Public Advocate for the City of New York

Dangerous Mistakes:

Analysis of ACS Corrective Actions Involving Child Fatalities in 2005

A REPORT BY PUBLIC ADVOCATE BETSY GOTBAUM

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EXECUTIVE SUMMARY

On January 11, 2006, seven-year-old Nixzmary Brown died inside her Brooklyn apartment, allegedly at the hands of her abusive stepfather. Nixzmary's death was treated as an unprecedented event. In its aftermath, task forces were formed, public hearings held, and reforms announced. Unfortunately, however, the case of Nixzmary was far from unprecedented. Her death was not an isolated incident, nor was it the result of new or previously unknown problems within the child welfare system. Rather, it was a brutal reminder of ongoing systemic failings. Information is now available about what was happening within the Administration for Children's Services (ACS) in the year leading up to Nixzmary's death. The Office of the Public Advocate analyzed state reports on all child fatalities investigated by ACS and uncovered an agency struggling with serious, growing problems.

The New York State Office of Children and Family Services (OCFS), in accordance with state law, reviews all child fatalities that ACS investigates and produces individual reports for each death. As part of this review process, OCFS identifies mistakes that ACS made in relation to cases involving these child fatalities. To shed light on the practices and procedures of the city's child welfare system, the Office of the Public Advocate analyzed all the mistakes made by ACS identified in the state reports.

Due to confidentiality rules that protect children and families involved with ACS, much of the agency's casework and decision-making is shielded from public scrutiny. The OCFS child fatality reports are one of the few glimpses inside New York City's child welfare system accessible to the public. The Public Advocate's analysis of these reports reveals an overburdened system that has trouble consistently performing basic child welfare functions.

In 2005, 75 children[1] from New York City[2] died under one or more of the following circumstances: the child's family had an open protective services case; the child's family had an open preventive services case; the child was in foster care at the time of death; or the child's death was suspicious. An analysis by the Office of the Public Advocate of the OCFS reports on these deaths found that while the number of overall deaths increased slightly from 2004 (3 percent) and the number of deaths involving families previously known to the child welfare system decreased, the number of mistakes made by ACS involving these cases increased by more than 44 percent (see chart on pg. 3). Furthermore, the number of child fatality cases in which the agency made at least one mistake increased by 20 percent from 2004 to 2005. On average, ACS made more than two mistakes per fatality in 2005.

The Office of the Public Advocate grouped mistakes made by ACS into eight categories: mistakes related to 1) investigations, 2) supervision, 3) case documentation, 4) child welfare assessments, 5) laws or procedures, 6) supervision/coordination with contract

[1] Seventy-six reports, some involving multiple children, were issued by the New York State Office of Children and Family Services (OCFS) for deaths occurring in 2005, but four reports involved children who died in previous years, and three reports involved children who either did not exist or were found to be alive. Four reports included fatalities involving multiple children (10 children total).

[2] Not all of the children died in New York City. One child died while in New Jersey, and two died while in Westchester County. The location of three additional deaths could not be determined by information provided in OFCS' fatality reports.

agencies, 7) legal consultations, and 8) casework. (See pg. 6 for an explanation of these categories.)

The Public Advocate's analysis of these mistakes reveals that, in 2005, ACS was having major difficulties conducting thorough and timely child welfare investigations. In fact, in 58 of the 75 child fatality cases (77 percent) it reviewed, OCFS found mistakes associated with the way ACS conducted its investigations, such as delays in completing investigations in violation of state law, and failure to interview all applicable parties involved in the case. Of the 173 total mistakes made by ACS in 2005, 111 (64 percent) involved investigations, resulting in an average of 1.5 investigative mistakes per fatality.

For instance, in *Case Number 95-05-006* involving the death of a newborn infant by her teenage mother due to abandonment, the OCFS review revealed that ACS made three separate mistakes in its investigations. The state cited ACS for failing to: 1) make necessary contacts with the accused mother's relatives, teachers, after-school programs, or friends; 2) complete its investigation within the timeframe required by law; and 3) complete a thorough investigation into the failure (by the ACS caseworker) to address the various inconsistencies in the information obtained from multiple sources.

ACS was also having difficulty supervising its staff, providing proper case documentation, and conducting accurate child welfare assessments. (See Appendix II for additional case profiles.)

Additional Findings

New York City Child Fatalities				
Year	*Total Fatalities*[3]	*# of Cases Requiring Corrective Action(s)*[4]	*Total # of Mistakes*	*Average # of Mistakes per Fatality*
2005	**75**	**59**	**173**	**2.31**
2004	73	49	120	1.64
2003	64	50	103	1.61

- 59 child fatality cases (79 percent) included at least one mistake by ACS;
- 90 of the 111 investigative mistakes identified (81 percent) were associated with ACS investigations into the child fatality itself.

