



The City of New York
Department of Investigation

ROSE GILL HEARN
COMMISSIONER

80 MAIDEN LANE
NEW YORK, NY 10038
212-825-5900

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DOI CONTACT: DIANE STRUZZI
(212) 825-5931

ACS CONTACT: SHARMAN STEIN
(212) 341-0999

DOI EXAMINATION OF ELEVEN CHILD FATALITIES AND ONE NEAR FATALITY FINDS SERIOUS DEFICIENCIES IN HOW THE CITY'S CHILD WELFARE AGENCY CONDUCTED INVESTIGATIONS
--DOI's principal recommendation: Hire more skilled investigators as consultants who can assist front-line caseworkers get the facts in abuse and neglect investigations--

ROSE GILL HEARN, Commissioner of the New York City Department of Investigation (DOI), and JOHN B. MATTINGLY, Commissioner of the New York City Administration for Children's Services (ACS) issued a Joint Report today that examined how ACS investigated abuse and neglect allegations in connection with cases that led to the deaths of 11 children, and one near fatality, between October 2005 and July 2006. In each of these cases, the parents were either under investigation by ACS for abuse or neglect or had been the subjects of completed ACS investigations. After an exhaustive 18-month investigation, DOI found that in all but one of the cases the investigations conducted by ACS were substantially inadequate and incomplete, according to the Report. DOI's principal recommendation is an innovative approach in child welfare reform that will add 100 skilled investigators as consultants who will strengthen the critical investigative skills that are needed to help the most vulnerable New Yorkers. The recommendation calls on these investigators to work hand-in-hand with caseworkers and supervisors and to assist them directly in the field.

Mayor Michael R. Bloomberg asked DOI to conduct this external, independent review as one of a number of initiatives aimed at strengthening ACS after the tragedy of Nixzmary Brown's death. In the past 18 months, ACS has implemented several initiatives, including assigning a Safety Solutions Team to each borough to improve the quality of case practices and managerial skills; hiring and training close to 800 child protective caseworkers; hiring 20 former law enforcement officers to provide consultation and support to caseworkers in connection with investigations; and instituting ChildStat, modeled on the NYPD's CompStat, to provide increased case guidance and supervision from senior managers.

The Joint Report describes in detail the investigative failures DOI found and outlines 26 recommendations pertaining chiefly to ACS' investigative practices, which DOI believes will strengthen ACS' investigations of child abuse and neglect reports, and assist ACS caseworkers in the difficult and complicated job of protecting children and families at risk. DOI's principal recommendation focuses on the need for ACS to significantly improve its investigatory capacity and calls on ACS to undertake a pilot program and hire 100 additional experienced investigators skilled in conducting probing, revealing investigations. As part of the initial set of reforms launched months after Nixmary Brown's death, ACS brought onto staff 20 former law enforcement investigators, including retired Special Victims Division detectives to act as consultants to ACS caseworkers. By expanding their presence by 500 percent, DOI recommends that ACS incorporate these experienced investigators into its workforce as consultants to assist in the training of front-line child protective staff, to go out into the field with caseworkers on more serious investigations, and otherwise act as a much-needed resource during serious child abuse and neglect investigations.

As part of its investigation, DOI also reviewed the history of child death cases in New York City under circumstances where the abuse or neglect was repeated and had been brought to the attention of officials. For over a century in the wake of such high-profile child abuse cases, the response had been to form task forces, issue reports, and the City often overhauled the child welfare agency. This is significant, since most of the investigative work examined as part of this Report reflects precisely the same investigative failures that were found in those previous cases.

DOI Commissioner Rose Gill Hearn said, "The examination by DOI of each of the child deaths was tragic and frustrating because there were so many investigative steps not taken, many questions not asked, witnesses and documents not sought. This Report makes many recommendations pertaining to the way ACS conducts investigations that DOI believes are crucial to ACS' ability to better protect children in abuse and neglect cases. Chief among them is that ACS hire more skilled investigators who know how to probe and get at the facts. History has shown us that opportunities will continue to be missed during child abuse and neglect investigations if ACS does not infuse its ranks with seasoned investigators who will assist ACS in getting the facts with which to make risk assessments. I think that if the investigations improve such that one child at risk is identified because of that improvement, it is worth it. I commend Mayor Bloomberg for tasking us with this review and I thank Commissioner Mattingly for his cooperation and assistance."

ACS Commissioner John Mattingly said, "This report is a big step forward in strengthening our ongoing reforms to improve child protective investigations. The recommendation to hire 100 more experienced law enforcement consultants will mean that many more of our caseworkers will get the support, guidance and training they need to conduct thorough investigations. This report calls for tough action on our part in order to do everything possible to protect children. That is what the Mayor wants, that is what our City expects and that is what I expect."

DOI began its examination after Mayor Bloomberg and Commissioner Mattingly requested that DOI examine ACS' investigations in cases where children had died or were almost killed. As a result, DOI examined ACS' investigations of child abuse or neglect allegations with respect to the following families, which resulted in eleven child deaths and one near death between late October 2005 and July 2006:

1. **Sierra Roberts:** On October 25, 2005 the seven-year-old girl was beaten to death. Her father has pleaded guilty to manslaughter in connection with her death.
2. **Dahquay Gillians:** On November 6, 2005 the 16-month-old drowned in the bathtub of his apartment. His mother has pleaded guilty to criminally negligent homicide and reckless endangerment in connection with his death.

3. **Jocelyn Collazo, Richard Laboy, Christian Gaston:** On December 6, 2005, these three children – Jocelyn, 18-months-old; Richard, 6, and Christian, 5 -- died in a fire in the illegal cellar apartment where they were living with their mother, Jennifer Gaston. Before the fire, Gaston had been the subject of repeated Reports that her children were abused and living in neglectful conditions in that apartment.
4. **Jozyah Bunch:** On December 28, 2005, the one-year-old boy was found beaten to death in his apartment. His mother was later charged with murder and manslaughter in connection with his death.
5. **Jaylee Logan:** On January 7, 2006, the two-month-old girl died of natural causes. Jaylee's mother was a 19-year-old single mother who was also the guardian of her two teenage sisters and the mother of Jaylee's twin brother. Jaylee's family had been receiving preventive services through ACS as far back as July 1999.
6. **Nixzmary Brown:** On January 11, 2006, the seven-year-old was found beaten to death in her Brooklyn apartment. Her mother and stepfather face murder charges in connection with her death. ACS received repeated reports that Nixzmary and her siblings were being abused and neglected.
7. **Michael Segarra:** On January 11, 2006, the two-month-old boy was found dead in his crib. It was determined he died of natural causes. However, Michael had tested positive for cocaine at birth and ACS received repeated Reports that his mother was using drugs in her older son's presence and neglecting him.
8. **Lizabeth Gonzalez:** On January 24, 2006, the five-month-old girl nearly drowned in a bathtub at her home. Her mother pleaded guilty to reckless endangerment in connection with the incident.
9. **Quachaun Brown:** On January 30, 2006, the four-year-old boy was found beaten to death in his apartment. His mother pleaded guilty to manslaughter in connection with his death and was sentenced to 2½ years in prison. Her boyfriend, who is charged with murder, is awaiting trial.
10. **Sharllene Morillo:** On July 28, 2006, the two-year-old girl died from head injuries. Her mother's boyfriend has been charged with murder and is awaiting trial. Although her death came six months after ACS announced various reforms, DOI found ACS' investigation of the allegations reflected many of the same failures DOI observed in its earlier examinations.

DOI's investigation of these cases was exhaustive consisting of interviewing approximately 146 individuals including ACS employees, witnesses including neighbors and friends of the families under investigation, members of the New York City Police Department (NYPD), the New York City Fire Department (FDNY) and the New York City Department of Education (DOE) as well as medical personnel. DOI also reviewed numerous records from ACS, medical reports, reports from the Office of the Chief Medical Examiner (OCME) and records from the NYPD, FDNY and DOE.

DOI's Report found substantial inadequacies in ACS' policies and procedures for investigating and responding to allegations of child abuse and neglect; revealed serious problems in the quality and integrity of the investigations conducted by ACS staff in all but one of the families examined and revealed that ACS staff often conducted careless, incomplete investigations of serious abuse allegations. Additional findings described in the Report include:

- Caseworkers routinely made conclusive determinations concerning abuse and/or neglect allegations based principally, or even exclusively, on the parents' denial of the allegations.
- ACS staff closed cases with what is known as an "unfounded" determination either prematurely or even after their investigations had substantiated the allegations, and where unstable, potentially deadly situations remained unresolved in the homes.
- Caseworkers repeatedly failed to obtain critical documents, such as school and medical records.
- ACS staff failed to take advantage of the many legal remedies available to them when their investigations were frustrated by uncooperative parents or other adults living in these households.
- ACS staff failed to monitor parents' participation in treatment programs after their investigations revealed that these parents were in desperate need of counseling or other services, such as substance abuse treatment programs or domestic violence counseling.
- ACS staff regularly documented their investigative findings long after the fact. A troubling finding involved two ACS staff members who made false entries in ACS records after the death of a child to make it appear as if they had taken certain investigatory steps or provided supervisory oversight, when they had not.
- Few front-line caseworkers had prior investigatory experience or training, yet they were expected to conduct difficult investigations involving highly sensitive and provocative criminal allegations.
- Caseworkers carried significant caseloads, often as high as 20 cases per worker.
- Serious failures in managerial oversight and most supervisors lacked any substantive investigatory experience or training.
- Supervisors repeatedly approved case closings when the caseworkers had not conducted complete investigations and when caseworkers had failed to complete most of the investigative steps identified as necessary by their supervisors.

The Mayor's Interagency Task Force on Child Welfare and Safety, which Mayor Bloomberg convened in late January 2006 and which is comprised of representatives from ACS, the Department of Education, the New York Police Department, the Department of Investigation, Health and Hospitals Corporation, and the Department for Homeless Services, has also implemented over 80 initiatives, including establishing 1400 educational liaisons, one in every public school to help facilitate communication on all matters concerning child abuse and neglect investigations to ACS; establishing electronic student absence alerts; imposing more stringent timeframes and supervision of the Department of Education's investigations of student absences; establishing Child Safety Coordinators at every New York City hospital to strengthen interagency coordination in child abuse cases; launching an unprecedented citywide abuse and neglect training for medical staff in both public and private hospitals; and providing training to thousands of medical personnel and child care providers regarding their obligations as mandated reporters.

The Report also explains that ACS has made significant progress and instituted a number of reforms over the past 18 months. Those reforms include:

- ACS has implemented Childstat, a new accountability tool for the assessment and strengthening of child welfare case practice and safety decision-making. Childstat, launched by ACS in June 2006 and inspired by the NYPD's renowned Compstat process, is a weekly, morning-long session during which child protective leaders from each of the City's 14 geographic zones meet on a rotating basis

with top ACS officials to conduct an extensive data and active case review. Practice and performance issues identified at Childstat are addressed at the meeting and are monitored afterward to ensure improvement and accountability.

- ACS one year ago opened the Safety First Office to handle calls from employees of City agencies and foster care and preventive service agencies to make sure critical safety concerns get to child protective caseworkers without delay, and improve collaboration with mandated reporters. The Safety First Office has handled in excess of 3,100 calls.
- ACS has restructured management throughout the ACS Division of Child Protection. Janet Flory, the former head of Children's Aid Society child welfare and delinquency programs, has been named Deputy Commissioner for Child Protection. Additionally, in January 2006, the overall management structure of the division was improved to strengthen administrative support to the field offices and provide greater accountability. A new Associate Commissioner for Child Protection was appointed in January – Gilbert Taylor. Four of seven Child Protective Borough Field Office heads have been elevated to the position of Assistant Commissioner. In addition, 25 new child protective managers have been hired, decreasing the span of responsibility of each manager to provide better oversight of child protective investigations.
- ACS has hired almost 800 additional child protective caseworkers since January 2006. ACS now has over 1200 child protective caseworkers on staff.
- Caseload averages have declined to 11 cases per specialist, down from an average of 21 in March 2006.
- The NYPD has created a dedicated phone number staffed at Police Headquarters to accommodate ACS requests for law enforcement assistance. Since this 24-hour, 7-days a week hotline was established in June 2006, Instant Response Team cases are now handled via the central intake desk, eliminating the need for child protective workers to go to police precincts to get assistance and increasing efficiency.
- The New York City Leadership Academy for Child Safety has been created, and the first class is currently in training. The Academy is designed to offer training and activities for child protective managers.
- ACS has implemented new regulations that clearly mandate child protective specialists seek entry orders when they are denied access to the residence of a child suspected to be at risk. From January through September 2006, 59 entry orders were sought, compared to requests for 14 entry orders in all of 2005.

DOI applauds ACS for the significant progress in identifying problems and proposing solutions. The Report also indicates that much more remains to be accomplished. To that end, DOI believes the following recommendations will allow ACS to move forward on improvements, including:

- **Principal Recommendation – Hire an Additional 100 Investigative Consultants to Work with Caseworkers and Supervisors on Investigations:**
 - DOI found that investigations conducted by ACS caseworkers of potentially deadly abuse and neglect allegations are wholly inadequate and incomplete. This is a result of a number of factors but most significantly it is the result of little or no investigatory experience among the ranks of the child protective staff.

- Hire 100 Investigative Consultants with prior investigative experience to assist front-line child protective staff. These consultants will be available to go into the field with existing caseworkers so these caseworkers can share the benefit of the seasoned investigator's prior experience and training. They should be deployed in the areas that experience the highest number of serious abuse and neglect Reports.
- The agency can draw from a large pool of retired law enforcement personnel that would be interested in the job, including retired detectives from the NYPD, the Drug Enforcement Agency, the Federal Bureau of Investigation, the Postal Inspection Service and the Bureau of Alcohol, Tobacco and Firearms.
- DOI is not suggesting that ACS become a law enforcement agency, or that these investigators carry weapons or have the power to arrest or execute search warrants. This recommendation is based solely on the fact that caseworkers are often required to conduct investigations that are criminal in nature and that these allegations will be more effectively investigated by individuals with prior law enforcement experience.
- DOI believes these seasoned investigators will enable ACS to "get the facts" about what is going on in a home under investigation. Learning the true circumstances in the homes under investigation will allow ACS to make more intelligent and informed decisions and better protect children.

➤ **Better Investigations:**

- Supervisors should hold case reviews with caseworkers at regular intervals to offer guidance and direction.
- Supervisors must never sacrifice a thorough investigation simply for the sake of meeting the legal requirement that investigations be completed within 60 days.
- ACS staff should receive refresher training on classifying cases as "indicated" or "unfounded," since DOI found those definitions were regularly ignored when closing cases.

➤ **Documenting Investigative Steps:**

- Develop procedures governing the creation and preservation of note taking in the field by caseworkers.
- ACS should set deadlines when caseworkers must obtain and evaluate medical records.
- ACS needs to make the appropriate referral for treatment immediately, have the parent sign a consent form permitting the program to disclose the details of the parent's participation and records should be included in the case file. Caseworkers also must be required to monitor the parent's participation.
- Remind caseworkers of the importance of reviewing the prior ACS history of the subject of a hotline Report.

➤ **Investigative Aids for Caseworkers:**

- DOI strongly supports a law that would make the assault of a caseworker a felony.
- DOI supports giving ACS caseworkers direct access to criminal histories of parents and caretakers under investigation provided ACS hires additional staff with law enforcement background.
- Pairing up of caseworkers on high-risk home visits and/or cases is recommended. It serves the safety of the caseworkers involved and the quality of the investigations conducted.

➤ **External Agency Considerations:**

- The New York City Department of Education must maintain appropriate oversight of tracking student attendance.
- DOI strongly recommends all calls to the State Central Register (SCR) hotline, which receives Reports of suspected child abuse and neglect throughout New York State, be recorded in a similar manner to “911” calls.

The Report states that DOI believes a child welfare agency needs two types of expertise – one brought by the trained social worker to assist a family and the second brought by a seasoned investigator who can ask the probing questions and “get the facts.” DOI has discussed its findings and recommendations with Commissioner Mattingly and his staff and looks forward to working with them in continuing to review ACS’ ongoing reform effort.

Commissioner Gill Hearn thanks ACS Commissioner Mattingly and his staff for their cooperation and support during the course of the investigation and their openness to attempt novel reform efforts aimed at better protecting the children of New York City. The Commissioner also commended Mayor Bloomberg for his focus on this issue and his support of this examination.

Commissioner Gill Hearn would also like to thank Special Commissioner Richard Condon and Gerry Conroy for their invaluable contribution to the investigation and the preparation of the Report.

Commissioner Gill Hearn also thanks the team within DOI for their dedication and hard work on this Report, including Kim A. Berger, Richard Sullivan, Julie Block, Benjamin Defibaugh, Rebecca Holland, Jennifer Fiellman, Inna Spector, Margaret Shivers, Jose Ramos, Joseph Caputo, Anthony Capek, Crissy DeAngelo, Eugenia Wells, William Holland, Jayme Naberezny, Pearse Conlon, Julie Divita, Michael Siller and Helen Kashimer.

Commissioner Mattingly thanks the thousands of ACS staff, many working long into the night and on the weekends, who work so hard to protect the most vulnerable of our City’s children.

Get the worms out of the Big Apple. To Report someone ripping off the city, call DOI at (212) 825-5959.



**A DEPARTMENT OF INVESTIGATION
EXAMINATION OF ELEVEN CHILD FATALITIES
AND ONE NEAR FATALITY**

A JOINT REPORT BY

**NEW YORK CITY DEPARTMENT OF INVESTIGATION
ROSE GILL HEARN
COMMISSIONER**

**ADMINISTRATION FOR CHILDREN'S SERVICES
JOHN B. MATTINGLY
COMMISSIONER**

August 2007

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Commissioner Gill Hearn would also like to thank Special Commissioner Richard Condon and Gerry Conroy for their invaluable contribution to the investigation and the preparation of this Report.

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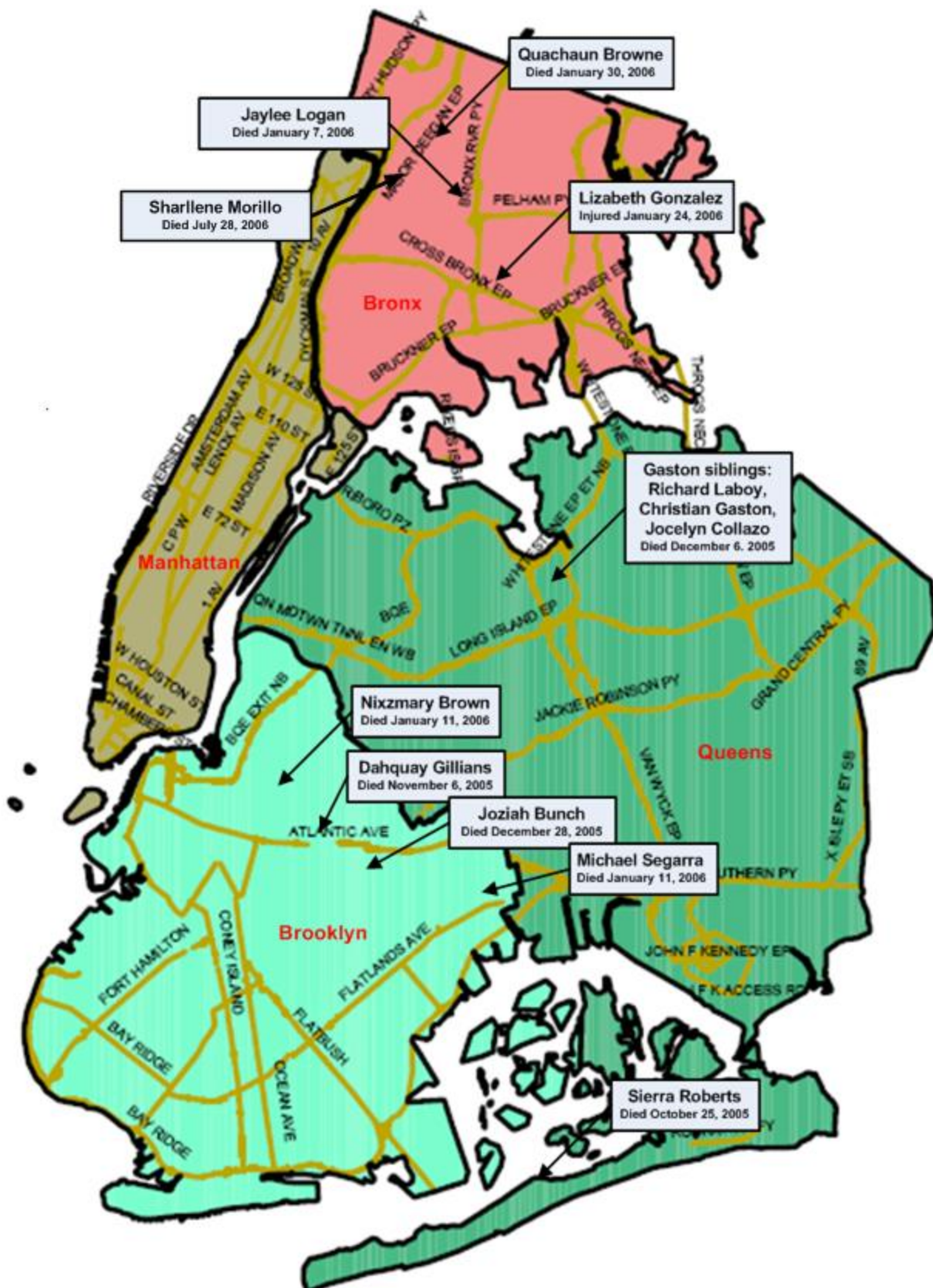
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Quachaun Browne
Died January 30, 2006

Jaylee Logan
Died January 7, 2006

Sharllene Morillo
Died July 28, 2006

Lizabeth Gonzalez
Injured January 24, 2006

Gaston siblings:
Richard Laboy,
Christian Gaston,
Jocelyn Collazo
Died December 6, 2005

Nixzmary Brown
Died January 11, 2006

Dahquay Gillians
Died November 6, 2005

Joziah Bunch
Died December 28, 2005

Michael Segarra
Died January 11, 2006

Sierra Roberts
Died October 25, 2005

Executive Summary of DOI's Investigation and Findings

ACS is the City agency responsible for investigating allegations of child abuse and neglect. Between late October 2005 and July 2006, eleven children died and one nearly drowned while their parents were under investigation by ACS for abuse or neglect, or after ACS had completed investigations concerning their parents. In all but one of these cases, DOI has found that the investigations conducted by ACS were substantially inadequate and incomplete.

The following are the cases DOI studied:

- On October 25, 2005, seven-year-old Sierra Roberts was beaten to death.¹ Her father has pled guilty to manslaughter in connection with her death.
- On November 6, 2005, 16-month-old Dahquay Gillians drowned in the bathtub of his apartment. His mother has pled guilty to criminally negligent homicide and reckless endangerment in connection with his death.
- On December 6, 2005, three siblings ranging in age from 18 months to six years old (Jocelyn Collazo, Richard Laboy, Christian Gaston), died in a fire that swept through the illegal cellar apartment where they were residing with their mother, Jennifer Gaston, who before the fire had been the subject of repeated reports that her children were abused and living in neglectful conditions in that apartment.
- On December 28, 2005, one-year-old Joziah Bunch was found beaten to death in his apartment. His mother was later charged with murder and manslaughter in connection with his death.
- On January 7, 2006, two-month old Jaylee Logan died. Her death was determined to be the result of natural causes. At the time of Jaylee's death, Jaylee's mother was a 19 year-old single mother who was also the mother of Jaylee's twin two-month old brother, a 19-month-old girl, as well as the legal guardian of her two teenage sisters both of whom were in therapy for mental health issues. Jaylee's family had been receiving preventive services through ACS as far back as July 1999.
- On January 11, 2006, seven-year-old Nixzmary Brown was found beaten to death in her Brooklyn apartment. New York City's Office of the Chief Medical Examiner ("OCME") concluded that she died as a result of a blow to her head. Prosecutors have charged both her mother and her stepfather with murder in connection with her death. Nixzmary's stepfather was also charged with sexually abusing Nixzmary, and unlawfully imprisoning her. In the year before Nixzmary's death, ACS had received repeated reports that Nixzmary and her siblings were being abused and neglected. Nixzmary's death received the greatest amount of public attention last year.
- On January 11, 2006, two-month-old Michael Segarra was found dead in his crib. His death was also determined to be the result of natural causes. However, Michael had tested positive for cocaine at birth, and

¹ Pursuant to Section 372 of the New York State Social Services Law, records maintained by ACS are confidential. As a result, names of parents and children are used in this report only when their names and the details of their cases were previously reported in the media.

ACS had received repeated reports dating back to 1999 alleging that his mother was using drugs in her older son's presence and was otherwise neglecting him.

- On January 24, 2006, five-month-old Lizabeth Gonzalez nearly drowned in a bathtub at her home. Her mother pled guilty to reckless endangerment in connection with that incident. ACS had received a report about and had opened a case relating to Gonzalez's mother shortly after the child was born.
- On January 30, 2006, four-year-old Quachaun Browne was found beaten to death in his apartment. His mother and his mother's 19 year-old boyfriend were charged with manslaughter and murder, respectively, in connection with his death. Quachaun's mother pled guilty to manslaughter in the first degree in connection with his death and has been sentenced to two and a half years in prison. Her boyfriend still awaits trial.
- On July 28, 2006, Sharllene Morillo died from head injuries. Her mother's boyfriend, Paul Jiminez, was charged with Sharllene's murder. ACS had been alerted to each of these ten families prior to these deaths. (See, Map *supra*, indicating where in the City's boroughs these deaths took place.)

In late January 2006, in the wake of widespread concern regarding the ability of ACS to properly investigate and respond to abuse allegations, Mayor Michael R. Bloomberg announced a series of initiatives to address these concerns, including the creation of a Family Services Coordinator, an Interagency Task Force, and an additional infusion of \$16 million for additional staff and training. Mayor Bloomberg also directed ACS to conduct a critical review of all its open cases, and requested that DOI examine ACS' investigations in cases where children had died or were almost killed.

In January 2006, ACS began taking disciplinary action with respect to employees who had various responsibilities for investigations relating to the nine subject families. Ultimately, ACS terminated or took other disciplinary action with respect to fourteen ACS employees. Moreover, in March 2006, ACS Commissioner John B. Mattingly issued a report entitled *Safeguarding Our Children: 2006 Action Plan*, which outlined the problem areas that ACS had identified and what they planned to do to address those problematic practices to better protect New York City's children. In November 2006, Commissioner Mattingly issued a report entitled *Safeguarding Our Children: Safety Reforms Update* that provided a status report on the reforms outlined in the March report. Notably, that report announced that the agency intended to hire a number of experienced law enforcement officers to act as investigatory consultants to its caseworkers. On February 1, 2007, ACS announced to its staff that 20 former law enforcement officers had been hired and were available for consultation. At this time, two of those consultants have since left ACS.

On February 27, 2007, Mayor Bloomberg and Commissioner Mattingly presided over the graduation of 230 new Child Protective Services caseworkers, bringing the total number of frontline caseworkers to 1,310. At the graduation ceremony, Mayor Bloomberg urged state legislators to give ACS caseworkers the ability to conduct criminal history checks of the adults living in households where credible allegations of abuse have been reported. Mayor Bloomberg also announced that he intended to lobby state legislators to make the assault of a caseworker a felony, a protection already

enjoyed by police officers, teachers, and transit workers. As more fully discussed below, the findings in this investigation demonstrate those statutory changes would be of great assistance to ACS in investigating children living in dangerous environments.

In January 2006, Commissioner Mattingly also asked DOI to conduct an investigation into the practices of ACS to determine if there was any sanctionable wrongdoing by ACS staff with respect to any of the fatalities, and to make recommendations as to how the agency's practices could be improved upon to prevent child fatalities from happening in the future. This report is the result of an 18 month probe of the investigatory practices of ACS and the investigations conducted by ACS in connection with the nine subject families. As part of this investigation, DOI investigators reviewed all available ACS records concerning the families of the deceased or injured children, including all past and current ACS investigations of these families, as well as records maintained by various organizations with which ACS had contracted for foster care and other services. DOI also reviewed records maintained by the Department of Education ("DOE"), medical records, reports from the OCME, telephone records and records maintained by the New York City Police and Fire Departments ("NYPD" and "FDNY"). In addition, DOI interviewed approximately 146 individuals, including relevant ACS employees and the staff of foster care and other agencies that provided services to these families through ACS, members of the NYPD and the FDNY, medical personnel, members of Office of Children and Family Services regarding the CONNECTIONS case-tracking system ACS is required to use, neighbors and friends of the families under investigation, and individuals who had reported suspicions of abuse and/or neglect.

Given the unique perspective of DOE staff to observe both the children and parents of the subject families, the Special Commissioner of Investigation for the New York City School District ("SCI") participated in this investigation, and, in the case of Nixzmary Brown, examined the policies and procedures of her school region for dealing with suspicions of abuse. SCI also considered whether school officials acted in accordance with those procedures in the case of Nixzmary's family. Toward that end, SCI investigators interviewed approximately 35 witnesses and helped review documents obtained during the course of the investigation. The findings and recommendations of SCI's review are incorporated into this report.

Moreover, this year DOI attended several Childstat sessions at ACS to see how the agency is now monitoring case work and holding workers accountable.

Finally, DOI examined the history of ACS and its many predecessor entities beginning with the first reported case of child abuse in the late 1800s and the scores of reported child fatalities that followed over the next hundred and forty years culminating in the death of Nixzmary Brown and the other children discussed in this Report. DOI also reviewed numerous reports written by a variety of investigatory agencies over the course of the last thirty years analyzing and critiquing the child protective investigations conducted by ACS and its predecessor entities. Further, DOI reviewed the court files of a litigation commenced by a child advocate's group in December 1995 which sought, among other things, to place ACS into receivership based on its allegedly poor case practices. Lastly, DOI researched the child welfare agencies in other states to see how they handle investigations of serious child abuse and found similar failed investigations that led to tragedies. We also found one state that has reported improvement in this area following several high-profile tragedies because, among other things, they decided

to hire experienced investigators at their frontline case level, and that state is now providing training to other jurisdictions on this issue.

Based upon this extensive investigation, DOI has found substantial inadequacies in ACS' policies and procedures for investigating and responding to allegations of child abuse and neglect. In addition, DOI's investigation has revealed grave problems in the quality and integrity of the investigations conducted by ACS staff in eight of the nine families at issue. To begin with, DOI's investigation revealed that ACS staff often conducted careless, incomplete investigations of serious abuse allegations. Caseworkers routinely made conclusive determinations concerning abuse and/or neglect allegations based principally, or even exclusively, on the parents' denial of the allegations. In many cases, rather than attempting to interview individuals who would likely have had relevant or corroborative information concerning the allegations, such as teachers, police officers, and individuals who had reported observing the events, injuries or conditions alleged, ACS simply closed their investigations concluding that there was no credible evidence to support the allegations. In other cases, ACS staff closed cases with what is known as an "unfounded" determination either prematurely or even after their investigations had substantiated the allegations, and where unstable, potentially deadly situations remained unresolved in the homes. Caseworkers repeatedly failed to obtain critical documents, such as school and medical records, which would likely have contained probative information about the allegations.

DOI also determined that ACS staff failed to take advantage of the many legal remedies available to them when their investigations were frustrated by uncooperative parents or other adults living in these households. Further, DOI's investigation revealed that ACS staff failed to monitor parents' participation in treatment programs after their investigations had revealed that these parents were in desperate need of counseling or other services, such as substance abuse treatment programs or domestic violence counseling. In some cases, enrollment in such a program was the basis for ACS determining that no further action needed to be taken for the child who was the subject of an abuse or neglect case, only to learn that the parent never enrolled in the program and no follow-up by ACS took place that would have readily discovered that. The investigation also revealed that ACS staff regularly documented their investigative findings long after the fact. A particularly troubling finding involved two ACS staff members who made false entries in ACS records after the death of a child, to make it appear as if they had taken certain investigatory steps or provided supervisory oversight, when in fact they had not.

DOI's investigation also revealed that very few frontline caseworkers had prior investigatory experience or training, yet they were expected to conduct difficult investigations involving highly sensitive and provocative criminal allegations. Additionally, caseworkers were routinely sent into the field alone to interview parents concerning abuse and neglect allegations. In several cases that DOI reviewed, the accused parents had prior criminal records involving violent felonies, including criminal weapons charges. In other cases, the parents had serious substance abuse issues. Yet caseworkers were sent into the field alone, unarmed, and in most cases, were not even provided with a cellphone. Caseworkers were also carrying significant caseloads. Further, caseworkers without the necessary language skills were often assigned to investigate allegations involving parents and children who spoke little or no English.

Finally, DOI's investigation revealed serious failures of managerial oversight within ACS. Most supervisors similarly lacked any substantive investigatory experience or training. Supervisors often failed to offer meaningful guidance to caseworkers, but instead repeatedly emphasized the need to close cases within the state-mandated 60-day period at the expense of a thorough and thoughtful investigation of the allegations. Virtually every case file examined by DOI revealed that supervisors repeatedly approved case closings when the caseworkers had obviously not conducted complete investigations, and in many instances, where caseworkers had failed to complete most, if not all of the investigative steps identified as necessary by their supervisors.

That being said, DOI's investigation has revealed that ACS has made considerable progress identifying the problems brought to light by the deaths of these children. In addition, the work of the Mayor's Interagency Task Force has helped the agency identify and begin to address difficult issues. Although ACS has made significant progress identifying problems and proposing solutions, much remains to be done.

In mid-June 2006, almost five months to the day of Nixzmary Brown's death, ACS received an anonymous report that two-year-old Sharllene Morillo was being physically abused by her mother's boyfriend, Paul Jimenez. In late July, while ACS was still investigating these allegations, Sharllene died from a brain hemorrhage. Jimenez has been charged with murder in connection with Sharllene's death. DOI's review of the investigation conducted by ACS in the Morillo case revealed many of the same shortfalls identified in the other investigations reviewed by DOI. Here again, the investigation was far from thorough or complete. Obvious witnesses were never interviewed, and the assigned caseworker made no effort to obtain medical records or consult with Sharllene's pediatrician. Interviews and other significant events were recorded in ACS' on-line case tracking system long after they occurred, and the investigation lacked any meaningful supervisory oversight. Language barriers also continued to be a significant problem. In fact, in this investigation, the caseworker actually interviewed Sharllene's mother in front of Jimenez (who was accused of abusing Sharllene) with Jimenez himself helping to translate between the caseworker and Sharllene's mother. This crucial interview was conducted in this manner despite the fact that ACS had already begun offering its caseworkers interpreter services by telephone. The caseworker assigned to the Morillo investigation told DOI investigators that she was unaware that this new service was available.

DOI's full set of policy and procedure recommendations are set forth in detail below. They call for a significant change in the way in which the agency and its caseworkers should approach investigations involving serious abuse and neglect allegations. ACS must initially approach these investigations as a trained investigator would approach a criminal investigation. In the event that the initial investigation determines that no child is in immediate danger of serious harm, then the agency should turn its focus to providing the family with valuable social services. In short, this recommendation calls for ACS to hire an additional 100 investigative consultants with prior law enforcement or investigative experience to assist frontline caseworkers and their supervisors with collecting the facts with which to make risk assessments. DOI believes this recommendation is vital to achieve true reform in the quality and effectiveness of the investigations conducted by ACS.

DOI's review of the history of ACS and its predecessor entities revealed a disturbing pattern going back over a century where the report of a horrific child death would generate public outrage and criticism of the City's child welfare agency. The criticism has remained remarkably consistent over many decades and invariably focuses on the poor investigatory practices of untrained caseworkers burdened with heavy caseloads. This criticism is often followed by a name change of the agency responsible for child welfare and promises of reform by that agency, including that caseworkers will receive more and better training on how to conduct investigations and that caseloads will be reduced. DOI urges this Administration to put an end to this cycle and finally equip ACS with skilled investigators who have the training and experience to consult with and assist caseworkers and their supervisors with investigations of serious criminal allegations. Although ACS has taken a positive step in this direction by hiring 20 former NYPD detectives to act as investigative consultants for their caseworkers, it is simply unrealistic to expect that these 20 consultants can possibly train over 1,300 caseworkers to become effective investigators and assist them with the thousands of cases they collectively face. In addition, during critiques of on-going cases in a July 2007 Childstat, Commissioner Mattingly had to remind case supervisors to contact those investigative consultants when they were experiencing delay or obstacles in investigations. Moreover, the ACS executives emphasized that in responding to allegations of abuse or neglect, the initial focal point for the caseworker must first be to get the facts so that potential risk can be assessed; then if services are needed that too can be addressed. Thus, DOI urges ACS add a cadre of 100 investigators with former investigative experience to serve as investigative consultants to caseworkers and supervisors, to assist with investigations, advise and follow-up on appropriate investigative steps, and to go into the field with caseworkers periodically for training purposes.

This report is organized as follows: Section I presents an overview of the legal framework within which ACS is responsible for protecting the welfare of New York City's children. This section also describes ACS' organizational structure and certain relevant policies and practices. Section II provides summaries of the investigations conducted by ACS of the nine families at issue. Section III sets forth DOI's findings as well as the findings of SCI's review. Section IV describes the corrective actions taken by Mayor Bloomberg and ACS following the deaths of these children. Finally, Section V outlines DOI's policy and procedure recommendations.

I. CHILD PROTECTIVE SERVICES

A. The Legal Framework

The New York State Social Services Law requires that each county establish a child protective service to “swiftly and completely” investigate reports of child abuse and maltreatment, to protect children from further abuse or injury, and to provide rehabilitative services for affected children and parents.² ACS is the agency responsible for providing these services to the children and parents of New York City. Reports of suspected child abuse and neglect throughout New York State are received by a hotline maintained by the New York State Office of Children and Family Services (“OCFS”), which is known as the State Central Register (the “SCR hotline”). OCFS then routes these reports to the appropriate local child welfare agency for investigation and response. Reports regarding children in New York City are routed to ACS.

Calls to the SCR hotline are taken by child protective specialists, who are responsible for determining whether the allegations provided by the caller sets forth reasonable cause to believe that a child is being abused or neglected. Calls to the hotline will generate a referral to a local child protective agency where the specialist determines that the caller has demonstrated reasonable cause, and the caller provides sufficient information to identify and locate the child or parents in question. Allegations of neglect may also include educational neglect, for example, where a caller reports that a child has been repeatedly absent from school without an adequate explanation.

Calls to the hotline are not recorded, and callers may ask to remain anonymous. The specialists do not attempt to produce verbatim transcripts of the caller’s allegations. Instead, the specialists create summaries of the allegations, known as call narratives, and often intentionally omit precise quotes to protect the anonymity of the caller. The specialists are expected to read back their narratives to allow the caller to clarify or make any necessary corrections. DOI’s investigation revealed that the call narratives tend to be very brief summaries of the caller’s allegations. Few were more than four of five sentences. Additionally, DOI’s investigators noted that the specialists who draft these call narratives often use the same phrases and words to describe the allegations. For example, subject homes were often described as being in “deplorable condition,” and children were often described as being “dirty and unkempt.”

Certain categories of professionals, referred to as “mandated reporters,” are required by law to report suspected abuse or neglect of children. These professionals include, among others, school officials, doctors and other medical personnel, social workers, emergency medical technicians (“EMTs”), law enforcement officials, substance abuse counselors, medical examiners and coroners. Mandated reporters are instructed to report their suspicions to a special hotline number meant only for them. Calls by these mandated reporters are also not recorded, but are summarized in the same manner as calls to the main hotline number. Although they are required by law to report suspicions of child abuse or neglect, mandated reporters may request to remain anonymous. This request for anonymity, however, could subject the caller to liability for failing to report their suspicions or observations. Finally, OCFS does not maintain any record of calls that specialists determine do not warrant a referral to a local child protective agency. In 2005, ACS received over 47,000 referrals from the hotline alleging

² N.Y. Soc. Serv. Law § 411 (McKinney 2003).

child abuse and/or neglect. In 2006, ACS received over 63,000 referrals from the hotline.

New York State regulations set forth the manner in which investigations involving child abuse and neglect must be conducted, including the time in which an investigation must be completed, mandatory elements of investigations, supervisory oversight, and the manner for documenting investigatory steps and findings. These regulations have been incorporated by ACS into the Casework Practice Guide of the Division of Child Protection (the "Practice Guide"). Local child welfare agencies are required to input reports of suspected child abuse and neglect and the progress of their investigations concerning those reports into CONNECTIONS, a computer system maintained by OCFS. If utilized properly, this system allows individual cases to be tracked from intake through the conclusion of the investigation. ACS developed the Case Practice Recording Template ("CPRT") as an additional component to CONNECTIONS, which prompts caseworkers to input a host of information about their investigative steps and other activities. These prompts, if followed, can assist caseworkers in developing a thorough investigative plan and allows for supervisory review and oversight. In addition, supervisory staff can enter instructions into CONNECTIONS to help caseworkers formulate and refine their investigatory plan. In the early stages of an investigation, these instructions, also known as directives, tend to recommend obvious investigatory steps, such as contacting the source of the hotline report, conducting home visits, and obtaining school and medical records. As caseworkers make entries describing what they have learned during the course of their investigation, however, the supervisory directives should become more specific and tailored to the unique circumstances of that particular investigation.

Caseworkers are required to ask a series of questions during their initial interviews of the subject parents to determine if domestic violence is an issue in a household under investigation. These questions are set forth in what is known as a screening tool, and include, among others: Would you describe your partner as jealous or controlling? Has your partner threatened you, or hit you or hurt you? If the interview subject answers yes to any of the questions in the screening tool, caseworkers are instructed to refer to the domestic violence assessment form. This form contains a series of questions about whether the partner has committed acts of physical violence, threatened or intimidated the interview subject, whether children in the household have witnessed violent incidents, and whether the subject physically punishes the children. When appropriate, caseworkers are instructed to ask a series of questions about whether the subject has taken any action to seek help or leave an abusive partner. The form includes suggestions for the caseworker in cases where a parent has acknowledged to being the victim of domestic violence. Caseworkers are also expected to ask whether the parent has prior or current orders of protection against their current or former partners. The form also includes 15 questions to be asked of the "suspected batterer" in an interview separate from the subject and children.

Caseworkers must also determine whether the NYPD has responded to the home in response to complaints of domestic violence and obtain copies of any corresponding domestic violence incident reports ("DIRs") made by the NYPD. In the event that there have been prior incidents of domestic violence in the household, caseworkers are expected to interview other sources with potentially probative information, such as medical and community service providers. Caseworkers must then document their findings in CONNECTIONS and brief their supervisors about the results.

In the event that a caseworker suspects that there is domestic violence in a home under investigation, the caseworker is expected to offer the family supportive services and safety planning. In all investigations, caseworkers are expected to conduct "rolling assessments" by asking questions about physical violence throughout the course of their investigation.

ACS staff have told DOI investigators that caseworkers are expected to ask parents about domestic violence incidents with previous partners. However, DOI's review of the relevant screening tool and domestic violence assessment form revealed that both instruct the caseworkers to ask questions about the current partner, and do not specifically instruct the caseworkers to inquire about past partners.

Pursuant to state regulations, each local child welfare agency must determine within 60 days of a report to the SCR hotline whether an allegation should be "indicated" or "unfounded."³ An "indicated" report of child abuse is defined as one in which "an investigation determines that some credible evidence of the alleged abuse or maltreatment exists."⁴ An "unfounded" report is defined as one in which credible evidence of the allegations is not found. If allegations are determined to be indicated, caseworkers are required to take appropriate action depending upon the circumstances. In cases where children are in immediate danger of serious harm, caseworkers must attempt to remove the children from the home. In less extreme situations, caseworkers are expected to refer the families for various services and/or to participate in programs, such as substance abuse treatment programs and domestic violence counseling. In cases where caseworkers determine that services or counseling are necessary, but the parents reject the offered services or refuse to participate in identified programs, caseworkers can seek judicial intervention compelling the parents' participation. In cases where the parents voluntarily agree to accept the services, or participate in the programs, caseworkers are expected to monitor the provision of those services and the parents' ongoing participation in the programs.

B. ACS' Organizational Structure

The Division of Child Protection ("DCP") within ACS is responsible for investigating and responding to child abuse and neglect allegations, as well as removing children from abusive homes and placing them into foster care. The DCP is comprised of the following units: Child Protective Services ("CPS"), Emergency Children's Services ("ECS"), the Family Services Unit ("FSU"), and the Family Preservation Program ("FPP").

ACS has numerous field offices throughout New York City. In Brooklyn, there are DCP staff members in six field offices. There are DCP staff members in four field offices in the Bronx, and in two offices in Manhattan. Queens also has two offices with DCP staff members, and Staten Island has one office with DCP staff.

Among the various units within the DCP, CPS has the principal responsibility for investigating allegations of child abuse and neglect. By law, CPS must commence an investigation within 24 hours of receiving a report from the SCR hotline, including making face-to-face or telephonic contact with the subjects of the report in this 24 hour period.

³ N.Y. Comp. Codes R. & Regs. 18 § 432.2 (b)(3)(iv).

⁴ N.Y. Soc. Serv. Law § 412 (11) (McKinney 2003).

