



The City of New York  
Department of Investigation

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Release #11-2016  
[nyc.gov/html/doi](http://nyc.gov/html/doi)

**FOR IMMEDIATE RELEASE  
WEDNESDAY APRIL 13, 2016**

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**DOI ARRESTS THREE ADDITIONAL STAFFERS AT CITY'S JUVENILE HOMES AMID INVESTIGATION OF  
INADEQUATE OVERSIGHT BY THE CITY ADMINISTRATION FOR CHILDREN'S SERVICES**

*ACS Failed to Take Adequate Steps to Supervise Youth and Maintain Public Safety in Two Year Old Program*

Mark G. Peters, Commissioner of the New York City Department of Investigation ("DOI"), in partnership with Kenneth Thompson, Kings County District Attorney, today announced the arrests of three former overnight staff members of Boys Town New York, Inc. ("Boys Town"), a City-contracted vendor, which had provided non-secure placement ("NSP") to juveniles adjudicated as delinquent. The arrests are part of DOI's larger investigation that found the City failed to properly supervise such NSPs upon the creation of the Close to Home program, an initiative designed to keep adjudicated juveniles close to their families and communities, and for the following two years, despite evidence of safety issues. On June 1, 2015, three AWOL juveniles escaped from a Boys Town home in Brooklyn and later raped and robbed a woman in Manhattan.

Three staffers were arrested on charges of falsifying log book entries claiming they conducted required bed checks to ensure youth were secure in their bedrooms when they had not actually monitored the youths' whereabouts. A fourth staffer will be arrested at a later time. In some instances, these employees were captured on surveillance video lying on floors of the facility or even leaving the facility unsupervised for periods of time when they should have been present and conducting bed checks. Three of the staffers worked at the Boys Town facility on St. John's Place in Brooklyn and the fourth staffer worked at the Boys Town facility on 6<sup>th</sup> Avenue in Brooklyn. DOI's investigation, which involved the review of hundreds of hours of surveillance video, found the failure to actually conduct recorded bed checks was endemic in the homes. Boys Town has since closed its NSP homes.

The arrests come as a result of DOI's investigation into the management of the City's residential NSP facilities for juveniles, launched in June 2015 after the teens' escape. In conjunction with the arrests, DOI released a Report today documenting its findings regarding supervision failures by Boys Town and oversight deficiencies by the City Administration for Children's Services ("ACS"), and recommended reforms to improve ACS' management of the Close to Home program. DOI's investigation found deficiencies in how ACS, which has custody of the juveniles and responsibility of the safe management of these facilities, monitored safety and security at Boys Town NSP homes. The investigation found that ACS had noticed certain homes had problems with juveniles going AWOL long before the June 1<sup>st</sup> rape because of poor supervision. The investigation also found that ACS failed on a systemic level to properly oversee Close to Home providers, including insufficient internal protocols and policies regarding site inspections, and safety and security at these facilities. A copy of DOI's Report follows the release and can be found here: <http://www.nyc.gov/html/doi/html/doireports/reports.shtml>

ACS has already ended its NSP contract with Boys Town, has accepted DOI's recommendations and has begun to implement them. DOI will continue to monitor.

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DOI Commissioner Mark G. Peters said, "This investigation showed a pervasive lack of oversight of City-contracted juvenile homes that resulted in a tragedy on June 1<sup>st</sup> of last year. The City and ACS have an obligation to safeguard both the public and the juveniles entrusted to their care, an obligation they failed to meet for several years."

ANDREW BEST, SORAYA DELANCEY, STANLEY STEPHENS are each charged in separate incidents with falsifying log book entries that inaccurately indicated they checked the whereabouts of the juveniles in the care of Boys Town. BEST faces charges of Offering a False Instrument for Filing in the Second Degree, Forgery in the Third Degree, and Criminal Possession of a Forged Instrument in the Third Degree, all class A misdemeanors. DELANCEY and STEPHENS each face charges of Offering a False Instrument for Filing in the Second Degree and Falsifying Business Records in the Second Degree, all class A misdemeanors. Upon conviction, a class A misdemeanor is punishable by up to a year in prison.

BEST, 23, of Brooklyn, NY, worked with the Boys Town organization as Overnight Program Staff for 9 months and was working at the Brooklyn Boys Town home on 6<sup>th</sup> Avenue on the night of the June escape. He was suspended by the organization on June 2, 2015, the day after the incident, and did not return to work thereafter.

DELANCEY, 36, of Brooklyn, NY, has worked with the Boys Town organization as Overnight Program Staff for 1 year and 3 months and was working at the St. John's Place facility. She remains employed by Boys Town as a Youth Care Worker in its Secure Placement facilities.

STEPHENS, 23, of Brooklyn NY, worked with the Boys Town organization as Overnight Program Staff for 5 months and was working at the St. John's Place facility. He was fired by the organization on June 18, 2015.

In June 2015, DOI as part of its ongoing investigation, also arrested a Boys Town overnight employee for falsifying a log book stating that the teenage residents were present at the home, when in fact, they had escaped and subsequently committed the rape in Manhattan. The case against the charged individual, DENZEL THOMPSON, is pending.

On a variety of occasions, according to DOI's investigation and the criminal complaints, each of the employees made entries in their log books stating in part, "youth in rooms" and "all is well" and initialed each entry. Video footage from cameras inside the facility, however, showed that during these periods the employees were, at times, lying on floors with pillows and sheets or remained in unoccupied bedrooms without approaching any of the youth bedrooms or making any bed checks. In the 25 days leading up to the June 2015 incident, employees made just 15% of the required bed checks reviewed by DOI, according to the investigation. While this number improved in the immediate days after the escape, of all 37 nights reviewed by DOI before and after the incident, the required bed checks were performed only 27% of the time.

As part of its comprehensive review of Boys Town management and policies, DOI's investigation revealed that Boys Town did not adequately supervise its overnight staff, including failing to review the available video footage – in real time and in retrospect – to ensure youth were being properly monitored or to conduct sufficient overnight visits to facilities. In addition, Boys Town did not address safety issues like malfunctioning alarms, which contributed to the June 1<sup>st</sup> escape. In fact, the investigation uncovered a supervisor who was aware of the alarm not working at the 6<sup>th</sup> Avenue home on the night of the escape did not address the issue with overnight staff until after the incident.

DOI also identified several systemic management and oversight deficiencies by ACS, which lacked adequate policies and procedures for the supervision of safety and security at Close to Home locations. ACS did not include specific requirements in its contracts with providers towards safety and security at Close to Home facilities nor did it conduct sufficient site visits or safety assessments. The agency also completely lacked enforcement and evaluation mechanisms for measuring the performance of its providers.

DOI has issued a number of recommendations in its Report to address these deficiencies and ACS has agreed to implement them or is already in the process of implementing them. DOI's recommendations include:

- ACS should develop and implement its own policies and procedures that include strengthening protocols on how it monitors and inspects NSP sites; establish a universal tracking system for each incident so

appropriate actions can be taken and troubling trends identified and fixed; require random video reviews and audits of these sites, among others.

- ACS should enhance its contracts with NSPs to require safety and security protocols are maintained at each facility; that consistent checks are made to ensure security and video systems are in working order; live feed from the security videos are monitored; and enforcement mechanisms with clear consequences are established.
- ACS should create a proper evaluation tool to monitor performance of all NSPs to be conducted bi-annually and results should be made publicly available.
- ACS has engaged the New York Police Department (“NYPD”) to visit each NSP site and assess safety and security, as well as provide recommendations that are in compliance with the foster care regulations.

DOI Commissioner Peters thanked Kings County District Attorney Kenneth Thompson and his staff, specifically Assistant District Attorney Michael Spanokas, Chief of the Rackets Bureau, and Assistant District Attorney Sara Walshe, of the Rackets Bureau, for their partnership on this investigation; and ACS Commissioner Gladys Carrón and Deputy Commissioner for the Division of Youth and Family Justice Felipe Franco and their staffs for their cooperation in this investigation, and DOI’s NYPD Detective Squad for their assistance in the investigation.

DOI’s Office of the Inspector General for City-funded Not-for-Profits and DOI’s Office of the Inspector General for ACS conducted this investigation, specifically Investigative Attorney Katerina Kurteva and Investigator Peter Relyea, under the supervision of Inspectors General Andrew Brunsden and Shelley Solomon, Associate Commissioner Susan Lambiase, Deputy Commissioner/Chief of Investigations Michael Carroll, and First Deputy Commissioner Lesley Brovner.

