



New York City Administration for Children's Services

Report on the Child Welfare Case of Zymere Perkins

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**Submitted to:
Mayor Bill de Blasio**

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OVERVIEW

On September 26, 2016, Zymere Perkins, age 6, was the victim of a homicide. Prior to his death, the Administration for Children's Services (ACS) investigated five child welfare reports involving Zymere. Three reports in 2015 and 2016 were "indicated"¹ after an ACS investigation found sufficient evidence of inadequate guardianship, a form of neglect. Two reports, one in 2010 and one in 2016, were "unfounded" after an ACS investigation resulted in insufficient evidence.² During the time that the indicated cases were open, Zymere and his mother, Geraldine Perkins, lived in a Department of Homeless Services (DHS) shelter and Zymere was enrolled in a Department of Education (DOE) public elementary school. ACS also referred the family to the Family Treatment Rehabilitation Program at Mt. Sinai St. Luke's (St. Luke's), an ACS contracted provider for preventive services.³ Prior to his death, ACS had last been involved with the Perkins family on May 9, 2016, when ACS closed the family's case. St. Luke's final visit with the Perkins family was on July 28, 2016, when Ms. Perkins informed the St. Luke's case planner that she was moving to Massachusetts. On September 26, 2016, ACS received a new child welfare report about the fatality of Zymere Perkins. Upon receiving this report, ACS opened a new investigation into the fatality.

On September 28, 2016, the New York Police Department (NYPD) arrested Geraldine Perkins and Rysheim Smith, Zymere's mother and Ms. Perkins' boyfriend, and charged them with endangering the welfare of a child. The Manhattan District Attorney (DA) began pursuing a criminal case against both individuals. The DA requested that ACS not conduct interviews with any ACS staff members, any relatives or neighbors of the Perkins family, any doctors who treated Zymere, or any other collateral contacts, and that ACS not discuss the details of the September 26, 2016 case publicly as not to jeopardize the ongoing criminal investigation. ACS has complied with this request but initiated a thorough investigation of all available records of our prior interactions with the family, including an immediate review of the work of the ACS staff and St. Luke's staff who had worked with the Perkins family.

On October 12, 2016, the Office of the Chief Medical Examiner ruled that Zymere's death was a homicide caused by Fatal Child Abuse Syndrome. Recently, the DA shared with ACS statements that were made by Ms. Perkins against Mr. Smith during the criminal case that had

¹ Child welfare reports can result in one of two outcomes. An "indicated" report means that ACS has found some credible evidence that the allegations contained in the report are true. An "unfounded" report means that ACS has not found credible evidence to sustain the allegations.

² Legally, unfounded investigations may not be disclosed, except in the limited circumstances. In this instance, these unfounded investigations were incorporated into the current (September 26, 2016) child protective investigation. In accordance with New York Social Services Law (SSL) § 422 and SSL § 422-a, the only information from an unfounded investigation that ACS may disclose is that which is specifically carried forward into the current investigation in CONNECTIONS (the New York State Child Welfare system of record) to inform or provide context to the current investigation.

³ Preventive services are programs designed to support and strengthen families and address maltreatment, which are administered by non-profit organizations under ACS contract.

critical implications for our child welfare investigation. These statements, taken together with the Medical Examiner's ruling, has given ACS sufficient evidence to indicate the September 26, 2016 case against both Geraldine Perkins and Rysheim Smith.

ACS investigates every child fatality report that we receive from the Statewide Central Register (SCR), the state child abuse and neglect hotline. If the family was known to ACS at any time in the last decade, we also conduct a comprehensive review of the family's prior involvement with ACS and other city government programs. At the request of Mayor de Blasio, ACS has produced this public report, which includes:

- Findings stemming from the ACS investigation, which revealed numerous and significant failures to thoroughly investigate issues regarding Zymere's safety and welfare, both by ACS staff and one of our provider agencies. These failures highlighted frontline case practice failures, supervisory and managerial oversight failures, and system gaps that underline deficiencies in coordination between ACS, their preventive service provider agencies, and other city agencies.
- A summary of all available ACS and St. Luke's case records, which detail interactions with Zymere Perkins, Geraldine Perkins, and Rysheim Smith prior to September 26, 2016.
- Disciplinary actions ACS has taken against nine staff who failed in their duties; ACS initiated termination proceedings against three staff, initiated suspensions without pay against two staff, and demoted four staff following 30-day unpaid suspensions.
- Fifteen critical reforms that address the core systemic failures found in both ACS frontline and supervisory processes as well as the broader deficiencies of interagency coordination intended to strengthen the safety net for our most vulnerable children.

The New York State Social Service Law precludes ACS from releasing case-specific information unless specific circumstances are present and certain criteria have been met. The unique circumstances presented in Zymere's case permits ACS to take the unusual step of publicly releasing this information. State law permits ACS to release this report due to the fact that the five following conditions have been met:

- ACS has indicated the case; AND
- The child named in the child welfare report has died; AND
- The subject(s) of the child welfare report have been charged with a crime; AND
- There are no surviving siblings; AND
- The Commissioner has issued a written statement prior to the Mayor prior to disclosing setting forth the statutory basis for disclosure.

ACS has confirmed with the DA that the information contained in this report and releasing it publically does not jeopardize the DA's ongoing criminal investigation of Geraldine Perkins and Rysheim Smith. ACS continues to abide by the DA's request that we not conduct interviews.

The safety of New York City children is ACS's number one priority and we strive for the highest levels of professionalism. ACS is committed to continuous reform and is working diligently to make necessary changes to address the lapses identified in this case, both within the agency and at our contracted providers.

FINDINGS OF ACS'S INVESTIGATION

- Throughout the two year investigative history prior to the fatality, ACS Child Protective Specialists (CPS) failed to completely and thoroughly investigate issues regarding the welfare of Zymere Perkins:
 - CPS failed to locate/contact Zymere's family members;
 - CPS failed to further investigate signs of domestic violence;
 - CPS failed to attach sufficient importance to Zymere's mother's ability to care for him in the investigative process;
 - CPS failed to seek medical examinations for Zymere despite allegations of serious physical abuse; and
 - CPS failed to directly contact relevant medical and mental health providers and to obtain appropriate releases to obtain records.

- Throughout the two year investigative history prior to the fatality, ACS Child Protective Supervisors failed to follow protocol and did not adequately supervise the CPS team involved in the Zymere Perkins investigations:
 - Child Protective Supervisors failed to properly assess casework and make recommendations regarding use of collateral contacts, which might have provided evidence to substantiate abuse claims;
 - Child Protective Supervisors did not make recommendations to CPS staff regarding timely and appropriate interventions for the Perkins family;
 - Child Protective Supervisors allowed CPS staff to prematurely close cases involving the Perkins family without having addressed all supervisory directives; and
 - In two separate cases that included physical abuse allegations (June 2015 and February 2016) Child Protective supervisors failed to direct CPS staff to further investigate allegations of physical abuse where further investigation might have found evidence to substantiate the abuse claims. Both cases were indicated solely for Neglect/Inadequate Guardianship.