[3] Includes deaths of all children within the given year for which the state OCFS, pursuant to state law, reviewed and issued a fatality report. This includes the deaths of children who died in a suspicious manner, of children in families that had open child protective service cases, and of children who were residing in foster care at the time of their death.

[4] Corrective Actions are steps that OCFS requires of the New York City Administration for Childrens' Services (ACS) or its contract agencies after its review and assessment of an individual fatality reveals mistakes by the agency. These Corrective Actions are next steps OCFS has identified that ACS or contract agencies must complete in order to better protect children in the future.

CASES REQUIRING ACS CORRECTIVE ACTIONS IN 2005		
Type of Corrective Action	*# of Cases Requiring ACS Corrective Actions*	*Percentage of Total Fatality Cases*
All Corrective Actions	59	78.7%
Investigations	**58**	**77.3%**
Supervision	20	26.7%
Case Documentation	12	16.0%
Child Welfare Assessments	7	9.3%
Laws or Procedures	6	8.0%
Supervision/Coordination with Contract Agency	4	5.3%
Legal Consultation	2	2.7%
Casework	1	1.3%
No Corrective Actions	16	21.3%

Recommendations

The purpose of this report is not to blame ACS for any particular death but to evaluate the overall state of New York City's child welfare system and its operations—and work to strengthen it.

Public Advocate Gotbaum is calling for the following steps to strengthen the child welfare system:

- **Create an Office of the Child Advocate to Improve Oversight:** New York State should create an Office of the Child Advocate to provide permanent oversight of the child welfare system, including ACS and contract agencies.
- **Improve ACS Investigations of Child Abuse and Neglect Allegations:** ACS should hire and train additional child protective caseworkers to reduce child protective caseloads to 12 cases per worker, the maximum caseload recommended by the Child Welfare League of America.[5]

[5] According to the most recent statistics available on the ACS website, the average caseload per caseworker is 16.6, and there are 30 caseworkers with 30 cases or more. ACS, *Monthly Update*, January 2006.

INTRODUCTION

On January 11, 2006, seven-year-old Nixzmary Brown died inside her Brooklyn apartment, allegedly at the hands of her abusive stepfather. This high-profile death set off a movement to reform New York City's child welfare agency, the Administration for Children's Services (ACS), after it was discovered that the agency had information of possible abuse and neglect involving Nixzmary but failed to act swiftly enough to protect her.

Nixzmary's death was treated as an unprecedented event. In its aftermath, task forces were formed, public hearings held, and reforms announced. Unfortunately, however, the case of Nixzmary was far from unprecedented. Her death was not an isolated incident, nor was it the result of new or previously unknown problems within the child welfare system. Rather, it was a brutal reminder of ongoing systemic failings. Information is now available about what was happening within ACS in the year leading up to Nixzmary's death, and it reveals an agency struggling with serious, growing problems.

This report focuses on the child fatalities that occurred in 2005, as well as the Corrective Actions required of ACS by the state in response to those fatalities. The purpose of this report is not to lay blame on ACS for any particular death but to gauge the overall health of New York City's child welfare system and its operations in the year leading up to Nixzmary's death.

BACKGROUND

The New York State Office of Children and Family Services (OCFS), in accordance with state law, prepares an individual fatality report for each child who dies while in the custody or under the watch of ACS or ACS contract agencies, or whose death was reported to have been caused by suspected neglect or abuse.[6]

Each state report examines the circumstances of the fatality by reviewing ACS and/or contract agency case documentation, autopsy and police reports, medical records, information on prior abuse and neglect cases, and any other pertinent information available. Each state-issued fatality report contains sections describing the sources of information and documentation used to review the death, the cause and circumstances of the death, the child welfare service history of the child and/or family, and any child-welfare-related services or actions taken involving the child and/or family.

OCFS child fatality reports also often include a section called "Corrective Actions." Corrective Actions are steps that OCFS requires of ACS or its contract agencies after its review and assessment of an individual fatality reveals mistakes by the agency. These Corrective Actions are next steps OCFS has identified that ACS or contract agencies must complete in order to better protect children in the future. It is important to note that Corrective Actions apply to mistakes made by ACS or its contract agencies both before (if applicable) and after the fatality. This report reviews only Corrective Actions directed at ACS and not those directed at contract agencies.

[6] Social Services Law §422.

