect systemic data on this critical issue, which indicates that ACS is unable to identify and address system-wide failures to comply with the mandated reporter law, but instead must rely on supervisors to ensure that caseworkers comply with the law on individual cases, which was clearly not sufficient in Case B. ACS' failure to collect this data means that criminal activity cannot be identified and, therefore, cannot be prosecuted and potential abuse and neglect allegations may go uninvestigated.

2. ACS Failed to Comply with Laws Intended to Timely Move Children to Permanency

Foster care is intended to be temporary, and the longer children remain in foster care, the less likely it is that they will be discharged to a permanent home.⁴³ Permanency for children in foster care generally means that they are either safely returned home, adopted, or discharged to the care of relatives or fictive kin.⁴⁴ ACS is responsible for ensuring that children who are in foster care are discharged to permanent homes timely and do not spend long periods of time in care.

Typically, after entering foster care, a child's first permanency goal is to return home to his or her parent(s). However, according to ACS policy,⁴⁵ and consistent with federal and state law,⁴⁶ in some egregious circumstances, ACS may file a motion asking

⁴² Criminal charges cannot be sustained against these staff due to the statute of limitations.

⁴³ Ringeisen, H., Tueller, S., Testa, M., Dolan, M., & Smith, K. (2013). Risk of Long-Term Foster Care Placement Among Children Involved with the Child Welfare System. U.S. Dep't of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation Report #2013-30, at 1, https://www.acf.hhs.gov/sites/default/files/opre/nscaw_lffc_research_brief_19_revised_for_acf_9_12_13_edit_clean.pdf.

⁴⁴ Fictive kin in this context are adults who are not related to a child in foster care by birth or marriage but have a significant relationship with that child.

⁴⁵ See *supra* note 8.

⁴⁶ Social Security Act § 471(a)(15)(D)(i-ii); New York Family Court Act § 1039-b.

the family court judge to release the foster care provider agency from having to make “reasonable efforts” to reunite a child with his or her parent(s). These motions are “used in situations where the parent’s past conduct has been so harmful that reunification would be contrary to the health and safety of the child,”⁴⁷ and, when granted by the court, allow for a more rapid process for discharging a child from foster care to a permanent home.

In Case C, the mother violently killed Alex and, therefore, reunification would not be safe for her surviving children. However, ACS did not file the ‘no reasonable efforts’ motion until 71 days after the mother pled guilty to this crime—long after she had been charged and arrested—and only after DOI asked why ACS had not filed the motion. Given how deeply traumatized the surviving children are, particularly by witnessing their sibling’s violent, and ultimately deadly beating at their mother’s hands, the motion should have been filed on the earliest possible date, and no later than upon the mother’s guilty plea.

Further, some parents, even after being provided with the services and supports they need to safely care for their children, are still unable to do so. In these cases, ACS must ensure that its foster care provider agencies find alternative safe, nurturing, and permanent homes for these children. When a child has been in foster care for 15 of the most recent 22 months, federal and state law require that a petition to terminate parental rights be filed in court, unless there is a documented “compelling reason” that doing so “would not be in the best interests of the child.”⁴⁸

The federal government actually uses a 17-month timeframe, which is 15 months plus 60 days after the child was removed from their home,⁴⁹ and, in New York City, the foster care provider agencies file termination of parental rights petitions; ACS does not. ACS does, however, have ultimate responsibility for the agencies’ compliance with the law. In the three cases DOI reviewed, this requirement has arguably not been violated because the family court’s failure to rule on the pending abuse and neglect petitions within the 17-month timeframe is, pursuant to State law and ACS policy,⁵⁰ a compelling reason not to file a petition to terminate parental rights if documented.⁵¹ However, DOI has found that the failure to timely file termination of parental rights petitions when there is no documented compelling reason not to do so is an overwhelming systemic problem and a violation of federal law. During the last three fiscal years, ACS’ foster care provider agencies only filed these petitions timely, using the 17-month timeframe, for approximately 18% of children for whom there was no documented compelling reason

⁴⁷ See *supra* note 8.

⁴⁸ See *supra* note 10.

⁴⁹ See *supra* note 11.

⁵⁰ N.Y. SSL § 384-b; Ronald Richter, Commissioner, ACS, ACS Policy and Procedure #2012/01, Permanency Planning (Oct. 24, 2012), at 13.