Within one business day of receiving a hotline report, ACS must review all prior reports of child abuse or neglect involving members of the subject family. This review should include all prior “unfounded” reports where the current report involves a subject of a prior “unfounded” report. Relevant state regulations and the Practice Guide also require caseworkers to contact the source of the SCR report and others who can provide information about whether children may be in immediate danger of serious harm, such as hospital personnel, school officials, law enforcement officers and social service agencies, within 24 hours of receiving the report.⁵

Within seven days of the hotline report, CPS staff must conduct a preliminary safety assessment to determine whether the children in the household are in immediate danger of serious harm and document the findings of the safety assessment in the case file. Additionally, CPS caseworkers are required to make at least two home visits per month to the subject family during the course of the investigation. Caseworkers are expected to obtain pedigree information for all adults living in the household, and to document any changes in the household composition during the course of the investigation.

DOI also learned that when new allegations are received about a family within 30 days of the closing of an investigation involving that same family, the caseworker who was responsible for the investigation of the prior allegations will be assigned to investigate the new allegations. Prior to August 2006, if new allegations were received about a family more than 30 days after the closing of an investigation, but within six months of the closing (the “six-month rule”), the investigation of the new allegations would be assigned to the same unit as the prior investigation, although not necessarily the same caseworker. In August 2006, ACS suspended the six-month rule governing the reassignment of cases. The six-month rule was suspended to address chronic neglect cases that were consistently determined to be “unfounded” by the same unit. By assigning the investigation of any new allegations about the subject family to a new unit, ACS hoped to bring a fresh perspective to the investigation of the new allegations. The practice of assigning cases to the same caseworker when new allegations are received within 30 days of the closing of a prior investigation remains in effect.

Although the CPS units in the field offices have the principal responsibility for investigating abuse and neglect allegations, other units within ACS also play critical roles in these investigations. The ECS unit is responsible for responding to reports alleging abuse and neglect in the evening and on weekends and holidays. After receiving a call, ECS is expected to review all prior reports concerning the family, make initial contacts with the source and depending on the seriousness of the situation may interview relevant witnesses and conduct a home visit. When necessary, ECS may also remove children from their homes on an emergency basis and place them in foster care. After the initial investigation is complete, ECS transfers all cases to CPS on the following business day for further investigation or response.

The FSU, which is also known as the Court Ordered Supervision Unit, receives cases after CPS caseworkers have concluded their investigation, and proceedings have been commenced in court against the parents or caretakers, but where the children remain in the home. FSU principally acts as a source of referrals for a wide variety of

⁵ 18 NYCRR § 432.2 (b)(3)(ii)(b). See also Casework Practice Guide, Third Edition, p. 5.

services for these families, including professional counseling, substance abuse treatment programs, parenting skills classes, homemaking services, and housing assistance. FSU staff is also responsible for ensuring that family members attend these programs, and for monitoring the progress of family members during the course of the court proceedings, and while any court ordered supervision is in effect. FSU can request an extension of the supervisory period if necessary due to risk and safety factors.

FPP is a unit through which ACS provides at-home services, including parenting skills, housekeeping skills, time management skills, job and education search assistance for parents and tutoring for children. FPP caseworkers are referred to as “preservationists,” and carry relatively small caseloads, as little as four cases at a time because they are required to spend five to ten hours per week with each of their assigned families. In addition, these caseworkers must spend between six to eight weeks with each of their assigned families, but may remain involved in a household for up to ten months.

The Office of Contract Agency Case Management (“OCACM”) oversees cases after children have been placed in foster care through various agencies under contract with ACS. Although the foster care agencies have the immediate responsibility for supervising the foster families and conducting home visits, OCACM maintains oversight responsibility and helps plan for the permanent placement of the children.

The Family Court Division of Legal Services (“DLS”) is comprised of attorneys who are responsible for representing ACS’ legal interest in family court proceedings. Attorneys from DLS rotate throughout the various ACS field offices so that caseworkers can discuss potential legal options in difficult investigations involving uncooperative parents. The Practice Guide recommends that caseworkers consult with a DLS attorney within five days of receiving a case involving the death or serious injury of a child, malnutrition, and children who have tested positive at birth for drugs. Where a caseworker has substantiated allegations in what the Practice Guide defines as a “high priority case,” the caseworker is expected to consult with a DLS attorney before closing the investigation.⁶ The Practice Guide also recommends that a caseworker consult with an attorney if the caseworker has been unable to meet with the family within 72 hours of receiving a hotline report, and in “indicated” cases when parents refuse services or are not in compliance with court orders.

In 1998, the Instant Response Team (“IRT”) program was created to allow for a joint response by ACS, the NYPD and the five New York City District Attorney’s Offices in certain select cases involving child abuse and neglect allegations. In these cases, a team comprised of ACS staff, the NYPD and the relevant District Attorney’s Office will respond immediately and conduct a joint investigation. One of the principal goals of this program is to minimize the trauma to the children who are at the heart of these investigations by conducting joint interviews of the children in child-friendly settings, such as Child Advocacy Centers. These joint interviews should minimize the need to conduct repeat interviews of the children. Another key goal of the program is to ensure that

⁶ The Practice Guide defines a “high priority” case as one, among others, involving the death or serious injury of a child, children who have tested positive for drugs at birth, malnutrition, sexual abuse, domestic violence, weapons noted in the report and four or more reports involving the same children or family.

critical evidence is obtained and secured through a coordination of efforts. A Memorandum of Understanding outlines this program and provides that there is to be an IRT Coordinator (“IRTC”) on staff in each ACS field office, as well as in the Office of Confidential Investigations (“OCI”), and in all ECS offices.⁷ The IRTCs are responsible for screening potential cases, and determining whether they should be designated as IRT cases. In the event that a case is designated as an IRT case, the relevant IRTC is responsible for coordinating the investigation and acting as the principal point of contact during the course of the investigation.

A case should be designated as an IRT case if the allegations fall into certain defined criteria. As a general matter, these involve the most serious allegations, including the death of a child, and severe physical and/or sexual abuse. From 2000 through 2005, the percentage of cases that were designated as IRT cases has consistently remained in the range of 5% to 6% of all abuse and neglect cases referred to ACS for investigation and response.

C. ACS’ Policies and Practices

DOI’s investigation revealed a number of troubling practices of the ACS caseworkers and supervisors responsible for investigating abuse and neglect allegations. To begin with, CPS caseworkers were carrying significant caseloads. Two caseworkers interviewed by DOI reported that they were typically investigating as many as 20 cases at any given time. Caseworkers burdened with such large caseloads will no doubt struggle to conduct comprehensive investigations in each case. DOI’s investigation also revealed that caseworkers and supervisors felt pressured to close investigations that were far from complete to satisfy the state-mandated 60-day period in which an investigation must be completed. In many cases DOI reviewed, caseworkers were instructed by their supervisors to close incomplete investigations in CONNECTIONS and then document additional investigatory steps and/or track the progress of the family in separate documents on their individual computers. This practice is very dangerous for a number of reasons. To begin with, caseworkers must make an “unfounded” or an “indicated” determination when closing an investigation in CONNECTIONS. That determination is very significant with respect to the level of ACS’ on-going involvement with the family and will help inform ACS’ response in the event that ACS receives further allegations about the family in the future. In cases where the investigation is not yet complete, this practice forces caseworkers to make an important determination based upon an incomplete understanding of the facts and circumstances in the home. In addition, having caseworkers track cases outside of CONNECTIONS means that caseworkers’ dockets are substantially larger than they appear in ACS’ case tracking system. Finally, there is a significant danger that cases tracked in this informal fashion will simply fall through the cracks. In fact, DOI’s investigation revealed that was often precisely what occurred to these cases; these families simply fell through the cracks.

One of the most troubling discoveries of DOI’s investigation was that caseworkers frequently conducted home visits alone without the benefit of another caseworker to act as a witness to critical witness statements, and to consult with when

⁷ OCI is a unit within ACS responsible for investigating allegations of child abuse and neglect of children in foster care and day care. OCI also investigates allegations of abuse and neglect made against ACS employees.

circumstances demanded that difficult decisions be made immediately. Further, caseworkers were expected to take public transportation to conduct home visits, very often in difficult neighborhoods, at all hours of the day. These caseworkers are typically alone and unarmed when confronting parents previously convicted of violent crimes with sensitive allegations; most caseworkers did not even have cell phones issued by ACS.

In addition to these serious obstacles, none of the caseworkers interviewed by DOI had prior investigatory experience. Not one had the benefit of prior law enforcement experience. And apart from what little was covered in ACS' Training Academy, none had prior training on investigative techniques and strategies or effective interrogation techniques. DOI's investigation revealed that most caseworkers simply read the allegations in the call narrative to the parents and asked whether the allegations were true. In several cases, the caseworker confronted the accused parent by reading the allegations to the parent over the telephone. In addition, caseworkers often confronted the accused parents with the allegations *before* they had interviewed other critical witnesses and gathered information that could be used to test the parent's assertions. Not surprisingly, in almost every case that DOI reviewed, the accused parents denied the allegations and caseworkers were very often ill prepared to challenge these denials.

DOI also learned that there was not a uniform practice among caseworkers with respect to note-taking in the field during the course of an investigation. Currently, ACS does not distribute notebooks to caseworkers to use during home visits or to record the substance of other interviews in order to maintain such notes as part of the case file by the agency. DOI's own experience has repeatedly shown that taking and maintaining contemporaneous field notes can be absolutely critical to the success of an investigation. Instead, each caseworker seems to have developed their own practice for taking (or not taking) contemporaneous notes of interviews or documenting other significant events. To the extent that caseworkers did take contemporaneous notes of interviews conducted in the field, very few maintained copies of these notes. Most field notes were shredded or discarded after the relevant entries were made into CONNECTIONS. Those caseworkers who did not take notes in the field made entries into CONNECTIONS from memory. This poor case practice was made far worse by the fact that many caseworkers made their CONNECTIONS entries long after the events or interviews being described.

II. CASE SUMMARIES

As noted above, during the period from October 25, 2005 through July 2006, eleven children died, and one was nearly killed, while their parents were under investigation by ACS or after ACS had failed to substantiate abuse and/or neglect allegations concerning these parents. The following is a summary of the investigations ACS conducted with respect to those families. It should be noted that the following summaries are an effort to highlight the most salient events and may not include every contact that ACS had with the subject families.

1. Nixzmary Brown

The most publicized of the cases discussed in this Report was the January 11, 2006 death of Nixzmary Brown, who was found beaten to death in her family's apartment in Brooklyn. Nixzmary's stepfather, Cesar Rodriguez, was indicted for murder, manslaughter, unlawful imprisonment, and sexual abuse in connection with her death. Rodriguez was also charged with assault and attempted assault in connection with incidents involving Nixzmary's siblings, J., S., and E. Nixzmary's mother, Nixzaliz Santiago-Rodriguez, was also indicted for murder, manslaughter, assault, unlawful imprisonment, and reckless endangerment in connection with Nixzmary's death. Before Nixzmary's death, Rodriguez and Santiago-Rodriguez were the subjects of two reports to the SCR hotline alleging physical abuse and educational neglect. In addition, ACS received several calls directly from school officials reporting that Nixzmary and her siblings had been absent from school for considerable periods of time.

A. May 2005 Hotline Report

The first SCR report concerning Nixzmary Brown was made on May 16, 2005 by a guidance counselor assigned to P.S. 256, where Nixzmary was enrolled in first grade, who reported that Nixzmary had missed 46 days of school. The report also noted that J., Nixzmary's eight-year-old brother and schoolmate, had told school staff that Nixzmary had burned her hand on a stove, and that she had fallen out of bed, hitting her head and foot. At the time of the guidance counselor's report, there were four other children living in the household, ranging in age from one to eight years old, and Santiago-Rodriguez was seven months pregnant.

According to ACS records, on the same day as the hotline report, an ACS caseworker attempted unsuccessfully to conduct a home visit at the family's apartment. On May 18, the caseworker returned, conducted a home visit and interviewed the family members. This caseworker was Spanish-speaking and conducted these interviews in Spanish because Spanish was the primary language spoken by the family members. The caseworker determined that the home was adequate for the family; there was sufficient food, clothing and sleeping arrangements for the five children. During this visit, the caseworker noticed what appeared to be a healing injury consistent with a burn on Nixzmary's hand. Both Santiago-Rodriguez and Rodriguez denied knowing how the injury had occurred. Santiago-Rodriguez also said that she was unaware that Nixzmary had fallen out of bed. Nixzmary told the caseworker that she had burned herself on the radiator in her bedroom which had been dripping hot water. She also said that she did not remember falling out of bed. Nixzmary's brother, J., told the caseworker the same explanation for Nixzmary's injury, although he had originally told the reporting guidance counselor that Nixzmary had burned her hand on the stove. The caseworker did not

confront J. about his earlier inconsistent statement. The caseworker also noticed that J. had scratches on his face. J. told the caseworker that he had scratched himself running into a tree outside school. Nixzmary's younger brother, E., who was a month away from his sixth birthday, told the caseworker that Nixzmary had burned her hand on the living room radiator. He also said that Nixzmary did not fall out of the bed. The record does not reflect that the caseworker asked Nixzmary or her siblings when she injured her hand, which could have been probative given that the home visit took place in mid-May when the radiator should not have been working.

During this home visit, Santiago-Rodriguez told the caseworker that Rodriguez was responsible for her pregnancy, and that he was also the father of her one-year-old son, C. She told the caseworker that another man was the father of her other children, and that she had an order of protection against that man as a result of domestic violence incidents when she lived with him in Connecticut. There is no record that the caseworker obtained a copy of this order of protection, investigated these prior domestic violence incidents or determined whether Santiago-Rodriguez had received any counseling as a victim of domestic violence. As noted above, caseworkers are expected to investigate domestic violence incidents with respect to both current and prior partners.

During this home visit, the caseworker expressed concern to Santiago-Rodriguez that Nixzmary appeared both shy and very thin. Santiago-Rodriguez claimed that Nixzmary often refused to eat, and that she had discussed this problem with Nixzmary's doctor. There is no record that the caseworker asked Nixzmary about her eating habits. There is also no record that the caseworker asked Santiago-Rodriguez or Rodriguez whether a doctor had treated Nixzmary's burn injury or J.'s scratches. Santiago-Rodriguez told the caseworker that the children were up to date on their immunizations, and provided the caseworker with the name and telephone number of the children's pediatrician. The caseworker also obtained Rodriguez's signature on a form intended to provide consent for ACS to review the children's medical records, but the caseworker never spoke to the children's pediatrician or obtained copies of their medical records. DOI reviewed a copy of this release form, which was filled out improperly by the caseworker, and actually grants consent for the release of Santiago-Rodriguez's medical records. In interviews with DOI, the caseworker said that she intended to get a release for the children's medical records, but admitted that she never obtained the children's medical records or contacted their doctor.

When asked about Nixzmary's absences from school, Santiago-Rodriguez did not deny that Nixzmary had missed a great deal of school as claimed in the SCR report. She claimed that she often had trouble getting her children to school due to her pregnancy. There is no record that the caseworker confronted Santiago-Rodriguez regarding this claim, despite the fact that the children's school was only a few blocks away from the family's apartment. School staff also told SCI investigators that Santiago-Rodriguez routinely escorted her children to school in the morning, and that Rodriguez picked them up at the end of the day. Additionally, the caseworker admitted in an interview with DOI that she was aware school records established that Nixzmary's brother, J., had been absent from school on 14 fewer days than Nixzmary, casting further doubt on Santiago-Rodriguez's claim that Nixzmary had missed so many days of school because of Santiago-Rodriguez's pregnancy. If she was able to get J. to school, she should have been able to do the same for Nixzmary. The caseworker told DOI that she believed the difference in the siblings' attendance records was the result of a school calculation error, claiming that "kids will be in school and they'll be marked absent." She

did not provide any basis for her belief that the school was likely to mark Nixzmary absent when she was actually in class.

Santiago-Rodriguez further claimed that Rodriguez was rarely available to take the children to school because of his work schedule. Rodriguez told the caseworker that he was a security guard at the state building at 55 Hanson Place in Brooklyn, where he earned \$450 a week. Rodriguez told the caseworker that he did not work on Monday and Wednesday and, on those days, he helped Santiago-Rodriguez drop off and pick up the children from school. There is no record that the caseworker asked Rodriguez the name of his employer or made any effort to verify that Rodriguez's reported work schedule prevented him from taking the children to school on Tuesday, Thursday and Friday.

Although the caseworker was instructed by her supervisor on the day of the hotline report to contact the reporting guidance counselor, and the Practice Guide instructs caseworkers to contact the source of hotline reports within 24 hours of the report, the caseworker did not speak to this counselor until June 27, nearly six weeks after the hotline report was made. When the caseworker finally interviewed the guidance counselor, it was by telephone, not a face-to-face interview. According to the caseworker's entries in CONNECTIONS, she did not ask the guidance counselor about J.'s initial statement that Nixzmary had burned her hand on the stove. There is also no indication that the caseworker discussed with the guidance counselor the allegations that Nixzmary fell out of bed and hurt her head and foot. ACS records reflect that the guidance counselor told the caseworker that Nixzmary's school attendance had improved, although that was incorrect. DOI reviewed the school attendance records which showed that Nixzmary had been absent for more than 50% of the school days between May 16 and June 28, the end of the school year.

In an interview with SCI investigators, the guidance counselor said that she did not recall speaking with anyone at ACS in late June or telling anyone from ACS that Nixzmary's attendance had improved. The guidance counselor did recall receiving a questionnaire by fax from ACS calling for her to answer various questions about Nixzmary and her siblings. The guidance counselor responded to that questionnaire after consulting with the children's teachers and the health office. DOI investigators reviewed the questionnaire, and confirmed that the guidance counselor reported that Nixzmary had been absent from school on 56 days out of a possible 177 days and late on 17 days during the course of the school year. The guidance counselor did not indicate anywhere on this questionnaire that Nixzmary's attendance had improved since her call to the hotline. The guidance counselor also noted in her response to this questionnaire that Nixzmary was below the height and weight of an average seven-year-old.

When DOI investigators asked the ACS caseworker why it took her almost six weeks to contact the school guidance counselor, she claimed that she believed she had attempted to contact the guidance counselor earlier but could not reach her. The case file does not reflect any prior unsuccessful efforts by the caseworker to reach the guidance counselor. The caseworker also claimed in her interview with DOI investigators to have offered the family what are known as homemaking services, which can include training and support in child care (including walking children to and from school) as well as assistance with light cleaning, laundry, and grocery shopping. The

caseworker told DOI that Santiago-Rodriguez refused those services. There is no record in the case file that these services were in fact offered to the family.

On July 7, 2005, the caseworker conducted another home visit, during which Rodriguez and the children were at home. Rodriguez said that Santiago-Rodriguez had given birth and was still in the hospital. The caseworker discussed Nixzmary's weight with Rodriguez. He also claimed, as Santiago-Rodriguez had, that Nixzmary often did not want to eat. The caseworker promised to provide a referral for a crib, and later arranged for a crib, a double-stroller, and a highchair to be delivered to the family.

Although the ACS caseworker confirmed through a variety of sources that Nixzmary had missed over 40 days of school, including school attendance records, the questionnaire completed by the school guidance counselor, and Santiago-Rodriguez's admissions during the May 18 home visit, ACS closed this case as "unfounded" on July 8, 2005. In connection with this determination, ACS records reflect that the parents were having difficulty getting the children to school given Santiago-Rodriguez's pregnancy, but were trying their best. The notes also reflect that the family did not anticipate any problems getting the children to school in September.

B. December 2005 Hotline Report

On December 1, 2005, a school social worker made a report to the SCR hotline alleging that Nixzmary and her mother were being physically abused by Rodriguez. The call narrative alleged that Nixzmary had a laceration on her forehead and a bruised eye as a result of a recent beating at the hands of Rodriguez. The narrative noted that Nixzmary was very withdrawn and often missed school. It also noted that Santiago-Rodriguez was withdrawn and passive, taking no action to protect herself or the children. The report further stated that Rodriguez intimidated all the children in the household to prevent them from discussing the abuse that was going on in the home. Notably, the social worker reported to the SCR that she did not want to send the children home from school because she had serious concerns for their immediate safety. The report further stated that Rodriguez typically picked the children up from school, and that Santiago-Rodriguez was pregnant again. The social worker also specifically requested that ACS send a Spanish-speaking caseworker.

Because the reporting social worker expressed concern for the safety of the children, the hotline report was routed to the IRTC at ACS' Brooklyn field office for immediate response. The IRTC has stated that she designated this case as an IRT case; however, there remains a significant dispute between ACS and the NYPD as to whether this report was designated as an IRT case. The IRTC documented in CONNECTIONS on December 2, 2005, the day after the hotline report, that she had "deemed" the case an IRT case, and had faxed the hotline report to a detective at the Brooklyn Child Advocacy Center. In interviews with DOI, the IRTC said that she spoke to both the reporting social worker and an NYPD detective stationed at the Brooklyn Child Advocacy Center. The IRTC also told DOI investigators that she faxed a copy of the hotline report to the detective, who confirmed receipt of the fax. The IRTC kept a copy of a receipt evidencing a fax transmission of documents to the Child Advocacy Center on that day. DOI has reviewed that receipt, which establishes that five pages were faxed to the Brooklyn Child Advocacy Center at 3:18 p.m. on December 1, 2005. There is no way to determine from this fax receipt whether these documents included the hotline report or were at all related to Nixzmary Brown. The IRTC also told DOI that

after her conversation with the detective, she believed that the NYPD would meet ACS staff at the school to assist in the initial interviews of the children and to provide whatever other support was necessary. It is significant to note that the ACS caseworker and supervisor arrived at Nixzmary's school at approximately 2:20 p.m. to interview the children. The fax receipt shows that documents were faxed to the Child Advocacy Center at 3:18 p.m., almost an hour after the ACS caseworker and her supervisor arrived at the children's school to begin the interviews. Had the IRT protocol been triggered, the ACS staff should have waited for the NYPD to arrive to conduct joint interviews of the children.

The NYPD has strongly contested that this report was ever designated as an IRT case. The NYPD has stated that at approximately 3:05 p.m., a detective from the Brooklyn Child Abuse Squad received a telephone call from the IRTC seeking advice about the case, stating in essence "let me run something by you."⁸ According to the NYPD, the IRTC told the detective that Nixzmary had visible injuries to her face, but said that no one was alleging that these injuries were intentionally inflicted. The NYPD has further stated that the IRTC told the detective that a caseworker and her supervisor were at Nixzmary's school, and Rodriguez, the children's stepfather, was on his way to the school and, although no criminality was alleged, he seemed belligerent in a telephone call with ACS staff. The NYPD detective had worked with the ACS supervisor at the Brooklyn Child Advocacy Center and because of that prior working relationship agreed to go to the school to assist the supervisor in dealing with Rodriguez. The NYPD has said that had the detective and the ACS supervisor not known one another, the detective would have directed the IRTC to call 911 for assistance, as required by the IRT protocol. The NYPD has also said that the IRTC never indicated in this telephone conversation that she had designated the case as an IRT or that she had faxed information about the case to the NYPD. The NYPD has also stated that they have no record of receiving a fax concerning this hotline report. According to the NYPD, the detective who talked to the IRTC and another NYPD detective arrived at the school at approximately 3:35 p.m., by which time the ACS staff had been at the school for over an hour and had already interviewed Nixzmary and her siblings. When the detectives arrived, the ACS caseworker told the detectives that "nothing" was going on and relayed Rodriguez's account that Nixzmary had fallen on a piece of wood. The ACS supervisor stated that they did not need any assistance from the detectives, although the detective offered to run a query in the NYPD Domestic Violence Database to determine if the family had a history. That check proved negative. The ACS supervisor told the detectives that they were leaving to take the family home and did not require any further assistance from the NYPD.

As noted above, at approximately 2:20 p.m. on December 1, an ACS caseworker and her supervisor arrived at P.S. 256. The assigned caseworker was unavailable so another caseworker conducted these interviews. The school social worker was also not available, but the caseworker and supervisor spoke to the interim acting principal who reported that Nixzmary had come to school on several occasions with bruises, although the school did not call the hotline on those occasions. The interim acting principal said that she was worried because Nixzmary's injuries appeared to be getting more serious. The caseworker and her supervisor then interviewed Nixzmary and her three siblings. Although the caseworker assigned to investigate the May 2005 allegations was fluent in

⁸ See Letter from Police Commissioner Raymond W. Kelly, dated February 16, 2006, to Deputy Mayor for Health and Human Services Linda Gibbs.

Spanish, and despite the specific request from the social worker to the SCR that ACS send a Spanish-speaker, the caseworker and the supervisor who conducted these interviews did not speak Spanish. In addition, the caseworker who was assigned to complete the investigation following these initial interviews did not speak Spanish. On the day of these interviews, Nixzmary had a bruised and swollen right eye and a bandaged gash above that eye about two inches long. During her interview, Nixzmary claimed that she had injured herself by falling on a piece of wood in her apartment. She also claimed that her stepfather had thrown the wood out after her fall, and had taken her to the hospital. Nixzmary's older brother J. repeated this story, but claimed that he and his younger brother had thrown the wood out. Nixzmary's younger sister, S., who was five years old at the time, told ACS staff that "Cesar," their stepfather, had caused Nixzmary's injuries. The caseworker asked S. to explain how it had happened, but S. only pointed to the window and did not offer an explanation. The caseworker asked again, but S. simply pointed to the window again, offering no explanation.⁹ The caseworker and her supervisor also attempted to interview Nixzmary's brother, E., who was six years old at the time, but his speech impediment made it very difficult to understand him.

Although the caseworker's summaries of these interviews reflect the inconsistent versions reported by the children, neither the caseworker nor her supervisor highlighted or attempted to reconcile these inconsistencies. Most notably, the caseworker seemed to ignore entirely that Nixzmary's younger sister had identified Rodriguez as the person who had caused Nixzmary's injuries. Finally, the caseworker and her supervisor claimed that consistent with ACS policy, the children were interviewed separately. The interim acting principal of P.S. 256, however, advised SCI that while each child was being interviewed in another room by the caseworker, the remaining children stayed in a group with the supervisor and the acting principal where there was a discussion about how Nixzmary was injured. This arrangement allowed the children to hear each other's version of events.

After interviewing the children, the caseworker and her supervisor interviewed Rodriguez at P.S. 256. Rodriguez said that Nixzmary had fallen on some wood and that he would say nothing further on the matter. Rodriguez did provide the caseworker with a copy of Woodhull Hospital's discharge summary from Nixzmary's visit to the emergency room on November 28 for her injuries. This summary indicated that Nixzmary should return to the hospital in seven days to have her stitches removed. The case file does not reflect that anyone from ACS contacted Woodhull Hospital to inquire whether the treating physician credited Rodriguez's version of how Nixzmary was injured. The caseworker claimed in an interview with DOI that she had a telephone conversation with a doctor at Woodhull Hospital's pediatric emergency room, who told her that Nixzmary's injuries were consistent with Rodriguez's version of events. When confronted with the absence of any record of such a conversation, and her inability to recall the doctor's name, the caseworker said that she must have forgotten to document this conversation in the case file. Neither the attending doctor nor the resident on duty recalled having a telephone conversation with an ACS caseworker about Nixzmary's injuries. DOI also learned during the course of its investigation that it would be unusual for an ACS

⁹ The supervisor told DOI investigators that although the NYPD officers did not participate in the formal interviews of the children, the supervisor and the NYPD officers did ask S. a number of follow-up questions in an effort to get her to elaborate on her statement that Rodriguez had caused Nixzmary's injuries. She did not provide any further information in response to this questioning either.

caseworker to speak directly with an emergency room doctor because calls from ACS were typically referred to the social work department of the hospital, which maintains a log of its contacts with ACS. The relevant log did not contain any record of contact with a representative of ACS regarding Nixzmary Brown.

The caseworker and her supervisor interviewed Santiago-Rodriguez later that same day at the family's apartment. This was the only successful home visit conducted by ACS in the investigation of the December abuse allegations. Rodriguez and the children were present in the apartment for that interview. The caseworker who conducted this home visit told DOI investigators that Rodriguez and Santiago-Rodriguez spoke to one another in her presence in Spanish during this home visit, and acknowledged that she could not understand the substance of their conversations. Santiago-Rodriguez said that she had a miscarriage on the day that Nixzmary was injured and, as a result, did not see how the injury occurred. She offered to show the caseworker and her supervisor the miscarried fetus, which she claimed to keep in a jar in her bedroom. Both declined this invitation. On December 5, the caseworker noted in CONNECTIONS that ACS should consider referring Santiago-Rodriguez for mental health services or grief counseling given that she was keeping her miscarried fetus in a jar. The record does not support that any such referrals were actually made. In addition, there is no record that the caseworker or her supervisor asked Rodriguez, Nixzmary or her siblings to identify precisely where Nixzmary had fallen on the wood once they were back at the apartment.

Following the December 1 interviews and home visit, the caseworker who was originally assigned to investigate the allegations took over the investigation. On December 5, the caseworker who participated in the December 1 interviews made a detailed entry into CONNECTIONS describing the interviews and home visit. On December 6, the supervisor made an entry directing the assigned caseworker to, among other things, conduct a follow-up home visit to introduce herself to the family, discuss any service needs with the family, encourage the family to address a number of necessary repairs identified during the home visit, discuss with Santiago-Rodriguez her desire to keep her miscarried fetus in a jar in her bedroom, and inquire whether the children have seen the fetus. The caseworker was unsuccessful in conducting any follow-up home visits or addressing any of the other directives identified by her supervisor. There is also no record that this caseworker had any substantive conversations with the caseworker and supervisor who had interviewed the family members and conducted the home visit on December 1 after assuming responsibility for the investigation or that she reviewed the other caseworker's December 5 CONNECTIONS entry summarizing the interviews.

According to ACS records, on December 8, 2005, the assigned caseworker attempted to conduct a home visit, but Rodriguez refused to allow her in, claiming that no one else was at home and he was about to leave. Rodriguez came downstairs and the caseworker gave her card to him, and said that she would contact him the following day to schedule a home visit. The following day, the caseworker called the home four times, but did not reach anyone.

At this point, the caseworker could have sought a warrant to produce the children or an entry order (also known as a warrant of entry). The Family Court can issue a warrant of entry where there is probable cause to believe that an abused or neglected child may be found on the premises, and the caseworker cannot gain access to those

premises. The Family Court can also issue a warrant directing that a child be brought before the court when there is a showing that a child is in danger and the parent refuses to permit ACS to investigate the reported allegations. In interviews with DOI, ACS staff has said that they consider entry warrants to be an extreme remedy and, as a result, were very conservative in seeking such warrants. According to the case file, the assigned caseworker's supervisor mentioned on two occasions the possibility of obtaining a warrant to produce the children should the caseworker's efforts to conduct a home visit continue to be unsuccessful. The caseworker told DOI investigators that her supervisor's supervisor instructed her to attempt additional home visits before seeking any warrants. An attorney from the Brooklyn DLS unit who was interviewed by DOI confirmed that ACS rarely sought warrants of entry. This attorney stated that from November 2005 through February 2006, she prepared at most one warrant of entry for ACS.

From December 16 through December 20, the assigned caseworker was out on vacation. The case was not temporarily re-assigned and ACS records reflect no activity during this period by a substitute caseworker or anyone else at ACS. On December 21 or 22, the caseworker's supervisor was contacted by school officials, who reported that Nixzmary and her siblings had not been to school in two weeks.¹⁰ The caseworker attempted to contact the family by telephone, but learned that their telephone number was not in service. The supervisor who participated in the December 1 interviews told DOI investigators that she attempted a home visit on December 21 or 22, but was unsuccessful. This supervisor acknowledged that ACS records do not reflect that a home visit was attempted on either day. On December 23, the caseworker made another unsuccessful attempt at a home visit. On January 4, 2006, ACS received a telephone call from a school social worker reporting that Nixzmary and her siblings continued to be absent from school. The caseworker told DOI investigators that she attempted another unsuccessful home visit on January 5. There is no record of this attempt in the case file.

On January 10, the caseworker and her supervisors decided to request that ECS attempt a home visit over the following weekend; however, the supervisor's supervisor expressed concern about waiting until the weekend, and directed the caseworker to attempt another home visit that evening. Because the caseworker had another assignment that evening, the caseworker's direct supervisor told her to attempt a home visit the following day.

On January 11, 2006, the caseworker attempted another home visit. When she arrived, police and EMTs were already on the scene, and Nixzmary was dead. One of the responding EMTs told DOI investigators that when he arrived, Nixzmary was lying on the floor, wearing only pajama bottoms, with a folded up shirt underneath her head. This EMT noticed that Nixzmary had injuries on her face, wrist, and ankles and immediately suspected abuse. According to the EMT report, Santiago-Rodriguez and Rodriguez claimed to have put Nixzmary in the bathtub and then forgotten about her for three hours. The OCME's report concluded that Nixzmary had died as a result of a brain hemorrhage caused by a blow to the head. The OCME also noted that she had a variety

¹⁰ The ACS records are unclear as to the date of this call. The school social worker told SCI investigators that the conversation occurred on December 21, after the ACS supervisor returned messages she had left for him earlier in the day and on December 16.

of injuries to her head, torso, arms and legs of varying ages. Nixzmary was seven years old, and weighed 36 pounds at the time of her death.

Nixzmary's stepfather, Cesar Rodriguez, was indicted for murder in the second degree, and manslaughter in the first and second degrees for repeatedly beating Nixzmary on her head and body between January 1, 2006 and January 11, 2006. The indictment further charged Rodriguez with unlawful imprisonment for keeping Nixzmary restrained between July 1, 2005 and August 31, 2005, and with sexually abusing Nixzmary. The indictment also charged Rodriguez with assault and attempted assault in connection with incidents where he injured or attempted to injure Nixzmary's siblings, J., S., and E. Finally, the indictment charged Rodriguez with various counts of criminal possession of a weapon and endangering the welfare of a child.

Nixzmary's mother, Santiago-Rodriguez, was also indicted for murder in the second degree, manslaughter in the second degree, and reckless endangerment in the first degree for inflicting injuries to Nixzmary, for being present while another inflicted injuries to Nixzmary, and for failing to seek prompt medical attention for her. The indictment further charged Santiago-Rodriguez with two counts of assault in the second degree in connection with incidents where she caused injury to Nixzmary, unlawful imprisonment, and various counts of criminal possession of a weapon and endangering the welfare of a child. Their cases are pending in New York State Supreme Court in Brooklyn.

Nixzmary's siblings are currently in foster care.

2. Quachaun Browne

On January 30, 2006, four-year-old Quachaun Browne died from injuries inflicted during a beating several days before. According to an indictment pending in New York State Supreme Court in the Bronx, the beating came at the hands of Jose Calderon, the boyfriend of Aleisha Smith, Quachaun Browne's mother. The indictment also charged Aleisha Smith with manslaughter, criminally negligent homicide and other charges in connection with Quachaun's death. On June 20, 2007, Smith pled guilty to manslaughter in the first degree. On July 18, 2007, she was sentenced to two and a half years in jail. Calderon's case is still pending. During the period from June 1996 through January 2006, the SCR hotline received ten different reports alleging that Aleisha Smith was both abusing and neglecting her children.

A. June 1996 Hotline Report

The first report was made on June 15, 1996 by a staff member of Metropolitan Hospital in the Bronx. The report concerned Aleisha Smith's daughter, L., who was then a year and a half old. The report stated that L. had been staying with her father and grandmother since the previous Saturday. L.'s father noticed that her lip was swollen during this visit and took her to the hospital, where she was diagnosed with a serious infection and significant tissue injury in her mouth. The hospital staff member reported that L.'s father and grandmother had placed L. at risk by not bringing her for treatment sooner.

According to ACS records, on June 18, three days after the report to the hotline, an ACS caseworker interviewed L.'s father at his home. L.'s father told the caseworker that L. lived with her mother, Aleisha Smith, and he did not know whether Smith had taken L. for treatment earlier. ACS records also reflect that a supervisor interviewed Aleisha Smith that same day at her home. Smith claimed that she had taken L. to a doctor in connection with her lip and was told that L. was teething. There is no record that the caseworker obtained L.'s medical records, the name of the treating doctor, or otherwise made any effort to verify that L. had received medical attention earlier as Smith claimed. ACS records also do not reflect that the caseworker made any effort to contact the reporting hospital staff member or anyone else from Metropolitan Hospital to determine if the symptoms they had observed were consistent with teething or to obtain any other information about L.'s condition. On September 13, 1996, ACS closed this case as "unfounded."

B. August 1998 Hotline Report

On August 18, 1998, the SCR hotline received a report from an employee at the shelter where Smith and her children were then living. At this time, Smith had two children: L. was three years old, and N. was a year old. This report alleged that Smith was typically one to two hours late picking up her children from day care. The report also claimed that Smith's room within the shelter was filthy, with "garbage, old food and bugs all over." According to ACS records, on the day of the hotline report, an ACS caseworker interviewed the shelter employee, who said that Smith's friend was supposed to pick the children up while Smith worked as an intern for the New York City Department of Parks and Recreation, but at times, that friend would pick up one child while forgetting the other. ACS records reflect that Smith was also interviewed by the caseworker that day and stated that interns at the Parks Department were assigned

escorts to pick up their children and that her assigned escort had been late picking up her children a couple of times. She also acknowledged that on one occasion, her escort had forgotten to pick up one of her children. The caseworker inspected Smith's room within the shelter, but concluded that it was not dirty enough to justify removal of the children.

According to ACS records, on September 2, 1998, the caseworker re-visited Smith and reported that her room within the shelter had been cleaned, and Smith said that she was now picking up her children from day care. On September 4, the caseworker spoke to the shelter employee who had made the August 18 report and was told that there were no further problems with Smith. On September 9, 1998, ACS closed this case as "unfounded."

C. May 2002 Hotline Report

On May 9, 2002, when Quachaun was three months old, the SCR hotline received a report from a staff member at Columbia Presbyterian Hospital alleging that Smith was beating her children with a belt and that when her two-year-old daughter, F., defecated on the floor, Smith and her boyfriend forced F. to pick up the feces with her hands. The report also alleged that Smith and her boyfriend often left the children alone for hours while they were in another room and that the home had "trash and diapers strewn about." At the time of this report, Smith had four children, ranging in age from three months to seven years old.

According to ACS records, on May 9, the caseworker attempted a home visit, but mistakenly went to an incorrect address. On May 10, the caseworker spoke by telephone with the source of the hotline report, a psychologist at Columbia Presbyterian Hospital who had been asked by one of his patients to call the SCR hotline. The psychologist reported that his patient knew Smith well and felt that Smith had been neglecting her children for years, but did not want to call the hotline because she did not want Smith to know that she had made a report. The psychologist also noted that doctor-patient confidentiality prevented him from revealing the identity of his patient.

On May 14, the caseworker went to the address provided in the SCR report, but that address was also incorrect. On May 15, the caseworker found the correct address and conducted a home visit. During that visit, the caseworker confirmed that the condition of the apartment was unacceptable, with food and trash on the floor and "an offensive stench" in the apartment. The caseworker also interviewed the two older children, both of whom confirmed the incident where F. was made to pick up her feces with her hands. Smith, who was also interviewed that day, initially denied the allegation, but later admitted it, insisting that she had cleaned F. after this incident. The caseworker learned that six-year-old N. was not enrolled in school as required by law. There is no record that the caseworker investigated the allegations that Smith was beating her children with a belt. Although Smith told the caseworker that her children received any necessary medical care at Mt. Sinai Hospital, there is no record that the caseworker contacted Mt. Sinai to obtain any relevant medical records about the family. On July 2, 2002, ACS closed this case as "indicated" concerning both the inadequate guardianship stemming from the incident with F. and the educational neglect of N., but left open the possibility of providing services for Smith and the children. Notes in the CONNECTIONS file indicate that CPS staff referred the family to the FPP unit for services, but ACS was

not able to locate any documentation that a referral to FPP had actually been made or that FPP actually provided services to the family at or around this time.

D. October 2004 Hotline Report

On October 9, 2004, at approximately 3 p.m., the SCR hotline received a report from a neighbor and family friend who identified himself alleging that three-year-old Quachaun had been burned on the neck, shoulder and arm the previous winter when four-year-old F. was removing a cup of tea from the microwave.¹¹ This source said that Smith was present during the incident, but was not watching the children. The source also reported that both Smith and Mandingo Browne, who was Quachaun's father, had to be coaxed to take Quachaun for medical treatment and then failed to take him for any follow-up treatment, and as a result, Quachaun was permanently scarred on his arms and back. The report also claimed that the children lived in "filthy, unsanitary, hazardous" conditions, in that there was "rotten garbage and moldy, food encrusted dishes throughout the apartment," and that the apartment had a strong odor of urine and rotten food. The report further alleged that the apartment was infested with roaches and mice, and the children had roach bites. The report indicated that the NYPD had gone to Smith's apartment that day based on a call that children were alone in the apartment, and later took Mandingo Browne to the precinct for questioning. Before leaving the apartment, the police officers asked the neighbor to baby-sit Smith's two younger children. According to the report, Smith was not at home when the police arrived, but was visiting her mother, along with Quachaun and two of her other children. The report stated that the neighbor was so disgusted by the state of the apartment that he called the hotline. The report also stated that the neighbor heard one of the NYPD officers say "My dog house is better than this."

According to ACS records, at 6:10 p.m. that same day, an ECS caseworker spoke by telephone with the neighbor who said that he had been reluctant to call the hotline because the parents are his friends, but he felt "the scenario" had been going on for too long. The neighbor then repeated the allegations in the hotline report. The ECS caseworker noted that he had a follow up conversation with the neighbor at 8:10 p.m. during which he confirmed that Smith's younger children were still in his care. ACS records also reflect that at 8:20 p.m. that evening, an ECS caseworker called the 52nd Precinct to inquire about Mandingo Browne, but was told that Browne had not been brought to that precinct for questioning.

Another ECS caseworker attempted home visits on October 10 and 11, but no one was at home. On October 12, a CPS caseworker conducted a telephonic interview with the source of the hotline report. The neighbor repeated what was in the initial report and added that Smith and Browne smoked marijuana daily. A CPS caseworker went to the apartment on October 12, but again, no one answered the door. The caseworker left what is known as a Notice of Existence under the apartment door; this is a document informing the family that they are under investigation by ACS and directing the family to contact ACS.

On October 13, a caseworker found Smith at home and confirmed that the apartment was filthy and infested with roaches. Smith told the caseworker that she could not recall the reported tea incident, but the caseworker noticed two marks

¹¹ The report actually uses nicknames that DOI has confirmed were references to Quachaun and F.

consistent with healed burn scars on Quachaun's right shoulder and arm and took photographs of the scars. Smith acknowledged that Quachaun had been burned once when he backed into a radiator, and said that she had taken him to North Central Hospital in the Bronx for treatment. There is no record that the caseworker verified that Quachaun had been treated by North Central Hospital. The caseworker later acknowledged in an interview with DOI that she never contacted North Central Hospital or obtained medical records to confirm that Quachaun had received medical attention for these burns. The caseworker stated that she had not done so because she was planning to refer the case to the FPP unit for intensive services and assumed that the FPP preservationist would obtain any relevant medical records.

On October 22, in the midst of the investigation of the October 9 hotline report, Smith gave birth to her sixth child. There had been no prior mention in the case file that Smith was pregnant again. The CPS caseworker told DOI investigators that she had not been aware that Smith was pregnant, but learned that Smith had given birth to a daughter, her sixth child, from the FPP unit. The CPS caseworker claimed that Smith had a large build and had not mentioned that she was pregnant.

On October 27, the caseworker referred Smith to the FPP unit for three months of intensive home-based services. DOI reviewed the referral form, which indicated that the children would be unsafe if these services were not provided or were discontinued.

On December 17, the case was closed as "unfounded" notwithstanding that the caseworker had confirmed that Smith's apartment was filthy and roach infested and that Quachaun had been burned in the recent past. In connection with the closing, both the caseworker and her supervisor noted that the caseworker would continue to monitor Smith while she was receiving services from the FPP unit. The caseworker did monitor the family until early April 2005, when the SCR hotline received a new report about Smith. In addition, DOI confirmed that the FPP unit provided a variety of services to the family from November 1, 2004 through February 8, 2005, including training in housekeeping, supervising children, time management, parenting skills, the importance of school attendance for children, meal preparation, and money management.

The progress notes of the FPP preservationist include the names of various men who were frequently in Smith's apartment, often acting as caretakers for the children. There is no record that the FPP preservationist obtained any information about these men beyond their names – and sometimes only their first names – or that she ran any background checks on these men. As noted above, the ACS Practice Guide requires caseworkers to obtain pedigree information for parents, household members and adults who frequent the home.

According to ACS records, in early March 2005, after the FPP services were concluded, the caseworker referred Smith for homemaker services so that she would have assistance with light cleaning, laundry, getting the children to school, and grocery shopping. On March 30, the caseworker was informed by the agency that was to provide the homemaking services that Smith had refused these services.

DOI interviewed Smith's neighbor, the source of the hotline report. He said that Smith had asked him to check Quachaun's burns after the tea incident because he had been a medical assistant. He told DOI that he urged Smith to take Quachaun to the hospital because he believed that Quachaun had sustained second or third degree

burns on his neck, arm, shoulder, and stomach. This neighbor accompanied Smith and Quachaun to North Central Hospital that day, but said that Smith later failed to bring Quachaun for necessary follow up care. The neighbor also told DOI investigators that about a week after the tea incident, Quachaun received additional burns, possibly from backing into a radiator. He did not indicate that he had witnessed that incident.

