



Office of
Bill de Blasio
PUBLIC ADVOCATE FOR THE CITY OF NEW YORK

Children's Services Planning Group
Final Report
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Executive Summary

The Administration for Children's Services (ACS), in conjunction with the Office of New York City Public Advocate Bill de Blasio, following the City Council hearing of October 5, 2010, formed the Children's Services Planning Group (the Planning Group) in November 2010 following the tragic death of Marchella Pierce on September 2, 2010. The Planning Group examined ACS' data driven review of issues related to preventive services and medically fragile children in the wake of her death to identify how to strengthen accountability and better protect at-risk children, with a particular focus on those who have extraordinary medical needs. The Planning Group, which served pro bono, consisted of child and family advocates, preventive service providers, experts in the provision of services to medically fragile children, and a parent of a medically fragile child.

Marchella Pierce's case raised several issues, including the challenges faced by medically fragile children and their families. Marchella died of abuse and neglect allegedly committed by her mother, Carlotta Brett-Pierce. Because of her complicated medical conditions, Marchella stayed in hospitals or related medical facilities for extended periods from her birth until she returned to her mother's care on February 9, 2010—where she remained until her death seven months later.

Investigation of her case records identified several areas where Marchella did not receive critical help from ACS or its contracted service provider in the case, the Child Development Support Corporation (CDSC). Specifically, CDSC did not provide adequate services to ensure that Marchella was safe or seek an Elevated Risk Conference. (Elevated Risk Conferences are requested by preventive service providers when they have new or heightened concerns about the safety of a child(ren) in a family.) When the contract with CDSC was terminated, the case was still open within ACS' Division of Child Protection (DCP). The case records indicate that ACS staff had virtually no contact with the family.

To assess whether the problems identified in the Pierce case signaled broader systemic weaknesses, the Planning Group analyzed the findings of four different case reviews, examined practices and protocols related to quality assurance, child protective investigations, and closedown of preventive services providers, as well as reviewed the services available to medically fragile children including case management and Medicaid waiver services.

While the case review findings do not suggest that the Marchella Pierce case points to overall systemic failure, they do indicate areas where ACS policy and practice requires strengthening. Among preventive cases closed during the review period, reviewers determined that three-fourths of the cases closed appropriately and required no follow-up. Of the remaining cases, fewer than 5% needed immediate follow-up. Among preventive cases closed and transferred to DCP, reviewers determined that nearly three-fourths required no follow-up. Of the one-quarter that were identified as needing follow-up, less than 2% (1 case) required immediate follow-up. While the use of Elevated Risk Conferences alone does not provide conclusive information about the quality of a program, nearly half of general preventive services providers held three or more such conferences during the review period. Finally, reviewers determined that over two-thirds of Additional Information reports were handled appropriately and required no follow-up. The remaining one-third were identified as needing further follow-up, including assessments of safety and risk concerns.

Based on the issues identified, preceding reviews and input from the Planning Group, ACS is taking a number of steps to improve its practices, including enhancing its monitoring of providers, responding to safety concerns in cases, improving closedown procedures, strengthening supervision of workers, and implementing new documentation requirements.

In addition to these actions, the Planning Group made a series of recommendations, a majority of which focus on instituting new supports for medically fragile children. These recommendations include:

- Develop a program for tracking medically fragile children in foster care or receiving preventive services;
- Improve safety assessments to include consideration of whether medically fragile children are in households;
- Develop an assessment tool for medically fragile children to determine their parents ability to care for them and what additional services they may need;
- Create a medically fragile child liaison in every DCP borough office; and
- Engage stakeholders and consult with experts to improve care for medically fragile children, including the Coalition for Medically Fragile Children.

Other recommendations include:

- Build upon the success of ACS' ChildStat model for examining data and case practice to institute Preventive ChildStat;
- Baseline the current ACS preventive budget at its current levels and protect homemaking services to ensure ACS can continue to serve all children that need its services;
- Pilot rapid response capacity to provide onsite technical assistance to ACS providers; and
- Improve ACS' technological solutions to improve its documentation of cases.

The Planning Group and this report represent a sustained and comprehensive effort to identify the lessons to be learned from Marchella Pierce's death to ensure safety and support for medically fragile children and all families in need.

ACS has committed to implement the recommendations that are within their responsibility and authority in a timely manner. Some of the recommendations require collaboration. ACS looks forward to working with other stakeholders and government agencies to advance the work of protecting New York City's children.

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Children's Services Planning Group

Final Report

I. Children's Services Planning Group

A. Purpose

The Administration for Children's Services (ACS), in conjunction with the Office of New York City Public Advocate Bill de Blasio, formed the Children's Services Planning Group (the Planning Group) in November 2010 following the tragic death of Marchella Pierce. The Planning Group consisted of child and family advocates including the Citizens' Committee for Children, preventive service providers, and experts in the provision of services to medically fragile children including the Coalition for Medically Fragile Children, New Alternatives for Children, and a parent of a medically fragile child (see previous page for a complete membership list). The Planning Group offered their extensive knowledge and decades of experience to ACS as it examined the circumstances and practice issues identified in the case.

ACS and the Public Advocate convened the Planning Group to conduct a data-driven review of the child welfare practice issues raised by the case and to inform and provide guidance to ACS as it implemented the action steps and recommendations following the agency's investigation of the death of Marchella Pierce (see Appendix 1, Preliminary Report into the Death of Marchella Pierce).

The Planning Group held six meetings (see Appendix 2 for meeting agendas) during which ACS presented on current practice, policies and procedures, and provided data and findings of its case reviews of 1) preventive cases closed in Spring 2010; 2) preventive cases closed and transferred to ACS' Division of Child Protection in Spring 2010; 3) use of Elevated Risk Conferences by preventive services providers; and 4) all Additional Information reports from January – August 2010. Experts also presented to the Planning Group on the types of services available to medically fragile children and how families can access them.

The Planning Group reviewed the data presented; where it identified weaknesses, the group worked to develop modified action plans to address them. In addition to examining issues related to preventive and protective services, the Planning Group considered the unique issues presented by medically fragile children in the child welfare context and the role hospitals and skilled nursing facilities should play in discharge planning for medically fragile children and their families.

There was rigorous discussion around each topic, with members contributing their expertise and unique professional perspectives. The Planning Group made recommendations to improve practice at ACS, and recommendations for other stakeholders outside the child welfare system who are involved in the care of medically fragile children.

This work occurred in the context of ACS' ongoing implementation of reforms since 2006. These reforms have improved the work of the agency -- affecting its investigations of abuse and neglect, the provision of preventive services to families to overcome the challenges that place children at risk, and removal of children from a home in which they are in imminent or immediate danger. The Pierce tragedy, however, revealed specific practice areas that required strengthening and new steps to address areas of weakness.

There are five sections of this report. The first provides a brief background of the case. The next section details the Immediate Action Steps that ACS committed to take based on its investigation of the death of Marchella Pierce as described in the October 2010 Preliminary Report. The third section of the report presents the findings and analysis of the case reviews that ACS conducted. The fourth section describes the specific changes that ACS is taking or has completed to improve its practice. The final section enumerates recommendations made by the Planning Group for both ACS and other stakeholders.

B. Background

Marchella Pierce died on September 2, 2010 of abuse and neglect allegedly committed by her mother, Carlotta Brett-Pierce. Marchella had a very challenging and difficult life; she was born in April 2006 approximately 15 weeks prematurely, her twin sister had been born three days prior and died shortly after birth. Because of her complicated medical conditions, Marchella stayed in hospitals or related medical facilities from her birth until she went to live with her mother in the Spring of 2007. She re-entered a hospital in May 2008 where she remained until February 2010. Beginning in late 2009, ACS became involved with the Pierce family after learning that Carlotta Brett-Pierce had a positive toxicology report at the birth of her fourth child in November 2009. Marchella returned to her mother's care on February 9, 2010 and remained at home until the time of her death seven months later.

ACS investigated the death and reviewed the services provided to the family to identify what occurred and determine potential practice issues for improvement. While the efforts of ACS since 2006 set a solid foundation of child welfare practice, the death of Marchella Pierce shows that there are still areas that need improvement.

ACS contracts with non-profit providers to deliver preventive services to families in crisis. ACS has oversight responsibility for its contracted providers. The safety practice and actions taken by the Child Development Support Corporation (CDSC), the contracted preventive provider involved with the Pierce family, to ensure that Carlotta Brett-Pierce received drug treatment and make certain that the three children in the home were safe and adequately cared for were deficient. CDSC did not make regular visits to the home as required to track Ms. Brett-Pierce's sobriety. It also did not carry out its responsibility to make a new State Central Register¹ report regarding Ms. Brett-Pierce's continued drug abuse, or take the necessary steps to confer with ACS to assess the risk of the children remaining safely in the home; in fact, mention of Marchella is largely absent in the case records. Independent of this case, ACS chose to terminate CDSC's contract in June 2010 due to performance issues.

The case also uncovered practice issues within ACS. The initial investigation, while focused correctly on the mother's drug abuse, should have involved an assessment of Marchella's status, including planning with CDSC and the family for her return home after she was released from the hospital. Also, there was a call concerning Marchella in March 2010 made to the Statewide Central Register that was identified as "Additional Information."² However, ACS' response to the new information was inadequate; a new investigation should have been initiated or a referral made to a preventive services provider specializing in medically fragile children. Finally, when

¹ The New York State Office of Children and Family Services maintains a Statewide Central Register (SCR) that receives telephone call reports of alleged child abuse or neglect within New York State. The SCR relays information from the calls to the local child welfare agency for investigation.

² An "Additional Information" report occurs when a call is made to the SCR with information regarding a family who is the subject of an open investigation or services case with ACS or other child welfare agency, which means that the information shared does not automatically need or require a full investigation.

CDSC's contract with ACS ended in June 2010, the ACS Child Protective Services unit, while not conducting an investigation and having very little contact with the family, decided to keep an active case open for the family with little or no documented contact with them from June to September. For a more detailed description of the case and what the ACS investigation showed, please see Appendix 1 (Preliminary Report released October 5, 2010).

Both ACS and CDSC focused on the allegations regarding Ms. Brett-Pierce's substance abuse in their work on the case as opposed to the risk and safety of the children in the family. Neither properly identified Marchella Pierce as a medically fragile child. No service provider referred Marchella and her family to a specialized preventive program to receive additional services focused on her needs. While it also is unclear what home health services the hospitals and skilled nursing facilities involved in Marchella's care proposed and were implemented when she was discharged, these occasions appear to have been other missed opportunities to intervene on her behalf.

II. Immediate Action Steps

Immediately following the death of Marchella Pierce, ACS conducted an investigation and developed several action steps to address the practice issues identified at both ACS and CDSC in the case. Subsequently, the Children's Services Planning Group reviewed ACS' implementation of the action steps and the policy changes that resulted from that work.

The action steps identified by ACS were as follows:

- **Assess Contracted Preventive Provider Performance:** Assess carefully how ACS can determine more quickly that a contracted provider is failing.
- **Increase Monitoring of Casework Supervision:** Implement increased monitoring of supervision of casework within the Division of Child Protection (DCP), both for quantity of contacts and quality of work, including assessment of safety and risk, as well as documentation of work done.
- **Improve Contracted Provider Closedown Procedure:** Improve the closedown procedure to create more structured communication between the closedown team and the assigned child protective staff. This communication should place greater emphasis on safety and risk issues in the home, and the plan for services to the family. A plan for follow through on cases active in both preventive and child protective services at the time of the closedown should be developed collaboratively and documented.
- **Require Uniform Note Taking and Documentation:** Require uniform field note taking practice across all of DCP. Issue modifications to the uniform note taking policy for DCP and implement a policy for more timely entry of progress notes into Connections.³
- **Review Cases Closed During Preventive Closures:** Review a sample of cases of families affected by program closures and capacity reductions in the Spring of 2010 to assess the quality of decision making and follow through, and to determine if there may be families that require follow-up.⁴

³ Connections is the New York State data system of record for child welfare cases.

⁴ Appropriate actions were taken as needed.