⁵¹ DOI has requested that ACS provided it with the documentation required to confirm that ACS has not violated the law. To date, ACS has not provided the documentation.

not to file. This means that, for the 4,510 children and youth for whom there was no documented compelling reason not to file, petitions were not filed timely for 3,732 children and youth.

Table 1: Timely Filing of Termination of Parental Rights Petitions, FY 2013-2015⁵²

	FY13		FY14		FY15	
Children who reached 17 of the most recent 22 months during the FY for whom there was no documented compelling reason not to file a TPR petition	1,677		1,447		1,386	
Termination of parental rights petitions filed timely (within 17 months)	309	18%	261	18%	208	17%

Despite this clear and compelling ACS data showing the failure to document compelling reasons, ACS disagrees with DOI’s finding that it is not in compliance with federal permanency guidelines.

3. ACS Repeatedly Failed to Identify and Address High Risk Issues

ACS failed to timely identify and address three ongoing high risk issues in the three cases DOI reviewed—chronic neglect, repeated abuse and neglect, and food deprivation.

First, chronic neglect occurs when a child’s basic needs are not met by a parent or caregiver on a recurring or enduring basis.⁵³ ACS policy confirms that “over time, chronic neglect patterns can seriously harm a child, impairing his or her emotional, physical, neurological and/or social development” and “can erupt into very serious incidents, or have a cumulative impact that can result in danger to a child, and can occasionally lead to the death of a child.”⁵⁴

ACS policy requires its CPS caseworkers to review a family’s child welfare history each time the family is the subject of a new investigation. The purpose of this review is to gather the information needed to make a comprehensive assessment of the child’s safety and risk of future harm, including assessing “the new allegations in the context of all previous reports [and] allegations.”⁵⁵ CPS caseworkers should be able to identify chronic neglect and take appropriate action.

⁵² See *supra* note 12.

⁵³ U.S. Dep’t of Health and Human Services, Children’s Bureau, Child Welfare Information Gateway, Chronic Child Neglect (Jan. 2013) at 2, https://www.childwelfare.gov/pubPDFs/chronic_neglect.pdf.

⁵⁴ ACS, Division of Child Protection Casework Practice Requirements Manual (5th ed. 2013), at 50, link to Chronic Neglect: An Introduction for Child Welfare Workers, at 1.

⁵⁵ ACS, Division of Child Protection Casework Practice Requirements Manual (5th ed. 2013), at 7-8.

In Case B, ACS failed, for many years, to identify and address the chronic pattern of neglect in Morgan’s family (e.g., seven “indicated” investigations over ten years, all for neglect). The family had eight of the potential chronic neglect risk factors set forth in ACS’ policy,⁵⁶ which were impaired parent-child relationships, mental illness, substance abuse, domestic violence, chronic school absenteeism, unemployment, unsuitable housing, and extreme poverty. ACS repeatedly referred the family for preventive services but failed to recognize that this service was not sufficiently addressing the mother’s ongoing neglect of her children.

DOI requested data from ACS to determine whether potential chronic neglect cases, which, according to ACS policy, should be reviewed by a manager,⁵⁷ actually receive those reviews. This data would assist DOI in assessing whether, as in Case B regarding Morgan’s family, the failure to identify and address chronic neglect is a systemic issue, based on whether the managerial reviews are occurring. Even more importantly, ACS should regularly collect and review this data in order to identify and address any failures to hold these reviews. However, ACS does not collect systemic data regarding these managerial reviews; therefore, neither ACS nor DOI can fully assess whether ACS is complying with this important policy.

The second high risk issue is repeat maltreatment, which ACS defines as children in “indicated” investigations with repeat “indicated” investigations within one year.⁵⁸ In order to minimize repeat maltreatment, the CPS investigator must, during each investigation, not only determine whether a child has been abused or neglected but must also assess whether a child is at risk of future abuse or neglect and take appropriate action to reduce any risk. Instances of repeated maltreatment are, in some cases, related to the failure of the child welfare agency to appropriately evaluate and address the risk of future maltreatment.

One way to assess whether a child welfare agency recognizes and appropriately acts on a child’s risk of being repeatedly abused or neglected is to examine the percentage who are repeatedly maltreated within a specified period of time, and whether over time these percentages are reduced, possibly as a result of high quality assessments, supports, and other interventions—including removing children from their homes when necessary—that prevent future maltreatment. Reviewing the percentage of children who experience repeated investigations is also useful.