The Public Advocate's Office reviewed and analyzed all Corrective Actions issued by OCFS in 2005 and divided them into eight categories. The categories include problems associated with ACS:

1. **Investigations** – such as delayed investigations or failure to contact parties with information relevant to child welfare investigations;
2. **Supervision of Caseworkers** – such as failure of ACS supervisors to identify and correct ACS caseworker mistakes;
3. **Case Documentation** – such as incomplete ACS documentation in case files;
4. **Supervision or Coordination with Contract Agencies**[7] - such as failure to monitor the well-being of children while they are in the care of contract foster care agencies;
5. **Child Welfare Assessments** – such as failure to appropriately determine the risk to children within households with allegations of abuse and neglect;
6. **Compliance with Laws or Procedures** – such as failure of ACS caseworkers to report additional allegations of abuse and neglect that are uncovered during the course of child welfare investigations in violation of New York State's Mandated Reporter law;
7. **Failure to Seek Legal Consultation** – such as failure of ACS caseworkers to consult with ACS attorneys to determine whether the agency has enough evidence to remove children from potentially dangerous households;
8. **Casework** – such as failure to keep close contact with those indicated in allegations of abuse and neglect.

(See Appendix II for specific examples of Corrective Actions in each category).

Once ACS receives a Corrective Action from OCFS in a fatality report, the agency is required to submit a written Corrective Action Plan to OCFS within 30 days.[8] The plan outlines how ACS plans to correct the identified mistakes and ensure they will not happen again, as well as what ACS has done or will do to inform the workers involved in the case of the correct procedures. The corrections often include proposed trainings for ACS workers to strengthen best practices or changes to agency policy to address systemic shortfalls.

Corrective Actions do not necessarily indicate that ACS can be faulted for failure to protect a child who died. In fact, many of the Corrective Actions were imposed by OCFS in response to problems that arose *after* the death of a child, such as inadequate or delayed investigations of the fatality (See Table 5).

Mistakes that occur during ACS investigations into child fatalities can have serious consequences, however, because families involved in child fatalities often have multiple children living in their households. It is important for ACS to complete a thorough and

[7] Includes foster care agencies and preventive services agencies.
[8] Social Services Law §424.7 and 18 NYCRR 432.

timely investigation following a child fatality to determine whether any other children in the household may be in danger.

It is also important to analyze Corrective Actions because they represent one of the only opportunities for those outside the child welfare system to assess the quality of ACS casework. Due to confidentiality rules that protect children and families involved with ACS, much of the agency's casework and decision-making is shielded from public scrutiny. Unfortunately, mistakes only come to light when a child dies and OCFS publishes a review of the case.

FINDINGS

Overview of Child Fatalities in 2005

In 2005, 75 children from New York City died under one or more of the following circumstances: the child's family had an open protective services case; the child's family had an open preventive services case; the child was in foster care at the time of death; or the child's death was suspicious. This is a small increase over the 73 children who died under such circumstances in the previous year. Of those 75 children, 45, or 60 percent, came from families that had some sort of contact with ACS or the State Central Register for Child Abuse and Maltreatment (SCR) prior to the child's death (a 15 percent decrease from 2004).[9]

Thirty-one, or 41 percent, of the 75 children who died in 2005 came from families that were known to ACS through previous substantiated cases of abuse or neglect or lived in foster care at the time of their death (a 25 percent decrease from 2004). Seven of these deaths involved medically frail children who died of natural causes in foster care. (See Table 1).

Table 1

New York City Child Fatalities

Year	Total Fatalities[10]	Fatalities Involving Children of Families with Previous Contact with ACS[11]	Fatalities Involving Children of Families with Previous Contact that led to Substantiated Cases/Children in Foster Care[12]
2005	75	45	31
2004	73	53	41
2003	64	42	33

[9] Includes deaths of children in families that had previous child welfare cases with ACS (founded or unfounded), previous reports to SCR or previous preventive service cases, or who had parents who were known to ACS as maltreated children. It also includes children who were in foster care at the time of their death. This category is a subset of footnote 10.

[10] Includes all deaths of children for which the state, pursuant to state law, reviewed and issued a fatality report. This includes the deaths of children who died in a suspicious manner, of children in families that had open child protective or preventive service cases, and of children who were residing in foster care at the time of their death.

[11] *See* 9.

[12] Includes the deaths of children in families with previous substantiated cases of abuse or neglect, open child protective cases that were not a result of the fatality, or open preventive service cases. It also includes deaths of children who were in foster care at the time of their death and children who died while in the care of teenagers in foster care. This category is a subset of footnote 9 and footnote 10.