- **Assess Appropriate Use of Family Team Conference Model:** Strengthen the monitoring of preventive providers' implementation of the Family Team Conference model. Reinforce expectations and clarify guidance for preventive programs about responding appropriately to elevated safety concerns, including making calls to the State Central Register and requesting Elevated Risk Conferences.⁵
- **Review Additional Information Reports and Follow-up:** Review and analyze all Additional Information reports made from January 2010 through August 2010 to determine what changes need to be made in Child Protective Services practice to assess Additional Information reports when they are received from the State Central Register.

III. Findings and Analysis of Case Reviews Conducted by ACS

ACS conducted record reviews in four categories of cases: 1) preventive services cases closed in Spring 2010 in anticipation of providers' contract changes; 2) preventive services cases closed and transferred to DCP in Spring 2010 in anticipation of contract changes; 3) cases served by preventive programs for which ACS has safety practice concerns and showed low utilization of Elevated Risk Conferences during the first nine months of 2010; and 4) Additional Information reports received from the SCR during the first eight months of 2010. The findings and analysis were shared with the Children's Services Planning Group and further analysis was conducted in some areas based on the Planning Group's input. The sections below show the results of these reviews.

ACS examined 1,175 cases across the four case record reviews. For each review, an ACS cross-divisional senior management workgroup consisting of representatives from Family Support Services, Child Protection, and Quality Assurance developed a tool to evaluate safety, risk, and ongoing casework practice through a reading of the case records (see Appendix 3 for copies of the tools). The reviewers were program monitors, support team specialists, directors, child protection managers, supervisors, and administrators -- approximately 175 in total -- with extensive experience in child welfare practice and/or evaluation. Each reviewer documented every review on the review tool. Senior staff at ACS quality checked and coded the reviews, and analyzed the resulting data.

ACS also presented to the Planning Group its system of monitoring of preventive providers. The record review confirmed that the quality assurance efforts provide ACS with comprehensive and current data on areas of strength and weakness in each provider agency and the overall system. ACS reaffirms its commitment to the quality assurance, oversight and technical assistance strategies in place. Where the reviews suggested new actions and efforts, that work is underway as detailed in the Strengthening Existing Policy section below.

In addition, as a result of the Pierce case, the New York State Office of Children and Family Services (OCFS), which has oversight responsibilities for ACS, conducted a review of the quality of services provided by both ACS and CDSC. The review targeted a sample (79 cases) of CDSC cases open in spring 2010. While the OCFS review identified some examples of good practice in the areas of safety and risk assessment, it also revealed areas where the application of practice, policies and procedures needed strengthening. Many of OCFS' findings are similar to those of ACS. It also should be noted that the OCFS confined its provider review to CDSC whose contract ACS had already terminated for poor performance prior to Marchella's death.

⁵ See inset box on page 7 for definition.

A. Preventive Cases Closed

The termination of CDSC's contract led to the transfer of the Pierce case to ACS and to closure of many other CDSC preventive cases. This process occurred at several other providers during Spring 2010 as ACS anticipated new preventive services contracts and a reduction of about 3,000 general preventive services slots. To explore and address concern that this process may have affected other children, ACS reviewed a random sample of cases from every preventive program that was preparing to close or to reduce its capacity by more than 40% during that period. The sample included 223 closed cases drawn from 55 preventive programs, with a minimum of 10% of cases closed by such programs.

The case record review showed:

- Of the 223 closed cases reviewed, 9 cases (4%) were determined to need *immediate* follow-up to address a safety concern identified by the reviewer.⁶
- For 162 (73%) of the cases, reviewers found that the decision to close was appropriate. Reviewers made this determination on the basis of evidence in the case record that risk and safety factors were addressed or resolved through parent/child completion of or engagement in services, or through the mitigation of a safety factor through other means (e.g., another adult moved out of the home).
- Twenty-eight cases (12% of the sample) were closed because families refused services, in some cases because they had moved out of their catchment area and in others because issues of concern had been resolved. Reviewers flagged eleven of these cases as needing follow-up, including 3 that needed *immediate* follow-up.⁶
- Thirty-three cases (15% of the cases reviewed), reviewers concluded that the case closing was not appropriate. Twenty-nine were flagged as needing additional follow-up to assess *risk* not *safety* factors in the home; of those, 6 were cases (2.6% of the sample) that needed *immediate* follow-up noted above.

B. Preventive Cases Closed and Transferred to DCP

During the same period, cases were closed by preventive programs with the note "transfer to DCP". The ACS review included all 70 cases transferred to DCP as a result of or during the preventive closedown process, except for CDSC cases which were reviewed separately by the New York State Office of Children and Family Services.

- Among the 70 cases that were transferred to DCP during the review period, the reviewers found that 52 (74%) were handled appropriately and did not require further action; 18 (26%) were identified as needing follow-up: one of which was an immediate call to the SCR, three to assess safety, nine to address risk, and five for both.

C. Use of Elevated Risk Conferences

The observation by the Planning Group that CDSC should have requested an Elevated Risk Conference when Marchella was discharged from a medical facility and at the point a substance abuse treatment program dismissed Marchella's mother for failing to abide by her treatment plan prompted an evaluation of the use of the Elevated Risk Conferences by preventive services

⁶ All of these issues were addressed and appropriately followed-up. Depending on the circumstances of the case, types of follow-up included a call to the SCR, follow-up on circumstances related to parental service needs, follow-up with the child's school or other similar actions.

providers. Elevated Risk Conferences are designed to prevent potential harm to children when a change in a family's situation poses an increased risk of harm or maltreatment (see inset box for a description of Family Team Conferences and their purposes).

Family Team Conferences

Family Team Conferences (FTC) are tools available to ACS staff, preventive providers, and foster care agencies to improve critical decision-making regarding children's safety, well-being and permanency by including people important to the family's life, key community supports, and providers with whom the family is involved. Decisions are made, and service plans are developed by a group (family supports, community supports and service providers) instead of an individual.

There are 4 types of Preventive Family Team Conferences:

Elevated Risk Conference (ERC): Elevated Risk Conferences are requested by preventive service providers when they have new or heightened concerns about the safety of a child(ren) in a family. An ACS conferencing specialist facilitates Elevated Risk Conferences in partnership with preventive providers. Elevated Risk Conferences are designed to prevent potential harm to children when a change in a family's situation poses an increased risk of harm or maltreatment.

Initial Preventive Planning Conference (PPC): Preventive Planning Conferences are convened and facilitated by preventive providers every six months, 2 to 4 weeks prior to the Family Assessment and Service Plan (FASP) to develop and refine the service plan with the family, address any concerns regarding safety or risk, reach agreement on strategies to reduce risk, assess progress toward achieving service plan goals and examine the need for ongoing preventive services. An ACS conferencing specialist attends one of the Preventive Planning Conferences.

Service Termination Conference (STC): Service Termination Conferences occur when cases approach the termination stage; ACS may attend a conference to discuss termination of services. The provider agency facilitates the conference using the same process as with the planning conference.

Quality Intervention Conference (QIC): Quality Intervention Conferences take place if, during the course of its ongoing monitoring of agencies, ACS staff identify a particular case requiring specialized attention; the provider may be asked to schedule a Family Team Conference, which ACS facilitates. The goal of the conference is to address specific concerns and reach an agreement about how to best resolve any outstanding issues.

There is also a Protective Family Team Conference:

Child Safety Conference (CSC): Child Safety Conferences are convened by DCP in the course of child abuse and neglect investigations when safety factors are so high that Family Court action is required to obtain court ordered supervision or removal unless a safety plan crafted during the CSC can lower the level of concern. A CSC must precede going to Family Court for any intervention.

As a result of the Pierce case, ACS examined the use of Elevated Risk Conferences across the preventive system and reviewed data on conferences held during the first nine months of 2010.

- Out of 111 general preventive programs, 53 (48%) held three or more Elevated Risk Conferences, 23 (21%) held none, and 35 (31%) had 1-2 conferences during the review period.

- Of 44 specialized programs⁷, 15 (34%) held three or more Elevated Risk Conferences, 13 (30%) held none, and 16 (36%) had 1-2 conferences during the review period.
- In the reviews of 129 cases from programs that held zero or one Elevated Risk Conference, reviewers recommended follow-up for 27 (21%) of the cases.
 - In 77 cases (60%), one or more Family Team Conferences were held. Some cases had more than one type of conference. The most frequent type of conference held was planning (55); followed by service termination (19), and child safety (17). There were only 4 Elevated Risk Conferences held for these 129 cases.
 - In 24 (19%) of the 129 cases reviewed, an Elevated Risk Conference would have been appropriate but was not held. The most frequent reason that the reviewers provide for this conclusion is that there were concerns in the case related to risk (ongoing or new) and the family was not following through with services, was resistant or uncooperative, or had disengaged from services.

Elevated Risk Conferences are one of many indicators of safety practice by a preventive program. The frequency of such conferences alone does not provide conclusive information about the quality of a provider's practice. Providers have various options for addressing safety and risk concerns, including Elevated Risk Conferences, calling in a report to the SCR, or intervening with a family but not bringing an ACS representative into the case – as occurs in Elevated Risk Conferences.

Elevated Risk Conference utilization data are one element in ACS' monitoring and annual evaluation of providers. ACS conducts a rigorous annual evaluation of its providers. The data from that process includes safety indicators that are developed through case record reviews. This data is an important companion to the Elevated Risk Conference data for a fuller picture of safety practice.

D. Case Review Analysis

Assessment: Across all three case record reviews, reviewers found that the majority of providers' safety and risk assessments were strong. The necessary elements of assessment, such as the child's physical health, home environment, and the parent's ability to meet the child's needs, were found in a majority cases. There was partial compliance with assessment standards in most of the remaining cases – meaning that the assessment was not as complete as required by ACS, but without omitting some elements of assessment listed above (18-21%); a very small portion (less than 5-10%) were deficient. Areas for continued technical assistance and monitoring include ensuring a comprehensive focus on family conditions and better attention to physical health, psychological well-being and mental health, the impact of domestic violence, and substance abuse issues.

Safety: Closed case records showed an assessment of safety and risk during casework contacts in 96.5% of cases. In 14% of cases, providers did not make contact with all children on at least a monthly basis. Results were fairly consistent across all three records reviews. ACS record reviews underscored the need for continued monitoring and technical assistance to ensure sound practice in this area. Providers did not in every case take all steps necessary to assess and monitor child safety, including assessing new conditions in the home and conducting the required number of visits with the family. For cases transferred to DCP, assessments were not always completed on all children in the home in the month prior to transfer, and the original

⁷ Specialized programs include Medically Fragile, Family Rehabilitation Programs, Enhanced Preventive, and Intensive Preventive Aftercare.

results of the investigation were not always incorporated into the safety assessment and documented in Connections.

Safety & Risk in Child Welfare Investigations

Safety

A child is considered safe when there is no immediate threat to the child's life or health as a result of the actions or inactions of the parent or person legally responsible for the child. When assessing whether a child is safe, child protective services staff assesses whether there is any immediate threat to the child's life or health.

Risk

A child is considered at risk when there is likelihood that the child may be abused or neglected in the future as a result of actions or inactions by the parent or person legally responsible for the child. When assessing for risk, child protective services staff assesses whether there is likelihood that the child may be abused or neglected in the future.

Risk Factors: The majority of risk factors were assessed appropriately in over 90% of cases. In a high number of closed preventive cases reviewed (213 of 223), provider staff conducted assessments of risk factors, and the majority of staff took appropriate actions to ensure that risk was significantly reduced for all family members and assessed the impact of services in changing families' risk-taking behavior. Cases transferred to DCP instead of closing during the review period showed that assessments indicated a continued need for ACS to monitor risk factors in close to 60% of cases, as would be expected for cases transferred back to DCP.

Documentation and Supervision: A small number of cases reviewed did not have sufficient documentation to demonstrate good case practice (6% of closed case records were deficient, as were 3% of transferred cases records). Reviewers were instructed to note *any* gap in supervision or deficient documentation. The review indicates that lack of documentation is not part of a widespread trend.

Case Transfers and Closings: In a majority of cases, the review confirmed that steps were taken to connect families with community resources (78%), assess caregivers' ability to maintain children's safety (96%), and demonstrate that risk factors had been mitigated (91%). But reviewers also noted areas in need of continued monitoring, including making joint home visits for transferred cases, ensuring that all children are assessed at the time of closing, and notifying ACS and other providers if a family disengages from services. The latter issues are being addressed in ACS' on-going monitoring and practice improvement with agencies (See Section IV. D).