Significantly, DOI's investigation revealed that this neighbor was a registered sex offender for two separate sodomy convictions in 1992 involving two male victims, who were 13 and 14 years old. He served four and a half years in jail as a result of these convictions, and a special condition of his release required that he have no unsupervised contact with minor children.

E. March and April 2005 Hotline Reports

On March 25, 2005, the SCR hotline received an anonymous report concerning an "Alicia Smith" in the Bronx, which alleged that Smith's home was dirty and the children were also dirty on a regular basis. The report also alleged that the children begged others for food because there was none in the home. The call report generated by the hotline provided a specific address on East 210th Street in the Bronx that the ACS caseworker discovered did not exist when she attempted a home visit later that day. On March 28, the caseworker tried to locate that address using a number of references, including a map and the Internet, but was unsuccessful. On April 4, the case was closed. There is no indication that anyone at ACS checked their database for prior or open cases under the name "Smith" or "A. Smith," which would have revealed the name and nearby address of Aleisha Smith. The relationship between this SCR report and Aleisha Smith was discovered for the first time by ACS in April 2006 as part of the document production for DOI's investigation.

According to ACS records, on April 6, 2005, at 7:45 p.m., a substitute caseworker made a home visit as a follow up to the investigation generated by the October hotline 2004 report. The caseworker originally assigned to that investigation was on field restriction for health reasons. During this visit, the caseworker found that Smith's apartment was filthy. The caseworker's notes also reflect that Smith claimed a frozen chicken on the table was intended for the children's dinner that night and that there was not much other food in the home.

Coincidentally, the following day, on April 7, 2005, a probation officer called the SCR hotline to report the "deplorable" condition of Smith's apartment. The probation officer had gone to the apartment to conduct a routine home visit with Mandingo Browne, Quachaun Browne's father, in connection with Browne's probation for an October 2004 robbery conviction. Once again, the allegations included that garbage and old food were strewn throughout the apartment. The report stated that the youngest children appeared dirty and thin, and that one child was begging for food in the probation officer's presence, and was later seen eating food taken from the garbage. The report also suggested that the conditions in the apartment posed a health risk to the six children living there.

On April 8, the same substitute CPS caseworker who had made the April 6 home visit conducted another home visit. The caseworker was greeted at the front door of the apartment building by three-year-old Quachaun, and his 18-month-old sister, T., was in the hallway of the apartment building. The door to Smith's apartment was closed but

unlocked, and was opened for the caseworker by five-year-old F. The caseworker had to call out several times before the children's grandmother, the only adult at home, appeared at the door. The caseworker chastised the grandmother, who had been in the bathroom, for leaving the young children unsupervised with an unlocked door. The caseworker noted that the apartment was cleaner than it had been two days before, and although there was still not much food in the home, there was baby formula and juice. The case file also reflects that an ECS caseworker conducted a home visit at 11:50 p.m. that same evening and reported that the apartment was filthy, with garbage on the floor and a closet full of dirty clothing. Smith told the ECS caseworker that she had very little food because her public assistance money was due the following day. On April 14, a supervisor directed that the family be referred for intensive preventive services, and that Smith be instructed to put a lock high enough on the door so that the younger children could not reach it. This supervisor also noted that the conditions in the home were troubling given that Smith had just completed training along with intensive home-based services from the FPP unit.

F. May 2005 Hotline Report

On May 16, 2005, while the investigation of the April 7 allegations was still open, a school guidance counselor called the hotline to report that Smith's children had missed a great deal of school throughout the year. One had been absent on 30 days and late for school 30 times, another was absent on 14 days and late 25 times, and the third was absent on 13 days and late 30 times. The report also indicated that the children were doing poorly in their studies, and that they came to school dirty, with uncombed hair, no undergarments, and wearing clothing that was too big for them. The report further alleged that the school had attempted to contact Smith numerous times without success. The guidance counselor also expressed concern that the children were being picked up from school by a teenager who attends a special education program. The guidance counselor reported that this teenager was not mature enough to meet her own needs, and should not be caring for Smith's children.

This case was assigned to the CPS caseworker who had recently been assigned the investigation of the April 7 allegations. This caseworker did absolutely nothing to investigate these allegations of educational neglect. Specifically, there is no record that the caseworker reviewed the children's school attendance records or contacted the reporting guidance counselor. In fact, the reporting guidance counselor told DOI that she was never contacted by ACS about this report, despite having made several attempts to reach the caseworker by telephone. On May 22, this report was consolidated into the investigation of the April 7 report made by Mandingo Browne's probation officer. The case file reflects no activity by ACS whatsoever until the hotline received another complaint about Smith on June 4. According to ACS records and DOI's interviews with the caseworker and his supervisor, the assigned caseworker went on sick leave on June 1. Despite the caseworker's utter failure to investigate any of the allegations in the May 16 report, the investigation was closed as "unfounded" on August 2, 2005. This closing was authorized by a manager who had assumed oversight of this unit in mid-May 2005.

In an interview with DOI investigators, this caseworker acknowledged that he was responsible for the investigation of the May 16 hotline report. However, he claimed that he was not responsible for the investigation until he returned from sick leave on June 28. He further claimed that he and several other caseworkers attended a meeting

to discuss the transfer of cases from the caseworker who was on field restriction for health reasons, and that he was instructed at that meeting not to complete the directives for any of the transferred cases. The caseworker could not recall who gave him those instructions at the meeting. DOI also interviewed the caseworker who was on field restriction, who said that a supervisor held a meeting to transfer her cases after she was placed on field restriction and specifically instructed the newly assigned caseworkers to conduct any necessary field work. In addition, she said that she had a separate conversation with the caseworker assigned responsibility for the Smith investigation and told him that he needed to follow up with Smith and advised him to consult with a DLS attorney about seeking judicial intervention to force Smith to cooperate with various services.

DOI also interviewed the manager of that CPS unit. The manager began working in the unit on May 17, and by June 11, when the newly assigned caseworker went out on sick leave, she already had concerns about the quality of his work. Because of these concerns, she asked other caseworkers to conduct home visits in his cases, and began to suspect that the caseworker was only performing about fifty percent of his home visits and was not reporting the true conditions in the households under his care. Ultimately, ACS brought disciplinary charges against this caseworker in connection with his work on the Smith investigations. He later resigned from ACS while disciplinary charges were pending against him.

G. June 2005 Hotline Reports

The SCR hotline received two additional reports regarding Smith on June 4 and 5, 2005. The first was made on June 4 at 10:28 p.m. by a police officer who had gone to Smith's apartment in response to an anonymous call that children were alone in the apartment. The police officer later reported to the SCR that Smith's children had been left alone in a filthy apartment with no food. The officer reported that Smith had left her children with her mother in the afternoon to go to Atlantic City, although her mother lived in a shelter, and had to be back at that shelter before Smith would return home. The report stated that Smith's mother had left the children alone so that she could return to the shelter and the children's father was working and unaware of the situation. The report further alleged that the Smith's home was "in a deplorable condition," and posed a "health hazard to the children." The children were transported to the hospital that evening for evaluation and treatment. On June 5, an EMT who also responded to Smith's apartment on June 4 called the hotline to report similar allegations. The EMT further reported that there was no milk or formula in the home for Smith's youngest child, and that two of Smith's children were asthmatic and needed medication.

On June 5, an ECS caseworker conducted a telephone interview with Smith's neighbor. (This was the same family friend and neighbor who had made the October 2004 hotline report.) The neighbor told the ECS caseworker that Quachaun had been burned twice, that the children were hungry most of the time, and that they were filthy and smelled bad. The neighbor also reported that the children were often left unsupervised, and that neighbors were clapping when the police removed the children from the apartment on June 4. There is no record that the ECS caseworker asked the neighbor any specific questions about whether he had seen Smith or her mother leaving the apartment that day or whether he knew if the children had been left alone.

In his interview with DOI, this neighbor said that Smith's mother had been in the apartment that day, but he had seen her leave while he was speaking with Smith. He then saw Smith leave home and when he realized that the children were home alone, he called Smith on a cell phone. Smith told him that the children would only be alone for a few hours because Browne would be home later that evening. She did not mention that her mother was responsible for watching the children.

The ECS caseworker also interviewed Smith on June 5. Smith claimed that she had left the children in her mother's care and that Mandingo Browne, Quachaun's father, had agreed to relieve her mother so that her mother could make curfew at the shelter in which she lived. Smith said that Browne had failed to show up, and her mother had left the children in the care of a neighbor, specifically identifying the neighbor who the ECS caseworker had interviewed on June 5.

There is no record that Smith's mother was ever interviewed by ACS about this incident. There is also no record that the caseworker attempted to interview Mandingo Browne. On August 3, ACS closed this case, along with the open April and May cases, concluding that the allegations against Smith were "unfounded." Although Smith's mother was never interviewed, ACS closed the case with an "indicated" finding of neglect against Smith's mother, based solely on Smith's representation that her mother was the last adult at home responsible for the children. Because the "indicated" finding was against Smith's mother and not against Smith, ACS took no action with respect to Smith. Apart from offering Smith a voucher for day care services, ACS did not offer any other services to Smith or the family. In addition, although ACS had initially observed the home to be filthy, with inadequate food as reported, the closing summary in CONNECTIONS noted that the conditions in the home had improved.

H. November 2005 Hotline Reports

On November 15, 2005, the same school guidance counselor who had made the May 16, 2005 hotline report called the hotline again to report that Smith's three oldest children continued to be absent from school on a regular basis. The guidance counselor reported that ten-year-old L. had missed 9 days of school, had been late 8 times and was failing her classes, and that nine-year-old N. and five-year-old F. had been absent and late a similar number of times. The report noted that Smith had been alerted to this situation, but had failed to take any action. This report further stated that Smith often left home to hang out on the streets, leaving ten-year-old L. to care for her five younger siblings. The report stated that L. was not mature enough to handle that responsibility. The hotline report went on to allege that Smith's apartment (which had been observed by a school attendance teacher and a student who lived in Smith's building) was in "deplorable condition," and was infested with mice and roaches. The report further alleged that there was no food in the home, and that the children often came to school dirty and disheveled.

On November 15, the same day as the hotline report, the guidance counselor also sent a "Report of Suspected Child Abuse or Maltreatment" to OCFS, to which nearly two full handwritten pages were appended. These notes reflected, among other things, that F. had told a guidance counselor that she did not brush her teeth because she did not have a toothbrush, and that she often came to school in the same dirty shirt. The notes added that Smith did not attend any of the children's parent-teacher conferences despite sending notes to the school indicating that she would attend. A student who was

a neighbor of the family had told school staff that there were roaches and mice in Smith's apartment and that the bathing facilities were so awful that L. had asked to bathe in the student's home. The document ended with the following plea from the guidance counselor: "Please, HELP THIS FAMILY!"

On November 15, the caseworker attempted a home visit, but no one answered the door. On November 16, the caseworker met with Smith at the apartment. During this visit, Smith claimed that her home was never dirty and denied that she had ever left her children alone. Smith also told the caseworker that she did not know L. had failing grades, insisted that she had only missed one parent-teacher conference, and had a school conference scheduled for the following week. The caseworker observed the apartment to be "fairly clean" and well kept. He noted that the walls were dirty, but reported that the family was in the process of painting the apartment. This caseworker, who had also been assigned to investigate the April, May, and June reports told DOI that he did not review ACS records concerning the family's prior history before he conducted this home visit because he was "familiar with the case." The caseworker admitted to DOI investigators that he did not challenge Smith's assertions about the cleanliness of her apartment or her claims about the children's school attendance and performance despite frequent notations in previous ACS investigations that contradicted her statements. He also acknowledged that he made no attempt to confirm Smith's statement that she had an appointment to meet with school staff the following week.

On November 17, the caseworker interviewed the reporting guidance counselor at the school. The guidance counselor told DOI investigators that she told the caseworker that Smith's girls almost always came to school hungry, but were often too late for the school breakfast to which they were entitled. She added that school staff often provided the children with milk and food to take home in the afternoon because of their concern that the children were not being adequately fed. The guidance counselor also told the caseworker that the PTA had donated hats, coats, gloves, soap, shampoo, toothpaste and toothbrushes to the children due to their poor hygiene and because the children did not appear to have warm clothing. When interviewed by DOI, the caseworker did not dispute that the guidance counselor had reported these things to him, but claimed that he was not concerned for the children's well being after his interview with the guidance counselor because the children were eligible for free breakfast and lunch at school, and because of the frequency with which children lose hats and gloves. He also claimed that Smith had told him that the children did not have toothbrushes because paint got on their toothbrushes when the apartment was being painted.

On November 18, 2005, the guidance counselor and the assistant principal escorted F. home from school in the morning because they thought she had an eye infection. When F. opened the door to the apartment, both smelled an odor of spoiled food, and the assistant principal was able to see bags of garbage. Smith came to the door, but did not invite them into the apartment. The guidance counselor said that she left several voicemail messages for the caseworker with detailed information about what they had observed in the apartment, but did not receive a return call. The caseworker's supervisor noted in CONNECTIONS that she and the caseworker met with Smith in December 2005 at the field office and discussed the importance of getting the children to school on time.

ACS' investigation of the November 15 hotline report was still open on January 30, when EMTs responded to a 911 call at Smith's apartment and found Quachaun Browne unconscious. He died at the hospital two hours later. Smith and Jose Calderon, a man later identified as Smith's boyfriend, both told police that Quachaun had been injured when a television fell on him two days earlier. The OCME determined that Quachaun was beaten to death, after receiving numerous blows to his head, torso, arms, and legs.

Smith's boyfriend, Jose Calderon, was indicted for two counts of murder in the second degree, manslaughter in the first degree, and endangering the welfare of a child for beating Quachaun between January 27, 2006 and January 30, 2006 and causing fatal injuries. Aleisha Smith was indicted for manslaughter in the second degree, criminally negligent homicide and endangering the welfare of a child in connection with Quachaun's death. On June 20, 2007, Smith pled guilty to manslaughter in the first degree. On July 18, 2007, she was sentenced to two and a half years in jail. Calderon's case is still pending in New York State Supreme Court in the Bronx.

On January 30, after learning of Quachaun's death, the caseworker assigned to the April, May, June, and November 2005 investigations made entries into CONNECTIONS purporting to document case activities from November 22 through December 15, 2005. These included entries indicating that he had visited the children's school and conducted a home visit on December 22, 2005. This caseworker further claimed to have conducted school and home visits on January 12, 2006. School officials have told DOI that the January school visit never took place, and the December school visit took place on a different date than the caseworker documented. DOI's review of school visitor logs confirmed that the caseworker did not sign in as a visitor on January 12 or on any other day in January.

DOI also learned from the building superintendent that Smith's new boyfriend, Jose Calderon, had moved into the apartment in December 2005 with his dog and belongings. The caseworker's notes relating to his purported December home visit do not mention that anyone new had moved into the apartment or that a dog was now living in the home. Similarly, the caseworker's notes concerning his purported January 12 home visit do not mention that Calderon or a dog were now living in the apartment. As noted above, caseworkers are required to document any new changes in household composition. Finally, DOI interviewed the school guidance counselor who reported that she was told on January 5 by one of Smith's children that an unknown man was in the home. The guidance counselor said that she left a message for the caseworker later that day reporting that an unknown man was in the house and suggested that Smith may be engaged in prostitution. The guidance counselor did not receive a reply from the caseworker or anyone at ACS in response to this message.

3. Joziah Bunch

On December 28, 2005, one-year-old Joziah Bunch was beaten to death. The OCME concluded that Joziah died as a result of blows to his neck and torso. The OCME also found that he had broken ribs and had suffered internal bleeding due to lacerations to his liver. Latifa Bunch, Joziah's mother, was charged with murder, manslaughter, and endangering the welfare of a child. Beginning nearly five years before Joziah's death, ACS investigated repeated allegations that Bunch was beating her older son, E., was abusing drugs and alcohol, and was otherwise neglecting E. In addition, ACS was aware at the time of Joziah's death that a local child welfare agency in New Jersey had terminated Bunch's parental rights with respect to her daughter, C., after substantiating neglect and abandonment allegations.

A. The New Jersey Division of Youth and Family Services

Before ACS' involvement with Latifa Bunch, she was the subject of an investigation by the New Jersey Division of Youth and Family Services ("DYFS"). In 1999, DYFS placed Bunch's daughter, C., who was then approximately seven months old, in foster care after Bunch abandoned C. at her paternal grandmother's home. In June 2001, DFYS terminated Bunch's parental rights with respect to C. after substantiating allegations of neglect and abandonment.

B. February 2001 Hotline Report

In February 2001, Bunch told an employee of the Nelson Avenue Family Shelter in the Bronx where she lived with her mother and her five-year-old son, E., that her mother had been fondling E. and "forcing him to mount her." On February 2, 2001, the shelter employee reported this to the SCR hotline. According to ACS records, an ACS caseworker spoke by telephone with the shelter employee on the day of the hotline report. The employee explained that she had not witnessed any of the reported conduct, but had only reported what Bunch had told her. The shelter employee said that she had tried to talk to E. about the allegations, but E. did not speak negatively about his grandmother or accuse her of sexual abuse. The shelter employee told the ACS caseworker that E.'s grandmother had been moved to another shelter to ensure E.'s safety and to avoid confrontations with Bunch.

On February 5, the caseworker interviewed E., who said that his grandmother had left the shelter because she was "being fresh." When asked what he meant by this, E. responded that his grandmother would curse at him and not let him play with the toys he wanted. On March 5, a month later, the caseworker interviewed Bunch. There is no record of any activity whatsoever on this investigation between February 5 and March 5. Bunch told the caseworker that she had become suspicious that E. was being sexually abused because she saw him playing with his genitalia in a way that appeared to be self-gratifying. She said that she believed her mother was responsible because she was the only adult, other than herself, who was ever alone with E., and that sometimes E. slept on top of her mother. Bunch said that she had been sexually abused by a cousin when she was a child and wanted to make certain that did not happen to E. The caseworker explained that what she was describing was normal for young children, and that sexually abused children were often deterred from normal sexual activity because they felt guilt about experiencing pleasure from sexual contact. The caseworker offered Bunch counseling to address her own abuse history, but she declined.

On March 12, the caseworker interviewed E.'s grandmother, who said that Bunch was paranoid because she had been sexually abused as a child. E.'s grandmother insisted that she had not sexually abused E., but admitted that when she baby-sat for E. he shared her bed so that he would not get up without her knowledge, and that while he might lay on top of her while they slept, there was nothing sexual in this behavior. On March 29, 2001, the caseworker noted that he had conducted a final home visit with Bunch and E. at the shelter, and both appeared stable and not in need of any services. On March 29, the investigation was closed as "unfounded" on the basis that there was no credible evidence to support the allegations.

C. April 2001 Hotline Report

On April 30, 2001, a child care coordinator at the Nelson Avenue Family Shelter called the hotline to report that Bunch's then five-year-old son, E., was often seen with bruises, bumps and scratches. The child care coordinator also reported that E. had been seen with a black eye and a tooth knocked out. The child care coordinator told the hotline that E. was very apprehensive when questioned about his injuries, and would typically claim that he fell or that his mother had told him not to "tell his business." The report also recorded as miscellaneous information that Bunch and E. had been living at the shelter since November 2000, and if E. was questioned in front of Bunch that she would attempt to coach his responses.

On the day of the hotline report, a CPS caseworker visited the shelter and interviewed the child care coordinator, Bunch and E. This was not the same caseworker who had investigated the February 2001 allegations concerning Bunch's mother. The child care coordinator reiterated the reported allegations, and added that Bunch was verbally abusive and had threatened physical harm to shelter staff members, and was going to be discharged from the shelter. In the course of her interview with E., the caseworker observed minor bruises and marks on his arms and legs which she noted "did not appear suspicious." E. told the caseworker that he was bruised because he had been pushed down the stairs by another child at the shelter. E. also had a small scratch on his forehead, which he said was the result of bumping his head while playing. E. denied that his mother hit him, but admitted that at times she "smashed" him on his behind or hit him with a belt. Bunch's explanations mirrored E.'s statements. Bunch denied hitting E., and claimed that he was very active and often got hurt while playing. She initially said that she disciplined E. by not allowing him to watch television or play with his toys, but then admitted to spanking him on his behind and using a belt on occasion. Bunch denied any issues with substance abuse. The caseworker instructed Bunch that physically disciplining E. this way was not an appropriate method of parenting. Bunch said that she understood and would refrain from doing so in the future.

According to ACS records, on May 4, 2001, an ACS supervisor instructed the caseworker to interview the child who E. had claimed pushed him down the stairs. There is no record that the caseworker attempted to do this. On May 10, the caseworker conducted a home visit, and noted that Bunch and E. were doing well and in good health, that E. was wearing clothing appropriate for the weather, and they had adequate food, sleeping arrangements and clothing. The caseworker specifically noted that E. had no marks or bruises, and that no safety factors existed in the home. The caseworker also noted that on May 15 he spoke by telephone with a lieutenant at the Bronx District Attorney's office, who told him that a detective had been assigned to the

case and this detective would “collaborate findings” with the caseworker after “going out to see family.”

DOI investigators interviewed both the detective assigned to that investigation and the lieutenant referenced in the caseworker’s progress notes. During the relevant time, both officers were working in the Child Abuse Investigation Unit within the Bronx District Attorney’s Office. The officers explained that ACS designated certain cases as “D.A.” cases where abuse allegations had the potential for criminal charges, but had not been reported to the SCR hotline by the NYPD. In those cases, an ACS liaison would send a copy of the hotline report to the appropriate D.A.’s office for investigation. The ACS case file does not mention that the April 2001 hotline report concerning Bunch had been referred to the Bronx District Attorney’s Office for investigation.

According to the detective’s files, the April 30 hotline report concerning Bunch was assigned to him on May 15. The following day, the detective left messages for the ACS caseworker and the reporting child care coordinator from the Nelson Avenue shelter. On May 21, the detective met with the shelter employee and was told that Bunch had been moved to a different shelter on the Grand Concourse on May 10. The shelter employee described the February 2001 allegations concerning Bunch’s mother. She also reported that she had seen many bruises on E., and that the bruises were visible despite his dark skin. She said that E. had been missing a front tooth, and that she had seen a “huge bump” on his forehead in March. The shelter employee said that when she asked E. about these injuries, he would say “mommy said not to say my business.” The detective’s notes of this interview also reflect that he was told that Bunch was belligerent and had threatened the shelter employee and her supervisor. These notes also reflect that he was told Bunch had threatened the shelter employee by saying that if E. was taken away, she would “come back to get her.”

According to the detective’s files, on May 23, he spoke with the assigned ACS caseworker, and was told that Bunch and E. had a loving relationship and both had denied the allegations in the hotline report. The caseworker told the detective that Bunch had told him that she disciplined E. by giving him timeouts, making him do push-ups, not allowing him to watch television, and “on rare occasions she would hit him on his hand or backside.” Although the ACS caseworker had documented that E. had acknowledged during his April 30 interview that Bunch “smashed” him on his behind or hit him with a belt and that Bunch had also admitted to this during her interview, there is no indication in the detective’s file that the ACS caseworker shared this information with him.

According to the detective’s file, on May 23, the detective interviewed E. and Bunch separately at the Bronx D.A.’s Office. When asked if anyone had ever “given him a bad touch,” E. told him that his grandmother had humped him on the bed, and touched his “private” with her hand under his clothes. E. told the detective that he got the mark on his forehead when his mother hit him. He said that he lost his tooth after it became loose and he took it out himself. The detective observed two small linear marks on E.’s lower right back and a ½ inch mark on his neck. E. told the detective that the neck injury occurred when he fell, and he did not remember what had caused the marks on his back.

In the detective’s interview with Bunch, she said that’s E.’s father lived in Pittsburgh, but they had not spoken for a while, and she did not know where her mother

was living. Bunch told the detective that she and E. had moved to New York after she was assaulted by a drug dealer in Long Branch, New Jersey for refusing his sexual advances. She said that she had lost her left eye as a result of the assault. Bunch gave the detective the name of the prosecutor in Monmouth County, New Jersey who was handling the case. Bunch said that she disciplined E. by either hitting him with her hands or with a belt. She said that E. was wild and jumped around a lot, but denied knowing for certain how he got the mark on his forehead. She said the injury that resulted in a scar on E.'s neck was the result of roughhousing with friends. Bunch said that she had yelled at E. that day, but denied having hit E. recently.

According to the detective's files, after he interviewed Bunch and E., he spoke by telephone with the ACS caseworker's supervisor and informed her that Bunch had admitted that she hit E. with a belt in the past. The detective told the ACS supervisor that the family was in need of counseling services. There is no record in the ACS case file of this conversation.

According to ACS records, on May 25, Bunch went to the ACS field office for a case conference, at which time the caseworker discussed parenting issues with her, examined E., but found no visible bruises or marks, and recommended that Bunch be referred to Citizens Advice Bureau, a non-profit agency that provides a variety of preventive social services, including parenting skills training, anger management, mental health treatment, and substance abuse counseling. An undated entry in the file indicates that the caseworker referred Bunch to this agency. On May 31, the caseworker visited Bunch and E. at the shelter on the Grand Concourse to which they had moved. Notably, the caseworker's comments describing that visit are identical to those in his entry describing the May 10 home visit at the Nelson Avenue shelter.

On June 5, the caseworker's supervisor noted that the caseworker needed to comply with the requirement of conducting two home visits per month.

According to the detective's files, on June 8, Bunch and E. were re-interviewed by the detective and his lieutenant. The detective and the lieutenant told DOI that they re-interviewed Bunch and E. because both felt that something was not right. During the June 8 interview, E. gave explanations for his injuries that were inconsistent with explanations he had provided on May 23. For example, during the June 8 interview, E. said that the mark on his forehead was caused by an injury he received when his mother pushed him, and he hit his head on the floor. He also said that he lost his tooth when his mother "smacked" his hand and his hand hit his mouth. E. told the officers that his mother had told him not to talk about "family business." In the interview with Bunch, she repeated her prior statements about how she disciplined E. She admitted that she had hit E. the day before because he ran off the bus without her. Bunch said that she did not have any other children and denied having ever used drugs. The officers asked Bunch to provide contact information for a family member. She told the officers that she was not speaking to her mother, but provided the name and telephone number of a maternal great-aunt who lived in New Jersey.

According to the detective's files, on June 11, the detective spoke to Bunch's maternal great-aunt and learned that Bunch had a two-year-old daughter in addition to her son, E. Bunch's great-aunt said that she had last seen Bunch three months earlier, but had not talked to Bunch's mother since August 2000. On that same day, the detective spoke to a staff member of DYFS, and learned that DYFS had an open case

concerning Bunch's daughter, C. The DYFS employee said that Bunch had dropped C. off at her paternal grandparents' home and never returned for her. The detective obtained the name and contact information for Bunch's DYFS caseworker and that caseworker's supervisor.

The detective spoke with the DYFS supervisor later that day, who reported that Bunch was a substance abuser, and had taken E. from his father when she went into a substance abuse treatment program at a halfway house. The DYFS supervisor reported that E. was supposed to live with Bunch for thirty days while she was in the program, but she left with E. without finishing her program and that DYFS had no information about her whereabouts since that time. The supervisor also told the detective that DYFS had filed a petition to terminate Bunch's parental rights with respect to her daughter C. due to neglect and abandonment. The lieutenant from the Bronx D.A.'s Office spoke to another DYFS supervisor that day and learned that DYFS did not have custody of or a warrant for E., and that E.'s father had not filed a missing persons report after Bunch left the program with E. The lieutenant received a 67-page fax from DYFS, which included a copy of DYFS' petition to terminate the parental rights of both Bunch and C.'s father. These materials also included the results of a September 2000 psychological evaluation of Bunch, which concluded that Bunch was suffering from a number of mental health problems, including paranoia, anxiety, and narcissistic personality traits, and stated that Bunch was possibly suffering from a manic disorder. The psychologist had also concluded that Bunch was not competent to provide for either of her children. The DYFS petition also noted that Bunch had been permitted to keep custody of E. only because she was living with him at a residential drug treatment program.

According to the detective's files, after receiving the faxed information from the DYFS, the lieutenant informed Bunch's ACS caseworker of what he had learned from DYFS, and suggested to the ACS caseworker that E. should not remain in Bunch's care. The lieutenant informed DOI investigators that she then overheard the caseworker repeat what she had said and heard a female voice that she believed to be that of the caseworker's supervisor say "we don't work for them" and then instruct the caseworker to obtain the information from DYFS. The lieutenant faxed what she had received from DYFS to ACS.

According to ACS records, the caseworker noted that he had talked to the detective on June 11 and later received by fax copies of documents from the DYFS case file from the detective. Significantly, the ACS caseworker's entry does not reflect the lieutenant's recommendation that E. not remain in Bunch's care.

According to ACS records, on June 12, the caseworker confronted Bunch with the information he had received from DYFS. Bunch confessed to having a substance abuse problem. She admitted that she smoked marijuana three to four times a week because it eased her depression. The caseworker noted that Bunch had already been referred to a preventive services provider and would undergo random drug tests.

According to the detective's files, on June 12, the lieutenant from the Bronx D.A.'s Office called the SCR hotline concerning E. and Bunch, but was told that the SCR could not accept a report because E. was not in imminent danger. Because the SCR hotline does not record any of its calls or maintain records of calls that do not generate a referral to a local child welfare agency it is impossible to verify this.

According to ACS records, on June 12, the caseworker had a telephone conversation with a litigation assistant in Mercer County, New Jersey and was told that Bunch had a child in foster care in Princeton, New Jersey and her parental rights were scheduled to be terminated. It is unclear from this entry whether this litigation associate was a DYFS employee.

D. June 2001 Hotline Report

On June 17, 2001, while the investigation of the April 2001 allegations was still open, the hotline received two anonymous calls concerning Bunch. These two calls were received within one-half-hour of each other. The first report alleged that Bunch often left E. alone for hours when she went out at night, that Bunch abused drugs and alcohol, and that she often had no food in her home, and relied on others to feed E. The report also alleged that Bunch was physically abusive to E., and hit and punched him on his back and face. The second hotline report alleged that Bunch smoked marijuana in E.'s presence, sold marijuana from her room in E.'s presence, and often left E. at home unsupervised while she went out partying. The second report alleged that a week earlier Bunch had gone out at 1 a.m. and returned at 5:43 a.m., and that E. was alone during that time. The report listed as miscellaneous information that Bunch lived in a shelter, and provided the apartment numbers of others at the shelter who may have additional information about the allegations. Both of these reports were assigned to the caseworker investigating the April allegations.

According to ACS records, on June 18, the supervisor instructed the caseworker to refer Bunch for drug testing, to have contact with Bunch twice a month until she was accepted by another social service provider, and to speak with the foster care caseworker in New Jersey. On that same day, the caseworker visited with Bunch at the shelter. She denied the allegations in the hotline report, including that she had lost custody of C. because of abuse or neglect. Instead, she claimed that she had left C. with her paternal grandmother because Bunch's mother, with whom she lived, was being evicted. She said that after three or four weeks, C.'s grandmother brought her to DYFS because she no longer wanted to care for her. There is no record that the caseworker confronted Bunch regarding her failure to mention in their previous conversations that she had a daughter. Bunch said that she had left E. with his father and then was homeless for six or seven months. The caseworker referred Bunch for random drug screening at the Morris Park Lab. The caseworker also spoke that day with a shelter employee, and was told that Bunch had been a "decent resident so far," but that another resident had complained about Bunch yelling at E. in the hallway, which occurred frequently.

According to a safety assessment completed by the caseworker on June 20, Bunch denied staying out all night as alleged in the hotline report, and said that she did not hit E. anymore since ACS had directed her that it was inappropriate parenting. A June 25 safety assessment completed by the caseworker noted that Bunch and E. were still in the shelter system, but had been put on a waiting list for a two-bedroom apartment. The assessment went on to say that Bunch was scheduled to start preventive services on June 28, and that she had admitted to smoking marijuana.

On June 26, 2001, the investigation of the April allegations was closed as "indicated" for inadequate guardianship based on Bunch's admission that she used physical forms of punishment to discipline E. The abuse allegations were determined to

be “unfounded” based on the caseworker’s assessment that the allegations of “lacerations, bruises, and welts” were unsubstantiated.

On June 28, 2001, a case manager from a shelter in the Bronx where Bunch had recently moved telephoned the ACS caseworker to report that Bunch had been arrested for fighting with another woman on a train and that E. was staying with Bunch’s friend. Bunch was released from custody on June 29, and the ACS caseworker met with her at the shelter that day. The caseworker noted that E. was well groomed and doing well. Bunch told the caseworker that the person she had been fighting with was either the girlfriend or the cousin of a man “she had a beef with.” The caseworker told Bunch to reschedule her appointment with the Citizens Advice Bureau because she had already missed two scheduled appointments. Bunch claimed the agency had told her that she was no longer eligible to attend their programs because she had moved outside their service area. The caseworker made a note to discuss this with his supervisor, although there is no record in the case file that this conversation occurred. There is also no record that the caseworker contacted the Citizens Advice Bureau to verify that Bunch was no longer eligible to attend their programs, nor is there any record that the caseworker referred Bunch to another agency for services.

According to ACS records, on July 2, Bunch telephoned the caseworker and informed him that E. was going to live with his paternal grandmother in New Jersey. At a case conference on July 6, the caseworker and his supervisor agreed to close the case because services could not be provided to Bunch if E. was living in another state. On July 9, the caseworker called E.’s grandmother, who confirmed that E. was living with her. The caseworker advised E.’s grandmother to file for custody or guardianship of E. as soon as possible. E.’s grandmother said that she would discuss that with E.’s father. E.’s grandmother told the caseworker that the only reason E. was returned to Bunch was that Bunch gave “a misleading sob story” about needing to get E. back in order to regain custody of her daughter. She said that neither she nor E.’s father had heard from Bunch since she took E. to live with her in the drug treatment program the previous year. There is no record that ACS conducted a home visit of the grandmother’s home or that ACS consulted with DYFS to determine if the grandmother had a history with DYFS or requested that DFYS conduct a home visit of the grandmother’s home.

The investigation into the first of the June 17 hotline report cases was closed in CONNECTIONS on July 10, 2001, and the investigation of the second June 17 report was closed on July 11. The allegations concerning Bunch’s drug and alcohol use were “indicated.” The case file does not reflect a determination concerning the other allegations in the two June hotline reports, including that Bunch often left E. alone for hours, that there was often no food in the home, and that Bunch was physically abusing E.

E. January 2004 Hotline Report

On January 7, 2004, the hotline received a report from a doctor at E.’s school, P.S. 249. The report alleged that a school medical examination had revealed marks all over E.’s back that appeared to have been inflicted by a belt. The report also alleged that Bunch was present during the examination and provided inconsistent explanations as to how E. sustained these injuries. The report listed as miscellaneous information that the reporting doctor was concerned about sending E. home, and asked that ACS send a caseworker to the school immediately to interview E. By this time, E. was seven

years old. ACS records are silent as to how or when E. came to be living with Bunch again.

On the day of the hotline report, the assigned caseworker left a message for the reporting doctor, and then went to E.'s school. By the time the caseworker arrived, the doctor had left, but the caseworker interviewed the school nurse. The nurse explained that the doctor was at the school that day to perform state-mandated medical examinations of the students. When E. took off his shirt for the examination, he had noticeable scars on his back, including welt marks that looked "like loops," and a thin narrow streak on his back. E. claimed that the scars on his back were the result of a fall, but the doctor did not believe E.'s account. Bunch was present for the examination and insisted that she did not beat E. The caseworker also spoke with E.'s teacher who said that E. was very articulate and smart, but was not applying himself and was often disruptive in class. The teacher also told the caseworker that E. had come to school with a big gash on the back of his neck and on his forehead. There is no record that the caseworker asked the teacher whether she had asked E. how these injuries occurred.

That same day, the caseworker conducted a home visit at the Brooklyn shelter where Bunch and E. were then living. The caseworker met with Bunch's shelter caseworker who said that she had observed E. with injuries, including a welt mark, but when she asked him about these injuries in Bunch's presence, Bunch claimed that E. had been injured while roughhousing at a friend's house. The caseworker noted that the one-room apartment was in disarray, but Bunch said that she was in the midst of cleaning up and discarding unwanted papers. Bunch told the caseworker that she was on a waiting list for Section 8 housing benefits. Bunch said that E. had behavioral problems, and was hyperactive. She also said that he did not listen, particularly when he was excited. Bunch further claimed that E. had been bitten on his lower back by a dog when he was four years old, and that he liked to antagonize cats. According to Bunch, she had sent E. to live in New Jersey with his father in 2001 after she was arrested in a physical altercation, and E. had stayed with his father for two years because she was homeless. She claimed that all charges against her in Bronx Criminal Court had been dropped. Bunch said that she did not feel that E.'s father was taking proper care of E., and that E.'s father later lost his apartment because he had been caught with heroin. Bunch also claimed that E. had told her that his father made him steal from stores and houses. Bunch also said that she had received training as a home health aide and had received her security license. There is no record that the caseworker obtained any records in connection with Bunch's criminal case in the Bronx. There is also no record that the caseworker attempted to interview E.'s father to confirm Bunch's statements or obtained any criminal records relating to his alleged heroin possession or his subsequent eviction. There is also no record that the caseworker attempted to confirm Bunch's statements about training as a home health aid and her unspecified security license.

The caseworker also interviewed E. that day, who told her that he liked being bad, and that he got wild when he was happy. According to the caseworker's notes, E. said he fell on a concrete floor during recess on one occasion, and fell backwards onto the edge of a closet door about two weeks earlier and hit his neck. The caseworker noted that E. had a healed mark "behind his neck." E. said that he had made his mother angry when she thought that he had broken a small radio, and she had beat him with a belt. The caseworker also documented having observed old healed parallel loop marks and thin narrow marks on E.'s back, the mark on the back of E.'s neck, and another

mark on his forehead. The caseworker noted that Bunch seemed to be providing for E.'s basic needs, but could benefit from "services to learn appropriate ways to discipline and provide supervision for him."

On January 9, 2003, the caseworker and a supervisor conducted a joint interview of Bunch at the field office, during which Bunch denied using drugs, but admitted to having been "put" in a residential drug treatment program in New Jersey because she told "the people" there that she drank alcohol and smoked marijuana. When asked about the termination of her parental rights to her daughter C., Bunch said that she had missed a scheduled court appearance on September 11, 2001 because of the World Trade Center attack, then missed subsequent court dates because she was arrested twice more for fighting and was in jail. The progress notes indicate that Bunch expressed a need for services, in particular to "know how to manage her son in a better way." An undated entry in CONNECTIONS reflects that the caseworker had reviewed Bunch's history with ACS and learned of Bunch's history with DYFS and the conclusions of her psychological evaluation. It was also noted that Bunch had been providing the minimum degree of care for E., and "could benefit from concrete service" such as counseling and drug testing.

The caseworker's supervisor noted on January 8 that Bunch and E. appeared stable and functional, that the marks on E.'s body were not severe and did not seem to require medical attention, and that E. appeared healthy and adequately cared for. The supervisor noted that Bunch had an extensive history with ACS, as well as substance abuse issues and psychiatric problems, but that E. was not nervous or fearful around her. He concluded that since Bunch was "cooperative and amenable" to ACS counseling that service referrals with monitoring was "the only practical way to proceed."

On January 15, the caseworker referred Bunch to the Haitian Flatbush Center for individual counseling, substance abuse treatment, and anger management. Bunch began attending these programs on January 22.

The next dated progress note reflects that Bunch failed to report to the Kings County Hospital on January 29 for a psychiatric evaluation and refused to be evaluated unless a court mandated her to do so. There is no prior mention in the case record of the scheduling of a psychological evaluation. On February 2, the caseworker referred Bunch to the New Directions Rehabilitation Program for drug testing, but she refused to be tested. The case file also indicates that the Haitian Flatbush Center called the caseworker on February 3 to report that Bunch had refused to submit to drug testing. An ACS supervisor contacted Bunch and advised her that the drug testing was not optional, and if she continued to ignore the referrals, ACS would pursue legal action against her. Bunch reportedly became irate and threatened to take the supervisor "to the news." The supervisor notified the staff at the shelter where Bunch was living that she was upset and suggested that they watch her. On February 13, Bunch told the caseworker that she would not comply with drug testing or "continue" with drug counseling unless she it was court-mandated.

On February 19, the supervisor noted "at this time" they had received information about Bunch's extensive history with both ACS and DFYS in New Jersey, had learned that her parental rights had been terminated with respect to her daughter in New Jersey, and had "received an extensive 20-page document" from New Jersey describing Bunch's psychiatric and drug problems. It is unclear why the supervisor described this

information as newly acquired given that ACS obtained copies of the DYFS petition and the accompanying psychiatric evaluation during the investigations of the April and June 2001 hotline reports. The supervisor also noted that a DLS attorney had tried unsuccessfully to get a court order to have E. removed from Bunch's care, but would try again the following day.

On February 20, a DLS attorney obtained an order to remove E. from Bunch's custody. Bunch, who had been notified of the court date, did not appear in court. E. was placed in the care of Little Flower Children's Services ("LFCS"), a foster care agency, which later found him a home with a foster parent. Because E. was in foster care, the family's case was assigned to the OCACM unit within ACS.

F. Joziah Bunch

On December 26, 2004, Bunch gave birth to Joziah.

On January 11, 2005, at a hearing in Family Court relating to E.'s foster care status, the judge was informed that Bunch had given birth to Joziah. At that hearing, an ACS caseworker testified concerning the investigative findings relating to the physical abuse allegations of E. The judge ordered that E. remain in foster care and that Bunch continue to have supervised visitation with him. The case was adjourned to January 25, for the caseworker's cross-examination and for ACS to file a permanency petition with respect to E. At the January 25 conference, the Family Court judge directed the caseworker who had testified on January 11 to prepare a written report and return for additional testimony on February 2. There is no record in the DLS attorney's files that Joziah was mentioned in court that day.

On February 2, the Family Court judge gave LFCS the discretion to increase Bunch's supervised visits with E., and the OCACM caseworker reported that Bunch was complying with ACS' directives. The case was adjourned for additional proceedings with the judge instructing ACS to file a permanency petition for E. "as soon as possible." The DLS records do not reflect that Joziah was discussed in this proceeding.

On March 28, the Family Court judge held a hearing on ACS' petition for the permanent placement of E. Records of the DLS attorney reflect that the judge was informed that Bunch had refused to participate in mental health services or parenting skills classes without a court order. The DLS records also reflect that the judge was reminded that Bunch had given birth to Joziah, and that ACS and LFCS would be proposing a plan to coordinate visits between E. and Joziah.

On April 11, LFCS submitted a report to the court which stated that Bunch had refused to provide LFCS with Joziah's date of birth or a copy of his birth certificate. In this report, LFCS stated that they could not comment on Joziah's progress, but noted that LCFS staff members had seen Joziah when Bunch brought him to her supervised visits with E., and he "looked clean and healthy." The LFCS caseworker informed the Family Court judge that Bunch's visits with E. had been sporadic since December 2004, and that she had missed several scheduled visits during the relevant period.

According to the DLS record, Bunch arrived late to the Family Court proceedings on April 12. Bunch said that she was late because she had transportation trouble and needed to fill a prescription for Joziah. There is no information in the DLS file about the

reason Joziah needed prescription medication. The case was adjourned to April 19 for further fact-finding, and the submission of an updated written report by ACS.

On the April 19 court date, an employee from the Woodruff Shelter testified concerning Bunch's use of marijuana. The judge ordered that an ACS supervisor appear on July 8 to testify and directed ACS to submit an updated written report. The judge also directed that additional supervised visits between E. and Bunch should be arranged.

On July 8, 2005, LFCS provided a report to the court which stated, among other things, that Bunch continued to refuse to cooperate with counseling, mental health services and parenting skills classes unless mandated by the court. The LFCS caseworker also noted that Bunch continued to refuse to provide any information regarding Joziah. The report further stated that although Bunch's visits with E. were sporadic, the visits were "usually very positive."

According to the DLS files, at a July 8 proceeding in Family Court, Bunch's attorney raised a question as to whether Bunch was required to allow ACS or LFCS caseworkers into her home given that E. was in foster care, and Joziah was not under ACS supervision. The DLS attorney responded that LFCS is required to monitor Bunch's home in order to make recommendations to the court about whether E. should be returned to Bunch's custody. Bunch's attorney claimed that the caseworkers had attempted home visits while she was at work or not at home, and then left notes stating that they had attempted a home visit, but Bunch had refused to allow them access. The attorney further indicated that Bunch was not obligated to comply with the various social services that the LFCS caseworker was trying to impose until the fact-finding was complete. The attorney noted that Joziah had been born at least six months earlier and there had been no new SCR reports made against Bunch. The Family Court judge ordered that Bunch allow an LFCS caseworker to conduct a home visit once a month. The case was adjourned to August 16, 2005.

The DLS attorney's file indicates that on August 16, 2005, Bunch did not appear in court due to a reported conflict with her work schedule. The case was adjourned to October 7 for continued fact-finding. On October 7, Bunch again failed to appear in court and the case was adjourned to October 21.

At an interview with DOI, an LFCS caseworker said that LFCS had called Bunch on October 11, and requested that she be available for a home visit on October 14. Bunch rescheduled for October 21, but then called to cancel the rescheduled home visit because a Family Court appearance had been scheduled for that day. According to the LFCS caseworker, Bunch told the caseworker that she would notify the media if E. was not returned to her by October 21.