- Throughout the two-year investigative history prior to the fatality, the ACS Child Protective Manager failed to follow standard protocol, and failed to provide proper supervisory oversight to ACS Supervisors and CPS staff involved in the Zymere Perkins investigations:
 - The ACS Child Protective Manager did not review case work files within the required timeline;
 - Despite allegations of serious physical injury, the Child Protective Manager did not offer appropriate guidance to the Child Protective Supervisors and CPS Staff. This resulted in failure to amend reports to include additional relevant allegations as well as in premature case closure;
 - The Child Protective Manager failed to guide the CPS team to consult with Family Court Legal Service attorneys to discuss possible family court intervention; and
 - The Child Protective Manager failed to guide the CPS team to consult with clinical specialists in mental health, substance abuse, and domestic violence to guide the CPS team’s decision making.

- Four senior ACS Managers – two lawyers and two managers in the Division of Child Protection – failed to follow up on specific concerns about the deficient case practice of one ACS CPS in May 2014; this employee was later involved in a 2015 Perkins investigation.

- In an April 2016 investigation of allegations of physical injuries and inadequate guardianship, which included an interview at the Manhattan Child Advocacy Center (CAC), ACS staff did not follow up on meaningful, conflicting information: Zymere’s account of the events leading to his injuries, his mother’s inconsistent explanations, and his prior history of injuries. This conflicting information should have prompted a deeper investigation including interviews with neighbors, relatives and medical providers. Instead, ACS closed this investigation as “unfounded” 23 days after the SCR report was received.

- In early 2016 ACS received two SCR reports from Zymere Perkins’ school regarding suspicious physical injuries. During the course of those investigations ACS learned that Zymere had been absent from school 24 times in the 2015/16 school year and been regularly late when he did attend. Despite this information, ACS failed to amend the investigation to include an allegation of Educational Neglect.

- ACS contracts with Mt. Sinai St. Luke’s Family Treatment Rehabilitation Program for Preventive Services. St. Luke’s failed to follow important protocols and standards in the

Perkins case. Despite case planner concern about the frequency of Zymere's injuries, St. Luke's:

- Failed to call the SCR or an elevated risk conference;
 - Failed to adequately conduct risk assessments; and
 - Failed to properly address safety and risk prior to case closing, including addressing documented reports from Ms. Perkins stating that Zymere was "accident prone" and confirming statements made by Ms. Perkins that the family intended to move out of state.
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- ACS was aware that Mr. Smith had a documented history of domestic violence prior to his relationship with Ms. Perkins. Caseworkers appropriately reviewed and documented his prior Domestic Incident Reports and asked Ms. Perkins questions about possible domestic violence. Nonetheless, Mr. Smith's history, combined with the physical abuse allegations involving Zymere, should have led caseworkers to probe more deeply about potential domestic violence.

SUMMARY OF ALL AVAILABLE ACS AND PREVENTIVE SERVICES CASE RECORDS

The following case summaries include information from all available ACS and St. Luke's case records, which detail interactions with Zymere Perkins, Geraldine Perkins, and Rysheim Smith prior to September 26, 2016, as well as the details surrounding the September 26, 2016 fatality investigation.

Child Welfare Investigation #1, dated June 22, 2010

Outcome August 19, 2010: Unfounded Parents' Drug/Alcohol Misuse⁴

On June 22, 2010, ACS received a report made to the SCR alleging that Ms. Perkins tested positive for marijuana after giving birth to Zymere; however the child's toxicology report was negative. The physician at the hospital stated that Ms. Perkins' drug use had not impacted the infant. ACS did not indicate the report.

Child Welfare Investigation #2, dated June 30, 2015

Outcome August 28, 2015: Indicated for Inadequate Guardianship

⁴ Legally, unfounded investigations and case records are "sealed" and may not be disclosed, except in limited circumstances. In this narrow instance, in accordance with SSL § 422 and SSL § 422-a, the only information from an unfounded investigation that ACS may disclose is that which is specifically carried forward into the current investigation, and so noted in CONNECTIONS (the New York State Child Welfare system of record) to inform or provide context to the current investigation.

On June 30, 2015, ACS received a report made to the SCR from an anonymous caller alleging that Rysheim Smith, Ms. Perkins' partner, had hit Zymere with excessive force "at least 20 times" on his buttocks and legs for not listening while at a picnic. Ms. Perkins was reportedly present during the incident and did not intervene. The report also noted that Mr. Smith hit the child hard enough that the source sitting at the picnic table was able to hear the slaps from each hit. According to the anonymous caller, after hitting the child Mr. Smith informed Zymere he would be getting another "ass whopping" when they get home.

At the time of the June 2015 report, Ms. Perkins and Zymere were residing in a homeless shelter. Mr. Smith did not reside in the shelter unit but lived in a nearby apartment. At the initial ACS contact, on July 1, 2015, Zymere was undressed by his mother. Observing Zymere's body, the CPS noted there were no marks or bruises. Ms. Perkins denied she allowed her boyfriend to discipline her child and refused to provide his contact information to the CPS. Ms. Perkins admitted that she smoked marijuana on occasion. Ms. Perkins refused to provide any information regarding Zymere's father.

During the initial contact on July 1, the CPS described Zymere as clean, well-groomed and polite. Ms. Perkins stated that she disciplined Zymere by issuing timeouts or taking items away but also admitted to "little spanks" as needed. Zymere initially denied being hit by his mother's boyfriend, Mr. Smith; however, the child later said Mr. Smith had hit him at a friend's house but not at the park. He also said he was not afraid of Mr. Smith and that Mr. Smith loved him. The case notes indicate that further questioning of this account did not take place.

On July 6, 2015, the CPS interviewed Mr. Smith in a community park. He denied the allegations. He said he had been involved with Ms. Perkins for approximately two months.

The CPS referred Ms. Perkins for an evaluation at the Upper Manhattan Mental Health Clinic and offered preventive services – programs designed to support and strengthen families and address maltreatment, administered by ACS contracted providers. Ms. Perkins did not visit the clinic and declined the services.

On July 29, 2015, the CPS received a signed medical examination form by mail from Zymere's pediatrician, noting that Zymere had a physical on July 14, 2015 and was deemed a well child.