⁵⁶ ACS, Division of Child Protection Casework Practice Requirements Manual (5th ed. 2013), at 50, link to Chronic Neglect: An Introduction for Child Welfare Workers, at 3.

⁵⁷ See *supra* note 55, at 13. Managers are required to review the records and provide guidance during investigations involving families that have had four or more hotline reports, which DOI is using here as a proxy for potential chronic neglect.

⁵⁸ The City of New York, Mayor’s Management Report (Sept. 2015), Indicator Definitions, at 105.

As shown in Table 2 below, over the last three years, 24% of children who experience an ACS CPS investigation also experience a second investigation within one year (regardless of whether those investigations are “unfounded” or “indicated”). As the table also shows, prior ACS involvement failed to prevent 16% of children from being abused or neglected at least twice within a year in all three years. This finding is more than double the State’s 7% target for this measure and has remained unchanged for the last four years.⁵⁹ In addition, 8% of children experience an “unfounded” investigation followed by an “indicated” investigation within one year.⁶⁰

Table 2: Repeat CPS Investigations, FY 2013-2015⁶¹

Type of Repeat CPS Investigations	2013	2014	2015
Children in complete investigations with repeat investigations, regardless of outcome, within 1 year, by FY ⁶²	24%	24%	24%
Children in “indicated” investigations with repeat “indicated” investigations within 1 year, by FY ⁶³	16%	16%	16%
Children in “unfounded” investigations with repeat “indicated” investigations within 1 year, by CY ⁶⁴	8%	8%	

In Case C, ACS failed to recognize that the mother’s repeated abuse and neglect of her children—six “indicated” investigations over ten years, coupled with the mother’s intense anger and the physical violence she inflicted upon her children—created a high risk that she would continue to harm and endanger her children. In the years before the mother killed Alex, ACS attempted to address the mother’s repeated abuse and neglect by using the same futile services over and over again. During the year prior to Alex’s death, ACS completed two investigations and “unfounded” both investigations. Seven months later, Alex died.

In Case B, after the children returned home from foster care, ACS investigated three reports alleging neglect within one year, “indicated” all three reports, and referred the family for the same type of preventive services that were repeatedly found to be unsuccessful in reducing the children’s risk for maltreatment in the past. Just a few

⁵⁹ See *supra* notes 5-6.

⁶⁰ ACS initially refused to provide information on these “unfounded” investigations, impeding DOI’s investigation in this regard. However, after recent intervention by City Hall, ACS has reversed its position. DOI will now be able to review this issue.

⁶¹ Comparable national data for these findings are not available.

⁶² See *supra* note 6.

⁶³ *Id.*

⁶⁴ Data provided to DOI by ACS, Nov. 20, 2015. Data for calendar year 2015 are not included because data regarding repeat “indicated” investigations that were completed at the end of 2015 are not yet available.

months after the third investigation was closed, Morgan died under suspicious circumstances while in the mother's care.

The third high risk issue, which arose in Case A, is food deprivation. New York State law and ACS policy define a parent's failure to exercise a minimum degree of care, including the failure to supply adequate food when financially able to do so, as neglect.⁶⁵ Chris was substantially underweight during ACS' last three investigations, the first of which specifically included a food deprivation allegation. Yet more than two weeks passed from the time ACS received the allegation of food deprivation to the time it obtained Chris' actual weight from a second hotline report, which was called in by hospital personnel who were treating Chris for a second set of injuries. Instead, during the initial investigation into food deprivation, the ACS caseworker actually guessed Chris' weight, significantly overestimating it by 30 pounds. ACS did not speak to Chris' pediatrician at any time and did not obtain Chris' medical records from his pediatrician until approximately a month after it received the initial allegation of food deprivation. In addition, the ACS caseworker did not interview Chris' friends, to whom he had reported that he was being deprived of food at home, for months. While DOI cannot speculate as to the ultimate outcome, DOI can say with certainty that if the caseworker had interviewed Chris' friends and had learned his actual weight earlier in the investigation, as required, ACS would have had more information with which to assess Chris' circumstances and to question Chris, perhaps leading Chris to feel safe disclosing the abuse, and would have had more information with which to petition the court to remove Chris from home.

4. ACS Failed to Follow Basic Casework Procedures as Required

DOI found that ACS CPS caseworkers repeatedly violated ACS policies and procedures. The most critical of these violations are summarized here.