E. Additional Information Reports

As previously noted, Additional Information reports are calls made to the SCR with information regarding a family that is the subject of an open investigation or services case with ACS or another child welfare agency. Reports are logged into the system as "Additional Information" when the SCR determines that the information provided does not include sufficient allegations to trigger a subsequent or new investigation. Since an "Additional Information" report was made to the SCR on Marchella Pierce in March 2010 when a medical provider had concerns regarding her mother's refusal to receive training on the proper use and care of her tracheal tube, ACS reviewed all 753 "Additional Information" reports from the SCR from January 1, 2010 to August 31, 2010 received by ACS.

All of the reports were reviewed by reading Connections records. This review showed that though the handling of Additional Information reports needed improvement, few of the reports involved allegations so serious that a new SCR report, which would trigger a new investigation, should have been made. Two hundred and forty-one reports (32%) were identified as needing further follow-up as defined in the review tool. Seventeen (2%) were assessed to need a new SCR report; 68 reports (9%) were assessed to need assessments of safety concerns; and 156 reports (21%) required a review of risk concerns. The findings show the need to strengthen ACS policy around how Additional Information reports are handled.

When DCP staff in the borough offices conducted follow-up on the above reports from November to December 2010, they found that activity on some of the reports that dealt with safety concerns had occurred during the intervening time period independently of the Additional Information report and ACS' subsequent review. There were a total of 31 new calls to the SCR - 17 related to the Additional Information and 14 new calls unrelated to the Additional Information report. Legal intervention for cases requiring either a removal or Court Ordered Supervision totaled 19 cases.

IV. Strengthening Existing ACS Policy

Based on the issues identified and the preceding reviews, and with input from the Children's Services Planning Group, ACS is taking a number of steps to strengthen practice and procedures both within the agency and with its contracted preventive services providers. Below are the changes that are underway or have already been implemented (See Appendix 4 for an implementation timeline).

A. Strengthen Performance Monitoring For Contracted Provider Agencies

ACS conducted a careful review of its process for monitoring provider agencies to identify ways to strengthen its capacity to make timely decisions about programs with poor performance. The review resulted in a recommitment to the basic tenets of ACS' monitoring process, inclusion of additional data elements and information sources in the process, and a renewed focus on the critical assessment of information on which decisions about programs are made. Among the new data elements from preventive service providers that will be examined include: joint home visits, practice trends for Family Team Conferences, and reviewing system-wide data to identify areas for improvement. A summary of the monitoring process produced for discussion by the Planning Group is attached as Appendix 5.

B. Respond to Heightened Safety Concerns in Preventive Services Cases

To clarify when and how preventive service providers should call an Elevated Risk Conference to address safety concerns, ACS will issue an Elevated Risk Conference Safety Alert (Appendix 6). In addition, ACS will take the following four steps regarding Elevated Risk Conferences: 1) share data with each individual provider (broken down by program) on their use of Elevated Risk Conferences; 2) hold small group meetings with providers to explore and define issues related to Elevated Risk Conferences; 3) develop a set of recommended actions to increase the use of Elevated Risk Conferences, where appropriate; and 4) review internal processes to confirm that scheduling systems and staffing are in place.

C. Change Contracted Provider Closedown Procedures

To manage and guide preventive program closures over the past couple of years, ACS developed and has periodically modified and strengthened the internal closedown protocol that it uses. In light of the current review, ACS will make improvements to that protocol in several key areas:

- Modify report templates to capture and track information, assessments, critical decision-making and plans for each case. This will result in creating a chronological summary of critical decisions and next steps for each case throughout the closedown process, leading to case resolution.
- Create feedback mechanisms within the ACS cross-divisional team (Quality Assurance, Family Support Services, and DCP) to update closedown information regarding conference outcomes and/or practice concerns stemming from Family Team Conferences at closing programs.
- Reinforce the case planning/case management role of the Division of Child Protection on cases when there is an active child protective investigation. Ensure that there is proper hand off of the case to DCP when a preventive program closes.
- Use technology to provide “real time” access to the systems of record -- namely Connections and PROMIS⁸-- during planning meetings that occur during the closedown process.
- Provide guidance to preventive services providers in the following three areas: 1) the use of Family Team Conferences during the closedown process; 2) the requirements for supervisory notes that must be created regarding family functioning; and 3) documentation requirements for closure or transfer of the preventive case. This guidance is documented for closing programs in the ACS “Preventive Services Closedown Protocol” and is being emphasized with providers during closedown meetings.

D. Improve Case Closure Decisions

ACS identified 19 programs with significant numbers/percentages of cases determined to have been closed inappropriately based on results of the case reviews. Concerns about the aspects of the case closings that were inappropriate are being reviewed with those programs. Programs that were not already implementing strategies to improve case closing decisions are being asked to identify strategies to improve case closing decisions and to implement those strategies within 30 days. ACS will assess the quality of case closing decisions within 90 days of strategy implementation. This will be complete for all programs by May 2011. (See Appendix 5 for description of APA process.)

ACS will use its provider Scorecard system⁹ to reinforce practice expectations, particularly for casework contacts and assessments of risk factors, through consistent evaluation of these areas occurring on at least a quarterly basis, and ongoing discussion with providers of performance in

⁸ PROMIS (Preventive Organization Management Information System) is an automated web-application to support contract and program management information needed for monitoring, evaluation and planning by ACS as well as preventive service agencies.

⁹ Scorecard is a comprehensive, annual evaluation of all preventive programs serving New York City’s children and families that is designed to promote accountability, learning, and quality improvement. Results provide a foundation for the continuous performance monitoring conducted by ACS, as well as benchmarks for the improvements that are achieved.

these areas. Further, ACS will intensify monitoring of agencies with the poorest Scorecard scores in Safety, Assessment, Engagement, and Services through more frequent contact, monitoring, and assistance. ACS will continue to implement strategies to strengthen this up-front work and prevent inappropriate case closings.

It also is strongly recommended by ACS that providers transferring cases to other programs conduct joint meeting sessions or a Family Team Conference with the family and other service provider to facilitate a smooth transition of the family for ongoing services. Meetings with receiving providers are an important step in the transfer of cases to facilitate a smooth transition of the family for on-going services. When DCP is involved in a case, whether or not it is being transferred to DCP, there must be a transition meeting between the provider, the receiving provider (if not DCP), and DCP staff. Case transfers should not be delayed because of logistical difficulties in scheduling this meeting. The transfer of the case can proceed and the transition meeting can occur soon afterwards.

E. Issue Additional Information Guidance

In the past, preventive service and child protective workers have not given enough attention to information reported by the SCR as Additional Information. The current policy has been modified and distributed to DCP staff to stress the importance of treating Additional Information as new and potentially critical information. It will direct staff to conduct risk and safety assessments contextually based upon the current open case including the new information. Work is underway with Child Protective Managers (CPMs -- mid level managers) who will now review all Additional Information reports to guide the cases of the units that they supervise. CPMs will give the same weight to the review of Additional Information reports as they do to open investigations.

The Planning Group recommended strengthening of safety and risk assessments in response to Additional Information reports. Guidance through an updated Child Safety Alert (Appendix 7) has been issued to agency staff. In addition, practice protocols, training and supervisory oversight are being developed and implemented to address this issue.

Throughout the analysis of the follow up case activity regarding Additional Information reports, it became apparent that case records were not updated to reflect staff knowledge of the case. Requiring documentation within five days as well as use of notebooks are intended to address this issue.

Reviews by supervisors will now include all Additional Information reports. Also, Family Services Units (FSU)¹⁰ case practice with Additional Information reports suggests that FSU staff may be treating Additional Information as part of their ongoing work with the family rather than new information that must be assessed in the context of the ongoing case for risk or safety. This issue will be addressed with FSU case practice through work with FSU units in each borough. Existing FSU supervisors, mid-level managers, and deputies are now reinforcing this practice with Family Services Units.

¹⁰ Family Services Units provides case management services for families when a New York State Family Court Judge orders supervision for a family. The FSU worker monitors and assists the family with services for the period ordered by the court.

F. Reinforce Supervisory Practice

To ensure that high quality supervision is taking place within DCP, ACS is reinforcing that appropriate supervision and oversight is ongoing, including mid-level managers and above. In 2009, a model of quality supervision in social work that utilized the Kadushin approach¹¹ as a framework was implemented throughout DCP with borough-specific plans and training. A workgroup of Borough Commissioners from DCP has recently reviewed current practice and developed updates for the division's supervisory practice that strengthens monitoring and is measurable.

To more closely monitor supervisory practice, ACS is tracking the quality and quantity of supervisory meetings. In addition to enhanced supervision, existing random case reviews -- an intensive review of case records in Connections looking at qualitative and quantitative indicators¹² -- conducted by mid-level managers will be used to strengthen the level of supervisory oversight. City-wide assessment of trends and patterns from the reviews will inform practice, as well as staff development and training.

G. Require Uniform Note Taking and Documentation

The notebook policy was revised to include more direct language that mandates that all workers and supervisors utilize agency notebooks to take notes while conducting investigations. A revised notebook policy was issued from the Deputy Commissioner's office and distributed throughout the division on October 6, 2010 (see Appendix 8).

Existing policies on "contemporaneous documentation" in Connections of work done in the field lacked clarity and explicit guidance as to the timeframe expectations for staff. A joint union/management workgroup was convened and recommended that a new policy require that all notes be entered into Connections within 5 business days following the documented event. That new policy has been developed and distributed effective February 4, 2011 (see Appendix 9).

V. Recommendations and Next Steps

Based on the work of the Planning Group, a series of recommendations were developed in addition to the above actions, some of which will be implemented by ACS, while others will require the participation and collaboration of other stakeholders and government agencies. Since Marchella Pierce had several complicated medical condition, she should have been considered medically fragile. There are several recommendations regarding what can be done to assist families who have a medically fragile child. The recommendations seek to ensure that there are systemic supports in place to strengthen preventive services practices and assist families with medically fragile children.

Caring for a medically fragile child is demanding for any family, and most families with medically fragile children need some level of support to succeed. Medically fragile children have one or more disabilities and/or serious illnesses that require continuous health and support services. For the vast majority of families, these supports come from medical professionals and private networks, and do not require the involvement of ACS. For families already in crisis, the

¹¹ The approach was developed by Alfred Kadushin in which the supervisor has a role of promoting and maintaining good standards of work and incorporates three parts of supervision: administrative, educational, and supportive.

¹² DCP is using a quality assurance tool that measures documentation of supervisory guidance given during prescribed timeframes and quality of fact gathering interviews.

presence of a medically fragile child in the home can substantially compound the stress and demands on the family, and increase the risk of abuse or neglect. Yet with sufficient support, even families in crisis often can safely care for their medically fragile children at home. Research has shown that these children are better off medically, psychologically, and socially when cared for at home, so long as families have supports they need to meet their complex health needs.^{13 14}

A. Strengthen Practice with Medically Fragile Children and their Families

Because of the special needs of and high risk to medically fragile children, the Planning Group recommends that ACS take steps that will improve practice and ensure that others involved in the child welfare system are educated about those needs. Taking the below steps, will help to ensure that medically fragile children receive needed services and avoid falling through the cracks.

- Provide annual trainings to family court institutional players including lawyers for children, parents, judges, hearing officers, preventive providers and foster care agencies to educate them on available resources for medically fragile children including Medicaid waivers and to sharpen their ability to assess whether medically fragile children are receiving appropriate supervision, monitoring and services.
- Consider developing a program for medically fragile children leaving the child welfare system to avoid re-entry into higher levels of care.
- Develop improved systems for tracking medically fragile children in foster care and those receiving preventive services and document what services they are receiving.
- Include in every safety assessment a consideration of whether there is a child in the home with complex health needs and develop a protocol to determine whether there are services in place in the home to support the child and family.
- Develop an assessment tool for medically fragile children that includes an assessment of their parent's ability and capacity to parent a medically fragile child, and identify what services could be put in place to support the parent in caring for the medically fragile child and family.
- Identify one person in each DCP borough office to serve as a resource for medically fragile children and their families. This person should have expertise in parenting medically fragile children, not just about abuse and neglect.
- Update the CPS developmental milestones card to include alerts regarding medically fragile children.