On October 21, the Family Court judge determined that LFCS had made reasonable efforts toward the goal of reunifying E. with Bunch by offering supervised visits between Bunch and E. The Court ordered LFCS to arrange for E. to meet with his assigned Law Guardian before the next court date. The Court also asked ACS to provide a written report by January 5, 2006 concerning the status of Bunch and the "child," although it is unclear whether this a reference to E. or to Joziah. An LFCS report submitted in connection with the October 21 court date stated that Bunch had brought Joziah with her on two supervised visits with E., and that he appeared to be clean and

healthy. The report stated that Bunch continued to refuse to provide LFCS with any information about Joziah's medical care, immunizations, and her child care arrangements for him when she was at work.

According to LFCS records, on October 22, the Family Court judge ordered Bunch to comply with home visits by LFCS caseworkers as previously ordered by the Court on July 8, 2005. On November 28, an LFCS caseworker conducted a home visit, and noted that Bunch's apartment was well kept and had adequate furnishing. The LFCS caseworker reported that Bunch was very nurturing toward Joziah, but refused to allow the caseworker to physically examine him, and continued to refuse to provide any information about Joziah, insisting that he was not part of the ACS case. As a result, LFCS requested a conference before the Family Court judge on December 28, 2005 to seek an order compelling Bunch to submit Joziah for a physical examination and to provide information about him. The DLS file indicates that Bunch was scheduled for a supervised visit with E. at LFCS on December 27, but cancelled the visit because she had a toothache.

On December 28, 2005, the LFCS caseworker telephoned Bunch to determine if she was at home and available for a home visit, but no one answered the phone. The LFCS caseworker appeared in Family Court later that day seeking an order compelling Bunch to submit Joziah to a physical examination and to produce a copy of his birth certificate. Bunch did not appear in court.

On December 28, 911 received a call reporting that an infant was not breathing in Bunch's apartment. A man identified as Bunch's boyfriend, who was in the apartment with Bunch when the EMTs arrived, claimed that Joziah had choked on juice, and then passed out. Joziah died shortly after arriving at the hospital. The OCME concluded that Joziah died as a result of blows to his neck and torso. The OCME also found that he had broken ribs and had suffered internal bleeding due to lacerations to his liver. Joziah was a year old at the time of his death.

Latifa Bunch was charged with two counts of murder in the second degree, manslaughter in the first and second degrees, and endangering the welfare of a child. Her case is currently pending in New York State Supreme Court in Brooklyn.

4. The Gaston Children

On December 6, 2005, Jennifer Gaston's eight-year-old son, B., started a fire in their illegal cellar apartment. B. escaped from the apartment as the fire began to spread, but three of Gaston's other children, ranging in age from 18 months to six years old, died in the fire. An 89-year-old man who was living in one of the other bedrooms in the apartment also died. Another man, who lived in a bedroom at the back of the house escaped through a window in his room.

Before the fire, Gaston was the subject of repeated reports to the SCR hotline alleging that she was living with her children in a cold, filthy and dangerous cellar apartment. The reports also alleged that Gaston routinely left her children unattended, used drugs in her children's presence, and worked as a prostitute out of her apartment.

Gaston was not charged in connection with the deaths of her three children. Her surviving two children were eventually placed in foster care with relatives. Gaston is permitted supervised visits with them.

A. March 1999 Hotline Report

Jennifer Gaston first came to the attention of ACS on March 29, 1999, at which time she had two children and was living in a shelter. A shelter employee called the hotline to report that Gaston had left her 22-month-old son unattended in the bathtub. According to ACS records, a caseworker interviewed the source of the hotline report, who reported that he had not witnessed the incident, but became aware of it a few days after it had happened from another shelter employee. Gaston was also interviewed by the caseworker and stated that she had left her son with a neighbor so that she could complain to the building superintendent about a leak in the bathtub. This was corroborated by her neighbor. Following this report, the ACS caseworker helped Gaston collect her public assistance benefits, and ensure that her children received their necessary immunizations. On June 10, 1999, ACS closed this case as "unfounded."

B. November and December 2004 Hotline Reports

In November and December 2004, the SCR hotline received eight separate reports about Gaston. By this time, Gaston had four children, ranging in age from seven months to seven years old, and was living in an illegal cellar apartment in Elmhurst, Queens. Four of the reports were made on November 29, 2004. The first report that day was made at 1:38 a.m. from someone who identified herself (although she did not provide an address or telephone number) and said that she was Gaston's friend. This friend alleged that Gaston was selling her food stamps, that there was no food in the household, and that the children were usually "dirty and unkempt." The report alleged that Gaston's youngest child was typically in a dirty diaper and had severe diaper rash. The report further alleged that Gaston worked as a prostitute out of the apartment, and that Gaston was pregnant.

The second and third reports on November 29 reports came from mandated reporters: a police officer who had responded to an anonymous 911 call at 1:10 a.m. reporting that the children were alone in the apartment, and an EMT who had also responded to the apartment that morning. Both the police officer and the EMT reported that the apartment was cold, filthy, and infested with cockroaches. The police officer

noted that there was clothing near the furnace, and chemicals, including paint thinner, that were stored on a fuse box. The EMT reported that the apartment had a cement floor, with garbage and broken furniture strewn about. The EMT also noted that Gaston was verbally abusive to her children. Both reports noted that the children had been taken to St. John's Hospital in Queens for evaluation.

In an interview with DOI investigators, the reporting police officer explained that when he and his partner arrived, they found the children in the cellar apartment, accessible only by a narrow alley from the sidewalk and a low-ceilinged staircase. The police officer felt that the apartment was clearly not suitable for young children in that it had a concrete floor, inadequate heat, and exposed electrical wires dangling from the ceiling. The police officer expressed particular concern about the exposed electrical wires, and flammable items, including paint thinner, that were stored on a fuse box. The police officer reported that when he arrived, Gaston was not at home, but there were two "older" men in the apartment with the children, but he was unsure of their relationship, if any, to the children. He also noted that the youngest child was only wearing a diaper to sleep and was overdue for a diaper change. The police officer explained that Gaston returned to the apartment while the police and the EMT were still in the apartment. The police called an ambulance to take the children to St. John's Hospital for evaluation. An NYPD sergeant arrived later and instructed the police officer to take photographs of the apartment because he was so appalled at the condition of the apartment. The officer also told DOI that Gaston appeared indifferent to the accusations that she was neglecting her children.

On November 29, at 10:49 a.m., the SCR hotline received an anonymous report which alleged that Gaston neglected her children, allowing them out on the street alone with no shoes or socks in wintertime, and that she hit the children with a broom stick for punishment, leaving marks and bruises. The source quoted Gaston as having said that she hits the children with the broom handle so often that they "don't even feel it anymore." This report also indicated that the family's basement apartment was cold and dirty, with a concrete floor, that there was little or no food in the home, and that Gaston was working as a prostitute in the children's presence. The source claimed that Gaston's older boys were aware that Gaston was working as a prostitute and had difficulty seeing her with different men. This source further alleged that Gaston spent whatever money she had on her boyfriend rather than on her children's basic needs. The report also alleged that Gaston was pregnant again. The hotline recorded as miscellaneous information that ACS had previously referred Gaston to a shelter with the children, but she stayed for only 24 hours before returning to the cellar apartment.

According to ACS records, on November 29 at approximately 4:05 a.m., an ECS caseworker spoke with the police sergeant who had been in the apartment earlier that morning. The sergeant told the caseworker that the children appeared to be in good health with no marks or bruises, and did not appear to be abused or neglected, but were taken to the hospital for an evaluation. The sergeant told the caseworker that he believed the unsanitary conditions in the apartment created a health risk for the children, and recommended that the family find alternative housing. Approximately two hours later, a different NYPD sergeant called the ECS caseworker and confirmed that the children were at home with their mother, and the apartment was filthy and unsafe. The ECS caseworker called the hospital and confirmed that the children had been examined and released that same morning.

At 6:20 a.m., the caseworker spoke by telephone with Gaston. Gaston denied that she was working as a prostitute and that her children were dirty and unkempt. She also denied being on welfare or selling food stamps. Gaston did admit that her daughter had diaper rash because she was using cheap diapers, but insisted that she had brought her daughter for treatment. She also admitted that her home was dirty, but claimed that she had planned to do laundry and clean the apartment. The caseworker advised Gaston that she must make alternative living arrangements or clean the apartment. Gaston told the caseworker that she would stay with her mother until the apartment was clean. Approximately 10 minutes later, the caseworker spoke with the NYPD sergeant who had been at Gaston's home that morning and was told that Gaston's mother would not allow Gaston and her children to stay with her. ACS and the NYPD sergeant agreed that the children could stay in the apartment that day if Gaston cleaned and ACS made a home visit to conduct a safety assessment.

On November 29, a supervisor directed the assigned CPS caseworker to review Gaston's past ACS case records, determine whether Gaston could stay with her mother and, if not, direct her to the DHS shelter system intake center. The supervisor further directed that the case remain open for a full 60 days to confirm that Gaston had gone to the shelter intake center or arranged for a more suitable apartment. He also instructed the caseworker to contact the children's pediatrician as well as their school and inquire whether they came to school "smelly or filthy." There is no record that the caseworker referred Gaston to the shelter intake system or that he contacted the children's pediatrician or the children's school.

According to ACS records, on November 29 at approximately 7:30 a.m., the caseworker conducted a home visit. Gaston was not at home. Gaston's uncle was at home with B., R., and J. and said that Gaston was at the laundromat. The caseworker described the apartment as a basement apartment with two bedrooms that was somewhat "unkempt." The caseworker noted, however, that the conditions were the fault of the landlord. The caseworker indicated that Gaston and the children recognized that the home had "constructional problems," but considered the apartment safe. The caseworker also noted that Gaston was "working to address the needs of the home." The caseworker offered no explanation as to what Gaston was doing toward that end or the source of that information given that Gaston was not at home during this visit. There is no record that the caseworker provided Gaston help in finding safe, alternative housing or contacted the landlord to discuss potential improvements to the apartment at any point during the investigation. There is also no record that the caseworker asked Gaston's uncle during this visit whether he had ever observed Gaston beating her children with a broom, working as a prostitute, or using drugs. This caseworker never interviewed the reporting police officer or EMT, and as a result, did not obtain the photographs that the officer had taken that evening. The caseworker identified one of the older men living in the apartment as Gaston's uncle, but did not make any effort to identify the other man reported by the police to be living in the apartment.

On November 30, at 1:17 p.m., an additional anonymous report was made to the SCR hotline regarding Gaston and her children. Like the earlier reports, this report alleged that Gaston was failing to take adequate care of her children. The report stated that Gaston and her children were living in a basement apartment and that Gaston beats her children with a broom. The report also alleged that Gaston was using cocaine and that she worked as a prostitute to support her "binges." The report also noted that she was eight months pregnant.

On the evening of November 30, the assigned caseworker returned to the apartment and interviewed Gaston, her seven-year-old son B., her five-year-old son R and her uncle.¹² The caseworker noted that B. denied having seen his mother drinking or using drugs, and denied that there were a lot of strange men in the apartment. R. told the caseworker that Gaston was a good mother and that he loved her. He also denied that there were any strange men in the home. The caseworker observed the other children, four-year-old C., and eight-month-old J., and determined that they had no physical injuries and that their basic needs were being met. She noted that they were too young to be interviewed. Gaston told the caseworker that she was a single mother, had little income, and relied on her uncle to help her with the children. Gaston admitted that the apartment was in poor condition, and that there had been paint thinner “by the radiator” when the police visited. She claimed that she was attempting to clean the home when the report was made. Gaston also claimed that she was committed to her children, and had worked “tirelessly” to make the household acceptable for them. Gaston also reported that her four children were fathered by three different men, but she did not have a current relationship with any of those men.

There is no record that the caseworker asked Gaston about the allegations that she was physically abusing her children, including beating them with a broom, or that she questioned Gaston about drug use, or whether she was working as a prostitute. Although one of the hotline reports alleged that Gaston was eight months pregnant, there is no record that the caseworker asked Gaston whether she was pregnant. In an interview with DOI, the caseworker claimed that she asked Gaston if she was pregnant, but Gaston denied it. She acknowledged that this exchange is not reflected in her case notes. The caseworker told DOI investigators that she did not ask Gaston about her drug use or ask her to submit to a drug test because she did not show any signs of drug use. She further claimed in this interview with DOI that had she been aware that Gaston was pregnant and her supervisor agreed, she would have asked Gaston to submit to a drug test. The caseworker also claimed to have interviewed a family friend, and a neighbor whose name she could not recall, but acknowledged that there is no record of these interviews in the case file. In addition, although Gaston had been the subject of a March 1999 hotline report, the caseworker’s notes indicate that there were no prior documented ACS reports on the family.

During the November 30 home visit, Gaston’s uncle told the caseworker that he was helping his niece by letting her live with him and that he provided for them because Gaston had nowhere else to go. He denied that Gaston worked as a prostitute in the apartment or had men frequenting the home. There is no record that the caseworker asked Gaston’s uncle whether he observed Gaston beating the children or using drugs. There is also no record that the caseworker asked Gaston’s uncle about his source of income. The caseworker told DOI investigators that she did not ask Gaston’s uncle for proof of his employment because she believed him when he said he was employed.

Finally, although the caseworker had a variety of sources available to her for confirming whether Gaston had a criminal record, including a criminal justice liaison in her field office, there is no record that the caseworker attempted to confirm whether Gaston had ever been arrested for prostitution. The caseworker told DOI investigators that she could not recall if she attempted to obtain Gaston’s criminal history. The

¹² Although this home visit was conducted on November 30, 2004, the caseworker did not enter her notes into CONNECTIONS until January 6, 2005.

caseworker's supervisor told DOI that he did not instruct the caseworker to consult the criminal justice liaison regarding the prostitution allegation because he felt that there was no evidence that the allegation was true. DOI's review of Gaston's criminal history revealed that in 2000 she was charged with and pled guilty to loitering for the purpose of prostitution.

On November 30, the caseworker completed a safety assessment form in CONNECTIONS. In this form, the caseworker noted that Gaston "appeared unwilling and/or unable" to meet the basic needs of her children with respect to food, clothing, shelter, and/or medical care. The caseworker also noted that the family's physical living conditions were hazardous. The caseworker concluded, however, that these factors did not place the children in immediate danger of serious harm because Gaston was willing to work with ACS to meet the needs of the children. That same day, the caseworker completed another computerized form called a "risk assessment profile," which is used to quantify elements of risk in the household and to assist ACS in determining what service referrals might be appropriate for a family. The caseworker noted that Gaston's family lived in "inadequate housing with serious health or safety hazards," but that Gaston was "attempting to address the needs of the home and make it safe for the children." There is no indication on this form or anywhere in the case file identifying what steps that Gaston was taking to improve the condition of the apartment. The caseworker later told DOI that she might have removed the children from the apartment had she observed the exposed electrical wiring and paint thinner on the fuse box as had been reported, but claimed that the apartment had been cleaned up by the time she arrived. She said that the exposed wires had been wrapped up with tape out of the children's reach, and the reported paint thinner was not in sight. The caseworker further claimed that because Gaston was unwilling to go to the DHS shelter system, she believed that her only options were to leave Gaston and the children in the apartment or to petition for the children's removal from Gaston's care. The caseworker said that she felt the latter option would have been punishing her Gaston being poor. The caseworker also recalled that relocating families at that time was difficult because Section 8 housing vouchers were suspended. There is no mention in the case file that Gaston had refused to consider entry into the shelter system.

On December 8, 2004 at 8:12 p.m., the SCR hotline received another anonymous call alleging that Gaston was a prostitute and a drug addict and left her children alone for hours while she went out to work as a prostitute and use drugs. The reporter also alleged that Gaston hit her older sons on their heads with a broom, causing bumps, and punched her children on their backs. The report alleged that the children were dirty and unkempt. The report also alleged that that there was no food in the household, and the children often went hungry.

On December 9, 2004, the hotline received two additional calls about Gaston. The first was an anonymous call placed at 8:17 p.m. which alleged that Gaston frequently hit her children with a broom leaving bruises. The report also alleged that there was often no food in the home because Gaston spends any money she has on herself. The report further alleged that Gaston often left her children alone without any supervision. At 8:18 p.m. that same evening, the SCR hotline received a call from the same named friend who had made the 1:38 a.m. report on November 29. On this occasion, the friend left a telephone number. In this report, the friend alleged that Gaston's children often play outside unsupervised, and on one occasion the previous summer, her son had been hit by a car, and another had almost cut his finger off playing

with a neighbor's bicycle. The friend also said that when Gaston was working as a prostitute, she brought men into the apartment and had sex with them in the apartment's bathroom. As in the other reports, this report also alleged that Gaston hit her son on the head with a broomstick and with a belt. The report alleged that there was often no food in the home, and the children were made to go hungry. The report also alleged that Gaston's uncle was never in the home, and that Gaston was pregnant. These three new reports were assigned to the same caseworker who was responsible for investigating the November 29 allegations.

On December 10, 2004, the caseworker's supervisor noted that the allegations in the 8:18 p.m. call on December 9 were almost identical to the previous reports, and instructed the caseworker to contact the source of that report. The supervisor noted in a December 10 entry that it is a misdemeanor to make false allegations. On December 10, at approximately 9:45 a.m., the caseworker spoke to the source by telephone, who denied being the source of the other anonymous calls. The caseworker noted that when asked about the "irony" that her reported allegations were virtually identical to the allegations in the other anonymous reports, the source insisted that she had not made the other reports. The caseworker notified the source that "if unfounded cases continue to be reported" about Gaston and her family, ACS would refer the source to the Queens District Attorney's Office and "criminal proceedings will be taken against her." The source told the caseworker that Gaston talked to her about things in Gaston's household, and that other friends in the neighborhood were also aware that Gaston did "awful things" to her children. The source eventually hung up on the caseworker, and the caseworker's subsequent calls went directly to voicemail. Not surprisingly, the source did not respond to the caseworker's messages.

Later that evening, at approximately 9:45 p.m., an ECS caseworker called the source. That caseworker's progress notes reflect that the source denied witnessing Gaston hitting her children or observing any bruises or marks on the children. The source admitted to having made anonymous reports about Gaston in the past, but denied calling the hotline the night before. The source expressed concern that ACS would not take action until something happened to the children. When asked how she knew that Gaston was having sex in the bathroom of the apartment, the source said that she had to get off the telephone because she was driving.

The caseworker's supervisor told DOI investigators that he had believed that all of the anonymous reports were made by the same source and that source was the "friend" who had left her name because the allegations and the wording of the call narratives were all so similar. This supervisor stated that he believed the call narratives were meant to be verbatim summaries of the caller's allegations.

On December 16, the caseworker returned to Gaston's apartment, where Gaston was sorting laundry and the children were watching television.¹³ The caseworker noted the children did not have any marks or bruises, and there was an abundance of food in the apartment. The caseworker also noted that the home was suitable, and "the children view the home as safe and they enjoy living in the apartment." Apart from the children's view of the safety of the apartment, the caseworker did not note what had changed since December 3 when she found Gaston's apartment inadequate and posing serious health

¹³ The caseworker did not enter a summary of this December 16 home visit into CONNECTIONS until January 6, 2005.

or safety hazards to the children. There is absolutely no indication that the caseworker addressed with Gaston any of the allegations in the three hotline reports received on December 8 and December 9, including that Gaston was beating her children, leaving them unsupervised with no food in the home and working as a prostitute. The progress notes also reflect that on December 17, a staff member of Elmhurst Hospital called the caseworker and reported that Gaston had brought her eight-month-old daughter, J., to the hospital who was later diagnosed with "RSV Bronchialitis." The hospital staff was concerned because Gaston had simply just dropped J. off and failed to tell hospital staff whether J. had her necessary immunizations.¹⁴

The next entry in the case file is a January 5 entry by the caseworker's supervisor documenting a conference with the caseworker the day before to review her entire caseload. With respect to Gaston, the supervisor noted that both had agreed that the case was "heading totally unf," but would remain open for "the mo. to obtain her shot." The supervisor also directed the caseworker to contact the children's pediatrician. This entry appears to be a reference that Gaston's case was heading toward an "unfounded" determination and perhaps a direction for the caseworker to keep the case open for a month to ensure that J. received any necessary immunizations. Alternatively, it could be a reference that the case would remain open until Gaston, J.'s mother, arranged for J. to receive her necessary immunizations. There is no record that the caseworker contacted the children's pediatrician or that she confirmed that J. was up to date on her immunizations.

On January 25, the caseworker attempted a home visit, but no one was at home. The caseworker noted that the case would be closed, but she would follow it "off line" to ensure that J. had received any necessary medical treatment. On January 27, the caseworker's supervisor noted that he would determine if ACS should offer services to Gaston, and that ACS should make a report of medical neglect to the SCR hotline if the caseworker confirmed that Gaston had failed to ensure that J. received proper medical attention. He also directed the caseworker to document the current condition of the apartment.

On January 28, the assistant to the deputy director of the Queens field office reviewed the case file and conferred with the caseworker's supervisor. The progress note indicated that the caseworker was unavailable. This entry reflects that a decision was made to close the case in CONNECTIONS; however, both the assistant and the supervisor agreed that there was still "much work" to be done, such as "a more comprehensive assessment of the home" and Gaston's ability to care for the children. The entry also noted that the caseworker should do an additional home visit the following week. On January 28, 2005, the investigation of the November and December hotline reports regarding Gaston were closed as "unfounded." The caseworker later told DOI investigators that she was uncertain of what, if any, investigatory steps she had taken after the case was closed in CONNECTIONS. The supervisor claimed in an interview with DOI that the case was monitored after it was closed in CONNECTIONS in what is known within ACS as an "off line" or "in Word," and that the progress notes during this investigatory stage could be found in the caseworker's computer and in the "hard copy" file. DOI requested these additional "off line" progress notes. As of the date of this report, none have been provided by ACS.

¹⁴ This entry was also not recorded by the caseworker until January 6, 2005.

C. July 2005 Hotline Report

In July 2005, by which time Gaston had five children, an additional SCR report was made regarding Gaston. On July 1, 2005, at 5:43 p.m., the hotline received a call from a source who identified herself as a friend of Gaston. This friend had the same first name as the friend who made the December 9 report, but a different last name and provided a different telephone number. This caller alleged that two days earlier Gaston had beaten her eight-year-old son, B., with a belt, causing bruises on his leg and a bump on his head. The report also alleged that Gaston's son, R., who was then six years old, had also been seen with small bruises on his arms. This report alleged that Gaston and her children lived in a one-bedroom apartment with her uncle, and that she often left the children with her uncle, who was not an adequate caregiver. The report alleged that Gaston knew that her uncle was not a suitable caregiver because he allowed the infant to cry until Gaston returned home and that was a concern because the infant suffered from asthma. The report further alleged that Gaston was working as a prostitute.

The caseworker responsible for investigating the November and December 2004 hotline reports was given the responsibility of investigating these allegations after an ECS caseworker conducted an initial home visit on July 1. During the July 1 home visit, Gaston claimed that there were "two prior ACS cases" that she suspected were called in by her "enemy." Gaston said that all of the allegations were false, and that any bruises on her children were the result of playing. She admitted that her uncle babysat the children, but insisted that she had never come home to a crying baby. Gaston also denied working as a prostitute. She said that her uncle supported her and her five children with his income from a job as a child care worker at Covenant House. The ECS caseworker also interviewed Gaston's children, B. and R., who both denied that Gaston hit them. B. was observed to have bruises and claimed that he got the bruises playing in water from a fire hydrant. The ECS caseworker noted that the apartment had clothing and other items all over the floor and lacked smoke or carbon monoxide detectors. The caseworker advised Gaston to clean the apartment and told her that the landlord was required to install detectors. The ECS caseworker concluded that Gaston's home did not appear to pose an immediate threat to the life or health of the children.

On July 5, the assigned caseworker's supervisor directed the caseworker to determine whether Gaston's claimed "enemy" was the source of the other reports. The supervisor also instructed the caseworker to contact the source of current hotline report and determine her basis for the reported information, and to instruct her that it was a misdemeanor to file false reports if the caseworker believed that she was also the source of the other anonymous reports.

On July 6, the assigned caseworker conducted a home visit, but found only Gaston's uncle and the two youngest children at home. Gaston's uncle told the caseworker that the allegations were false and that he had supported Gaston since she had her first baby when she was a teenager. He said that he had purchased a carbon monoxide detector and would install it that day. The following day, the caseworker returned to the apartment and found Gaston at home. Gaston told her that she had "been intimate" with a man with whom the source was also involved with and as a result the source had threatened to "report a case to the authorities on her." In connection with this July 7 home visit, the caseworker noted in a safety assessment form that although there were safety factors present – specifically that Gaston appeared unwilling and/or unable to provide adequate supervision of her children – the factors did not place the

children in danger of serious harm. The caseworker did not identify what, if anything, had improved in the family's living conditions since December 2004 when she had concluded that the apartment posed serious risks to the children's safety.

On August 3, the caseworker conducted another home visit and confirmed that the smoke and carbon monoxide detectors had been installed. The caseworker noted that the apartment was slightly untidy. The caseworker returned to the apartment on August 17 to speak with Gaston's uncle, who said that he had not seen Gaston abuse the children, leave the apartment late at night, or leave the children alone. In this interview, Gaston's uncle said that he was a maintenance worker at Covenant House and supported himself, Gaston and her five children. He also claimed that the hotline reports were a form of harassment by someone who knew Gaston. Apart from her interviews of Gaston, the children and Gaston's uncle, the caseworker made no effort to investigate the allegations that the children were being physically abused or that Gaston was working as a prostitute. There is no record that the caseworker obtained school records for the two school-aged children or attempted to interview Gaston's neighbors regarding the allegations. There is also no record that the caseworker contacted the children's pediatrician or obtained their medical records to test Gaston's denials regarding the allegations of physical abuse. Finally, there is no record that the caseworker attempted to obtain Gaston's criminal history to test her denials about drug use and prostitution. Instead, ACS closed this case as "unfounded" in August 2005.

D. December 2005 Fire

At approximately 6:20 p.m. on December 7, 2005, the SCR hotline received a report from an NYPD officer that three of Gaston's children had been killed in a fire at their home the day before. The report alleged that Gaston's eight-year-old son, B., started the fire while playing unsupervised with a lighter. The report stated that there were conflicting reports about Gaston's whereabouts at the time the fire started, but at least one witness reported she was outside the house without the children before the fire started. The report also noted that Gaston had left her children unsupervised in the past. The report alleged that Gaston's failure to properly supervise her children had resulted in the death of three of her five children.

Gaston's three children who died that day were Jocelyn Collazo, who was 18 months old; Christian Gaston, who was five and a half years old; and Richard Laboy, who was a month away from his seventh birthday. An 89-year old man who was living in one of the other bedrooms in the apartment also died. B. escaped from the apartment as the fire began to spread. Another man, who lived in a bedroom at the back of the house, escaped through a window in his room. Firefighters' rescue efforts were significantly impeded because access to the cellar apartment from the first floor was blocked by a locked metal door and the only other access to the apartment was a smoke-filled narrow alley and low-ceilinged staircase.

Gaston was not charged in connection with the deaths of her three children. Gaston's surviving two children were eventually placed in foster care with relatives. Gaston is permitted supervised visits with them.

5. Dahquay Gillians

On November 6, 2005, Dahquay Gillians drowned in a bathtub in his apartment. He was 16 months old at the time of his death. Although the OCME concluded that the cause of death was drowning, the autopsy confirmed that Dahquay had other recent injuries, including bruises to his face, a bruised back, and a bruise to the back of his head. The autopsy also noted that Dahquay had suffered internal bleeding. Daquay's mother, Tracina Vaughn, pled guilty to criminally negligent homicide and reckless endangerment in connection with Dahquay's death. On November 29, 2006, she was sentenced to three and a half to seven years in prison.

According to the report of the Accountability Review Panel, Tracina Vaughn first became known to the child welfare system in March 1986 in connection with a hotline report against her mother. The following month, Vaughn's mother voluntarily placed Vaughn and her siblings in foster care. Her mother later died of AIDS and Vaughn was raised by her grandmother. On August 27, 2002, when Vaughn was 22 years old, she gave birth to her first child, T.

A. December 2003 Hotline Report

On December 9, 2003, the SCR hotline received a call from an NYPD officer who had responded to a 911 call at approximately 2:15 p.m. that day at Vaughn's apartment in Brooklyn. Vaughn called 911 following a violent incident with her boyfriend, Tyrone Gillians. The hotline report alleged that Tyrone Gillians had hit Vaughn with a piece of molding, and then slapped, choked and punched her, and shoved her onto a bed. The report also alleged that Gillians had thrown Vaughn's then 16-month-old son, T., onto the bed. The report stated that Gillians had been arrested by the NYPD, charged with assault and was in police custody.

According to ACS records, an undated entry reflects that at 5:20 p.m. an ECS caseworker interviewed the reporting NYPD officer by telephone.¹⁵ That officer confirmed that he had responded to Vaughn's 911 call and that Gillians had been arrested for assault in the second degree. The officer said that Vaughn would be seeking an order of protection and was planning to press charges against Gillians. The NYPD officer stated that Gillians was not T.'s father, and that T. had not been injured during the incident. The officer also said that Vaughn had refused medical attention.

Another undated entry in the case file reflects that at 5:30 p.m. the ECS caseworker spoke by telephone with Vaughn. The caseworker read Vaughn the allegations in the call narrative, and Vaughn confirmed that the allegations were true. Vaughn told the caseworker that this was not the first time that Gillians had hit her, but this was the first time that Gillians had "tossed" T. while he was hitting her. She also told the caseworker that she was very afraid of Gillians, and promised the caseworker that she would not allow him back into her home. Vaughn insisted that Gillians did not live in the apartment, but did have some things at the apartment. Vaughn further stated that she would be pressing charges against Gillians, and would do whatever she needed to do to protect T. The ECS caseworker noted in that same entry that she was unable to make a home visit to assess the safety of the home environment, but based upon the

¹⁵ Other ACS records reflect that the ECS caseworker was assigned this case at 5:18 p.m. on December 9, suggesting that this telephonic interview was conducted on December 9.

information provided by Vaughn, T. did not appear to be in any imminent risk of harm. The case file is silent as to why the caseworker was unable to conduct a home visit despite having just spoken with Vaughn by telephone, who was at home.

According to ACS records, a CPS caseworker conducted a home visit on December 11, 2003. During that visit, Vaughn again confirmed that the allegations in the hotline report were true. Vaughn added that Gillians had hit her with a stick and punched her in the arm leaving bruises. The caseworker noted that she had observed the bruises on Vaughn's arm. Vaughn further confirmed that Gillians had tossed T. onto the bed. The caseworker noted that she did not observe any physical injuries, marks or bruises on T. Vaughn also told the caseworker that she took T. for regular medical checks-ups and that he was up to date on his immunizations. There is no record that the caseworker asked for or obtained contact information for T.'s pediatrician or asked Vaughn to sign a release for T.'s medical records. The caseworker noted that Vaughn's apartment was adequate, and contained an ample supply of food and baby supplies. Vaughn also told the caseworker that she was receiving public assistance, food stamps and Medicaid. There were no other children in the household at that time. Vaughn again promised that she would not allow Gillians back into the home.

According to ACS records, on December 26, the caseworker interviewed a neighbor, who told the caseworker that he would rather not provide his name because he did not want any trouble. The neighbor reported that Vaughn and Gillians argued on occasion, but he was uncertain if these arguments ever escalated into physical violence. That same day, the caseworker met with his supervisor and both agreed that the allegations of inadequate guardianship were substantiated against Gillians. The case file reflects that the caseworker was unable to interview Gillians because he was incarcerated. As demonstrated in a subsequent ACS investigation involving both Vaughn and Gillians, the caseworker could have made arrangements to interview Gillians even though he was incarcerated. There is also a notation in the case file that the caseworker offered Vaughn unspecified services, which she declined because she was in the process of receiving an order of protection. On January 2, 2004, ACS closed the case, substantiating the allegation of inadequate guardianship against Gillians. In the closing entry, it was noted that there were no safety risks in the home, that Gillians had been arrested, and that Vaughn had committed that she would not permit Gillians back into the home.

There is no record that the caseworker contacted T.'s doctor, obtained T.'s medical records or arranged to have T. examined by a doctor to confirm that he had not been injured during the incident with Gillians before closing the investigation. Finally, the caseworker did not contact the relevant District Attorney's Office to confirm that Vaughn had in fact received an order of protection against Gillians or obtain the terms and duration of the order of protection.

B. May 2004 Hotline Report

On May 28, 2004, the SCR hotline received a report from an NYPD officer who had responded to a 911 call from Tracina Vaughn. On this occasion, Vaughn called 911 to report that her son had been burned and needed to go the hospital. The hotline report alleged that Tyrone Gillians had left 21-month-old T. unattended in a bath tub with the water running. The report alleged that when Gillians returned, T. had burns over 20% of his body. According to the report, Vaughn was not at home during the incident, but was

made aware of what had happened, and that neither Gillians nor Vaughn had sought medical attention for T. for two days after the incident. The call narrative also noted that Gillians' explanation of how T. was injured was not consistent with the injuries that T. sustained. The call narrative stated that T. had been taken to Cornell Hospital and provided the name and telephone number of the treating physician. The report further noted that Vaughn was nine months pregnant, and that both Vaughn and Gillians had been arrested and were being held at the precinct.

According to ACS records, on May 28 at 9:30 p.m., an ECS caseworker spoke by telephone with the reporting NYPD officer. The officer said that the EMTs, who also responded to the 911 call, told Vaughn that T.'s burns appeared to be a few days old, and it was later determined that T. was burned in an incident two days prior on May 26. The officer said that Gillians claimed that T. was in the bath with the water running and when he stepped away to throw away a dirty diaper, he heard T. scream. Gillians claimed that an upstairs neighbor must have flushed a toilet, causing the water to get very hot. Gillians told Vaughn about the incident when she came home, and the two decided to put cocoa butter on the burns. When questioned by the officer, Vaughn stated that when she returned home, both Gillians and T. were crying. Gillians had written a note about the incident. Vaughn claimed that she did not think the burns were too bad, and treated the burned areas with cocoa butter, but yesterday the areas had blistered. The officer said that T. was burned on his buttocks, penis, scrotum, and left back thigh. The officer described T. as dark skinned, but explained that the burned areas were now white. The caseworker's notes also reflect that she spoke with a sergeant at the precinct that day and was told that Gillians and Vaughn were still at the precinct being processed. The sergeant said that Gillians had been charged with assault and reckless endangerment, and Vaughn had been charged with reckless endangerment and endangering the welfare of a child.

According to ACS records, on May 28, the ECS caseworker also spoke by telephone with a doctor from the Child Protective Team at Cornell Hospital and was told that T. had been burned on his buttocks, penis, scrotum, upper back thighs, and portions of his upper abdomen and chest, but his legs, feet, hands and arms were unharmed. The doctor told the caseworker that the story Gillians and Vaughn had provided was not consistent with T.'s injuries. The doctor also told the caseworker that the burns were infected because Vaughn had put cocoa butter on the burned areas and then covered those areas with a diaper. The doctor was uncertain how long T. would need to remain in the hospital.

According to ACS records, on May 29, a different caseworker spoke with an NYPD detective by telephone and was told that both Gillians and Vaughn were still in custody, had just given written confessions and were about to provide videotaped confessions. The detective told the caseworker that Vaughn would likely be released that evening or the following day. There is no record that the caseworker asked the detective to describe the substance of the confessions given by Gillians and Vaughn. The next day, a different caseworker attempted a home visit at Vaughn's apartment in the evening, but no one was at home. This caseworker also spoke by telephone with a nurse at Cornell Hospital and was told that T. was in stable condition. The caseworker called the Child Advocacy Center to obtain information about Vaughn's confession, but the detective was unavailable.

On June 1, 2004, the assigned CPS caseworker spoke by telephone with T.'s treating physician at Cornell Hospital and was told that Gillians provided conflicting accounts of how T. was burned, neither of which was consistent with his injuries. Gillians told the doctor that Vaughn was not at home when T. was burned, but when she returned, she observed the burns and put cocoa butter on the burned areas. Later, the skin began to blister and Gillians said that he popped the blisters with a needle. Friends of Gillians and Vaughn saw T. and threatened to take him to the hospital if Gillians and Vaughn refused. The doctor also told the caseworker that when T. arrived at the hospital he was dehydrated and the blisters were infected. The doctor indicated that T. would need to remain in the hospital for at least another week. The doctor also said that Vaughn was nine months pregnant and was due any day. On that same day, the caseworker spoke by telephone with the detective who repeated the explanations that Gillians had provided and confirmed that Vaughn and Gillians had waited two days to take T. for medical treatment. The detective also confirmed the charges and said that both Gillians and Vaughn would be arraigned over the weekend. The detective also told the caseworker that there was a prior criminal case against Gillians arising from an incident where Gillians threw T. onto a bed during an argument with Vaughn.

On June 14, the caseworker received a telephone call from a social worker at Cornell Hospital who said that T. was ready to be discharged, although he would need follow up treatment. The social worker provided the caseworker with contact information for Vaughn's grandmother and her cousin as potential foster caretakers for T., and said that she would await placement information from the caseworker. That same day, the caseworker spoke by telephone with the Assistant District Attorney ("ADA") responsible for prosecuting both Gillians and Vaughn. The ADA confirmed the charges against both Gillians and Vaughn. The ADA also stated that Vaughn had received an order of protection against Gillians on January 28, 2004 that was still in effect, and would be so for at least another year. The ADA said that hospital officials had estimated that the water into which T. was placed must have been at least 100 degrees given the severity of his burns. There is no record that the caseworker asked the ADA for or obtained a copy of the order of protection that Vaughn had received against Gillians.

On June 15, the caseworker conducted a home visit of Vaughn's cousin in connection with T.'s placement into foster care upon his release from the hospital. The caseworker described the home as a small two-bedroom house that was very clean and well furnished.

That same day, the caseworker interviewed Vaughn, who was still being held at Riker's Island, via videoconference. In that interview, Vaughn stated the following. On the morning of May 26, she had a doctor's appointment. When she returned home at about noon, she found a note on the door from Gillians apologizing for T.'s injuries. Gillians then gave Vaughn a similar account of how T. was injured that he had provided to the NYPD. Gillians insisted that it was an accident. Vaughn said that by this time, T.'s skin was bubbling. Vaughn admitted that she waited a few days before taking T. to the hospital because she was hoping to treat the burns at home. Vaughn also admitted that both she and Gillians were afraid that ACS would remove T. from the home if they took him to the hospital. Ultimately, friends came to the home, saw T.'s injuries and threatened to take T. to the hospital if Vaughn and Gillians continued to refuse to do so.

Vaughn also told the caseworker that she and Gillians had been together for about a year. He moved in with her and T. in August 2003, and about four months later,

became physically abusive to her. She said that in December 2003, she and Gillians got into an argument and he punched her in the mouth while T. was sitting in her lap. She said that when they began to fight, Gillians took T. and threw him on the bed. She insisted that T. was not hurt in this incident. Gillians was arrested and she later got an order of protection against him. Vaughn recalled that an ACS caseworker came to her home and confirmed that T. was not hurt, but she did not see that caseworker again. She described another incident in January or February 2004 when she and Gillians got into an argument and he punched her in the arm and in the face. T. was in the apartment during this incident. Vaughn called the NYPD, but Gillians was allowed to remain in the home. Vaughn stated that these were the only occasions that Gillians had hit her. Vaughn also provided the caseworker with the names and telephone numbers of T.s' pediatrician and of the doctor that she had been seeing in connection with her pregnancy. Vaughn said that she was due in about three weeks. There is no record that the caseworker contacted T's pediatrician or Vaughn's doctor or that the caseworker attempted to obtain medical records for either T. or Vaughn.

On the following day, June 16, the caseworker interviewed Gillians via videoconference. Gillians repeated the story that he had told to the NYPD on the day of his arrest. Gillians claimed that he and Vaughn did not take T. to the hospital because they panicked and were worried that ACS would take T. away from them. Gillians expressed regret and insisted that he loved T. as if he were his own child. Gillians also denied ever having been physically abusive to Vaughn. He insisted that anytime Vaughn was upset with him, she called the police. With respect to the December 2003 incident, Gillians claimed that he had an argument with Vaughn and she called the NYPD and said that Gillians had beat her and T. Gillians said that he was arrested, and later took a plea because he wanted to get out of jail before the holidays. He acknowledged that an order of protection had been issued. Gillians said that after he was released, he went to live with his sister, but returned to Vaughn's apartment about a month later. He said that some time later, he and Vaughn got into another argument and a neighbor called the NYPD. The officers were going to arrest him for being in violation of the order of protection, but did not because the order of protection was limited. He said the officers told him that he could remain at Vaughn's apartment. Gillians provided the caseworker with the name and office address of his probation officer as a result of his assault conviction. Gillians was required to meet with his probation officer twice a week and complete a drug treatment program as well as an anger management class. Gillians admitted to using both cocaine and marijuana within the last two to three months, but said that he was enrolled in a drug treatment program at Daytop in Brooklyn. Gillians also said that he was unemployed.

According to ACS records, on June 16, 2004, ACS filed an abuse petition in Family Court, and was granted temporary custody of T., who was placed in foster care that same day with Vaughn's cousin through Little Flower Children's Services ("LFCS"). While he was in foster care, T. was identified as needing speech therapy, physical therapy, and other programs for his educational development. He also required substantial medical treatment for his burns. When T. was released from the hospital, he was fitted with a special burn pressure garment that he was to wear 23 hours a day to facilitate the healing process and reduce scarring.

On June 23, the CPS caseworker noted in CONNECTIONS that she had tried several times without success to interview the source of the hotline report. The entry is

silent as to the number of attempts or the dates on which the caseworker attempted to contact the source of the hotline report.

Vaughn was released from jail while her criminal case was still pending. Tyrone Gillians remained in jail. On June 25, following her release, Vaughn met with an ACS caseworker, an ACS child evaluation specialist and a representative from LFCS to outline a treatment plan for her, which included parenting skills classes, individual and family counseling, and early intervention. Vaughn agreed to participate in these programs.

On July 2, Vaughn gave birth to Dahquay. Tyrone Gillians is Dahquay's father. Five days later, on July 7, ACS petitioned the Family Court to have Dahquay removed from the home and placed in the same foster home as T. That petition was granted and because both T. and Dahquay were in foster care, Vaughn's case was transferred to the OCACM unit.

During the period from July 2004 through March 17, 2006, T. and Dahquay remained in foster care, and Vaughn was permitted supervised visits with them.

On February 8, 2005, Vaughn pled guilty to reckless endangerment in the first degree stemming from the bathtub incident and was sentenced to five years' probation. ACS records show that after her release from jail, a CPS caseworker referred Vaughn to a program which the caseworker believed would offer parenting skills training, and individual therapy, and would conduct a psychiatric evaluation of Vaughn. LFCS records confirm that Vaughn received a referral to that program, and also reflect that Vaughn received referrals to other programs offering similar counseling services. ACS and LFCS records reflect that from August 2004 through April 2005, Vaughn participated in some of these programs. However, DOI's review of the records from these programs demonstrated that Vaughn's attendance was sporadic, that she was frequently late, and that she only met the minimum requirements to receive her parenting skills certificate. DOI also learned that none of these programs provided domestic violence counseling to Vaughn.

In March 2005, Tyrone Gillians was sentenced to four years' imprisonment following his guilty plea to assault in the second degree for placing T. in a scalding tub of water. That same month, Vaughn admitted in a Family Court proceeding to having neglected T.'s medical needs after he was burned. On March 17, the Court ordered that T. and Dahquay be returned to Vaughn's custody the following day on the condition that she complete domestic violence counseling and continue with individual counseling, ensure that her children received necessary medical care, and that Gillians be forbidden to visit the children unsupervised.

On April 8, 2005, the CPS caseworker made a home visit and observed that Vaughn had sufficient food and the children appeared safe, but there was no crib for Dahquay. The caseworker later arranged for LFCS to provide Vaughn with a crib. The caseworker noted that T. had been receiving speech and occupational therapy while in foster care, and that these services should continue. During her interview with DOI, the caseworker admitted that she did not follow up to confirm that T. was continuing to participate in these therapies because she thought that the FSU caseworker would do so when the case was transferred to that unit.

On April 13, 2005, a final hearing was held in Brooklyn Family Court, and Vaughn was ordered, among other things, to continue and complete domestic violence counseling, continue and complete individual counseling, maintain all appointments for medical treatment of both children, and ensure that T. continued to receive speech and occupational therapy. During this hearing, the ACS caseworker submitted a report to the court, dated April 11, 2005, which she later told DOI had been prepared by an LFCS caseworker. The report informed the Court that Vaughn was attending domestic violence counseling at Safe Horizon. DOI later confirmed that Safe Horizon has no record that Vaughn ever attended their domestic violence program.

Both the ACS caseworker and the LFCS caseworker were interviewed by DOI concerning the submission of this false information to the Family Court. The ACS caseworker said that she asked the LFCS caseworker to draft a report because the children were in foster care and therefore the foster care agency was principally responsible for monitoring the family and making referrals for any necessary services. The ACS caseworker admitted that she did not independently verify whether Vaughn was enrolled in a domestic violence program at Safe Horizon, but relied upon the information provided by the LFCS caseworker and insisted that was the "standard process." The LFCS caseworker told DOI investigators that he gave Vaughn a referral to Safe Horizon for domestic violence counseling and said that he recalled her telling him that she was participating in this program. This LFCS caseworker said that he did not recall contacting Safe Horizon to verify that Vaughn was in fact enrolled in a domestic violence program, although he acknowledged that calling to confirm "would have been something to do."