Criminal complaints are accusations. Defendants are presumed innocent until proven guilty.

*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**

### **INVESTIGATION INTO THE CLOSE TO HOME PROGRAM AND THE INADEQUATE OVERSIGHT BY THE CITY ADMINISTRATION FOR CHILDREN'S SERVICES**

**MARK G. PETERS**

**COMMISSIONER**

**April 2016**

## **I. Executive Summary**

Earlier today, the Department of Investigation (DOI) arrested one current and two former workers at City-contracted homes for youth adjudicated as delinquent. A fourth former employee will be arrested at a later time. The arrests arise out of DOI’s investigation finding that the Administration for Children’s Services (ACS) systematically failed to manage and supervise such homes. These failures were made evident after three residents of one such Brooklyn home escaped and raped a woman in Manhattan last year. DOI’s investigation now shows that the security failures that made this possible were the result of systemic monitoring and oversight deficiencies that ACS failed to address long before the rape occurred. This report details DOI’s findings.

In April 2012, New York State enacted legislation authorizing the Close to Home (CTH) juvenile justice reform initiative, which was designed to keep New York City youth adjudicated as juvenile delinquents<sup>1</sup> close to their families and communities. The initiative allows New York City youth, after Family Court has determined they do not require placements in secure detention facilities, to be placed in the custody of ACS for residential services and aftercare in non-secure and limited secure placements.<sup>2</sup> Under the CTH program, ACS through its Division of Youth and Family Justice (DYFJ) contracts with not-for-profit organizations to operate non-secure placement (NSP) homes at residences throughout New York City, while ACS retains ultimate responsibility for the safe management of the facilities. CTH currently consists of eight providers who offer approximately 235 NSP beds for adjudicated youth and three providers of what are called Limited Secure Placements (LSPs).<sup>3</sup> Until July 2015, Boys Town New York Inc. (Boys Town) was one of ACS’ contracted NSP providers.

During the overnight hours on June 1, 2015, three 16-year old youths residing at a Boys Town NSP residence in Brooklyn escaped the residence through a bedroom window whose alarm was not working, undetected by the Boys Town staff charged with watching them. According to the criminal complaint from the youths’ arrest, the three youths escaped to an Internet café in Manhattan, where surveillance video showed them “repeatedly touching” a woman as she tried to push them away. The complaint states that the youths then took the woman to a nearby stairwell where they hit her and sexually assaulted her. The complaint further indicates that the youths took

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<sup>1</sup> A “juvenile delinquent” is “a person over seven and less than sixteen years of age, who, having committed an act that would constitute a crime if committed by an adult, (a) is not criminally responsible for such conduct by reason of infancy, or (b) is the defendant in an action ordered removed from a criminal court to the family court pursuant to article seven hundred twenty-five of the criminal procedure law (which calls for the sealing of records in criminal court once the case is transferred to family court).” New York Family Court Act § 301.2(1).

<sup>2</sup> The Close to Home initiative consists of two phases. Phase I, which began implementation in 2012, involved youth adjudicated as juvenile delinquents being placed in non-secure levels of placement. Phase II, which is currently being implemented, involves youth adjudicated as juvenile delinquents being placed in limited secure facilities. Both phases are monitored by the Division of Youth and Family Justice (DYFJ), the juvenile justice arm of ACS.

<sup>3</sup> This report does not address LSPs or ACS’ oversight of them.

the woman's personal belongings, including her driver's license and keys. The youths used those items to enter the woman's building, which was captured on video. The youths then returned to the Boys Town home, again undetected by Boys Town staff. The three youths were later arrested and pled guilty to charges of Rape in the First Degree, Burglary in the First Degree, Burglary in the Second Degree, and Robbery in the Second Degree.<sup>4</sup>

Because the youths were able to escape a CTH program that was supposed to be staffed to prevent such an escape, DOI initiated an investigation into the supervisory failure at the Boys Town NSP homes in New York City and into ACS' oversight of safety and security at Boys Town NSP homes, as well as over NSP homes generally. This report discusses the findings of DOI's specific investigation into the lack of supervision on the night of June 1, 2015, as well as its broader investigation of supervision and oversight failures by Boys Town and by ACS, which is responsible for overseeing the youth in NSP homes. A total of four arrests have now arisen out of this investigation. DOI's recommendations to improve security, management, and accountability in the ACS Close to Home program and among its NSP providers are set forth at the end of this report, and have been accepted fully by ACS.

DOI's investigation found that a Boys Town overnight staff member, who was responsible for monitoring the teens' whereabouts by checking on them every 15 minutes to physically observe that the teens were in their bedrooms and by recording it on the half hour in a log book, did not check on the teens at all between the hours of 1:30 a.m. and 6:30 a.m. on June 1<sup>st</sup>, during which time they escaped from the home. This employee, Denzel Thompson, admitted to DOI investigators that he recorded in the log book that he had checked the whereabouts of the teens every half hour during that time period, stating "all youth down in bed," when he did not observe or check on the teens at all during that timeframe. On June 11, 2015, DOI arrested Thompson and charged him with Offering a False Instrument for Filing in the First Degree, a class E felony, and Falsifying Business Records in the Second Degree, a class A misdemeanor.

DOI's investigation also revealed a widespread lack of monitoring by Boys Town overnight employees, resulting in the further arrests of one current and three former Boys Town employees. Based on its review of security camera video, DOI determined that these Boys Town employees, like Thompson, failed to conduct the required bed checks to ensure the youth were secure in their rooms during the overnight hours. DOI further found that these employees falsified log books by making entries that purported to show they checked on the youth when, in fact, they failed to do so. Additionally, DOI's larger investigation found that Boys Town managers failed to provide adequate oversight of its overnight staff. DOI's analysis of video, which was available for review to Boys Town managers, showed that, of almost 600 required bed checks that DOI reviewed, such checks occurred less than one third of the time. Even after the June 1<sup>st</sup> escape, that

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<sup>4</sup> <http://manhattanda.org/press-release/da-vance-three-teenagers-convicted-2015-chinatown-rape-robbery-and-burglary-case>.

number increased to only 50% compliance. DOI also found Boys Town experienced persistent vulnerabilities with respect to faulty security alarms and staffing shortages.

DOI's investigation further uncovered that the safety deficiencies at Boys Town are pervasive in ACS' Close to Home NSP program. Indeed, ACS was well aware of the problem of juvenile residents going "absent without leave" (AWOL) long before the events of June 1<sup>st</sup>, had taken numerous steps to reduce the numbers of AWOLs, and reports that it had reduced them by over 50% by then. Nonetheless, four years into the program, ACS is still developing sufficient protocols and proper oversight to address the serious safety concerns the providers had experienced concerning youth in the Close to Home program. Specifically, ACS lacks internal protocols within the three DYFJ units that monitor the Close to Home Program and its providers, and sufficient policies regarding site inspections, safety, and security at the NSP facilities. Since the June 1<sup>st</sup> incident, ACS has increased the number of site visits to NSP facilities, required ACS staff to have a working knowledge of the security systems in the facilities, and engaged the NYPD for assistance to perform safety assessments at facilities. However, written policies and procedures are still being developed and are in various stages of implementation. DOI additionally found that ACS' contracts with Close to Home providers give generic guidelines of what is expected of each facility without specific enforcement mechanisms, and to date ACS completely lacks evaluation and scoring tools to properly evaluate NSP providers. Until the Boys Town incident, ACS had not begun developing an evaluation tool or process. After the incident, ACS engaged an expert who drafted a report in September 2015. ACS has recently begun the process of implementing the expert's recommendations by developing evaluation tools and adding staff to conduct appropriate and comprehensive quality assurance assessments.

Given ACS' systemic failure to oversee the NSP program from its outset, the security failures at the Boys Town facilities – including on the night of June 1, 2015 – were all but inevitable and, absent significant additional changes, which ACS has acknowledged and begun, there can be no guarantee against further incidents at NSP facilities. Based on these findings, DOI's recommendations aim to ensure the safety of the youth under ACS' care and provide the communities that house NSP facilities assurance that the juveniles placed in their neighborhoods are kept safe and secure. ACS has agreed to implement all of DOI's recommendations, and had begun instituting its changes prior to the conclusion of DOI's investigation in multiple instances. DOI will continue to monitor.