First, it should be noted that, although DOI did not review the caseloads of the CPS caseworkers in these three cases, caseload is a key factor in whether a caseworker can carry out all basic casework practice as required. The nationally recognized caseload standard for these caseworkers is 12 cases.⁶⁶ However, in FY14, 19% of ACS' CPS caseworkers had caseloads that exceeded the recommended standard and, in FY15, that

⁶⁵ FCA § 1012(f)(i)(A); ACS, Division of Child Protection Casework Practice Requirements Manual (5th ed. 2013), at 85.

⁶⁶ Child Welfare League of America, Standards of Excellence for Services to Abused or Neglected Children and their Families (Revised 1999), <http://66.227.70.18/newsevents/news030304cwlacaseload.htm>.

percentage rose considerably, to 28%.⁶⁷ A large caseload negatively impacts a caseworker's ability to serve families effectively.⁶⁸

Child Safety

When ACS investigates allegations of abuse and neglect, its CPS caseworkers must determine whether each child is “in danger of serious harm.”⁶⁹ When a caseworker identifies a safety concern that places a child in danger, the caseworker must then determine whether the parents are able to take the necessary actions to protect the child and, if they cannot, the caseworker must put interventions in place to protect the child.⁷⁰

In Case B, approximately a year before Morgan died under suspicious circumstances, a CPS caseworker repeatedly visited the family's home while conducting a new investigation and, during these visits, ACS notes reflect that the home was in a rapidly declining and uninhabitable condition and the mother was overwhelmed and unable to appropriately parent her children. ACS failed to immediately and appropriately address the obvious safety issues, and allowed the children to remain in an unsafe, hazard-filled apartment with an incapacitated parent for many months until a second CPS caseworker, conducting a second investigation, insisted that the family move from the home. However, during this second investigation, ACS failed to hold a timely Child Safety Conference and to adequately address the mother's inability to care for and protect her children, as required by ACS policy,⁷¹ continuing to place the children in serious danger.

In Case A, during the first of the three overlapping investigations, ACS failed to obtain a medical professional's opinion regarding whether the injuries to Chris were consistent with the explanations provided by Chris and his parents. This failure to follow ACS policy⁷² may have contributed to Chris' repeated abuse and near-fatal injury inflicted by his parent.

Unfortunately, ACS does not maintain the type of data that would allow ACS—or DOI—to determine whether these problems are widespread. These failures, if systemic, give rise to general concerns over child safety and well-being. ACS' failure to collect data

⁶⁷ The average CPS caseload was 9.7 in FY14 and 10.5 in FY15. The median caseload was 10.1 in FY14 and 11.1 in FY15. Data provided to DOI by ACS, Oct. 8, 2015.

⁶⁸ See e.g., U.S. Dep't of Health and Human Services, Administration for Children and Families, Children's Bureau, Child Welfare Information Gateway, Issue Brief: Caseload and Workload Management (Apr. 2010), https://www.childwelfare.gov/pubPDFs/case_work_management.pdf.

⁶⁹ See, e.g., ACS, Division of Child Protection Casework Practice Requirements Manual (5th ed. 2013), at 11-12.

⁷⁰ *Id.* at 11, 48-49.

⁷¹ A Child Safety Conference must take “place in real time” and the decision made at the Conference must be carried out immediately to ensure the safety of the children. See *supra* note 52, at 79.

⁷² See *supra* note 55, at 25-26.

regarding these important systemic issues raises concerns about ACS' ability to manage its own performance.

Court Ordered Supervision

ACS' obligation regarding Court Ordered Supervision cases is to ensure the safety and well-being of children who are living at home, and "to support parents and caretakers in providing a safe and nurturing home for the children."⁷³ This is to be accomplished using "a team approach through ongoing supportive supervision and managerial input at critical decision-making points and throughout the life of the case[.]"⁷⁴

In "split cases," where, for example, one child is living at home under Court Ordered Supervision and the child's siblings are in foster care, the FSU caseworker must not only provide Court Ordered Supervision but must also work closely with the foster care caseworker to ensure "all information is shared and service planning is coordinated."⁷⁵

In Case C, the FSU caseworker violated ACS policies and procedures by failing to:

- Visit the family within a week of receiving the case and twice a month thereafter.
- Contact the other agencies that were providing services to the family—including the foster care provider agency—on a monthly basis to share information and coordinate service planning.
- Address the substance abuse after care case manager's concern that the rapid return of all the children to the mother's care was setting the mother up for failure—a potential child safety issue—and inform the court and the other service providers once she received this information.
- Include in her report to the court the fact that she had completed and "unfounded" a new hotline report regarding neglect allegations against the mother just prior to the expiration of the Court Ordered Supervision.⁷⁶
- Record any case activities in an ACS-provided notebook.⁷⁷

Supervisory oversight is also a critical process in ensuring that all caseworkers are implementing policy and procedural requirements, including addressing safety and risk issues and effectively serving families. In Alex's case, Case C, the FSU caseworker's supervisor failed to ensure that the caseworker followed ACS policy and procedural

⁷³ ACS, Division of Child Protection, Family Services Casework Practice Guide (May 2002), at 2.

⁷⁴ *Id.*

⁷⁵ *Id.* at 7.

⁷⁶ *Id.* at 9, 13, 29, 30.

⁷⁷ See *supra* note 52, at 153.

requirements and failed to provide required bi-weekly supervisory reviews, completing only 6 of the required 24 reviews (25%) during a one year period.⁷⁸ The FSU caseworker and supervisor also failed to hold any of the required family case conferences. Further, the FSU manager, to whom the supervisor reported, was required to approve the case closing⁷⁹ but the case record contained no such approval. All of these failings also violated ACS policies and procedures.

In addition, the FSU caseworker, and presumably the supervisor, decided to close the Court Ordered Supervision case when the court order expired, rather than ask the court to extend its order, despite many factors that should have, per ACS guidelines,⁸⁰ led ACS to request an extension. These factors included the mother's failure to regularly attend the substance abuse after care program and to submit to frequent drug screenings and a hair follicle drug test, and the warning from the substance abuse after care case manager that returning the children to the mother's care so quickly may be setting the mother up for failure.

ACS data shows that FSU caseworkers have bi-weekly contact, as required by policy, with only 82% of the families on their caseloads.⁸¹ While DOI requested ACS data regarding numerous measures of supervisory and managerial oversight of Court Ordered Supervision cases, ACS does not have systemic data pertaining to these oversight functions. Supervisory failures, including failing to ensure that FSU caseworkers comply with all policies and procedures, if systemic, give rise to general concerns over child safety, permanence, and well-being. Failure to collect and analyze this data raises concerns about ACS' ability to manage itself.

5. ACS' Policy Requiring Its FSU Caseworkers to Investigate New Hotline Reports Regarding Families They are Already Providing with Court Ordered Supervision Creates Conflicts of Interest

ACS policy states that, when a new hotline report alleging abuse and/or neglect is received regarding a family that is under Court Ordered Supervision and an ACS FSU caseworker is assigned to provide that supervision, the new report must be investigated by the same FSU caseworker, rather than a CPS caseworker.⁸² This policy creates the

⁷⁸ See *supra* note 73, at 31.

⁷⁹ *Id.* at 37.

⁸⁰ ACS' practice guidelines state that "a judgment must be made regarding the safety of [the] children and the capacity of [the] parents to provide a nurturing home ... based on a variety of factors, including [the] extent of service plan goal achievement, regular contact and observation of family members ... and discussion with knowledgeable service providers." ACS, Division of Child Protection, Family Services Casework Practice Guide (May 2002) at 35.

⁸¹ Data provided to DOI by ACS, Nov. 20, 2015. According to ACS, Court Ordered Supervision cases comprise 89% of the total FSU caseload.

⁸² See *supra* note 73, at 39.

potential for bias and conflicts of interest that can lead to insufficient investigations, inappropriate investigation determinations, and unaddressed safety and risk factors that jeopardize the health and well-being of the children involved. For example, the mere existence of new allegations of abuse and/or neglect allegedly perpetrated by a parent who is receiving Court Ordered Supervision presents the inherent possibility that the FSU caseworker supervising the family missed something critical and provides an incentive for the FSU caseworker to “unfound” the new investigation. In addition, because the FSU supervisor is responsible for supervising the FSU caseworker on both cases, these same concerns apply to the supervisor, who is similarly exposed to a potential conflict of interest. As a result, this investigation assignment policy can lead to inadequate investigations and/or inappropriate decisions to “unfound” investigations.