LFCS currently has a contract with ACS to provide foster care services.

On April 22, 2005, the ACS caseworker conducted a home visit and noted that Dahquay and T. appeared safe and that T. did not appear to be frightened or intimidated by Vaughn. The caseworker conducted another home visit on May 4, 2005, and noted that the crib she had requested from LFCS had been delivered, and the home was clean and appropriately furnished. She also noted that she did not observe any marks or bruises on the children and both appeared happy. The caseworker observed that Vaughn did not have enough formula for Dahquay, and Vaughn said that she could not receive benefits for the children through a federal nutrition program without a letter from ACS. The following day, the caseworker brought Vaughn a letter, a copy of which is in the case file, so that Vaughn could receive benefits through this program.

On May 18, 2005, the caseworker conducted a home visit and noted that the children appeared fine, but there was a limited amount of food in the apartment. Vaughn said that the public assistance office had not yet put the children on her budget because their system still showed that the children were in foster care. The caseworker told Vaughn to call her the following Monday so that the caseworker could call Vaughn's public assistance caseworker. On May 23, the caseworker brought food to Vaughn's apartment, and noted that Vaughn had received formula, cereal, juice and milk through the federal nutrition program. Vaughn told the caseworker that she still had problems with public assistance and the caseworker offered to assist Vaughn in opening a public assistance case. Vaughn said that she would like to return to school and asked for a referral for day care for the children. The caseworker instructed Vaughn to first locate a day care facility with openings for both children, and then she would refer her to the

Agency for Child Development (“ACD”), a unit within ACS that would assist her with day care.

On May 24, 2005, the caseworker called the New York City Human Resources Administration (“HRA”) regarding Vaughn’s public assistance benefits and was informed that Vaughn’s case had been closed. The caseworker then called a supervisor from the HRA center where Vaughn’s case was previously and was informed that in order to reopen her public assistance case Vaughn needed to bring a letter from ACS to the HRA center and to fill out a new application. The caseworker relayed that information to Vaughn, and Vaughn agreed to go to the HRA public assistance office.

On May 25, 2005, Vaughn’s probation officer informed an ACS supervisor that Vaughn was on probation, and the supervisor instructed the assigned caseworker to contact Vaughn’s probation officer. This is the first indication that ACS was aware that Vaughn was on probation, although ACS knew that Vaughn had been arrested in connection with the scalding of T., and knew that criminal charges had been brought against her. As noted above, Vaughn pled guilty to reckless endangerment in the first degree on February 8, 2005, and was sentenced to five years’ probation. The caseworker documented several attempts to reach the probation officer and also left a message with Vaughn asking her to tell her probation officer that ACS was trying to contact her. The dates and times of those calls were not documented. On May 26, 2005, Vaughn told the caseworker that she had been accepted for public assistance, but would not receive her benefits for 30 days and only had food for one more day. The caseworker told Vaughn that she would put in a request for emergency food money. The caseworker called the HRA public assistance supervisor, who said that she did not have any paperwork reflecting that Vaughn had applied for public assistance benefits. The caseworker then called Vaughn and told her to go back to the HRA public assistance office and to call her from that office.

According to ACS records, on June 3, 2005, during a home visit, and at a time when Vaughn was still on probation from her guilty plea, Vaughn told the ACS caseworker that she had been ordered by her Criminal Court judge to participate in a drug treatment program after she tested positive for marijuana in May 2005. Vaughn indicated that she needed to get her children into a day care program so that she could attend the court-mandated drug treatment program. Vaughn told the caseworker that she had smoked marijuana once, that it was a mistake and would not happen again. She also told the caseworker that her children were not with her when she smoked marijuana because she had left them in the care of a friend. On June 8, the caseworker spoke to the probation officer and confirmed that Vaughn had tested positive for marijuana and that Vaughn needed to get into a drug treatment program. The probation officer also reported that Vaughn had said that she was having difficulty getting into a program because she did not have child care. The caseworker told the probation officer that she would refer Vaughn to a unit within ACS that would help her identify child care.

The caseworker conducted a home visit on June 22, 2005, and observed the children to be fine. Vaughn said that she would receive her first cash benefit from PA on June 26. Vaughn told the caseworker that the children were going to the clinic on Fulton Street for all of their medical needs and that Dahquay had an appointment to get his immunizations on June 24, but T. did not have a scheduled appointment. Vaughn said that T.’s burns were healing well and that she needed to schedule a follow-up appointment for him. Vaughn again discussed that she could not attend her mandated

drug treatment program until she found day care, but said that she had an appointment with the ACD unit on June 25. DOI learned from the director of eligibility services at the ACS Division of Child Care (previously known as ACD unit) that their office has no record that Vaughn applied for child care, and a search of their system did not identify any child care vouchers issued to Vaughn.

On June 17, 2005, Tyrone Gillians admitted in Brooklyn Family Court that he had placed T. in scalding water and thereafter failed to take him for medical treatment. Based on this admission, the Court found that Gillians had abused T., and made a finding of derivative abuse regarding Dahquay. A final order of protection was issued requiring Gillians to stay away from T. until he turned 18, and an additional order of protection required Gillians to stay away from Dahquay for one year.

In July 2005, Vaughn's case was transferred to the FSU because her children, T. and Dahquay, had been returned to her in March 2005. On July 8, the CPS caseworker and the new caseworker from the FSU met with Vaughn at her home. Vaughn insisted that since she tested positive she had stopped smoking marijuana. Vaughn informed the FSU caseworker that she needed to find child care so that she could attend a drug treatment program. She also said that she did not feel that she needed a drug treatment program, but was willing to submit to random drug tests. There is no record that either caseworker asked Vaughn about her appointment with the ACD unit that had been scheduled for June 25 to help Vaughn identify child care.

On July 22, the FSU caseworker spoke with Vaughn's probation officer and was told that probation "had violated" Vaughn because she had not enrolled in a drug treatment program, and that Vaughn needed to appear in court on this violation. The probation officer asked the FSU caseworker for proof that Vaughn had completed parenting skills classes and a counseling program, and the caseworker said that she would fax the certificate to the probation officer.

According to ACS records, on July 26, the FSU caseworker conducted a home visit at which Vaughn said that she had gone to take a drug test at Counseling Service EDNY, but was turned away because the drug testing unit did not have records indicating that she was to be tested. There is no record that the caseworker confirmed Vaughn's claim with Counseling Service EDNY. Vaughn said that she had an appointment in two days with her probation officer, and the caseworker directed her to take a drug test after meeting with her probation officer. Two days later, on July 28, the FSU caseworker spoke with Vaughn by telephone. Vaughn stated that she had not gone for the drug test because she had taken a drug test in connection with her probation that day and was uncertain if ACS wanted her to take an additional test. On August 8, the FSU caseworker spoke by telephone with Vaughn's probation officer, who confirmed that Vaughn had been drug tested on July 27 and the results were negative.

On August 16, the FSU caseworker conducted a home visit. During that visit, the caseworker told Vaughn that she wanted her to submit to a random drug test, and directed Vaughn to take a test on August 18. Vaughn agreed, but said that she still had not identified child care and as a result had to take the children everywhere.

On August 23, the caseworker conducted another home visit. The caseworker confronted Vaughn with her failure to show up for the August 18 drug test. Vaughn told the caseworker that she would go for a test the following day after she finished with her

probation officer. The caseworker said that she would have to contact Vaughn's attorney and inform the Family Court judge that Vaughn was not complying with ACS' requests for drug testing if she did not take the test.

On August 24, Vaughn submitted to a drug tested arranged by the ACS caseworker, and on August 30, the caseworker was notified by the testing lab that the results were negative.

On September 2, 2005, Vaughn called the caseworker and said that she did not have any diapers for the children because she ran out of her public assistance money and would not be getting additional money until the following week. The caseworker agreed to bring Vaughn diapers, but would not do it every week, and that Vaughn had to budget herself to allow for the cost of diapers. The caseworker brought the diapers later that day and observed the children playing. The caseworker also asked Vaughn why she was not actively looking for a larger apartment since she had been approved for Section 8 housing subsidies.

On September 15, 2005, the caseworker conducted a home visit and noted that T. and Dahquay had no marks or bruises. After discussing scheduling, the caseworker told Vaughn to take a drug test on September 17.

On October 6, 2005, the caseworker and her supervisor met with Vaughn at the field office to review her service plan. During this meeting, they discussed Vaughn's failure to identify a day care facility for Dahquay. Vaughn claimed that she was having difficulty because most day care facilities in her neighborhood refused to accept a one-year-old child. The supervisor identified a day care provider in Vaughn's neighborhood that accepted young children and Vaughn said that she would contact them about Dahquay. The caseworker provided Vaughn with a new ACD referral form, a copy of which is in the case file. The caseworker also noted that Vaughn had taken only one of the four drug tests which ACS had asked her to take. Vaughn claimed she forgot because she got busy, and was told that forgetting scheduled drug tests was unacceptable. The caseworker told Vaughn that she had spoken with her probation officer and that if Vaughn submitted to four or more random drug tests and continued to test negative, they might agree that a drug treatment program was unnecessary. Vaughn said that her grandmother had taken T. to the Cornell Burn Center that day. Vaughn also said that she was having difficulty getting to the Section 8 housing office, and the caseworker said that she would call that office for her.

According to ACS records, at a Family Court appearance on October 17, 2005, the caseworker was ordered to have Vaughn submit to random drug screening. The caseworker told the Court that T.'s burns were healing and that his next medical appointment was on October 27. The Court also ordered ACS to continue monitoring T.'s medical treatment and adjourned the case to January 6, 2006. The following day, the caseworker conducted a home visit and told Vaughn that she was going to refer her to a preventive services agency that would provide her with additional support. Vaughn told the caseworker that she had met with her probation officer that day and said that her appointments with her probation officer were going to be reduced from once a week to twice a month.

On October 21, 2005, Vaughn called her caseworker and said that she needed to vacate her apartment in the next 30 to 60 days because her building had been

purchased by a new landlord, but the building manager had told her that the new owner would give her \$2,000 to relocate. The caseworker told Vaughn to get a letter from the building manager and take it to the public assistance office. In addition, the caseworker told Vaughn to attempt to get her expired Section 8 voucher reinstated so that she could get a new apartment. The caseworker then called the building manager and asked him to give Vaughn a letter, which he promised to do. On October 25, the caseworker spoke to Vaughn to confirm that she had spoken with the building manager regarding the letter. Vaughn told the caseworker that she had left several messages for the building manager, but he had not returned her calls.

On November 3, 2005, the caseworker conducted a home visit, and observed the children sleeping on a bed without sheets. The caseworker told Vaughn that she was going to refer her for preventive services with a program called Family Dynamics. Vaughn expressed gratitude because she needed assistance finding housing and said that the building manager had still not returned her calls about the letter.

C. Dahquay's Death

On November 6, 2005, Vaughn called 911. In that call, she claimed to have fed Dahquay, and given him a bath, but when she took him out of the bath and put him on the bed, he stopped breathing. She also said that his stomach was full of water. When the EMTs arrived, Vaughn give several different accounts of what had happened, all of which were inconsistent, and each one differed from the account that she had told the 911 operator. The EMTs administered CPR on the scene and then transported Dahquay to the emergency room, where he was pronounced dead.

In interviews with DOI, the EMTs reported that Dahquay had an injury in his groin area that appeared to be the result of a recent burn. In addition, the treating physician at the hospital reported that Dahquay had what appeared to be recent injuries, including a bruise to the left side of his face, and scalding burn marks in his "diaper area." The autopsy conducted by the OCME confirmed that Dahquay had suffered internal bleeding. The OCME concluded that Dahquay's death was a homicide and ruled the cause of death was drowning. Dahquay was 16 months old at the time of his death.

Vaughn was charged with manslaughter in the second degree, criminally negligent homicide, reckless endangerment in the first degree, and endangering the welfare of a child in connection with Dahquay's death. At the time of Dahquay's death, Tyrone Gillians was still in jail in connection with the scalding of T. On November 28, 2006, Vaughn pled guilty to criminally negligent homicide and reckless endangerment in the first degree in connection with Dahquay's death. She was sentenced the following day to three and a half to seven years in jail.

T. was later placed in foster care with relatives.

6. Lizabeth Gonzalez

On January 24, 2006, five-month-old Lizabeth Gonzalez nearly drowned while her mother, Carol Gonzalez, was bathing her. Carol Gonzalez was indicted for attempted murder, attempted assault, reckless endangerment, and endangering the welfare of a child. On January 9, 2007, she pled guilty to reckless endangerment, and shortly thereafter was sentenced to one year in jail. After serving her sentence, Gonzalez was deported to Honduras.

A. October 2005 911 Calls

On October 17, 2005, Carol Gonzalez called 911 to report that her two-month-old daughter, Lizabeth, was having difficulty breathing. The EMT who responded did not find any evidence of respiratory distress, but took Lizabeth to Woodhull Hospital for observation. Hospital staff determined that Lizabeth was suffering from sleep apnea, a condition where breathing is temporarily suspended repeatedly during sleep. On October 21, Lizabeth was discharged from the hospital, and Gonzalez was given a sleep apnea monitor, which would help monitor Lizabeth's breathing. Hospital staff also showed Gonzalez how to use the monitor. On October 22, Gonzalez called 911 again concerning Lizabeth's breathing. The EMT who responded to this call noted that Gonzalez also expressed concern about Lizabeth's neck. Although she appeared to be resting comfortably and her breathing appeared normal, Lizabeth was taken to the pediatric intensive care unit at Brooklyn Hospital for observation.

B. October 2005 Hotline Report

On October 28, 2005, during Lizabeth's stay at Brooklyn Hospital, the SCR hotline received a call from a social worker at Brooklyn Hospital. The social worker reported that Lizabeth had been admitted to the hospital with respiratory distress and alleged that Gonzalez was not using the sleep apnea monitor as directed, which was affecting Lizabeth's ability to breathe. The report stated that Gonzalez had claimed that the sleep apnea monitor was not working properly, but hospital staff confirmed that the monitor was working. The social worker also reported that Gonzalez had called 911 claiming that hospital staff was trying to kill her daughter by not feeding her. The social worker reported that Gonzalez had told hospital staff that Lizabeth was foaming at the mouth, was dehydrated and swollen, but hospital staff did not observe any of these conditions. The social worker was uncertain if Gonzalez had any mental health issues, but stated that a psychological evaluation had been scheduled for her.

According to ACS records, on October 28, a caseworker from the ECS unit spoke to a pediatrician at the hospital who reported that Lizabeth's condition was improving, but that she was not yet ready to be released from the hospital. Gonzalez, a recent immigrant from Honduras, who did not speak English, was interviewed over the telephone by a Spanish-speaking ACS supervisor. During that interview, Gonzalez denied having told 911 that anyone at the hospital was trying to kill her child. She said that she was having difficulty communicating with the hospital staff who did not speak Spanish and that the Spanish translator the hospital provided had been unclear about Lizabeth's condition. DOI reviewed a recording of the relevant 911 call and confirmed that Gonzalez did not accuse hospital staff of trying to kill Lizabeth, but had complained about the staff's refusal to release Lizabeth from the hospital.

On October 29, 2005, the day after the hotline report, an ACS caseworker visited the home of Gonzalez's grandfather, with whom Gonzalez and Lizabeth had been living, and found that there was a crib that was not fully assembled and Progress Notes did not indicate where she was sleeping. There was formula in the house. The caseworker noted that Gonzalez and Lizabeth had their own bedroom, and the home did not pose any immediate danger to Lizabeth's safety and well being.

On November 1, 2005, ACS arranged for Gonzalez to receive a psychological evaluation through the Woodhull Hospital's Mobile Crisis Unit. The evaluation was performed by a psychologist from the Mobile Crisis Unit on November 2. ACS records are unclear as to who was actually briefed concerning the conclusions of this evaluation. An ACS manager noted in CONNECTIONS that he spoke with "the worker" from the Mobile Crisis Unit on November 2 regarding the evaluation and was told that Gonzalez was coherent and oriented, and was not exhibiting signs of psychotic behavior. The ACS manager noted that this "worker" believed there had been a misunderstanding between Gonzalez and hospital staff, and he asked that the evaluation report be faxed to ACS. The assigned caseworker also claimed to have received a telephone report from the Mobile Crisis Unit about the evaluation on November 2, although her progress note was not entered into CONNECTIONS until November 9. The caseworker's entry, however, appears to have been copied verbatim from the manager's entry about the evaluation.

DOI investigators interviewed a community liaison from the Mobile Crisis Unit, who stated that he informed an ACS staff member that the evaluation had taken place, but did not provide any information about the findings of the evaluation because he was not authorized to but more importantly because he did not have that information. The liaison was certain that the ACS staff member to whom he spoke was not the ACS manager or the caseworker referenced above. There is no record that the assigned caseworker or the manager attempted to speak directly to the examining psychologist. In addition, although ACS had not yet received a written copy of Gonzalez's psychological evaluation, ACS cleared Lizabeth to be discharged into Gonzalez's care on November 2. ACS did not receive a copy of Gonzalez's psychological evaluation until after Lizabeth's near-drowning. That evaluation reflected far more serious conclusions about Gonzalez's mental health than was reflected in the earlier progress notes, including that Gonzalez had a major depressive disorder without psychotic features, and that an additional assessment was necessary to rule out post-partum depression and an adjustment disorder. The CONNECTIONS entries made by both the manager and the assigned caseworker made no mention that the psychological evaluation had determined that Gonzalez was suffering from a significant depressive disorder.

According to CONNECTIONS, Gonzalez moved into her aunt's apartment in the Bronx with Lizabeth in early November 2005. On November 14, ACS referred Gonzalez for preventive services at Leake and Watts East Bronx Family Center for parenting skills, assistance with Lizabeth's medical treatment, public assistance advocacy, housing assistance and homemaking services. On December 23, 2005, the investigation concerning the October 2005 allegations was closed as "unfounded," with a notation that the caseworker had referred Gonzalez for preventive services. At the time of the referral, Leake and Watts did not have any Spanish-speaking caseworkers, and therefore was unable to provide any services to Gonzalez who spoke only Spanish. In an interview with DOI, the Leake and Watts intake coordinator stated that she informed

the ACS caseworker who had referred Gonzalez that the agency did not have Spanish-speaking caseworkers on staff. The intake coordinator then called the ACS caseworker back in December and told her that Leake and Watts had hired two Spanish-speaking caseworkers who would begin working on January 6, and suggested that the caseworker re-refer Gonzalez to the agency if the need still existed. The only conversation with the Leake and Watts intake coordinator documented by the ACS caseworker reflects that on December 12, the intake coordinator said that someone from Leake and Watts would be making an assessment of Gonzalez's home. The intake coordinator told DOI that ACS re-referred Gonzalez on January 10 and that she sent a letter to Gonzalez scheduling a meeting for January 17. The intake coordinator told DOI that she conducted Gonzalez's intake interview on January 17, using Gonzalez's aunt as an interpreter to supplement her minimal Spanish, and that Leake and Watts was in the process of assigning Gonzalez a caseworker when she learned about the near-drowning of Lizabeth.

C. January 2006 911 Call

On January 24, 2006, 911 received a call from the home of Gonzalez's aunt reporting that a child was dying at the home. The 911 operator gave the aunt instructions on how to administer CPR. The FDNY responded and found Lizabeth lying on the floor with a weak pulse. She was not breathing and was unresponsive. Gonzalez's aunt told a firefighter that she found Lizabeth floating on her back in the bathtub. Gonzalez told a Spanish-speaking paramedic that she was bathing Lizabeth, left the room and when she returned, Lizabeth was under water. EMTs rushed Lizabeth to Jacobi hospital, where she recovered. At the hospital, Gonzalez told a police officer that she was taking a bath with Lizabeth, when she slipped from her hands and she panicked.

Following this incident, Carol Gonzalez was indicted for attempted murder in the second degree, attempted assault in the first and second degrees, reckless endangerment in the first degree and endangering the welfare of a child. The indictment charged Gonzalez with submerging Lizabeth in a bathtub filled with water. On January 9, 2007, Gonzalez pled guilty to reckless endangerment in the first degree. On January 30, 2007, she was sentenced to one year in jail.

After serving her sentence, Gonzalez was transferred to a facility in Houston for deportation proceedings. On April 11, 2007, Gonzalez was deported to Honduras.

Lizabeth is currently in foster care with her aunt.

7. Jaylee Logan

On January 7, 2006, two-month-old Jaylee Logan died. The OCME concluded that Jaylee had died of Sudden Infant Death Syndrome, and no one was charged in connection with her death. At the time of Jaylee's death, Jaylee's mother, Jasmine Morales, had two other children of her own, Jaylee's twin brother J. and a 19-month-old daughter, J. In addition, Morales was the legal guardian of her two teenage sisters, M. and N.

The Morales family was known to ACS as early as 1989. Jasmine Morales and her sisters, M. and N., were adopted by their grandmother in 1997, after ACS filed a neglect petition against their mother. Beginning in late July 1999, ACS arranged for the Morales family to receive preventive services through the Salvation Army.

In September 2004, Morales' grandmother died. Following her grandmother's death, Morales petitioned to become the legal guardian of her two sisters. On April 28, 2005, by order of a referee in Bronx Family Court, Morales was appointed the legal guardian of her two younger teenage sisters, M., who was then 16 years old, and N., who was then 13 years old. At the time that Morales became the legal guardian of her two teenage sisters, she was herself only 19 years old. According to ACS records, a caseworker for the Salvation Army assisted Morales with the guardianship petition and testified on her behalf in Family Court. The caseworker also helped Morales obtain an adoption subsidy to help her support her sisters.

A. March 2005 Hotline Report

On March 11, 2005, the SCR hotline received a call from an anonymous source, who reported that Morales and her "paramour" James allowed drug dealers into their apartment where they sold drugs, used crack cocaine and smoked marijuana while the children were in the apartment. The source alleged that people who were high from drugs had picked up one-year-old J., and that Jasmine's sisters, 14-year-old N. and 16-year-old M., also smoked marijuana in the apartment. The report included as miscellaneous information that N. and M. had missed a lot of school, and that the apartment was dirty, although not to the point of being a health hazard to the children.

On the day of the hotline report, an ACS caseworker conducted a home visit and interviewed Morales, M., N., and James Logan. The caseworker noted that the apartment was a clean three-bedroom apartment with working smoke and carbon monoxide detectors, and there was plenty of food. M. denied all of the allegations. She insisted that no one in the apartment used or sold drugs, and that she had never tried marijuana. N. was also interviewed, who said that the source of the report "doesn't have their facts straight." She also denied that she or anyone in the household used or sold drugs. The caseworker asked N. how she felt about her sister being her guardian. N. replied that it was better than being in a group home and explained that she had been in foster care once when she was in third grade after her mother had hit her. Both M. and N. provided the caseworker with information about their school, and both indicated that they were asthmatic and provided their pediatrician's name. M. and N. denied that James lived in the apartment with them. The caseworker observed eight-month-old J. and noted that she did not appear to have any injuries.

Morales told the caseworker that she lived in the apartment with her sisters and her daughter, and received public assistance and food stamps, as well as an adoption subsidy for M. and N. She explained that she was the legal guardian of her sisters. Morales denied using or selling drugs and said that she was willing to take a drug test. She said that James Logan was J.'s father, but said that he did not live in the apartment with them. Logan was also interviewed. He similarly denied using or selling drugs and also agreed to submit to a drug test.

On March 15, the caseworker met with Morales at the field office. Morales said that she was going to take a drug test the following day. On March 17, the caseworker confirmed that both Morales and Logan had submitted to drug tests. That same day, the caseworker spoke by telephone with a Salvation Army caseworker. The Salvation Army caseworker said that her agency had been working with the Morales family for over two years after ACS referred their grandmother for services. After their grandmother died, the Salvation Army continued providing care for the family. The Salvation Army caseworker said that Morales was not using drugs. She said that the apartment was kept clean, that Morales took good care of J., and that she followed through with referrals.

The caseworker called the drug testing lab on March 21 and learned that both Morales and Logan had tested negative for all substances. On March 24, the caseworker interviewed Logan who said that he worked in construction, but was currently unemployed. He said that J. was his only child and that he provided for her financially by giving Morales \$100 per week. According to Logan, he and Morales were no longer "together," and he lived with his grandmother at a nearby address. On March 29, the caseworker made a home visit, during which Morales, J., M. and N. were all present. The caseworker saw J.'s immunization card and observed that the apartment was neat and clean, with adequate food. On March 30, the caseworker confirmed that Logan did not have a prior history with ACS.

On March 31, the investigation was closed as "unfounded." A CONNECTIONS entry noted that the case had been transferred to the OCACM unit.

B. June 2005 Hotline Report

On June 13, 2005, two months after Morales was appointed as the guardian of her two sisters, the SCR received a report from a social worker at the Fordham Tremont Community Center in the Bronx. The report alleged that Morales was not providing adequate medical care for her two teenage sisters, M. and N. The report alleged that Morales' 16-year-old sister M. was suicidal and homicidal, was cutting herself and was aggressive toward family members. The report also alleged that M. was recently released from the hospital, and was not receiving follow up treatment and counseling. The report did not state what hospital M. was released from or why she was in the hospital. The report also alleged that Morales' 13-year-old sister N. was not receiving her prescribed mental health medications.

According to ACS records, on the day of the hotline report, a CPS caseworker attempted a home visit, but only M. was at home. Morales was not at home. The caseworker left a note with M. asking Morales to contact her. On June 14, 2005, a newly assigned CPS caseworker conducted a home visit at Morales' apartment. Morales' sisters were not at the home during this home visit. Morales told the

caseworker that she had custody of her two sisters, and her daughter, who was 11 months old at the time. Morales told the caseworker that N. had been diagnosed with depression and prescribed Prozac, but she had stopped taking the medication because she did not believe that she needed it. Morales said that she had told N.'s therapist at the Fordham Tremont Community Center that N. had stopped taking her medication. Morales said that N. had an appointment with her therapist on June 17. The caseworker noted that Morales' apartment was a clean three-bedroom apartment with adequate food, beds, and a crib for the baby. The caseworker also noted that there were window guards on each window. Morales told the caseworker that the family was receiving public assistance, food stamps and Medicaid. The caseworker also noted that Morales did not appear to have any mental or physical disabilities, and denied having any substance abuse issues. The caseworker concluded that Morales was meeting the basic needs of her sisters, including food, clothing, shelter, supervision, and medical attention. There is no record that the caseworker confronted Morales about the allegations concerning M. during this home visit, including that she was suicidal, homicidal, was cutting herself, and was aggressive toward family members.

According to ACS records, on June 16, 2005, Morales and her sisters, M., and N., were interviewed by the caseworker's supervisor at the ACS field office in the Bronx. The assigned caseworker did not participate in these interviews because she was unavailable. The caseworker from the Salvation Army was also present. Morales stated that she had been taking care of her sisters since September 7, 2004 when their grandmother passed away. Morales said that in February 2005, M. began exhibiting dangerous behavior, including cutting herself with knives. M. was admitted to St. Vincent's Hospital for two weeks and was prescribed psychotropic medication. After M. was released, Morales attempted to schedule an appointment for M. at the Fordham Tremont Community Center for follow up treatment, but she was not yet M.'s legal guardian and the Center would not allow her to make an appointment M.'s behalf. Morales said that M. was re-admitted to the hospital on March 16, 2005 because she was having outbursts and Morales could not control her. M. remained in the hospital until June 3 when she was discharged and taken off medication. Morales said that M. had an appointment with her therapist on June 21. According to Morales, M. had been doing much better since she was released from the hospital the second time. Morales insisted that she had never been neglectful of her sisters, and stated that she disciplined her sisters by talking to them, by not letting them go outside and by not allowing them to use the telephone. Morales also stated that no one in the home was using drugs, and that neither she nor her sisters had ever been in a substance abuse program. Morales stated that her daughter's father came in and out of their lives. She also said that their mother lived in the Bronx and visited from time to time. Morales said that her and her sisters' father was in jail.

During her interview that same day, M. stated that she had been hospitalized twice, the first time in February 2005 for two weeks because she was upset and started cutting herself. She said that she went back into the hospital again in March 2005 for two months because she was upset and was arguing with her sister. She said that she did not want to go to therapy, but would attend the intake appointment. M. said that she was getting along with Morales and wanted to continue to live with her. Morales' sister, N., was also interviewed. N. stated that she was in therapy because someone did something to her and she was hurting herself, but she did not want to talk about it. N. also said that she got along with her sister, M., and enjoyed living with Morales. N. denied having any problems at school or at home.

The ACS supervisor also interviewed the caseworker from the Salvation Army, who stated that she had been working with Morales since her grandmother's death. The caseworker said that she had assisted Morales with the guardianship petition and testified on her behalf in court. She also helped Morales obtain an adoption subsidy after she was appointed as the guardian of her sisters. The Salvation Army caseworker said that she provided both individual and family counseling to Morales and her sisters at least twice a month and more often if necessary. She also said that she conducted at least two home visits each month. The Salvation Army caseworker confirmed that Morales had been unable to make an appointment at Fordham Tremont Community Center for M. because Morales had not yet been appointed the guardian of her sisters, but that M. had an appointment at the Fordham Tremont Community Center on June 21. The caseworker stated that she was in contact with N.'s therapist and confirmed that N. was attending her therapy sessions regularly. She also said that Morales had been cooperative and participated in all services provided by Salvation Army, and that she did not have any concerns about the family.

On June 20, one week after the hotline report, the caseworker attempted without success to contact the source of the hotline report. This was the first documented attempt by the caseworker to contact the source of the hotline report.

According to ACS records, on June 20, another supervisor reviewed the case notes and suggested that both M. and N. should follow up with a mental health facility given their documented mental health issues. This supervisor also suggested that the caseworker have Morales sign a release for the medical and mental health records of M., N., and J., and ensure that her sisters attend regular therapy sessions. There is no record that the caseworker ever obtained a release for M., N., or J.'s medical and mental health records or that the supervisor followed up with the caseworker to ensure that this was done.

According to ACS records, on June 21, 2005, another ACS supervisor reviewed the case file and noted that it appeared that Morales was meeting the basic needs of her sisters, but suggested that the case be referred to a mental health consultant and that the family be enrolled in an intensive case management program to coordinate all the family's needs. There is no record that this was ever done.

On July 5, 2005, the caseworker conducted a home visit and noted that the apartment was clean and neat and had adequate provisions. The caseworker noted that Morales's sister, N., and Morales' daughter, J., were at home and were clean and neatly dressed. M. was not at home. Morales said that she took M. for her intake appointment on June 21 and was waiting for a follow-up appointment. Morales also reported that the school had determined that both M. and N. should skip a grade for the following school year and that she was very proud of them. The caseworker again noted that Morales appeared to be meeting the basic needs of her sisters and her daughter.

On July 6, 2005, the caseworker spoke by telephone with the social worker at the Fordham Tremont Community Center, the source of the June 13 hotline report. The notes do not reflect that the caseworker asked the social worker any questions about the allegations in the hotline report. In fact, the only information noted in this entry is that M. was seen on June 21 and would be working with the same therapist who had been treating N. The caseworker then left a message for the therapist at Fordham Tremont Community Center for progress reports on both M. and N.'s treatment.

According to ACS records, on July 13, 2005, the caseworker spoke by telephone with M. and N.'s therapist from the Fordham Tremont Community Center. The therapist stated that she had not met with M. to date because an appointment had not been scheduled, and when she attempted to make contact with the family, she learned that their telephone number was disconnected. The therapist stated that she had been treating N. for about a year, and had seen her the day before. The therapist stated that N. was not taking her medication because she did not believe she needed it. The therapist said that N. had told her that the Salvation Army was not doing very much for the family, and was not in the home very often. The therapist also told the caseworker that Morales was not cooperative with respect to N.'s treatment and did not take an active role in the therapy sessions. The therapist stated that she did not feel that the Salvation Army was pushing the family to do what needed to be done, and she had concerns for both M. and N. because of their history of depression and aggressive behavior. She also said that Morales had a hard time implementing rules and that M. and N. were difficult teenagers. The therapist said that although she had not yet met with M., her file indicated that she had a history of aggressive behavior, major depression and suicidal thoughts. She also noted that M. was last hospitalized on May 17, 2005.

That same day, the caseworker spoke by telephone to the supervisor of the Salvation Army caseworker. That supervisor assured the ACS caseworker that the Salvation Army caseworker was working very closely with the family and was meeting with them on a weekly basis. The supervisor said that the caseworker attempted to enroll Morales in a parenting class, but it was difficult to find a class that did not conflict with her school schedule. The supervisor stated that both she and the caseworker had counseled Morales about setting limits for her sisters and advised her about the importance of keeping up-to-date with her sisters' therapy appointments and medication. The ACS caseworker told the supervisor that Morales had not yet made a follow up appointment for M. with the therapist, and that the therapist said the family's telephone number was disconnected. The supervisor said that she would have the caseworker conduct a home visit that week.

On July 18, 2005, the ACS caseworker spoke by telephone with M. and N.'s therapist and was informed that M. had been diagnosed with major depressive disorder, but was not prescribed medication. The therapist stated that N. had also been diagnosed with a major depressive disorder and had been prescribed Prozac.

On July 19, 2005, the ACS caseworker conducted a home visit. Morales was home alone; M., N., and J. were not at home. Morales stated that N. was calmer and easier to get along with since she stopped taking her medication. Only the day before, N.'s therapist had told the caseworker that N. had been prescribed Prozac and did not say anything about N. being taken off this medication because she was behaving too aggressively. There is no record that the caseworker confronted Morales about this inconsistency. Morales said that M. had been staying with their aunt for a little while, but had been sent back because she was stealing from her aunt. Morales said that she had made an appointment for M. to see her therapist on July 21, and that she had applied to two boarding schools for M. because she wanted her to do well and grow into a responsible adult. Morales said that she was afraid that her daughter and her sisters would be removed from the home as had happened to her and her sisters when they were younger. Morales said that she missed her grandmother very much. The caseworker offered to refer Morales to grief counseling, but Morales declined. Morales

said that she would comply with any services that the caseworker felt were necessary because she loved her sisters and did not want them to enter the foster care system. The caseworker left Morales with a letter indicating that she must schedule a therapy session for M. and must ensure that N. attends her therapy sessions. Morales repeated that she had scheduled an appointment for M. on July 21 and said that she had never attended any of N.'s therapy session because she had never been asked to attend. Morales agreed to bring both M. and N. to the ACS field office on July 22.

There is no record that the caseworker interviewed Morales, M. and N. at the field office on July 22 nor is there any explanation in the case file as to why the interviews did not take place on that day.

On July 27, 2005, the caseworker met with the field office's mental health consultant, who recommended that N. and M. be referred to an Integrated Case Management caseworker. It is unclear what the caseworker was referring to in this entry. The caseworker also noted that "the report" is in the file, but did not specify which report she was referring to, and DOI has not received a file containing a report relating to either M. or N.

On August 4, 2005, the caseworker conducted another unannounced home visit and noted that the apartment was clean and neat with adequate provisions and that Morales appeared to be meeting the basic needs of her sisters. M. and N. were both at home. Both said that they had been meeting with their therapist regularly. Morales told the caseworker that she just learned that she was five months pregnant with twins. She said that the pregnancy had caught her by surprise.

On August 5, 2005, the caseworker recommended that the investigation be closed as "unfounded" because the family was receiving preventive services from the Salvation Army and there were no further child protective services issues that needed to be addressed with the family. On August 12, 2005, the caseworker's supervisor approved this recommendation. On August 15, 2005, another supervisor reviewed and approved the caseworker's findings and closed the case. This supervisor noted that the investigation demonstrated that Morales had been following up with her sisters' mental health treatment, but might be having difficulty coping with her sisters' behavior. This supervisor noted that the family required supportive services and closed the child protective services case and recommended that the case be referred to OCACM. DOI did not receive any documents from ACS evidencing that the OCACM unit monitored the family after the CPS case was closed.

The Salvation Army continued to work with Morales and her sisters after the CPS case was closed, making regular visits to their home, as well as telephone contacts, from September through December. CONNECTIONS files from the Salvation Army showed that the Salvation Army caseworker also monitored M. and N.'s educational progress, including getting reports from the schools, and documented that she was assisting Morales in getting back into high school. The caseworker made sure that the girls attended their therapy sessions. In October 2005, the Salvation Army caseworker assisted M. in enrolling in the Job Corps, and by October 18, M. had moved to upstate New York.

On October 28, Morales gave birth to Jaylee and her brother J. In November 2005, the Salvation Army caseworker documented that she was assisting Morales

identify day care and visiting nurse services to help with the twins. The agency also referred Morales to receive "homemaker services."

There is no documentation in the CONNECTIONS progress notes of the Salvation Army caseworker concerning any communication with staff of the OCACM unit.

According to ACS records, on January 6, 2006, Morales took her three children to Dr. Walsh, their pediatrician, for a checkup. Jaylee received a flu shot and other necessary immunizations. Morales told Dr. Walsh that Jaylee was having difficulty keeping down milk, and the doctor advised her to put a teaspoon of rice cereal into Jaylee's bottle at each feeding. On January 9, an ACS caseworker contacted Dr. Walsh, who confirmed the January 6 visit and his instructions to Morales about the rice cereal. Dr. Walsh also told ACS that Jaylee and her twin appeared healthy, and that he had no concerns about Morales' ability to care for her children.

On January 7, 2006, Morales noticed that Jaylee, who was in her bassinet, was cold, blue in the face, and not moving. She called 911 and began to administer CPR according to the 911 operator's instructions. EMS responded to the apartment, and Jaylee was pronounced dead at Bronx-Lebanon Hospital a short time later. The OCME concluded that Jaylee had died of natural causes, more specifically, of Sudden Infant Death Syndrome.

8. Sierra Roberts

On October 25, 2005, seven-year-old Sierra Roberts was beaten to death. Her father, Russell Roberts, pled guilty to manslaughter in connection with her death, and was sentenced to 10 years in prison. In the year and a half leading up to Sierra's death, she was treated for a fractured left arm, a fractured spine, and a fractured right leg.

Sierra Roberts first became known to ACS on January 5, 1998, when she tested positive at birth for cocaine. ACS petitioned the Family Court and Sierra was immediately placed into foster care through Miracle Makers, a foster care agency. According to the records of Miracle Makers, by July 1998, Sierra's mother's whereabouts were unknown, and there is no subsequent mention of her in ACS records. In December 2000, Sierra was reunited with her father, Russell Roberts, and ACS closed its case in early 2001.

A. May 2003 Hotline Report

On May 30, 2003, the SCR hotline received a call from Sierra's pediatrician, Dr. Rakesh Dua. The call narrative stated that Dr. Dua reported that Russell Roberts, Sierra's father, had brought her to his office with a broken right leg two weeks before his call to the hotline. The call narrative stated that Roberts told Dr. Dua that Sierra had fallen from his arms while he was carrying her up the stairs. Dr. Dua reported that Sierra had been treated at Brookdale Hospital in Brooklyn for her broken leg. During this call, Dr. Dua also reported that Sierra had sustained a fractured spine in December 2002, which required surgery and extensive rehabilitation. Dr. Dua noted that Sierra was hospitalized for three months at Cornell New York Hospital in connection with her spinal surgery, and later received rehabilitation at Blythedale Children's Hospital in Westchester. The call narrative stated that there was no suspicion of abuse or maltreatment at the time of Sierra's spinal surgery. Additionally, according to the call narrative, Dr. Dua had *not* called the hotline because he suspected that Sierra's injuries were the result of child abuse, but rather because he believed that there was an open child protective services case concerning Sierra, and felt that her caseworker should be aware of both injuries.

According to ACS records, on the day of the hotline report, a CPS caseworker conducted a home visit. Sierra was not at home during that visit; Roberts said that she was at her former foster parents' home. Roberts told the caseworker that Sierra had been placed in foster care after testing positive at birth for both cocaine and HIV. Roberts said that he had remained in close contact with Sierra's foster parents, and that both he and Sierra visited their home often. Roberts said that he had no contact with Sierra's mother, but thought that she was living in North Carolina. With respect to Sierra's injuries, Roberts told the caseworker that Sierra had back surgery in January 2003, but claimed that the surgery had been performed to correct a curvature of her spine. Roberts claimed that sometime in December 2002 Sierra fell at her foster mother's home. At the time of the fall, she did not appear to have been injured. About three days later, Sierra's teacher told Roberts that Sierra had been complaining about her back. Roberts took Sierra to her pediatrician, who referred her to a specialist, which led to the surgery to correct a curvature in her spine. Roberts told the caseworker that Sierra had the surgery in January 2003, underwent rehabilitation, and came home in May 2003.

With respect to Sierra's broken leg, Roberts claimed that he fell while carrying Sierra up the stairs of her former foster parents' home. Roberts said that he took Sierra to Brookdale Medical Center, where she was referred to an orthopedic doctor for further care. Roberts insisted that he would never do anything to hurt Sierra and that the incident that led to her broken leg was an accident. He claimed that he was having a difficult time carrying her up the stairs, dropped her and then fell on top of her leg. The caseworker noted that Roberts and Sierra were living in a one-bedroom apartment that was neat with adequate food. Roberts also provided the caseworker with the names and contact information for Sierra's physicians.

On June 2, 2003, the caseworker returned to the apartment and interviewed Sierra. During that interview, Sierra told the caseworker that she was doing fine. Sierra's explanation for her broken leg was consistent with the explanation that Roberts had provided to the caseworker. She said that Roberts had fallen on her leg when they both fell on the stairs. There is no record that the caseworker asked Sierra where this incident happened. The caseworker asked Sierra what had happened to her back, and she said that she had surgery, but was doing fine. Sierra also told the caseworker that Roberts did not yell at her or hit her.

On June 3, the caseworker spoke by telephone with Dr. Dua. Dr. Dua told the caseworker that Sierra had been his patient for approximately one year. He stated that in December 2002, Roberts brought Sierra to see him in because she had been complaining about her back. Dr. Dua referred her to the emergency room at Brookdale Hospital because Sierra was having difficult walking. He said that Brookdale Hospital thought that Sierra might have a tumor and sent her back to him. Dr. Dua then referred Sierra to New York Hospital and learned sometime later that Sierra had a fractured spine that required surgery. Dr. Dua told the caseworker that he was under the impression that a report was called in to the SCR hotline, although the caseworker's notes do not indicate who he believed had called in the report or the substance of that report. Dr. Dua told the caseworker that he did not suspect child abuse in connection with Sierra's back injury. However, about two weeks ago, Roberts brought Sierra to his office with a broken leg. Roberts claimed that he had fallen on Sierra. Dr. Dua said that after that visit he decided to call the hotline. The caseworker asked Dr. Dua to send her copies of Sierra's medical records. There is no record that Dr. Dua told the caseworker in this conversation that Sierra had first become his patient in January 2002 when Roberts brought Sierra to his office with what later proved to be a fractured left arm.

On June 4, the caseworker received a copy of Sierra's records from Dr. Dua by fax. Among these records there is a somewhat cryptic notation about the Sierra's initial visit with Dr. Dua in connection with her left arm. There is no record that the caseworker had a follow up conversation with Dr. Dua after receiving copies of Sierra's medical records. There is also no record that the caseworker noticed that the date of Sierra's visit to Dr. Dua's office regarding her broken right leg occurred the day before Dr. Dua's call to the hotline and not two weeks before as reported in the SCR call narrative.

On June 18 and June 25, the caseworker attempted additional home visits, but no one was at home. On June 25, the caseworker left a note asking Roberts to contact her. On June 26, Roberts telephoned the caseworker and told her that Sierra was doing fine, and that he and Sierra had been at her former foster parents' home. The caseworker set up a home visit for the following week.

On July 1, 2003, the caseworker spoke by telephone with the woman who had been Sierra's foster mother from the time that she was six weeks old until she was three years old and returned to Roberts' custody. Sierra's former foster mother said that Sierra was an active child and that she saw Roberts and Sierra every week. She acknowledged that Sierra had fallen once during a visit to her house, but she was not certain if that fall was the cause of Sierra's back injury. She was certain that Sierra's leg injury had not occurred in her home. She said that she believed Roberts was a good father and meeting all of Sierra's basic needs, but that Sierra needed a mother.

On July 1, Roberts called the caseworker and explained that he was being evicted from his apartment and was going to the DHS intake center for entry into shelter system. Roberts said that he would contact the caseworker the following Monday with information about his whereabouts. There is no record that the caseworker confronted Roberts with Sierra's former foster mother's denial that Sierra did not fall and break her leg at her home. On July 7, Roberts called the caseworker and said that he and Sierra had been placed in a family services center on the Grand Concourse in the Bronx. He provided the name and telephone number of a social worker at the shelter.