On August 28, 2015, the CPS Supervisor Level II (CPSS II) interviewed Ms. Perkins, Mr. Smith and Zymere at the borough office. Ms. Perkins had what appeared to be burn

marks or scars on her arms, neck and face. The case notes do not reflect any conversation about the marks or scars. Ms. Perkins denied hitting Zymere as a form of punishment and again denied that she allowed Mr. Smith to hit her child.

Zymere initially denied that Mr. Smith hit him. However, Zymere disclosed that Mr. Smith had placed him under a cold shower with no clothing as a form of punishment. Zymere stated that his mother was present during the incident and had yelled at him and slapped him in the face. Later in the interview, he said Mr. Smith made him do five push-ups and beat him with a belt when he misbehaved. Mr. Smith denied hitting the child, but eventually admitted that he placed Zymere in the shower without the water running as “leverage” to encourage the child to behave. CPS told Mr. Smith that pushups and cold showers were inappropriate for discipline and could not be used. Mr. Smith stated that he would stop.

ACS Investigative Consultants confirmed that Mr. Smith had four Domestic Incident Reports on record between 2005 and 2015. None of those reports involved Ms. Perkins. The CPS completed a domestic violence screening, and Ms. Perkins denied there was any domestic violence in her relationship with Mr. Smith.

The investigation included four visits with Ms. Perkins and Zymere, one meeting with Mr. Smith alone, and another at the ACS borough office with Mr. Smith, Ms. Perkins, and Zymere. There is no documentation of other collateral contacts to substantiate the statements of Ms. Perkins. This investigation lacked diligence regarding the statements by Zymere about the incidents of corporal punishment and the impacts of emotional abuse.

Outcome: On August 28, 2015, ACS substantiated the allegation of inadequate guardianship against Rysheim Smith and Geraldine Perkins, and the investigation concluded. The CPS offered Ms. Perkins preventive services but she refused them. The CPS Supervisor and CPS scheduled a follow up meeting with Ms. Perkins and Zymere for September 1, 2016 (see Child Welfare Investigation #3, below).

Child Welfare Investigation #3, dated August 31, 2015

Outcome October 2, 2015: Indicated for Inadequate Guardianship

On August 31, 2015, ACS received a report made to the SCR from a staff person from the homeless shelter where Zymere and his mother were living alleging that Ms. Perkins and Mr. Smith physically assaulted another resident in the shelter for unknown reasons, and that Zymere witnessed the violence. The caller said that police were contacted, but

Mr. Smith fled the scene with Zymere before the police arrived. Ms. Perkins was arrested, issued a desk appearance ticket and was released soon after.

The same CPS and CPS Supervisor assigned to the Perkins family in Child Welfare Investigation #2 were assigned to this investigation.

The CPS investigation revealed that, three days earlier, on August 28, 2015, shelter staff had called 911 and reported an “abandoned child” after a shelter resident observed Zymere in the presence of an “old man” and brought him back to the shelter. Zymere remained with the shelter staff until the police arrived. Police arrived at the shelter and waited with Zymere until his mother arrived and explained that she left him with the “old man” so she could celebrate her birthday. Later that evening, Mr. Smith, Ms. Perkins, and the shelter resident who returned Zymere to the shelter got into a physical altercation in Zymere’s presence. Ms. Perkins and Mr. Smith stated the other tenant started the altercation, but two shelter staff said that Mr. Smith and Ms. Perkins physically assaulted the resident causing a black eye and resulting in her walking with a cane. CPS did not interview this resident about the incident.

During this investigation, Ms. Perkins admitted to the CPS that on one occasion, Mr. Smith had placed Zymere in a cold shower for discipline. Zymere told the CPS that Mr. Smith beat him with a belt when he misbehaved. The CPS assessed Zymere at the Borough office and did not observe injuries. However, the CPS failed to further investigate the claims of corporal punishment, despite the fact that these claims had also arisen in Child Welfare Investigation #2.

On September 1, 2015, the Supervisor held the previously planned meeting with Ms. Perkins and Zymere in the ACS office. The ACS team again referred the family to preventive services and this time, Ms. Perkins accepted the referral.

On September 24, 2015, the CPS and the St. Luke’s Family Treatment and Rehabilitation preventive program’s case planner conducted a joint home visit. Neither the CPS nor the case planner observed marks or bruises on Zymere. Ms. Perkins reported Zymere had been acting up in school and that she wanted to have him evaluated.

The 32-day investigation included three visits with Zymere and Ms. Perkins and two interviews with Mr. Smith. The CPS interviewed shelter staff and collected medical documents provided by Ms. Perkins, but did not document having any contact with a medical provider. The CPS also did not document any conversations with the other individuals involved in the incidents that led to the August 28, 2015 911 call or the August 31, 2015 SCR call, as is standard practice.

During this investigation period, there were no attempts to visit the house of Mr. Smith to assess safety, nor did CPS ask Mr. Smith about the reported incidents of corporal punishment. The team made no attempts to contact family members or other collateral contacts. The CPS completed a domestic violence screening and indicated that the conditions that would have required further analysis were not present in this case. Nonetheless, Mr. Smith's history, combined with the physical abuse allegations involving Zymere, should have led caseworkers to probe more deeply about potential domestic violence.

Outcome: On October 2, 2015, ACS substantiated the allegation of inadequate guardianship against Rysheim Smith and Geraldine Perkins, on the basis that Mr. Smith and Ms. Perkins engaged in a physical altercation with a female shelter resident in the presence of Zymere. Their actions placed Zymere at risk of harm while he was in close proximity to the incident. ACS indicated the report and concluded the investigation. Ms. Perkins and Zymere participated for the next 10 months in the intensive St. Luke's preventive program.

**Preventive Service Case Record, September 24, 2015 through January 31, 2016
Mt. Sinai St. Luke's Family Treatment and Rehabilitation Program**

Geraldine and Zymere Perkins began preventive services through the Family Treatment Rehabilitation services at St. Luke's in September 2015. Mr. Smith frequently accompanied Ms. Perkins to the office visits with the St. Luke's case planner, but was not present during home visits. Between September 2015 and July 2016, the case planner documented 42 visits with the family in the home and at the office, as well as frequent conversations with school staff, mental health professionals, the shelter case manager and other professionals involved with the family.

The St. Luke's case planner had met with the family eight times after the initial joint visit, when, on October 26, 2015, Ms. Perkins called to inform the case planner that Zymere fell from his scooter in Riverside Park the previous day. She said she had taken him to school that day and the school told Ms. Perkins to take Zymere to the dentist. Case notes also indicate that the St. Luke's case planner told Ms. Perkins to take Zymere to the dentist.