Child Fatalities by Borough:

Of the 75 child fatalities reviewed by the state:[13]

- 26, or 35 percent, occurred in Brooklyn;
- 13, or 17 percent, occurred in the Bronx;
- 13, or 17 percent, occurred in Manhattan;
- 13, or 17 percent, occurred in Queens;
- 4, or 5 percent, occurred on Staten Island.

Child Fatalities by Age and Gender:

The 75 child fatalities reviewed by the state involved children and teenagers ranging in age from newborn to 19 years old. Of these 75 child fatalities:

- 34, or 45 percent, involved children less than one year old;
- 57, or 76 percent, involved children five years old or younger;
- 60 percent of the children were male, 40 percent female.

Manner of Death:

Deaths from Natural Causes

Of the 75 child fatalities reviewed by the state:

- 22, or 29 percent, were due to natural causes;
- Respiratory infections/asthma was the most frequent natural cause of death (9 deaths total).

Deaths from Homicide

Of the 75 child fatalities reviewed by the state:

- 20, or 27 percent, were due to homicide (a 25 percent increase from the previous year);
- Beating or fatal child abuse was the most frequent cause of death in the cases of homicide (7);
- Boyfriends of the mothers or babysitters were responsible for 7 of the 20 deaths from homicide.

Deaths of Undetermined Intent

Of the 75 child fatalities reviewed by the state:

- 17, or 23 percent, involved a child who died in a manner in which the intent could not be determined;
- 16 of these children were infants age 6 months old or younger who were suspected to have died from improper sleeping position[14] (co-sleeping and positional asphyxia).

Deaths from Accidents

Of the 75 child fatalities reviewed by the state:

- 16, or 21 percent, were due to accidental causes;
- House fires were the most frequent cause of accidental death (7);
- 3 children died due to improper use of a child car seat or baby carrier, 3 from improper sleeping position.[15]

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[13] *See* 2.

[14] This report uses the term "improper sleeping position" to describe deaths of infants from both co-sleeping and positional asphyxia.

[15] Determination of the Manner of Death is based on evidence from the fatality scene and the autopsy results. Manner of Death (Natural, Accident, Undetermined etc.) for improper sleeping position deaths is determined based on the facts of the individual fatality.

ACS Mistakes in Cases Involving Child Fatalities Soar in 2005

In 2005, OCFS reviewed the deaths of 75 children[16] from New York City.[17] While this represents only a small increase (less than 3 percent) over the total number of child deaths OCFS reviewed in 2004 (73), the number of Corrective Actions required of ACS increased by more than 44 percent.[18] In all, OCFS found that ACS committed 173 mistakes, an average of 2.31 mistakes per fatality.[19] Likewise, the number of cases reviewed by OCFS in which at least one mistake requiring Corrective Action was made increased by more than 20 percent from 49 in 2004 to 59 in 2005.[20] (See Table 2).

Table 2

New York City Child Fatalities				
Year	*Total Fatalities*[21]	*# of Cases Requiring Corrective Action(s)*	*Total # Mistakes*	*Average # Mistakes per Fatality*
2005	**75**	**59**	**173**	**2.31**
2004	73	49	120	1.64
2003	64	50	103	1.61

Findings of Corrective Action Analysis involving Child Fatalities in 2005

The Office of the Public Advocate's analysis revealed that in cases requiring Corrective Action, ACS most frequently failed to conduct adequate and timely child welfare investigations, provide adequate supervision of ACS workers, provide proper documentation for cases, and conduct accurate child welfare assessments (See Table 3).

[16] *See* 1.
[17] *See* 2.
[18] *See* Table 2.
[19] Not all fatality reports included Corrective Actions.
[20] *See* Table 2, # of Cases Requiring Corrective Action(s).
[21] Includes deaths of all children within the given year for which the state OCFS, pursuant to state law, reviewed and issued a fatality report. This includes the deaths of children who died in a suspicious manner, of children in families that had open child protective service cases, and of children who were residing in foster care at the time of their death.

Table 3

CASES REQUIRING ACS CORRECTIVE ACTIONS IN 2005		
Type of Corrective Action	*# of Cases Requiring ACS Corrective Actions*	*Percentage of Total Fatality Cases*
All Corrective Actions	59	78.7%
Investigations	**58**	**77.3%**
Supervision	20	26.7%
Case Documentation	12	16.0%
Child Welfare Assessments	7	9.3%
Laws or Procedures	6	8.0%
Supervision/Coordination with Contract Agency	4	5.3%
Legal Consultation	2	2.7%
Casework	1	1.3%
No Corrective Actions	16	21.3%

OCFS identified at least one mistake in need of a Corrective Action in 59 cases (79 percent) of the 75 fatalities that occurred in 2005. Furthermore, OCFS' review revealed that ACS made multiple mistakes in 46, or more than 60 percent, of the cases. In two cases ACS made seven mistakes each, the maximum number of mistakes made by ACS per fatality case in 2005.

