SUPREME COURT OF THE STATE OF NEW YORK
KINGS COUNTY

IN THE MATTER OF **THE INVESTIGATION INTO** **R10-359**	**8830/2010**

GRAND JURY REPORT

PURSUANT TO

CPL § 190.85(1)(c)

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PRELIMINARY STATEMENT

On September 2, 2010, four-year-old Marchella Pierce died in her Brooklyn apartment from starvation and abuse only eight months after she joined her family following an extended period of hospitalization for serious medical conditions relating to her premature birth. Throughout these eight months, the Pierce household was under the supervision of the New York City Administration for Children's Services [ACS] because Marchella's mother had given birth to another child while under the influence of an illegal substance. However, neither the addition of the medically-fragile Marchella to a household already under significant stress nor her declining physical condition was recognized by ACS, which undertook none of the obvious steps that would have saved her life.

A criminal investigation into the circumstances surrounding the murder of Marchella Pierce culminated in the indictment by a Kings County Grand Jury of four individuals. That investigation, in turn, prompted the District Attorney of Kings County to direct that a special Grand Jury be convened. Beginning in May 2011, this Grand Jury heard evidence regarding the possible role played by ACS' practices and procedures in the deaths of Marchella Pierce and seven other children in Kings County since August 2007, while their families were under investigation by or supervision of ACS. The goal of this investigation was to determine whether children had died and were at a continued heightened risk of dying from abuse, neglect, and outright violence while under the supervision of ACS because ACS had not implemented needed reforms of its investigatory and supervisory practices that were identified in 2007.

In conducting this investigation, we, the Grand Jury, found that New York Social Services Law tasks the ACS – and, in particular, the Division of Child Protection – with the vitally important mandate of, first, investigating all reports of abuse and maltreatment of children who reside within the City and, second, taking all steps necessary to protect and safeguard the children who reside in the households under investigation. As this Grand Jury has learned from its consideration of the testimony of 40 witnesses and 111 exhibits, along with our

legal advisors' instructions on the applicable laws, rules, and regulations, the difficulties faced by the staff of ACS, which undertakes annually an average of 60,000 such investigations, cannot be overestimated.

Our consideration of this evidence has, of course, all the benefits of hindsight, but with hindsight comes perspective. In that light, we have found that the evidence heard by this Grand Jury supports the conclusions that (i) prior to 2007, children died unnecessarily because ACS did not implement in a professional and effective manner the laws and regulations governing that agency's conduct of investigations of child abuse, and (ii) beginning in August 2007, additional children died because ACS did not implement in a timely or effective manner the highly constructive measures identified by the New York City Department of Investigation that would have improved the ability of its Division of Child Protection to investigate allegations of abuse and neglect and to determine and implement the steps necessary to safeguard the subject children. Critically, the evidence further supports the finding that, should this failure to implement and rigorously enforce necessary changes in its investigative practices and procedures continue, children will continue unnecessarily to live and die in fear and in pain.

Accordingly, and as authorized pursuant to Criminal Procedure Law section 190.85(1)(c), this Grand Jury has formulated and does hereby propose recommendations for legislative, executive or administrative action in the public interest based upon stated findings that are supported by a preponderance of the evidence.

The implementation of the majority of these recommendations will require little if any additional funding. They simply seek to ensure that ACS will be required to undertake to do what it is already required to do by the existing laws and regulations governing the activities of its Division of Child Protection, but to do so from this point forward in a manner unhindered by any artificial and counterproductive distinction between social work and law enforcement investigatory standards and techniques. The deaths of infant after infant and child after child during the course of well-meaning but ultimately ineffectual and in some instances outright amateurish investigations dictate that the time has long-since passed for ACS to insist that the conduct of skilled investigations employing law enforcement paradigms are antithetical to effective social work. Instead, ACS must accept the necessity for the disciplined employment of proven investigative skills and techniques while complying with not only the letter but the

spirit of the requirements of the Social Services Law, and these skills and techniques must be the linchpin of the Division of Child Protection.

The Grand Jury also recognizes that implementation of some of our recommendations may require additional funding or other assistance from federal, state, and local government sources. However, and as the testimony of ACS child protection caseworkers and their supervisors so vividly made clear, it is simply not enough to recruit a baseline number of conscientious and well-meaning individuals to assume the wrenching responsibility of ensuring the safety of children who are suspected of being the victims of abuse and maltreatment. Those individuals must be hired in sufficient numbers, they must be rigorously trained by qualified and experienced instructors, and they must be provided with sufficient resources and skilled supervision so that they can fully and effectively comply with the laws and regulations that prescribe how they are supposed to investigate complaints of child abuse and neglect.

While our findings and proposals necessarily reflect a degree of criticism of ACS practices, procedures, and policies, they do not entail and are not intended to convey criticism of any current or former public servant, within the meaning of Criminal Procedure Law section 190.85(1)(a), (b). Our proposals arise out of a deeply felt concern that children have died who might otherwise have been saved

had only ACS implemented identified measures to improve the functioning of its Division of Child Protection, and, if possible, out of an even more deeply felt concern that more children will be lost if these measures are not implemented in full. By this report, issued pursuant to section 190.85(1)(c), we seek to improve the practices of ACS in order to safeguard the children who are entrusted to that agency's protection and to better equip and enable ACS staff to perform their arduous and sometimes thankless roles on behalf of those children.

FINDINGS OF THE GRAND JURY

In New York State, little is left to chance or discretion with regard to the manner in which critical investigations into reports of alleged child abuse are supposed to be conducted, documented, and resolved. Although the Social Services Law and corresponding regulations may – in the opinion of this Grand Jury – err on the side of preserving families over removing children from homes in borderline risk situations, those same laws and regulations nevertheless dictate that local social services agencies must promptly, rigorously, and comprehensively investigate all allegations of child abuse and maltreatment in order to be able accurately to assess all risks posed to the safety of the children should they be allowed to remain in the home.

Article 6, section 411 of the New York Social Services Law articulates the State's mandate in the realm of child protection thusly:

> Abused and maltreated children in this state are in urgent need of an effective child protective service to prevent them from suffering further injury and impairment. It is the purpose of this title to encourage more complete reporting of suspected child abuse and maltreatment and to establish in each county of the state a child protective service capable of investigating such reports swiftly and competently and capable of providing protection for the child or children from further abuse or maltreatment and rehabilitative services for the child or children and parents involved.

The Administration for Children's Services is the local social services district agency that is charged with implementing within the five boroughs of New York City the vital mandate of the Social Services Law and the corresponding regulations set forth in Title 18 of the New York Code, Rules and Regulations relating to the protection of abused and mistreated children.[1] Although nominally under the supervision of the New York State Office of Children and Family Services [OCFS], ACS is a mayoral agency that receives significant funding from New York City, as well as from the state and federal governments.

In New York State, every allegation of suspected child abuse in any form and from whatever source is referred to the State Central Register of Child Abuse and Maltreatment [SCR][2] and inputted into CNNX, the state-wide system constituting the official record of all child abuse cases. Both the SCR and CNNX

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[1] State regulations implementing the Social Services Law are promulgated by the New York State Office of Children and Family Services pursuant to sections 20, 34, 421, 427 of the SSL and are codified in Title 18 of the New York Code, Rules and Regulations. ACS is required to formulate and maintain an internal compilation of rules, regulations, and practices, and it does so through a Casework Practice Guide, albeit it has existed in a draft format since July 2007. SSL § 421(6); 18 NYCRR § 423.6(a); see also NYC Charter § 1043: "Each [NYC] agency is empowered to adopt rules necessary to carry out the powers and duties delegated to it by or pursuant to federal, state or local law. No agency shall adopt a rule except pursuant to this section. Each such rule shall be simply written, using ordinary language where possible."

[2] SSL § 422(1). Certain persons and officials are required by SSL § 413(1)(a), (d) to report or cause a report to be made to the SCR when they have reasonable cause to suspect that a child is an abused or maltreated child. These "mandated reporters" include physicians, law enforcement officers, teachers, District Attorneys and their staffs, and social services workers such as ACS caseworkers and supervisors. Willful failure to do so is a class A misdemeanor. SSL § 420(1).

are administered by OCFS. The SCR system categorizes each incoming complaint based upon a variety of factors, the most important being the seriousness of the allegations, and forwards those reports involving children in NYC to ACS. Within ACS, the staff of the Division of Child Protection [DCP], which has offices in each borough, responds on a 24-hour basis to SCR reports of abuse or mistreatment pursuant to the requirements of the SSL and regulations and as further detailed in the ACS Casework Practice Guide. [3]

As provided by SSL sections 397(2) and 398(2)(a), ACS through its Division of Child Protection must:

(a) Investigate complaints of neglect and abuse of children and offer protective social services to prevent injury to the child, to safeguard his welfare, and to preserve and stabilize family life wherever possible.
(b) Bring such case when necessary before the Family Court for adjudication.
(c) Institute proceedings in a court of competent jurisdiction against a parent or adult for neglect or abuse of a child.

Because the safety of children is at issue, applicable laws and regulations require that the investigation of an SCR report must be promptly commenced and

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[3] DCP satisfies the requirement of 18 NYCRR § 432.2 that ACS must "establish a child protective service within [ACS] which shall operate as a single organizational unit," which shall have exclusive responsibility for investigation of SCR reports and arranging and coordinating the provision of services "necessary to safeguard and ensure the abused or maltreated child's well-being," and to which "no other responsibilities" may be assigned.

expeditiously but comprehensively conducted.[4] In general, when a report has been categorized by the SCR as high priority, DCP caseworker staff is required by laws and regulations to make initial face-to-face contact with the household and the child within 24 hours in order to commence the process of assessing the safety of the children and risks to which they are being exposed.[5] In non-high priority cases, the initial contact must be made within 48 hours. Thereafter, DCP staff is required to make contact with the family through visitation no less than twice-monthly and to conduct an investigation that allows the case to be closed within 60 days with a finding that the report was either "indicated" or "unfounded." Whether the report is deemed indicated or unfounded depends upon whether the investigation discloses the existence of "some credible evidence of the abuse or maltreatment."[6]

Every step of the handling of the investigation and its aftermath by DCP staff, including supervisory directives and all "information that is relevant, useful,

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4 SSL §§ 421, 424; 18 NYCRR § 432.2(b)(3).

5 A "risk assessment" is the process of gathering and analyzing information in order to determine the risk elements that are affecting the family function – such as multiple children, domestic violence, inadequate housing, etc. The "safety assessment" is the process of weighing whether the results of the risk assessment "suggest[s] there is an immediate threat to a child, which, if not controlled or alleviated, will be likely to cause serious harm to the child." In turn, "controlling interventions" are "activities or arrangements which protect a child from unsafe situations, behaviors or conditions which are associated with immediate danger of serious harm." 18 NYCRR § 428.2(h) – (j).

6 SSL § 412(6) and (7).

factual and objective," is required to be documented by entry into CNNX, the computerized official case record.[7] DCP caseworkers, under the supervision of more experienced staff, are required to review promptly the CNNX records of all prior contacts with the family by ACS or another social service district. The investigation must also entail the review of the prior criminal history of adult members of the household and the interviews of "collateral" sources of information relevant to the allegations. These sources may include pediatricians, school staff, family members, child care providers, and neighbors familiar with the functioning of the household and the condition of the children. Caseworkers must consult with agency attorneys and seek the intervention of Family Court when households do not cooperate with, or otherwise frustrate, the course of the investigation. Necessary Family Court intervention may include the issuance of "entry orders," the means by which caseworkers gain entry to a home under investigation, and "removal orders," which empower ACS to remove children from the home.

State law directs DCP staff to "take all appropriate measures to protect a child's life and health including, when appropriate, taking or keeping a child in protective custody without the consent of a parent or guardian if [DCP staff] has

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7 18 NYCRR §§ 428.1, 428.3; 428.5, 428.6, 428.7, 430.9.

reasonable cause to believe that the circumstances or condition of the child are such that continuing in his or her place of residence or in the care and custody of the parent, guardian, custodian or other person responsible for the child's care presents an imminent danger to the child's life or health." However, and although the children of the household may in certain circumstances be removed and placed into foster care by order of a Family Court, the goal is, as stated above, to "preserve and stabilize family life wherever possible." Thus, based upon the conduct by DCP staff of a statutorily required "risk assessment" and "safety assessment," appropriate "preventive services," most often provided through outside agencies under contract to ACS, are typically offered to the family during the investigation phase and/or subsequent to its closing.

While in some cases a child and his family who are in receipt of protective services may receive mandated preventive services because the child is deemed at imminent risk of foster care, in other cases the preventive services may be offered to the family but participation is not mandated because there is only a possible future risk that removal may be required. [8] If a family fails to participate

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[8] "Preventive services" mean "those supportive and rehabilitative services provided to children and their families in accordance with the provisions of this Part for the purpose of: averting a disruption of a family which will or could result in placement of a child in foster care[.]" 18 NYCRR §§ 423.2(b), 428.2(k), 430.9. Preventive services are provided "according to the needs of the child and his family" for a period of beyond six months only if a new

in preventive service programs that DCP determines are necessary to ensure the safety of the children of the household, ACS is required to seek Family Court intervention, which may involve a petition for an order that the child is in need of care and protection, court-ordered participation in the preventive services, or the removal of the children from the home.[9]

State law prohibits OCFS from dictating the number of DCP staff employed by ACS.[10] Instead, state law requires only that ACS "shall have a sufficient staff of sufficient qualifications to fulfill the purposes of this title and be organized in such a way as to maximize the continuity of responsibility, care and service of individual workers toward individual children and families. [ACS] shall have flexibility in assigning staff to the child protective service provided that each staff assigned to such service has the staff qualifications and has received the training required by the department regulations[.]"[11] Caseload is defined as "the number

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determination is made that the child will be placed in foster care unless such services are provided and that it is reasonable to believe that by providing such services, the child will be able to remain with the family. 18 NYCRR § 423.4(a) and (b). A case involved in the preventive services stage is managed by ACS staff, but case planning is undertaken either by ACS or in conjunction with the preventive services provider. 18 NYCRR § 423.4(c), 428.2(b) – (d). At least 12 home visits or face-to-face contacts with the child/family in receipt of preventive services must be conducted during each six-month period. 18 NYCRR § 423.4(d). ACS is reimbursed by the state for 65% of its costs for providing preventive services pursuant to SSL § 409; 18 NYCRR § 423.5.