B. Baseline Preventive Capacity and Restore Homemaking

When ACS conducts an investigation of possible abuse or neglect, preventive services are often key to ensuring that children are able to remain safe in their home and preventing them from entering foster care. The kinds of preventive services that ACS provides through its partner

¹³ Wong D. Transition from Hospital to Home for Children with Complicated Medical Care. *J Pediatr Onc Nurs*. Jan 1991 8(1); 3-9.

¹⁴ Deming L, Wolf J. Case Management for Ventilator-Dependent Children. *Journal of Care Management* Oct 1997 3(5): 15-29, 77

contracted providers include home-based visits, family or individual counseling, parenting classes, assessment of mental health issues and referrals for treatment, assessment of substance abuse and referrals for treatment, domestic violence assessments and intervention, home care, support for pregnant and parenting teens, and other services. Currently ACS has 2 specialized preventive service providers for medically fragile children that are at about 95% capacity.

Preventive services have been a highly utilized resource for ACS to ensure safety for children and support families in crisis. The factors that are associated with the need for this service remain strong; ACS is seeing a small increase in the annual number of investigations by DCP, suggesting that the current scale of the preventive system is necessary to meet the need. In this environment, projections of utilization -- which is currently relatively low as the result of a system transition in spring 2010 -- indicate a rate of growth of 6-12% % through the end of June. Based on current trends, ACS expects the rate of growth to accelerate such that utilization rates will reach the mid-90s by summer 2011.

ACS' funding for preventive programs is supplemented for Fiscal Year 2011 by City Council funding. This funding underwrites 2840 slots out of a total of 11,745 slots across General Preventive, Family Rehabilitation and Special Medical programs. (Note: City Council funding supports an additional 60 slots in a preventive program for sexually exploited youth.) This funding enabled ACS to maintain stable capacity in the preventive programs between FY 2010 and FY 2011, and this stability and continuity are critical for the smooth functioning of the system.

- Baseline the full FY 2011 budget to enable ACS to preserve capacity and fund capacity building with special populations, broader use of preventive services for families who are being reunified post foster care to prevent re-entry, and enhanced support for general preventive programming to assist with the handling of education, substance abuse, domestic violence and mental health issues.

Homemaking services also provide critical support to families with multiple and complex needs allowing children to remain in a family, as well as supporting and teaching a parent to carry out homemaking and parenting roles.

- Restore homemaking services capacity to support work with families who have a medically fragile child or other significant need and are coping with those challenges.

C. Institute Preventive ChildStat

Building on the success of ACS' ChildStat model for examining data and case practice within the Divisions of Child Protection and Family Permanency, ACS will institute within the next six months Preventive ChildStat. ChildStat is an accountability mechanism where extensive data regarding practice outcomes are reviewed and randomly selected cases are discussed to understand and improve practice. It is anticipated that the new Preventive ChildStat would examine a case with active child protective and preventive services involvement.

D. Engage Stakeholders to Improve Services and Access to Care for Medically Fragile Children

It became apparent from the work of the Planning Group that there are a number of stakeholders who are involved in the care of medically fragile children; in many instances these children are outside of the child welfare system. ACS will work with external entities to improve coordination of services for medically fragile children and help focus attention on their needs among a broader group of stakeholders regardless of whether the children enter the child welfare system.

- Collaborate with the Coalition for Medically Fragile Children to convene a roundtable discussion for Discharge Planning Directors and ACS staff regarding discharge planning for medically fragile children.
- Work with the Coalition for Medically Fragile Children to identify the next steps in working with the New York State Department of Health to ensure better discharge planning for children in hospitals and skilled nursing facilities.
- Work with the Coalition for Medically Fragile Children to identify next steps in improving access to Medicaid Waivers for families with all medically fragile children whether or not they are known to ACS.

E. Seek Technological Improvements to Enhance Timely Documentation

While ACS is implementing a new policy on the use of notebooks while conducting investigations and requiring timely documentation in Connections, those solutions do not fully address the lack of contemporaneous note taking and updates in Connections.

- Continue to investigate technological solutions to enhance timely documentation and move to contemporaneous note-taking.

F. Deploy Onsite Technical Assistance to Struggling Preventive Providers

Discussion with the Planning Group led to a recommendation for ACS to create a Rapid Response Team that will provide immediate hands-on technical assistance for struggling programs. There are instances where practice at contracted providers deteriorates and the provider does not have the capacity or resources to make the necessary corrective actions.

- Pilot a rapid response capacity that will provide intensive onsite technical assistance to contracted providers where ACS has determined that program quality has deteriorated and could benefit from such assistance. The capacity will be deployed when staff in ACS' Divisions of Family Supportive Services, Child Protection and/or Quality Assurance identify a provider that is struggling and immediate action is required as demonstrated through declining or low scores, serious critical incidences, or other such indications of potentially concerning practices.
- The capacity will initially consist of an ACS professional with 20 years of preventive child welfare experience. Examples of the type of assistance to be given to providers include hands-on training, case consultation, observation of supervisory sessions, and observation of conferences.

Successfully implementing these recommendations requires further work that demands coordinated expertise crossing disciplines and agencies. ACS is committed to fostering collaborative efforts to develop and implement these recommendations in order to ensure that the child welfare system can address the needs of medically fragile children.

Appendix 1

**Preliminary Report
ACS Investigation
Death of Marchella Pierce
October 5, 2010**

Child's History

Marchella Pierce was born on 4/3/06 at 23 weeks gestation. Her twin sister had been born 3 days prior and died shortly after birth. Marchella stayed in hospitals or related medical facilities from her birth until she went to live with her mother sometime in the spring of 2007. She re-entered the hospital in May 2008. Marchella returned to her mother's care on 2/9/2010.

ACS Investigation

On 11/29/09 a case was called in to the State Central Register by a mandated reporter with allegations that the mother had a positive toxicology test at the birth of her son. The infant was drug-free. After a full investigation by the Administration for Children's Services (ACS), the report was appropriately indicated for neglect, and a referral was made to the Child Development Support Corp (CDSC) preventive program for families with substance abuse histories. ACS also made a referral to a drug treatment program. The assigned preventive case planner and Child Protective Services conducted a joint visit to the family on 1/13/10. The mother agreed to continue drug treatment; the preventive agency agreed to open a service case for the family; and the ACS investigation was closed.

CDSC Involvement

Marchella left the hospital and returned to her mother on 2/9/10. The CDSC case planner reported that she saw Marchella on 2/11/10 and 2/17/10.

On 2/26/10, the CDSC supervisor documented that Ms. Pierce was not compliant with the drug treatment program to which she had been referred, and was a difficult client to engage. CDSC did not contact the mother, did not inform ACS and ask for an Elevated Risk or Child Safety Conference (as required), and did not make a new report to the State Central Register. On the same day, the CDSC supervisor noted that the case planner reported that the mother said she had everything under control but that the supervisor was concerned about the three young children in the home, especially the one with significant medical needs. However, there is no indication in the record of follow-up regarding these concerns.

On 3/2/10 a mandated reporter called the State Central Register saying that (s)he did not want to make a formal report, but that the mother had brought Marchella in for medical attention due to the tracheal tube not working correctly, that the child had been medically cleared, but that the mother had left before being trained on how to take care of the tracheal tube. Medical caregivers asked that the mother come in for further training. The call was taken by the State as an "Additional Information" report, was referred as such to ACS, and was thus not treated as cause for a full-scale investigation. However, ACS Emergency Children Services did dispatch an investigator that night who reported that, while all seemed fine with the children, the mother was hostile and that the mother should be evaluated on her ability to care for a special needs child. The following day a Child Protective Services supervisor reviewed the case and noted that the mother's overall ability to care for the children should be explored, particularly for Marchella who had significant medical impairments. Neither the ACS supervisor nor the worker assigned to the case started a new investigation, which should have happened under these circumstances, but continued the case as an open-service case.

On 3/3/10 the drug treatment program reported to the CDSC case aide that the mother had again tested positive for marijuana, and that she was not cooperating with the program. On or about 3/17/10, the drug treatment program faxed a report to CDSC which stated that the mother had threatened an employee at the treatment program, had not met with her counselor for five weeks, and was no longer enrolled in the program. Attached to the report were the results of a series of toxicology screenings showing continued, frequent drug use by the mother since her enrollment in the program. Once again, CDSC did not contact the assigned child protective specialist or ask for an Elevated Risk or Child Safety Conference, and did not make a new report to the State Register. There is no indication in the record that the CDSC staff confronted the mother about her continued drug use, or made an effort to assess the impact of her drug use on her functioning as a parent of a medically fragile child.

From 2/26/10 until 6/3/10, the only recorded contacts by the CDSC case planner were home visits on 3/10 when Marchella was reported seen and contacts on 3/24, 3/31, 4/14, and 4/28 when she was not reported seen. In the progress note for the home visit conducted on 3/10, CDSC noted that the mother was attending the drug treatment program regularly, despite what that drug treatment provider reported to the CDSC case aide on 3/3. On 3/24, the CDSC case planner reported that the mother was not in the treatment program because of loss of Medicaid but that she is "responsive to service goals." Notes were made on 4/14 reporting that the latest drug test was negative. On 6/2/10 the CDSC case planner wrote that a visit had been made to the home on 5/5/10, that home is "stable and children ...safe... and case is requested be closed." On 6/16/10, CDSC notes that the latest drug test was positive, and CDSC would talk with the mother at the next home visit. No further entry was made by CDSC.

Further ACS Involvement

Since CDSC failed to win a new contract, ACS began closedown meetings with CDSC in May 2010. During these meetings, ACS and CDSC staff discussed the program's active cases to assess which families' risks had been ameliorated such that their cases could be closed, and which families still needed help and should be transferred to another preventive agency. In May when the closedown process began, CDSC recommended closing the Pierce case, stating that the home was stable, and the children were assessed to be safe. Later in the closedown process, after the mother once again tested positive for marijuana use, the closedown team determined that further services were warranted. Because there was already an open child protective case, the determination was made to keep the case open, return it to the jurisdiction of ACS's Division of Child Protection to assess the family and if necessary follow through with a referral for needed services.

However, the record did not indicate that child protective staff had any contact with the family after what appears to have been a brief visit on the evening of 3/2/10 in response to the mandated reporter's call. During the transfer process in June, however, a Child Protective Services worker did record that he visited the home on 6/9 but reported no one home. However, after the child's death the Child Protective Services worker reported that children and grandmother were seen on that visit. Again, after the fatality, the Child Protective Services reported that the home was visited and children seen on 4/6, 7/22 and 8/12. However, no record was made of those visits at the time.

The current child abuse investigation, regarding Marchella's death, began on 9/2/10. In summary, while the Child Protective Services team will need to await the Medical Examiner's report to make a final determination on the fatality itself, they intend to indicate the case for both abuse and neglect. It appears from the investigation conducted by ACS into the death of Marchella that her home care was grossly inadequate, she had been tied down for substantial

periods of time on her bed, she weighed less than when she was released from the medical facility in February and was not normal weight even for a child with significant medical problems since birth, and that Marchella was hit with a video box as a form of punishment.

Analysis

Child Support Development Corporation

It is clear that the preventive agency's involvement in seeing to it that the mother received drug treatment and in making sure the children were safe and adequately cared for was woefully inadequate. By contract, the agency was required to have 2-3 case contacts a week for the first four weeks or until sobriety was achieved. However, CDSC had been informed that sobriety had not been approached much less achieved. Further, the child Marchella was only seen by the CDSC case planner on three occasions from February until June. On other occasions, the case planner was told that Marchella was with her father or out with the mother. Most important, the agency at no time carried out its responsibility to make a new State Central Register report regarding the mother's continued drug abuse, notify ACS of same, or request an Elevated Risk or Child Safety Conference with ACS to determine if the children could remain safely in the home.

ACS

There are several serious problems with ACS' handling of the case. First, the initial investigation, while focused correctly on the mother's drug abuse, should have involved an assessment of Marchella's status and planning with CDSC and the family for when she was released from the hospital. Secondly, the report in March 2010 was identified as Additional Information--which does not automatically require a full investigation. However, ACS's response to the Additional Information was not adequate—with the notable exception of the Emergency Children Services worker's visit and report. Of note, from the time Marchella returned home in February and the Additional Information report was made in March, no other reports were received regarding the family—from neighbors, relatives, etc. Nor were any abuse/neglect reports filed after the March incident by medical authorities, neighbors, relatives, or concerned citizens.