It is important to note that, in many cases, OCFS identified within an individual fatality case multiple mistakes requiring Corrective Actions in the same category (i.e., investigations). In these cases, the Public Advocate's Office counted these as multiple Corrective Actions. For instance, in *Case Number 95-05-006* involving the death of a newborn infant by her teenage mother due to abandonment, the OCFS review revealed that ACS made three separate mistakes in its investigations. The state cited ACS for failing to: (1) make necessary collateral contacts with the accused mother's relatives, teachers, afterschool programs, or friends; (2) complete the investigation of the report of DOA/Fatality, Lack of Medical Care, and Abandonment within the timeframe required by law; and (3) complete a thorough investigation into the failure (by the ACS caseworker) to address the various inconsistencies in the information obtained from multiple sources. The Corrective Actions associated with these three mistakes were, for the purposes of this report, counted as three separate Corrective Actions in the "investigation" category.

2005 Child Fatality Reports Show ACS Fails to Conduct Timely and Thorough Investigations

The agency's inability to perform comprehensive and timely investigations in cases involving fatalities was the most troubling problem revealed by OCFS child fatality reports. In 2005, it was far more common for ACS to make mistakes in its investigation of child welfare cases involving fatalities than not. In fact, 77 percent of the child fatality cases from 2005 (58 cases) involved at least one mistake associated with the way ACS conducted an investigation (See Table 3). Sixty-four percent of all the mistakes cited by OCFS in 2005 (which resulted in 111 Corrective Actions) involved ACS investigations, an average of 1.5 mistakes involving investigations per fatality (See Table 4).

Table 4

TOTAL ACS MISTAKES BY TYPE IN 2005		
Type	*Total # of Mistakes*	*% of Total Mistakes*
Investigations	**111**	**64.2%**
Supervision	22	12.7%
Case Documentation	13	7.5%
Supervision/Coordination with Contract Agency	11	6.4%
Child Welfare Assessments	7	4.0%
Laws or Procedures	6	3.5%
Legal Consultation	2	1.2%
Casework	1	0.6%
Total	173	100.0%

The problems identified by OCFS pertaining to ACS investigations into allegations of abuse and neglect focused on two periods of time: before the fatality (if applicable) and after the fatality. Each Corrective Action related to investigations could be further divided into two types of problem: inadequate investigation by ACS or delayed investigation by ACS.

"Inadequate investigation" is the designation given by the Public Advocate's Office to Corrective Actions indicating a failure on the part of ACS to follow proper investigative procedure, such as failure to follow up on investigative leads, failure to interview collateral witnesses who may have pertinent information about a reported incident (i.e., social workers, doctors, the child's relatives, EMS workers, etc.), or failure to settle discrepancies discovered during the investigation. "Delayed Investigation" is the designation given by the Public Advocate's Office to Corrective Actions indicating ACS did not complete an investigation within 60 days, the amount of time allowed by State law.[22]

The Public Advocate's Office analyzed the Corrective Actions related to investigations and categorized them into one of four categories:

A. Delayed investigation prior to the fatality;
B. Inadequate investigation prior to the fatality;
C. Delayed investigation following the fatality;
D. Inadequate investigation following the fatality.

The Public Advocate's Office found that mistakes related to investigations tended to occur following the fatality. In fact, 90 of the 111 mistakes related to investigations (81 percent) made by ACS involved investigations resulting from a fatality and corresponding allegations (See Table 5).[23] Of the 90 mistakes made during investigations into fatalities in 2005, 51 (57 percent) were due to delays and 39 (43 percent) were due to inadequate investigations.

[22] Social Services Law §424.7.
[23] DOA/Fatality reports often include other allegations of abuse that must be investigated (i.e. Inadequate Guardianship, Lack of Medical Care, etc.).

Table 5

ACS INVESTIGATIVE MISTAKES BY TIME AND TYPE			
	Prior to Fatality	*After Fatality*	*Total*
Delayed Investigation	11	51	**62**
Inadequate Investigation	10	39	**49**
Total	**21**	**90**	**111**

While the majority of the mistakes were made during ACS investigations following fatalities, the number of mistakes made during investigations prior to fatalities is also noteworthy. Of the 75 child deaths reported in 2005, 45 involved families with some previous contact with ACS. In six of these 45 cases, ACS made a total of 21 investigative mistakes prior to the fatalities – a far from insignificant number.