9 SSL § 424(6) - (13); 18 NYCRR § 423.4.

10 SSL § 20-a.

11 SSL § 423(1)(c). (continued next page)

of cases to which an individual child protective services worker provides either pre-determination or post-determination services" in cases initiated by SCR reports, but neither the Social Services Law or its regulations sets a limit on the number of SCR investigations that may be assigned to a caseworker.[12]

The August 2007 Department of Investigation Examination of Eleven Child Fatalities and One Near Fatality

Between October 2005 and February 2006, 10 children died and one child nearly died while under supervision of the Division of Child Protection of the New York City Administration for Children's Services, and, in July 2006, yet another child would be dead, the victim of a homicide in her own home. These 12 children were seriously injured or died as a result of intentionally inflicted violence or neglect at the hands of their parents or guardians. ACS' role in each of these cases was reviewed by ACS and by OCFS.[13] However, those reviews focused almost entirely on ACS' own records and files.

Qualifications for the positions of "child protective services" workers and supervisors are set forth in SSL § 421(4)(a) and (b), and require no more than "any baccalaureate or equivalent college degree and/or relevant human services experience" for caseworkers, and any baccalaureate degree or three years relevant work experience for supervisors.

[12] 18 NYCRR § 432.1(u). 18 NYCRR § 431.5 establishes a limit "per intake worker of 20 applications for care or services per month" and a limit of 20 families per worker providing preventive services," but no corresponding limit for caseworkers investigating SCR reports of abuse.

[13] Pursuant to SSL § 421(8) OCFS is required to monitor and supervise the performance of local agencies, such as ACS, and, pursuant to SSL §§ 20(5)(a) and 422-b, following an investigation at the state or regional level of a fatality, OCFS produces a Child Fatality Report

Rose Gill Hearn, Commissioner of the New York City Department of Investigation [DOI], recognized that a different approach was needed in order to assess whether the policies and practices of ACS had played a role in these painfully adverse outcomes and, if so, to identify what steps could and must be undertaken to prevent their repetition. Accordingly, and pursuant to her authority under NYC Charter section 803, Commissioner Gill Hearn directed her staff to undertake an investigation of ACS' response to the allegations of abuse and maltreatment that culminated in 11 deaths and 1 serious physical injury of children from October 2005 through July 2006. For 18 months, DOI diverted and devoted a significant percentage of its staff and resources to this investigation, which was of unprecedented scope and which included not merely a review of

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which it forwards to ACS within six months of the fatality. The report may include requests that ACS undertake further investigation or make recommendations for local or state administrative or policy changes. ACS has 45 days to review the report and submit a Corrective Action Plan. Although available to the public upon request to OCFS, the reports do not identify the deceased child, family or surviving siblings. See also, SSL § 34: General Powers and Duties of the [OCFS] Commissioner.

From June 1999 through October 2011, the NYC Regional Office of OCFS had prepared 993 child fatality reports relating to deaths in the city, 911 of which involved allegations of abuse or neglect:

1999	56 reports	2006	89 reports
2000	54 reports	2007	95 reports
2001	67 reports	2008	107 reports
2002	58 reports	2009	89 reports
2003	54 reports	2010	109 reports
2004	72 reports	1/2011 – 10/2011	76 reports
2005	67 reports		

case files and records of ACS' handling of the twelve cases, but also the de novo re-investigation of these cases. DOI staff also looked more broadly into the practices and procedures employed by ACS' Division of Child Protection when investigating reports of abuse and neglect of children. DOI's investigation culminated in August 2007 with the issuance of a report of *A Department of Investigation Examination of Eleven Child Fatalities and One Near Fatality* [2007 Report].

The 2007 Report, formulated and drafted by DOI personnel, appropriately acknowledged the commitment of ACS' staff to fulfilling the extremely difficult mandate of safeguarding the children of New York City. However, the findings of serious investigative and other failures necessitated that the 2007 Report was significantly critical of ACS' performance in all but one of the cases that had culminated in the deaths of 11 children and almost culminated in the death of another child during a 9-month period. DOI found that the ability of caseworkers to conduct effectively the investigations that were mandated by the Social Services Law and regulations and, indeed, by ACS' own Casework Practice Guide, was hampered by inexperience, inadequate training, ineffectual supervision, untimely, incomplete and inaccurate case documentation, and a shortage or outright lack of necessary equipment and logistical support. The 2007 Report

further concluded that the failure to conduct meaningful, thoughtful, and thorough investigations of the families involved in the subject cases was not an anomaly: If changes were not made, children continued to face avoidable risk of death or serious injury at the hands of negligent and abusive parents and caregivers while their families were under ACS investigation and/or supervision.

Although DOI was and is empowered to conduct investigations of city agencies, it does not have the authority to compel or require ACS or any other agency to make changes in its policies, practices, and procedures.[14] Therefore, DOI was limited in the 2007 Report to *recommending* how ACS could and should change the manner in which its Division of Child Protection performed its functions. In advancing these recommendations, the 2007 Report nevertheless left no doubt that their implementation or effectuation was necessary in order to avoid the repetition of the investigative failures that had already resulted in the protracted abuse, neglect, serious injury, and murder of children.

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[14] NYC Charter § 803(b): "The commissioner [of DOI] is authorized and empowered to make any study or investigation which in his opinion may be in the best interest of the city, including but not limited to investigations of the affairs, functions, accounts, methods, personnel or efficiency of any agency.

NYC Charter § 803(c): "For any investigation made pursuant to this section, the commissioner shall prepare a written report of findings and shall forward a copy of such report or statement to the requesting party, if any. In the event that the matter investigated involves or may involve allegations of criminal conduct, the commissioner, upon completion of the investigation, shall also forward a copy of his written report or statement of findings to the appropriate prosecuting attorney[.]"

Among the 16 enumerated Findings of Investigative Failure – many of which addressed multiple institutional shortcomings – were those that reflected the need for greater coordination between ACS and other city agencies, including the Police Department, the Department of Education, and the Department of Buildings.[15] The specified Recommendations to redress those problems necessarily required action by agencies other than ACS alone. Other Findings reflected specific problems that could be addressed only by or in conjunction with the New York State Office of Children and Family Services and/or the State Legislature. However, those Findings and Recommendations were the exception; the clear majority of the 2007 Report's Findings reflected the failure by ACS to implement or comply whole-heartedly with the investigative standards that were already clearly set forth in the Social Services Law and regulations and, indeed, in ACS' own Casework Practice Guide.[16] The corresponding Recommendations

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[15] These Findings were denominated "Conclusions" in DOI's official "Closing Memorandum," dated October 31, 2007, which also included the Recommendations addressed herein.

[16] Pursuant to SSL §§ 421(6) and (7), OCFS promulgated 18 NYCRR § 300.6, which requires ACS to "make local procedural manuals and service directories available to employees of a child protective service." ACS must file any proposed new or changed rule or procedure with OCFS at least 30 days before the proposed effective date. Such new or changed provision becomes operative "upon approval" of OCFS or "if not disapproved."

The ACS Casework Practice Guide that was in effect throughout the time frame covered by this Grand Jury Report had last been issued – in draft form only – in July 2007. It included supplemental "Safety Alerts" and Commissioner's Memoranda dating back to 2006 that augmented or changed provisions within the body of the Guide, and more had been added

largely called upon ACS to do what it was already required to do by the existent laws, regulations, and its own Practice Guide while investigating reports of child abuse and maltreatment. Only a few of the Findings triggered Recommendations that ACS do more. The Recommendations were straightforward, and their implementation, as ACS would subsequently acknowledge, largely did not require additional staff or funding.

For example, a significant number of the Findings of Investigative Failure and the corresponding Recommendations addressed the seemingly general category of ACS' failure to conduct the type of investigation that was both necessary and already required in order to accumulate sufficient credible evidence that would permit ACS to either substantiate or "indicate" the report of abuse or neglect, or that would alternatively permit ACS to "close" the case based upon a determination that the allegation was "unfounded." The risk posed by the premature or erroneous closing of an investigation in reliance upon the incorrect "unfounding" of an allegation of abuse or neglect based upon inadequate or incorrect information was clear cut: Children who could and should have been removed from households were not, and families who should have been accorded

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after its draft-form issuance. The Practice Guide was referred to by ACS witnesses as the caseworkers' "bible]"; however, it is possible only with difficulty to ascertain, with certainty, what the current ACS policy or procedure on any matter is.

greater supervision and services did not receive them, with the result that children were left in unsafe and outright dangerous households to suffer and die at the hands of negligent, incompetent, abusive, and violent parents and caregivers.

This category of purely investigatory Findings that resulted in DOI's calling upon ACS to comply with existing requirements included the following:

- Although existing laws, regulations, and policies required that ACS conclude a thorough investigation into a report of abuse or maltreatment to the State Central Register within 60 days with either and "indicated" or "unfounded" determination, ACS supervisors often authorized the closing of cases within the 60-day period notwithstanding that caseworkers had not completed the investigations and where, as a result, potentially dangerous situations remained unresolved in homes under investigation.
- Although required by existing laws, regulations, and policies, ACS caseworkers were failing to conduct the "critically important" review of the prior ACS history of the subject[s] of an SCR hotline report, which could "reveal troubling patterns of behavior."
- Although required by existing laws, regulations, and policies, to interview "collateral" sources of information about the household and children under investigation, caseworkers were disposing of abuse or neglect allegations as "unfounded" by crediting explanations provided by the very family members who were alleged

to have engaged in the abuse/neglect, without acknowledging the existence of inconsistent evidence and without attempting to establish which version was accurate.

- Although required to do so by existing laws, regulations and policies, caseworkers were not conducting the bi-monthly [every 2 weeks] visits to households under investigation, and caseworkers were incorrectly delaying in seeking – or failing to seek – a court issued entry order when denied entry into a household under investigation.
- Although required by existing laws, regulations and policies to do so, caseworkers were failing to obtain pedigree [identifying and contact] information for the adult members and frequenters of a household, and were then failing to request and review their criminal histories. ACS staff was instead relying upon unverified information obtained from family members or even the subject adults of the investigation.

Restating the relevant provisions of the Social Services Law, and recommending that ACS retrain its staff in the legal requirements, DOI specified that "ACS staff *must* classify a case as 'indicated' where the investigation has established credible evidence that support the allegations," and "cases should be classified as 'unfounded' only when a thorough investigation of the underlying allegations does not yield credible evidence substantiating the allegations." Leaving no room for interpretation of the importance of this recommendation in light of the tragic outcomes documented in the report, DOI emphasized,

"[I]nvestigations should never be closed and classified as 'unfounded' where the allegations have been unsubstantiated simply because the subject parent agrees to correct the situation. . . . [or] where the caseworker has been unable to conduct a home visit or interview the accused parents or other critical witnesses." The 2007 Report called upon ACS to establish a deadline by which caseworkers must have obtained and evaluated relevant medical records. DOI further recommended that, in the event a parent under investigation refuses at the initial casework contact to consent to the release of the subject child[ren]'s medical records, ACS require caseworkers to consult with an agency attorney within 24 hours of the refusal.

The 2007 Report also documented a troubling failure by ACS to ensure that the front-line caseworkers were provided with adequate support and supervision, as required by existing laws, regulations and policies. DOI stated that "supervisors must never sacrifice a thorough investigation simply for the sake of meeting the 60-day period" that the Social Services Law specifies for the conduct and completion of investigations of SCR hotline complaints. The 2007 Report recommended that ACS require supervisors to hold regular case reviews with assigned caseworkers to offer – and document in the case file – guidance and direction for the continuation and correct resolution of the investigation. DOI

also recommended that ACS implement procedures to insure appropriate case coverage when assigned supervisors are for any reason no longer available. In lieu of ACS' "unrealistic and unfair" ad hoc system of asking supervisors to take on these cases in addition to their own assignments, DOI recommended that ACS put into place a formal system in which "substitute supervisors rotate through units on an as-needed basis in order to maintain meaningful supervision of cases" in the absence of the original supervisor.

While recognizing that ACS trained caseworkers in some aspects of investigation techniques, the 2007 Report identified the lack of investigative experience and skill within the ranks of caseworkers and supervisors as the single greatest factor contributing to the inadequate and incomplete investigations that were being conducted by ACS. The 2007 Report applauded ACS for having already hired 20 former law enforcement officers as Investigative Consultants [ICs],[17] but it forcefully concluded that 20 ICs were "simply not enough based upon what we have seen in this extensive, 18-month study":

> Given the long, documented history of poor quality investigations conducted by ACS and its predecessor entities, as well as the stakes involved, specifically, the safety and welfare of the children of New York City . . . . DOI is suggesting that ACS begin immediately to take the steps necessary to hire an additional 100 individuals with law

[17] Only 18 Investigative Consultants (ICs) were on ACS' staff when the report was issued in August 2007.

enforcement or investigation experience over the next 12 months to be deployed throughout ACS starting in the areas that experience the highest number of serious abuse/neglect reports.[18] DOI recommends that those former law enforcement officers serve as investigative consultants and integrate those individuals to work with the frontline caseworkers to assist with and continually review investigations of the most serious abuse and neglect cases.

With this recommendation, DOI is not advocating that ACS become a law enforcement agency. DOI is not suggesting that these investigative consultants carry weapons or have the power to effect arrests or execute search warrants. This recommendation is based on the indisputable fact that ACS caseworkers are often required to conduct investigations that are criminal in nature involving parents with criminal histories who may be abusing their children and do not want that abuse to be discovered. There is no question that those allegations will be more effectively investigated by individuals with prior law enforcement experience. These individuals are not meant to replace caseworkers and other ACS staff who provide invaluable social services to countless families throughout New York City. Instead, this cadre within the child protective unit should be used to assist with investigations of the most serious cases to better enable ACS to make more intelligent and informed decisions about a child's safety and a family's future.

The 2007 Report focused on the difficulties and dangers involved in the caseworker's role in the Division of Child Protection:

- Because ACS imposed on caseworkers responsibility for monitoring cases following case closing but before the family had been assigned

[18] The 2007 Report noted that the Office of the Mayor had already authorized and directed the "immediate" hiring of these investigative consultants, and that ACS had agreed that these ICs would: train the caseworkers on investigative techniques, consult on investigative issues as they arise, follow-up as necessary on key investigative steps, and accompany caseworkers into the field on the more serious cases.

to preventive services, the real risk arose that such families could "fall through the cracks,"[19] while the actual caseload borne by the caseworkers exceeded that reflected in ACS' reported caseload tracking system, which included only cases that were still undergoing the 60-day investigation.[20]

- Caseworkers, who were almost always assigned alone to investigations, were required nevertheless to interview all members

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[19] The 2007 Report documented that when ACS referred parents under investigation to drug, alcohol, parenting, anger management or other counseling programs run by outside contract agencies in order to remediate risk factors in the household, ACS staff did not "communicate regularly or effectively with the outside agencies with which ACS contracted for the provision of counseling and other preventive services or otherwise monitor parental compliance and that caseworkers rarely monitored the parents' participation in those services," notwithstanding that the ACS Casework Practice Guide required that they do so, and then entered false or inaccurate information into CNNX.