Since there was no current ACS investigative case open, ACS staff should have looked more carefully at what progress had or (more importantly) had not been made in CDSC's service case since December 2009. If they had done so, they would have seen that Ms. Pierce was by no means maintaining sobriety. Since Marchella was medically fragile, moreover, a full-scale investigation was called for. Most important, the Child Protective Services unit carried the family as an open services case but did not do an investigation and had very little contact with the family. Thus they were carrying an open case involving a very fragile child, a baby, and a five-year old within a substance-abusing household. Yet prior to the fatality, it is simply not in the record that ACS representatives visited the family at all after June 2010, and it is questionable whether any visits occurred after March 3, 2010. Not recording contacts is a serious issue. Not making them is inexcusable. One Child Protective Services worker and one Child Protective Services supervisor have each received an unpaid 30-day suspension, the maximum allowable period, pending final disciplinary action in the case.

Children's Services' Actions

When CDSC failed to win a new contract for preventive services in the spring of 2010, a closedown process was undertaken, involving a review of the agency's cases to determine whether they should be handed off to another preventive agency or closed. As that review got underway, it became clear that there was a pattern of a number of CDSC's cases not being in a condition to be closed because of the poor quality of the work the agency had done with the families involved. Thus, while ACS could have extended their contract for some months, Children's Services decided to close out the contract immediately. That action has been taken.

However, CDSC's poor record raises other issues for ACS as well: Why didn't ACS catch this pattern sooner? While CDSC had been on corrective action status in the past, there was no clear indication in 2010 that their work had become so inadequate. Clearly, ACS needs to assess carefully how it can determine more quickly that a contract agency is failing. For example, ACS will assess whether and why some preventive agencies are not routinely requesting Enhanced Risk conferences. ACS will review this matter immediately and take appropriate action ACS by the end of November, 2010.

ACS has been involved in a series of closedowns of agencies who have not won new contracts, whose contracts are being downsized, or who will be assigned to new communities under the new contracts. While the closedown process does not appear to be the primary contributing factor in this child's death, it does raise the question of how carefully these closures or transfers are occurring. The State Office of Children and Family Services has begun reviewing the process and will be reviewing a sample of CDSC's cases to determine if there may be families who need further intervention; OCFS expects to complete the review by the end of October. In addition, ACS will be conducting a review of a sample of case records from families affected by program closures in the past six months to assess the quality of decision-making and follow through, and to determine if there may be families requiring follow-up; this will be complete by November 15, 2010.

One shortcoming that ACS has discovered in the closedown process is that the assessment of child safety and risk as well as family service needs is often delegated to Child Protective Services workers assigned to provider agency cases; yet there is not a systematic process for verifying that the assessment and follow through have occurred. Children's Services will revise the closedown procedure to ensure that needed preventive referrals are made for every family, even when the case is active with Child Protective Services. Changes in this protocol will be completed by the end of November.

In 2006 ACS issued a Child Safety Alert to all staff about taking Additional Information reports to the State Register seriously, assessing the new information and determining whether further action and a new investigation is needed. In this case, ACS acted immediately to respond to the report but then made no serious or ongoing effort to determine the need for a full investigation. It is clear that ACS must more rigorously assess the additional information, incorporating past case history, which may require a full investigation even of these reports.

In addition, ACS has begun reviewing a sample of all Additional Information Cases received since 1/1/10 by supervisory unit and is re-assessing cases where warranted and expects to be finished within the next week. A complete review of all Additional Information reports since January 2010 will be complete within three weeks. Based on this review, by mid-November

ACS will consider issuing new guidance to staff on assessing Additional Information reports to determine whether a full investigation is necessary.

Recordkeeping by both ACS and its provider agencies remains a challenge. While ACS has obtained notebooks similar to those used by police detectives, they are not being consistently utilized. This means that entries into the formal electronic record (CNNX) that are substantially delayed cannot be fully verified. ACS expects to make the use of notebooks uniform across Child Protection; this will be implemented by October 8, 2010. In addition, ACS will issue a policy directive by November 15, 2010 calling for all CNNX progress notes to be put into the system of record within a set number of days after contact.

As our reviews continue, ACS will make any and all improvements necessary to address any other gaps in practice identified.

Appendix 2

**Children's Services Planning Group
Agenda for Meeting #1
December 6, 2010**

- 1. Introduction** **Commissioner Mattingly**
Handout #1: Preliminary Report on the Death of Marchella Pierce

- 2. Overview of Process & Discussion** **Belinda Conway**
 - Review and discuss plan and agendas for future meetingsHandout #2: Membership list
Handout #3: Meeting dates and proposed agendas

- 3. Preventive Practice Discussion**
 - **Monitoring of agency performance** **Valerie Russo**
Handout #4: Agency Program Assistance Monitoring Process and Accountability Mechanisms

 - **Program Closedown Process** **Danielle Weisberg**
 - **Closedown Protocol**
Handout #5: Program Closedown Protocol
Handout #6: Program Closedown Process

 - **Preventive Case Review Report**

 - **Monitoring of Elevated Risk Conferences** **Danielle Weisberg**
Handout #7: Elevated Risk Data analysis
Handout #8: Elevated Risk guidance

- 4. Recommendations** *(We assume that the general discussion will also include recommendations.)*

**Children's Services Planning Group
Agenda for Meeting #2
December 13, 2010**

1. **Review of notes from Meeting #1** **Belinda Conway**
Handout #1: Notes from Meeting #1

2. **Protective Practice** **Jan Flory**
Handout # 2: DCP Proposed Actions **Marie Philippeaux**
 - **Review of Additional information cases and practice**
Handout #3: Summary of DCP Review of Additional Info Cases
 - **Timely Documentation**
 - **Quality of Supervision in Protective Cases**
Handout #4: DCP Quality Supervision Model (Background Document)

3. **Preventive Referrals And Utilization** **Danielle Weisberg**
Jan Flory

4. **Follow-ups**
 - **Clarify Child Safety Conferences and Elevated Risk Conferences**
Handout # 5: Flow Chart FTC **Danielle Weisberg and Jan Flory**
 - **Planned CFS reduction – effects on timely conferencing**

5. **Recommendations** *(We assume that the general discussion will also include recommendations.)*

**NYC Children's Services Planning Group
Meetings # 3
January 4, 2011
Agenda**

1. Introductions

2. Review and Discussion of Meeting Notes from Meeting #2

Handout #1: Notes from Meeting #2 Belinda Conway

3. Practice Concerns raised by the Marchella Pierce Case related to Medically Fragile Children

Jan Flory & Nancy Martin

4. Overview of ACS Services for Medically Fragile children and their Families

Nancy Martin

Handout #2: ACS Services for Medically Fragile children & their families

5. Review of agenda for Meeting #4

Belinda Conway

Background Materials for discussion

- CMFC Aging Out Report
- CMFC Bring Our Children Home Report

We would like to take the opportunity to discuss with the full planning group agenda topics for meeting #4. They could include:

An overview of Medicaid Waivers

- What waivers exist? e.g. Lombardy, Care at Home
- Is NYC taking full advantage of waiver opportunities?
- B2H

What about discharge planning?

Next steps on work with Medically Fragile Children and their families beyond this group

Recommendations

(We assume that the general discussion will also include recommendations.)

NYC Children's Services Planning Group
Meeting #4
January 14, 2010
Agenda

- 1. Review and Discussion of Meeting Notes from Meeting #3**
Handout #1: Notes from Meeting # 3 Belinda Conway

 - 2. An Overview of Medicaid Waivers** Melinda Dutton

 - 3. Review of Discharge planning regulations** Melinda Dutton
Handout # 2: Discharge Regulations (Hospitals)
Handout # 3: Discharge Regulations (Nursing Facilities)

 - 4. Work with Medically Fragile Children and their families – a NYC perspective – Next Steps?** Belinda Conway

 - 5. Plan for Meeting #5 – on follow-ups from previous meeting** Belinda Conway
Handout # 4: Follow-ups from previous meetings
Handout # 5: Recommendations from previous meetings
- Recommendations** *(We assume that the general discussion will also include recommendations.)*

NYC Children's Services Planning Group
Meeting # 5
January 19, 2010
Agenda

- 1. Review and Discussion of Meeting Notes from Meeting #4**
Handout #1: Notes from Meeting # 4 Belinda Conway

- 2. Update on Follow-Up requests from Meetings 1 – 4** J
Jan Flory, Nancy Martin, Valerie Russo, Susan Fojas
 - Case Review findings
 - Policy updates
 - Other issues

- 3. Discussion of Preventive Utilization & Baseline Recommendation**
Nancy Martin

- 4. Discussion of Recommendations** Belinda Conway

- 5. Plan for Meeting #6 (Review of Draft Report)** Belinda Conway

Appendix 3

**CLOSED PPRS AGENCY TRANSFERRED CASES – DCP/FSS REVIEW
REVIEW INSTRUMENT**

Agency Name:	
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Case Name	
CNNX Case #	

Reviewer:			
Referral Date:		Transfer Date:	

Recommendation following Review		
	1. Yes	2. No
Immediate call to SCR		
Immediate assessment of safety required		
Follow-up to address present risk required		
No further action required		

1: Family Characteristics				
Case name information:				
First name	Last name	DOB	Gender	Relationship

Detail All reasons/presenting problems that led to preventive service referral:	Detail All resource and service need/request at time of preventive service initiation:
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2: Assessment

		1. Yes	2. No	3. Partially	88. NA
A1	Reviewer's assessment: Overall, did agency staff conduct with appropriate reassessments in correspondence to the family's presenting problems and current circumstances?				
A2	Overall were interventions/actions taken consistent and in correspondence to the findings of assessments? (please provide details regarding these interventions/actions in the comments section below)				
A3	Were there any barriers in obtaining full assessments? (please provide details regarding these barriers in the comments section below)				
A4	Were there any barriers in providing services based on needs identified in the documented assessments? (please provide details regarding these barriers in the comments section below)				

Assessment Comments Section:

3a. Safety

		1. Yes	2. No	3. Partially	88. NA
S1	Were the original results of the CPS investigation that led to the preventive service referral incorporated into the assessment of safety and risk?				
S2	Did agency staff see and assess the safety of all the children living in the household in the month prior to transfer?				
S3	Did agency staff identify any safety concerns? (please provide details regarding these concerns in the comments section below)				
S4	To address the safety concerns, did agency staff take immediate actions				

	to DCP?	
T3	Was the family involved in an active FSU case at the time of transfer?	
T4	Was the family the subject of an active investigation at the time of transfer?	
T5	Were discussions held with the family regarding the termination of the agency's involvement?	
T6	Was there a joint home visit between the DCP/CPS and the agency case planner?	
T7	Did the case record include a progress note/closing summary documenting the intention of transferring the case to DCP?	
T8	Was there a supervisory note regarding the assessment of the case and the decision to transfer?	
T9	Was there an assessment of the BP/CG's abilities to ensure child safety without agency intervention/monitoring?	
T10	Reviewer's Assessment: Were appropriate steps taken during the transfer of the case to ensure the safety of the children in the family?	

Transfer Comment Section:

5. DCP Involvement					
Actions following Transfer		1. Yes	2. No	3. Partially	88. NA
D1	Did DCP make an assessment of all the adults in the household, and their ability to meet the children's needs?				
D2	Did DCP make an assessment of the home conditions and environment?				
D3	Did DCP identify any unattended safety concerns present at the time of transfer? (please provide details regarding these concerns in the comments section below)				
D4	Did DCP discuss the safety concerns directly with BP/CGs?				
D5	Did DCP involve BP/CGs in the development of a plan to address the safety concerns?				
D6	Was the intervention/safety plan put in place appropriate in addressing the safety concerns?				
D7	Did DCP identify any unattended risk factors present at the time of transfer?				