## **II. DOI's Investigation**

DOI's investigation into Boys Town focused on the supervision of the youths at Boys Town NSP homes by overnight employees, oversight of overnight employees by Boys Town managers, and Boys Town's security procedures. DOI's investigative steps included, among other things, reviewing surveillance video of the Boys Town NSP homes showing the activities of

overnight employees; conducting site visits to each of the Boys Town NSP homes; reviewing documents obtained from Boys Town and ACS, including but not limited to contracts, site visit reports, policies and procedures, and electronic communications; and interviewing six current and former Boys Town employees, including the New York Executive Director, the Senior Director of Program Operations, the NSP Program Director, the Boys Town supervisor assigned to the 6th Avenue location, and two overnight employees.

Regarding ACS oversight and monitoring, DOI’s investigation included, among other things, reviewing documents such as ACS policies, procedures and guidelines; ACS’ contracts with the NSP providers; and various ACS reports tracking incident data throughout the NSP system, as well as interviewing executive level staff within the three DYFJ units that monitor the Close to Home Program.

### **III. DOI’s Investigation and Findings Regarding Boys Town and its Employees**

#### **A. Boys Town’s NSP Contracts**

In July 2012, ACS contracted with Boys Town to operate four NSP sites for male youths at three locations in Brooklyn and two NSP sites for female youths at one location in Queens. Boys Town’s NSP homes had the capacity for a total of twenty-five males and thirteen females.<sup>5</sup> In January 2013, ACS began placing youth at the Boys Town NSP homes.

In January 2014, ACS placed Boys Town on Corrective Action status (CAS)<sup>6</sup> due to concerns it had regarding “inadequate staffing ratios, lack of direct care staff supervision and the inability of staff to manage youth behaviors both at home and at school.” ACS also noted that “of greatest concern is the 6<sup>th</sup> Avenue site.”<sup>7</sup> At that time, ACS closed the 6th Avenue home, located in Park Slope, Brooklyn, until further notice based on “[the] instability of the program.”<sup>8</sup> Boys Town’s other sites remained open. In April 2014, ACS notified Boys Town that it was “stepping [the organization] down from Corrective Action status to Heightened Monitoring status.”<sup>9</sup> While ACS noted a “reduction in serious incidents and safety issues,” it also stated that the Heightened Monitoring status (HMS) “does reflect that ACS continues to have concerns about [Boys Town’s] NSP sites.”<sup>10</sup> In December 2014, ACS removed Boys Town from HMS and resumed regular

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<sup>5</sup> ACS Capacity (June 5, 2015).

<sup>6</sup> ACS places a provider on Heightened Monitoring status when it requires enhanced monitoring beyond ACS’ regular monitoring procedures. Corrective Action status is an elevated monitoring status above Heightened Monitoring; ACS develops an improvement plan for the provider and requires the provider to meet its requirements within 90 days.

<sup>7</sup> Letter from ACS to Boys Town (January 15, 2014).

<sup>8</sup> Letter from ACS to Boys Town (December 19, 2014).

<sup>9</sup> Letter from ACS to Boys Town (April 16, 2014).

<sup>10</sup> *Id.*

monitoring. ACS stated that “[t]he management plan developed by program leadership to address areas of concern raised in connection with HMS resulted in positive outcomes that promote stronger youth supervision, improve consistent staff supervision and support, and allow for successful implementation of the Boys Town Model.”<sup>11</sup> Additionally, in December 2014, ACS allowed Boys Town to reopen the 6th Avenue home.

On June 2, 2015, after the three youth escaped from the 6th Avenue home without detection by Boys Town staff, ACS again placed Boys Town on CMS and closed the 6th Avenue home. On June 16, 2015, Boys Town notified ACS by letter that it would not seek to renew its Close to Home contract, which terminated on July 31, 2015.

## **B. Boys Town Overnight Staff Failed to Monitor Youth and Falsified Log Books**

Boys Town policy required its NSP overnight staff to be positioned in a way to allow effective monitoring of youths, rooms, and exits; to conduct bed checks every 15 minutes; and to record the youth’s whereabouts in a log book that the staff was required to fill out and initial every 30 minutes.<sup>12</sup>

To assess the adequacy of the Boys Town overnight staff’s monitoring of CTH youth, DOI reviewed video footage from Boys Town’s security cameras to observe staff’s positioning and activities during the overnights while they were responsible to monitor youth. For the time period from May 1, 2015 through June 17, 2015, DOI reviewed a sample of 37 nights of footage from the Boys Town NSP homes.<sup>13</sup> DOI identified Boys Town’s overnight employees who worked during this time period and selected at least two nights of video to review for each employee. DOI reviewed additional video with respect to employees who were found not to be conducting the requisite bed checks. In addition, DOI reviewed Boys Town log book entries made by overnight employees during the time period observed on the video.

As discussed in further detail below, DOI’s video review revealed that 10 out of 22 overnight employees failed to conduct the requisite bed checks and falsified log book records on multiple nights. DOI found that overnight staff not only routinely failed to appropriately monitor youths before the June 1<sup>st</sup> escape of three teens from the 6th Avenue location, but also, that these failures continued even after the escape and after Boys Town was aware there had been a breach in security policy. Moreover, DOI found that overnight employees, like Thompson, also falsified the log books by recording purportedly contemporaneous but blatantly false “observations” of the

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<sup>11</sup> Letter from ACS to Boys Town (December 30, 2014).

<sup>12</sup> Boys Town Operating Guideline: Overnight Program Staff (effective date 03/17/2015). According to Boys Town policies and witness statements, to perform bed checks, overnight staffers were required to physically enter the bedroom and observe the “youth’s face and body.” *Id.*

<sup>13</sup> For each night reviewed, DOI reviewed footage from approximately 10:00 p.m. until the youths awoke, which was between the times of 6:00 a.m. and 10:00 a.m.

youths when, in fact, the video showed that employees were not checking on the youths at the required intervals and were not filling out the log books in real time. Overnight employees routinely wrote entries in log books such as “all youth are asleep” or “all youth are in rooms” for every thirty minutes during the overnight hours when video showed that employees were not checking on youth at required times. DOI investigators observed several instances on the video where staffers appeared to fill out the log books at the end of a shift rather than in real time.<sup>14</sup> In addition to staff’s failure to conduct required checks, DOI’s video review also revealed eleven nights where overnight employees left the premises during the overnight hours when they were required to remain on site. These employees left the facility for periods of time ranging from a few minutes to approximately an hour and a half. In two instances, both overnight employees left the home at the same time, leaving youths in the home alone for at least some period of time; it is unknown whether youths were free to leave or were locked inside the home.

## **1. Boys Town Overnight Staffer Andrew Best Failed to Conduct the Required Checks and Falsified Log Book Entries**

DOI found that Andrew Best, a former Boys Town overnight employee who worked with Denzel Thompson at the 6th Avenue home on the night of the June 1<sup>st</sup> escape, failed to conduct the requisite bed checks and falsified the log book during two overnight shifts at the 6th Avenue home in May 2015. Boys Town video showed that on May 18, 2015, from approximately 12:00 a.m. to approximately 6:30 a.m., Best did not conduct any checks on the youths. During this time, he primarily sat in a chair on the stairs below the floor where the youth’s bedrooms were located, sat in the lounge on the floor below the youths’ bedrooms, or went into the office within the lounge. Best recorded in the log book that he had checked the whereabouts of the teens every half hour during that time period, stating “youth in bed asleep” when he did not check on the teens at all during that timeframe. Video also showed that on May 19, 2015, from approximately 11:30 p.m. to 6:30 a.m., Best did not conduct any checks. During this time, Best primarily sat in the lounge or the office within the lounge on the floor below the youths’ bedrooms. Best recorded in the log book that he had checked the whereabouts of the teens every half hour during that time period, stating “youth in bed asleep, all is well,” or “youth in bed asleep” when he did not observe or check on the teens at all during that timeframe.

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<sup>14</sup> DOI determined the signatories on the log books by, among other things, reviewing the staff census in logbook entries, Boys Town schedules, Boys Town staff lists, Boys Town staff photos, and security footage showing employees writing logbook entries. DOI identified the falsification by employees despite the use of handwritten entries in log books and the frequent signatures of employee initials rather than full names.