ACS' Ability to Provide Supervision of Workers, Case Documentation, and Child Welfare Assessments Also in Question

The Office of the Public Advocate's analysis of the state-issued Corrective Actions revealed that ACS also frequently has problems supervising its workers, maintaining proper case documentation, and making accurate child welfare assessments.

Supervision problems were cited in more than one-quarter of the reports (20 cases) issued by OCFS. These problems generally involved inappropriate decisions by ACS caseworkers that should have been identified and corrected by a supervisor.

Likewise, problems with case documentation and child welfare assessments were discovered in 16 percent (12 cases) and 9 percent (7 cases), respectively, of the reviewed cases.

RECOMMENDATIONS

New York State should take the following action:

Improve Oversight of the Administration for Children's Services

- The state should create an independent Office of the Child Advocate that would provide permanent oversight of the child welfare system, including ACS and contract agencies. The Legislature should pass and the Governor should sign bill A.304, sponsored by Assemblywoman Barbara Clark, which would create the office. State Senator Martin Golden has also introduced a bill in the Senate that would create an Office of the Child Advocate (S.4990).

New York City should take the following actions:

Improve ACS Investigations of Child Abuse and Neglect Allegations

- Following the death of Nixzmary Brown, ACS hired 20 law enforcement officials to help improve the effectiveness of ACS child protective investigations. This is a step in the right direction, but ACS must work to ensure that *all* child welfare investigations are completed in a timely and thorough manner; ACS should pay particular attention to improving investigations of child fatalities.
- ACS should hire and train additional child protective case workers to reduce child protective caseloads to 12 cases per worker, the maximum caseload recommended by the Child Welfare League of America.

APPENDIX I – SELECTED CHILD FATALITY PROFILES

Case Number 95-05-048
Fact Pattern: On October 23, 2005, a two-month-old boy died while co-sleeping with his mother in a Queens' homeless shelter. While the cause and manner of the death could not be determined through autopsy,[24] it is believed that the child died when his mother rolled over and suffocated him while sleeping. Prior to the fatality, the mother was known to the child welfare system as both a maltreated child and as an abusive/neglectful parent. **Before the fatality, the infant was observed by ACS staff sleeping in unsafe conditions. ACS staff had knowledge that the baby regularly slept in unsafe conditions but failed to inform the mother about safe sleeping practices.**

On September 30, 2005 ACS received a report of Inadequate Guardianship on the part of the then six-week-old boy's mother.[25] This report, received just 24 days before the fatality, was called into ACS by hospital staff after the mother displayed erratic and irrational behavior during a post-partum evaluation at Flushing Hospital Medical Center. The report indicated that the mother endangered the child while at the hospital and was diagnosed with "clinical issues" and prescribed an undisclosed psychotropic medicine.

As part of its investigation into the report, ACS interviewed the mother via telephone on the day of the report and visited the infant at his godmother's home the next day. During the visit, the ACS Specialist observed the infant sleeping in an unsafe position and arrangement (on a couch, face down, surrounded by four large pillows). The godmother informed the case specialist that when the child and mother both slept over,[26] the mother would sleep on the couch, the infant in an adult bed, and the godmother on the floor.

The Specialist failed to make face-to-face contact with the mother, the subject of the report, until 21 days after the initial report and just three days before the fatality. According to the state's review of the case, there was no casework documentation to indicate that when the Specialist finally met with the mother, he/she spoke to her about the dangers of improper sleeping position.

After the fatality, OCFS reviewed the case pursuant to state law and found that ACS mishandled many aspects of the case, including both the child protective case before the fatality and the investigation of the fatality itself. The state's findings are documented below:

Mistakes:
1. **Delayed Investigations** – ACS failed to make a timely determination in both the child protective case dated 9/30/05 and the fatality dated 10/24/05.[27]
2. **Inadequate Safety Assessment** – Inadequate Safety Assessment of mother in the Inadequate Guardianship Report of 9/30/05. According to the state, ACS "did not consider the seriousness of the 9/30/05 report and did not assess the infant's need for protection." Because the report "involved a newborn infant and the mother was reportedly behaving irrationally…telephone contact with

[24] The autopsy was conducted by New York City's Office of the Chief Medical Examiner.
[25] The report was received by ACS via SCR.
[26] This was reported to occur at least two times per week.
[27] The fatality occurred on 10/23/05 but was reported to SCR on 10/24/06.

the mother cannot be considered a significant contact to assess the safety of the newborn child."