[20] This Grand Jury heard testimony from current and former ACS staff concerning caseloads and learned that, while ACS had succeeded in statistically reducing the average DCP caseworker caseload of SCR investigations to 12, the caseworkers were unable to comply with the strictures of a full and complete investigation within a normal 8-hour workday. Instead, in order to investigate the cases and properly document their efforts during the 60-day window in which they are required to conduct and complete an SCR investigation, caseworkers were working 10 or more overtime hours per week in order, primarily, to input data into CNNX. Varying policies were applied to those overtime hours. Some caseworkers reported that they were not paid for the extra hours and received only "comp time" unless they received an express directive to work, while nevertheless being subject to criticism if they did not fulfill their duties in a timely manner. Other caseworkers and supervisors reported that overtime was always compensated. In any event, the majority of caseworkers testified that it was not possible in a normal workday and workweek to fulfill their responsibilities in 12 SCR investigations while also fulfilling their post-closing monitoring duties in yet more cases that were awaiting or receiving preventive services.

This problem was exacerbated (i) by the absence of a system to ensure that the handling of investigations was not impaired by the temporary or permanent unavailability through attrition of the assigned caseworker(s) and supervisors, and (ii) by poor documentation of the investigations in CNNX: If the caseworker did not make timely and complete entries documenting an investigation, or if those entries were "boilerplate" and did not convey accurately all relevant facts and circumstances, then a substitute or replacement caseworker would be ill-informed or uninformed of potentially critical information.

of a household, including the children and those alleged to have abused or mistreated them, "were often confronted with frightening and intimidating situations in homes that are under investigations." DOI intended initially to recommend that ACS require caseworkers to work in pairs when in the field, reflecting the same procedural practice employed by every other city agency including the NYPD, FDNY, and DOI when dispatching investigators in the field. Although DOI continued to believe that teams were best able to conduct investigations, ACS disagreed and had issued in 2006 a "Safety Alert" that encouraged caseworkers to work in pairs "where the allegations suggest that the caseworker may encounter a dangerous situation in the home," when "complex family situations make it difficult to assess the safety of the children" and when removing children from a home. Based upon ACS' assurances that it would "attempt to ensure worker safety and the integrity of the investigations by strongly encouraging caseworkers to go out in pairs in the situations outlined in the [2006] Safety Alert," DOI elected only to "strongly recommend[] that ACS caseworkers be encouraged to conduct home visits and other significant field work in pairs where necessary." [21]

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[21] This Grand Jury heard consistent testimony that the ability of caseworkers to conduct simultaneously field investigations of multiple cases was further complicated by their need to utilize either public transportation or their own vehicles while engaged in field work. Caseworkers also expressed frustration because ACS did not provide Metrocards. Caseworkers were instead required to purchase Metrocards and then apply for reimbursement which, some testified, they did not receive for weeks.

Further reflecting concern for the safety of caseworkers, DOI urged the State Legislature to enact a new section of the Penal Law designating the assault of a caseworker a felony offense. Finally, DOI called upon ACS to implement a procedure allowing caseworkers to trigger

- The 2007 Report observed that the ability of caseworkers to effectively interview the members of the household was detrimentally impacted by the failure of ACS to implement a program under which a caseworker would only be assigned to investigate a household if the caseworker was conversant in the language of that household. [22]

The 2007 Report also found that the effectiveness of ACS' Division of Child Protection was seriously undermined by the pervasive failure of its child protection staff to comply with even the minimal record-keeping requirements of the Social Services Law and regulations. By thus failing to document critical steps undertaken during the investigation, ACS undermined its own ability to safeguard children during the course of investigations, to correctly resolve investigations, and to determine where the fault lay when an investigation was incorrectly concluded. In particular, DOI found:

- ACS caseworkers and their supervisors consistently failed to enter relevant information into the official computer record-keeping system – CNNX – on a timely basis, and that staff instead routinely made entries into CNNX long after the events described. Caseworkers and supervisors made entries into CNNX that were

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the "IRT" [Instant Response Team] protocol from a field situation when a more serious situation is found to exist than was reported in the SCR hotline report.

[22] 18 NYCRR § 423.4(m)(2) provides that "[r]easonable efforts shall be made by the preventive services agencies to communicate with the child and his family in their primary language."

couched in superficial boilerplate language or were inaccurate and/or false. In some cases, DOI investigators were unable to verify that the documented investigatory activity – such as home visits and interviews – had, in fact, occurred. DOI recommended that ACS issue and *require its caseworkers to use* field notebooks to document their investigations for later inclusion of the notes in the case files, referencing procedures used by the NYPD. [23] With regard to the CNNX record system, DOI advised that ACS must instruct caseworkers to "immediately document significant events into the system, and supervisors must diligently monitor that this is followed." DOI further recommended that ACS caseworkers be provided with mobile equipment allowing them to access and input data into CNNX while not in the office.

- The 2007 Report concluded that "[p]erhaps the most troubling discovery of DOI's investigation was that caseworkers made false or inaccurate entries into CNNX or other computer records after a child had died, in which they claimed to have taken certain investigatory steps or other actions before the child's death, which DOI's investigation established did not actually happen." DOI concluded that the current safeguard – whereby ACS had merely instructed its staff "not to access or add information to an existing CNNX file after the death of a child . . . under investigation" – was "not sufficient."

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[23] DOI noted that ACS had advised that (i) "all caseworkers will soon have access to digital cameras" and (ii) ACS "will begin to provide field notebooks to its caseworkers and *ensure that contemporaneous notes of interviews or other significant events are taken and maintained as part of the case file.*"

DOI specified: "ACS must freeze all access to an existing CNNX file as soon as it learns of the death or serious injury of a child in a family due to what becomes an active investigation. Any new activity that needs to be documented should be recorded in a new CNNX file. ACS should not be permitted to input information about activities or events that purportedly occurred prior to the death or injury in the existing file." To the extent that ACS had informed DOI that the CNNX system did not permit the creation of a new file on the same family, DOI recommended that "ACS work with the OCFS to allow the creation of a new file post-fatality."

- The Report called upon ACS to require parents who had been referred to a contract agency for counseling and other preventive services to consent in writing to ACS monitoring of the parent's participation in the programs so that the caseworker can make part of the ACS case file a record of the actual participation or non-participation in the program. In the event that a parent refuses to participate, fails to progress, or participates only sporadically, DOI recommended that ACS require the caseworker to consult with an agency attorney about seeking judicial intervention compelling parental participation or other judicially ordered action.[24]

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[24] Preventive services are "supportive and rehabilitative services provided to children and their families . . . for the purpose of averting a disruption of a family which will or could result in placement of a child in foster care". 18 NYCRR § 423.1, 423.4. 18 NYCRR § 423.2(3) enumerates the variety of preventive services that may be provided directly by ACS or, most commonly, through a contracted outside agency. SSL § 20-c. Such preventive services are offered by ACS to family members of a child suffering from abuse or maltreatment. However, ACS cannot compel a family to accept or participate; its recourse is to petition the Family Court

Finally, the 2007 Report recommended that ACS allow DOI to play a greater role in post-fatality inquiries conducted by the ACS Accountability Review Panel, as is allowed by the Social Services Law at the discretion of ACS.

The Release of the 2007 Report and Its Aftermath

During the investigation, DOI and ACS officials conferred over the Findings and the Recommendations that would be included in the report, and both agencies discussed with other City officials the feasibility of implementing and funding the Recommendations, including the hiring of 100 investigative consultants.[25] However, ACS's actual contribution to the 129-page 2007 Report[26] consisted of the 5-page "ACS' Response," which focused primarily on the "initiatives" contained in ACS' March 2006 "Safeguarding our Children: 2006 Action Plan" ["ACS Action Plan"]. Nevertheless, and although portions of the report arguably could have been withheld from the public pursuant to section 422-a of the Social Services Law,[27] ACS requested that the report be publicly

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for a determination that the child is in need of care and protection or removal. SSL § 424(10, 11).

[25] Thereafter, on more than one occasion from 2008 through 2010, Commissioner Gill Hearn offered to advocate on ACS' behalf with regard to its budget; ACS did not act upon those offers.

[26] Brief Responses by the Office of the Mayor and the Department of Education were also made part of the 2007 Report.

[27] SSL § 422-a accords to the Commissioner of ACS and the Commissioner of OCFS concurrent authority to disclose information regarding the abuse or maltreatment of a child, and the investigation thereof, "if he or she determines that such disclosure shall not be

issued by ACS and DOI, jointly, in order to portray ACS' openness to the investigation. Although it was not then and is not now the practice of DOI to issue a report jointly with an agency under investigation, DOI consented.

However, the evidence before this Grand Jury does not sustain the conclusion that ACS was open to the investigation or intent upon implementing its Recommendations. ACS internally downplayed the 2007 Report, beginning during the investigation itself and continuing throughout the four years after its issuance. Although DOI had drafted the report with the caseworkers and their supervisors in mind, ACS did not make the report available to its caseworkers and supervisors, and it did not sponsor or foster discussions about the Findings and Recommendations. ACS did not inform its staff whether it intended to implement the Recommendations, and if not, why not.[28]

Indeed, even during their testimony before this Grand Jury, ACS officials -- more than one of whom acknowledged not having read the 2007 Report at all or

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contrary to the best interests of the child, the child's siblings or other children in the household," and if other enumerated factors are present.

[28] The 2007 Report is not distributed or used as such during the formal 3-month training of new caseworkers at ACS' own facility – the Satterwhite Academy – which received a single copy of the report in 2007. An ACS official testified that the contents of the 2007 Report are not disseminated to new caseworkers, but that it "feeds into how we develop our training. In the same way that as we sit at the ChildStat case reviews . . . . So it's used in terms of improving what we do, and taking [*sic*] the recommendations to make sure we put them into place."

in its entirety until shortly before testifying, almost 4 years after its release -- consistently testified that the DOI investigation was, at best, an unwarranted and unnecessary intrusion into ACS' operations by a law-enforcement centric agency. These same witnesses opined that the Findings and Recommendations were unsound and/or unrealistic because DOI had approached its review of ACS practices and procedures from a "law enforcement" perspective, which they believed rendered it impossible for DOI to offer ACS constructive advice about the manner in which it undertook its work from a "social work" perspective.

Indeed, each and every ACS official who appeared in this Grand Jury recounted that the 2007 Report was largely inconsequential in view of the implementation by ACS of its own 2006 Action Plan initiatives, which were, they testified, sufficient to redress the few legitimate concerns that the officials acknowledged were identified in the 2007 Report. In marked contrast, as expressed in the 2007 Report itself and in DOI officials' testimony, DOI viewed the ACS Action Plan and the 2007 Report as "completely different exercises": The 2007 Report documented a "boots on the ground investigation" of a statistically significant number of cases that had resulted in the injury and deaths of children that was designed to determine precisely what had gone wrong at the caseworker/supervisor level and identify the measures that, if implemented by

ACS, would prevent the recurrence of these adverse outcomes. By comparison, the Action Plan explained, in broad strokes, how ACS planned to utilize additional funding allocated by the city to ACS during the immediate aftermath of the 2006 murder of Nixzmary Brown.

Officials from ACS, OCFS, and DOI concurred that a critical comparison of the 2007 Report and the 2006 Action Plan sustains DOI's assessment of the relative utility of the 2007 Report and the Action Plan when assessed in terms of which report functioned best to identify and propose fixes for what was demonstratively broken in the Division of Child Protection.[29] The Action Plan had been issued after what was necessarily a time-constrained superficial "review" of *10,000* open SCR cases, which review was completed in the timeframe of mere weeks following the high-profile murder of Nixzmary Brown. The "initiatives" were both broad in scope and largely managerial in focus, reflecting a big-picture view of various aspects of the agency as a whole and not focusing on the Division of Child Protection. The 2007 Report, in contrast, was based upon the detailed re-investigation of 12 cases from the ground up, along with numerous staff

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[29] Only four Action Plan "initiatives" correlated, according to witnesses, with any aspect of Recommendations in the 2007 Report, and none contained the specificity or detail included in the 2007 Report: hire 20 ICs; strengthen Instant Response Team (IRT) protocol; refine educational neglect allegation procedure, and improve supervision over DCP case practices through ChildStat case review of randomly-selected cases.

interviews over the course of many months, and it advanced specific Recommendations of how best to address the repeated occurrence of failures in the practices and procedures of the Division of Child Protection that had been demonstrated to have had a highly adverse effect upon these cases.

Furthermore, and as DOI detailed in the 2007 Report, the murder of the 12th subject child of the 2007 Report occurred late in July 2006 – approximately four months following the issuance of the ACS Action Plan. DOI found that a significant number of the same findings of significant investigative failings that had transpired during ACS' handling of the 11 other cases had occurred during ACS' handling of this 12th case. DOI reasonably concluded that this evinced that, notwithstanding the self-imposed initiatives contained in the Action Plan, ACS still needed to respond to and implement the very specific Recommendations advanced in the 2007 Report.

Based upon the evidence heard by this Grand Jury, budgetary issues were rarely determinative of why ACS did or did not implement Recommendations. Between August 3, 2007 and September 9, 2009, ACS self-reported to the New York City Office of Management and Budget that implementation of the Recommendations – which largely called upon ACS to implement existing investigative procedures and standards – would largely be *"cost neutral,"*

requiring no additional funds. ACS directly or indirectly identified only a few of the Recommendations as requiring the expenditure of funds. Bearing in mind that ACS' total adopted budget exceeded on average $2.65 *billion* during each year under consideration by this Grand Jury, with approximately $773 million coming from the City – the ACS-identified costs were nominal: $2.5 million for unspecified "staff training"; $2.5 million for "language/interpretation services"; $5.33 million for notebooks, storage of notebooks, "mobile technology," and digital cameras, and $6.62 million to hire 100 additional investigative consultants and 2 supervisors and to provide them with vehicles. ACS also identified $50,000 as required to add a building inspector to its staff, and $900,000 for 20 social workers to be assigned to schools.