## **2. Boys Town Overnight Staffer Soraya Delancey Failed to Conduct the Required Checks and Falsified Log Book Entries**

DOI found that Soraya Delancey, a current Boys Town employee who used to work overnight at Boys Town NSP sites, failed to conduct the requisite bed checks and falsified the log book during two overnight shifts at the St. John's home in May 2015. Video showed that on May 9, 2015, from approximately 12:15 a.m. to approximately 9:00 a.m., Delancey did not conduct bed checks. On the video, Delancey, along with another employee, went into an unoccupied bedroom on the 3rd floor at around 12:00 a.m. and remained in the room for the majority of the night until 9:00 a.m. Delancey recorded in the log book that she had checked the whereabouts of the teens every half hour during that time period, stating "youth in rooms nothing to report," when she did not check on the teens at all during that timeframe. Video also showed that on May 3, 2015, from approximately 1:15 a.m., when the first youth went to bed, to approximately 9:20 a.m., when Delancey departed the facility, Delancey and another employee conducted no bed checks on that youth's bedroom and remained in the unoccupied bedroom on the third floor for the majority of the time. Additionally, video showed that from approximately 2:40 a.m., when a second youth went to bed in a different bedroom, to approximately 9:20 a.m., Delancey conducted no bed checks on the second youth's bedroom. Delancey recorded in the log book that she had checked the whereabouts of the teens every half hour during that time period, stating "(4) youth in rooms nothing to report," or "(4) youth in beds nothing to report" when she did not check on the teens during that timeframe.<sup>15</sup> DOI investigators also observed on video that Delancey left the home for approximately 23 minutes at 1:30 a.m. and approximately 20 minutes at 3:50 a.m.

## **3. Boys Town Overnight Staffer Stanley Stephens Failed to Conduct the Required Checks and Falsified Log Book Entries**

DOI found that Stanley Stephens, a former Boys Town overnight employee, failed to conduct the requisite bed checks and falsified the log book during two overnight shifts at the St. John's home in May 2015. Video showed that on May 17, 2015, Stephens went into the unoccupied bedroom on the 3rd floor at approximately 1:45 a.m. and remained in that room until approximately 8:35 a.m. without doing any checks during that time. Stephens recorded in the log book that he had checked the whereabouts of the teens every half hour during that time period, stating "(4) youth in rooms," "(4) youth in rooms, asleep" or "(4) status remains" when he did not check on the teens at all during that timeframe. Video also showed that on May 22, 2015, Stephens went into the unoccupied bedroom on the 3rd floor at approximately 12:45 a.m. and remained in that room along with another employee until approximately 7:15 a.m. without doing any checks during that time. Stephens recorded in the log book that he had checked the whereabouts of the teens every half hour during that time period, stating "(4) youth in rooms, asleep" or "(4) status

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<sup>15</sup> Delancey also recorded in the log book that she had conducted a "perimeter patrol of living area" at 4:30 a.m. when she did not conduct any inspection of the living area.

remains,” when he did not observe or check on the teens at all during that timeframe. Stephens also left the St. John’s home for approximately 36 minutes at 12:05 a.m. on the night of May 22.

Because of their failure to conduct the required checks and falsification of the logbooks the above referenced employees were arrested and are being charged in Kings County with various misdemeanor counts including Falsifying Business Records in the Second Degree, Offering a False Instrument for Filing in the Second Degree, Forgery in the Third Degree, and Criminal Possession of a Forged Instrument in the Third Degree.

#### **4. Boys Town Overnight Staffer [REDACTED] Failed to Conduct the Required Checks and Falsified Log Book Entries**

DOI found that [REDACTED], a former Boys Town overnight employee, who will be arrested at a later time, failed to conduct the requisite bed checks and falsified the log book during two overnight shifts at the St. John’s home. Video showed that on June 4, 2015, after the night of the three youths’ escape, from approximately 1:30 a.m. to 7:25 a.m., [REDACTED] conducted no bed checks. During that time, one of the other employees conducted two checks on one of the two youth bedrooms. During much of this time, [REDACTED] was lying down with a pillow and a sheet or blanket. [REDACTED] recorded in the log book that he had checked the whereabouts of the teens every half hour during that time period, stating “(5) youth in rooms. All is well,” “(5) youth asleep in RM. All is well,” or “Status Remains” when he did not check on the teens at all during that timeframe. Video also showed that on June 6, 2015, [REDACTED] and other employees did not conduct the requisite bed checks. Video revealed that an ACS employee arrived during the early part of the overnight shift and remained at the St. John’s home for approximately two hours. At approximately 12:00 a.m., [REDACTED] conducted a bed check with the ACS employee. After the departure of the ACS employee, [REDACTED] and the other employee on duty conducted two additional checks of the youth in the fourth floor bedroom and seven additional checks of the youth in the third floor bedroom. However, during much of the overnight, [REDACTED] and the other employee were lying on the floor with pillows and sheets or blankets. In other words, after the ACS employee departed the home on June 6, [REDACTED] and the other employee did not conduct the requisite bed checks. [REDACTED] recorded in the log book that he had checked the whereabouts of the teens every 15 minutes during the overnight hours, stating “(5) youth in bed asleep, all is well, bed check conducted, call-in made,” “(5) youth in beds asleep, all is well, bed check conducted,” “(5) youth in beds asleep, bed checks conducted, call-in made,” “(5) youth in beds asleep, call made, bed check conducted,” “(5) youth in beds asleep, call made,” “(5) youth in beds asleep, nothing to report,” “(5) youth in beds asleep, bed checks done,” “(5) youth in beds asleep,” or “Status Remains,” when he did not do the requisite checks.

## **5. Six Additional Employees Failed to Conduct the Required Checks and Falsified Log Book Entries**

DOI's video review showed an additional six overnight employees who failed to conduct the required bed checks and made entries in log books indicating those checks were done. These employees failed to conduct checks for periods of several hours or conducted sporadic checks during the overnight. Some of these employees were observed sitting in a chair without getting up or lying down for an extended period of time, including an employee who was lying down with a pillow.

### **C. Boys Town Managers Failed To Adequately Supervise Overnight Staff**

DOI also reviewed the supervision of Boys Town overnight staff by Boys Town managers and supervisors and discovered several deficiencies in Boys Town's policies and practices.

First, Boys Town managers did not sufficiently review and utilize available video footage to uncover and respond to the widespread failure of overnight staff to perform the requisite bed checks. Witnesses informed DOI that the Boys Town NSP Program Director and its Senior Director of Program Operations had access to view the footage from the security camera system both in real time and retrospectively. The Program Director, who was primarily responsible for review of video in the months before and on the night of the escape, said that she generally checked the video at least once per day during either the daytime or overnight hours. However, both the Program Director and the Senior Director acknowledged that video review by supervisors was ad hoc; they stated that Boys Town did not have any policies governing supervisors' review of the footage or specifying the frequency of review of overnight hours.

DOI's video review indicates that had a robust, standardized system of monitoring the video been in place at Boys Town in the month prior to the escape, Boys Town supervisors likely would have identified that a substantial number of overnight employees routinely failed to check on youths as required. DOI compiled information on the number of bed checks conducted by staff from 2:00 a.m. until 6:00 a.m. on 25 nights of video from before June 1, 2015 and 12 nights after the June 1<sup>st</sup> escape. This information is set forth in the chart below.

|   | <b>Number of Required Bed Checks</b> | <b>Number of Bed Checks Performed</b> | <b>Percentage of Bed Checks Performed</b> |
|---|--------------------------------------|---------------------------------------|---|
| <b>25 Reviewed Nights Before the Escape</b> | 400                                  | 60                                    | 15%                                       |
| <b>12 Reviewed Nights After the Escape</b>  | 192                                  | 98                                    | 51%                                       |
| <b>37 Total Reviewed Nights</b>             | 592                                  | 158                                   | 27%                                       |

As the chart above shows, on the 25 nights before the June 1<sup>st</sup> escape, overnight employees were required to conduct 16 bed checks per night over the course of the four-hour timeframe from 2:00 a.m. to 6:00 a.m., representing a total of 400 bed checks. However, during this timeframe, DOI determined that staff conducted only 60 out of the 400 required bed checks, or 15% of required bed checks. While DOI's review showed that overnight employees conducted bed checks at a higher rate on the 12 nights after the June 1<sup>st</sup> escape, employees still only conducted 98 out of 192 required bed checks, or 51% of required bed checks after the escape. In total, during the four-hour time period on the 37 nights reviewed, employees conducted 158 out of 592 required bed checks, or 27% of required bed checks. Although the Program Director stated that she occasionally observed instances on video where overnight employees were seen not doing checks, and that she confronted these employees, the oversight system in place as practiced by Boys Town managers prior to the escape was insufficient to identify the widespread nature of the misconduct and the attendant security vulnerabilities.