On July 9, 2003, the caseworker contacted Blythedale Children's Hospital and spoke to the director of social work regarding Sierra. The director explained that he had not been the social worker on Sierra's case, but provided the name of that social worker, and promised to have that social worker call the caseworker. On July 9, the caseworker spoke by telephone with the social worker assigned to Sierra's case during her rehabilitation at Blythedale Children's Hospital. The social worker said that Sierra had been transferred to Blythedale from New York Foundling Hospital on March 5, 2003 for rehabilitation in connection with her spinal surgery. The transfer was made at the request of Roberts who had not been satisfied with her care at New York Foundling Hospital where Sierra had initially been sent for rehabilitation following her surgery. Roberts told the staff at Blythedale that he first noticed Sierra's back injury in late December 2002 and took her to the emergency room at Brookdale Hospital. Roberts said that Sierra had injured her back by falling backwards down stairs. The social worker said that she was suspicious of Roberts' explanation and suggested that she should have made a report to the SCR hotline. The social worker expressed no concerns about Roberts' ability to care for Sierra, but said that he had not visited as frequently as she would have expected given that he was unemployed during that time. The social worker speculated that Roberts visited infrequently because he could not afford the transportation costs. The social worker said that when Sierra was able to go home for visits, Roberts took her to her former foster parents' home because he said there were three flights of stairs at his home.

On July 17, the caseworker spoke with Roberts, who stated that he and Sierra were still at the shelter in the Bronx. He said that Sierra was doing fine and that her cast had been removed. Roberts said that he was putting Sierra in a stroller as she was getting comfortable with her leg out of the cast. The caseworker contacted Roberts' case manager at the shelter on July 22, who told her that Roberts had become eligible for housing in a Tier II shelter apartment, and in 90 days he would be eligible for housing subsidies. The social worker said that she had no concerns about Roberts and Sierra, and that Roberts was one of the most functional residents at the shelter. She said that he kept his appointments at the public assistance office and made certain that Sierra kept her doctor's appointments.

On July 22, 2003, the caseworker spoke by telephone to a social worker at New York Foundling who had worked with Sierra during her rehabilitation. The social worker said that she had some suspicions about Roberts because she saw him scolding Sierra, but Sierra never indicated that Roberts had hurt her and she seemed happy in his care. The social worker stated that Roberts had said that Sierra had fallen down stairs, and a lump later formed on her back. She also said that Roberts had missed many scheduled conferences with hospital staff.

On July 22, the caseworker attempted a home visit at the Bronx shelter where Roberts and Sierra had moved, but Sierra and Roberts were not there. The caseworker received a message from Roberts the following day informing her that they were moving to the Flatlands Family shelter in Brooklyn. On July 24, Roberts called and said that they had arrived at the Flatlands shelter, and that he had taken Sierra to the doctor and she was fine. On July 28, the caseworker conducted a home visit at their new address. She noted that Roberts and Sierra were living in one room that contained two twin beds and that the apartment was neat and contained adequate food. Roberts said that they would be staying at that address until a permanent apartment became available. Sierra hugged the caseworker and said that she was doing fine and was ready to go back to school. The caseworker noted that Sierra appeared to be safe and in no risk of harm.

DOI investigators interviewed Dr. Dua twice. During the first interview, Dr. Dua stated that Sierra had first become his patient in January 2002. Dr. Dua did not mention in this initial interview that he first treated Sierra for a fractured left arm. Almost a year later in December 2002, Roberts brought Sierra into his office with a back injury. Dr. Dua said that Roberts told him that Sierra had hurt her back in a fall, but did not provide any further detail. The doctor said that he had not called the SCR hotline at that time because he did not suspect abuse. Dr. Dua observed swelling around Sierra's spine and she appeared uncomfortable. Because he did not have x-ray capabilities in his office, Dr. Dua referred Sierra to the emergency room at Brookdale Hospital for x-rays and an examination by an orthopedic surgeon. Dr. Dua could not recall the conclusions of the staff at Brookdale Hospital, but he did recall that Sierra was referred to New York Presbyterian Hospital, New York Weill Cornell Center for Special Surgery ("New York Presbyterian") for surgery to repair a spinal fracture. Dr. Dua stated that he spoke by telephone with the doctors at New York Presbyterian about Sierra's condition and that at some point the resident on duty told him that the neurosurgeon did not believe that Sierra's injury was the result of an accident. Dr. Dua could not recall the name of this resident. Dr. Dua stated that following her surgery, Sierra underwent rehabilitation at Blythedale Children's Hospital. Dr. Dua saw Sierra after she was discharged from Blythedale Children's Hospital, and observed her to be walking with a slight limp.

According to medical records from New York Presbyterian, Sierra had surgery to repair a fracture to her spine on January 2, 2003. The records reflect that Roberts told hospital staff that Sierra had fallen down the stairs about three weeks before, and that she began to complain about pain in her back about two weeks after the fall. There is no mention at all of a curvature to Sierra's spine. Following her surgery, on January 10, 2003, Sierra began rehabilitation at the New York Foundling Medical Center for Pediatrics and Rehabilitation. There is no record that the ACS caseworker ever obtained copies of these records which clearly contradict Roberts' explanation as to the reason for Sierra's surgery.

None of the medical professionals who treated Sierra in connection with her spinal surgery called the SCR hotline.

According to Dr. Dua, Roberts brought Sierra to his office in the late afternoon of May 29, 2003 with a broken right leg. Sierra's leg was already in a cast and Roberts told Dr. Dua that Sierra had fractured her leg about a week or so before. Dr. Dua thought that she had been treated initially at Brookdale Hospital emergency room and that Roberts brought her in for a follow-up visit. He gave Roberts a referral for an orthopedic surgeon to remove the cast. Dr. Dua told DOI investigators that Roberts claimed that Sierra had injured her leg when he was carrying her up the stairs when she slipped out of his arms and fell.

Dr. Dua told DOI that he called the hotline the day after Roberts brought Sierra to his office. His medical records confirm that on May 29, the day before his SCR report, Dr. Dua saw Sierra and referred her to an orthopedic surgeon to have her cast removed. Dr. Dua denied that he had called the hotline because he thought there was an open child welfare case concerning Sierra, as indicated in the SCR call narrative, but insisted that he had called the hotline *specifically* because he suspected abuse. Dr. Dua also told DOI investigators that he had not called the SCR hotline until the day after Roberts' brought Sierra in because he wanted to speak with someone from Blythedale Hospital to determine if they had previously reported Roberts to the SCR. Because the SCR does not record calls or require that call reports be verbatim transcripts of the callers' allegations, it is not possible to determine whether Dr. Dua's reported to the SCR hotline that he suspected abuse. Dr. Dua also told DOI that he had never personally called the hotline before. During his residency at Brookdale Hospital, before he went into private practice, when Dr. Dua suspected abuse or maltreatment, he contacted the hospital social worker who was responsible for making calls to the SCR hotline on behalf of the hospital.

Dr. Dua and the social workers from New York Foundling and Blythedale Children's Hospital all told the ACS caseworker that Sierra's back surgery was performed to address a fractured spine. Roberts, however, told ACS that his daughter underwent surgery to correct a curved spine. The ACS caseworker did not confront Roberts with the conflicting explanation provided by Dr. Dua and the social workers and did not obtain any medical records regarding Sierra's back surgery. Roberts also told the ACS caseworker that Sierra had broken her leg when he fell down the stairs while carrying her at her former foster parents' home. Sierra's former foster mother told the caseworker that she was certain that Sierra's leg injury had not occurred in her home. Once again, despite the obvious inconsistencies, the caseworker did not confront Roberts as to how and where Sierra had broken her leg. Neither the caseworker nor her supervisor took any other action as a result of Robert's inconsistent explanations as to Sierra's spinal surgery and broken leg.

The caseworker obtained Sierra's medical records from Dr. Dua, which included a notation that Sierra first became a patient of Dr. Dua in connection with an injury to her left arm. The caseworker said in an interview with DOI that she had not understood Dr. Dua's notation in the file concerning Sierra's arm, and admitted that she had not called Dr. Dua or taken any other action to determine the meaning of the notations in his files. Had she done so, the caseworker would have learned that Roberts first brought Sierra to Dr. Dua in January 2002 with a fractured left arm. This is significant in that it reveals a troubling history, specifically, in January 2002, Sierra was treated for a fractured left arm.

In December 2002, Sierra began to complain of back pain, and on January 2, 2003, she had surgery to repair a fracture to her spine. Following this spinal surgery, Sierra underwent extensive rehabilitation and returned home in early May 2003. Less than a month later, in late May 2003, Sierra was treated for a fractured right leg.

On July 28, 2003, ACS closed this investigation relating to Dr. Dua's call to the hotline without a finding. In the closing entry, the caseworker noted that the case had been classified as additional information because Dr. Dua had not alleged abuse or neglect in the hotline report. The caseworker further noted that Sierra appeared to be safe and was not at risk of immediate harm.

On October 25, 2005, an NYPD detective called the hotline to report that Sierra had died. The detective reported that Roberts had called EMS that day to have Sierra transported to the hospital. The call narrative noted that Sierra was brought to Peninsula General Hospital, where she was pronounced dead. The report also noted that Roberts had refused to provide an explanation as to how Sierra had died, and that his refusal to do so was suspicious. The OCME later determined that Sierra was beaten to death. Specifically, the OCME concluded that her death was the result of multiple blows that caused severe internal injuries. The OCME also found injuries to Sierra's head, torso and extremities. She was seven years old at the time of her death.

Russell Roberts was charged with manslaughter in the first and second degrees and endangering the welfare of a child in connection with Sierra's death. On November 27, 2006, Roberts pled guilty to manslaughter in the first degree, and was sentenced to 10 years in prison.

9. Michael Segarra

On January 11, 2006, two-month-old Michael Segarra was found dead in his crib. The OCME concluded that he died of undetermined natural causes, and no one was charged in connection with his death. Before Michael's death, ACS received repeated reports beginning in September 1999 alleging that Michael's mother, Melissa Segarra, was using drugs in her older son's presence and otherwise neglecting him. In addition, ACS was notified on November 4, 2005 that Michael had tested positive for cocaine at birth, and allowed him to be released from the hospital into his mother's custody based upon her promise that she would attend a drug treatment program.

A. September 1999 Hotline Report

On September 24, 1999, Melissa Segarra was the subject of an anonymous report to the SCR hotline alleging that she was abusing marijuana and cocaine, that she was keeping her two-year-old son M. up all night while she was getting high, and then leaving him unattended all day while she slept. The report also stated that M. was seen standing on a windowsill that had no window guard. The report further alleged that Segarra was hitting M. with excessive force. The report recorded as miscellaneous information that men were in and out of the apartment at all hours of the night.

On the same day as the hotline report, an ECS caseworker attempted to conduct a home visit, but no one answered the door. On September 25, 1999, another ECS caseworker attempted a home visit. On this occasion, Segarra was not at home, but Segarra's mother was at the apartment with M. Segarra's mother told the caseworker that Segarra had gone out and she was not certain when she would be home. Segarra's mother said that she did not know if her daughter was using drugs, and that Segarra was having problems with her upstairs neighbor. During this visit, the caseworker examined M. and did not observe any marks, bruises or welts on him.

According to ACS records, on September 28, a CPS caseworker conducted a home visit. During this visit, Segarra denied using drugs, and claimed to have recently passed a drug test in connection with a job interview with COMP USA near Broadway and 59th Street in Manhattan. Segarra also claimed that her upstairs neighbor was harassing her and suggested that her neighbor was the source of the hotline report. There is no record that the caseworker confirmed that Segarra had applied for a job at COMP USA or that she had submitted to and passed a drug test. During this visit, the caseworker examined M. and noted that he appeared clean and healthy, and did not have any suspicious marks or bruises. The caseworker also noted that M. exhibited age-appropriate behavior.

The following day, the same CPS caseworker interviewed by telephone the upstairs neighbor that Segarra claimed was harassing her. The neighbor admitted to being the source of the anonymous hotline report. The neighbor repeated the allegations that Segarra was using drugs, and added that she had witnessed Segarra smoking marijuana. However, the neighbor denied reporting that Segarra was hitting M. with excessive force. Because the hotline does not record calls, there is no way to confirm whether the neighbor alleged physical abuse. The neighbor told the caseworker that she was tired of Segarra's friends beeping their car horns from the street, and that Segarra often had male visitors frequenting the home. She also complained that Segarra's son, M., was constantly running in the hallway. The neighbor also told the

caseworker that she was begging the landlord to throw Segarra out of the building, and admitted that she was no longer speaking to Segarra because they had had a falling out.

An undated entry reflects that the caseworker conducted a telephone interview with Segarra's mother, who said that she was not aware that Segarra was using drugs, and confirmed that Segarra and her neighbor were not getting along. There is no record that the caseworker interviewed any other proximate neighbors who were not caught up in the apparent rivalry between Segarra and the reporting neighbor to determine whether other neighbors had smelled or observed drug activity. There is also no record that the caseworker required Segarra to submit to a drug test or that the caseworker attempted to have M. examined by a doctor to confirm that he was not being physically abused.

On October 14, the caseworker received a voicemail message from Segarra, who said that she was staying at her mother's home because the water had been turned off on her block due to construction. On October 18, the caseworker left a message for Segarra at her mother's home. On October 26, Segarra's mother informed the caseworker that Segarra had returned to her apartment "long ago" because the construction had been completed. Two days later, the caseworker conducted a home visit and determined that Segarra and M. were "functioning in an appropriate manner." Segarra also told the caseworker that she was not having any contact with her upstairs neighbor.

The caseworker concluded that Segarra's neighbor had made the report maliciously as a result of her falling out with Segarra. The caseworker also noted that she had found no evidence that Segarra was using drugs. On November 17, 1999, the case was closed as "unfounded."

B. June 2004 Hotline Report

On June 23, 2004, the SCR hotline received another anonymous call alleging that Segarra had been in a drug treatment program for abusing crack cocaine, but was possibly using crack cocaine again, and was smoking marijuana. The report alleged that Segarra was using drugs in front of M., and allowing others to do so. The report further alleged that Segarra's apartment had no electricity or food, and that M. would often ask his neighbor for food. The report recorded as miscellaneous information that M. stayed with Segarra's parents every weekend, and that Segarra's parents were aware of but in denial about her drug use.

On the evening of June 23, a CPS caseworker attempted without success to conduct a home visit. No one answered the door on that attempt, but the caseworker left a Notice of Existence on the door of Segarra's apartment. By this time, Segarra was living in a different apartment than the apartment she was living in during the investigation of the September 1999 hotline report. In addition, the caseworker who investigated these allegations was a different caseworker than either the ECS or CPS caseworker who investigated the September 1999 allegations. There is a notation in the case record that the CPS caseworker assigned to investigate the June 2004 allegations reviewed unspecified materials in connection with the September 1999 investigation, and was aware of the prior "unfounded" finding.

According to ACS records, on June 24, the caseworker attempted two additional home visits -- one in the morning and one in the evening. No one answered the door on

either occasion. In the morning, the caseworker left a letter on Segarra's door requesting that she contact the caseworker. That same afternoon, the caseworker interviewed M. at his school in the presence of a school social worker. M. told the caseworker that he was not afraid of his mother or anyone who visited his home. He admitted that the electricity was not working, and that Segarra's friend had food available for them in her apartment because their refrigerator was not working. M. told the caseworker that he had brothers and sisters, but they did not live with him. He was not certain if these were Segarra's children or his step-siblings.

According to ACS records, the caseworker also interviewed the school social worker and M.'s teacher during this visit. The school social worker stated that he was not familiar with M. or his family. He explained that he will get involved whenever a school staff member raises child protective concerns, and that M. had not been brought to his attention this school year. M.'s teacher said that she did not have any concerns about him. She said that M. was well behaved, that he was an average student, who completed his homework on a daily basis, and that he came to school clean and dressed appropriately for the weather. She also told the caseworker that M. brought a note from his mother whenever he was absent, and that Segarra had attended a parent-teacher conference.

According to ACS records, on June 25, at approximately 6 p.m., the caseworker attempted another home visit, but again no one answered the door. The caseworker left a letter with Segarra's neighbor directing Segarra to contact the caseworker. The case file does not reflect that the caseworker asked this neighbor any questions about Segarra.

According to ACS records, on June 28, Segarra left a message for an ACS supervisor. Later that same day, the caseworker spoke to Segarra by telephone and confronted Segarra with the allegations in the hotline report. Segarra insisted that the allegations were untrue. Segarra admitted that her electricity had been turned off for a few days, but it had been turned back on. Segarra also said that she had "support" from her parents who lived nearby and from a very good friend who lived in her apartment building. Segarra said that between her parents and her friend, she and M. were taken care of during the few days that she was without electricity. The caseworker made an appointment to conduct a home visit later that week.

According to the ACS records, on June 30, the caseworker conducted a home visit, during which the electricity was on and there was food in the apartment. Segarra initially denied using drugs, but then admitted to smoking marijuana and drinking alcohol on the weekend when M. was with his grandparents. Segarra told the caseworker that she received public assistance and M. received Medicaid. Segarra also provided the caseworker with the address and telephone number of her parents. She repeated that on the few days she was without electricity, she and M. had slept at her parents' home or in her friend's apartment. She denied that there was a lot of traffic in and out of her apartment. Notably, Segarra told the caseworker that she had been in a voluntary in-patient drug treatment program at the Kingsborough Addiction Treatment Center for abusing marijuana, cocaine and alcohol in September and October 2003, and showed the caseworker a certificate of completion, dated October 21, 2003, from that program. She also said that she had attended an after-care program at Canarsie Aware from October 2003 through about April 2004, but that she stopped going to the after-care program because she started smoking marijuana on the weekends. Segarra denied that

she was using cocaine again, and agreed to submit to random drug tests and to re-enroll in the program at Canarsie Aware. Segarra identified M.'s natural father and said that he was in and out of M.'s life, but did not pay child support. Segarra said that no one else lived in the home and that she had no other children. Segarra told the caseworker that M. had a medical check-up a few months ago, and that he had no medical conditions and was not taking any medication. She said that she had taken M. to Medisys Medical Center, a medical clinic on Atlantic Avenue, but she could not recall the exact address of the clinic. There is no record that the caseworker contacted this clinic to confirm Segarra's statements or that she obtained copies of M.'s medical records.

According to ACS records, the caseworker also interviewed M. during this home visit. M. repeated that he was not afraid of Segarra or anyone else who visited the home. The caseworker noted that M. did not appear to have any physical injuries or to be in need of immediate medical treatment. She described M. as being of average height and weight for his age. The caseworker also noted that M. had his own bed within the one-bedroom apartment, that there was an ample supply of food in the home, and that she did not observe any unsafe conditions in the home. There is no record that the caseworker interviewed any neighbors to determine whether they had smelled crack cocaine or marijuana, both of which have very distinctive odors, or whether they had observed evidence of drug activity in and around Segarra's apartment.

On July 1, the caseworker spoke by telephone with a counselor at Canarsie Aware. The counselor said that he could not confirm Segarra's prior participation in a treatment program without a release, and instructed the caseworker to call back on July 6 to schedule an intake appointment for Segarra. On July 6, the caseworker scheduled a July 14 intake appointment for Segarra. There is no record that the caseworker obtained a release for records relating to Segarra's prior participation in a drug treatment program at Canarsie Aware.

The caseworker conducted another home visit almost two weeks later, on Tuesday, July 13. During that visit, Segarra agreed to attend the intake appointment at Canarsie Aware. The caseworker also requested that Segarra submit to a random drug test, but Segarra said that she was leaving for Pennsylvania that weekend and would be gone for a few weeks. She promised to submit to a drug test when she returned. On July 19, the caseworker was advised by the intake counselor at Canarsie Aware that Segarra had failed to show up for her scheduled appointment on July 14. On July 28 and again on August 5, the caseworker attempted two home visits without success. No one answered the door on either attempt. On both days, the caseworker left a letter requested that Segarra contact the caseworker.

On August 23, the caseworker's supervisor made an entry into CONNECTIONS stating that on August 13 he had advised the caseworker to conduct a home visit and prepare the case for closing because the investigatory conclusion was "coming due." On August 20, the caseworker attempted another home visit, but a man answered the door and refused to identify himself. The man told the caseworker that Segarra and M. were not at home, and refused to allow the caseworker into the apartment. The caseworker left a letter with this man asking Segarra to contact her. That same day, the caseworker and her supervisor agreed to close the investigation, but to have the caseworker continue to pursue Segarra's participation in a drug treatment program. Both the caseworker and the supervisor's last entries in CONNECTIONS appear virtually identical, and reflect that the caseworker needed to re-interview both Segarra and M.

and to pursue Segarra's participation in a drug treatment program. The decision to close the investigation was made notwithstanding that the caseworker had been unable to conduct a follow-up home visit or speak with Segarra about her failure to attend the July 14 intake appointment for the drug treatment program. On August 23, exactly 60 days after the hotline call was made, the investigation was closed as "indicated" as to Segarra's drug use.

C. September 2004 Hotline Report

On September 14, 2004, the hotline received another anonymous report alleging that Segarra was using marijuana and cocaine on a daily basis in front of her then seven-year-old son, M., and allowing others to use drugs in her apartment. The report indicated that building security personnel and the NYPD had been to her apartment on several occasions. The report did not specify why the NYPD and building security had been called to Segarra's apartment, although from the context of the report it appears to have been in response to reports of drug activity. The last entries relating to the investigation of the June 2004 allegations indicated that the caseworker needed to re-interview both Segarra and M., and pursue Segarra's participation in a drug treatment program. There is no record that ACS attempted to contact Segarra between August 23, when the June 2004 investigation was closed, and September 14, when the hotline received this new report alleging that Segarra was using drugs in the presence of her son.

According to ACS records, on September 15, an ECS caseworker attempted to contact Segarra without success. The case file is unclear whether this was by telephone or an attempted home visit. A sergeant at the local police precinct informed the ECS caseworker that the precinct had no record of calls to Segarra's apartment during the relevant period. There is no record that the ECS caseworker attempted to confirm whether building security had responded to alleged drug activity at Segarra's apartment.

On September 16, a CPS caseworker attempted a home visit, but no one answered the door. This caseworker was a different caseworker than the caseworker assigned to investigate the June 2004 allegations. Later that same day, the caseworker attempted another unsuccessful home visit (again no one was at home) and left a Notice of Existence at the apartment.

According to ACS records, on September 17, the assigned caseworker had a meeting concerning Segarra with the caseworker, who had investigated the June 2004 allegations, and a supervisor. The caseworker from the June 2004 investigation described Segarra as difficult to get in touch with. On September 17, the assigned caseworker's supervisor entered a series of directives into CONNECTIONS instructing the caseworker to review the ECS caseworker's notes and all materials concerning Segarra's prior contacts with ACS, and relevant welfare records. The supervisor noted that the prior investigation concerning Segarra was closed less than six months ago by a caseworker in another unit. The supervisor also suggested that the caseworker visit Segarra's apartment early in the morning or in the evening since welfare records showed that Segarra was no longer receiving public assistance, suggesting that she might have a job. The earliest documented visit by this caseworker was at 9:30 a.m. and the latest was at 6:15 p.m. The supervisor directed the caseworker to attempt another home visit, conduct a safety assessment and then transfer the case to the former caseworker's unit.

According to ACS records, on September 17, the caseworker attempted two unsuccessful home visits, the first at 2:30 p.m. and the second at 6:15 p.m. On September 20, at approximately 9:30 a.m., the caseworker attempted another home visit, but no one answered the door. The caseworker left a handwritten note asking Segarra to contact ACS. That same day, a supervisor noted that the caseworker had attempted a number of home visits without success, and that the case would be transferred to the caseworker who had investigated the June 2004 allegations.

According to ACS records, on September 21, the caseworker who had investigated the June 2004 allegations attempted a home visit. No one was at home, and the caseworker left a Notice of Existence under the door. On that same day, the caseworker called M.'s school and confirmed that M. had been in school every day since the beginning of the term. On September 23, the caseworker attempted another home visit, but no one was at home. On October 5, three weeks after the call to the hotline, the caseworker interviewed M. at his school. M. stated that he lived with his mother, and that everything at home was fine. M. said that no one else lived in the apartment. The caseworker gave M. a letter to take home requesting that Segarra contact the caseworker. The records do not reflect that this caseworker ever questioned M. about his mother's alleged drug use or when she was likely to be found at home. On that same day, the caseworker also interviewed the school social worker. There is no record that the caseworker asked any questions about Segarra during this interview, but focused only on M.'s school performance. The school social worker stated that M. was well behaved and had never come to his attention, apart from ACS' request to interview him in connection with the June 2004 investigation. The caseworker also asked to review M.'s attendance records. The system was down when the caseworker was at the school, but the caseworker received a copy of M.'s attendance records later that same day. Those records reflected that that M. had not been absent from school since the beginning of the school year.

According to CONNECTIONS records, on November 17, the caseworker's supervisor made an entry reflecting that on October 8 he had directed the caseworker to attempt another home visit, update her progress notes, document all attempted contacts with the family and make collateral contacts. On October 12 through October 24, the assigned caseworker was on medical leave. There is no indication that another caseworker was re-assigned the investigation during that period or that there was any activity by ACS during this period. From October 29 through November 8, the caseworker's supervisor was on vacation. There is no indication that another supervisor covered the unit during this period.

On November 8, the caseworker made a follow-up visit to M.'s school and was told by school officials that he was absent. After learning that M. was absent from school, the caseworker attempted a home visit, but no one answered the door.

On November 17, the caseworker's supervisor made an entry in CONNECTIONS reflecting that on November 8 he had directed the caseworker to update her progress notes. The entry also indicated that both the supervisor and the caseworker would confer with a child protection manager about a possible legal consultation concerning the caseworker's inability to conduct a successful home visit and to seek the manager's approval to close out the investigation. The supervisor also directed the caseworker to send a certified letter to Segarra asking her to contact ACS to schedule a home visit. The supervisor noted that the caseworker should prepare the case for closing because

the investigatory conclusion was “due,” but the caseworker should continue to track and document the investigation in a separate document on the caseworker’s computer. In a separate entry, the supervisor noted that the caseworker had made numerous attempts to contact Segarra at her home address, but Segarra had been unresponsive throughout the investigation. The supervisor noted that the case would be closed in CONNECTIONS as “unfounded” due to the fact that ACS had been unable to obtain any credible evidence to substantiate the allegations. There is no indication that the caseworker and the supervisor ever had a conference with a child protection manager to discuss possible legal remedies or to seek approval to close the investigation.

On November 17, 2004, the caseworker re-interviewed M. at his school. Here again, there is no indication that the caseworker asked M. any questions about his mother’s drug use or whether he had observed others using drugs in the home. There is also no record that the caseworker asked M. when his mother was typically at home so that the caseworker could conduct a successful home visit. M. repeated that everything was fine at home, that he ate every day, and was not afraid of anyone who visited the home. The caseworker noted that M. was polite and well mannered. On that same day, the caseworker interviewed the school social worker and M.’s teacher, but here again focused only on M.’s school performance and did not ask any probative questions about Segarra. The social worker said that M. is well behaved. M.’s teacher said that M. was one of her best students, that he came to school dressed appropriately for the weather, and that she “did not have any concerns” about M. On November 17, the caseworker noted that she held a conference with her supervisor and briefed him on the interviews she had conducted that day, but that she was still unable to gain access to the home and that Segarra had ignored all attempts to contact her. The caseworker noted that the case needed to be closed that day because it was “overdue.” On November 17, ACS closed this case as “unfounded.” The allegations were classified as “unfounded” even though the caseworker never interviewed Segarra or conducted a home visit.

On January 5, 2005, the caseworker noted in a separate document on her computer that she had attempted a home visit on December 6. No one was at home, but the caseworker left a letter requesting that Segarra contact her. The caseworker also noted that she had mailed a letter to Segarra’s home requesting that Segarra contact her. The caseworker made an additional entry on January 5 indicating that she had visited M.’s school that day and interviewed M., the school social worker and M.’s teacher. The caseworker also obtained M.’s attendance records and confirmed that his attendance was good. M. continued to insist that everything was fine at home. M.’s teacher said that she was not concerned for M., but would be watching for any changes in his work habits or behavior. The caseworker gave M. a letter to bring home requesting that Segarra contact ACS. The caseworker noted that the case would be closed out of MS Word because M. appeared to be doing fine and school officials did not have any concerns about him.

D. November and December 2005 Hotline Reports

On November 4, 2005, a social worker from the Kings County Hospital notified the SCR hotline that Segarra had given birth to a son, Michael, the day before. The report stated that both Segarra and Michael had tested positive for cocaine. A different caseworker than the caseworker who was assigned to investigate the September 2004 allegations was assigned to this report. Although Michael was born with cocaine in his system and despite the numerous prior reports about Segarra’s drug use, ACS did not

petition the Family Court to remove Michael and place him in foster care as ACS had done when Sierra Roberts tested positive at birth for cocaine. Instead, Segarra spoke with the assigned caseworker and agreed to attend a drug treatment program as well as parenting skills classes and counseling. In addition, Segarra's parents agreed to help Segarra care for both Michael and M. in their home. The caseworker and her supervisor later directed the hospital to release Michael from the hospital into Segarra's custody without consulting with an attorney from DLS or seeking judicial intervention mandating that Segarra participate in these programs. Instead, ACS relied solely on Segarra's verbal agreement that she would attend a drug treatment program and live at her parents' home with the children.

On November 29, the caseworker conducted a home visit at Segarra's parents' home. Only Segarra's parents and M. were at the home that day. There is no record that the caseworker asked any questions about the whereabouts of Segarra or M. On November 30, the caseworker conducted a home visit at Segarra's apartment. During this visit, Segarra claimed that she had missed an appointment with the agency responsible for arranging preventive services, including the drug treatment program that she had agreed to attend, because she did not have adequate day care for Michael. She claimed that it was too difficult for her mother to assist her because they were living at two different addresses. In the face of this documented conversation with Segarra, this caseworker later told DOI that it had not occurred to her that Segarra and Michael had actually moved out of her parents' home and back into Segarra's apartment. The caseworker insisted in an interview with DOI that she thought Segarra and Michael were at her apartment that day because they had dropped M. at his school, which was nearby, earlier in the day.

On December 7, 2005, the hotline received a call from Michael's father alleging that Segarra was getting high on a daily basis to the point where she was incapable of caring for Michael and M. At this time, the investigation relating to the November hotline report was still open. Two ECS caseworkers went to Segarra's apartment in the early morning of December 7, and three unidentified individuals – a man and two women – were in the apartment. These individuals refused to let the caseworkers in, and claimed that Segarra was not at home. One of the women claimed that the children were with Segarra. The caseworkers called 911 to request police assistance, but cancelled the call after all three individuals left the apartment. Another caseworker conducted a home visit later that day and determined that the children were not in any danger. The caseworker also noted that Segarra had agreed to stay at her mother's home for a while. There is no record that the caseworker ever asked Segarra who these three individuals were and what they were doing in her apartment, or where she and the children had been in the early morning hours of that day.

ACS records reflect that the caseworker referred Segarra to Family Consultation Service ("FCS"), an agency that arranged for her to participate in a drug treatment program. This agency was also responsible for making arrangements for Segarra's parenting skills training. Segarra went to an intake session and one follow-up session at the drug treatment program, but never returned thereafter. There is no record that the caseworker made any effort to ensure Segarra's continued participation in the drug treatment program. DOI interviews with FCS staff revealed that Segarra did not receive any parenting skills training because they were planning to have her attend those classes after she made significant progress in the drug treatment program. On December 19, the ACS manager supervising the investigation closed the investigation

relating to the December hotline report as “unfounded,” but noted that the allegations would be addressed in connection with the November report. On January 5, 2006, the same manager closed the investigation into the November hotline report as “indicated” for drug abuse and “unfounded” concerning the allegations of inadequate guardianship.

Six days later, on January 11, 2006, two-month-old Michael Segarra was found dead in his crib. The OCME did not find any evidence of physical abuse, and concluded that he had died of undetermined natural causes. In an interview with DOI investigators, the medical examiner who performed the autopsy explained that Michael had a slight cold when he died, which prevented her from classifying the death as Sudden Infant Death Syndrome. The autopsy findings must be completely negative in order to classify a death as Sudden Infant Death Syndrome.

10. Six Months Later: A New Fatality – Sharllene Morillo

On June 13, 2006, five months after the death of Nixzmary Brown, the SCR hotline received an anonymous report that two-year-old Sharllene Morillo was being physically abused by her stepfather, Paul Jimenez. The hotline report alleged that Jimenez had grabbed Sharllene by the jaw, leaving a purple bruise, and that she had bruises around her eye, a belt mark on her back, and a bite mark on her left leg from Jimenez hitting her and biting her. The report further claimed that Sharllene's mother, Karen Mejia, was aware that Jimenez was abusing Sharllene, but was doing nothing to stop the abuse. The caller claimed to be a neighbor, but did not provide a name, address or telephone number. The SCR recorded as miscellaneous information that both the source of the hotline report and the family was Spanish-speaking. On July 23, while ACS was still investigating these allegations, Sharllene was brought to the hospital unconscious. She died five days later. The OCME determined that Sharllene died from a brain hemorrhage. According to the hotline report made on the day of Sharllene's death, Jimenez admitted to shaking Sharllene and then dropping her on her head. The report also stated that Mejia was not at home at the time of the incident, but came home to concoct a story with Jimenez before bringing Sharllene to the hospital.

On August 30, 2006, Jimenez was indicted for murder in the second degree, manslaughter in the first and second degrees, and endangering the welfare of a child. Jimenez's case is currently pending in New York State Supreme Court in the Bronx. Mejia was not charged in connection with Sharllene's death.

Given that Sharllene Morillo died over six months after Nixzmary Brown's death, DOI reviewed relevant ACS records and conducted interviews of ACS staff to determine if the reforms announced by ACS in January and March 2006 had made a significant difference in the quality of ACS' investigations, and in its ability to prevent child fatalities after receiving credible reports of abuse and neglect.

In fairness to ACS, at the time of Sharllene's death in late July 2006 many of the initiatives outlined in its March 2006 action plan had only been in operation for a short time and others had not yet been introduced. In addition, at the time of Sharllene's death, ACS was dealing with an unprecedented surge of hotline reports. However, DOI's review of the Morillo investigation revealed many of the same fundamentally flawed investigatory practices seen in the other investigations discussed in this report. For example, the assigned caseworker read the allegations to Jimenez and Mejia and then accepting their denials without significant probing. ACS staff involved in the investigation also failed to interview obvious witnesses who would have had relevant information, failed to obtain medical records and a failed to timely and accurately document investigatory steps and results. Caseworkers burdened with heavy caseloads and serious language barriers also continued to be a problem.

More specifically, although ACS announced in March 2006 that its goal was to bring down the average caseload to 12 cases per caseworker, the caseworker assigned to the Morillo investigation was already responsible for investigating over 20 cases when she received the Morillo report. Additionally, although the hotline report made clear that both the source of the hotline report and the family was Spanish speaking -- as in the case of Nixzmary Brown -- ACS assigned a caseworker who did not speak or understand Spanish. This caseworker told DOI that she was unaware that ACS had begun offering interpreter services by telephone at the time of this report. In addition, as

in earlier investigations, the caseworker in the Morillo investigation entered her progress notes into CONNECTIONS long after the events described. This caseworker also claimed in interviews with DOI to have conducted witness interviews that were not documented at all. Further, DOI's review showed the investigation suffered from a complete lack of supervisory oversight in that the caseworker repeatedly failed to follow directives entered into CONNECTIONS by her supervisors.

A troubling revelation of DOI's review of the Morillo investigation was that it proved to be as incomplete as many of the other investigations discussed in this Report. To begin with, during the initial home visit, the caseworker interviewed Sharllene's mother with an unidentified man who she believed was a cousin or family friend of Jimenez and Jimenez himself acting as an interpreter. Not surprisingly, with Jimenez actually helping to translate between the caseworker and Mejia, both Mejia and Jimenez denied that Jimenez was abusing Sharllene. Instead, Mejia insisted that to the extent Sharllene was bruised or scratched, these injuries were the result of rough play at day care. The caseworker noted that she had observed a few small scratches on Sharllene's cheek, but did not notice a bite mark on her back. It is significant to note that the SCR call narrative reported that the bite mark was on Sharllene's left leg. The case file is silent as to whether the caseworker checked for the reported belt mark on Sharllene's back.

The caseworker also failed to interview witnesses who would likely have had relevant information. Here again, the caseworker simply accepted the denials of both Mejia and Jimenez without attempting to test their assertions through other witness interviews or by a review of medical records or other relevant documents. Mejia gave the caseworker the name of Sharllene's pediatrician, but there is no record that the caseworker contacted this doctor. In addition, the hotline report identified the source of the call as an unidentified neighbor. There is no record that the caseworker attempted to interview any of Mejia's neighbors in an effort to identify the source of the hotline report or determine whether any of Mejia's neighbors had information about the allegations. Further, although Mejia insisted that Sharllene's scratches and bruises were sustained at day care, the caseworker did not interview Sharllene's day care provider. In fact, ACS did not identify that day care provider until after Sharllene was hospitalized with what proved to be fatal injuries. The caseworker later told DOI that when she asked Mejia for contact information for her day care provider, Mejia claimed that she could not recall the name, address or telephone number of the provider. The caseworker accepted this facially ridiculous claim even though Mejia dropped Sharllene at this day care five days each week, and paid for the services herself. ACS' first contact with the day care provider was a telephone interview conducted after Sharllene was hospitalized and shortly before she died. ACS did not conduct a face-to-face interview with the day care provider until after Sharllene's death.

This failure is particularly troubling in light of Mejia's claim in her interview with the caseworker that Sharllene's injuries were sustained at day care. After Sharllene was hospitalized, ACS learned that the anonymous call to the hotline had been placed by Sharllene's day care provider. The day care provider told DOI that she called the hotline after Sharllene had told her that her mother's boyfriend had both hit her and bitten her. There is no question that the day care provider -- a mandated reporter obligated to report her suspicions -- made the caseworker's investigation more difficult by placing an anonymous call to the hotline. In addition, on June 12, 2006, the day care provider called the office of the Kingsbridge Heights Community Center ("KHCC"), an

organization that helped Mejia find Sharllene's day care provider, to report her suspicions that Sharllene was being abused. The KHCC staff member told the day care provider that she must report her suspicions to the SCR hotline. On June 12, 2006, the day before the hotline report, two staff members from KHCC went to the day care and observed Sharllene's injuries. The following day, the day care provider called the hotline from KHCC's office. According to the progress notes of a KHCC staff member, the day care provider made an anonymous call because she feared retribution by Jimenez who she said had a violent temper. Neither KHCC staff member called the hotline based on their own observations of Sharllene's injuries.

The investigation conducted by ACS following the initial home visit was also lacking. At the initial home visit, the caseworker asked Mejia to come to ACS' offices at noon two days later, without Jimenez, so that she could take photographs of Sharllene and interview both Mejia and Sharllene with an interpreter. Mejia arrived at ACS' office on the scheduled day with Sharllene and Jimenez, and the provider advocate from KHCC. The assigned caseworker was unavailable so the caseworker's supervisor interviewed both Mejia and Jimenez. Both Mejia and Jimenez again denied that Jimenez was physically abusing Sharllene. During her interview, Mejia said that she suspected Sharllene's day care provider had called in the report. Even after this claim, no one at ACS made any effort to identify or contact Sharllene's day care provider. Photographs were taken of Sharllene, including a photo of an old burn mark under her right arm that Mejia claimed was the result of Sharllene reaching for something under a radiator, and marks on her face that Mejia said were bug bites.

DOI obtained the notes taken by the KHCC provider advocate during this meeting. Those notes reflect that she told the ACS supervisor that she had worked with Sharllene's day care provider. Her notes indicate that she called the day care provider by name during this interview. The corresponding ACS records of that same meeting do not include the name of the KHCC provider advocate, or the name of Sharllene's day care provider. The provider advocate also told DOI that ACS never contacted her after that meeting.

There is also no record that anyone at ACS attempted to run a criminal history check of Jimenez. As noted earlier in this report, it was not standard practice for caseworkers to request criminal history checks given the cumbersome practices available to ACS staff to obtain that information. DOI's review of Jimenez's criminal history revealed that Jimenez was convicted in September 2005 for criminal contempt in the second degree in satisfaction of all charges against him which included charges of stalking and harassment. Jimenez was also convicted in January 2003 of DWI and of assault in December 2003 in connection with a domestic violence incident.

On June 16, the supervisor instructed the caseworker to make an appointment for Sharllene at the Child Advocacy Center for a medical evaluation. On June 19, the caseworker called the Montefiore Hospital's Child Advocacy Center and discussed Sharllene's case with an intake staff member. According to a CONNECTIONS entry made on July 24 (after Sharllene was hospitalized) on June 22, the caseworker called the Advocacy Center and was given an appointment for July 6, more than three weeks after the abuse allegations were reported. ACS has advised DOI that the appointment at the CAC was scheduled for more than three weeks after the hotline report due to scheduling constraints at the CAC. There is no record that the ACS caseworker expressed any sense of urgency to the CAC intake staff or demanded an earlier

appointment. In addition, ACS did not receive a copy of the CAC evaluation until July 24, after Sharllene was brought to the hospital unconscious. ACS has advised DOI that it was standard practice for a CAC to notify ACS immediately if there were any concerns following an examination, and in all cases, the CAC would submit a written report of the findings. Here, the CAC did not immediately notify ACS following Sharllene's examination and express concern. The written report of the CAC's examination of Sharllene noted that it was "significant for well-healed scratch marks" under her armpit and "a well-healed loop shape mark on the right upper arm." Mejia claimed that these marks were the result of Sharllene scratching herself and a burn that she sustained from a portable heater. The report also noted that Sharllene had a dime sized purple mark on her face that Mejia claimed Sharllene woke up with that morning. The report concluded that the noted injuries appeared to be consistent with the explanations offered by Mejia, but that Sharllene should be "more closely supervised in her activities." Significantly, the report also noted that Mejia told a social worker at the CAC that she took Sharllene to a home-based child care provider arranged through the KHCC and provided the first name of the day care provider. Mejia also told the social worker that the day care provider had accused Jimenez of abusing Sharllene and that she had asked the day care provider whether she had called the hotline, but the day care provider had denied doing so.

On July 11, while the assigned caseworker was on vacation, a substitute caseworker conducted a home visit. Mejia, Jimenez and Sharllene were in the apartment. The caseworker noted that he did not see any bruises on Sharllene's body. Mejia told the caseworker that Sharllene was in good health and was up to date on her immunizations. Jimenez told the caseworker that he and Mejia were "seeing each other," but were not married and he lived elsewhere.

The following day, July 12, Mejia and Jimenez took Sharllene to her pediatrician, Dr. Jorge Cornielle, with complaints that Sharllene had been unable to raise her arms over her head for the past four days. Dr. Cornielle instructed them to take her to the emergency room at Montefiore Hospital. Dr. Cornielle sent a handwritten referral to Montefiore Hospital. DOI has reviewed that referral, which notes that Sharllene could not elevate both of her arms and had a small bruise on her forehead. Sharllene was admitted to Montefiore Hospital that afternoon and underwent a battery of tests, including extensive blood tests, a spinal tap, and an MRI, in an attempt to diagnose the problem. The weakness in Sharllene's arms resolved itself over the next several days, and Sharllene was discharged from the hospital on July 15 with a referral to see a pediatric neurologist in a month. Neither Dr. Cornielle nor anyone at Montefiore Hospital notified ACS or called the SCR hotline in connection with this hospitalization.

On July 23, the SCR hotline received a call from a social worker at Montefiore Hospital reporting that Sharllene had been admitted to the hospital that day with a head injury. The call narrative noted that Jimenez had provided several inconsistent explanations for her injuries, all of which were implausible. The report also noted that Sharllene had a head injury the week before and it took several days for her parents to bring her for treatment. A supervisor responsible for the investigation noted in CONNECTIONS that the hospital had sent an e-mail reporting that Sharllene had suffered severe trauma and was on life support. That same day, the caseworker obtained for the first time a copy of the Montefiore Advocacy Center's July 6 interview and medical evaluation of Sharllene. As noted above, that evaluation stated that Sharllene had healed scratch marks, a healed burn mark, and a purple mark on her

face, but credited Mejia's explanation as to how each occurred, and recommended that Sharllene be closely supervised.

On July 24, the caseworker also spoke with Jimenez's mother at the hospital. She claimed that Sharllene had been visiting her and hit her head while playing with another child. Jimenez's mother also told the caseworker that Sharllene had been hospitalized on July 12, a day after the substitute caseworker was in Mejia's apartment, because she was feeling weak, but was discharged a few days later on July 15. The caseworker noted in CONNECTIONS that she obtained Jimenez's mother's telephone number, although that number is not included in the case file. The caseworker also met that day with an NYPD sergeant, who told her that Mejia and Jimenez were both in police custody and therefore unavailable for an ACS interview.

On July 25, a KHCC caseworker called the ACS caseworker to report that Sharllene's former day care provider was in her office, and had heard that Sharllene was in the hospital. She also said that the day care provider was the source of the original hotline report. This July 25 entry is the first time that the day care provider's name is documented in the ACS case file. The caseworker interviewed the day care provider over the telephone, using a KHCC supervisor to translate because the provider did not speak English. The day care provider said that she had asked Mejia about the marks and bruises that she regularly observed on Sharllene, and Mejia attributed them to Sharllene being overactive. The ACS caseworker asked if Sharllene had gotten scratched or cut while in her care, and was told that she had not.

On July 25, a doctor from Montefiore Hospital called the caseworker and reported that although it was too early to draw a definite conclusion, it appeared that Sharllene had been shaken. The doctor said that Sharllene's prognosis was poor, and that even if she survived she would never fully recover. The doctor also told the caseworker that Jimenez had been arrested and that Mejia had attempted suicide and was at the hospital awaiting admission to the psychiatric unit.