D8	To address the risk factors, did DCP take appropriate actions to ensure the risk is significantly reduced for all family members?				
D9	If a family member was assessed at risk/involved in risk taking activities did DCP staff attempt to provide services directly or through appropriate referrals?				
Ongoing Case Planning		1. Yes	2. No	3. Partially	88. NA
D10	Was there a face-to-face with all of the children in the family within the first 30 days following the case transfer?				
D11	Is the case still active in DCP? (If yes, please proceed to questions D12-D15. If no, please proceed to questions D16-D18.)				
D12	Is the case active in a PD unit?				
D13	Is the case active in an FSU Unit?				
D14	Is the case active in an FPP Unit?				
D15	Is there currently an active investigation involving the family? (please proceed to question D19)				
D16	Was the case assigned to a PPRS agency prior to closing within DCP?				
D17	Was the case referred to a CBO prior to closing within DCP?				
D18	Was the case closed in DCP without any additional service referrals? (please provide details as to why this decision was made in the comments section below, and proceed to question D19)				
D19	Is the case currently active with a PPRS provider? (please provide details in the comments section as to the current case status.)				
D20	Is the case planner closely monitoring the degree to which the intervention/plan is effective in resolving the safety concerns and reducing risk factors in the family?				
D21	Is the case planner monitoring the at risk family member's progress in services provision through communication with collaterals?				
D22	If an at-risk family member was referred to a service but refused to participate did the case planner explore his/her reluctance?				
D23	If a family member either refused services or did not make progress in services did the case planner take steps to obtain an alternative service?				

DCP Involvement Comment Section:

**Preventive Case Review Instrument for PPRS Cases
Closed from April through July 2010**

Detail ALL reasons/presenting problems that led to preventive service referral:

Detail ALL resource and service need/request at time of preventive initiation:

**Preventive Case Review Instrument for PPRS Cases
Closed from April through July 2010**

2: Assessment - (focusing on the last 6 months of case)

A1: Was assessment of the family's needs a component of casework activities?

1. Yes 2. No 3. Partially 88. N/A

A2: Was there an assessment of the BP/CGs ability to meet the children's needs?

1. Yes 2. No 3. Partially

A3: Was an assessment of children's Physical Health a component of casework activities?

1. Yes 2. No 3. Partially

A4: Was there an assessment of children's Development/Cognitive well being? (including Education)

1. Yes 2. No 3. Partially

A5: Was there an assessment of children's Emotional/Psychological well being? (including MH)

1. Yes 2. No 3. Partially

A6: Was there an assessment of children's Social/Behavioral well being?

1. Yes 2. No 3. Partially

A7: Was there an assessment of the home conditions and environment?

1. Yes 2. No 3. Partially

A9: Was assessment of substance use/abuse a component of casework activities?

1. Yes 2. No 3. Partially 88. N/A

A10: Was assessment of domestic violence and associated behaviors a component of casework activities?

1. Yes 2. No 3. Partially 88. N/A

A11: Was assessment of mental health a component of casework activities?

1. Yes 2. No 3. Partially 88. N/A

Reviewer's assessment:

A12: Overall, did agency staff conduct appropriate reassessments in correspondence to the family's presenting problems and current circumstances?

A12

1. Yes 2. No 3. Partially

A13: Overall were interventions/actions taken consistent and in correspondence to the findings of assessments?

A13

1. Yes 2. No 3. Partially

Preventive Case Review Instrument for PPRS Cases
Closed from April through July 2010

Assessment Comment Section:

**Preventive Case Review Instrument for PPRS Cases
Closed from April through July 2010**

3a: Safety:

S1: Did agency staff assess BP/CGs' risk of abuse/neglect/maltreatment of children during case work contacts?

1. Yes 2. No 3. Partially

S2: (CWS only) Were the original results of the CPS investigation that led to the preventive service referral incorporated into the assessment of safety and risk?

S2

1. Yes 2. No 3. Partially 88. N/A

S3: Did agency staff make contact with all children living in the household on a monthly basis during the review period?

1. Yes 2. No 3. Partially

S4: Did agency staff assess family dynamics/parent/child interactions during family casework contacts?

1. Yes 2. No 3. Partially

S5: If an additional adult/s came to reside in the home did agency staff assess the new member's impact on family dynamics/interactions during casework contacts?

S5

1. Yes 2. No 3. Partially 88. N/A

S6: If a child resided at another residence part-time did agency staff assess the home for safety?

1. Yes 2. No 3. Partially 88. N/A

S7: Did agency staff identify any safety issues during the review period? (please provide details in the comments section)

1. Yes 2. No

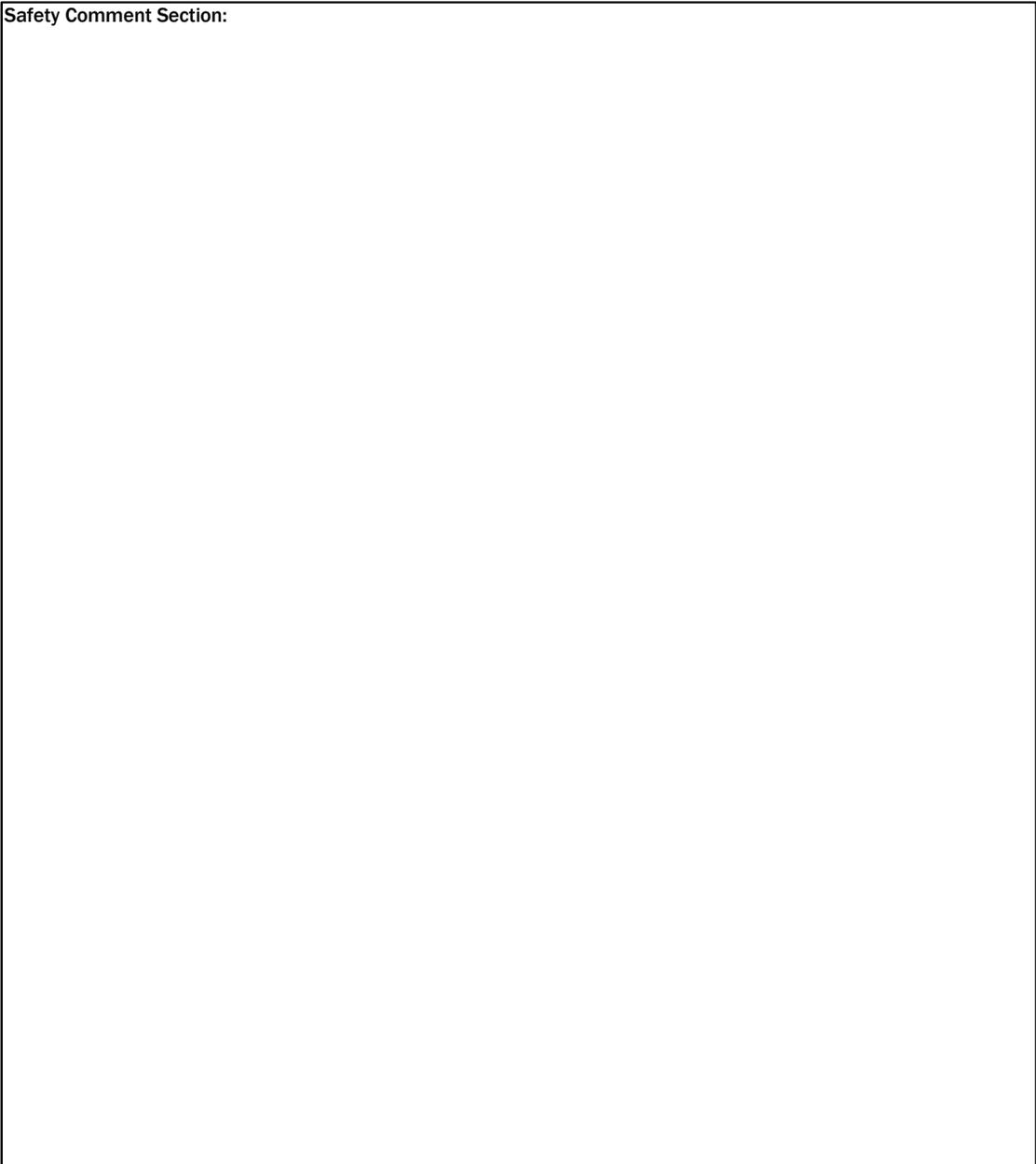
S8: Did the Reviewer identify any safety concerns, not already identified by agency staff, during this review period? (please provide details in the comments section)

S8

1. Yes 2. No

Preventive Case Review Instrument for PPRS Cases
Closed from April through July 2010

Safety Comment Section:



**Preventive Case Review Instrument for PPRS Cases
Closed from April through July 2010**

3b: Risk:

R1: Did agency staff complete an assessment of risk factors?

1. Yes 2. No 3. Partially

R2: Did agency staff identify any risk factors during the review period? (please provide details in the comments section)

1. Yes 2. No

**R3: Did the Reviewer identify any risk factors, not already identified by agency staff, during this review period?
(please provide details in the comments section)**

R3

1. Yes 2. No

R4: To address the risk concern, did agency staff take appropriate actions to ensure the risk is significantly reduced for all family members?

R4

1. Yes 2. No 3. Partially

R5: If there was a newborn in the home did agency staff assess the BP/CGs' coping/parenting abilities in response to the new member joining the family?

R5

1. Yes 2. No 3. Partially 88. N/A (no newborn)

R6: If there was a newborn in the home, did agency staff monitor for appropriate home conditions/sleeping arrangements?

R6

1. Yes 2. No 88. N/A (no newborn)

R7: Did agency staff assess the impact of services in changing the family's risk taking behaviors?

R7

1. Yes 2. No 3. Partially

R8: If a family member either refused services or did not make progress in services did agency staff take steps to obtain an alternative service?

R8

1. Yes 2. No 3. Partially

Preventive Case Review Instrument for PPRS Cases
Closed from April through July 2010

Risk Comment Section:

**Preventive Case Review Instrument for PPRS Cases
Closed from April through July 2010**

4: Documentation:

Progress Notes

PN1: Was there sufficient Progress Note documentation for review to make a quality assessment of CW practice?

1. Yes 2. No 3. Partially
-

Family Team Conference (FTC)

FTC1: Did a Family Team Conference occur in association with the closing?

1. Yes 2. No 3. Only for ERC, or if DV was present

FTC2: If there was a Family Team Conference, which type occurred?

1. ERC 2. Planning 3. Svc. Termination 4. Quality Intervention

FTC3: If no conference, does reviewer think conference should have been held?

1. Yes 2. No 3. Partially
-

5: Supervision/Case Record Review:

SU1: Upon review, does it appear that the supervisor made appropriate decisions/recommendations?

1. Yes 2. No

SU2: Was there a Supervisor note regarding case assessment and decision to close?

1. Yes 2. No

**Preventive Case Review Instrument for PPRS Cases
Closed from April through July 2010**

6. Case Closing:

Select all reasons that further describe the agency's case closing decision corresponding to response selection to question CC1.

CC1: The decision for case closing was implemented as a result of:

- 1. Planned agency initiation only
- 2. Unplanned agency initiation due to family's non-participation in services
- 3. Family initiation/request only
- 4. Collaboration between agency and family
- 5. Foster care placement

CC2: Presenting and/or subsequently identified problems were addressed through services and/or the development of family's own strengths/supportive resources:

CC2

- 1. Yes
- 2. No
- 3. Partially

CC3: Services adequately mitigated problems/risk factors:

- 1. Yes
- 2. No
- 3. Partially

CC4: Family is connected to community resources/services:

- 1. Yes
- 2. No
- 3. Partially

CC5: Children no longer require monitoring aspect of services to ensure safety & well-being:

- 1. Yes
- 2. No

CC6: Family refused preventives services:

- 1. Yes
- 2. No

CC7: All children were removed to foster care:

- 1. Yes
- 2. No

CC8: Youngest child in the family turned 18:

- 1. Yes
- 2. No

CC9: Family moved out of NYC and/or cannot be located:

- 1. Yes
- 2. No

**Preventive Case Review Instrument for PPRS Cases
Closed from April through July 2010**

6. Case Closing, *cont.*:

Select all reasons that further describe the agency's case closing decision corresponding to response selection to question CC1.

CC10: If the family initiated case closing or if the family was refusing/not participating in services and there were unresolved safety/risk issues, did agency staff notify appropriate ACS areas or service providers?

CC10

1. Yes 2. No 3. Partially /Sometimes 88. N/A

CC11: If the family was resistant to services and/or could not be located, did the agency demonstrate diligent efforts prior to closing?

CC11

1. Yes 2. No 3. Partially /Sometimes 88. N/A

CC12: Was there an assessment of the BP/CG's abilities to ensure child safety without agency intervention/monitoring?