Second, Boys Town supervisors failed to conduct sufficient overnight visits to enable them to adequately monitor staff. The Program Director stated that Family Home Consultants, who supervised particular homes, were expected to conduct overnight site visits of their assigned homes at least once per month. However, the Program Director acknowledged that these visits "w[ere] not consistently happening."<sup>16</sup> According to a report after the escape, the Boys Town supervisor for the 6th Avenue and St. John's homes stated that he had last conducted an overnight visit approximately one month before the escape.<sup>17</sup> A Boys Town overnight employee stated to DOI that this supervisor infrequently visited the 6th Avenue site. Further, multiple Boys Town overnight staff members at another Brooklyn home reported to ACS employees, who visited the

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<sup>16</sup> Interview with the Boys Town Program Director (Aug. 4, 2015).

<sup>17</sup> Boys Town Internal Investigation, Interview with Boys Town supervisor, p. 2 (June 4, 2015).

home after the escape, that Boys Town supervisors did not generally visit or call staff during the overnight shift.<sup>18</sup>

Additionally, while Boys Town had an overnight call-in system to monitor overnight staff, Boys Town employees did not consistently utilize the system and managers do not appear to have enforced compliance. Boys Town witnesses informed DOI that overnight staff members were required to call a dedicated telephone line every thirty minutes and leave a message documenting their name, location, and the activities of the youths.<sup>19</sup> Witnesses also explained that Boys Town administrative staff were responsible for tracking overnight call-in information and disseminating this information to Boys Town managers and supervisors. DOI's review of overnight call-in records<sup>20</sup> revealed several nights when overnight employees either did not call into the overnight call-in system or called in on only a few occasions during the night. For example, at the St. John's facility on May 31, 2015, overnight employees called in three times and did not call in after 3:00 a.m. Additionally, at the St. John's facility on June 14, 2015, 13 nights after the escape, overnight employees failed to call in after 3:00 a.m.

#### **D. Boys Town Supervisors and Overnight Staff Failed to Address Security Risks and Vulnerabilities Associated with the Alarms**

ACS' NSP Quality Assurance Standards require alarms on doors and windows at NSP homes. DOI interviewed Boys Town managers who explained that the youths who escaped from the 6th Avenue home appeared to go out through one of the bedroom windows where an alarm was not working. A Boys Town supervisor for the 6th Avenue home stated that he was aware by the beginning of the overnight shift on the date of the escape that the alarm for the bedroom window was not working. However, the supervisor acknowledged that he did not discuss the disabled alarm with Denzel Thompson and Andrew Best, the two overnight employees at the home that evening.<sup>21</sup> The 6th Avenue home had additional bedrooms with alarms. Because the supervisor did not address the disabled alarm with the employees, he also did not direct staff to take precautions, such as the possibility of moving the youths into a bedroom with a functioning window alarm.

Witnesses told DOI that Boys Town had past operational issues with alarms at its facilities, that youths at the 6th Avenue home had tampered with the alarm in the past, and, as a result, that

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<sup>18</sup> ACS DYFJ Site Visit Instrument, Boys Town, Bensonhurst I, p. 2 (June 8, 2015); ACS DYFJ Site Visit Instrument, Boys Town, Bensonhurst II, p. 2 (June 8, 2015).

<sup>19</sup> As per Boys Town witnesses, the call-in system was instituted by Boys Town, but not required by ACS.

<sup>20</sup> DOI reviewed emails containing overnight call-in system logs for the period from January 1, 2015 through July 9, 2015.

<sup>21</sup> Records indicate that Best was aware of a "fault" on the window alarm for the bedroom on the third floor. Boys Town Internal Investigation, Interview with Andrew Best, p. 3 (June 2, 2015).

the alarm sensors, which had previously been located on the outside of the wall, were relocated inside the wall. DOI also learned that NSP providers are required to file Movement Control and Communications Unit (MCCU) reports regarding problems with alarms. Nonetheless, as discussed further below, the Boys Town supervisor for the 6th Avenue location indicated that he was not aware of this reporting requirement. DOI was never provided with any records of Boys Town reports to ACS regarding alarm malfunctions or problems, including on the night of the escape.

The Boys Town NSP Program Director told DOI that staff were trained on the alarm systems, were directed to perform checks on alarms at the start of each shift, and were required to report any issues. However, when DOI conducted site visits of the Boys Town homes after the escape, staff members were unable to explain the meaning of displayed faults on the alarm readout system for various windows. Further, based on its visits after the escape, ACS also reported that a Boys Town staffer stated that he was not trained on how to arm or disarm the security system.<sup>22</sup>

#### **E. Boys Town Lacked a Sufficient Number of Overnight Personnel**

DOI found that Boys Town experienced persistent staffing shortages at its NSP sites. According to Boys Town's contract, it was required to maintain a minimum of two staff members at a site at all times.<sup>23</sup> DOI reviewed a significant number of ACS reports noting concerns with Boys Town's inadequate staffing and turnover. With respect to the overnight shift, DOI learned that in January 2014, approximately 10 out of 21 budgeted overnight positions at six sites were vacant.<sup>24</sup> Later reports indicated that staffing concerns continued into 2015.<sup>25</sup>

During its video review, DOI found two instances where only one employee worked at a site during the overnight shift. Similarly, after the June 1<sup>st</sup> escape, when ACS visited Boys Town sites, it identified two Boys Town sites where only one staff member was present during the overnight hours. Several overnight staff members reported to ACS during these visits that working double shifts was commonplace.<sup>26</sup> While the ACS Placement & Permanency Director told DOI

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<sup>22</sup> ACS DYFJ Site Visit Instrument, Boys Town, Bensonhurst I, p. 2 (June 8, 2015); ACS Email re: "BT Visits" (June 7, 2015).

<sup>23</sup> We note that the 2012 ACS – Juvenile Justice – Non-Secure Placements Quality Assurance Standards states that “[t]he ratio of youth to direct care/supervisory workers in all types of regular NSP residential settings shall be eight (8) youth to one direct care/supervisory staff during all waking hours and twelve (12) youth to one direct care/supervisory staff during sleeping hours.” Further, “[a]ll NSP facilities (general and specialized) are required to maintain a minimum of two (2) direct care/supervisory staff at all times regardless of size of the program.”

<sup>24</sup> Boys Town letter to ACS, Organizational Charts, pp. 5-10 (January 15, 2014).

<sup>25</sup> ACS Boys Town Monthly Provider Call Summary (January – May 2015).

<sup>26</sup> ACS Email re: "BT Visits" (June 7, 2015).

that she advised Boys Town to hire additional staff, Boys Town managers acknowledged having difficulties hiring sufficient staff and stated that the needs of the youth contributed to high turnover.

#### **IV. DOI's Investigation and Findings into ACS Oversight Over Boys Town and the Close to Home Providers**

Close to Home is a New York State run juvenile justice reform initiative designed to keep youth close to their families and the community. The initiative allows New York City youth adjudicated as juvenile delinquents, whom Family Court has determined do not require a secure placement, to be placed in the custody of ACS for residential services and aftercare. The Close to Home initiative consists of two phases. Phase I involved youth adjudicated as juvenile delinquents in non-secure levels of placement. Phase II involves youth adjudicated as juvenile delinquents who are in limited secure facility placements. Both phases are monitored by DYFJ within ACS. Close to Home currently consists of eight providers who offer approximately 235 non-secure placement beds for adjudicated youth in 29 locations. After the June 1<sup>st</sup> escape, it has become apparent that ACS needs to exercise more robust oversight of its Close to Home NSP providers.