DOI was – as it continues to be – largely constrained to rely upon self-reporting by ACS with regard to compliance with or implementation of the Recommendations.[30] Therefore, following the issuance by DOI of the formal

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30 The final Recommendation in the 2007 Report was addressed by DOI to itself:

> DOI recognizes that ACS has exerted great effort in the wake of the death of Nixzmary Brown and the other children discussed in this Report to put in place important initiatives that will improve its ability to investigate cases and thereby better ensure the safety of New York City's children. *Given the importance of this mission, and at the Mayor's request, DOI will continue to meet with ACS to review and assess the effectiveness of the reforms implemented by ACS.*

Policy and Procedure Recommendations [PPRs] on October 9, 2007, and continuing until May 11, 2011, DOI periodically asked ACS to report on the status of compliance with the Recommendations. ACS largely did so by stating that it was doing so through compliance with its own Casework Practice Guide, various Safety Alerts that were largely issued before August 2007, and training, as well as through the implementation of "ChildStat," a random case review modeled upon the NYPD's Comstat program.[31] As of May 11, 2011, ACS had reported that it could not or would not implement only two of the Recommendations, including one requiring coordination with the Department of Buildings, and one consisting of a request that DOI be permitted to participate on ACS' Accountability Review Panels [ARP]convened following a child's death.[32]

With regard to the Recommendations that directly implicated the performance of the Division of Child Protection during investigations of reports of

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[31] ACS witnesses acknowledged that ChildStat did not focus on cases with adverse results. Notably none of the fatality cases addressed subsequently in this Grand Jury Report had been the subject of ChildStat.

[32] ACS's explanation reflected its on-going position – reiterated by witnesses before this Grand Jury – that DOI's so-called law enforcement perspective was at odds with ACS' social work mandate:

> The thinking at ACS at this time is that one of the primary goals of the Panels is that people (staff and consultants) be able to speak freely in order to strengthen, police and/or make systemic changes. It is stressed at meetings that ARP is not a disciplinary unit. DOI's presence at these meetings could possibly inhibit the sharing of information and opinions. Therefore, ACS does not plan to implement this particular recommendation.

abuse and maltreatment, ACS for the most part reported that it would continue to require its staff to comply with its Casework Practice Guide, as augmented prior to the issuance of the 2007 Report by Safety Alerts and internal policy pronouncements. With few exceptions, ACS passively but effectively declined to implement Recommendations that went beyond ACS's then-currently documented practices and procedures.

For example, ACS notified DOI that it was satisfying the Recommendations by complying with its draft July 2007 Casework Practice Guide, which included Safety Alerts that ACS had issued in 2006 following the murder of Nixzmary Brown, albeit most of which did not fully reflect the specifics of Recommendations:

- ACS reported that, pursuant to previously issued (June 16, 2006) Child Safety Alert # 16, caseworkers could already initiate the triggering of an IRT from the field by calling IRT coordinators who, in turn, contact NYPD.
- ACS reported that, pursuant to previously issued Child Safety Alert # 21, ACS already *"encouraged"* but did not require caseworkers "to go out in pairs when making an initial home visit during an investigation, when there are complex family situations" and specified only that supervisors should *"consider"* sending caseworkers in pairs when dangerous situations arose.

- ACS advised DOI that per its previously promulgated draft Casework Practice Guide, caseworkers were already required to conduct a complete review of prior ACS history at the onset of investigation.
- ACS advised that it was relying upon previously issued Child Safety Alert No. 17, which outlined the guidelines for gathering and assessment of information from medical providers during an investigation in satisfaction of the requirement to obtain medical records by a deadline.

With regard to other Recommendations, ACS's implementation did not rise to the level sought by the 2007 Report. For example:

- ACS reported that it had "secured funding" for an additional 40 Investigative Consultants (for a total of 60 – or ½ of the 120 total specified as necessary in the 2007 Report); that it had hired and deployed 39 of the 40 additional ICs, and that it was awaiting final approval to hire the 40th. ACS advised DOI that "budget cuts in FY 2010 may cause some of these positions to be cut."
- ACS reported that it had "*[a]*ssessed [Field Office] current practice and note taking and use of cameras during investigations," and that "[d]igital cameras are available in child protection offices for use during investigations." However, ACS did not inform DOI if it had instituted policies requiring note taking in agency issued notebooks and the use of the cameras during investigations.
- ACS informed DOI that it had "[d]eveloped protocol for on-site interpretation services when investigating in the field," but it did not

report instituting a practice of assigning caseworkers based upon any knowledge of the language of the investigated household.

Finally, ACS appeared to convey to DOI that it had implemented some of the Recommendations, including:

- ACS reported that it "[f]roze access to CNNX when fatality or serious physical injury occurs to a family currently under investigation"; and "[a] copy of the case record is secured, reviewed, and maintained at 'point in time.'"
- ACS informed DOI that it had discussed with the NYPD, City Council, and State Legislature the need for access by its staff to the criminal history database, and that "investigative assistants are available to retrieve that information upon request."
- ACS reported that its Division of Child Protection had "[i]mplemented supervision changes through Sup[ervisor] II and CPM role changes," and "issued a memo about structured supervision" directing supervisors to "[h]old case reviews with caseworkers at regular intervals;" during which supervisors were to "[e]nsure that staff are documenting investigatory steps and review progress" and "include discussion and monitoring of bi-weekly home visits."
- ACS also reported the collaboration with the FBI on a 2-day training session attended by 150 caseworkers and ICs on "Forensic Interviewing of Children, Adolescents and Adults." ACS informed DOI that it had "[i]ssued a Child Safety Alert on Interviewing Neighbors and Superintendents as part of a CPS Investigation."

DOI accepted all of these responses from ACS at face value, believing that they accurately conveyed that ACS was pursuing the satisfaction of the 2007 Report Recommendations in a good faith manner reflective of ACS' stated desire in 2007 to promulgate that report jointly with DOI.

DOI's Report on the Investigation into the Marchella Pierce Fatality

On September 2, 2010, 4-year-old Marchella Pierce died in the home of her mother and grandmother, the victim of a homicide at their hands. In February 2010, only two months after ACS had opened an investigation of Marchella's mother, who had given birth to a younger child while under the influence of a controlled substance, Marchella was returned to the household. She had spent virtually her entire life to that point in subsidized long-term care medical facilities in treatment of life-threatening medical conditions associated with her premature birth, which would require on-going medical and supportive care while she lived at home.

From January through September 2010, the Pierce household was under the supposed supervision of ACS, whose staff was charged with ensuring compliance by Marchella's mother with preventive care services and the safety of the 3 children who were allowed to remain in the mother's custody. ACS' records documented that ACS staff seemingly failed to register Marchella's existence,

much less the significance of her special medical and developmental needs, and did not undertake any steps to insure her safety or well-being. The required home visits were not made. Representations by the adults in the household were credited without question. Collateral sources of information were not questioned or were ignored. The mother's failure to provide routine medical care and to comply with recommendations for medical and rehabilitative care for Marchella went unnoticed by ACS, which made no effort to acquire her complete medical records, confer with her past physicians, or inquire whether she was under the treatment of a pediatrician while living in the home. Indeed, a report by emergency room staff that the mother did not know how to care properly for Marchella was not pursued by ACS. The mother's continued drug use and failure to participate in a drug treatment program was either not noticed or ignored, as was the prohibited childcare role of the grandmother, notwithstanding that woman's refusal to participate in a drug treatment program. ACS did not seek judicial intervention to compel entry by caseworkers into the home, to compel compliance with preventive services programs, or to remove the children from what was a patently abusive and dangerous environment.

At the time of her death, Marchella weighed only 18 pounds and had many-times the adult dosage of two sleep-inducing medications in her system. She had

been tied to her bed for protracted periods, beaten, starved, emotionally abused, and denied necessary medical care during the entire 9 months she had spent in the care of her mother and grandmother.

Following Marchella's death, access to the CNNX case file was not frozen. As a result, post-mortem entries were made about investigatory steps that investigators determined had not been undertaken.

DOI learned of the homicide of Marchella Pierce from published news reports. Because the case appeared to bear disturbingly significant similarities to the facts of the 12 cases included in the 2007 Report, DOI opened an investigation into what DOI staff came to view as the "13th case." DOI's purpose was not only to learn what may have gone wrong in the Pierce case, but to assess whether, four years later, ACS had taken advantage of the guidance contained in the 2007 Report by implementing the Recommendations in a timely and effective manner.

Unfortunately, the findings and conclusions reached by DOI in its May 11, 2011 report on the "Investigation of the Marchella Pierce Fatality" [2011 Report] confirmed that ACS had failed in significant aspects to make good on its voiced commitment to the 2007 Report. As the 2011 Report stated:

> Based upon this comprehensive investigation, DOI found consequential flaws in the manner in which ACS responded to reports of abuse and neglect involving the Pierce family. ACS itself

> has publicly acknowledged "several serious problems with ACS's handling of the case" open at the time of Marchella's death. In addition DOI's investigation revealed some ongoing inadequacies in ACS's policies and procedures for conducting investigations and providing preventive services.

DOI correctly acknowledged that ACS had taken "some measures" to improve its investigations following the issuance of the 2007 Report, including hiring some investigative consultants, implementing the ChildStat random case review process, and reducing caseworker caseloads. Nevertheless, DOI observed that, although ACS had informed DOI over the intervening years that it had adopted and implemented the majority of DOI's 2007 Report Recommendations, DOI's investigation of the Pierce fatality demonstrated that ACS had not implemented some Recommendations at all or had done so ineffectually.

In particular, DOI found that ACS' response to the 2007 Report Recommendations had not been comprehensive or timely with regard to the following 2007 Report Findings and Recommendations:[33]

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[33] ACS staff who appeared before this Grand Jury generally recognized a significant substantive correlation between the 2007 Report's Findings/Recommendations and those in the 2011 Report. Two of the three ACS-affiliated witnesses agreed, when asked, that no fewer than 12 of the 16 2011 Report enumerated Findings raised the same issues presented in 12 Findings in the 2007 Report.

A representative of OCFS testified that seven of the 2007 Report's Findings/Recommendations correlated with that agency's Child Fatality Report conclusions and required actions regarding the Pierce fatality.

- ACS did not effectively address the failure by caseworkers to contemporaneously document investigations by issuing and requiring caseworkers to use field notebooks. Although ACS finally distributed notebooks in *December 2008*, it did not make their use mandatory.
- While ACS had made digital cameras available to caseworkers to record evidence of the physical condition of children and the condition of the home, ACS had left their use to the discretion of caseworkers and supervisors.
- Not until *January 8, 2011*, did ACS require that all case related events be entered into CNNX within five business days of the event, a substantially less rigorous requirement than the immediacy recommended by DOI in 2007.
- The 2007 Report "recommended" that ACS require its caseworkers to conduct home visits every two weeks. Those visits were largely not conducted by ACS during the approximately eight months that Marchella resided in the Pierce home prior to her death. The 2011 Report called upon ACS to actively enforce this policy requirement through regular supervisory reviews of CNNX records, clear instructions to caseworkers, and, where appropriate, disciplinary action. ACS had also not effectively addressed the cursory nature of home visits being conducted by its caseworkers. DOI renewed this concern and recommended that ACS require caseworkers to

include in their field notebooks and CNNX the length of the home visits and conferences.

- Although ACS had reported the acquisition of 2,000 cell phones, the 2011 Report found that not all caseworkers had ACS-issued phones.
- The 2011 Report found that it was again necessary to reiterate to ACS the critical importance of obtaining and reviewing all relevant medical records during an investigation of abuse or mistreatment.
- ACS was not routinely interviewing the person who reported a possible abuse or neglect situation and was closing cases too soon "merely to comply with the legal requirement to close cases within 60 days."
- ACS continued to improperly and erroneously make findings that allegations were unfounded notwithstanding the credible evidence that the allegation of abuse was founded or notwithstanding that the investigation had not progressed far enough to reach any conclusion. Not until after the murder of Marchella Pierce did ACS implement a procedure for responding to such reports of medical neglect of a known medically-fragile child.
- The 2011 Report again called upon ACS to enforce its own guidelines by requiring its ACS caseworkers to review all prior ACS history "at the onset of an investigation."

- ACS had not remedied the problem of its staff failing to secure criminal histories of adult members of households under investigation – a critical step in assessing the potential dangers faced both by children in and caseworkers entering that household.
- The 2007 Report recommended that, "where ACS determines that a parent under investigation is in need of treatment for substance abuse or other counseling, ACS should make the appropriate referral and in cases where the parent refuses to participate in the program or attends it sporadically, consult with legal staff about compelling the parent's full and active participation in the program. Although ACS had previously informed DOI that the agency implemented this recommendation, ACS did not comply with this during the Pierce investigation. The 2011 Report stated: "ACS should take steps to require that its caseworkers and service providers request a clinical consultation or a child safety conference upon learning that a parent or caretaker in the household has tested positive for illegal drugs. DOI recommends that ACS mandate time frames within which such referrals to ACS legal staff should be made, and child safety conferences scheduled, after the caseworker learns of said substance abuse issues." ACS had also failed to implement a system to ensure that caseworkers supervise and coordinate with contract providers of preventive services such as drug abuse counseling, which

was not undertaken in the Pierce investigation. DOI called upon ACS to establish a protocol whereby the ACS caseworker and the preventive services caseworker would be required to have at least one documented meeting or telephone call per month, during which time the case is discussed, all of which must be memorialized in the caseworker's field notebook, in CNNX, and verified by supervisors.

- The 2007 Report strongly urged ACS to put into effect a policy pursuant to which it was not left to the discretion of caseworkers whether to work in pairs on an investigation, both for their own safety and to better undertake an effective investigation. ACS had continued to leave it to the discretion of caseworkers and supervisors. DOI, while "mindful that this presents a staff and budgetary issue," nevertheless found it appropriate and necessary to reiterate that recommendation in the 2011 Report.
- The 2007 Report recommended hiring an additional 100 ICs and maintaining at least 120 ICs on staff to train caseworkers, to advise caseworkers on their investigations, and to participate in investigations when circumstances signaled the need for their expertise. The 2011 Report found that ACS' complement of ICs had never exceeded 60, which was insufficient to perform the critical functions described in the 2007 Report.

- The 2007 Report "recommended that supervisors should hold case reviews at regular intervals and document the investigatory steps for the next case review. ACS had previously informed DOI that it had accepted and implemented that recommendation; however, the required supervision was not employed during the Pierce case, and this failing contributed to the adverse outcome. In the 2011 Report, DOI "reiterate[d] its prior recommendation that ACS should take steps to ensure that its DCP CPMs and supervisors conduct regular case reviews, while noting that ACS had announced reinforcement of supervisory practices."
- The 2007 Report forcefully recommended that "ACS freeze access to an existing CNNX file upon learning that a child in a family under ACS investigation died or suffered a serious injury so as to avoid having the CNNX record contain deliberate fabrications or erroneous information." In April 2008, ACS affirmatively advised DOI that, it "[f]roze access to CNNX when fatality or serious injury occurs to a family currently under investigation," and that "a copy of the case record is secured, reviewed, and maintained at 'point in time'." The 2011 Report found that ACS did not freeze access to CNNX following the murder of Marchella Pierce, and that ACS instead affirmatively permitted the making of post-mortem entries concerning alleged case activity and decision making, without regard to the reliability, accuracy, or truthfulness of the entered data.