CC12

1. Yes 2. No 3. Partially /Sometimes 4. Family refused svcs, not participating

CC13: Was the risk of child abuse/neglect/maltreatment assessed to be significantly reduced so as to support the decision for closing?

CC13

1. Yes 2. No 3. Partially /Sometimes 4. Family refused svcs, not participating

CC14: Were all children seen and assessed for safety prior to the case closing? (within one month of closing)

CC14

1. Yes 2. No 4. Family refused svcs, not participating 88. N/A

CC15: Were there any unattended safety/risk issues remaining? (if yes, please describe in detail in the comments section)

CC15

1. Yes 2. No 4. Family refused svcs, not participating 88. N/A

CC16: Reviewer's Assessment: Was the closing of this case appropriate?

CC16

1. Yes 2. No 4. Family refused svcs, not participating 88. N/A

CC17: Does reviewer recommend additional follow-up on this case?

1. Yes 2. No

CC18: Check appropriate follow-up:

1. Immediate call to SCR

2. Immediate assessment of safety required

3. Follow-up to address present risk required

4. No further action required

Preventive Case Review Instrument for PPRS Cases
Closed from April through July 2010

Case Closing Comment Section:

Preventive Case Review Instrument

Detail ALL reasons/presenting problems that led to preventive service referral:

Detail ALL resource and service need/request at time of preventive initiation:

Preventive Case Review Instrument

2: Assessment - (focusing on the last 12 months of case)

Reviewer's assessment:

A12: Overall, did agency staff conduct appropriate reassessments in correspondence to the family's presenting problems and current circumstances?

A12

1. Yes 2. No 3. Partially

A13: Overall were interventions/actions taken consistent and in correspondence to the findings of assessments?

A13

1. Yes 2. No 3. Partially

Assessment Comment Section:

Preventive Case Review Instrument

3a: Safety:

S7: Did agency staff identify any safety issues during the review period? (please provide details in the comments section)

1. Yes 2. No

S8: Did the Reviewer identify any safety concerns, not already identified by agency staff, during this review period? (please provide details in the comments section)

1. Yes 2. No

Safety Comment Section:

Preventive Case Review Instrument

3b: Risk:

R7: Did agency staff assess the impact of services in changing the family's risk taking behaviors?

1. Yes 2. No 3. Partially

R8: If a family member either refused services or did not make progress in services did agency staff take steps to obtain an alternative service?

1. Yes 2. No 3. Partially

Risk Comment Section:

Preventive Case Review Instrument

4: Documentation:

Progress Notes

PN1: Was there sufficient Progress Note documentation for review to make a quality assessment of CW practice?

1. Yes 2. No 3. Partially
-

Family Team Conference (FTC)

FTC1: Did Family Team Conferences take place during the review period?

1. Yes 2. No

FTC2: If there was a Family Team Conference, which type(s) occurred (check all that apply)?

- ERC Planning Service Termination Quality Intervention Child Safety Conference

FTC4: If no ERC occurred, based on your review, should an ERC have occurred during the review period?

1. Yes 2. No N/A - An ERC conference was held

Preventive Case Review Instrument

FTC5: If yes, please indicate the reason for the ERC to have occurred (check all that apply):

- A (A) The family has disengaged from services without sufficiently addressing the issues placing the children at risk of maltreatment
- B (B) Children and youth have not been seen, or preventive workers are not given access to observe and interview a child/youth
- C (C) A family consistently misses appointments, refuses to come to the office or is not available for home visits
- D (D) Family members are not willing to share information that will help the provider agency understand what is going on in the family
- E (E) Case planner is unsure if the family can protect the child and needs to consult with ACS about the facts and situation that lead them to that conclusion
- F (F) The service model chosen for the child/youth does not meet the level of care that the child, youth or family needs
- (G) Additional issues/conditions have surfaced that create an increased risk of maltreatment to the children and the family is not working with the agency to address them. For example:
- G G-A * *Not following through on services, i.e. drug treatment when in the FRP program; mental health services, when there are young or multiple children in the home*
- G-B * *A parent or child tests positive for drugs*
- G-C * *Child or youth not attending school*
- G-D * *A child/youth's untreated or under treated medical condition*
- H (H) Other: _____

Preventive Case Review Instrument

FTC6: During the review period, should an SCR report have been made?

1. Yes 2. No

FTC7: Was a SCR report made?

1. Yes 2. No

FTC/SCR Comments:

CC17: Does reviewer recommend additional follow-up on this case?

1. Yes 2. No

CC18: Check appropriate follow-up:

1. Immediate call to SCR
 2. Immediate assessment of safety required
 3. Follow-up to address present risk required
 4. No further action required

6. Case Assessment (Review case / FSS Progress notes)

Based on review of the case could the Add Info. potentially have risen to a safety or risk concern? Yes No

If no, please explain

If yes, identify the one or more safety factors or risk elements that are present

If yes, identify the safety intervention or risk reduction activity that was utilized to address these concerns

7. Recommendation:

- Immediate call to SCR
- Immediate assessment of safety require
- Follow-up to address present risk required
- No further action required

Case Reviewer: _Date of Review: _____

Appendix 4

**Strengthening Existing ACS Policy
Timeline**

Policy	ACS Division Responsible	Status
Strengthen Performance Monitoring For Contracted Provider Agencies	Quality Assurance	Ongoing – ACS began strengthening its performance monitoring as described in this document in October 2010.
Responding to Heightened Safety Concerns in Preventive Services Cases	Family Support Services	Group meetings with providers are happening January – March 2011; Data on ERC use are being shared with providers February –March 2011; Develop recommended actions to increase use of ERC February - March 2011; Steps to improve internal processes are underway and will be completed by April 2011.
Changes To Contracted Provider Closedown Procedures	Family Support Services	Completed – closedown procedure protocol was updated in January 2011
Improvements to Case Closure Decisions	Family Support Services	Work is underway with providers and will be completed by May 2011.
Additional Information Guidance	Child Protection	Completed – Safety Alert distributed February 24, 2011
Supervisory Practice Guidance	Child Protection	The Division of Child Protection’s approximately 800 supervisors, mid-level managers, leadership, and Deputies will attend a training session on enhanced supervisory practice guidance by April 2011.
Guidance on Uniform Note Taking and Documentation Requirements	Child Protection	Completed – Note taking policy distributed October 6, 2010, and documentation requirements distributed February 4, 2011

Appendix 5

**Summary of Agency Program Assistance Process
for Discussion with the Children’s Services Planning Group
December 2010**

APA’s mission is to help improve the quality of services provided and the outcomes achieved by Children’s Services provider agencies for New York City’s children and families. Located within the Division of Quality Assurance, the Agency Program Assistance (APA) unit is comprised of performance monitors assigned in teams to Children’s Services preventive and foster care providers. These teams are responsible for the major monitoring functions described below, as well as the dissemination of promising practices throughout the system.

Ongoing Monitoring

The following activities are conducted in the course of typical, ongoing monitoring of each provider agency. The list of data indicators reviewed is not exhaustive, but is typical.

Monthly	<ul style="list-style-type: none"> – Refer to Action Plan and most recent performance letter to create workplan for month and ensure completion of planned tasks, such as targeted reviews and technical assistance – Disseminate Agency Update to Deputy Commissioners – <i>Preventive Data Review</i>: PROMIS – <i>Foster Care Data Review</i>: Vacancy Control, FASP Timeliness, Family Court Practice, OCFS Casework Contacts, SSPS
Quarterly	<ul style="list-style-type: none"> – Update Action Plan based on activities of prior quarter – Receive information regarding practice trends emanating from Family Team Conferences – <i>Preventive Data Review</i>: Joint Home Visits, Length of Service – <i>Foster Care Data Review</i>: Outcomes, Foster Parent Recruitment, OSI Indicated Cases, Census
Semi-annually	<ul style="list-style-type: none"> – Performance Management Meeting held with agency at least semi-annually – <i>Foster Care Data Review</i>: NYS Indicated Cases
Annually	<ul style="list-style-type: none"> – PAMS Data Review* – Scorecard Review* – Staff and Client Interviews** – Review of system-wide data to identify critical performance areas – Set system-wide performance targets – <i>Preventive</i>: Administrative Review* – <i>Foster Care</i>: Site Reviews**, Foster Parent Training Review**, Staffing Review
As needed	<ul style="list-style-type: none"> – Incorporate, respond to, and provide feedback to stakeholders, including other ACS Divisions, OCFS, DOI, Comptroller, and clients. – Produce timeline of agency performance issues when recommending moving to an elevated level of concern.

* These monitoring activities are followed by a Performance Management Meeting, and results are summarized in a letter to the agency (see below).

** The results of these reviews are summarized in letters to the agency.

Results of monitoring activities are continually assessed to determine the appropriate next steps with an agency. APA supports several different forums in which this assessment occurs.

- Supervision is a critical component of the assessment process. Regular, ongoing supervision is held between monitor and supervisor, supervisor and team, supervisor and Director, Director and Associate Commissioner, and Associate Commissioner and Deputy Commissioner. The status of agency performance is discussed in each meeting.
- Staff meetings include foster care and preventive supervisors bi-weekly, as well as the foster care and preventive units, all supervisors, and all staff meetings monthly.
- Planning sessions are a regular forum in which staff discusses issues of concern, shares improvement strategies, refines evaluation tools, and sets system-wide goals for performance improvement.

Performance Management Meetings

Performance Management Meetings are held at least semi-annually during the course of typical monitoring. The meetings incorporate all of the available information from the data and other sources described above. Data packets that illustrate trends and notable areas of performance are prepared in advance of the meetings. During the meeting, agency and APA staff develops hypotheses about the causes for performance, as well as strategies to improve performance where necessary. APA staff communicates clear expectations for improvement, including timeframes.

Performance Letters

Performance Management Meetings, Administrative Reviews, Foster Parent Training Reviews, and other significant meetings are followed by performance letters, which summarize the meetings held. Specifically, letters: a) identify strengths and challenges; b) include relevant data or other results in the letter or as attachments; c) describe hypotheses for the causes of performance issues and possible strategies for improvement; d) reiterate clear expectations for improvement; and e) include next steps and timeframes for reassessment.

Accountability Mechanisms

Accountability mechanisms are not intended to be the primary drivers of agency performance improvements. APA uses these tools when standard monitoring does not achieved desired results, ***or when a significant issue arises that necessitates immediately elevating the level of monitoring.*** APA regularly shares the actions taken related to the use of accountability mechanisms with other divisions of ACS. Additionally, information may be shared with stakeholders external to ACS when appropriate. The table below describes the process involved in using accountability mechanisms to improve performance.

	Standard Monitoring	Accountability Mechanisms	
	Identified Areas of Concern	Corrective Action Status (CAS)	Probationary Corrective Action Status (PCAS)
Definition	An area of concern may stem from a low score, downward trend, concerns from stakeholders, recommendations from DOI or a Comptroller’s Audit, or an organizational issue such as high staff	CAS may be implemented due to insufficient response or improvement to identified areas of concern, persistent concerns, or a significant concern that	PCAS may be implemented when the response to CAS is insufficient or is not implemented timely, or if the agency situation is critical enough to

	Standard Monitoring	Accountability Mechanisms	
	Identified Areas of Concern	Corrective Action Status (CAS)	Probationary Corrective Action Status (PCAS)
	turnover. It may also be the result of a single event such as a critical incident, fatality, or alert related to practice issues.	requires an immediately heightened level of monitoring to achieve correction.	immediately enact the consequences described below.
Provider Responsibilities	The provider is responsible for a thorough review of the implicated policies and practice; prompt implementation of strategies to address deficiencies and achieve improvement; submission of a summary of actions taken; and the timely submission of plans, when requested, to address the potential for issues to recur.	In addition to the actions required for identified areas of concern, the provider will participate in more frequent meetings and provide more frequent updates to support oversight.	In addition to the actions required for Corrective Action Status, the provider will involve Board members in monitoring activities.
APA Responsibilities	APA is responsible for prompt notice to the provider of the identified issue; monitoring the frequency of similar issues; monitoring the quality of the agency response; coordinating technical assistance (TA) when appropriate; setting expectations for improvement; assessing improvement and sustainability after set timeframes, usually three months; providing TA in designing improvement strategies if necessary; and informing an agency of the possible consequences of continued deficiencies.	During CAS, in addition to the responsibilities for Identified Areas of Concern, APA staff will meet with the provider more frequently, provide intensified TA and consultation, and conduct more frequent checks on practice and data related to the area of concern.	In addition to the responsibilities for CAS, the AC, DC, and/or CIR meets with agency and Board of Directors.