On July 27, the caseworker spoke with an NYPD sergeant who reported that Jimenez had confessed to shaking Sharllene during the day when Mejia was at work, and did not take her to the hospital until Mejia returned home later in the day because he wanted her to corroborate the story he had invented. That story was that they had noticed a bump on Sharllene's head the night before and concluded that she must have fallen while playing at his mother's house the previous day.

Sharllene died on the morning of July 28.

In short, DOI's review of the Morillo investigation has demonstrated that as of July 2006 there were still very serious issues with the investigations conducted by ACS of abuse and neglect allegations.

III. DOI's FINDINGS

DOI's investigation has revealed significant flaws in the investigations conducted by ACS with respect to eight of the nine families detailed above. In particular, DOI repeatedly found that ACS staff failed to conduct meaningful, thoughtful, and thorough investigations. More specifically, DOI's investigation established:

- ACS staff often closed cases as “unfounded” when little or no investigation had been conducted. In some instances, ACS closed cases as “unfounded” based solely on the parents’ denials of the allegations, without interviewing the individuals who had reported the allegations or others who would likely have had relevant and probative information.
- ACS staff also often closed cases as “unfounded” after their investigation had substantiated the factual allegations of the reports.
- ACS staff often failed to conduct a comprehensive review of the agency’s own prior investigations of subject families, causing caseworkers to overlook alarming patterns of behavior that should have triggered more aggressive intervention.
- ACS staff often failed to even acknowledge, much less attempt to reconcile, inconsistent explanations offered by reporters of suspected abuse, including police officers and teachers who are mandated by law to report suspicions of abuse, and competing versions of events offered by parents or caretakers accused of abuse and/or neglect.
- ACS caseworkers often failed to undertake specific investigatory steps within the time frame mandated by law.
- ACS staff regularly failed to document their investigative findings, and when they did document events, it was often not done in a timely fashion.
- ACS staff often failed to monitor subject parents’ participation in programs intended to help them address critical issues, such as substance abuse and ongoing domestic violence. In many cases, ACS staff failed to take any action after learning that subject parents were not attending these programs.
- ACS staff often failed to take advantage of legal remedies available to them when their investigations were frustrated by uncooperative parents, such as warrants of entry or other court-ordered means of compelling parents to cooperate in their investigations.
- ACS staff and the staff of the SCR hotline were often careless about accurately recording the names and addresses of subject families, interfering with ACS’ ability to make connections among investigations.
- In at least two instances, ACS employees made false entries in ACS records reflecting that they had taken certain investigatory steps or other

actions before the death of children in cases for which they were responsible, when they had not. In one instance, a caseworker entered what purported to be entries supporting over a month's worth of case activities after the death of a child in a family that he was investigating.

- ACS supervisors often failed to provide meaningful guidance to caseworkers investigating allegations of abuse and neglect.
- ACS supervisors routinely approved closing cases as “unfounded” in which caseworkers had not followed many or any supervisory directives.

A more detailed examination of these failings follows.

A. Investigative Failures

1. No Meaningful Investigation Conducted

DOI's review revealed that ACS staff rarely conducted comprehensive investigations despite the serious nature of the allegations. Instead, ACS staff often closed cases as "unfounded" when little or no investigation had been conducted. Notably, ACS caseworkers often failed to contact individuals who were likely to have crucial information about abuse or neglect allegations, such as police officers, medical personnel, and school officials, even when those individuals were the source of the hotline reports. For example:

- On May 16, 2005, a school guidance counselor reported that Quachaun Browne's three sisters had missed a great deal of school, were doing poorly when they were present, and came to school filthy, wearing ill-fitting clothing. The ACS caseworker responsible for investigating these allegations did not contact the reporting guidance counselor despite the guidance counselor's repeated efforts to reach the caseworker by telephone. The caseworker also made no effort to review the girls' school attendance records. In fact, ACS records reflect that the caseworker conducted absolutely no investigation relating to these allegations. The investigation was closed by ACS on August 2 as "unfounded" on the basis that the caseworker was unable to substantiate the allegations.

There were also repeated instances where ACS staff conducted very limited investigations in the face of serious allegations.

- In September 2004, after receiving reports that Melissa Segarra was using marijuana and possibly crack cocaine in the presence of her seven-year-old son and allowing others to do so as well, ACS attempted several times to conduct a home visit, but never found Segarra at home. The caseworker interviewed Segarra's son at his school, but never asked him whether his mother or others used drugs in his presence. Although the caseworker never interviewed Segarra or conducted a successful home visit, ACS closed this case as "unfounded" on the basis that the caseworker was unable to find credible evidence to substantiate the allegations.
- In November and December 2004, the hotline received eight separate calls concerning Jennifer Gaston. A number of these calls alleged that Gaston was physically abusive to her children, and was working as a prostitute in her home. The only investigative efforts that the caseworker undertook with respect to these allegations was to ask Gaston's children whether she hit them or if they had observed strange men in the home, and to ask Gaston and her uncle whether the allegations were true. All investigations relating to these eight reports were later closed as "unfounded." DOI's review of Gaston's criminal history confirmed that she pled guilty in 2000 to loitering for the purpose of prostitution.

In some cases, ACS simply accepted parents' explanations without any real effort to test or probe the credibility of their statements.

- In June 1996, ACS received a report from a hospital alleging that the father of Quachaun Browne's sister, L., had failed to provide necessary medical care for L., who by then had an infection and significant injury to her mouth. The hospital reported that L. had been placed at risk by not being treated earlier. The caseworker's interview of L.'s father revealed that L. lived with her mother, Aleisha Smith. Smith insisted that she had taken L. to a doctor, who told her that L. was teething. The caseworker did not ask Smith for the name of the doctor or obtain the relevant medical records to confirm that this treatment had in fact occurred. Instead, ACS determined that Smith had taken appropriate action and the report was closed as "unfounded."

2. Substantiated Allegations Classified as "Unfounded"

DOI's investigation revealed that ACS often closed cases as "unfounded" although their investigations had clearly demonstrated credible evidence substantiating the allegations. This classification is significant because, pursuant to ACS policy, prior "unfounded" allegations need not be scrutinized as carefully as substantiated allegations of an "indicated" report in the event that ACS receives new allegations about the family.

- The very same day that an NYPD officer and an EMT called the hotline to report that Jennifer Gaston's cellar apartment was filthy, roach infested, cold and unsafe, an ACS caseworker visited the apartment and noted in CONNECTIONS that the conditions in the apartment were dangerous, and posed serious risks to the children's health and safety. The caseworker's notes claimed that Gaston was attempting to make the apartment safe for the children, but did not specify any measures beyond cleaning that she was undertaking. ACS later closed the investigation as "unfounded" despite the fact that the caseworker's own documented observations about the apartment were consistent with the reported allegations.
- The ACS caseworker responsible for investigating the May 2005 allegation that Nixzmary Brown had missed over 40 days of school reviewed DOE attendance records which confirmed that Nixzmary had missed over 50 days of school during the relevant period. In addition, when interviewed by the caseworker, Nixzmary's mother did not dispute that Nixzmary had often been absent from school. Despite this clear evidence establishing the allegations of educational neglect, ACS closed this investigation as "unfounded."
- In April 2005, a New York City probation officer reported to the hotline that Aleisha Smith and her children were living in a filthy apartment, in which the children were begging for food and eating from the garbage. A caseworker who visited the apartment the following evening also reported that the apartment was filthy, with very little food. The reporting probation officer was never interviewed by ACS. Although ACS records indicate

that the conditions in the home had improved slightly by late July, ACS closed the case in August 2005 as “unfounded.” In closing this case, the relevant ACS records included specific notations claiming that ACS staff had never observed Smith’s apartment to be dirty, or found the children without adequate food.

3. Failure to Reconcile Inconsistent Statements

In a number of instances, ACS did not even acknowledge, much less attempt to reconcile or investigate inconsistent statements offered by accused parents with those of mandated reporters.

- In May 2003, after Sierra Roberts was treated for a broken leg, her pediatrician told ACS staff that Sierra had surgery the previous year to repair a fracture to her spine. Social workers from two hospitals where Sierra received rehabilitation following the surgery also told ACS that the surgery was performed to repair a fractured spine. When interviewed by ACS, Sierra’s father claimed that this surgery had been performed to correct a curvature in Sierra’s spine. Sierra’s father also told ACS that Sierra’s recent broken leg occurred when he fell down the staircase at her former foster mother’s home while he was carrying her. Sierra’s former foster mother told the ACS caseworker that Sierra had not injured her leg at her home. Despite these obvious inconsistencies, the caseworker did not confront Roberts about the reason for Sierra’s back surgery or where and how she had broken her leg. In addition, the caseworker did not obtain copies of relevant medical records in connection with Sierra’s back surgery. Instead, ACS closed this investigation as “unfounded.”

ACS also failed to attempt to reconcile or investigate inconsistent statements among siblings.

- During the investigation of the December 2005 allegations that Nixzmary’s stepfather, Cesar Rodriguez, was physically abusing both Nixzmary and his wife, Nixzmary told ACS that she had cut her head and bruised her eye falling on some wood in the apartment, and that her stepfather had discarded the wood. Her older brother repeated that Nixzmary had hurt herself after falling on wood, but claimed that he and his younger brother had discarded it. Nixzmary’s younger sister told ACS that Rodriguez had caused Nixzmary’s injuries. The ACS caseworker did not attempt to reconcile the discrepancies among the children’s versions of events.

4. Failure to Obtain Pedigree Information

Pursuant to ACS guidelines, caseworkers must obtain pedigree information, including date of birth, social security number and contact information, for all adults living in the home under investigation, and adults who spend significant periods of time in the home. Caseworkers are then expected to use this information to query available databases to determine if these individuals have documented histories of abuse and

neglect. DOI's investigation revealed that ACS staff routinely failed to obtain pedigree information for the adults living in or spending significant periods of time in the households under investigation.

- ACS never obtained pedigree information concerning a neighbor who often babysat for Quachaun Browne and his sisters even after learning in the course of several investigations that this neighbor had a close relationship to the family, and often spent considerable periods of time in the home. After Quachaun's death, DOI's investigation confirmed that this neighbor was a registered sex offender as a result of two separate convictions in 1992 for sodomy in the second degree involving two male victims, ages 13 and 14. The neighbor served approximately four and a half years in jail as a result of these convictions. It is particularly notable that a special condition of his release was that he have no unsupervised contact with minor children.
- ACS received numerous reports concerning the dangerous conditions of the apartment in which Jennifer Gaston and her children were living. After responding to one such complaint, the NYPD reported that two older men were also living in the apartment. Although Gaston, her children and her uncle lived in only two of the four bedrooms of this cellar apartment, ACS never made any effort to identify or obtain any information about the other man who shared a kitchen, bathroom and other common areas in the apartment with Gaston's five children. In addition, after the fire, ACS learned from the FDNY that another unrelated man was renting a bedroom within the apartment.

5. Failure to Obtain Medical Records

ACS staff routinely failed to consult with medical personnel or obtain relevant medical records in the course of their investigations. This was true even in cases where physical abuse or inadequate medical care were at the heart of the reported allegations. Instead of obtaining these records and then consulting with the treating physicians, who no doubt could offer critical insight concerning the allegations, caseworkers generally relied on the explanations provided by parents accused of abuse and/or neglect.

- After receiving reports that Cesar Rodriguez was beating both Nixzmary and her mother, and after hearing conflicting versions from family members as to how Nixzmary was injured, the caseworker never obtained Nixzmary's medical records or interviewed her doctor. This caseworker claimed in interviews with DOI to have had a telephone conversation with a doctor, who purportedly confirmed that Nixzmary's injuries were consistent with the version of events provided by Rodriguez. Notably, this conversation is not documented in any ACS records. In addition, the treating doctor and resident on duty do not recall talking to any ACS representative regarding Nixzmary's injuries. Further, the relevant hospital logs do not reflect any communication between ACS and the hospital regarding Nixzmary Brown.
- After Michael Segarra tested positive for cocaine at birth, the ACS caseworker responsible for the ongoing investigation concerning his mother made no

inquiries and took no steps to verify that Michael was receiving appropriate medical attention following his release from the hospital.

6. Failure to Monitor Participation in Counseling Programs

DOI's investigation further revealed that when ACS referred parents under investigation to various counseling services, caseworkers rarely monitored the parents' participation in those services as required by the ACS Practice Guide.

- After Michael Segarra tested positive for cocaine at birth, ACS did little to confirm that his mother was attending a substance abuse treatment program. This is particularly noteworthy given that ACS had authorized the hospital to release Michael into Segarra's custody based solely on her verbal promise that she would attend a substance abuse treatment program.
- After Dahquay Gillian's mother, Tracina Vaughn, was released from jail, ACS and LFCS referred her to a number of programs, including domestic violence counseling, individual and family therapy, and a drug treatment program. ACS did not properly monitor Vaughn's attendance in many of these programs, some of which she was mandated to attend in connection with her criminal case. DOI's investigation revealed that Vaughn's attendance in these programs was sporadic at best. In addition, the ACS caseworker submitted a report to the Family Court erroneously reporting that Vaughn was attending domestic violence counseling.

7. Failure to Document Events

DOI's investigation revealed that ACS caseworkers often failed to document significant events and critical interviews on a timely basis. In other cases, caseworkers claimed to have conducted crucial witness interviews, and to have undertaken other important investigative steps, that were not reflected in the case files. When DOI investigated these undocumented events, witnesses often denied having been interviewed by ACS staff, and other independent records, such as visitor logs, did not support the caseworkers' claims at all or supported that the events actually occurred on different dates.

- The caseworker responsible for investigating the May 2005 allegations of educational neglect concerning Nixzmary Brown insisted in an interview with DOI that she had conducted many home visits that were not documented in the case file. The caseworker had no explanation for her failure to document these home visits, but insisted that she was certain she had made them.
- The caseworker assigned to the last four active cases concerning Quachaun Browne's family acknowledged having received information that the family's neighbors expressed concerns for the children's safety. When interviewed by DOI, this caseworker claimed to have interviewed one neighbor, although the case file contained no record of any such interview. The caseworker told DOI that he knew this neighbor only by a nickname that he could no longer recall,

but he believed she was Smith's best friend. He was also unable to recall the apartment in which this neighbor lived.

DOI discovered that ACS caseworkers consistently failed to enter relevant information into CONNECTIONS on a timely basis. The CONNECTIONS system allows caseworkers to record an "event date," which reflects the date the event actually occurred. The system automatically records the date that the caseworker made the entry into the system. For example, if a caseworker made an entry into the CONNECTIONS file on January 1 about an event that occurred on December 15, the system will reflect that the entry was made on January 1. It is not possible for ACS staff to manipulate the date of entry. However, a caseworker can go back into that CONNECTIONS file within 15 days of making an entry and modify the substance of that entry. Using this same example, the caseworker could go back into CONNECTIONS anytime from January 1 through January 15, and modify the substance of the entry.

ACS staff routinely made entries into CONNECTIONS long after the events described. ACS staff reported to DOI that the CONNECTIONS system was frequently inaccessible, making it impossible for them to document events in a timely fashion.

- In at least two cases, one involving Nixzmary Brown and one involving Quachaun Browne and his siblings, ACS staff entered dates of significant events into CONNECTIONS well after the events occurred. Those dates later proved to be incorrect.
- In the November 2005 investigation concerning Quachaun Browne's siblings, the caseworker reported in CONNECTIONS that he had visited the children's school on a date that later investigation proved was inaccurate. This caseworker acknowledged to DOI that it was possible the date was incorrect because he entered the information about the school visit into the system more than a month after the fact, and based on notes from his field notebook, which very often did not reflect the date of the events he was recording.

Perhaps the most troubling discovery of DOI's investigation was that caseworkers made entries into CONNECTIONS or other computer records after a child had died, in which they claimed to have taken certain investigatory steps or other action before the child's death, which DOI's investigation established did not actually happen. In at least one instance, an ACS manager admitted to DOI investigators that he had falsified records after the death of a child to make it appear as if he had been actively supervising the investigation. This manager documented in ACS records that he had conducted a supervisory conference with the caseworker responsible for investigating allegations relating to Dahquay Gillians' mother before Dahquay's death in which he purported to give guidance to the caseworker on how to further the investigation. However, he later admitted to DOI that the case conference never took place. ACS suspended this manager on December 9, 2005 as a result of this conduct. The same manager coincidentally had also been responsible for supervising the unit investigating the December 1 allegations that Rodriguez was beating Nixzmary and Nixzmary's mother. DOI has consulted with the Brooklyn District Attorney's Office concerning this conduct.

8. Inadequate Descriptions in Progress Notes

DOI's review of relevant ACS records also reflect that caseworkers repeatedly used the same boilerplate language to describe the living conditions they found during home visits, instead of specifically describing those conditions as required by the ACS Practice Guide. For example, caseworkers often described a home to be in "deplorable condition," without further elaboration. This repetitive use of the same terms and phrases often obscured the true conditions of the households under investigation. In some cases, the caseworker's failure to accurately describe what they had observed in the subject homes may have prevented more aggressive intervention by ACS.

- A good illustration of this can be found in the case notes concerning Aleisha Smith's apartment, which caseworkers repeatedly described as "deplorable" and "roach-infested." When asked by DOI to elaborate on these conditions, one caseworker said that she had seen cockroaches on the walls of the apartment, in the children's beds, and that roaches had crawled onto her while she sat on a sofa during a home visit. This caseworker also recalled that cockroaches had crawled out of Smith's purse during a meeting at an ACS field office. Had these very specific descriptions been included by the caseworker in the case record, perhaps her supervisors would have demanded that ACS intervene in a more aggressive fashion.

9. Supervisory Directives Ignored

Although ACS supervisors are required to approve the closing of all open investigations, in many of the investigations reviewed by DOI, cases were closed, oftentimes with "unfounded" determinations, when there was no indication in the case file that the caseworkers had actually completed the investigatory steps that their supervisors had identified as necessary. In addition, DOI's review revealed that supervisory directives were routinely ignored during the course of ongoing investigations.

- In April 2005, following one of the many hotline reports that Aleisha Smith's apartment was filthy and without sufficient food for the children, a supervisor instructed the caseworker to conduct a home visit, document the condition of the apartment, obtain Smith's authorization for the release of the children's medical records, and contact school officials and relevant health care providers. There was no evidence in the case file that the caseworker had Smith sign a release for the children's medical records, or that the caseworker ever contacted school officials or the children's health care providers. This was particularly significant because ACS staff had received information that some of Smith's children had asthma and required medication. In addition, Smith had been the subject of an "indicated" finding of educational neglect in 2002. The April 2005 investigation was ultimately closed as "unfounded" although none of the supervisor's instructions were followed.
- On December 7, 2005, the child protective manager initially responsible for supervising the investigation of the December 1, 2005 allegations that

Nixzmary Brown was being abused by her stepfather directed the caseworker to attempt to clarify how Nixzmary had been injured by requesting incident reports from school officials, and speaking with extended family members and relevant medical professionals. The caseworker did not follow a single one of these instructions. This investigation was still open at the time of Nixzmary's death on January 11.

ACS procedures also require the involvement of a supervisor at specific stages in investigations. DOI's investigation revealed that this supervisory oversight rarely took place, and, when it did, was often not documented in the case files. When interviewed by DOI, ACS caseworkers and supervisors claimed that a great deal of informal (admittedly undocumented) supervision is provided throughout investigations.

10. Failure to Track Closed Cases

As noted above, state regulations require that ACS complete an investigation within 60 days, with either an "indicated" or "unfounded" determination. Because of this requirement, ACS often closed cases in CONNECTIONS within the 60-day period, although investigations were incomplete and potentially dangerous situations remained unresolved in homes under investigation. In these cases, ACS staff used an informal process whereby caseworkers were expected to monitor the subject parents' compliance in a variety of activities and record that progress or any subsequent investigatory steps in a separate document on the caseworker's computer. DOI's investigation revealed that this informal tracking process often led to cases simply falling through the cracks. In addition, keeping these cases on a caseworker's dockets in this informal fashion often meant that caseworkers had significantly larger caseloads than reflected in ACS' case tracking system.

- In June 2004, ACS received an additional report that Melissa Segarra was using drugs in her son's presence. Following a home visit, Segarra agreed to participate in a substance abuse treatment program. Although ACS was advised by the drug treatment program that Segarra was not attending the program, and had not even shown up for the intake appointment, ACS closed the case in August 2004, with the informal understanding that the caseworker would continue to pursue Segarra's participation in a drug treatment program. In mid-September 2004, the hotline received another call alleging that Segarra was using drugs in front of her son. As of the date of that call, Segarra was still not attending a drug treatment program.

11. Failure to Obtain Prior Criminal History

ACS had established procedures whereby caseworkers could request criminal background checks for family members or adults living in households under investigation. In order to obtain this information, caseworkers had several options. To begin with, the caseworkers could request the IRT Coordinator at their field offices to ask the NYPD to run criminal history checks of the relevant individuals. If the IRT was unsuccessful, the caseworker could appeal to ACS' Criminal Justice Coordinator for help obtaining the necessary information. In addition, each field office had a liaison with the

District Attorney's Office, who could request criminal history checks as well as information about pending cases from the relevant Assistant District Attorney. Finally, all managers in the field offices had access to the internet, where they could access the website of the NYS Department of Correctional Services, which contains conviction and sentencing information about all state inmates. Caseworkers could also access a website called the NYS Unified Court Systems WebCrims, which contains charging information concerning all pending criminal cases statewide. It is not clear whether caseworkers or managers were aware that this information was available or trained on how to use these websites. As of January 2006, all caseworkers now have access to the internet.

Having a full understanding of the extent and nature of the criminal history of a parent or caretaker accused of abuse is obviously critical to a caseworker's ability to accurately assess the dangers posed to the children, and to ensuring their own safety in the course of their investigation. Mayor Bloomberg recently highlighted the importance of this information in urging state legislators to give ACS caseworkers the ability to conduct criminal history checks. Although ACS had ways in which ACS staff could obtain this information, DOI's investigation revealed that ACS staff rarely attempted to obtain criminal history information about parents or caretakers under investigation. In several cases that DOI reviewed, instead of using the avenues identified above to obtain criminal history information, caseworkers typically relied on family members or the caretakers themselves to describe their criminal histories and the status of their pending cases. Some examples include:

- ACS received reports in 2004 that Jennifer Gaston was working as a prostitute in her home in the presence of her children. The report also alleged that Gaston was using cocaine in the home. The caseworker interviewed Gaston about both allegations, which she denied. The caseworker made no effort to obtain a copy of Gaston's criminal history, which would have revealed that in 2000, she had been charged with and pled guilty to loitering for the purposes of prostitution.
- Mandingo Browne, Quachaun Browne's father, was arrested several times during the period that the family was under investigation by ACS. The assigned caseworkers were aware that Browne had been arrested, but relied on Aleisha Smith's representations as to what Browne was charged with and the status of his criminal cases, even though Browne's probation officer was the source of one of the many hotline reports. Had an ACS caseworker obtained a copy of Browne's criminal history, it would have revealed that he had been arrested in late August 2000 on criminal weapons charges, and later pled guilty to disorderly conduct. It would also have revealed that in October 2004 -- while ACS had on open investigation in the home -- Browne was arrested for first-degree robbery and criminal weapons charges, for which he pled guilty to robbery in the third degree. In August 2005, Browne was arrested once again for robbery and weapons charges. He pled guilty to robbery in the first degree with respect to those charges. The August 2005 arrest came just weeks after ACS closed an investigation involving allegations that the children were living in filthy conditions and eating from the garbage, were often absent from school, and were left unattended in the apartment. This investigation was closed as "unfounded" after little or no investigation was conducted.

- Although Cesar Rodriguez, Nixzmary's stepfather, was accused of physically abusing both Nixzmary and her mother, the ACS caseworkers never obtained a full record of Rodriguez's criminal history. Instead, the caseworkers only requested information from the NYPD concerning domestic violence calls to Nixzmary's home. A review of Rodriguez's criminal history would have revealed that he had been convicted of assaulting a family member in Texas in 2002.

12. Failures to Seek Legal Advice

Attorneys from DLS are available to consult with caseworkers concerning a variety of legal options and remedies. As noted above, DLS attorneys rotate through the various field offices for these consultations. DOI's investigation revealed that caseworkers rarely consulted with DLS attorneys even in investigations where the parents were particularly obstructionist and uncooperative or after their supervisors had specifically directed them to consult with an attorney.

- The caseworkers investigating the September 2004 allegations that Melissa Segarra was using drugs in front of her seven-year-old son did not consult with an attorney about available legal options after the caseworkers attempted eight unsuccessful home visits. In addition, Segarra had failed to respond to a series of notes directing her to contact ACS, which were left at Segarra's apartment over the course of three months. Instead, ACS closed this case as "unfounded" without ever interviewing Segarra or conducting a home visit.
- ACS did not seek a legal consultation after Michael Segarra tested positive for cocaine at birth in November 2005. Instead, ACS consented to Michael's release from the hospital into Segarra's custody without seeking any court-ordered supervision, based solely on Segarra's promise that she would attend a drug treatment program and live at her parents' home with her children. ACS still did not seek legal advice or judicial intervention after receiving an additional hotline report alleging that Segarra was using drugs, after learning that her attendance in the drug treatment program was sporadic at best, and after the caseworker specifically noted that Segarra was living with Michael at a different address than her parents.
- The ACS staff responsible for investigating the December 2005 abuse allegations in the Nixzmary Brown case did not consult with an attorney about the possibility of obtaining a warrant to produce the children or a warrant of entry despite the caseworker's repeated inability to gain access to the family's apartment. On January 11, when the caseworker finally gained access, the police and EMTs were already on the scene and Nixzmary was dead.

13. Language Barriers

The staff of ACS is frequently called upon to communicate with individuals, including children, parents, and witnesses, who are not fluent in English. DOI's investigation revealed a number of instances where caseworkers without appropriate language skills were assigned to investigate abuse allegations. Obviously, a caseworker is unlikely to get a true assessment of a situation if they cannot communicate fully and freely with the subject parents or important witnesses. In addition, the subject of an investigation could attempt to coach or threaten a witness in the presence of the caseworker if the caseworker does not speak or understand the primary language of the subject.

The danger posed by these language barriers was illustrated in the Nixzmary Brown investigation. There, the caseworker assigned to investigate the initial allegations in May 2005 was fluent in Spanish and communicated with the family primarily in Spanish. However, another caseworker assigned to investigate the December 2005 allegations that Nixzmary and her mother were being physically abused by Rodriguez did not speak Spanish and communicated with the family exclusively in English. This caseworker was assigned despite the specific request by the reporting school official that ACS send a Spanish-speaking caseworker. In the course of investigating these allegations, the caseworker interviewed Nixzmary and her siblings as well as Rodriguez and Santiago-Rodriguez. Given the sensitive nature of these interviews, it is beyond question that a caseworker who was fluent in Spanish would have been better equipped to question the family on the subject of physical abuse. In fact, the caseworker who interviewed the family members on December 1 admitted to DOI that Santiago-Rodriguez and Rodriguez had conversations in Spanish in her presence that she could not understand. In addition, Rodriguez, the parent accused of beating both Santiago-Rodriguez and Nixzmary, was more conversant in English than his wife and, therefore, more likely to control what the caseworker learned about the family.

In early 2006, ACS established an interpreter service through which caseworkers in the field can call the office and obtain translations by telephone. It is unclear how well ACS has publicized the availability of this new service to its staff. In late 2006, DOI interviewed a caseworker who was not aware that interpreters were available to speak to caseworkers in the field by telephone. In June 2006, that caseworker, who did not speak or understand Spanish, was assigned to investigate allegations that a two-year-old child was being physically abused by her mother's boyfriend. This caseworker was assigned despite the fact that the hotline report made clear that the family spoke Spanish. At this caseworker's home visit, the caseworker interviewed the child's mother with an unidentified person she believed to be a cousin or friend of the boyfriend and the boyfriend himself translating the mother's statements.

14. Failure to Address Inadequate, Illegal and/or Dangerous Housing Conditions

According to the ACS Practice Guide, caseworkers performing home visits are required to assess whether the conditions at the home pose a safety risk to the children living in the home. If the caseworker determines that the conditions in the home are

unsafe, the caseworker is required to document those conditions and arrange for appropriate safety interventions. A caseworker confronted with a family living in unsafe housing has a number of options, including escorting the family to the DHS for admission into a shelter or referring the family to the ACS Housing Unit, which will determine whether the family is eligible for housing subsidies. If a parent refuses to cooperate with a referral to DHS and insists on remaining in housing that is dangerous to the children, ACS staff should consult with a DLS attorney about initiating proceedings to remove the children from the home. ACS does not require that children be removed immediately so long as there is no imminent danger and the parents are working together to improve a family's housing situation.

DOI's investigation revealed that ACS staff were not adequately trained to identify unsafe housing conditions and were not instructed to notify the New York City Department of Buildings when they observed children living in dangerous and/or illegal housing.

In the investigation of the Gaston family, where three children died in a fire in their illegal cellar apartment, both the caseworker and her supervisor told DOI that most of the homes that ACS investigates in the Elmhurst section of Queens involve families living in illegal cellar apartments. Both claimed that ACS does not require the families to find alternate housing unless there is an immediate risk to the children due to a lack of resources. The caseworker told DOI that she believed that the only options available to her were either to leave Gaston and the children in the cellar apartment or to petition the Family Court to remove the children from the mother's care. The caseworker said that she felt the latter option would have been "punishing the mother for being poor." The supervisor, who has worked for ACS for over 25 years, said that as far as he knew the only alternative housing options for the Gaston family was to have them clean the home or refer them to DHS for admission into the City's shelter system. The relevant files in CONNECTIONS concerning the Gaston family reflect that the supervisor had suggested that the family be referred to DHS, but when the caseworker suggested that to Gaston, she rejected the idea. No further action was taken.

15. Supervision of Outside Vendors

DOI also uncovered a consistent pattern in which ACS failed to communicate regularly and effectively with the many outside vendors with which they contract to provide various services to children and their parents, such as foster care agencies, substance abuse treatment programs and other counseling services. This failure of communication seriously undermined ACS' ability to monitor subject parents' attendance and progress in these programs as required by the ACS Practice Guide.

16. Leave and Vacancy Issues

DOI also observed deficiencies in the way in which ACS field offices managed absences of frontline caseworkers and supervisory staff. For example, there were long periods during the investigations of Quachaun Browne's family when the unit worked without any supervisory support or oversight. Caseworkers have told DOI that they typically rely on one another and their supervisors to cover necessary home visits during their absences, and there was no formal process in place to ensure that these visits

were actually conducted. One caseworker reported to DOI that she felt pressured to close cases before leaving for vacation.

B. Other Issues

1. The SCR Hotline

As described above, reports of child abuse and/or neglect are received by the SCR hotline, maintained by OCFS. These calls are taken by child protective specialists, whose role it is to determine whether the information provided by the caller sets forth reasonable cause to believe that a child is being abused or neglected. The specialists have discretion as to whether a report calls for an investigation by a local child protective agency. OCFS does not document any aspect of a call that a specialist determines does not warrant a referral to a local agency.

According to the OCFS, calls to the hotline are not recorded because many callers wish to remain anonymous, and because of their concern that recording calls would have a chilling effect on the number of calls to the hotline. Instead, calls to the hotline are summarized by the specialists in what are known as call narratives. The call narratives are not expected to be a verbatim account of what the caller reported. In fact, the specialists are instructed to draft the narratives in a generic fashion to protect the identity an anonymous report. Although there is no formal list of acceptable words for specialists to use in summarizing calls, over time, an informal practice of using particular words and phrases has developed, which accounts for the frequent use of certain words and phrases in the call narratives. For example, DOI noted that call narratives would often reflect that a caller had reported that a subject's home was in "deplorable" condition when a caller reported that a home was particularly dirty.

DOI's investigation also revealed that certain ACS staff did not understand how hotline calls were documented. One employee who has worked for ACS for more than 25 years told DOI that he believed the call narratives were an effort to record a "word for word" summary of each call. Based on this incorrect assumption, the ACS manager believed a source that had identified herself in one call to the hotline about Gaston was also the source of numerous anonymous calls about Gaston because the wording in all of the call narratives was virtually identical. This manager and the assigned caseworker had determined that the allegations made by the source who had identified herself were "unfounded," and then assumed that she was making all of the other anonymous calls to the hotline in an effort to harass Gaston. Based on this flawed reasoning, the manager directed the caseworker to inform this source that she could be criminally prosecuted for filing false reports to the hotline.

Although OCFS is rightly concerned that callers not be discouraged from reporting suspicions of child abuse to the hotline, the limitations of call narratives was demonstrated in the Sierra Roberts case. There, the call narrative stated that Sierra's pediatrician, Dr. Dua, had called to report her broken leg, and reflected that he did NOT suspect her injury was the result of abuse. When interviewed by DOI, Dr. Dua insisted that the ONLY reason he had called the hotline was because he suspected abuse. Had the call been recorded, it would have been possible to verify what Dr. Dua actually reported.

In addition, the OCFS does not record calls placed by mandated reporters. Given that these individuals are required by law to report suspicions of child abuse or neglect, there is absolutely no reason that these calls should not be recorded.

2. New York City Police Department

As noted above, the IRT program was created to improve coordination among ACS, the NYPD and the District Attorney's Offices in certain child abuse investigations, and an investigation can benefit tremendously as a result. One of the principal goals of this program is to limit the number of times that children are subjected to interviews during the course of an investigation. In expressing some frustration with the IRT program, ACS employees reported that the IRT NYPD detectives often asked ACS staff to conduct preliminary interviews of the children with which the detectives were assessing whether to get involved.

3. New York City Probation Department

DOI's investigation also revealed that ACS often failed to communicate effectively with representatives of the New York City Probation Department. For example, Dahquay Gillians' mother, Tracina Vaughn, was sentenced to five years' probation after pleading guilty to reckless endangerment stemming from the bathtub incident involving her older son. During her probation, and while she continued to be under investigation by ACS, Vaughn often failed to report for drug tests scheduled by both ACS and the Probation Department. DOI's investigation revealed little communication or coordination of efforts between the two agencies. In addition, ACS staff failed to speak with Mandingo Browne's probation officer even though this officer was the source of a hotline report concerning the disturbing condition of the family's home.

4. Accountability Review Panels

Accountability Review Panels are independent advisory bodies, comprised of physicians, attorneys, mental health professionals, ACS employees and other experts, which examine the circumstances surrounding the deaths of children in families who were previously known to the child welfare system and otherwise meet the statutory criteria for such a review. A Panel is convened anytime the SCR hotline receives a report that a child has died due to abuse or neglect, and the child's family had been investigated by ACS within the past 10 years. The Panel is expected to examine the quality of ACS' investigation, service planning and service delivery, identify case-specific and systemic issues, and recommend ways in which to improve the overall functioning of ACS. In conducting this review, the Panel reviews relevant ACS records, medical records and family court records, and conducts interviews of ACS caseworkers, supervisors, and other individuals involved with the families. Each Panel prepares preliminary reports which contain detailed case synopses, general observations of the

panel, and preliminary recommendations. The Panel must then issue a final report within six months after each death that is reviewed.¹⁶

DOI reviewed the reports issued by the Panels in connection with the child fatalities discussed in this report. Based on that review, DOI has determined that the reports issued by the Panels were detailed, thorough assessments of ACS' performance in the various investigations. The reports also contained detailed critiques of ACS' adherence to statutory and internal procedural requirements. In addition, each Panel's recommendations were thoughtful, comprehensive and attempted to address the principal failings of each investigation.

C. SCI's Review

SCI's investigation revealed that there was a substantial failure of communication among the staff at Nixzmary Brown's school, P.S. 256, which prevented school officials from reporting suspicions of abuse concerning Nixzmary and her siblings earlier. In addition, SCI's review revealed that school officials at Nixzmary's school failed to ensure that the procedures relating to chronically absent students were followed.

Pursuant to the DOE Chancellor's Regulations, every school must establish a child abuse prevention and intervention team.¹⁷ This team, which should include an administrator and a guidance counselor, is required to develop and implement a plan to prevent and intervene in cases of suspected child abuse. The plan must outline the school's child abuse and neglect ("C/AN") reporting protocol, and describe the training that will be provided for school staff and team members. The plan must be signed by the principal and the school's designated CA/N liaison, and submitted annually to the relevant DOE regional office.

According to DOE records, P.S. 256 failed to submit these plans for at least three years prior to Nixzmary's death. SCI's review also demonstrated that this failure was not unique to P.S. 256. Records for Region 8, the region in which P.S. 256 falls, showed that during the last four school years, a significant percentage of schools had failed to submit these plans as required. For example, during the 2003-2004 school year, 88 schools, or 62% of the schools in Region 8 failed to submit their plans. For the 2006-2007 school year, 69 schools or 49% had not submitted their plans more than six months after the deadline. To the extent that these prevention and intervention plans were submitted at all, school officials did little to ensure that the plans were thoughtful or comprehensive. Notably, the deputy director of Region 8's Youth Development Office told SCI that when she did receive these plans from the schools in the region, she merely verified that they were signed and dated. She did not review the adequacy of the plans before filing them, and was not aware of anyone else in the region who did so.

SCI learned that staff members at P.S. 256 met on a weekly basis to discuss students identified as being at risk for abuse and/or neglect. This group was comprised of school social workers and counselors, however, the group lacked a clear leader and the principal, assistant principals and staff from the health office rarely attended these meetings. In addition, a central file of minutes of these meetings was not maintained,

¹⁶ N.Y. Soc. Serv. Law §§ 20(5), 422-b.

¹⁷ Chancellor's Reg. A-750 (4.1.3).

although SCI did obtain copies of minutes retained by individual participants of the meetings. These documents reflect that school staff members observed and discussed among themselves injuries to both Nixzmary and her brother as early as March 2004. Notes from a March 2004 meeting reflect that the group discussed the fact that Nixzmary's older brother had reported to school staff that their stepfather hit him and his siblings and pulled their hair. School officials told SCI investigators that this was reported to the SCR hotline, but the report did not generate a referral by OCFS. Because OCFS does not record calls to the hotline or otherwise make a record of calls that do not generate a referral, SCI investigators were unable to determine if this call had been made. In addition, although classroom teachers (who are mandated reporters) are typically in the best position to notice signs of abuse, the DOE requires teachers to report any suspicions to the principal or the principal's designee.¹⁸ SCI learned that principals, in turn, often delegated the responsibility of reporting suspected abuse to the hotline to guidance counselors, school social workers, or school nurses. Not surprisingly, this often resulted in misunderstandings about whether calls to the hotline had been made and prevented appropriate follow-up by school officials.

SCI's investigation also uncovered significant shortfalls in the procedures used by P.S. 256 to monitor student absences. Each DOE school is required to monitor student attendance by having all teachers submit a daily attendance sheet to an attendance secretary, who then enters the information into the DOE computer database. This system will generate a report, known as a Form 407, for any student who has been absent for 10 consecutive days, 20 aggregate days over the course of four months, or eight consecutive days if there has been a prior 407 filed. For the 2004-2005 and 2005-2006 school years, the principal of P.S. 256, and his successor, the interim acting principal, delegated the responsibility of tracking student attendance to an assistant principal. When interviewed by SCI investigators, however, this assistant principal said that she was not involved in efforts to contact the parents of chronic absentees and was largely uninformed about the efforts taken by the attendance teachers, family workers and guidance counselors with respect to Nixzmary Brown and her siblings. A family worker at P.S. 256 was given the responsibility for calling and writing to the parents of absentees after three consecutive absences. If the parents did not respond to the calls and/or mail and the students did not return to school, the family worker was expected to visit the students' homes. P.S. 256 also had an attendance teacher who was assigned to the school two days per week. He was responsible for investigating absenteeism in P.S. 256, but had no supervisory authority over the family worker, who was in the school every day. The attendance teacher was not supervised by the school's principal, but reported to a supervisor at the regional offices. This lack of oversight of the attendance teacher and the family worker by the administration of P.S. 256 and the lack of communication between the attendance teacher and the family worker resulted in lost opportunities to meaningfully address chronic attendance problems.

¹⁸ See Chancellor's Reg. A-750(1.1.1).

IV. THE CITY'S RESPONSE TO THE FATALITIES

A. Mayor Bloomberg's Response

In late January 2006, in response to the deaths of Nixzmary Brown and the other children described in this report, Mayor Bloomberg announced that ACS would receive an additional \$16 million in funding to hire additional staff and train both new and existing staff members. At the same time, ACS committed to re-directing \$9 million in existing funding to preventive programs in the neediest communities. Mayor Bloomberg also created a new position -- the Family Services Coordinator -- who is responsible for improving communication among the various City agencies servicing children at risk of abuse and their families. Mayor Bloomberg also convened an Interagency Task Force on child welfare and safety which brought together representatives from ACS, the DOE, the NYPD, DOI, the DHS, the Office of the Criminal Justice Coordinator ("CJC"), the Health and Hospitals Corporation ("HHC"), and other City agencies to identify ways in which to improve the City's ability to respond effectively to allegations of child abuse. The Task Force later issued a wide range of initiatives and continues to meet regularly to monitor the implementation of those initiatives.

Two of the major areas addressed by the Task Force have been partnerships between ACS and the DOE, and between ACS and the NYPD. With respect to ACS and the DOE, a system has been established whereby each school has a designated individual for reporting all matters to ACS and each ACS field office has an educational liaison. The Task Force also worked with the DOE to establish electronic student absence alerts in New York City schools. These alerts are generated every Monday morning and identify the names of students who have open investigations for extended absences and provide information about the status of each investigation. The Task Force working with the DOE has also revised DOE's practices with respect to students who are chronically absent, including imposing more stringent timeframes and supervision of the DOE's investigations of student absences. These efforts appear to have had an impact. From 2005 through 2007, the number of educational neglect cases reported by school officials increased by 33% and there has been a 5% decrease in students who were chronically absent during that same period. In addition, the number of DOE investigations of student absences that were open for more than 10 days has decreased by 27% from the 2005-2006 to the 2006-2007 school year. There are also plans to launch pilot student attendance programs in Harlem and Red Hook in September 2007 which will be aimed at high-risk students and families.

The Task Force also reached an agreement with the OCFS regarding referrals in cases of educational neglect. Previously, the OCFS required a reporter to demonstrate the following to generate a referral for educational neglect: (1) reasonable cause to suspect that the parents were aware or should have been aware of illegal absenteeism; (2) reasonable cause to suspect that the parents contributed to the problem or were failing to take adequate steps to address the problem; and (3) reasonable cause to suspect educational impairment/harm to the child or imminent danger of impairment/harm.

This standard created a fair degree of confusion. Now, the hotline will make a referral to a local child welfare agency anytime a hotline specialist determines that “a typical student in [the reported] situation would be educationally harmed.”¹⁹

With respect to the NYPD, many of the concerns raised by ACS employees about the IRT process have been addressed by the Task Force’s initiatives. These include the establishment by the NYPD of a central command center that is operational 24 hours a day, seven days a week for reports of severe child abuse and to assist ACS execute warrants or entry orders. The NYPD and ACS now have access to a shared database for IRT cases so that prior histories, investigative results and other information can be shared in real time. In addition, a law enforcement professional with over 20 years of experience at the NYPD has been added to the executive management of ACS as a senior advisor to work directly with Commissioner Mattingly on law enforcement issues. In addition, an NYPD lieutenant is now based full time at ACS headquarters to facilitate coordination between the NYPD and ACS and each NYPD precinct has a child abuse liaison. There has also been an effort to increase the use of Child Advocacy Centers in abuse and neglect cases. Finally, the NYPD established a centralized hotline for IRTs, and increased training for 911 operations concerning calls involving child abuse.

The Task Force has also worked to increase awareness concerning child abuse within the medical community and to educate medical professionals with respect to their reporting obligations. Toward this end, the Task Force has launched citywide child abuse and neglect training for medical staff in both public and private hospitals and has provided training to thousands of medical personnel regarding their obligations as mandated reporters. In addition, Child Safety Centers, known as Comprehensive Evaluation and Treatment of Child Abuse and Neglect facilities (“CETCANs”) have been created at all HHC emergency departments. Beginning in September 2007 professionals trained in responding to child abuse allegations will be available in these facilities 24 hours a day, seven days a week, and a new 911 protocol for ambulance calls will ensure that suspected victims of child abuse will be brought to a CETCAN facility. Further, each hospital in New York City now has a Child Safety Coordinator to strengthen interagency coordination in child abuse cases. The Task Force has also partnered with the OCFS, ACS and the DOHMH to provide training to child care providers concerning child abuse and their reporting obligations. Although there are currently approximately 25,000 child care providers at City-regulated facilities in New York City, child care providers have made the fewest hotline reports of all mandated reporters in the City. To date, over 1,000 child care providers have been trained. In addition, a child safety campaign aimed at child care providers will be launched this Fall.

Further, in February 2006, following the reports of these tragic deaths, a number of City agencies came forward to offer assistance to ACS with respect to badly needed equipment for their caseworkers. For example, DOI, the Department of Transportation, and the Department of Sanitation agreed to transfer a number of City-owned vehicles to ACS. The Department of Buildings also donated a number of cameras for the caseworkers to use in their fieldwork.

¹⁹ City of New York, *Report of the Interagency Task Force on Child Welfare and Safety* p.10 (Mar. 29, 2006).