In November 2015, Zymere began receiving therapy at the Child and Family Institute (CFI). During an office visit on December 9, 2015, Ms. Perkins stated that Mr. Smith did not like Zymere's therapist because he did not acknowledge him as the man in Zymere's life. Mr. Smith told the St. Luke's case planner he thought Zymere was doing much better

because he, Mr. Smith, was the male role model Zymere needed. He said Ms. Perkins was “soft” with Zymere and added that he taught Zymere “how to be a man.” Both caretakers denied that they spanked Zymere. The case planner counseled the couple on age-appropriate manners of discipline, but did not document any discussions about Mr. Smith’s controlling behavior. At the end of December, Ms. Perkins terminated Zymere’s sessions at CFI.

The couple also complained about disliking Phoenix House, where they were sent to by St. Luke’s for drug testing after they acknowledged using marijuana. Phoenix House requested that Mr. Smith not return to the agency with Ms. Perkins, as he was intimidating to staff. Mr. Smith claimed that Phoenix House was “setting up” Ms. Perkins by tampering with her toxicology screening. Again, the case planner documented no discussions about Mr. Smith’s controlling behavior.

On January 28, 2016, during a home visit, the case planner observed Zymere lying in Ms. Perkins’ bed with a blanket covering his mouth. Ms. Perkins said he had not gone to school that week after falling on ice in the park and breaking his tooth. Ms. Perkins said she took him to the dentist. The case planner noted that “Zymere did not have any teeth in the top of his gum.” The case planner expressed concern about the frequency of Zymere’s injuries and discussed the prior incident where he was said to have fallen off a scooter and hurt his jaw. Despite these concerns, the case planner did not call the SCR and did not seek an Elevated Risk Conference with ACS, as is required in such situations.

Zymere denied being hit by either caretaker. However, the case planner did not interview him alone; Ms. Perkins attempted to answer for him when he was asked about being harmed by his mother or Mr. Smith. The case planner noted feeling uncomfortable about the injury and that the last two injuries were around the mouth. She cautioned Ms. Perkins that an SCR report could be filed if neglect was suspected. Again, the case planner did not call the SCR and did not seek an Elevated Risk Conference with ACS, as is required in such situations.

Child Welfare Investigation #4, dated February 2, 2016

Outcome March 25, 2016: Indicated for Inadequate Guardianship

On February 2, 2016, ACS received a report made to the SCR from a staff member at Zymere’s school stating that Zymere had a series of suspicious injuries, including, she alleged, a “fractured jaw” four months earlier in October 2015, scratches near his eye a few weeks earlier, and a knocked-out tooth the previous week. The report said Ms. Perkins attributed all three injuries to falls, but she had not provided a doctor’s note and had made threats to transfer Zymere out of the school. Additionally, the report alleged the

“stepfather,” Mr. Smith, was known to be rough with Zymere. The source also said Zymere exhibited behavioral problems in the classroom but was not receiving services.

On February 2, 2016, ACS spoke to the school guidance counselor, who stated that Zymere had 24 absences in the school year.

At the February 3, 2016 initial home visit by CPS, Ms. Perkins denied her son was being abused. She claimed Zymere was very clumsy and fell a lot. Ms. Perkins provided the CPS with notes from a Manhattan dentist, which stated that Zymere had been seen on January 26, 2016, with trauma to the “lower Ant region—two loose teeth as result of a scooter incident.” Zymere had been referred to an oral surgeon for a tooth extraction. Ms. Perkins stated she had provided the school with documentation regarding her son’s injuries. Although, as noted above, the St. Luke’s case planner was aware of the January injury to Zymere’s mouth, there was no open child protection case at that time. The St. Luke’s case planner did not call the SCR and did not seek an Elevated Risk Conference with ACS to raise concerns, so ACS was not notified about the injury until this February report. Ms. Perkins added that Mr. Smith had broken up with her after learning of the new ACS case.

On February 5, 2016, ACS organized a “Family Team Meeting.” Ms. Perkins attended, along with Zymere, the CPS, and the CPS supervisor. Again, Ms. Perkins said the injuries were due to Zymere falling in the park. She reported that Zymere was riding his scooter on the steps when he fell and hit his face and mouth. Ms. Perkins said X-rays were taken and his jaw was not fractured; Ms. Perkins provided a note from the doctor who reviewed the X-rays which stated that the jaw was not fractured.

The CPS interviewed Zymere alone. He stated that he fell on the snow, hurt his mouth and the dentist took his teeth out. The CPS noted a circular hand scratch in the middle of Zymere’s back and documented that the mark looked like it was made by a child. According to Zymere, the mark on his back was caused by his cousin who hit him. The record does not reflect efforts to contact relatives to verify this account. Zymere reported that his mother spanked him with a belt. He said Mr. Smith did not hit him, “ever.”

On February 8, 2016, the St. Luke’s preventive case planner stated that Ms. Perkins appeared to be “greatly” influenced by Mr. Smith. The preventive case planner recounted her concerns about an injury to Zymere’s mouth, and a conversation she had with Ms. Perkins at that time. The St. Luke’s case planner told the CPS she had suspected that Mr. Smith may have been hitting the child. The CPS did not explore what led to the case planner’s suspicion, and the child denied it.

On February 18, 2016, the CPS and St. Luke's case planner followed up with a joint visit to the home, in which the CPS suggested that Ms. Perkins buy Zymere a helmet to avoid injuries when riding his scooter.

ACS Investigative Consultants again reviewed Mr. Smith's prior Domestic Incident Reports. On February 9, 2016, the CPS received the results, noting the four that were reported in earlier investigations, as well as two additional reports, dated 6/26/05 and 7/29/15. Neither of these reports involved Ms. Perkins. The CPS again completed a domestic violence screening, and again indicated that the conditions which would have required further analysis were not present in this case.

Additional Information Report, dated March 14, 2016

On March 14, 2016, staff at Zymere's school made a report to the SCR. The SCR categorized this call as "additional information" for the already-open investigation, which is standard practice. The report stated that Zymere had an eye injury and scratches around his right eye. Zymere said he was kicked in the face by his cousin.

In response to the report, a CPS from ACS Emergency Children's Services (overnight child protective investigators) visited the case address, but was informed by shelter security that Ms. Perkins had signed out of the shelter. The security manager stated that Ms. Perkins signed out every evening and returned the following day.

On March 15, 2016, the regularly assigned CPS investigator called Ms. Perkins and advised her to take the child to the doctor the following day to have his eye examined. Ms. Perkins agreed.

On March 16, 2016, the CPS followed up with a home visit. Ms. Perkins reported that Zymere had a fight with another child in the park, and denied the other child was a cousin. Ms. Perkins claimed that she had not taken Zymere to the doctor because, she said, ACS had told her Zymere could not miss more school. The CPS provided Ms. Perkins with carfare to take the child to the New York Eye and Ear Infirmary of Mount Sinai. The CPS observed a bright red dot in Zymere's right eye with a light reddish bruise under the eye and several long scratches around the eye.