DOI's investigation revealed that ACS, as the oversight agency over Boys Town's NSP homes, insufficiently monitored the safety and security at the Boys Town NSP homes. Additionally, the safety deficiencies that ACS failed to detect at Boys Town are issues that exist throughout the Close to Home NSP program. Six of the nine Close to Home NSP providers have also been on CAS<sup>27</sup> or HMS<sup>28</sup> at some point in the four years this program has existed. For example, NSP provider Children's Village (CV) was placed on HMS in July 2013 due to chronic AWOL concerns in some of their Queens locations.<sup>29</sup> In December 2012 NSP provider New York Foundling (NYF) was also placed on HMS due to high rates of AWOLs and other incidents at the program's Staten Island site.<sup>30</sup> One of these incidents included a staff member locking herself in a resident's room to avoid being attacked by the resident. For these reasons, NYF remained on HMS until July of 2013 when it decided to terminate its contract with ACS for providing Non-Secure Placement Residential Care Services.<sup>31</sup>

After a thorough review of existing ACS policies and procedures and interviews with staff, DOI found that ACS lacks sufficient policies and procedures to properly oversee the youth in the

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<sup>27</sup> Corrective Action status (CAS) is an elevated monitoring status under which the program has 90 days to meet all items in their CAS improvement plan. ACS NSP Response to DOI, p. 5 (April 1, 2016).

<sup>28</sup> Heightened Monitoring status (HMS) is a monitoring status implemented when OPPP discovers programmatic gaps within a program or when a facility or provider does not meet established NSP standard. ACS NSP Response to DOI, p. 4 (April 1, 2016).

<sup>29</sup> Children's Village Heightened Monitoring Status Letter, July 17, 2013, pp. 1-2.

<sup>30</sup> New York Foundling Heightened Monitoring Status Letter, December 28, 2012, p. 1.

<sup>31</sup> New York Foundling Heightened Monitoring Status Letter, July 25, 2013.

Close to Home program, which includes a lack of internal protocols within its DYFJ units and a lack of sufficient policies regarding site inspections, safety, and security at the facilities. Additionally, DOI found that ACS contracts with Close to Home providers lack specific safety requirements and, to date, ACS lacks evaluation and scoring tools to properly evaluate provider performance. ACS has recently begun to address these deficiencies.

## A. ACS Lacks Policies and Procedures to Oversee Close to Home Youth

### 1. ACS DYFJ Units Lack Internal Protocols to Sufficiently Oversee Safety and Security at Close to Home Locations

As part of the first phase of the Close to Home Initiative, New York City youth who were in the custody of the New York State Office for Children and Family Services (OCFS) because they were adjudged to be juvenile delinquents on September 1, 2012 were transferred to ACS' custody. Under this new model, OCFS, "as the State regulatory agency, is responsible for overseeing and monitoring: (1) NYC's overall implementation of the NSP Plan, (2) ACS' direct provision of case management and aftercare services, and (3) the licensing and functioning of the provider agencies."<sup>32</sup> ACS has direct responsibility for each youth and for placing each youth with a specific NSP provider. ACS also has the immediate oversight responsibility over all the contracted provider agencies that make up the Close to Home NSP system.<sup>33</sup> At the State level, OCFS assesses whether the policies and procedures implemented and applied by ACS conform to the approved State and foster care regulations and policies of the CTH system as a whole.

The Close to Home Unit of ACS' DYFJ is comprised of two principal areas: Placement and Permanency and Field Operations (Field Ops). It has also recently created the Office of Planning, Policy, and Performance (OPPP). OPPP is responsible for juvenile justice programming, monitoring placement, and supporting provider agencies who run the facilities through technical assistance.<sup>34</sup> OPPP staff works with provider agencies to oversee that program models are in line with ACS Quality Assurance standards and policies and OCFS regulations. OPPP staff also monitors program performance through site assessments, which are done through visits to service provider sites.

The Close to Home Placement and Permanency division directly oversees the youth in the Close to Home program, and is staffed with Placement Permanency Specialist (PPS) workers who are responsible for meeting with each youth once a month to address issues the youths may have.<sup>35</sup>

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<sup>32</sup> CTH Year One Review Report, p. 2.

<sup>33</sup> *Id.* at 5.

<sup>34</sup> ACS' Office of General Counsel's Email to DOI (10/30/2015).

<sup>35</sup> Interview with the Deputy Executive Director of Placement Services (Sept. 8, 2015).

Lastly, the Field Ops division provides onsite support to the Close to Home providers and the youths, including crisis management and emergency transportation.<sup>36</sup> Field Ops is also responsible for providing technical assistance and training around safety and security-related standards, and works with the providers to reduce incidents and the rate of youth who are AWOL.<sup>37</sup> Despite the variety of DYFJ monitoring tools, DOI found a lack of accountability, communication, and documentation among the DYFJ units if or when they followed up on incidents at the facilities, and no one division was solely responsible or assigned to ensure safety and security.

For example, every morning a representative from each of the three DYFJ divisions participates in a conference call referred to as the “Daily Huddle.” During this call, each unit would review the MCCU reports from the previous day and decides which unit would address each incident. However, in the past decisions made and information gathered during the Daily Huddle were not memorialized in any standard way and not distributed among the units. Furthermore, as DOI learned through interviews of various employees from all of these units, there are no specific guidelines detailing which unit should take the lead on what type of incident. According to the Director of Quality Assurance within OPPP, which unit would take responsibility over any given incident on any given day would just depend on what was decided at that day’s Daily Huddle. Additionally, there had been no protocols regarding follow up with the unit assigned to handle the incident.<sup>38</sup> ACS was also unable to identify any form of a tracking system or policy in place that would maintain a thorough record of how an incident was addressed and what course of action was taken, which often led to the same or similar issues recurring within the facilities. As of April 2016, ACS informed DOI, that in December 2015, it added a Director of Incident Review to lead the Daily Huddle, review critical incidents, coordinate the team to follow-up, and to actually follow-up to ensure issues are resolved.

Additionally, at the time of DOI’s interviews in Fall 2016, meetings and site visits were often conducted and decisions often made among the Close to Home units without any written accompanying documentation, and no policy or procedure was in place for anyone to document, track, or follow-up on decisions and plans. Therefore, often, if a site visit was conducted as a result of an incident, there could be no follow up. The Senior Advisor of Field Ops told DOI that, in 2014, two years after the program had begun operating, she decided to create documentation for site inspections for use in her unit.<sup>39</sup> While the Senior Advisor stated that she provides her reports to the other DYFJ units, there is no follow up regarding whether the issues listed are resolved. She

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<sup>36</sup> ACS’ Office of General Counsel’s Email to DOI (10/30/2015).

<sup>37</sup> An AWOL is when a youth leaves without permission or without supervision for a period of time that is outside the agreed upon terms between the youth and the NSP provider. NSP Incident Reporting Policy, p. 21.

<sup>38</sup> Interview with the Director of Quality Assurance within OPPP (Sept. 14, 2015).

<sup>39</sup> Interview with the Senior Advisor of Field Ops (Sept. 24, 2015).

stated that ACS did not have a good “close the loop process.”<sup>40</sup> Presumably, this is now addressed with the addition of the Director of Incident Review and that position’s concomitant responsibilities.

2. *ACS DYFJ Lacks Sufficient Policies on Oversight of Safety and Security at the Facilities*

ACS often defers to the NSP providers to create new procedures or processes when an issue is uncovered rather than exercising its duty as the oversight agency to provide concrete guidelines for all NSPs. In its Heightened Monitoring Assessments and Corrective Action Assessments, ACS identifies the critical issues that necessitated the heightened or corrective action status and what steps the NSP plans to take to remedy the issues. These assessments include discussions with ACS; however, they do not always include directives from ACS as the oversight agency. Critical incidents and security concerns at NSPs are recurrent reasons for a NSP to be placed on heightened or corrective action status. While ACS will inform the NSP that these are areas of concern that need to be addressed ACS provides no guidance or mandate on how that is to be accomplished. It is unrealistic to believe that the NSP, which has been placed on HMS because of its inability to successfully run the program, will, when left to its own devices, create protocols to remove itself from that status. ACS, as the oversight agency, must provide the protocols and resources necessary for the NSPs to determine what standards must be met but ACS fails to do so.

In March 2014, OCFS issued its “Close to Home-Year One Review” report reviewing the program’s implementation for the period of September 2012 through August 2013. The report identified safety and security of the New York City Close to Home facilities as an area of concern, specifically due to the high number of AWOLs and physical altercations occurring in the facilities. DOI’s review of ACS documentation covering January 2013 to June 2015 revealed that many NSP providers experienced various security and safety-related issues. For example:

- NSP provider St. Vincent’s Services (SVS) hired employees without performing the proper background checks and/or was allowing employees to work while such checks were pending. This was in direct violation of the SVS’ contract with ACS, which requires that each employee pass a background check before performing any work under the contract.<sup>41</sup>

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<sup>40</sup> Interview with the Senior Advisor of Field Ops (Sept. 24, 2015).