DOI renewed its 2007 recommendation that ACS freeze access to an existing CNNX file upon learning that a child in a family under ACS investigation had died or suffered a serious injury.[34]

Based upon these findings, which were at odds with representations that had been made by ACS since August 2007, DOI called upon ACS in the future to inform DOI promptly when ACS changed its position after informing DOI that it had adopted a DOI policy and procedure recommendation, such as those contained in the 2007 Report.[35]

On September 2, 2011, ACS communicated to DOI a detailed response to the 2011 Report Findings, with more particular focus on DOI's findings of a marked repetition of the investigative failures found in the 2007 Report. Among the responses were the following:

- Mandatory Documentation of Evidence in Notebooks and Taking of Photographs to Document Evidence:

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[34] ACS by written communication disputed DOI's finding that ACS had ever claimed to have frozen access to CNNX, and in any event disputed the necessity for doing so. In an opinion shared by some ACS senior staff witnesses, and notwithstanding evidence to the contrary before this Grand Jury, ACS insisted it would never have informed DOI that it had frozen access to CNNX following reported fatalities. These witnesses nevertheless agreed that, even if access could not be technologically "frozen" due to constraints in the system administered by OCFS, nothing prevented ACS from ordering members of its own staff to cease making entries into CNNX.

[35] DOI noted, "Because DOI is required to report to the Mayor's Office of Operations information regarding PPRs, DOI must have accurate information transmitted to it for publication in the Mayor's Management Report."

ACS stated that it would reissue the policy that "in addition to maintaining contemporaneous progress notes in CNNX, handwritten notes taken during the course of phone calls, interviews, visits, and other case activities shall be recorded in DCP Notebooks." However, ACS stated it would not mandate the use of cameras to photograph during home visits beyond what was called for in the Practice Guide, which directed staff to photograph injuries "if and when appropriate."

- Contemporaneous Entries into CNNX:

  ACS advised that it had implemented once-monthly reviews of progress notes to "ensure timely documentation."

- Meaningful Home Visits and Investigations:

  ACS informed DOI that information about the length and substance of home visits was recorded in notebooks, within the progress note in CNNX, and reviewed by the supervisors when appropriate.

- GPS Enabled Cell Phones:

  ACS stated that by the fall of 2011 it expected all Child Protective Specialists would have GPS enabled cell phones.

- Mandatory Review of Medical Records – Hospital and Sex Abuse Units:

  ACS advised that medical records received "on consent or after subpoena through Family Court" were mandated to be reviewed by the Hospital and Sex Abuse units and that medical consultants were available to assist the caseworkers and their supervisors. ACS further advised that a policy on reviewing medical information was being

drafted to provide caseworkers "guidance on identifying, assessing safety and risk issues, as well as safety planning in cases with medically fragile children."

- Adequate Review of ACS History:

  Per ACS, the recommendation that "caseworkers be instructed on the critical importance of reviewing all prior ACS history at the onset of an investigation" had already been implemented and enforced via case review, training, and supervision.

- Criminal History Review:

  ACS characterized the task of conducting a criminal history investigation on all parents as a "substantial workload," even when undertaken by Investigative Consultants, whose access to the necessary database pursuant to "Use and Dissemination Agreement with the New York State Department of Criminal Justice Services" "limits the Investigative Consultants to search persons over 18 years of age who (1) are currently residing in the residence of any child suspected of being abused, neglected or maltreated, or (2) are named in any report of suspected or alleged child abuse, neglect or maltreatment."

- Communicate with Preventive Service Providers:

  When there was an open investigation, ACS agreed with the DOI suggestion to have at least one documented meeting or telephone call a month between ACS and the preventive services caseworker. If the case had been closed, ACS stated the contracted preventive services agency was responsible for monitoring the family, but ACS

encouraged such agencies to call ACS to request an Elevated Risk Conference and was required to report these concerns to the State Central Register.

- Mandated Home Visits:

  ACS responded that they implemented this recommendation via the Casework Practice Guide, which directed two contacts per month as the standard, with at least one visit in the home.

- Conducting Home Visits in Pairs:

  ACS responded that they had implemented this recommendation by means of the June 11, 2007, ACS-issued Child Safety Alert #21, which encouraged staff to make home visits in pairs, particularly for initial home visits and in complex family situations. ACS stated it would "reissue" the Safety Alert and reinforce it with supervision.

- Investigative Consultants:

  ACS informed DOI that it would attempt to maintain a full complement of ICs and that current hiring efforts would bring IC staffing up to 120 positions.[36]

- Counseling and Substance Abuse Treatment:

  ACS informed DOI that there is a current directive in place for caseworkers to request clinical consultations when indicated, and caseworkers were directed to request Child Safety Conferences "after considering the seriousness of parental drug use and its impact

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[36] This Grand Jury heard evidence that ACS did not seek approval to hire the final 60 of the total 120 ICs that DOI had deemed necessary until the summer of 2011 – subsequent to the issuance of the 2011 Report. Those IC's were not on ACS' staff at the time of the testimony of the final ACS witnesses in this Grand Jury.

on their children." ACS advised that referrals made to Family Court Legal Services "only occur after a determination is made at the Child Safety Conference that Court intervention is necessary."

- Supervision:

  ACS agreed with DOI's "reiteration of its prior recommendation" on the need for supervisors to conduct regular case reviews. ACS stated it had reinforced this policy through additional training in June 2011.[37]

- Freeze Access to CNNX Post-Mortem/Serious Injury:

  ACS and OCFS opposed opening a second or parallel case file when there had been a fatality because duplicate case files caused confusion and interfered with coordination of various reports/interventions with the family of the deceased child.

ACS did not authorize the public release of any portion of the 2011 Report, citing privacy concerns pursuant to SSL § 422-a. Upon obtaining the report via this Grand Jury's subpoena, the District Attorney of Kings County, as authorized by the supervising court of this Grand Jury, requested that the Commissioner of OCFS authorize such a release. The Commissioner of OCFS granted the request, subject to only minor redactions of the report.

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[37] This Grand Jury heard evidence that ACS had not implemented a system, as recommended in the 2007 Report, for substitute supervisors who would be available to fill in for absent supervisors. Instead, ACS continues to call upon supervisors who already had a full complement of supervisory assignments to cover for absent supervisors.

Seven Additional Child Deaths in Brooklyn

On May 23, 2011, ACS cautioned DOI against what ACS characterized as "making broad general statements and conclusions about system-wide ACS practice based on this [Marchella Pierce] case." According to ACS:

> When DOI previously investigated ACS in 2007, it reviewed approximately twelve cases from which conclusions were drawn and recommendations were made for improvement. While even the twelve cases chosen in 2007 by DOI was a small sample of arguably ACS' most tragic cases, the findings related to one case certainly cannot be extrapolated to portray a system-wide analysis.

However, the results of the investigation by this Grand Jury of the deaths of seven other children that occurred in Brooklyn following the issuance of the 2007 Report and prior to the murder of Marchella Pierce are markedly consistent with the conclusions reached by DOI in both the 2007 and the 2011 Reports. In each of the seven cases, ACS engaged in the significant repetition of the same fundamental failures in investigatory procedures and practices found by DOI in both the 2007 and 2011 Reports. Based upon all of the evidence heard and considered by this Grand Jury, it is not possible to view these findings of serious errors and shortcomings in ACS' handling of 20 cases that resulted in 19 fatalities and one near fatality in only a five-year period as other than indicative of the existence of a systemic failure within the Division of Child Protection.

December 2007: 3-year-old TM

TM died as a result of a large laceration of the liver caused by blunt impact injuries of the body inflicted when the father repeatedly struck and twice threw the toddler to the floor. There was evidence of prior violence, including healed and unhealed abrasions and contusions on every region of TM's body, as well as an unhealed burn covering the upper surfaces of a foot.

The Office of the NYC Medical Examiner ruled the cause of death a homicide.

ACS case history as documented by the OCFS Child Fatality Report and the (redacted) ACS Accountability Review Panel Report:[38]

> TM had previously lived with the birth mother and father; however, at the time of death, TM lived with the father, his girlfriend, and the girlfriend's three children, 2 months and 3 and 4-years old.
>
> In addition to TM, the father had 6 other children from 4 relationships, while TM's mother lived out-of state with another

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38 The ACS Accountability Review Panel Reports, as acquired pursuant to Grand Jury subpoenas, are in a redacted form that obliterated all references and allusions to ACS' investigations of prior reports to the State Central Register that were determined by ACS to be unfounded. By redacting the reports in this manner, albeit in stated compliance with SSL § 422-a, ACS ignored findings by OCFS in its corresponding Child Fatality Reports that many of these determinations and case-closings had been incorrectly based upon deficient and inadequate investigations that had failed to take into account critical indicators that the child[ren] at issue were at risk or in danger, or that ACS had failed in subsequent investigations of the household to take into account the record of those prior investigations.

child. Both birthparents had been the subjects of prior investigations by ACS on multiple occasions from 2000 through 2005 of allegations of drug and alcohol abuse, inadequate guardianship and supervision, sexual abuse, life-threatening behaviors, failure to provide medical care, and causing burns/scalding. ACS concluded that each of these allegations was unfounded. The father was the subject of an additional 2005 investigation, which was concluded as unfounded.

The girlfriend had been the subject of four investigations by ACS in 2004, 2005, and 2007, the latter two investigations also involving TM's father. ACS investigated allegations of the domestic violence and substance abuse in the presence of the household's children, failure to supervise, infliction of burns, failure to provide medical care, and placing a pillow over the face of the then 9-month-old TM because TM would not sleep, each of which allegations was determined by ACS to be unfounded.

The OCFS Fatality Review Report concluded that the investigations of the prior allegations into TM's household "lacked depth" because the caseworker(s) did not contact appropriate collateral sources, such as neighbors, pediatricians, and family members. Moreover, although the father admitted to using marijuana and father and mother agreed to submit to drug testing, ACS did not schedule the tests. TM's mother failed to keep appointments, the household telephones were disconnected, and caseworkers did not see 2 of the 3 children then in the home for more than one month. ACS unsubstantiated allegations of domestic violence

and drug use in the home solely because the subject adults denied the allegations and the mother and two of the children tested negative for drugs. The supervisor inappropriately concluded that the cases should be closed based upon the determination that the children were safe in the home notwithstanding that the caseworker had failed to obtain information necessary to determine and respond to safety and risks concerns.

OCFS found that ACS' handling of the three 2005 reports of drug and alcohol abuse, inadequate guardianship and supervision, frequent domestic violence and drug use by the father and his girlfriend in the presence of the children was again deficient. Collateral sources, including obvious witnesses to events, were not contacted. Court intercession was not sought when attempts to visit the home were not successful, and only telephone contact was established by the fifth day following the receipt of one report. The claims by adults that the children were not being left alone and their denials of drug use and domestic violence were not questioned, notwithstanding that the mother refused to take a drug test and there were three domestic incident police reports concerning the father in 2004. OCFS concluded that ACS had inappropriately unfounded the allegations and then inappropriately closed the investigations because ACS had failed to undertake a thorough investigation and had incorrectly applied available

information to the legal standard for an indicated determination of maltreatment before rendering the decision.

ACS Accountability Review Panel Report stated and recommended, as follows:

> In the case and in other cases, SCR reports are often concluded without all of the supervisory and managerial directives being completed. Without some of these key directives completed, it is difficult to ensure that a thorough investigation has taken place and at times, results in critical issues not being addressed. In this case, the 2004 SCR reports were unfounded without a drug test for the father or an interview of the four-year old despite directives to do so.
>
> DCP should support its staff to ensure that all directives are completed before investigations are concluded.

In responding to the OCFS Fatality Report findings, ACS acknowledged, inter alia, that it had failed to seek Family Court intervention when the father failed to cooperate with ACS regarding his drug use; ACS failed to conduct a complete interview of the mother, failed to engage in an adequate level of casework activity and supervisory oversight, and failed to obtain information necessary to determine and respond to safety and risk concerns. ACS also acknowledged that it had based unfounded determinations on incomplete and inadequate

investigations and applied inappropriate legal standards for a determination of maltreatment.

ACS informed OCFS that it would "ensure" that all guidelines and procedures on quality case practice were adhered to in the future by, inter alia, emphasizing the requirement to conduct complete interviews of collateral sources of information, providing ongoing safety assessment and risk assessment training, and training supervisors how to better monitor and supervise on-going investigations to ensure thoroughness and completion within required time frames.

This Grand Jury finds that during ACS' role in the matter of TM it engaged in the repeated commission of numerous and significant 2007 Report Investigative Failures, including:

- Failure to conduct meaningful investigations resulting in substantiated allegations incorrectly classified as unfounded rather than indicated.
- Failure to assign two caseworkers to work together in the conduct, at a minimum, of the initial stages of the investigation in light of the number of adults and children residing in the household.
- Failure to classify a case "as 'indicated' where the investigation has established credible evidence that support the allegations," and failure to classify a case "as 'unfounded' only when a thorough investigation of

the underlying allegations does not yield credible evidence substantiating the allegations."

- Failure to access and review and take into account prior ACS history of members of the household and family members.
- Failure to contact and interview obvious collateral sources of information.
- Failure to conduct meaningful home visits no less than every two weeks.
- Failure to seek legal advice and judicial intervention when access to home or children has been denied.
- Failure to obtain medical records and/or to consult with medical providers.
- Failure to keep investigations open for further necessary investigation in lieu of improperly and dangerously closing the case as unfounded based solely or primarily upon denial by parents/guardians of allegations of domestic violence, drug and alcohol abuse, and failure to provide adequate guardianship, medical care, and supervision.
- Failure to obtain pedigree information and prior criminal history of adult members of household.

June 2008: 3-year-old KS

KS died as a result of multiple blunt injuries of the head, face, torso, and extremities, a broken hip and legs, significant burns, a ruptured anus, and internal bleeding admittedly caused by beatings and abuse by a non-kinship guardian and her paramour in the one-bedroom apartment in which they resided.

The Office of the NYC Medical Examiner ruled the cause of death a homicide.

ACS case history as documented by the OCFS Child Fatality Report and the (redacted) ACS Accountability Review Panel Report:

> In October 2007, a Kings County Family Court ordered ACS to complete by the end of the month an investigation to determine the fitness of an unrelated woman to serve as guardian of 3-year-old KS. In support of the petition, the woman [hereafter, "the guardian"] had provided the Family Court with a notarized letter by both birth parents ostensibly granting her physical custody of the child.
>
> The guardian informed ACS that KS' mother had asked her to care for KS and then moved out of state to undergo drug and other counseling. The guardian was on public assistance and claimed to reside alone with KS; however, she identified a man [hereafter "boyfriend"] who she said was financially assisting her.
>
> The caseworker visited the guardian's home and reported finding no safety concerns. The caseworker did not inquire whether the guardian had children or if she had been involved with child welfare authorities in any other state. The caseworker documented an interview with a private source who attested that the guardian was the "best person" to provide for KS. The caseworker did not conduct any inquiry about the boyfriend, who was, in fact, residing in the home with KS. The caseworker did not investigate the relationship between the birthmother, KS, and the guardian. ACS

conducted no interviews of neighbors or other collateral sources of information.