DOI identified this policy as a concern in Case C, in which the FSU caseworker “unfounded” a new investigation while she was providing Court Ordered Supervision to the family prior to Alex’s death.⁸³ The timing and type of allegations, which had been made against the mother repeatedly in the past and which ACS had “indicated” during some of those investigations, raise serious concerns regarding whether the investigation conducted by the FSU caseworker was conducted appropriately. Specifically, ACS received a hotline report alleging drug abuse and inadequate guardianship against the mother while this family was receiving Court Ordered Supervision. ACS had “indicated” these allegations against the mother more than once during prior investigations. Yet, despite the mother’s admission to using drugs on one occasion, her failure to attend the substance abuse after care program regularly, and the concern raised by the after care case manager regarding the mother’s ability to appropriately care for her children—all during this investigation—the FSU caseworker “unfounded” this investigation without addressing these concerns. This case highlights the conflict of interest created by ACS’ case assignment policy, which can result in the failure to “indicate” investigations for which credible evidence of abuse or neglect exists, leaving children in unsafe homes without adequate services to protect them from harm.

⁸³ In addition, during DOI’s investigation of an unrelated case, staff from a Department of Homeless Services-contracted shelter informed DOI that a shelter staff member, who is a mandated reporter, reported alleged maltreatment of children to the hotline. ACS was already providing Court Ordered Supervision to this family and, after making the report, shelter staff spoke with the ACS FSU caseworker, who would now be conducting the new investigation, as well as that caseworker’s supervisor. Shelter staff informed DOI that the FSU caseworker and her supervisor chastised them for calling the hotline, and, in her case record, the FSU caseworker noted that she spoke with the shelter staff about this issue and told them that a new investigation regarding this family could disrupt the progress that had been made. DOI’s findings and recommendations regarding this investigation will be provided to ACS.

6. ACS Failed to Adequately Oversee its Foster Care Provider Agencies

Pursuant to New York State law and with OCFS approval, ACS has delegated responsibility for most case management services, including critical decision-making, to the preventive services and foster care provider agencies with which it contracts.⁸⁴ Nonetheless, ACS maintains responsibility for ensuring that the provider agencies adhere to all relevant ACS policies, practices, and quality control standards.⁸⁵

Although required to do so, ACS failed, in Cases B and C, which involved children who had spent time in foster care prior to each child's death, to adequately oversee and coordinate with two of its contracted foster care provider agencies to ensure that these agencies followed ACS policies and procedures, implemented court orders, provided necessary services, and made appropriate critical decisions.

In Case C, during a one year period, ACS and one of its foster care provider agencies were both providing services to Alex and her family—ACS providing Court Ordered Supervision and the foster care agency providing foster care and after care services. ACS FSU staff and provider agency staff rarely communicated with each other, failed to share critical information, and made incomplete assessments and ill-advised decisions. Most critically, the provider agency made insupportable trial discharge decisions as previously described, without any input from the FSU team or follow up by the ACS facilitators who led the conferences during which these decisions were made.⁸⁶ In addition, ACS did not require its own facilitators to lead all final discharge conferences, and, in this case, ACS staff did not facilitate the final discharge conference. Further, because ACS did not have an open case with the family at the time, no ACS staff attended this conference. Therefore, ACS was not present in order to weigh in or challenge the final discharge decision that was made regarding Alex and her siblings.

In Case B, following the children's discharge from foster care to their mother, three ACS-contracted preventive services provider agencies were responsible for working with the Morgan's family over a 15 month period, and the third preventive services agency was working with the family up to the day Morgan died. ACS' basis for determining that any of these programs were best suited to the needs of this family is not clear from the records. What is clear is that, over the course of the period during which these agencies were responsible for providing preventive services to this family, the safety and well-being

⁸⁴ One of the few exceptions is when both ACS and one of its provider agencies are working with the same family, as in the "split cases" example noted earlier in this report. In those cases, ACS staff should function as the case manager.

⁸⁵ N.Y. SSL § 153-k(4)(c).

⁸⁶ ACS staff who attend trial and final discharge conferences can request an ACS "management review" when decisions made at the conference do not adequately address a potential health or safety risk. If ACS management and the provider agency program director cannot then resolve the issue, "ACS can make a unilateral decision that addresses the health and/or safety issue." ACS, Office of Family Permanency Team Conferencing Protocol Phase II (Apr. 2009), at 34.

of the children deteriorated significantly. The home became uninhabitable, the school-aged children were either not enrolled or rarely attended school, and the mother was unable to provide the necessary care for the children or comply with mental health and other services she and the children needed. Morgan died on a day when, much like previous allegations concerning this family, the mother was not supervising her children and the father of the younger children was not at home.