On March 16, 2016, the CPS also interviewed Zymere at school. He stated he was sitting on the slide and refused to move to allow another child to go down the slide; the other child kicked him in the face and scratched him. The case notes do not reflect if the other child was interviewed separately. The following day, the CPS wrote that Zymere "was seen at the NY Ear and Eye Infirmary at Mt. Sinai. Child was assessed and his vision is

20/20. Child is cleared to return to school. Follow up in 6 months. Document in case record.”

During a school visit on March 22, 2016, Zymere stated to the CPS that his mother and Mr. Smith had taken him to the park and then repeated his earlier account. Zymere disclosed that he saw Mr. Smith every day but they did not live in Mr. Smith’s house. Zymere stated that his mother and Mr. Smith used to spank him on his butt when he did not listen; however, they no longer spanked him. He also stated they used to hit him with a belt but did not anymore, “they just talk.” The CPS failed to further investigate the claims of corporal punishment, despite the fact that these claims had also arisen in Child Welfare Investigation #2 and #3.

While at the school, the CPS reviewed the child’s attendance and noted he had missed 24 days of school and had been late 36 times. School staff noted that his promotion was in jeopardy due to poor attendance. Throughout this investigation, CPS documented only two conversations with school staff. The CPS did not flag evidence of chronic absenteeism for further action and the ACS team did not amend the allegations to include educational neglect.

Further, the CPS collected medical documentation from Ms. Perkins but did not document any conversations with medical or dental providers, which is standard practice. Despite these concerns, the case planner did not call the SCR and did not seek an Elevated Risk Conference with ACS, as is required in such situations. Again, Mr. Smith’s history, combined with the number of physical abuse allegations involving Zymere, should have led caseworkers to probe more deeply about potential domestic violence and corporal punishment.

Outcome: On March 25, 2016, ACS substantiated the allegations of inadequate guardianship against Mr. Smith and Ms. Perkins. ACS indicated the report and concluded the investigation. Ms. Perkins and Zymere continued to participate in the intensive St. Luke’s preventive program.

**Preventive Service Case Record, dated February 1, 2016 through April 18, 2016
Mt. Sinai St. Luke’s Family Treatment and Rehabilitation Program**

As stated in Child Welfare Investigation #4, on February 2, 2016, ACS received a report made to the SCR from staff at Zymere’s school alleging suspicious injuries. On February 5, 2016, the St. Luke’s case planner spoke with the caseworker from the homeless shelter, who reported that Ms. Perkins had been evasive in a meeting with him. Ms. Perkins continued to deny hitting Zymere.

On February 18, 2016, the St. Luke's case planner and the investigating CPS conducted a joint home visit. Ms. Perkins had not entered a drug program and was not receiving the services as she had agreed to earlier in the fall of 2015. Additionally, she was no longer submitting to drug testing. Ms. Perkins claimed that Mr. Smith had broken off their relationship because ACS had accused him of hitting Zymere, but said they would remain friends. In March 2016, Zymere began therapy at the Jewish Board for Children and Families (JBFCF).

On March 16, 2016, the St. Luke's case planner observed that Zymere had a red eye. Ms. Perkins said he had a fight in the park with a boy. Ms. Perkins said she took him to the doctor and was given a referral to the eye specialist; ACS confirmed the visit to the specialist on March 17, 2016. Following a meeting with Ms. Perkins at St. Luke's on March 24, 2016, the case planner noted that Ms. Perkins was following up with Zymere's medical and mental health appointments, but failing to follow up with her own appointments. At the meeting, St. Luke's staff discussed Zymere as being "accident prone" and having trouble focusing in school.

Child Welfare Investigation #5, dated April 18, 2016
Outcome May 10, 2016: Unfounded

On April 18, 2016, additional allegations raised by school staff began an investigation that resulted in an unfounded determination. The facts of this investigation were reviewed and incorporated into Child Welfare investigation following Zymere's death, dated September 26, 2016.⁵

The allegations of suspicious bruises and scratches on both of Zymere's legs led the ACS CPS to elevate the case so that it would be jointly investigated by the ACS/NYPD Instant Response Team (IRT). That same day, Zymere and Ms. Perkins were brought to the Manhattan Child Advocacy Center (CAC), where separate interviews were conducted with Zymere and Ms. Perkins by the IRT. Participants in the CAC interview included an NYPD detective, an assistant district attorney, an ACS CPS, and a social worker/forensic interviewer from Safe Horizon.

While the SCR report alleged that the child had multiple scratches and bruises to the legs, the notes from the CAC session describe only faint redness on Zymere's leg; no other

⁵ Legally, unfounded investigations and case records are "sealed" and may not be disclosed, except in the limited circumstance. In this narrow instance, in accordance with New York Social Services Law (SSL) § 422 and SSL § 422-a, the only information from an unfounded investigation that ACS may disclose is that which is specifically carried forward into the current investigation, and so noted in CONNECTIONS (the New York State Child Welfare system of record) to inform or provide context to the current investigation.

marks or bruises were observed by any of the four individuals who observed the child. Photographs were taken at the CAC, but no marks or bruises are visible. This information did not support the reports from the school. CPS did not document any efforts to follow up with the school nurse to review and compare her account.

Despite the CPS' request for a medical examination, the CAC physician was not available to see Zymere on the day of the interview because she was with other patients. The CPS Supervisor wrote in the case notes that Zymere would be scheduled for a medical assessment at the CAC.

A videotape of Zymere's interview reveals an active, mostly cheerful child, making inconsistent statements about corporal punishment. According to Zymere, his mother no longer hit him but instead punished him by not letting him watch movies. Later in the CAC interview, he said he was spanked. Zymere said he injured his knee on the scooter at his aunt's house. He added he could not remember what day he fell. He said his mother was not present when he fell.

The NYPD Detective and the Assistant District Attorney determined that they did not have sufficient evidence to pursue a criminal case. Following the CAC interviews, the CPS Supervisor forwarded the initial safety assessment, which stated the child was not in immediate danger of harm, to the Child Protective Manager (CPM). The CPM approved the safety assessment with no additional directives.

The St. Luke's preventive case planner organized a meeting that was held the next day, April 19, 2016, at the child's school. ACS representatives, the case planner, school nurse, teacher and Ms. Perkins were present. The child's absences and tardiness were reviewed and school staff mentioned an unexplained mark on the boy's face the previous week.