3. **Inadequate Fatality Investigation** – According to the state's review, ACS "did not contact all relevant collateral sources who had responded to the case address at the time of the (fatality) incident."
4. **Inadequate Supervision of a Child Protective Case** - According to the state's review, "ACS unsubstantiated the allegation of DOA/Fatality of the infant by (the) mother based on the ME's (Medical Examiner's) report that the cause and manner of the death were Undetermined, but substantiated the allegation of Inadequate Guardianship which covered the underlying factors that led to the child's death. It was evident that ACS did not make the causal connection between the Inadequate Guardianship and the fact that this led to the death of the child." The state concluded that ACS supervisors must review pertinent information at case conferences with staff and determine if the facts are consistent with each allegation.

Case Number 95-05-049

Fact Pattern: On October 25, 2005, a seven-year-old female was beaten to death by her father in a Queens apartment. The child and family were previously known to the SCR and ACS through past substantiated cases of neglect. In fact, on the basis of the findings of the previous reports (Inadequate Guardianship, Parent's Drug/Alcohol Misuse), the child was removed from her home and placed in foster care. Approximately four years before her death, the child was reunified with her father**. It appears that in the period of time between this reunification and the child's death, ACS missed many warning signs that the child was being physically abused by her father.**

ACS was first made aware of the child through a report made on January 5, 1998, alleging Parent's Drug/Alcohol Misuse and Inadequate Guardianship after the then newborn tested positive for cocaine at birth. The allegations were substantiated by ACS, and the child was removed from the household. In November 2001, the child was reunified with her father.

In the summer of 2003, ACS received information from the SCR indicating that the child had a fractured spine as the result of an injury sustained in the fall of 2002. Over the course of two months, ACS interviewed the father, the child's former foster mother, her pediatrician, social workers from two hospitals, and a social worker at the Tier 1 shelter where the family was staying at the time.

During the course of the investigation into the child's injury, ACS discovered that the child had also suffered a broken leg approximately six months after the fractured spine. After the child's death, the state review revealed that despite several discrepancies in the father's explanation of how the child received such severe injuries, the ACS Specialist "did not analyze and draw the appropriate conclusions from the information gathered." The child died approximately 14 months after ACS concluded its investigation into her injuries. After the fatality, the state reviewed the case and found that ACS mishandled many aspects, including both the child protective case before the fatality and the investigation after the fatality. The state's findings are documented below:

Mistakes:

1. **Failed to Report Abuse or Neglect to SCR** – ACS failed to file an additional report of possible abuse or neglect following its investigation into the information received from SCR concerning the child's injuries prior to her death. ACS failed to do so despite specific information from a social worker who indicated suspicions about the father's interactions with the child and his accounts of the injuries and despite the discrepancies in the father's story as documented by ACS casework.
2. **Poor Documentation –** The ACS case file had significant lapses in case activity documentation.
3. **Inadequate Fatality Investigation** – The state cited ACS for not conducting a thorough investigation of the fatality, including failure to make pertinent collateral contact with those with specific knowledge of the fatality scene including EMS workers. Additionally, ACS never conducted a face-to-face interview with the father or acquired statements from police that could reasonably replace an interview with the father.
4. **Delayed Fatality Investigation** – The state indicated that, as of the writing of its fatality report on the case, released on April 18, 2006, ACS had not made a determination or even finished its fatality investigation.

Case Number 95-05-019

Fact Pattern: On March 15, 2005, a two-month-old female infant died while co-sleeping with her mother and two-year-old sister on a futon in an apartment in the Bronx. The Medical Examiner was unable to determine the cause and manner of death but it is believed by ACS that the child suffocated after the mother or sibling rolled over her while sleeping. The mother was known to ACS and was the subject of four reports, two of which were substantiated. The child became known to ACS 56 days before her death, in a report dated January 18, 2005.

The January 18, 2005, report indicated that the newborn baby girl tested positive for methadone and the mother tested positive for opiates, cocaine, and marijuana. Based on the findings of ACS' investigation and advice from its legal department, the child remained under the care of the mother. The family was referred to preventive services and remained under the watch of ACS. At the time of the child's death, the family had both an open child protective case and an active preventive service case stemming from the January report. In fact, the preventive service agency visited the household the day before the child's death. The child's father was incarcerated at the time of the child's death.

After the fatality, the state reviewed the case and found that ACS mishandled many aspects, both before and after the fatality. The state's findings are documented below:

Mistakes:

1. **Failure to Properly Monitor an Open Preventive Service Case –** According to the state's review of this case, ACS failed to "closely follow up with parents nor (or) maintain close casework" following the January 18, 2005 report. The state attributes this failure to "personnel issues."
2. **Delayed Investigations –** ACS failed to make a determination in regard to either the January 18, 2005 report of drug use or the subsequent fatality within

60 days of the initial report, as required by law. At the time the state wrote its child fatality report, ACS had yet to make a determination in the case.