ACS reported that an out-of-state child protective staff person paid a "courtesy visit" to the birthmother's home, finding it "satisfactory." The caseworker interviewed the birthfather, who stated that the guardian had denied him access to KS and that he and his mother wanted to assume custody of KS. The paternal grandmother informed the caseworker that she had witnessed the guardian "punch" KS. Because the caseworker did not report this incident to the State Central Register, ACS did not open an investigation of the guardian for alleged abuse of KS; the caseworker also did not pursue a medical examination of the child, notwithstanding that KS had last received documented medical care in 2005. The caseworker instead "counseled" the guardian against using "corporal punishment."

The report filed by ACS with the Family Court when it closed its case in November 2007 did not address the status of KS' medical history, the fact that KS' father and grandmother sought custody of him, or the absence of any plans by the guardian for child care. ACS' records did not document that ACS ever complied with the order of the Family Court to conduct an investigation of the home of the paternal grandmother [PGM].

Virtually simultaneously, another Family Court case had been instituted involving the custody of the two children of the guardian's boyfriend. At the order of a different Family Court judge, ACS

conducted an investigation, which found that the boyfriend was living with the guardian, who told ACS caseworkers different information than the guardian had conveyed during the other Family Court-ordered investigation. The guardian disclosed that she was the victim of domestic violence and that she had four children of her own in another state. While ACS reported to the Family Court in this matter the presence of KS in the home, ACS credited to the guardian information that she had "temporary custody of KS," whom she claimed had been neglected by his mother, but ACS did not seek to verify this information or otherwise determine KS' status.

ACS' records did not reflect that ACS was aware that the two court-ordered investigations involved the same household.

ACS' records did not reflect the date on which guardianship of KS was or was not transferred by Family Court to the guardian. However, it was later established that the Family Court dismissed the guardianship petition in February 2008 when the guardian failed to appear. This triggered no action by ACS, which had closed its case in November 2007.

After the murder of KS, ACS investigated and learned that the guardian was a habitual marijuana user whose own four children had been permanently removed from her custody in 2002 by officials in another state, where she had locked the children inside a squalid home for protracted periods with no food, electricity, running water, or plumbing. ACS acknowledged that "this history was not identified during the Family Court custody process."

ACS interviewed neighbors of the guardian, who recounted that the guardian smoked marijuana daily, frequently argued with her boyfriend, and spoke to KS using obscene and derogatory language. Other witnesses stated that KS "acted like a robot" in the presence of the guardian, and that the guardian had said that she "hated kids" as she shoved KS into a car.

The OCFS Child Fatality Report concluded that ACS conducted a deficient investigation and improperly closed as unfounded an investigation into the 2006 report of child abuse or mistreatment of KS by the birthmother relating to injuries she attributed to a fall. Medical history was not investigated and a witness was not interviewed relevant to statements that the mother was a prostitute and drug user who left her children unsupervised. The investigation was improperly closed when the family moved and ACS did not undertake to locate them.

Beyond finding fault with aspects of the post-mortem investigation; however, the only criticism lodged by OCFS of ACS' role in this case prior to the murder was that "ACS' management and supervisory staff did not provide adequate monitoring of the [Family] Court ordered investigation. ACS supervisors must, at case conferences with Specialists, review cases thoroughly and address

any information obtained during the investigation in accordance with 18 NYCRR § 432.2(b)(3)(v).[39]

ACS Accountability Review Panel assessment characterized its pre-fatality role as "seriously deficient and cursory," and concluded that its report to the Family Court "did not include critical information and assessment [needed] to evaluate child safety and well-being." ACS also concluded that the two uncoordinated court-ordered investigations failed to gather and include and take into consideration relevant and basic information critical to the investigation and to address serious inconsistencies. ACS recommended, inter alia:

- All managerial and supervisory directives must be case specific.
- In all cases where an unrelated child is unexpectedly found in the home, clear case practice guidelines must be followed to ensure child safety.
- Court Ordered Investigations must follow the same protocols as all other CPS investigations.

This Grand Jury finds that during ACS' role in the matter of KS, it engaged in the repeated commission of numerous and significant 2007 Report Investigative Failures, including:

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[39] 18 NYCRR § 432.2(b)(3)(v): "A child protective service supervisor must review and approve the decision to either indicate or unfound the allegation(s) of child abuse and/or maltreatment."

In its formal response to OCFS, ACS reported that in a meeting with the assigned caseworkers and supervisors, a senior staff member discussed . . . "the importance of proper supervisory oversight and assessment for court ordered investigation."

- Failure to conduct meaningful investigations resulting in substantiated allegations incorrectly classified as unfounded rather than indicated.
- Failure to classify a case "as 'indicated' where the investigation has established credible evidence that support the allegations," and failure to classify a case "as 'unfounded' only when a thorough investigation of the underlying allegations does not yield credible evidence substantiating the allegations."
- Failure to contact and interview obvious collateral sources of information.
- Failure to conduct meaningful home visits, including interviewing the subject child.
- Failure to obtain medical records and/or to consult with medical providers.
- Failure to keep investigations open for further necessary investigation in lieu of improperly and dangerously closing the case as unfounded based solely or primarily upon denial by parents/guardians of allegations.
- Failure to identify and obtain pedigree information and prior criminal history of adult members of household.
- Failure to review and take into account prior ACS or other social services agency reports on family members.

August 2008: Two-year-old SJ

SJ died from a perforated duodenum and resulting peritonitis. SJ had healed fractures of arm and hands of variant ages.

Nine months after SJ's death, the Office of the NYC Medical Examiner ruled the cause of death as child abuse syndrome.

ACS case history as documented by the OCFS Child Fatality Report and the (redacted) ACS Accountability Review Panel Report:

> The birthmother, 18 years old, was homeless and had a second child born in May 2007 in addition to SJ. The fathers of both children were incarcerated. The birthmother, a "slow learner" who still sucked her thumb at the age of 17, had herself been a maltreated child whose very large family had been the subjects of more than 15 SCR reports and had received ACS preventive services to stabilize family functioning. ACS was aware of SJ and her mother's second pregnancy, aware that the mother was the victim of family violence, aware that the mother and other members of her family were developmentally handicapped and sometimes homeless, but as a parent she was not the subject of any report of abuse or neglect until the reported death of SJ.
>
> All cases involving the family members were closed at the time of SJ's death.
>
> By arrangement with SJ's mother, on the day of death SJ resided in a two-bedroom apartment with the paternal grandmother [PGM] and the PGM's 5 children, who ranged in ages from 10 to 15. The PGM had been the subject of 14 SCR reports from 1986 to 2003, 11 of which were indicated, including lack of supervision, excessive corporal punishment, lack of food, and drug use. ACS' records

documented that the PGM's use of crack cocaine impacted her ability to care for her own children.

On the day of SJ's death, SJ suffered "stomach pains." PGM later claimed that the birthmother had not provided her with medication for SJ, so she administered to SJ an asthma medication prescribed for one of her own children. She did not seek appropriate medical care for SJ, who stopped breathing. When emergency service workers responded to a 911 call, they found SJ unresponsive.

The OCFS Child Fatality Report concluded with the finding that "there are no actions required for this case," beyond calling upon ACS to complete post-fatality investigations within the required 60 days. However, the ACS Accountability Review Panel Report found that "[b]oth the maternal and paternal families had a large number of SCR reports and appeared to have experienced long-term chronic neglect. There were many SCR reports that were not properly or thoroughly investigated over the years. Many reports repeatedly alleged drug use, inadequate guardianship and educational neglect. It was questionable if the grandparents were appropriate caretakers for their own children or for their grandchildren."

This Grand Jury finds that during ACS' role in the matter of SJ, it engaged in the repeated commission of numerous and significant 2007 Report Investigative Failures, including:

- Failure to conduct meaningful investigations resulting in substantiated allegations incorrectly classified as unfounded rather than indicated.

- Failure to classify a case "as 'indicated' where the investigation has established credible evidence that support the allegations," and failure to classify a case "as 'unfounded' only when a thorough investigation of the underlying allegations does not yield credible evidence substantiating the allegations."
- Failure to contact and interview obvious collateral sources of information.
- Failure to conduct meaningful home visits.
- Failure to obtain medical records and/or to consult with medical providers.
- Failure to keep investigations open for further necessary investigation in lieu of improperly and dangerously closing the case as unfounded based solely or primarily upon denial by parents/guardians of allegations and/or refusal of services.
- Failure to review and take into account prior ACS or other social services agency reports on all family members.
- Failure to monitor compliance with preventive services and/or seek court ordered compliance with necessary services.
- Failure of supervision of activities of caseworker.
- Failure to continue an investigation beyond 60 days when inadequate information has been developed to warrant closing the case without jeopardizing the safety of children in the household.

August 2008: 3-year-old GJ

GJ died from blunt force impacts of the head, face, torso and extremities, rib fractures, deep liver lacerations, diffuse mesenteric contusions, and lacerations of the connective tissue between the liver and bowel. An autopsy also discovered healed fractures of the right arm and right clavicle, as well as evidence of a post-traumatic myocardial infarction. At the time of death GJ's height and weight (24 lbs.) placed GJ in the third percentile for 3-year-old children.

The Medical Examiner ruled the cause of death as homicide/battered child syndrome.

ACS case history as documented in the OCFS Child Fatality Report and in the (redacted) ACS Accountability Review Panel Report:

> In 2007 GJ lived with the birthparents, maternal grandmother [MGM], and one younger sibling in a two bedroom apartment. The mother and her sisters were known to ACS as the victims of sexual abuse by a stepfather.
>
> The family was the subject of two reports to the SCR in 2007. The first report alleged that the home was filthy and that GJ routinely played in a cat's litter box. GJ's mother initially fled with the two children to another state, where she reported she was a victim of domestic violence and received counseling. The MGM confirmed that the relationship was violent; in the presence of the two children,

the father had threatened to kill GJ's mother, and he had previously been arrested for assaulting her.

GJ's mother returned with the two children and moved with the father to a shelter. She denied her earlier claims of domestic violence.

ACS initially properly addressed the issue of domestic violence, and ACS legal personnel advised the caseworker to file a petition in Family Court for court ordered supervision. ACS did not follow through on that recommendation and instead unsubstantiated the allegation of domestic violence and closed the investigation into the allegation of inadequate guardianship solely because GJ's mother informed the caseworker that she was no longer fearful of her husband and wanted to maintain her relationship with him

Later in 2007, ACS investigated a new SCR report of ongoing domestic violence in the presence of the two children; the allegations were substantiated against the father but not against the mother. However, ACS documented no interviews of the children's medical care providers; ACS simply referred the family for domestic violence preventive services at a contract provider.

ACS documented that the caseworker was informed by the contract agency that both parents were attending counseling sessions. In fact, the provider agency had informed the caseworker that it had no record of the parents ever utilizing the counseling or other services.

After GJ's death, the father admitted that he threw GJ against a wall and repeatedly punched the child. The father admitted also that he used a belt to discipline GJ and that he "liked to bite"; GJ's younger surviving sibling – who was also substantially underweight – had bite marks and bruises all over his/her body and had previously suffered a broken leg at the hands of the father.

Notwithstanding the above facts, which were noted in the OCFS' Child Fatality Report, OCFS reached no conclusions requiring ACS to undertake and report any actions regarding the pre-fatality role of ACS in this case. ACS made no critical self-assessments.

This Grand Jury finds that during ACS' role in the matter of GJ it engaged in the repeated commission of numerous and significant 2007 Report Investigative Failures:

- Failure to conduct meaningful investigations resulting in substantiated allegations incorrectly classified as unfounded rather than indicated.
- Failure to classify a case "as 'indicated' where the investigation has established credible evidence that support the allegations," and failure to classify a case "as 'unfounded' only when a thorough investigation of the underlying allegations does not yield credible evidence substantiating the allegations."
- Failure to contact and interview obvious collateral sources of information.

- Failure to conduct meaningful home visits, including interviewing the subject child.
- Failure to obtain medical records and/or to consult with medical providers.
- Failure to keep investigations open for further necessary investigation in lieu of improperly and dangerously closing the case as unfounded based solely or primarily upon denial by parents/guardians of allegations.
- Failure to review and take into account prior ACS or other social services agency reports on family members.
- Failure to monitor compliance with preventive services.
- Failure to make accurate entries into CNNX.
- Failure of supervision of activities of caseworker.
- Failure to continue an investigation beyond 60 days when inadequate information has been developed to warrant closing the case without jeopardizing the safety of children in the household.

October 2008: 14-day-old DW

DW died from traumatic brain injuries inflicted by the birthmother in the one-bedroom apartment they shared with DW's maternal grandmother [MGM], two siblings, ages 1 and 2, and two maternal aunts, ages 10 and 19. DW's decomposing body was found in a garbage bag hidden in a closet inside the apartment.

The Office of the NYC Medical Examiner determined that the fatal injuries were inflicted up to three days before death and ruled the cause of death a homicide.

ACS case history as documented in the OCFS Child Fatality Report and in the (redacted) ACS Accountability Review Panel Report:

> Members of the MGM's household had been known to ACS since 1995 and 1997, when allegations against the MGM were substantiated. In 1999, ACS substantiated an allegation of abuse of DW's mother by a family member.
>
> The household again came to ACS' attention in 2007, when ACS substantiated allegations of inadequate guardianship by MGM of both maternal aunts, including use of excessive corporal punishment and otherwise placing them at risk of harm. ACS also substantiated allegations of inadequate guardianship by DW's mother of her 2-year-old child. According to ACS findings, DW's mother "wandered the streets during the day and at night, going from home to home with the . . . two-year-old surviving sibling without making adequate plans for the care of the child."
>
> Although ACS found that one or more factors were established to exist that placed the 2-year-old sibling at risk, ACS nevertheless assigned a low "Risk Assessment profile," which OCFS concluded "did not adequately reflect the circumstances of the case."

In April 2007, ACS referred DW's mother to a provider agency for preventive services, including parenting skills classes, individual housing assistance, and daycare assistance. Ten months later, ACS documented that the mother had become resistant to scheduled visits and had not participated in the preventive services programs.

In November 2007, the mother's second child was born.

The "Family Service Stage" was officially closed in February 2008. The record indicated that the mother had not followed through on referrals for child care and parenting and anger management training, and was "adamant about discontinuing services."

In October 2008, the mother's third child – DW – was born; all were under the age of 3.