On April 25, 2016, a medical assistant from the CAC called Ms. Perkins to schedule the medical assessment. Ms. Perkins refused to make an appointment. Neither the CAC medical assistant nor the CPS followed up to ensure that the appointment was made. There is no documentation indicating that a medical exam was completed at the CAC or elsewhere.

On May 6, 2016, the CPS documented the result of the Investigative Consultant's clearance of Mr. Smith, which were the same six reports noted in the February investigation, none of which involved Ms. Perkins. The CPS again completed a domestic violence screening and again indicated that the conditions that would have required further analysis were not present in this case.

On May 9, 2016, the CPS made a final visit to the family at the homeless shelter. Ms. Perkins discussed steps she was taking to limit Zymere's injuries – such as watching him closely when they were outside – and plans she had made for moving out of the homeless shelter to Brooklyn.

On May 16, 2016, the CAC held a regular case review meeting, during which the Perkins case (among others) was addressed. ACS representatives did not recommend that additional steps be taken to further investigate the case.

**Preventive Service Case Record, dated April 19, 2015 through September 19, 2016
Mt. Sinai St. Luke's Family Treatment and Rehabilitation Program**

On May 3, 2016, Zymere's JBFCS therapist, who Zymere was referred to by St. Luke's, called the St. Luke's case planner to state that Zymere was in therapy. However, on May 26, 2016, the JBFCS therapist called to inform that Zymere's case was being closed due to poor attendance.

In May and June, the St. Luke's case planner met with the family six times and spoke with Ms. Perkins often by phone. On July 11, 2016, Ms. Perkins told the case planner that the shelter discharged Ms. Perkins and Zymere due to frequent absences.⁶ In a phone conversation, Ms. Perkins said she was living with an uncle in Manhattan but the St. Luke's case planner did not verify this. Ms. Perkins said her uncle would not allow home visits. The St. Luke's case planner met with Ms. Perkins on July 12, 2016 in the St. Luke's office, and spoke with Ms. Perkins two more times on the phone. However, St. Luke's did not attempt further visits outside the office.

On July 28, 2016, Ms. Perkins informed the St. Luke's case planner that she and Mr. Smith would be moving to Massachusetts. She said they planned to enter a shelter in Springfield and they would leave New York on August 1, 2016 by Greyhound bus. The case planner provided Ms. Perkins with a list of emergency numbers and held a "termination conference" with her and Zymere in the office. This was the final contact with the family. The case planner's supervisor entered a note on August 1, 2016 stating that the case was being closed because the family was moving. The move was not verified. On September 19, 2016, the preventive case was officially closed in the Connections system.

⁶ Ms. Perkins and Zymere left the shelter and did not come back. Per DHS standard protocol, families are discharged from shelter when they have been absent from a facility for 48 consecutive hours without having complied with the facility's rules concerning absence.

Throughout the year that St. Luke's worked with Ms. Perkins and Zymere, the case planner discussed appropriate forms of discipline for a 5-year-old with both Ms. Perkins and Mr. Smith, documented child safety and risk assessments and made scheduled and unannounced visits to the shelter where Zymere and Ms. Perkins lived. In addition, the case planner discussed domestic violence and inquired about Zymere's injuries. Ms. Perkins and Mr. Smith consistently denied inflicting injuries to the child, as well as denied domestic violence. The case planner documented many collateral contacts with service providers during the length of preventive services, with ACS, service providers, DHS and the DOE psychologist and school staff. Nevertheless, St. Luke's failure to act with urgency on more than one occasion on suspicions that Zymere was being physically abused remains a troubling and persistent deficiency in their case practice here.

Child Welfare Investigation #6, dated September 26, 2016

Outcome December 13, 2016: Indicated for fatality; internal injuries; inadequate guardianship; lacerations welts and bruises

On September 26, 2016, ACS began an investigation into the death of Zymere Perkins. ACS began a standard investigation starting with contacting family, school personnel and others who had interacted with the family.

On September 29, 2016, the Manhattan DA requested that ACS not conduct interviews with any ACS staff members, any relatives or neighbors of the Perkins family, any doctors who treated Zymere, or any other collateral contacts, and that we not discuss the details of the September 26, 2016 case publicly as not to jeopardize the ongoing criminal investigation. ACS complied with this request.

On October 12, 2016, the Office of the Chief Medical Examiner ruled that Zymere's death was a homicide caused by Fatal Child Abuse Syndrome. Recently, the DA shared with ACS statements that were made by Ms. Perkins against Mr. Smith during the criminal case that had critical implications for our child welfare investigation. These statements, taken together with the Medical Examiner's ruling, gave ACS sufficient evidence to indicate the September 26, 2016 case against both Geraldine Perkins and Rysheim Smith.

DISCIPLINARY ACTIONS AGAINST ACS AND PREVENTIVE PROVIDER STAFF

As soon as ACS learned of Zymere's death, ACS immediately placed five child protective staff who worked directly on one or more of the 2015 and 2016 investigations on modified duty pending further review, which removed them from conducting case work or interacting directly

with families. ACS's investigation concluded that both frontline and supervisory staff involved in the June and August 2015, and the February and April 2016 investigations failed to completely and thoroughly investigate issues regarding Zymere's safety and welfare. ACS has taken or initiated the following disciplinary actions against these five staff:

- **Child Protective Manager (2016 case):** ACS suspended this Child Protective Manager for 30 days without pay and initiated termination proceedings.
- **CPS Supervisor II (2016 cases):** ACS suspended this Child Protective Supervisor for 30 days without pay and initiated termination proceedings.
- **CPS (2016 cases):** ACS suspended this CPS for 30 days without pay and initiated termination proceedings.
- **CPS Supervisor II (2015 cases):** ACS served disciplinary charges and initiated proceedings for a 60-day suspension.
- **CPS (2015 case):** ACS served disciplinary charges and initiated proceedings for a 60-day suspension.

In addition, on October 12, 2016, ACS initiated disciplinary actions against four senior managers – two lawyers in the Office of the General Counsel and two managers in the Division of Child Protection – who failed to follow up on specific concerns about the deficient case practice of one ACS employee in May 2014; this employee was later involved in a 2015 Perkins investigation. All four were suspended without pay for 30 days and demoted.

- **Director, Employment Law Unit:** ACS suspended this Director for 30 days without pay, and, upon return, demoted him/her with concomitant reduction in salary, and moved him/her to a different ACS division.
- **Assistant Director, Employment Law Unit:** ACS suspended this Assistant Director for 30 days without pay and, upon return, demoted him/her with a concomitant reduction in salary.
- **Borough Commissioner, Division of Child Protection:** ACS suspended this Borough Commissioner for 30 days without pay and, upon return, demoted him/her with concomitant reduction in salary.
- **Assistant Commissioner, Division of Child Protection:** ACS suspended this Assistant Commissioner for 30 days without pay, and, upon return, demoted him/her with concomitant reduction in salary.