Timeframes	Improvement in areas of concern is generally expected within three months. Improvement plans are expected to be submitted within two weeks when requested. Reassessment of the area of concern is usually conducted by APA in three months.	In addition to the timeframes expected in identified areas of concern, CAS also requires at least monthly meetings between APA and the provider to monitor progress toward improvement.	Due to the severity of the types of concerns that cause a provider to be placed on PCAS, all timeframes are accelerated. Meetings between ACS and the Board occur immediately and communication with the agency is at least twice per week. Progress is assessed at least monthly.
Consequences	Without improvement, APA will elevate the level of concern by placing the provider on Corrective Action Status.	Any of the following may be the consequences to the provider on CAS: slot reduction, reduced preventive enhancement funds, closure of intake, and exclusion from the allocation of additional slots. CAS is reflected in negative ratings in the Vendex.	The provider faces possible immediate program closure and termination of all contracts. No provider on PCAS will receive slots or enhancement funds. Intake will be closed. PCAS is reflected in negative ratings in the Vendex.

Appendix 6

**DRAFT SAFETY ALERT:
Responding to Heightened Safety Concerns
in Preventive Services Cases**

During the course of our work with families engaged in preventive services, preventive program staff may develop heightened or new safety or risk concerns for the children. In those situations, it is imperative that case planners act swiftly to conduct an assessment and determine a plan of action for those children and the family. Depending on the nature and severity of the concerns, program staff is encouraged to engage Children's Services through one of two means:

1. requesting an ACS-facilitated Elevated Risk Conference
2. calling in a new report to the State Central Register (SCR)

Providers must be alert to the conditions and risk factors in a family that warrant one of those actions.

1. Elevated Risk Conferences

The Elevated Risk Conference model was expressly designed for preventive services providers; it is an important option for bringing concerns about a family to Children's Services for discussion. The attached protocol explains the value and purpose of this forum as a decision-making tool when case circumstances change and there is a new element of risk for the children in the family.¹⁵

If a conference is appropriate, the preventive provider should request an Elevated Risk Conference from the Office of Preventive Family Team Conferencing (OPFTC). OPFTC staff will facilitate this conference. If DCP is involved in the case also, OPFTC staff will invite DCP or advise the provider to do so, depending on the circumstances of the case.

If you have questions about the use of Elevated Risk Conference or need information about how to request one, please contact the OPFTC Manager assigned to your program (see attached roster).

2. New Reports to the State Central Register (SCR)

A new report to the SCR should contain a new or changed set of circumstances or an incident creating a heightened level of risk or safety concern for children in the family. An SCR report will trigger a new investigation, and this could lead to a Child Safety Conference (CSC) held by DCP. *A Child Safety Conference can occur as the result of a DCP investigation.* DCP will utilize this conference when the case is determined to need some level of Family Court intervention, to develop a safety plan that lowers the level of determined risk or safety concern.

Appendix 7

Child Safety Alert

From Commissioner John B. Mattingly

#31 (Revised)
February 24, 2011

Additional Information Received from SCR on Open Cases – Need for Close Attention and Assessment

Please see bullet #3 below which reflects a revision for Safety Alert #31 sent out earlier this month. This alert replaces Safety Alert #16 which has been withdrawn.

At times, a reporter will provide the State Central Register (SCR) with additional information on cases already active in ACS. When this information does not rise to the level of a new abuse or neglect report, it is sent to ACS from the SCR as "Additional Information."

This memo is being updated and reissued to remind staff that the "Additional Information" must be fully assessed to determine the safety and well-being of the children involved.

Given that these are families who may have children already in foster care or who are receiving services from ACS, the "Additional Information" should be assessed by the CPS to determine if any further safety or risk issues are present. If the information refers to the birth of a new child, refer to "Safety Planning for Newborns Whose Siblings Are in Foster Care," issued by Commissioner Mattingly on June 1, 2006. If the case is open in ACS for the provision of foster care or preventive services, but not open with a CPS, the "Additional Information" will be assigned to a separate CPS for assessment. If the case is currently under investigation, the information should be integrated into the ongoing assessment of the family.

The following actions must be taken to assign the "Additional Information" to CPS:

1. The SCR will send the "Additional Information" to the Applications Unit in the borough office. The Applications Unit will conduct clearances to determine where the case is active.
2. If the case is actively being investigated in a Protective Diagnostic Unit, the assessment of the child(ren) will be done by the CPS unit assigned to the case.
- 3. If the case is active in a Family Services Unit, the Applications Unit will assign the case to the Family Services Unit where the case is active. The assessment of the children will be done by the Family Services Unit CPS assigned to the case.**

Except for demographic information that is transmitted from the SCR as "Additional Information" such as address updates or name changes, **all other information received from the SCR as "Additional Information" must be carefully reviewed and assessed by the assigned CPS.** Demographic information received as "Additional Information" should be forwarded by the receiving Applications Unit to the CPS or case management unit in which the case is currently active to add to the case record.

In addition to any other steps necessary to gather information that will help determine whether interventions are necessary to ensure the safety and well being of the children, the following actions must be taken by the CPS to assess the "Additional Information" :

1. CPS must consult with his/her unit supervisor upon receipt of such information to determine if the "Additional Information" is related to the allegations contained in previous investigated reports concerning the family.

2. A contact with the reporter of the "Additional Information," if known, must be made to clarify the basis of the reporter's concern and determine whether the reporter has reason to suspect child abuse or neglect. Following the contact with the source of the report, the CPS must discuss the case with the supervisor to determine whether there is a basis to make a new SCR report. If a new report is called in to and accepted by the SCR, a complete investigation of the allegations must be conducted.
3. If there is insufficient basis to make a report of child abuse or neglect to the SCR, the CPS should continue his/her assessment. At any point during the assessment, if any information is uncovered that leads to suspicion that a child may be abused or neglected, a new report must be made to the SCR.
4. CPS must make contact with the foster care or preventive service provider and the FSU unit to discuss the open case, the additional information received, and any information the workers may have concerning the family.

The CPS must consult with his/her unit supervisor to consider the information gathered and determine if any safety interventions are necessary. All casework activities must be documented in CONNECTIONS in the open stage associated with the "Additional Information." Supervisory review and approval is required during the assessment of "Additional Information" consistent with the same timeframes as a CPS report. The "Additional Information" should only be closed by a supervisor after a complete review and approval of the information gathered and the assessment documented.

Appendix 8

**City of New York
Administration for Children's Services
Division of Child Protection**

SUBJECT:	Use of DCP Notebooks
APPROVED BY:	Jan Flory
DATE:	October 6, 2010
PAGE:	1 of 1 (with attachment)
IMPLEMENTATION RESPONSIBILITY:	Division of Child Protection Staff

PURPOSE:

Since the inception of CONNECTIONS (CNNX), the Administration for Children's Services (ACS) and the Office of Children and Family Services (OCFS) policy has been that all case activities must be documented contemporaneously in CNNX as the official system of record. To assist in maintaining up-to-date and accurate progress notes, ACS staff also take handwritten notes during the course of business. This guidance is issued to ensure that all such handwritten information documented during the course of ACS casework is gathered and recorded in agency issued DCP notebooks for transfer into the official case record.

SCOPE:

This policy applies to all staff in the Division of Child Protection (DCP), including Child Protective Specialists (CPS), Supervisors, and Managers who receive any case information that must be entered into CNNX.

POLICY:

All staff must continue to maintain contemporaneous progress notes in CNNX, which is the official record of case activities.

In addition, handwritten notes taken during the course of phone calls, interviews, visits, and other case activities shall be recorded in DCP Notebooks. Staff are expected to carry DCP Notebooks with them at all times.

The use of DCP Notebooks does not replace the need to contemporaneously record progress notes in CNNX. Existing policy regarding CNNX progress notes remains in effect.

Notes must be recorded in DCP Notebooks as follows:

- Each page of the notebook (front and back) must be dedicated to only one case. Case information on multiple cases must not be recorded on the same page.
- Each page must be clearly marked with the first name and last initial of the case name, and CNNX case number assigned to the case.

When the notebook is full:

- The DCP notebook must be clearly marked with the recorder's first and last names, whether s/he is the worker, the supervisor or the manager; plus the date range for the notes.
- Filled DCP Notebooks shall be given to on-site office managers who will issue new notebooks and arrange for storage of filled DCP Notebooks.

This policy replaces the “Use of DCP Notebooks,” dated 12/19/2008 and is effective immediately.

Martha S.

CNNX: 1234567

1/6/08 @ home visit. MGM Sarah Smith DOB 5/20/1961; child Justin DOB 8/2/04.

MGM: Uses care - pain in R leg. Severe asthma. Says no prior DV in the home. Says BM does not use substances. Does not know where BM's boyfriend went after incident. Says boyfriend's name is Jackson (last name unk). Will move into household to take care of children until BM is released. Does not know when children's last medicals were.

Justin: 3 y.o. medium complexion. Good verbal ability. Does not seem afraid of MGM or MA. Is afraid of Jackson. Misses his mom. Did not see incident.

Per MGM: Justin school = Sunny Day Pre-K program, daily. Director Ms. Simpson 212-987-6543.

1/8/08 @ Bellevue Hospital. Dr. Smith says wounds to John are not fatal. John to be released within 1-2 weeks. Dr. Smith pager: 212.123.4567.

EXAMPLE DCP NOTEBOOK NOTE

Appendix 9

SUBJECT : Timeframes For Connections(CNNX) Entries

APPROVED BY: Jan Flory, Deputy Commissioner, Division of Child Protection



DATE : January 28, 2011

PAGE:1 of 2

IMPLEMENTATION RESPONSIBILITY: Division of Child Protection

PURPOSE:

Specific time frames for recording entries in Connections(CNNX) guide and support good case practice by assuring accurate recall of case actions and

assessments, continuity of work done with the case, and ongoing maintenance of CNNX records.

New York laws * permit business records to be admitted into evidence if, among other things, they were made within a "reasonable time" after an event. For evidentiary purposes, New York Courts have interpreted "reasonable time" as within days of an event. The critical work of Child Protective Staff requires that events are documented within a reasonable time after such events occur.

This policy is intended to provide clear guidelines on the timeframe for entering case related documentation into Connections(CNNX).

SCOPE

This policy applies to all Division of Child Protection Staff required to document case related actions in CNNX, except for ECS staff. ECS staff must record actions taken at the end of each shift of work so that the case can be picked up by the

* New York Civil Practice Law and Rules, Rule 4518

next ECS shift or borough office. . The policy does not replace the requirement for timely recording of 24-48 hour contacts on new investigations or the 24 hour fatality report on child fatality investigations. This policy applies to all open CNNX cases including cases open in the Family Service Stage.

POLICY

When there is an open CNNX case, Division of Child Protection staff are required to document all case related events in CNNX within **5 business days** of such events.

PROTOCOL

CNNX documentation must be specific, detailed and provide a clear understanding of the purpose and outcome of each case related contact or event. When there is direct contact with children or families on open cases, the documentation must provide a detailed description of the children and an assessment of the safety and

risk to the children. Documentation of collateral contacts must be equally detailed and reflect whether the information obtained changes the assessment of safety and risk to the children.

CNNX documentation must not be copied and pasted from prior closed investigations. The guidelines for consolidating cases remain unchanged. However, each report received on the same family must have a documented re-assessment of safety and risk. Information obtained during prior investigations should help inform the current assessment but must not be documented as current information.

The assessment and documentation of follow up visits should be the same quality as that required at the start of an investigation. The **5 business day** documentation requirement must be consistently applied throughout the investigation and the duration of the Family Service Stage.

Supervision

Supervisors and managers are required to provide timely and ongoing guidance to staff and record in CNNX all case related actions including the guidance given as soon as possible, but no later than **5 business days** after such an event.

Supervisors and managers are also required to meet regularly with their staff to monitor and provide the necessary support to assure timely entry of notes in CNNX by all staff involved in a case. Available data including the CNNX report should be used during such supervision.

EFFECTIVE DATE: February 4, 2011