<sup>41</sup> Under SVS’ contract with ACS, SVS had the responsibility to conduct all criminal background checks of the employees they choose to hire. ACS’ NSP Contract, Sec. 6.04 (B).

- This led to two employees being hired despite one being the subject of an indicated case for child abuse or neglect and the other having been arrested for endangering the welfare of an incompetent person.<sup>42</sup>
  - As a result, ACS began requiring and receiving all staff background clearance checks from SVS.<sup>43</sup>
  - According to ACS, the contract with SVS was terminated in the summer of 2013 because of the provider's inability to comply with its requirements intended to keep the youth, the staff and the surrounding communities safe.
- Another provider, St. Christopher-Ottilie (SCO), experienced a critical incident in one of its Close to Home facilities, in which two youths stole another youth's medication out of the medication cabinet.<sup>44</sup>
  - ACS addressed this issue by telling SCO to develop its own procedure to ensure the future security of the medication without demanding an explanation of how the medication was removed from the required double lock box where it was supposed to be kept.
  - ACS did not provide any directives nor did it monitor whether the problem was resolved.
- NSP provider Children's Village (CV) was placed on HMS because of its failure to report critical incidents to ACS in a timely manner as required by MCCU guidelines.
  - Two months after being placed on HMS and participating in the assessments twice a month, CV still failed to report an incident on the day that it occurred, as required by MCCU guidelines. In that incident, a youth threatened another youth with a knife.<sup>45</sup>
  - Although it appears that, following this incident, CV reported with more frequency; however, ACS was still concerned with CV's lack of supervision during altercations.
  - This concern continued to be articulated on CV's assessments from September to January 2013 with no change in practice, no resolution, and no ACS intervention or consequences.

DOI's document review also revealed that ACS does not have policies in place to properly monitor that the NSP providers enact the security measures ACS does require. Although ACS requires providers to have "video cameras for the common areas of all placement facilities;

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<sup>42</sup> SVS HM Status Assessment June 19, 2013, p. 40.

<sup>43</sup> *Id.*

<sup>44</sup> SCO Weekly HM status Meeting 9/20/13 – 9/29/2013, p. 62.

<sup>45</sup> Children's Village Heightened Monitoring Status Assessment September 26, 2013, pp. 25-26.

alarmed windows and doors; and delayed exit doors,”<sup>46</sup> ACS does not ensure these devices are properly working. DOI’s review further showed a lack of site visit requirements, documentation requirements, and protocols for its staff to follow when issues with alarms and/or security cameras are reported. In fact, even the reporting requirements for alarm failures are vague.

NSP providers are supplied with certain guidelines and procedures from MCCU for incident reporting. The NSP Quality Assurance Standards note that NSP providers must report incidents to MCCU related to youth AWOLs or when a youth has not returned from a home visit.<sup>47</sup> Currently, MCCU guidelines state that alarm issues are only considered a critical incident if they are defined as a “major security breach.”<sup>48</sup> According to ACS’ Incident Reporting Policy, a malfunctioning video security recording system should be considered a “Mechanical Breakdown”<sup>49</sup> and therefore called into MCCU. Additionally, MCCU guidelines further note that all incidents, critical and non-critical, are to be reported by phone to MCCU within one hour of their occurrence or as soon as staff becomes aware of the incident.<sup>50</sup> However, after conducting interviews with various Boys Town employees, DOI learned that Boys Town was unaware that it was required to report alarm issues to ACS. Furthermore, after the escape, DOI also learned that the alarm on the window out of which the youths allegedly escaped was not working, had malfunctioned various times in the past, and Boys Town had not reported it to ACS.<sup>51</sup> If ACS had an alternate oversight mechanisms in place, i.e., regular site visits, Boys Town’s failure could have been identified and addressed prior to the June 1<sup>st</sup> youth escape that resulted in a violent crime being committed.

In addition to alarms, every NSP is required to have a video security system in all common areas of the house. Certain off site NSP supervisory staff is able to watch live feeds of the video to monitor activity in the facility. However, such checks are left to the discretion of each NSP. ACS is just now developing a policy requiring NSP supervisory staff to monitor the live feed and a system for its oversight staff to randomly watch video. Until recently, ACS video checks were exclusively done by ACS Field Ops staff only upon request from other DYFJ units after a NSP provider reported an incident. During her interview with DOI, the Senior Advisor of Field Ops acknowledged that having ACS conduct random video checks would be beneficial in order to

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<sup>46</sup> NYC ACS Close to Home NSP Plan 2012 (provided by ACS), p. 79.

<sup>47</sup> NSP Quality Assurance Standards, 2013, p. 30.

<sup>48</sup> MCCU NSP Incident Reporting Policy, p. 2.

<sup>49</sup> According to ACS, a “Mechanical Breakdown” is “any incident involving a malfunction/breakdown of hardware, plant management equipment, electronic equipment, plumbing, or any machinery that affects the operation of a facility or vehicle. Such a breakdown can occur in any facility, court building or vehicle.”

<sup>50</sup> MCCU NSP Incident Reporting Policy, p. 3.

<sup>51</sup> Interviews with Boys Town staff (June 5, 2015 and Oct. 5, 2015).

oversee youth and staff safety in the facilities and prevent additional misconduct.<sup>52</sup> ACS also fails to conduct any checks to ensure the NSP video recording systems are working properly. The Director of Field Ops told DOI that he would occasionally call a provider to check whether a video recording issue was corrected, but would never conduct a site visit to check himself.<sup>53</sup>

### 3. *ACS DYFJ Fails to Conduct Site Visits or Safety Assessments of the NSP Homes where Youth in its Custody are Placed to Live*

Despite the fact that ACS is responsible for the youth in Close to Home facilities and that ACS' plan to OCFS for Close to Home implementation stated ACS' intent to perform site visits to assess the progress of the NSPs,<sup>54</sup> ACS primarily relied on OCFS to conduct all site inspections. For example, after the 6<sup>th</sup> Avenue location was re-opened in January 2015, ACS did not conduct any site visits until after the June 1<sup>st</sup> escape. Prior to the June 1<sup>st</sup> escape, even when a program was placed on HMS or CAS, ACS failed to require any mandatory site visits. Instead, ACS' involvement was mostly by phone or in provider meetings at ACS offices. After the June 1<sup>st</sup> escape, ACS informed DOI that each program would now be visited twice, one announced and one unannounced, by the end of 2015.<sup>55</sup>

After the June 1<sup>st</sup> escape, DYFJ “identified gaps that expose youth and the public to safety and security risks”<sup>56</sup> and recognized that it “needs a more robust oversight of [its] Close to Home NSP, LSP, and aftercare providers.”<sup>57</sup> Therefore, DYFJ requested additional funding for resources<sup>58</sup> to “better monitor daily census, increase the frequency of site visits, improve [its] ability to respond to incidents, enhance [its] ability to locate and return AWOL youth, and develop a data-driven approach to monitoring and evaluating Close to Home residential and aftercare programs.”<sup>59</sup> However, ACS is still in the process of developing effective and concrete policies to support these additional resources.

During the first months of the Close to Home program, from December 2012 through August 30, 2013, OCFS conducted site visits bi-weekly. Thereafter, OCFS determined its site visit

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<sup>52</sup> Interview with the Senior Advisor of Field Ops (Sept. 21, 2015).

<sup>53</sup> Interview with the Director of Field Ops (Sept. 24, 2015).

<sup>54</sup> NYC ACS Close to Home NSP Plan 2012 (provided by ACS), p. 79.

<sup>55</sup> Interview with the Associate Commissioner of OPPP (Sept. 10, 2015).

<sup>56</sup> DYFJ New Needs Request, p. 2.

<sup>57</sup> *Id.* at 1.

<sup>58</sup> A New Needs Request was made by DYFJ to request additional funding from New York City’s Office of Management and Budget (OMB) in order to perform its oversight responsibilities of NSPs and LSPs.