ACS has also taken swift and deliberate action to address practice and supervisory failings found within Mount Sinai St. Luke's Family Treatment and Rehabilitation (FTR) Program, which provided preventive services to Zymere and his mother. On October 13, 2016, ACS placed St. Luke's on a Corrective Action Plan, which includes the following measures:

- **Closed St. Luke's Intake:** On October 13, 2016, ACS shut down all further preventive services placements into the FTR Program. Intake remains closed until St. Luke's demonstrates full compliance with the Corrective Action Plan.
- **Placed Staff on Modified Duty:** On October 13, 2016, ACS instructed FTR Program Executive Director to remove the case worker and supervisor involved in the Perkins case from work on all ACS cases pending further review of their case practice by ACS and Mt. Sinai St. Luke's. These two staff remain on modified duty.
- **Conducting Comprehensive Review of all Active Cases:** On October 13, 2016, ACS directed St. Luke's to conduct an internal audit of all 34 active FTR cases, to be completed by December 31, 2016 and to share findings with ACS by January 31, 2017. ACS also completed its own review of these 34 cases. Following this review, ACS raised five concerns that required St. Luke's to take action immediately. St. Luke's responded to all five within 48 hours as required and ACS confirmed that the issues that prompted the concerns were addressed. This review, combined with the review of the closed cases handled by the Perkins supervisor, led ACS to place the provider on Corrective Action status and implement the Corrective Action Plan.
- **Conducting Staff Training:** On October 13, 2016, ACS directed St. Luke's to retrain all FTR staff in several practices areas, including: assessing safety and risk and appropriately elevating concerns; appropriately assessing safety and risk prior to closing cases; mandated reporter training; and supervision. Training has begun and will be fully completed by the end of January 2017.

ACS also conducted a comprehensive case record review of the 48 closed cases within the prior nine months that were overseen by the supervisor who worked on the Perkins case. While the review of closed cases revealed generally sound practice, we uncovered some deficiencies in case supervision. In response, ACS recommended additional oversight of the program and this supervisor by Mt. Sinai, which oversees the St. Luke's Treatment and Rehabilitation Program.

St. Luke's has been cooperative and compliant with the Corrective Action Plan and has provided detailed, bi-weekly updates on implementation. However, if St. Luke's fails to follow or complete actions required in the Corrective Action Plan, ACS could terminate their contract and reassign the families to another provider. ACS is closely monitoring St. Luke's practice and providing ongoing technical assistance.

CHILD WELFARE REFORMS AT ACS AND OTHER CITY AGENCIES

In addition to taking disciplinary actions against specific staff members, ACS has implemented fifteen reforms that address the failures uncovered in the Zymere Perkins case. These reforms are designed to strengthen the practices, policies, and procedures that ensure effective

investigations and prevent critical errors. The following fifteen reforms improve both the ACS child welfare system and ACS's coordination with other city agencies, including the NYPD, DOE, and DHS.

1. **Increase staff and enhance case review process at all five Child Advocacy Centers.** ACS made several reforms to the staffing and processes at the five CACs, including:
 - Stationing a Child Protective Manager in every CAC to provide tracking and oversight of all cases that come to the CAC. This Child Protective Manager will review all CAC cases that do not result in law enforcement action to ensure that all child safety objectives have been met.
 - Increasing the number of Child Protective Specialist Supervisors during day and evening hours to ensure expanded coverage and manageable supervisory caseloads.
 - Placing a Family Court Legal Services attorney at each of the CACs to reinforce follow-up, even in cases that do not result in law enforcement action.
 - Convening an automatic Child Safety Conference for all CAC cases that do not result in a Family Court filing or law enforcement action to ensure that the case continues to receive a heightened level of oversight.

In addition, Safe Horizon is adding medical staff, including doctors and nurse practitioners trained in child abuse, and expanding their presence during day and evening hours.

2. **Require ACS participation in the decision to end contracted preventive services in high-risk cases.** Preventive providers who are seeking to end services on cases that involve allegations of physical abuse against children must now include ACS in the decision-making process. Prior to October 6, 2016, preventive providers were not required to include ACS in these decisions. ACS now mandates that these high-risk cases have a Service Termination Conference, initiated by the provider and facilitated by ACS, to ensure that safety concerns and other important issues are addressed with ACS before any determinations on closing the case are made.
3. **Establish heightened DOE guidelines and protocols for closely monitoring the attendance of child welfare-involved students and for triggering an educational neglect investigation by schools whenever a student has 10 or more consecutive unexplained absences.** The Department of Education released an emergency protocol in November that establishes clear guidelines for when the absence(s) of a child welfare-involved student must be reported to ACS. The new protocol establishes an automated system to track the daily attendance of these students and directs school staff to timely escalate concerns to ACS if they are unable to reach the family or have any reason to suspect maltreatment. The protocol reiterates the strict and explicit guidelines set forth in Chancellor's Regulation A-750 for making timely reports of suspicions of abuse or neglect to the State Central Register. These

policies will guide school outreach efforts in response to student absences and strengthen interventions for students and preventative services for families when necessary. In addition, revised Chancellor's Regulations that codify these policies will be presented this month for approval from the Panel for Education Policy. The DOE will continue working closely with school staff and will be providing additional guidance to support the implementation of these policies.

4. **Conduct ongoing, enhanced training for all caseworkers on how to handle suspected physical abuse.** ACS Child Protective Specialists and Supervisors and frontline staff at all provider agencies will attend a new, specialized, in-depth course at the ACS Workforce Institute on the proper assessment and analysis of evidence, including on cases of suspected physical abuse and excessive corporal punishment. Child Protective Managers will receive enhanced training, led by expert investigators, covering the supervisory review of cases using an investigative lens, case-specific guidance for staff after the review, and confirmation that the guidance is followed.
5. **Create a new, specialized accountability unit to strengthen oversight of the Division of Child Protection.** The ACS Division of Policy, Planning and Measurement (DPPM) will now conduct performance reviews and audits of work done within the ACS Division of Child Protection (DCP). This new specialized accountability unit will screen and review case practice on all child fatalities and critical incidents, as well as other cases where there are concerns about staff performance.
6. **Establish dedicated ACS liaisons to each of the five District Attorney's Offices.** Ten CPS Supervisor Level I staff are serving as liaisons to each of the five DA's offices to share information, refer cases, and enhance investigations and case contacts between the DA, NYPD detectives, and ACS child protective specialists. This restores a staffing cut made during the prior administration.
7. **Move oversight of the Instant Response Team, which handles the most serious cases, to the ACS Senior Advisor for Investigations.** The ACS Senior Advisor for Investigations now oversees the Instant Response Team, previously overseen by the Division of Child Protection. The IRT began in 1998 to ensure that ACS and NYPD respond jointly on the most serious abuse and neglect cases. The Senior Advisor for Investigations, a former Commanding Officer of the NYPD's Special Victims Unit, has established a new oversight and review process to ensure that IRT Coordinators follow the protocol on serious physical injury cases that require collaboration with the NYPD. This team will also prevent cases from being improperly screened-out of IRT.