B. ACS' Response

On March 23, 2006, ACS issued a strategic plan entitled *Safeguarding Our Children: 2006 Action Plan*, the result of its own critical review of all open cases, and its plans for improving the identified flaws. The plan focused on the three principal areas: (1) improving the performance of its staff and the performance of various provider agencies; (2) improving the investigatory skills and decision making of its staff; and (3) placing more emphasis on child safety throughout the agency. The plan included 21 initiatives, many of which had already been implemented by the plan's release in March 2006. The initiatives already implemented by March 2006 included:

- Reviewing all 10,000 open protective cases by field officers and managers, with another sample review conducted by ACS central office staff.
- Redeploying 200 ACS staff to assist caseworkers in the field until new caseworkers and managers could be hired.
- Assigning high-level managers to each of the fourteen field offices to identify and address issues raised by managers and staff at those offices.
- Hiring new leadership for the Division of Child Protection, including a new Deputy Commissioner, two new Associate Commissioners, and a new Assistant Commissioner.
- Hiring 275 protective staff and beginning their training.
- Hiring a Special Advisor to the Commissioner who had over twenty years of NYPD experience, most recently heading its Special Victims Division, and who was overseeing the hiring of twenty investigative consultants with law enforcement experience.
- Assigning 22 ACS staff members to help resolve problems with CONNECTIONS.
- Creating the Office of Safety First to respond to concerns of mandated reporters about their calls to the hotline.

In the fifteen months following the plan's release, ACS continued to implement and make progress on all of the plan's initiatives, while investigating more than 63,000 reports of abuse and neglect in Calendar Year 2006 – a 31.7% increase from Calendar Year 2005 when ACS investigated over 47,000 abuse and neglect reports.

Following ACS' review of all open protective cases, ACS assigned a Safety Solutions Team to each borough. These teams were comprised of national experts in child welfare who worked intensively with supervisory staff and front line caseworkers to improve the quality and consistency of case practices as well as managerial skills. ACS is currently using this same process to improve the interaction between DLS attorneys and caseworkers during the investigative process. ACS also implemented Child Safety Conferences, beginning in Manhattan, which is bringing nationally recognized best practices when an investigation suggests that a child should be placed in foster care. This conferencing model is designed to involve the biological family, ACS child protective staff and trained facilitators. It encourages the family to provide critical information about the child's background and brings a team together to make the placement decision rather than leaving it up to an individual caseworker. This model has been used successfully in other U.S. cities, such as Los Angeles, Baltimore, Cleveland and Detroit and should ensure more consistency in ACS' placement decisions.

Since January 2006, ACS also made significant leadership changes in the Division of Child Protection. As noted above, ACS hired a new Deputy Commissioner, two new Associate Commissioners and a new Assistant Commissioner. In addition, ACS created the new position of Assistant Commissioner who is responsible for the Child Protection operation in each borough and filled more than half of these new positions with candidates from outside the agency, with the hope of bringing a fresh perspective to the work of the agency. After the case reviews, ACS pursued disciplinary actions against staff in five cases due to their actions. This resulted in one demotion, six suspensions, two resignations, and four terminations. ACS also developed borough leadership teams led by First Deputies to oversee the training units and strengthen administrative support. ACS continued its aggressive hiring schedule, bringing on 25 new Child Protective Managers and three Deputy Directors. By December 2006, close to 800 child protective caseworkers had been hired and trained, and over 1,200 caseworkers were on board by April 2007. ACS also hired 20 former law enforcement officers to provide consultation and support to caseworkers in connection with their investigations.

In addition, ACS is working to improve the training offered to child protective staff. That training currently consists of 29 days of classroom instruction interspersed with ten days of on-the-job training, and 90 days of field practice in a training unit. This training currently focuses first on skills and competencies and second on applying those skills to child protective practice, including investigations. Over the last year, ACS made changes to integrate child protective examples into the first part of the curriculum, and ACS is working with the State to completely revise the curriculum so that the skills and competencies are taught in the context of child protective practices and investigations. The revised training also seeks to hone protective staff's understanding of how to conduct an effective and thorough child protective investigation. Over the last year, ACS also worked with the OCFS and the National Resource Center for Child Protective Services to evaluate the existing safety and risk model. As a result of these efforts, ACS provided safety and risk refresher training to all child protective staff and supervisors.

With respect to the supervisory skills of its staff, ACS secured private funding to open a leadership academy, which provides training programs for ACS managers from experts in the areas of child protection case practice, management, policy, and leadership. The Academy will also provide targeted assistance to individual managers to enhance their leadership abilities.

In November 2006, ACS issued an update on the status of its March action plan, entitled *Safeguarding Our Children: Safety Reforms Update*. Among the updates included in that report was that ACS instituted ChildStat, modeled on NYPD's CompStat, where each week child protective managers present summaries of ongoing cases to senior executives, who then provide guidance and specific recommendations on how to improve the caseworker's performance in those and other cases. ChildStat has proved to be one of the most effective staff accountability initiatives implemented by ACS. These three-hour weekly accountability sessions bring child protective leaders from each of the City's fourteen geographic zones to meet on a rotating basis with top ACS executives. Wide-ranging zone performance data is analyzed, and an open child protective case is reviewed in-depth. The case reviews are analyzed against model investigatory practices and reinforce best practices, such as reviewing prior investigations, interviewing all household members and other relevant witnesses, and ensuring supervisory oversight. The discussion focuses on what did and did not

happen, and what should have happened. Leaders from every ACS divisions are required to be represented at each ChildStat so that issues – such as facilities, staff equipment, data monitoring, and training – are fully understood and addressed.

Some specific examples of positive changes that have resulted from ChildStat include increasing access to preventive services from child protective referrals. The Division of Family Support Services worked with preventive providers to increase preventive service availability in targeted neighborhoods by closing out long preventive cases which no longer needed services. In response to issues raised in ChildStat, ACS also issued revised practice policies to guide caseworker's investigative work.

ACS has also issued Child Safety Alerts via email as a method of instant communication to both remind and update staff about specific practice issues. 21 child safety alerts have been issued in the last sixteen months. Some examples include:

- Updated Procedure for Warrants and Entry Orders (February 15, 2006)
- Case Recording and Documentation (March 10, 2006)
- Strengthening our Partnerships to Better Protect Children (March 13, 2006)
- CPS Investigations: 24/48 Hour Contact Documentation (March 22, 2006) (Reissued: October 24, 2006)
- ACS Encourages Care Be Taken When Relative Custody is Being Recommended (April 3, 2006)
- Strengthened Preventive Services Now Available for At-Risk Teens and Babies Born with a Positive Toxicology (May 18, 2006)
- Working with Parents Experiencing Domestic Violence (May 19, 2006; Reissued June 12, 2006)
- Instant Response Team Protocol (June 16, 2006)
- Safety Planning for Newborns Whose Siblings are in Foster Care (June 16, 2006)
- Additional Information Received from the SCR on Open Cases (August 17, 2006)
- Gathering and Assessment of Information from Medical Providers During CPS Investigations (August 22, 2006)
- Investigating Allegations of Educational Neglect and Coordinating with DOE During PCS Investigations (September 20, 2006)
- Protecting Children of Young People Living in Foster Care (January 29, 2007)
- Initiating an Investigation: The First Interview with the Subject (March 13, 2007)
- Going Out in Pairs when Conducting CPS Investigations (June 11, 2007).

In the February 2006 Safety Alert on updated procedures for warrants and entry orders, ACS revised its procedure to provide that when a parent or other legally responsible adult refuses to allow a caseworker to enter the home, and the caseworker has reasonable cause to believe that a child is in immediate danger of serious harm, the caseworker must seek police assistance, which can enter the home forcibly, under certain circumstances, without a warrant. In cases where the police determine that they do not have the authority to enter forcibly without a warrant, the caseworker is instructed to work with an attorney from DLS to obtain an entry order. In non-emergency situations, caseworkers are now expected to consult with a DLS attorney within 72 hours after two unsuccessful home visits. "Unsuccessful" in this context refers to visits where

no family member appears to be at home. In cases where the parent answers the door, but refuses to allow the caseworker to come in, the caseworker is expected to consult with a DLS attorney within 24 hours of being denied entry.

More recently, on June 11, 2007, a Safety Alert encouraged all CPS caseworkers to go out in pairs when making an initial home visit during an investigation, particularly in cases where the allegations suggest that the caseworker may encounter a dangerous situation in the home. The Safety Alert also encouraged caseworkers to work in pairs when complex family situations make it difficult to assess the safety of the children, and when taking children into protective custody. The Safety Alert encourages caseworkers to work in pairs, but does not mandate that they do so.

ACS also revised its policy concerning the securing of case files in February 2006. That policy now requires that the physical case record be copied, sealed, and hand-delivered to the Office of their General Counsel as soon as ACS learns of the death, near-death or serious injury of a child in a family under investigation. In addition, following a child's death, access to view the relevant CONNECTIONS files will be restricted to individuals above a certain managerial level. However, this new policy does not restrict access of the assigned caseworker and other supervisors who had responsibility for the investigation. As a result, the assigned caseworker and supervisors can still make entries into the CONNECTIONS file after a child's death about investigatory steps or other action that purportedly took place before the child's death.

The Instant Response Protocol was also revised to include a central NYPD contact for case assignment. An NYPD lieutenant is based at ACS to facilitate coordination, and NYPD child abuse liaisons have been established in each precinct. A real-time database for IRT actions has been created and is accessible to both the NYPD and ACS.

To address provider accountability, ACS terminated its contracts with two under-performing service agencies and one foster care agency. ACS also announced an initiative known as Improved Outcomes for Children, which will focus on improving the results achieved by the agencies under contract to ACS. The expected results include:

- Helping children in foster care experience fewer moves while in foster care;
- Finding permanent, safe families in an expedited manner;
- Reducing the frequency of youths being placed in group care, rather than in family foster care; and
- Strengthening the preventive agencies' work with children and families.

ACS staff will be working closely with providers through teams of performance monitors to ensure high quality service delivery. ACS is also developing technical assistance teams to troubleshoot specific cases and provide training and consultation to provider agencies.

Community organizations, leaders, and residents are critical in efforts to keep children safe. To strengthen linkages between ACS and communities, ACS created and funded demonstration grants to local coalitions of community organizations, foster care and preventive agencies, Head Start and child care agencies, City agencies, and

community leaders. ACS has awarded these Community Partnership Initiative grants to eleven communities, beginning with Jamaica, High Bridge, and Bedford Stuyvesant.

ACS has also distributed more than 2,000 cell phones to child protective staff, deployed fifty-five additional cars within ACS, and has made telephone interpretation services available in more than 100 languages to help its frontline caseworkers investigate abuse and neglect allegations. In addition, ACS continues to respond to an increased number of reports alleging abuse and neglect.

- ACS investigated and provided services in 13,152 active preventive cases in Calendar Year 2006, an increase of 16.3% over Calendar Year 2005 which had 11,309 active preventive cases;
- ACS “indicated” 24,946 reports in Calendar Year 2006, an increase of 55.8% from Calendar Year 2005 where 16,007 reports were “indicated.”
- ACS investigated 14,203 educational neglect cases in School Year 2006, an increase of 41.4% over School Year 2005 which had 10,044 educational neglect cases; and
- ACS has responded to over 3,100 calls through the Safety First Office through the end of May 2007.

Finally, ACS has taken disciplinary action against fourteen employees based upon their involvement in the investigations of the nine families described above. Those employment actions are as follows:

- A caseworker and two supervisors responsible for investigating allegations relating to Nixzmary Brown’s family were terminated.
- Two other caseworkers involved in the Nixzmary Brown investigations were suspended without pay for 60 days, and a supervisor was suspended without pay for 30 days.
- A caseworker responsible for investigating the active cases concerning Quachaun Brown’s mother from May 2005 through the date of Quachaun’s death was terminated.
- A supervisor responsible for the Gaston family investigations was suspended for 10 days without pay and demoted, and a caseworker who worked on the investigations was suspended for 30 days without pay.
- A caseworker and a supervisor responsible for investigating the 2005 allegations concerning Melissa Segarra were suspended for 60 days without pay.
- A caseworker responsible for the investigation of the September 2004 allegations against Melissa Segarra resigned after ACS filed disciplinary charges against her. A supervisor responsible for overseeing the investigation was suspended for 60 days without pay.

- A manager with supervisory responsibility for investigating allegations in the cases of Nixzmary Brown and Dahquay Gillians resigned after admitting to both ACS staff and DOI investigators that he had made false entries in ACS records concerning the investigation after Dahquay died.

Eight employees have challenged these disciplinary actions. All of those challenges are pending.

Although more remains to be done, these efforts have made ACS a significantly more effective agency than the one operating in January 2006.

C. DOE's Response

In April 2007, the DOE's Director of Mandated Responsibilities advised SCI of initiatives undertaken by DOE subsequent to Nixzmary Brown's death and in response to the findings and directives of the Mayor's Interagency Task Force.

The DOE provided ACS with a list of DOE school-based "Designated Reporters" and ACS provided the DOE with the name and contact information for the DOE liaison in each ACS field office, and the contact information for the ACS "Instant Response Coordinators." This information is posted on the DOE website.²⁰

The DOE released new procedures for identifying and reporting cases of abuse and neglect in the April 25, 2006 edition of "Principals Weekly," a bulletin e-mailed to DOE school principals. These directives included the following for grades K through 8:

Investigations of absenteeism must be completed within ten days of the issuance of a Form 407. Every Monday, each school is issued a "School Absence Alert" for all 407s which remain open more than ten days, including information regarding any previous 407s concerning the subject student during the school year. The DOE Regional Office is to assist schools with difficult cases, which must be closed within a five days. The DOE Central Office is to review and monitor open cases. Three new fields are to be completed on the Form 407s: Confirmation that the investigation was completed, whether a report was made to the SCR, and the date of any SCR report.

The April 25 "Principal's Weekly" also alerted Principals that DOE Regional Attendance Supervisors would be contacting them to schedule training sessions. The June 27 edition included a reminder of the new directives and a reference guide for summer school personnel.

The beginning of the 2006–2007 school year prompted more editions of the Principal's Weekly stressing the new attendance and educational neglect procedures and requirements, including mandated training sessions. A reminder appeared in the October 31 edition, and the December 12 edition featured a form letter for principals to

²⁰ Available at <http://schools.nyc.gov/Offices/DYD/OYD/OSS/ChildAbuse>.

send to parents reminding them of the importance of regular attendance, especially before and after the winter recess.

With respect to training, beginning in June 2006, the DOE conducted several mandated sessions for staff in the DOE Youth Development Borough Offices, Attendance Teachers (including a joint training session with ACS) and, at the school level, Designated (ACS) Reporters. According to the DOE, more than 1,300 of the latter school staff members have received training between October 2006 and April 2007 on how to identify child abuse and neglect, and on the new educational neglect policy.

Finally, the DOE has continued to grant authorized ACS workers with training on and access to the DOE ATS student information system.

D. Document Production Issues

In the course of this investigation, DOI faced certain obstacles relating to access to relevant ACS case records that significantly delayed its investigation. At the outset of the investigation, DOI served ACS with a subpoena that called for the production of every document, record, and computer file relating to the nine families at issue. ACS worked on responding to DOI's subpoena and produced thousands of documents to DOI over the course of the investigation. However, after reviewing the initial document production, DOI was forced to make repeated requests for additional documents and materials that should have been included in ACS' original production. In particular, although DOI requested in February 2006 that ACS produce all records relating to the subject families, ACS' initial document production only included printouts from the CONNECTIONS system. Thereafter, DOI made repeated requests to ACS for production of all files concerning the subject families, including those containing medical records, educational records, preventive services and foster care agency files, copies of consent forms, and documents maintained by caseworkers after cases were closed in CONNECTIONS. Despite these repeated demands, DOI has still not received much of these materials for several cases. In addition, DOI's interviews with ACS staff and the subsequent document productions by ACS made clear that some of the CONNECTIONS printouts initially produced by ACS were incomplete. Finally, DOI has made numerous requests for ACS to produce the field notebooks of caseworkers responsible for the investigations at issue. As of the date of this report, ACS has not produced a single field notebook. DOI received only one field notebook during the course of the investigation from a caseworker who was interviewed by DOI and later provided a notebook to DOI directly. This caseworker also told DOI that she was never asked by ACS management to turn over her notebook in connection with any document production to DOI.

DOI is not suggesting that ACS intentionally attempted to obstruct or impede the investigation in any way. Rather, it appeared that ACS' record retention practices and the individual record keeping practices of the caseworkers and supervisors responsible for the investigations at issue made it very difficult for ACS to respond quickly and comprehensively to DOI's subpoena. ACS' record keeping practices are obviously critical to its mission and will be addressed in more detail in the policy and procedure recommendations that follow.

E. Further Updates

On February 27, 2007, Mayor Bloomberg and ACS Commissioner Mattingly presided over the graduation of 230 new caseworkers, bringing the total number of frontline caseworkers and other child welfare investigators to 1,310. This represents a 44% increase in the number of caseworkers on staff since the death of Nixzmary Brown in January 2006. At the graduation of these new caseworkers, Mayor Bloomberg urged state legislators to give ACS caseworkers the authority to conduct criminal background checks of adults living in homes where credible abuse allegations have been reported. Such a measure would add a significant tool for ACS with which they could more effectively and knowledgeably assess the safety of children potentially at risk and in need of help. Currently, as described in more detail above, ACS caseworkers must request information about the criminal history of the adults living in the households that they are investigating from other sources. Mayor Bloomberg further announced his plans to lobby state legislators to make assaulting an ACS caseworker a felony, a protection already afforded to teachers, police officers, and transit workers. The safety of ACS workers is a very real issue reported by many of them who were interviewed by DOI. Safety was also a topic raised at a recent ACS Childstat where a series of threatening incidents were reported and discussed. ACS workers, whose mission it is to go into potentially dangerous environments, need and deserve to be protected by the fullest extent of the law. Moreover, it was abundantly clear from DOI's investigation, that if ACS workers, whose job it is to get the facts in cases alleging serious abuse or neglect by going into the field and by asking probing questions, feel unsafe or intimidated it will and does impact investigations.

On March 22, 2007, ACS announced plans to reform the way in which it finances and monitors the outside agencies that provide foster care to New York City's children, with the twin goals of holding these agencies more accountable and reducing the time that children spend in foster care.

ACS has also been working to improve communication and cooperation with the Family Courts. Beginning in early 2005, the Commissioner and Executive Deputy Commissioner of ACS and the Deputy Commissioner for Family Court Legal Services have been meeting every six months with the Family Court judges, the supervising attorney and the assistant commissioner for each borough. These 90-minute meetings offer the judges the opportunity to share their concerns about the performance of ACS and provider agencies. For example, after the last meeting with the Staten Island judges, the Division of Quality Assurance within ACS arranged for a private foster care agency's executive director and staff to meet directly with the judges so that the agency could be made aware of their poor performance. During a visit with the Bronx judges about seven months ago, the judges raised a concern about the preparedness of ACS child protective staff for removal hearings. As a result, ACS developed a tool for attorneys to provide to CPS staff for use in preparation for court appearances while they wait for their cases to be called. During a visit a year ago with the Brooklyn judges, the perceived unwillingness of ACS to settle cases came up. In response, ACS developed a practice guide about the various settlement options and shared this with all DCP staff; training will follow.

V. DOI's RECOMMENDATIONS

The following are DOI's policy and procedure recommendations to ACS, the DOE and OCFS regarding the SCR hotline. As noted above, these include SCI's recommendations.

1. Hire an Additional 100 Investigative Consultants To Work With Caseworkers and Supervisors on Investigations

DOI's investigation has demonstrated that the investigations conducted and supervised by ACS caseworkers of potentially deadly abuse and neglect allegations are often very inadequate and incomplete. This is the result of a number of factors, but far and away the most significant is that these investigations are conducted by caseworkers and supervised by managers who have little or no investigatory experience. This lack of investigatory experience is particularly troubling given that the subject matter of these investigations involve criminal accusations that parents or other adults in the household are physically and/or sexually abusing their children or are so neglectful as to put their children in serious danger. Asking individuals without investigative experience to probe whether these provocative, potentially explosive allegations have merit while in someone's household under what may be intimidating circumstances is unfair to caseworkers, some of whom do not welcome the role, but more importantly, unfair to the children and families at risk. Services are often needed in these homes and should be provided, but ACS and anyone else with a role in these investigations must first and foremost recognize that these investigations can be criminal in nature and that ACS must get the facts. There are children present in our City who are experiencing serious abuse/neglect situations, but it is imprudent to think that we are now as equipped as we can be to get the facts as soon as necessary. Training caseworkers is important and ACS has independently identified investigatory training as an important focus of its reforms, with Commissioner Mattingly emphasizing it in particular in serious abuse/neglect cases. However, training alone is not a substitute for investigative experience and supervision. To that end, ACS has already hired 20 former law enforcement officers to act as investigative consultants (18 are currently in place) to its caseworkers. But this is simply not enough based on 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 urges ACS to undertake an innovative pilot program geared toward improving ACS' investigative capability. Thus, DOI's principal finding is that ACS infuse experienced investigators into its workforce. To accomplish that, DOI recommends that ACS recruit from the vast pool of retired law enforcement officers in the New York City area, including retired detectives from the NYPD, the Drug Enforcement Agency, the Federal Bureau of Investigation, the Postal Inspection Service, and the Bureau of Alcohol, Tobacco and Firearms.

Specifically, DOI is suggesting that ACS begin immediately to take the steps necessary to hire an additional 100 individuals with law 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. DOI recommends

that ACS hire those former law enforcement officers to 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.

In making this recommendation we are aware that these investigations often take place in someone's home, in front of children, or in connection with someone who has been abused or is otherwise in need of assistance. Thus, we recognize that any former law enforcement officer hired to work at ACS would have to be sensitive to such situations. But we also know that law enforcement officers already have experience dealing with victim witnesses who require some tenderness and sensitivity, and that eliciting information often requires a light or smart touch.

By this recommendation, DOI is taking no position on whether ACS should be more aggressive about removing children from homes or whether more efforts should be expended on keeping families intact. Those decisions are rightly made by the highly experienced members of ACS staff. Instead, DOI is advocating that ACS hire skilled investigators who are simply better equipped to assist with gather the facts about what is truly going on in a home under investigation.

Our research has revealed that two years ago in the wake of a series of high profile child fatalities much like the child fatalities discussed in this Report, the Texas legislature enacted a number of sweeping reforms in an effort to prevent further tragedies. An important component of this reform package was the creation of an Investigations Division within the Child Protective program and an infusion of resources that permitted the Texas Department of Family and Protective Services ("DFPS"), that state's child welfare agency, to hire more than 400 former law enforcement officers as Special Investigators. To date, the DFPS has hired 200 Special Investigators, most of whom are embedded within units of 4 other frontline caseworkers. DFPS acknowledged that merging individuals from a law enforcement culture with the social work background of most caseworkers was a challenge. However, once the caseworkers saw the benefits a skilled investigator brought to their investigations, the program became more integrated with the workers of both backgrounds having developed mutual respect and use for one another's skills - which has greatly facilitated their ability to understand what is going on in the homes they are charge with investigating. One example the DFPS Commissioner described for DOI, was a case where the agency received a report from hospital officials concerning a child brought to the hospital with a head injury. A Special Investigator and a caseworker went to the hospital to investigate. Family members

claimed that the child injured his head when he fell out of bed. The caseworker was satisfied by the family's explanation, but the Special Investigator remained skeptical and insisted that they go to the family's home. That home visit revealed that the child slept on a mattress on a floor, discrediting the family's version of how the child was injured, and preventing the case from being closed as "unfounded."

Investigative consultants with prior investigative experience will probe, seek corroboration and, in some cases where their experience tells them to be, skeptical of explanations provided by parents or caretakers regarding abuse. That would have been critical in, for example, the Quachaun Browne, Joziah Bunch and Michael Segarra situations. They have experience knowing how to question, probe and test explanations through witness interviews, and by examining documentary and physical evidence, all of which can be crucial in discrediting a proffered explanation. This does not mean that skilled investigators will approach every interview in an adversarial, confrontational fashion. Skilled investigators have also been trained to establish a rapport with victim witnesses who have often been traumatized by a violent encounter, and engage with that witness to elicit all of the facts concerning an attack. In addition, notwithstanding the dramatization in movies and television, the ability to question an individual accused of a serious crime and conclude that interview with a confession requires an investigator who can deftly handle an emotionally charged situation. The goal of this pilot program would be to have the investigative consultants impart that invaluable type of experience to frontline caseworkers and their supervisors. DOI is not advocating that ACS send uniformed officers with weapons drawn to break down the door of a home under investigation loudly confront the accused parents and then take those parents away in handcuffs.

A review of the Morillo investigation makes painfully clear how essential it is that ACS hire skilled investigators. To be truly effective, caseworkers must learn effective interview techniques, including how to deal with difficult and uncooperative witnesses, and when and how to effectively confront witnesses with prior inconsistent statements or documents that belie their statements. Caseworkers must know when to test and probe the assertions and the denials of parents accused of abuse. Caseworkers must be able to conduct probing interviews of witnesses who will likely have critical information concerning the allegations, including the source of hotline reports, such as doctors, teachers, police officers, and neighbors. In addition, caseworkers must evaluate the explanations offered by parents accused of abuse after obtaining and digesting critical documentation that can shed light on the allegations, such as medical records and school attendance records. To the extent that special expertise is necessary to fully understand these records (as will often be the case with medical records), caseworkers must seek any necessary assistance so that they fully understand the significance of the information contained in these records.

Further, caseworkers must question witnesses individually so that the witnesses do not have an opportunity to hear each other's version of events. Caseworkers should never be permitted to question parents in front of the children they have been accused of abusing. Finally, caseworkers must never conduct important witness interviews if there are significant language barriers.

In short, it is simply unrealistic to expect 20 consultants to teach over 1,300 caseworkers with little or no investigative experience these and other critical investigative skills.

In preparing this report, DOI has invited numerous discussions with Commissioner Mattingly and his staff about DOI's findings and recommendations. In addition, both agencies discussed the issues with Mayor Bloomberg. As a result of that constructive dialogue, DOI understands that Mayor Bloomberg has authorized Commissioner Mattingly to implement this pilot program and hire 100 additional investigative consultants immediately. These investigative consultants will be deployed in the field offices receiving the highest volume of the most serious abuse/neglect reports. ACS plans to eventually assign one of the new investigative consultants to each Child Protective Manager, each of whom oversees several units of caseworkers. These investigative consultants will be expected to help train caseworkers on investigative techniques, consult on particular issues that arise in cases, follow-up as necessary on key investigative steps that are needed in the most serious cases, and go out into the field with caseworkers on more serious cases. Commissioner Mattingly's agreement to hire these 100 individuals with investigatory experience is a substantial and welcome step that will increase the amount of attention that can be given to the important cases. He has indicated that the additional 100 investigative consultants will be assigned to caseworkers on what will be a ratio of approximately 15 caseworkers to each of the investigative consultants, based on current staffing levels. Lastly, Commissioner Mattingly plans to expand the potential pool of frontline caseworkers by recruiting recent graduates with degrees in criminal justice in addition to graduates with social science degrees.

2. Triggering IRT from the field

DOI and ACS recommend that ACS be permitted to trigger the IRT protocol from the field in the event that a home visit or other investigatory field work reveals that the case involved substantially more serious conditions than alleged in the hotline report.

3. Going Out in Pairs

DOI strongly recommends that ACS caseworkers be encouraged to conduct home visits and other significant field work in pairs where necessary. This recommendation serves both the safety of caseworkers and the quality of the investigations conducted by ACS staff. Many of the ACS caseworkers interviewed by DOI said that they are often confronted with frightening and intimidating situations in the homes that are under investigation. DOI is not aware of any other City agency that conducts investigations or responds to calls from the public and expects its employees to go into the field alone. Most City agencies (e.g., DOI, NYPD, FDNY) send employees in pairs to conduct investigations or otherwise respond to calls about problems from the public. ACS recently issued a *Safety Alert* which encourages caseworkers to go out in pairs when making an initial home visit during an investigation, particularly in cases where the allegations suggest that the caseworker may encounter a dangerous situation in the home. The *Safety Alert* also encouraged caseworkers to work in pairs when complex family situations make it difficult to assess the safety of the children, and when taking children into protective custody. The *Safety Alert* encourages caseworkers to work in pairs, but does not mandate that they do so. DOI initially recommended that caseworkers working in teams be mandatory not a suggested practice. However, ACS

stated that while working in pairs is not necessary in many types of interviews, the agency will attempt to ensure worker safety and the integrity of investigations by strongly encouraging caseworkers to go out in pairs in the situations outlined in the *Safety Alert*.

4. Contemporaneous Notes/Field Notebooks

As it currently stands, ACS does not distribute field notebooks to its caseworkers. As a result, individual caseworkers have developed their own practices with respect to contemporaneous note-taking during home visits and other interviews conducted in the field. In addition, ACS does not have a policy that requires caseworkers to maintain notes taken in the field for inclusion in the agency's case file. DOI strongly recommends that ACS change this policy and develop a procedure governing the creation and preservation of the notes taken by staff in the field during the course of their investigations. Field notebooks should be distributed to caseworkers with instructions to date and record the substance of significant interviews or events in these notebooks. Once a caseworker has filled a notebook, it should be numbered and maintained as part of the agency's files, with the number of the relevant notebook cross-referenced in the corresponding case files. It is recommended that ACS base these procedures on the procedures followed by the NYPD for the maintenance of police memo books.

In addition, DOI recommends that ACS provide its caseworkers with re-fresher training on the crucial information that absolutely must be recorded at each initial home visit and all subsequent follow-up home visits. For example, caseworkers must be reminded that it is critical to obtain pedigree information for all adults living and spending significant time in the household, as well as contact information for pediatricians, day care providers, and school officials. Caseworkers should also be provided with digital cameras and be required to take photographs at every home visit. These photographs will help document the conditions of the home, and any physical injuries sustained by the children. All photographs should then be made a part of the case file. ACS has advised DOI that all caseworkers will soon have access to digital cameras.

ACS has also advised DOI that it 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.

5. Review of Prior ACS History

DOI recommends that ACS caseworkers be reminded of the importance of reviewing the prior history of the subject of a hotline report. This should include a review of past ACS investigations, including allegations that were determined to be both "indicated" and "unfounded." DOI's investigation revealed that caseworkers were not diligent in reviewing the agency's findings of past investigations. This is critically important because a review of prior reports and the corresponding findings could reveal troubling patterns of behavior. In addition, caseworkers should be instructed to discuss the findings of past investigations with the caseworkers and/or supervisors responsible for those investigations to ensure that the agency is drawing upon its collective knowledge concerning a subject family.

6. Criminal History

As noted above, ACS caseworkers currently have a number of avenues to obtain the criminal histories of parents or caretakers under investigation. Those avenues, however, are cumbersome and time-consuming. The New York State Senate has passed a bill that would give ACS staff direct access to criminal records, but the bill has not yet passed the Assembly. DOI supports giving ACS caseworkers direct access to the criminal histories of parents and caretakers under investigation provided that ACS hires additional staff with law enforcement background who could train caseworkers to read and understand criminal history records.

7. Assault of Caseworkers

The New York State Senate has passed a bill that would make the assault of a caseworker a felony. This bill has also not yet passed the Assembly. DOI strongly supports a law that would make the assault of a caseworker a felony.

8. Medical Records

ACS should set a deadline by which caseworkers must obtain and evaluate medical records. Parents under investigation should be asked to sign consent forms authorizing the release of their children's medical records at their very first contact with ACS on a new investigation. In the event that a parent refuses to consent to the release of these records, the caseworker should consult with an attorney within 24 hours of the refusal. In addition, after obtaining the medical records, the caseworker should be required to consult with the treating doctor or another medical professional concerning the significance of the information contained in the records. This is particularly important in cases involving allegations of physical abuse. As with field notes, all medical records obtained in the course of an investigation should be preserved and made a part of the case file.

9. Counseling and Substance Abuse Treatment Records

In cases where ACS staff determines that a parent under investigation is in need of treatment for substance abuse or requires other counseling, ACS should make the appropriate referral immediately. ACS should then have the parent sign a consent form permitting the program to disclose the details of the parent's participation and progress in the program to ACS. These records should also be included as part of the case file. Caseworkers must be required to actually monitor the parent's participation in these programs, and document that progress or lack thereof in the case file. In cases where the parent refuses to participate in a program identified by ACS or where ACS learns that the parent's attendance is sporadic, ACS should consult with a DLS attorney about compelling the parent's full and active participation in the relevant program.

10. Documentation in CONNECTIONS

DOI's review revealed significant delays between the dates of significant witness interviews or events and the dates that caseworkers actually documented those interviews and/or events into CONNECTIONS. This delay is extremely problematic in that long delays increase the likelihood that the substance of these interviews or events as well as the dates on which these events occurred will not be accurately recorded by the caseworker. Additionally, significant delays prevent supervisors from monitoring the progress of an investigation in real time. This delay also creates problems when the assigned caseworker is unavailable and a new issue arises. Without up to date recording of the progress of the investigation, ACS management has no way of determining what investigation has actually been completed and what that investigation has revealed. ACS staff repeatedly told DOI that the delay in documenting the progress of their investigations was often the result of the CONNECTIONS system crashing, preventing their access to the system. The ACS Project Manager responsible for maintaining the CONNECTIONS system corroborated that there have been frequent problems with access to the system. Periodic problems with CONNECTIONS, however, cannot account for all the delays documenting investigations observed by DOI. Caseworkers must be instructed to immediately document significant events into the system, and supervisors must diligently monitor that this is followed. In the event that the system is down, caseworkers should document the substance of an interview or other material event on their own computer for transfer into CONNECTIONS as soon as the system is up again.

ACS staff members have repeatedly complained to DOI about the CONNECTIONS system and DOI's investigation confirmed that the system is terribly outdated, difficult to use and is often more of an obstacle than an asset to caseworkers. For example, accessing the prior history of a family under investigation through CONNECTIONS is slow and cumbersome. In addition, the fields for inputting data are rigid and inflexible. Given the incredible array of software and mobile technology available today, this situation is unacceptable. DOI recommends that OFCS be required to update this antiquated system and provide all child welfare agencies throughout New York State with a computer database that is fast and easy to use.

ACS has also informed DOI that they are currently in discussions with the OCFS, which maintains the CONNECTIONS system, and the New York City Department of Information and Technology ("DoITT") about a proposal by which ACS would have control of the computer system insofar as it pertains to ACS. Although this proposal is still in preliminary stages, DOI supports a system that would maintain the integrity of the data and result in fewer periods where the system was unavailable for ACS staff.

DOI further recommends that ACS caseworkers be provided with mobile technology in the field that would allow access to the prior history of a family from the field and would allow caseworkers to input summaries of interviews in the field. ACS has advised DOI that it will begin providing caseworkers in two field offices with tablet PCs. DOI recommends that ACS receive funding to provide all caseworkers with this mobile technology. DOI has also learned of a dictation service that would allow a caseworker to dictate a summary of an interview from the field to a service that would then provide the caseworker with a typed summary of that interview a short time later. DOI suggests that ACS explore the use of this service to ease the documentation burdens of its caseworkers.

11. Freezing Access to CONNECTIONS and Computer Case Records

DOI's investigation revealed numerous instances where caseworkers made entries into CONNECTIONS and other computer records after a child's death or hospitalization, reflecting that they had taken certain action or conducted various interviews before the child had died or was hospitalized. In at least one instance, a manager documented events that simply never happened to make it appear as if he had been diligently supervising an investigation. In other cases, caseworkers recorded events long after the fact, and often recorded that events had occurred on incorrect dates. As it currently stands, ACS staff have been instructed not to access or add information to an existing CONNECTIONS file after the death of a child or the serious injury of a child in a family under investigation. This is not sufficient. ACS must freeze all access to an existing CONNECTIONS 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 CONNECTIONS file. ACS staff should not be permitted to input information about activities or events that purportedly occurred prior to the death or injury in the existing file. ACS has advised DOI that CONNECTIONS does not currently allow the creation of a new file on the same family. DOI recommends that ACS work with the OFCS to allow the creation of a new file post-fatality.

12. Determinations

It was very evident from DOI's investigation that ACS staff regularly ignored the definitions of "indicated" and "unfounded" in making these critical determinations when closing investigations. ACS staff *must* classify a case as "indicated" where the investigation has established credible evidence to support the allegations. On the contrary, cases should be classified as "unfounded" only when a thorough investigation of the underlying allegations does not yield credible evidence substantiating the allegations. ACS caseworkers and supervisors should receive re-fresher training as to the meaning of these definitions. Additionally, caseworkers and supervisors must be reminded that investigations should never be closed and classified as "unfounded" where the allegations have been substantiated simply because the subject parent agrees to correct the situation. Additionally, an investigation should never be closed and classified as "unfounded" where the caseworker has been unable to conduct a home visit or interview the accused parents or other critical witnesses.

13. Closing Cases

The legal requirement that investigations be completed within 60 days, combined with the fact that units within ACS are evaluated based in part on the number of cases open beyond this 60-day period provides supervisors with the incentive to authorize closing cases where the investigations are clearly incomplete. Ideally, a caseworker should be able to complete a thorough investigation within the mandated time frame. Where, however, an investigation remains incomplete, supervisors must never sacrifice a thorough investigation simply for the sake of meeting the 60-day period. In addition,

supervisors should never authorize closing a case when the caseworker has not yet completed the investigatory steps identified by the supervisor. In the event that information developed in the course of the investigation suggests that the supervisor's directives are no longer necessary, that should be documented in the case file before the case is closed.

14. Supervision

Supervisors should hold case reviews with their caseworkers at regular intervals to offer guidance and direction concerning the progress of investigations. Supervisors should document the investigatory steps that the caseworker agreed to undertake and review the progress of those steps with the caseworker at the next review session.

15. Case Coverage

ACS should implement procedures to insure appropriate case coverage when caseworkers and supervisors are on extended leave or have left the agency. One suggestion is that ACS considers implementing a system of "substitute" supervisors to rotate through units on an as-needed basis in order to maintain continuous meaningful supervision when supervisors are on vacation or out on sick leave. The current system of asking other supervisors to take on the oversight of additional units is unrealistic and unfair, especially in circumstances when they are asked to cover for supervisors who are on extended leave or when they are covering for more than one absent supervisor.

In addition, ACS should require that any time a new caseworker is assuming responsibility for an ongoing investigation that the previous caseworker brief the new caseworker concerning what investigative steps have been conducted to date and what that investigation has revealed. Ideally, this briefing should take place in person, but telephonic briefing would also be acceptable. It is unrealistic to expect that a new caseworker can seamlessly assume responsibility for an investigation involving serious abuse and neglect allegations by simply reading the progress notes in CONNECTIONS. The requirement of a briefing is critical given that DOI's investigation revealed that many caseworkers often do not record critical interviews or other events into CONNECTIONS until long after they have occurred.

16. Dangerous and Illegal Living Conditions

All ACS staff should receive training immediately, and then on an annual basis, on identifying dangerous and illegal living conditions. ACS should request that representatives from the Fire Department and the Department of Buildings who have significant experience in this area provide this training. ACS staff should be required to report any illegal living conditions that they observe to the Department of Buildings and thereafter work with that department to pursue orders to vacate as well as the removal of children from dangerous situations. DOI suggests that ACS arrange for a liaison in the Department of Buildings to provide rapid response to ACS referrals.

17. Home Visits

State law requires that Child Protective Services conduct home visits twice a month. ACS should require that its caseworkers conduct home visits on a bi-weekly basis to prevent long periods in which the caseworker does not visit the home during an investigation.

18. Speaking with Sources

Supervisors must demand that caseworkers interview the source of all reports to the hotline (to the extent that the sources identify themselves) and that caseworkers attempt to conduct these interviews within 24 hours of the hotline report. When an institution, such as a school or a hospital, has a designated reporter who was not the direct witness to the events alleged in the report, caseworkers must demand to interview the actual witness. The process for establishing communication between sources who report allegations of abuse from the NYPD, and the FDNY, including EMTs, who work night shifts and ACS caseworkers who are later assigned to investigate those allegations and work during the day must be improved.

19. Language Barriers

ACS should develop an intake system that provides for the matching of bilingual caseworkers with families who are known to communicate in languages other than English. In addition, ACS must do a better job of communicating to its staff the interpretation services now available via telephone. ACS has advised DOI that interpreters are available to accompany caseworkers in the field. Caseworkers should be encouraged to take advantage of this service where language barriers will likely be an obstacle. ACS has advised DOI that although interpretation services are currently available to CPS caseworkers additional funding would allow ACS to offer these services throughout the agency.

20. Refusal of Homemaking Services

Given that homemaking services are effectively an offer to provide a family with assistance in the home including training on parenting skills and housekeeping, caseworkers should be on alert when these services are rejected by a family with an obvious need for them. Although there may be legitimate reasons for a family to reject the offer of homemaking services, it may also signal a desire to hide abusive behavior going on at the home. In cases where a family in need rejects the offer of homemaking services, the investigating caseworker should consult with their manager concerning alternatives, such as more frequent home visits to monitor the household.

21. Accountability Review Panels

DOI recommends that ACS carefully review each Panel's findings and ensure that all recommendations are carefully considered and implemented when appropriate. In addition, the relevant statute permits law enforcement representatives to be included

on all Panels. DOI requests that a representative from DOI participate in the interview stage of the reviews.

22. Foster Care Agencies

In certain cases, ACS investigations result in children being removed from their homes and placed temporarily with foster care agencies. At times these foster care agencies may have principal responsibility for monitoring the progress of the parents and children. In those circumstances, ACS must remain in close communication and supervise the activities of those agencies. DOI's review of the case involving Dahquay Gillians' mother, Tracina Vaughn, revealed that an ACS caseworker provided a report prepared by a caseworker from Little Flower Children's Services, a foster care agency, to the family court judge overseeing Vaughn's case. That report erroneously reported that Vaughn was enrolled in a domestic violence program at Safe Horizons. The ACS caseworker simply took a report prepared by the caseworker from Little Flower Children's services and submitted it on behalf of ACS without confirming whether the information in the report was accurate.

23. DOE Issues

Chancellor's Regulation A-210 charges the principals of all DOE schools with implementing a procedure to monitor the attendance of its students. Principals must maintain appropriate oversight of this process. In addition, each DOE school must ensure that key staff members charged with tracking student attendance and for reporting suspected abuse are communicating effectively with one another. Relevant Integrated Service Center officials should also conduct a substantive review of the child abuse prevention and intervention plans submitted annually by each school.

24. DOE/ACS Liaison Role

One initiative of the Mayor's Task Force requires that every school designate a DOE/ACS liaison. This liaison should maintain files on every child in the school whose family is or has been under investigation by ACS. The liaison should maintain chronological notes reflecting the school's interaction with ACS regarding those children. When families are the subject of an ACS investigation, the liaison should review the attendance records of each child in that family on a weekly basis, and make weekly inquiries of the children's teachers and of the school health office. The liaison should provide this information to the assigned ACS caseworker on a weekly or bi-weekly basis. Liaisons should also be required to keep a record of these contacts in their own files, and maintain copies of all communication with ACS. In addition, principals should be required to conduct regular meetings with their liaison to discuss the status of all students with open ACS cases.

25. The SCR Hotline

As noted above, the OCFS does not currently tape any calls to the SCR hotline because of the concern that taping calls will result in fewer reports to the hotline. Instead, calls to the hotline are summarized by the child protection specialists. These call narratives are not meant to be verbatim transcripts of the caller's allegations. In fact, these specialists are instructed to write the narratives in a generic fashion so that the subjects would be unable to identify the source of an anonymous report. Further, the specialists have discretion in deciding whether or not to generate a report that calls for an investigation by a local child protective agency. The OCFS does not document any aspect of a call that a specialist determines has not established reasonable cause to suspect abuse or neglect, thereby not warranting a referral to a local agency.

DOI strongly recommends that all calls to the hotline be recorded and maintained in the same or similar manner that 911 calls are recorded and maintained. Given that the subject matter of these calls involves reports of potentially deadly situations involving children, where an immediate response may be necessary, ensuring that an accurate record of these calls is preserved is critical. As in the case of 911 calls, recording calls to the hotline still allows callers to remain anonymous if they wish, but preserves a verbatim record of the call. At the very least, the SCR hotline should record calls of mandated reporters, who are required by law to report suspicions of abuse and neglect. A bill is currently pending that would require the OCFS to record all hotline calls. DOI strongly urges the legislature to pass that bill.

It is also very clear that not all ACS employees have an accurate understanding of the way in which call narratives are drafted. In at least one case reviewed by DOI, an ACS supervisor instructed a caseworker to contact the source of a hotline report and issue a strong warning that the source could be subject to criminal prosecution for making false reports to the hotline. In this case, the supervisor assumed that a source who identified herself in one report was also the source of other anonymous reports because of the similarity of the call narratives. Accordingly, in the event that the OCFS rejects DOI's suggestion that calls be taped, DOI recommends that call specialists be trained to attempt verbatim summaries of the caller's allegations.

DOI's investigation also revealed a need for additional training for mandated reporters. For example, Sharllene Morillo's day care provider called the SCR anonymously unaware that she was legally obligated to report her suspicions to the special number reserved for mandated reporters. As a result of the work of the Mayor's Task Force, doctors and other hospital staff members have already received training on what to look for and the importance of erring on the side of caution in deciding whether to call the hotline. Training of all licensed day care providers throughout the City about their responsibilities as mandated reporters is underway. These trainings should be conducted regularly.

26. Follow-Up

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.