<sup>59</sup> DYFJ New Needs Request, p. 2.

schedule according to each program's needs.<sup>60</sup> OCFS has stated that programs reporting greater numbers of critical incidents are typically visited on a bi-weekly basis, while programs with fewer issues are visited monthly, but OCFS appears not to require any set number of visits, nor does it require ACS to conduct its own site visits.<sup>61</sup> Additionally, no policy sets the number of critical incidents that would necessitate more frequent OCFS site visits. Finally, all OCFS visits are announced to the NSPs a month in advance – there are no unannounced visits.

Furthermore, OCFS' visits do not address any facility safety or security issues, but instead focus on two areas: logbooks and facility aesthetics. The logbooks are inspected for accuracy in reporting incidents as compared to the MCCU reports, and the facility is checked for being “clean and tidy,” whether posters of various topics were displayed,<sup>62</sup> and whether the paint color was “vibrant and therapeutic.”<sup>63</sup> Monitoring of safety and security issues – and all other NSP supervision – is left to ACS, which continuously failed to require any minimal number of site visits or set guidelines for conducting such visits.

## **B. ACS' Contracts with NSP Providers Lack Specific Safety Requirements**

In addition to failing to provide more concrete guidelines in its policies and procedures, ACS' contracts with NSPs are void of specific requirements for safety and security measures, technical assistance, required documentation, and site visits. ACS' contract with Boys Town and other NSPs simply lays out generic guidelines of what is expected of each facility without concrete enforcement mechanisms with clear consequences. As detailed fully below, the NSP contracts must be enhanced to require specific requirements for all safety and security protocols.

## **C. ACS Lacks Evaluation and Scoring Tools and Therefore Fails to Evaluate Provider Performance**

ACS' NSP Plan to OCFS stated that ACS would develop a scorecard to, among other things, “ensure compliance with OCFS, ACS, and other promulgated administrative standards.”<sup>64</sup> However, the scorecard program was abandoned early into the program because ACS decided that it was too early to evaluate the programs.<sup>65</sup> During DOI's investigation, ACS officials were unable to state when or if scorecards or any other evaluation system would be implemented, and advised DOI that two years into the program is still too early in the process to create an evaluation tool. To

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<sup>60</sup> Close to Home Year One Review Report, p. 6.

<sup>61</sup> Close to Home Year One Review Report.

<sup>62</sup> Boys Town/Astoria 2 Monthly Update June 2014, p. 4 (discussing that the Allergy/Yuck List was displayed).

<sup>63</sup> Boys Town/Astoria 1 Monthly Update January 2015, p. 50.

<sup>64</sup> NSP ACS Close to Home NSP Plan 2012, p. 131.

<sup>65</sup> Interview with the Associate Commissioner of OPPP (Sept. 10, 2015).

date, there are no program evaluations in place and, as such, there are not even any baselines against which to assess future performance. DYFJ’s New Needs Request, submitted to the New York City Office of Management and Budget (OMB) on July 1, 2015, noted that “producing a Scorecard that will evaluate Close to Home placement and aftercare providers, as well as a team of staff dedicated to reviewing incidents and implementing the Scorecard to measure the performance of Close to Home providers” was one of its planned strategies to enhance safety.<sup>66</sup>

Currently, ACS uses a Vendor Information Exchange System (Vendex) report as its substitute for a yearly evaluation of the NSPs.<sup>67</sup> The feedback is provided in three categories: time, quality, and fiscal.<sup>68</sup> The Vendex submission also provides for a narrative for ACS to detail its findings.<sup>69</sup> In the Vendex report for 2013-2014, Boys Town was placed on HMS, which was quickly raised to CAS, and then placed back on HMS where it remained at the time of the June 1<sup>st</sup> escape. In spite of this, ACS still gave Boys Town an overall “fair” rating on the Vendex report.<sup>70</sup> In fact, despite the June 1<sup>st</sup> escape, at least one ACS manager reported that ACS was prepared to renew its Boys Town contract.<sup>71</sup>

## V. Policy and Procedure Recommendations

Based on the above findings DOI is making following recommendations:

1. ACS should develop and implement its own policies and procedures that include:
  - i. Setting forth clear assignment of responsibility within the different DYFJ units and reorganizing such assignments as necessary.
  - ii. Developing a universal logbook policy that requires consistency among all NSPs for documenting information.
  - iii. Requiring ACS staff to conduct unannounced day and overnight quarterly site visits, which should include:
    1. A standardized safety and security checklist, with clear responsibility for who conducts them;

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<sup>66</sup> DYFJ New Needs Request, p. 1.

<sup>67</sup> Interview with the Associate Commissioner of OPPP (Sept. 10, 2015).

<sup>68</sup> The “time” score is based on whether or not the provider complied with the various terms of the contract in a timely manner. “Fiscal” refers to keeping adequate records for audit purposes or a record of invoices. The score for “quality” is determined by looking at the effectiveness of the staff, adequacy of procedures and recordkeeping, and whether site visits were performed and if any deficiencies were discovered. Vendex Report Boys Town 8/20/14.

<sup>69</sup> Vendex Report Boys Town 7/2/14, p. 1 (stating that Boys Town struggled with the timely submission of requested documents).

<sup>70</sup> Vendex Report Boy Town 7/2/14, p. 3.

<sup>71</sup> Interview with the Associate Commissioner of OPPP (Sept. 10, 2015).

2. A requirement of additional visits for NSP providers on CAS and HMS;
    3. A procedure for storing and tracking the visit results electronically; and
    4. Timely follow up to ensure corrective action measures are implemented.
  - iv. Requiring additional ACS staff training on how each NSP's security system operates in order to check if it is functioning properly.
  - v. Requiring ACS DYFJ staff and NSP providers to conduct random video review, including live streaming.
  - vi. Requiring ACS staff to conduct random audits of logbooks and compare with MCCU incident reports and video footage.
  - vii. Requiring ACS staff to properly document decisions made during the "Daily Huddle" and ensure that those decisions are implemented and followed-up on.
  - viii. Requiring ACS to provide technical assistance on a scheduled basis and increase such assistance as a NSP's monitoring status changes.
  - ix. Creating an ACS DYFJ universal tracking system for each incident that is followed-up on, which includes steps taken, updated actions taken by ACS staff, NSP workers, and OCFS, and the final resolution and date of resolution.
2. ACS should enhance its contracts with NSPs to require:
    - i. All NSPs to have policies and procedures regarding:
      1. Safety and Security Protocols maintained at each facility;
      2. Systematic checks of security and video system's functionality; and
      3. Monitoring the live feed from the security videos at the facilities
    - ii. All NSPs to report video malfunctions under MCCU guidelines.
    - iii. Enforcement mechanisms that have clear consequences.
  3. ACS should create a proper evaluation tool to monitor performance of all NSPs to be conducted bi-annually and results should be made publicly available.
  4. ACS should examine whether similar guidelines as the ones stated above need to be implemented with LSP contracts and policies and procedures.

ACS has agreed with all of DOI's recommendations and are in various stages of implementing them. For example:

1. In July 2015, ACS engaged an expert in quality assurance for juvenile justice programs to recommend steps to improve its quality assurance process. As of January 2016, ACS reports it has taken concrete steps to implement many of these recommendations. Some of these recommendations include:
  - a. Hiring 24 additional staff within the DYFJ and 11 staff across the rest of ACS, which include an Assistant Commissioner of Quality Assurance, who will enhance and oversee structured monitoring for all juvenile justice programs, and an Executive Director who will focus on contract management to ensure providers for the entire division are in compliance with standards.
  - b. Implementing the Performance Based Standards (PbS) system to measure outcomes in juvenile justice residential settings.
  - c. Revising the Quality Assurance Standards in order to create more measurable standards for the providers to follow.
2. ACS will revise and update the log book policy to include instructions on including frequency of bed checks, including notations regarding the time conducted, and the name of staff who conducted the check. ACS will also require that NSP provider management regularly view video footage and match against logbook entries.
3. ACS has engaged the New York Police Department to visit each NSP site and assess safety and security, as well as provide recommendations that are in compliance with foster care regulations.
4. Beginning in May 2016, ACS staff will conduct eight site visits, which will include four unannounced overnight visits, per year at each NSP facility.
5. As of April 2016, DYFJ requires that all NSP providers review their video footage weekly and is in the process of finalizing the logistics.
6. The newly hired Director of Incident Review will lead the Daily Huddle, review each incident, determine what elements require follow-up, and assign the follow-up items. The Director of Incident Review will then send out a written confirmation to the team, identifying who is responsible for each incident follow-up.

DOI will continue to monitor implementation.