During ACS' post-fatality investigation and supervision of the household, the agency learned for the first time of the violent criminal history of the father of DW. ACS concluded that DW's mother had inflicted or allowed to be inflicted the injuries that caused DW's death, and substantiated the allegation of inadequate guardianship of DW by the mother. ACS also substantiated allegations of inadequate guardianship by the MGM and DW's mother of DW's two siblings.

Notwithstanding that the mother had failed to comply with recommended preventive services, notwithstanding that the mother gave birth to a second child, and notwithstanding that the circumstances within the household had not been

remediated but had, in fact, become more untenable with the addition of a 4th child and 7th occupant of a one-bedroom apartment which had been the subject of multiple reports of inadequate guardianship, including the use of excessive corporal punishment and failure to ensure the safety of the resident children:

- ACS' Accountability Review Panel Report contained no critical analysis, conclusions, or recommendations.
- OCFS' Child Fatality Report criticized only ACS' failure to complete its investigation into the fatality within 60 days, as legally required. While OCFS noted the premature closing of the 2007 report, it made no recommendations relating to that or any other pre-fatality matter.

This Grand Jury finds that, during ACS' role in the matter of the family of DW, it engaged in the repeated commission of numerous and significant 2007 Report Investigative Failures, including the following:

- Failure to assign more than one caseworker to investigate and supervise the household in light of the number of adults and children in residence and the number and complexity of the risk and safety issues.
- Failure to contact and interview obvious collateral sources of information.
- Failure to conduct meaningful home visits, including interviewing all resident children and adults.

- Failure to obtain medical records and/or to consult with medical providers.
- Failure to keep investigations open for further necessary investigation in lieu of improperly and dangerously closing the case as unfounded based solely or primarily upon denial by parents/guardians of allegations.
- Failure to identify and obtain pedigree information and prior criminal history of adult members of household.
- Failure to review and take into account prior ACS or other social services agency reports on family members.
- Failure to monitor compliance with preventive services.
- Failure to address inadequate housing conditions.
- Failure of supervision of activities of caseworker.
- Failure to continue an investigation beyond 60 days when inadequate information has been developed to warrant closing the case without jeopardizing the safety of children in the household.

December 2009: 11-month-old MG

MG died at home from pneumonia and enterocolitis.

The Office of the NYC Medical Examiner ruled that the manner of death was "natural."

ACS case history as documented in the OCFS Child Fatality Report and in the (redacted) ACS Accountability Review Panel Report:

At the time of death, the infant MG lived in a studio apartment along with the mother, 6 siblings, ranging in age from 2 to 8 years old, the father of some or all of the 7 children, and possibly two other adult relatives. The birthmother's three oldest children, possibly by another father – ages 9, 10, and 12 – lived with relatives, one of whom had been awarded legal custody. ACS records did not reflect whether one, two, or three men had fathered the mother's 10 children.

The family had been the subject of two reports in 2004 to the SCR alleging lack of medical care and inadequate guardianship relating to the significant special needs of an older sibling of MG. ACS' investigation resulted in a finding that the allegations were indicated: The children in the family at that time were found to be in need of updated medical evaluations, updated immunizations and improved nutrition because they were "severely anemic." Notwithstanding that the mother failed to obtain the children's immunization records and prevented the sibling from receiving special education services, and notwithstanding that ACS had failed to verify school enrollment, ACS closed the case because the mother had refused services and ACS was "unable to take legal action." ACS records do not document any discussion with the mother about any of her children's health and nutritional needs or any inquiry whether the mother was able to properly feed and ensure their well-being.

OCFS found that in closing the case in April 2004, ACS "did not appropriately assess the risk factors in the case. ACS completed a

RAP [Risk Assessment Profile] and assigned a low risk rating to the case which did not accurately reflect the circumstances of the case. The risk assessment did not include assessment of the mother's pattern of parenting, ability to manage the household, and the fathers' contribution to the household. An adequate assessment of the risk factors was necessary for the purpose of developing a plan to stabilize family functioning."

The second report to the SCR in 2004 also alleged the lack of medical care and inadequate guardianship of the same sibling plus an older child. The reporter characterized the mother as low functioning and described the sibling as having special needs and having been ill for months. The reporter noted that the siblings were unkempt and wore soiled diapers. ACS did not contact the children's pediatrician. The mother again refused services. ACS characterized the family as being at "moderate risk," while noting that the mother had seriously impaired ability to supervise the children. Nevertheless, in August 2004, ACS unsubstantiated the allegations because the mother had sought appropriate medical care to treat the children's illnesses and "provided the children with a minimum degree of care."

By early December 2009, the 29-year old mother had given birth to 4 more children, including MG, for a total of 10, with 7 of those children living with her and her husband in a studio apartment along with a maternal great grandmother and at least one other adult relative. The older children slept on the floors. ACS received

reports from a school that all of the school-aged children were performing below grade level and appeared inadequately cared for. ACS conducted a conference with the mother at the school, at which she acknowledged that one of the children had a medical condition, but she did not provide documentation for it.

At a subsequent home visit, ACS reported, the mother denied there were any issues or concerns. She admitted the children received inadequate sleep and that she was sometimes late to pick them up from school, but she offered the explanation that she and the children had moved to the maternal great grandmother's home while she looked for a larger apartment. ACS did not document whether ACS explored the issue of proper supervision and housing with the mother.

Six days after the home visit, MG's parents left MG home alone for a little more than two hours with the 2, 3, 6 and 8-year old siblings, while they went shopping with two other children. All of the children were sick with colds or the flu. Upon returning, the parents later reported, MG was unresponsive and had a bruise on his forehead. Attempts to revive MG were unsuccessful.

In the post-fatality investigation, ACS assigned a bi-lingual caseworker. The apartment was very messy and cluttered: "clothes were everywhere, there were roaches, blood droppings from the menstruating pug dog, and dirty dishes in the sink." The apartment contained a single bed.

OCFS concluded that ACS "did not conduct a thorough investigation of the 2004 reports as the agency did not obtain updated medical records and a medical consultation regarding the children's health status." OCFS did not reach any adverse findings regarding ACS' investigation of the initial 2009 report. The ACS Accountability Review Panel Report reached no adverse conclusions about ACS' role with the family.

This Grand Jury finds that during ACS' role in the matter of MG, it engaged in the repeated commission of 2007 Report Investigative Failures, including:

- Failure to conduct meaningful investigations resulting in substantiated allegations incorrectly classified as unfounded rather than indicated.
- Failure to assign more than one caseworker in light of the number of adults and children residents of the household.
- Failure to document and address substandard and unsafe housing conditions.
- Failure to assign a caseworker conversant in the primary language of the household until after the fatality.
- Failure to classify a case "as 'indicated' where the investigation has established credible evidence that support the allegations," and failure to classify a case "as 'unfounded' only when a thorough investigation of the underlying allegations does not yield credible evidence substantiating the allegations."

- Failure to contact and interview obvious collateral sources of information.
- Failure to conduct meaningful home visits.
- Failure to obtain medical records and/or to consult with medical providers.
- Failure to keep investigations open for further necessary investigation in lieu of improperly and dangerously closing the case as unfounded based solely or primarily upon denial by parents/guardians of allegations.
- Failure to accurately document the circumstances of the household, including dangerous and unhealthy conditions.
- Failure to monitor compliance with preventive services or request judicial intervention when necessary.
- Failure of supervision of activities of caseworker.

February 2010: 2-month-old JW

JW died from bronchopneumonia caused by blunt impact injuries of the body. At the time of JW's death, there were multiple healing and unhealed rib fractures, hemorrhages of the surface of the thoracic spine, and fractures of the tibia.

The Office of the NYC Medical Examiner ruled that the manner of death was homicide.

ACS case history as documented in the OCFS Child Fatality Report and in the (redacted) ACS Accountability Review Panel Report:

> At the time of death, JW lived with the birthmother and a 1-year-old sibling.
>
> The mother first became known to ACS when she was born to a crack-addicted mother and placed in foster care. She was adopted at age 9, and gave birth to a child at age 17; an out-of-state social services agency placed that child into foster care and it was subsequently adopted out. In NYC, the birthmother lived in a shelter and gave birth at 19 to JW's sibling, whose paternity ACS did not document.
>
> In the fall of 2008, ACS received reports from the NYPD of drug and alcohol misuse and inadequate guardianship of the older sibling, by both parents, as well as burns and scalding of the mother by the father. ACS learned that the father, who smoked marijuana, used cocaine, and drank alcohol daily, routinely assaulted the mother. During the incident, the father threw a chemical suspected to be an acid at the mother while she held the sibling, injuring neither. Although the mother reported the incident to the police, she was angry when the police referred the matter to ACS because she feared ACS would remove her child.
>
> ACS located but did not document a prior domestic incident report involving the father. Although ACS substantiated the allegations of the report against the father (including burns although

no one was burned), ACS did not substantiate the allegations of inadequate guardianship against the mother, citing a lack of credible evidence. As a result, the Family Court paroled the sibling to the mother and issued an order of protection against the father for the mother and the sibling. A similar order was issued by a Criminal Court.

The OCFS Child Fatality Report did not document any contacts between the family and ACS after the issuance of the orders of protection. However, the (redacted) ACS Accountability Review Panel Report documented as follows:

ACS referred the mother and father for preventive services, although the father refused to participate in drug testing/counseling. The service providers' entries into CNNX regarding the mother's participation were incomplete, inconsistent, and inadequate to assess the effectiveness of the intervention. The ACS case remained open on the date that JW died in the home.

In the meantime, the mother continued to reside with the sibling at a homeless shelter until ACS arranged for subsidized housing in late 2008. ACS failed to document the mother's source of income or her childcare arrangements and did not verify if the mother was providing medical care for the sibling.

In March 2009, the mother informed ACS that she resented ACS' interference and that she had provided the father with a key to her apartment in defiance of the orders of protection. ACS records did not document that the caseworker took any action, including

counseling the mother of the dangers she and her child faced from further domestic violence, or informing the police or the Family Court that the orders of protection were being violated with the consent of the mother.

In April 2009, the father ransacked the mother's apartment looking for money. The mother and the sibling were relocated to a shelter. In May 2009, the Family Court returned a finding of neglect against the father, extended court ordered supervision, and issued a final order of protection against the father effective until May 2010. ACS did not document this hearing in CNNX.

The mother returned to her apartment with the sibling and changed the locks. She informed the ACS caseworker that she was four months pregnant and in need of high risk pre-natal care. In July 2009, the mother informed a preventive service's agency caseworker that she depended on the father for financial support, as documented in CNNX.

JW was born in November 2009, as documented in the ACS CNNX file. ACS did not inform the Family Court in order to expand the order of protection to include JW. The ACS reassessment of the household – including a series of home visits – did not refer to the father's continuing involvement with the family. On January 15, 2010, the ACS worker conducted a home visit and learned from the mother that JW had suffered a broken leg, allegedly by falling from a bed. ACS did not report the injury to the SCR, initiate an investigation, conduct a new safety assessment, contact the hospital

or treating physician about the injury, or consider that it could have been the result of abuse..

On February 4, 2010, the mother, later citing the absence of child care, invited the father into the home in violation of the order of protection and left him there alone with the two children while she visited a friend. The father telephoned the mother approximately five hours later and informed her that JW was not breathing, but neither one called 911 because the father was in the home in violation of the order of protection. The mother called 911 more than one hour later but only after a neighbor did so while attempting CPR on the infant's already cold body. By the time the police arrived, the father had departed and the mother falsely claimed that she alone was home at the time of JW's death.

On the date of JW's death, the caseworker from the provider agency made entries into CNNX, documenting that the mother had cancelled three counseling sessions in January and that she had made unannounced home visits on the latter of those days. This post-dated entry documented that the children were well and happy and that the mother was preparing to go out, but made no reference as to who would care for them in her absence. The supervisor's entry on that date addressed plans to close the case.

After the fatality, ACS learned that the father ceased complying with all aspects of the preventive service plan and was arrested on four occasions for burglary and the possession and sale of controlled substances.

The (redacted) ACS Accountability Review Panel Report concluded that there were "multiple family risk factors in this case," and that ACS and the outside agency services provider had "failed to ensure safety when it was learned that [JW] had a fracture." ACS further concluded that the Division of Child Protection "did not take appropriate action at critical points in the case," resulting in "inadequate oversight of [domestic violence] issues," which deficits included:

- Failing to inform the Family Court upon learning from the mother that she had resumed her relationship with the father, placing him in violation of the order of protection;
- Failing to advise the mother of the scope and meaning of the order of protection and discuss with her the nature of her relationship with the father;
- Failing to address the paternity of JW, while tacitly acknowledging that the father was the subject of the order of protection;
- Failing to inform the Family Court of the birth of JW in order that the court could amend the order of protection to include JW;
- Failing to address with the Family Court, or otherwise, the mother's opinion that the order of protection was an impediment to her ability to cope and care for her children and her refusal to press criminal charges against the father when he assaulted her and stole from her.

The ACS report also found that the CNNX record entries "were often unclear, incomplete, and difficult to understand," containing insufficient information about the mother, her needs, support system, employment, daily schedule, and how compliance with the court-ordered service plan affected her work schedule. The CNNX file also failed to document information about the older sibling's daycare, and no information was included about who was caring for either child when the mother needed to be out of the home.

In addition, the service provider agency failed to document in CNNX the content of discussions with the mother concerning "a wide range of important topics, including her safety plan in relation to [the father] and her emotional attachment and dependence on him," as well as her employment, her parenting skills training, and her child care arrangements.

The ACS Accountability Review Panel Report recommended that ACS should, inter alia:

- Clarify in its Child Safety Alert No. 29 regarding SCR investigations of injuries to babies and young children and modify the alert "to ensure that staff is aware of the need for rigorous, complete investigation of an injury of a baby even if there is no SCR report in place."
- Train staff "on the importance of conducting in-depth investigations, verifying medical and other information that

parents provide, and informing Family Court of significant case incidents."

- Affirm in training "that a young parent without family and social supports is a very high-risk case and even at higher risk when there is domestic violence, homelessness and lack of financial resources."
- "[C]ontinue training staff on the importance of comprehensive and accurate case record recording. Staff needs [to] strengthen writing skills so that entries are comprehensible and well organized."
- "[C]ontinue to re-affirm to staff and [preventive service agencies] the core responsibility to make medical collateral contacts, confirm children's medical status and clarify the parent's ability to ensure medical care."

The OCFS Child Fatality Report concluded that:

- ACS had, following the acid-assault incident, wrongly unsubstantiated allegations of inadequate guardianship of the older sibling by the mother "based on lack of credible evidence."
- ACS' post-fatality investigation of the family involved an "insufficient" level of casework.