8. **Require managerial oversight on all serious physical injury cases.** Child Protective Managers (CPMs) are now required to review all cases alleging serious physical injury. Previously, CPMs only reviewed cases involving families with four or more reports, as well as all cases involving child fatalities. ACS has issued guidance that will require CPMs to also review all serious physical injury cases.
9. **Strengthen guidance to child protective staff on working on cases involving suspected physical abuse.** CPS workers are currently required to seek a medical examination or consultation whenever there are concerns of serious physical abuse. ACS will revise and reissue “Child Safety Alert 17: Gathering and Assessment of Information from Medical Providers During a Child Protective Investigation,” which will require CPS workers to seek medical exam or guidance when they suspect serious physical abuse or a pattern of repeated physical abuse.
10. **Increase access to legal consultations on high-risk physical abuse cases.** ACS has expanded the use of its Family Court Legal Services (FCLS) unit to provide legal consults with DCP staff on cases with allegations of serious physical abuse and/or sexual abuse, and cases with frequently encountered families. The ACS attorneys are an additional check on high-risk cases to confirm that ACS makes accurate decisions about when court intervention is warranted and how it should be pursued.
11. **Require non-social service staff at homeless shelters serving families to undergo mandated reporter training.** While social service staff at DHS shelters are already mandated reporters, DHS is now requiring non-social service staff at all family shelters to undergo training in identifying and reporting child abuse and maltreatment. Now, all staff that interacts with clients, including front desk, security, and maintenance staff, will be able to better recognize and report suspected child abuse or neglect.
12. **Require school nurses to photograph injuries when child abuse is suspected.** The Department of Health and Mental Hygiene’s (DOHMH) Office of School Health will issue enhanced guidance and provide training to DOE school nurses on how to photograph suspected child abuse injuries and how to include the photographs in their SCR report; nurses will also be trained in steps needed to protect the privacy of the child.
13. **Train parent coordinators on child welfare and safety procedures.** ACS Workforce Institute will expand ACS’ current efforts to train DOE school staff to include parent coordinators, providing training on the assessment of safety and risk, follow up and referral to preventive family support services, and navigation of the child welfare system.

14. **Enhance communication and information sharing between ACS and DHS.** DHS and ACS are developing an agreement to allow DHS to obtain more information about a family's child welfare case as they enter the shelter system in order to better facilitate service provision to the family while they are in shelter. While this agreement is being finalized, DHS and ACS have convened a workgroup that includes ACS and DHS providers to discuss policy changes that may be made to facilitate communications and information sharing between the agencies when a family in shelter has a child welfare case.
15. **Strengthen guidance and increase training on identifying domestic violence for child protective, preventive and foster care staff.** The Mayor's Office to Combat Domestic Violence (OCDV) is working with ACS to strengthen the current procedures that child protective, preventive and foster care staff use to identify domestic violence throughout a family's interaction with ACS. OCDV and ACS will bolster and expand the questions that ACS caseworkers ask to elicit information about potential Domestic Violence, and will develop enhanced domestic violence training for all new ACS employees. In addition, OCDV will develop ongoing trainings and technical support that can be provided to ACS on domestic violence cases.

RESPONSE TO NEW YORK STATE OFFICE OF CHILD AND FAMILY SERVICES REPORT ON THE ZYMER PERKINS CASE

ACS is in receipt of a draft report that our New York State oversight agency, the Office of Children and Family Services (OCFS), compiled upon their review of ACS' case practice related to the Perkins family. As a result of this review, OCFS makes four primary recommendations. Each of these recommendations are discussed below.

1. **With regard to ACS case practice, OCFS directs ACS to meet with the staff involved in Perkins investigation and submit a corrective action plan identifying what action we will take to address these issues.**

A total of five ACS staff were directly involved in the Perkins investigations in 2015 and 2016; one Child Protective Manager (CPM), two Child Protective Supervisors, and two Child Protective Specialists (CPS). As stated previously, the Manhattan District Attorney requested that ACS not discuss the Perkins case with these staff in order to not jeopardize the ongoing criminal investigation. However, based on our investigation of all available case records involving the Perkins family, ACS has taken significant disciplinary actions against all five staff for their deficient case practice in this case, as outlined on page 18 of this report.

- 2. With regard to the case practice of ACS' preventive services contractor, St. Luke's, OCFS directs ACS to meet with the St. Luke's staff involved in Perkins investigation and submit a corrective action plan identifying the actions we will take to address the concerns identified.**

Again, the Manhattan District Attorney requested that ACS not discuss the Perkins cases with St. Luke's staff in order to not jeopardize the ongoing criminal investigation. However, ACS has taken substantial action with respect to this provider. On October 13, 2016 ACS placed St. Luke's on a Corrective Action Plan, the details of which are outlined on page 19 of this report.

- 3. OCFS directs ACS to hire an external, OCFS-approved monitor to conduct a comprehensive evaluation of ACS' Child Protective and Prevention services programs.**

ACS will hire an independent monitor to review our Child Protective and Preventive Services programs, which will complement the work underway by Casey Family Programs to strengthen child safety practice. ACS will work with OCFS to ensure the objectives for this monitor are being met.

- 4. NYS directs ACS to conduct a full evaluation of caseworkers, case supervisors, and borough managers in the Manhattan Field Office to assess competencies, strengths, and weaknesses and take appropriate action necessary to respond to any identified issues.**

ACS has begun a thorough audit of cases handled by the five ACS staff involved in the Perkins case. This includes the 55 cases handled by these staff over the past year as well as the 188 cases that these five staff had on their caseloads or under their supervision before being placed on modified duty. The next phase of this analysis will assess all of ACS child protective investigative units to determine if casework and supervision practice adheres to appropriate standards. ACS and OCFS are in conversation about this evaluation and how it applies to this directive.

CONCLUSION

The death of Zymere Perkins is an unacceptable tragedy. This mission of ACS is to ensure the welfare of every child, but in this case, the City failed. The safety of New York City children is ACS's number one priority and we strive for the highest levels of professionalism. We are working diligently to address the lapses identified in this case, both within the agency and at our

contracted providers, and make the essential reforms and improvements required to prevent the lapses and failures that can lead to tragedy.