3. **Inadequate Safety Assessment –** The state found that ACS did not make "an adequate safety assessment of the surviving sibling" following the fatality.
4. **Inadequate Fatality Investigation** – Over the course of its fatality investigation, ACS failed to interview collateral sources that could have provided more information about the fatality scene and the family. The state specifically mentions that a doctor, the family's neighbor who performed CPR on the infant, and an EMS technician were not interviewed.
5. **Inadequate Fatality Investigation II** – The state found that ACS was not thorough in its investigation of the fatality of the two-month-old infant. According to the state, ACS failed to properly explore the "condition of the bedding…how the infant was placed to sleep after feeding…where and how the child was discovered…whether the child's airways (sic) was obscured by covers or whether the mother or surviving sibling had rolled over on the now deceased child."
6. **Poor Documentation –** The state found ACS' documentation over the history of the family's child welfare case to be poor.

Appendix II – Examples of Corrective Actions

Below are examples of corrective actions as identified by OCFS and categorized by the Public Advocate's Office:

1. **Investigations** – *Case Number 95-05-018* – In its review of the murder of an 18-month-old male child on March 6, 2005 at the hands of the family's informal child care provider, OCFS found that ACS had "not completed a thorough investigation with regard to determining the number of children for whom the babysitter provided care; the ages of these children; the hours of care and whether the children were at risk in the babysitter's home." According to OCFS, ACS must meet with staff involved and discuss the case.

2. **Supervision** – *Case Number 95-05-002* – In its review of the death of a two-month-old female infant due to improper sleeping position (co-sleeping with parents), the state found that ACS "did not link the parents' pattern of co-sleeping with their child and the substantiation of the Inadequate Guardianship allegation to the DOA/Fatality. ACS supervisors must conference with the staff during the course of the investigation and review cases for information that is relevant and consistent with the determination being made regarding the allegations of the report."

3. **Case Documentation** – *Case Number 95-05-067* – In its review of the death of a two-year-old male child due to an upper respiratory infection on December 31, 2005, OCFS found that ACS' "narrative did not include the investigative finding to support the decision (of the allegation). ACS must address each allegation of the report with respect to the determination of the nature, extent and cause of any condition enumerated in the report."

4. **Supervision/Coordination with Contract Agency** – *Case Number 95-05-022* – In its review of the beating death of a one-year-old male child by the mother's boyfriend on April 9, 2005, OCFS found that ACS' Office of Contract Agency Case Management (OCACM) "did not fulfill its role as CPS (Child Protective Services) monitor prior to the child's death. There was no documentation that OCACM met with the purchase preventive services agency, Big Brothers/Big Sisters, regarding key issues such as the mother's acceptance and application of positive parenting behavior towards her children, including her ability to assess the appropriateness of childcare options. OCACM as CPS monitors must ensure that open child protective cases are appropriately monitored."

5. **Child Welfare Assessments** – *Case Number 95-05-005* - In its review of the death of a four-year-old male child due to meningitis on January 14, 2005, OCFS found that "ACS completed three Safety Assessments during the investigation; however, the assessments documented no safety factors present but ACS filed an Article Ten Neglect Petition and sought alternative placement for the surviving sibling. ACS must assess and document the current safety and risk of future abuse and maltreatment to the children in the home."

6. **Laws or Procedures** – *Case Number 95-05-003* - In its review of the death of a two-month-old male infant due to improper sleeping position (co-sleeping with

parent) in a domestic violence safe house on January 3, 2005, OCFS found that the ACS Specialist involved with the family before the death failed to "register a report with the SCR after learning of new allegations of maltreatment of the now deceased infant by the mother" in violation of the state's Mandated Reporter Law.[28] According to OCFS, ACS must meet with staff involved in this fatality investigation to discuss this mistake.

7. **Legal Consultation** – *Case Number 95-05-027* – In its review of the death of a three-month-old female infant due to suspected improper sleeping position while residing with her teenage mother in the mother's kinship foster care home on April 27, 2005, OCFS found that ACS "had appropriately opposed the children's placement with the maternal relative but did not return to court to alert the judge of the 9/23/05 SCR report and the children's accounts of the foster mother's actions. ACS should have sought legal advice and returned to Family Court to express their concerns regarding the safety of the surviving siblings."

8. **Casework** – *Case Number 95-05-029* – In its review of the death of a two-year-old male child due to a car accident on June 5, 2005, OCFS found that ACS "did not closely follow up with (the) parents or maintain close casework contact. There were significant gaps in the contacts with the family and with collateral sources. ACS must address with Specialists the need to maintain ongoing contact with the family and document the scope of these contacts in the progress notes."

[28] NYS Social Services Law §415.