This Grand Jury finds that during ACS' role in the matter of JW, it engaged in the repeated commission of 2007 Report Investigative Failures, including:

- Failure to conduct meaningful investigations resulting in substantiated allegations incorrectly classified as unfounded rather than indicated.
- Failure to classify a case "as 'indicated' where the investigation has established credible evidence that support the allegations", and failure to classify a case "as 'unfounded' only when a thorough investigation of the underlying allegations does not yield credible evidence substantiating the allegations."
- Failure to contact and interview obvious collateral sources of information.
- Failure to conduct meaningful home visits.
- Failure to obtain medical records and/or to consult with medical providers.
- Failure to keep investigations open for further necessary investigation in lieu of improperly and dangerously closing the case as unfounded based solely or primarily upon denial by parents/guardians of allegations.
- Failure to identify and obtain pedigree information and prior criminal history of all adult members or frequenters of the household.
- Failure to accurately document the circumstances of the household.
- Failure to monitor compliance with preventive services or request judicial intervention when necessary.
- Failure of supervision of activities of caseworker.
- Failure to seek Family Court intervention when and as necessary to ensure compliance with preventive services.

RECOMMENDATIONS OF THE GRAND JURY

Based upon all of the evidence concerning a subject of utmost seriousness and concern that this Grand Jury has heard and considered at great length, we conclude as follows:

First: The existing Social Services Law and corresponding regulations governing the investigation of reports to the State Central Register of child abuse and mistreatment are detailed, comprehensive, and designed to ensure that the subject children are safeguarded from further abuse, neglect, and harm, *but only insofar as* local social services agencies such as the New York City Administration for Children's Services methodically, effectively, and conscientiously implement them through the deployment of a sufficient number of highly trained, adequately equipped, and carefully supervised child protection staff who are held, as are all staff, to the highest professional standards and level of accountability.

Second: As previously found by the New York City Department of Investigation in August 2007, the failure by the Administration for Children's Services to methodically, effectively, and conscientiously conduct the investigation of reports to the State Central Register in strict compliance and conformance with both the letter and the spirit of the applicable laws and regulations resulted in the abuse, injury, and deaths of children who could and should have been saved by ACS action.

Third: ACS' reliance upon its internally-generated 2006 Action Plan initiatives rather than wholeheartedly adopting, implementing, and effectuating the recommendations advanced by DOI in 2007 to improve the functioning of the

Division of Child Protection was highly ill-advised and resulted directly in the continued and on-going failure of ACS' staff to conduct competent and professional investigations in full compliance with the Social Services Law and applicable regulations. This failure, in turn, played a causative role in the deaths of 8 more children, in Brooklyn alone, between August 2007 and September 2, 2010.

Fourth: ACS and its Division of Child Protection will continue to underperform, and children will as a result continue to be injured and to die unnecessarily unless and until ACS sets aside its aversion to incorporating the proven, professional investigation standards and techniques recommended by DOI in 2007, following the murder of Nixzmary Brown, and again in 2011, following the murder of Marchella Pierce. Such standards and techniques are not antithetical to effective social work because they are based in part upon experience garnered by law enforcement professionals. To the contrary, only their implementation by the Division of Child Protection will finally slow the steady litany of child deaths in New York City due to failures within and by ACS.

Fifth: It cannot be left to ACS alone to make the necessary changes. The New York State Office of Children and Family Services, the New York City Department of Investigation, and other agencies must play a greater role in enabling and supervising ACS' implementation of a more rigorous and professional standard of execution of its mandate to protect the children of New York City.

While as Grand Jurors we are bound to accept and apply the law as given to us by our legal advisors, Criminal Procedure Law section 190.85(1)(c) gives us the

opportunity to propose recommendations for legislative, executive or administrative action in the public interest based upon stated findings. We have identified a number of deficiencies in the operations of ACS as well as in the supervision over and accountability of ACS that we have concluded are the appropriate subjects for legislative, regulatory and administrative actions. Therefore, this Grand Jury has decided to exercise its discretion and submit to the Court this report recommending the following action in the public interest based upon stated findings.

The Grand Jury respectfully recommends:

The New York State Legislature should adopt the following proposed legislative changes of and enactments to the Social Services Law,

and

The New York State Office of Children and Family Services should enact corresponding implementing regulations in Title 18 of the New York Code, Rules and Regulations.

1. Divest from the commissioner of a county social services agency the discretion under SSL § 422-a(1) to withhold from public release all or any part of the contents of any audit or investigation report, results, or findings if the report, results, or findings are critical of that agency's operation,

staffing, policies, performance, or the results of a case or cases, and reserve that discretion solely to the Commissioner of OCFS.

2. Require OCFS (a) to conduct annual audits of child protection divisions of local social services agencies, focusing on cases that were resolved adversely to the subject children, in order to ascertain the level of compliance by each such agency with all relevant laws and regulations; and (b) to report the audit results to the appropriate county-level officials, including the Mayor and City Council of New York City.

3. Amend SSL § 422-b(3) so as to expressly permit OCFS to include a representative of the Commissioner of the New York City Department of Investigation as a member of the OCFS Fatality Review Team.

4. Amend SSL § 20(5)(a) and (b) to require OCFS, in the conduct of the fatality review and in the resulting Child Fatality Report, *to address in detail* any and all specific failures by the local social services agency to comply with the requirements of the Social Services Law and corresponding regulations relating to the investigation of reports to the State Central Register, and to do so in such a manner as will permit local authorities to assess and effectively supervise the functioning of the local social services agency.

5. Amend SSL § 20-a to (a) define a child protective service caseworker "caseload" as encompassing any assignment to a caseworker of primary, co-equal, or secondary responsibility for the investigation of a report to the State Central Register of child abuse or maltreatment; (b) establish a maximum caseload of no more than 12 active investigations per month per child protective service caseworker, subject to the requirement that the assigned caseload in conjunction with other assignments must allow for at

least 11 hours per protective case per month, including travel time; require the quarterly reporting to OCFS of actual (not average) monthly caseloads; and (c) require OCFS to conduct annual analyses of outcomes of SCR case investigations relative to time spent on cases by assigned caseworkers and to formulate and recommend corresponding revisions of caseload standards and reporting requirements.

6. Enact a Social Services Law provision and implementing regulations limiting (a) the number of weekly/monthly overtime hours that a social services agency can require of a child protective service caseworker who is assigned to investigate reports of abuse or maltreatment; (b) the number of weekly/monthly overtime hours that a social services agency can permit such a child protective service caseworker to work; and further require the social services agency to report annually to OCFS the actual (not average) overtime hours worked by child protective service caseworkers assigned to investigate reports of abuse or maltreatment.

7. Enact a Social Services Law provision and implementing regulations requiring county social services agencies to assign child protective service caseworkers in teams of no fewer than 2 to conduct initial investigatory home visits and follow-up home visits in designated situations, including when (a) the social services agency possesses information that the household contains more than one adult resident and/or more than 2 children, and/or when (b) the home visit is conducted before the criminal histories of all adult residents have been obtained; and/or when (c) the social services agency is on notice of any reported or known criminal

activity, including drug use, domestic violence, and child sexual abuse, in the household or by its residents or guests.

8. Enact a Social Services Law provision and implementing regulations specifying that a supervisor and/or manager must accompany the assigned caseworker on at least one home visit prior to the closing of any investigation of a report of child abuse or maltreatment when it has been determined during the course of said investigation that a child or children have been or are at high risk of abuse, maltreatment, or neglect.

9. Amend Social Services Law section 424, corresponding regulations, and the Family Court Act to provide: (a) when a child protective service caseworker has been verbally or physically denied entry by one or more individuals into a residence upon being informed by said caseworker that one or more resident children is the subject of a State Central Register report of abuse, maltreatment, or neglect, such refusal shall constitute grounds to seek and issue an immediate warrant to enter such residence; (b) a county social services agency shall not delay more than 24 hours following a denial of entry into a residence under the circumstances described hereinabove to seek a warrant to enter such residence to investigate the safety and well-being of the child or children believed to reside therein; (c) under these circumstances, the county social services agency shall dispatch no fewer than two caseworkers to enter the residence through use of the warrant to enter and that no fewer than two caseworkers shall undertake all home visits unless or until such time as the county social services agency has determined and documented that the safety of the caseworker and the effective conduct of the investigation will not be jeopardized.

10. Enact a Social Services Law provision and implementing regulations requiring social services agencies to provide appropriate and safe transportation or transportation services at no cost to child protective service caseworkers while engaging in home visits, court appearances, and investigations.

11. Designate as an offense under the Social Services Law the knowing inclusion or direction to include by a social services agency official or employee of materially false, inaccurate, incomplete, or otherwise misleading information in response to any request by OCFS for information or documentation regarding a child fatality or the serious physical injury of a child.

12. Designate as an offense under the Social Services Law the knowing inclusion or direction to include by a social services agency official or employee of materially false, inaccurate, incomplete, or otherwise misleading information into any official record of the investigation of a report to the SCR.

13. Designate as a felony under the Social Services Law the commission of an offense under 11 and 12, above, when the proscribed conduct pertains to and transpires following the death or serious physical injury of a child.

14. Enact a Social Services Law provision and implementing regulations prohibiting the making of post-mortem entries into CNNX by any local agency staff who had been previously assigned to or who had previously supervised any aspect of that agency's investigation of a report of abuse or maltreatment to the SCR or to that agency's provision of preventive services to the subject household.

The Grand Jury respectfully recommends:

That the New York City Charter and/or Administrative Code be revised to include provisions that:

1. Require ACS to notify the Department of Investigation within 12 hours upon the occurrence of the death, serious injury, or disappearance of a child while the child or the family of said child is or has been under investigation by or under supervision of ACS.
2. Require ACS to admit a representative of the Commissioner of DOI as a participating member of the Accountability Review Panel.
3. Require ACS to post on its official internet site and to otherwise make available to the public each ACS Accountability Review Panel Report relating to a death of a child in New York City, along with the agency's updated response to the report findings.
4. Require ACS to (a) adopt and promulgate an official Division of Child Protection Casework Practice Guide in a format that is both readable and accessible to caseworkers, that incorporates and accurately reflects all applicable laws, rules, and regulations, and that presents a clear, consistent, and unambiguous statement of ACS policies and standards; (b) require that said guide be updated as frequently as necessary to comply with (a), but in no event less than annually; (c) provide said guide contemporaneously with its issuance to DOI and ensure that any and all interim updates or revisions are contemporaneously provided to DOI.
5. Require ACS to impose the following penalties for failures by Division of Child Protection staff to perform their duties in conformance with applicable laws, regulations, and guidelines: (i) for the first offense: a

formal written warning; (ii) for the second offense committed within the same 12-month period as (i): probation and mandatory retraining; and (iii) for the third offense committed within the same 12-month period as (i) and (ii): termination of employment.

6. Designate as a misdemeanor offense under the City Charter the knowing inclusion or direction to include by a city official or employee of materially false, inaccurate, incomplete, or misleading information in any response, whether oral, written, or documentary, to a written request by DOI.

7. Require DOI to submit to the City Council a copy of any written report of an investigation into the operations of the ACS Division of Child Protection, and to thereafter report to the City Council on the compliance or non-compliance by ACS with recommendations made by DOI that are designed to remedy observed failures and shortcomings.

8. Require DOI to conduct an annual audit of 20 cases selected randomly by DOI from each zone of the Division of Child Protection to assess and ensure compliance with all applicable laws, regulations, and guidelines by ACS staff, including but not limited to senior officials, managers, supervisors, and caseworkers.

9. Appointment an ombudsman, independent of ACS, to whom ACS staff may confidentially report complaints or concerns relating to the operation or functioning of ACS.

10. Require the New York City Office of Management and Budget to report to the City Council all actual and projected delays or denials in supplying "new needs" funding requested by ACS for its Division of Child Protection in

response to DOI and OCFS recommendations, including Policy and Procedure Recommendations.

11. Require ACS to report annually to the New York City Office of Management and Budget and the City Council on its use and expenditure of "new needs" funding referenced in paragraph 10, above.

Finally, the Grand Jury further recommends:

1. That OCFS, as administrator of the CNNX system, take whatever steps necessary to put into operation an alternative record-keeping system to allow for the documentation of post-fatality investigations and the on-going supervision of surviving siblings of the deceased child without compromising the integrity of the pre-fatality record, and, in the interim, direct that no post-fatality entries are made unless expressly authorized by a representative of OCFS.
2. That the New York City Council conduct regular public hearings geared to ensuring that ACS' perception and implementation of its mandate is in line with and best meets the needs of the children of New York City.
3. That ACS implement an incentive program, designed to recognize on a monthly basis superior performance by Division of Child Protection caseworkers in each zone, who shall then be awarded appropriate compensatory time and/or certificates, as determined by the zone supervisors.
4. That ACS undertake to augment the effectiveness of the State Central Register system of reporting allegations of child abuse and maltreatment by better taking advantage of the internet, social media, and the news media,

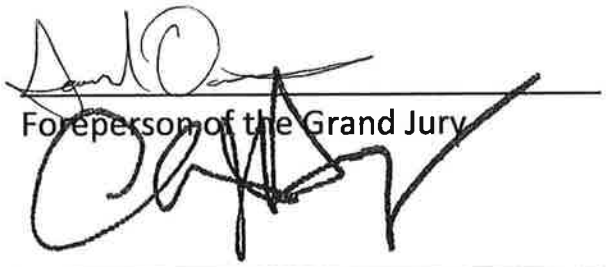
as well as by conducting public meetings and visits to schools, community centers, etc., in order to inform the public about child abuse and maltreatment, the urgent need for the public to report to the State Central Register any suspicions that a child is in need of assistance, and how to do so.

5. That ACS update its Division of Child Protection Casework Practice Guide to incorporate and include each recommendation concerning the investigatory practices and procedures employed by the Division of Child Protection that were advanced by the New York City Department of Investigation in its August 2007 report of the Examination of Eleven Child Fatalities and One Near Fatality, and in its May 2011 report of the Investigation of the Marchella Pierce Fatality.

CONCLUSION

We, having been summoned to serve as members of this Grand Jury, have willingly devoted ourselves over the course of more than one year to fulfilling our responsibilities because we have been and are grateful for the opportunity that we have been accorded: To seek to better protect the most vulnerable of all – the frightened, abused, and neglected children of our city. Bearing in mind that we are limited by the strictures imposed by the terms of CPL § 190.85, we nevertheless believe that implementation of the Recommendations that we have put forth is vital to the protection and safeguarding of those children, and with the greatest sense of urgency we call for their immediate consideration and prompt implementation.

Dated: Brooklyn, New York
August 14, 2012



Foreperson of the Grand Jury

CHARLES J. HYNES
District Attorney of Kings County