ACS was unable to provide data regarding the percent of trial and final discharge conferences it facilitates, the percent of trial and final discharge conferences attended by ACS staff who also had an open case with the family at the time of the conference (e.g., Court Ordered Supervision), or the percent of conferences during which safety concerns were identified but were not elevated for management reviews, as required. ACS' failure to collect data and track performance on these important systemic issues raises concerns regarding ACS' ability to oversee its provider agencies and ensure that child safety, permanency, and well-being issues are being appropriately addressed during and, when necessary, after these critical case conferences.

V. SUMMARY OF DOI'S RECOMMENDATIONS AND ACS' RESPONSES

Both during and at the conclusion of this investigation, DOI provided ACS with a number of policy and procedure recommendations (PPRs), the most important of which are summarized below. Also listed below are ACS' responses. DOI notes that ACS accepted many, but not all, of DOI's recommendations. ACS has also agreed to other changes not detailed here.

1. In order to address potential conflicts of interest, ACS should, within the next 30 days, develop a new CPS case assignment policy requiring new investigations involving families who are receiving Court Ordered Supervision to be assigned to CPS investigators who do not also carry Court Ordered Supervision cases.

ACS accepted this recommendation conditioned on resolution of certain technological issues.

2. In order to ensure that all critical case information is available to all ACS investigative staff, ACS should, within the next 30 days, develop a policy requiring that all relevant information collected by and/or findings made by its Investigative Consultants, who assist CPS caseworkers on some cases, is documented in CONNECTIONS.⁸⁷

ACS accepted this recommendation.

⁸⁷ CONNECTIONS is the statewide electronic system of record for all child welfare-related services.

3. In order to improve ACS' oversight of its provider agencies, ACS should provide DOI with routine updates regarding the implementation of its improved oversight plan, including providing DOI with the necessary new and/or revised policies, procedures, and training protocols associated with this plan, as well as ACS' projected goals and any tools and data ACS uses to measure progress.

ACS did not accept this recommendation. ACS will provide quarterly updates to the Deputy Mayor for Health and Human Services.⁸⁸

4. In order to ensure that ACS takes appropriate disciplinary actions when necessary, ACS should revisit its decisions not to discipline employees in Case A and should develop a new policy whereby ACS either suspends employees who are under review for potential disciplinary action from performing casework responsibilities or provides additional oversight of their performance during the pendency of these reviews.

ACS accepted this recommendation in part. In Case A, ACS again determined that discipline on the case facts was not appropriate or likely to be sustained. In response to a DOI recommendation regarding Case C, ACS audited a sample of three ACS employees' cases and began the progressive disciplinary process for one of those employees. ACS stated that a new policy is not necessary because it can suspend staff when practice is so deficient as to require immediate disciplinary action and can remove a CPS investigator from performing casework responsibilities in appropriate cases.

5. ACS and DOI should agree upon specific data measures that ACS will provide to DOI at agreed upon intervals. Specific data measures should be identified concerning the following areas:
 - i. Mandated reporting;
 - ii. Bi-weekly casework contacts;
 - iii. Collateral and service provider contacts;
 - iv. Child Safety Conferences;
 - v. Supervisory oversight;
 - vi. Court Ordered Supervision;
 - vii. Foster care provider agency performance;
 - viii. Length of stay in foster care; and
 - ix. Preventive services provider agency performance.

ACS accepted this recommendation.

⁸⁸ DOI will continue to demand specific documents from which it can undertake its own review of the implementation.

VI. CONCLUSION AND NEXT STEPS

DOI's investigation uncovered violations of two laws and numerous ACS policies and procedures, committed by ACS and its provider agencies' staff, some of which may have contributed to the deaths of two children and the near-death of a third child. Although DOI did not review a large number of cases, the number and nature of the violations and other deficiencies DOI found in these three cases over a protracted period, as well as the data findings and lack of available data highlighted in this report, raise serious concerns regarding ACS and its provider agencies' ability to consistently comply with legal obligations and ACS policy and practice requirements. ACS and Commissioner Carrión now have responsibility to address these legal, policy, and procedure violations and to make expedited changes.

DOI will monitor ACS' progress implementing the recommendations it has accepted and will track the results. DOI will also continue to thoroughly investigate potential violations of ACS' obligations, at the systemic, provider agency, and individual case level.