City of New York

OFFICE OF THE COMPTROLLER

Scott M. Stringer
COMPTROLLER

MANAGEMENT AUDIT

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Deputy Comptroller for Audit

Audit Report on the Administration for Children's Services' Controls Over Its Investigation of Child Abuse and Neglect Allegations

MG15-061A

June 15, 2016

http://comptroller.nyc.gov

THE CITY OF NEW YORK
OFFICE OF THE COMPTROLLER
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June 15, 2016

To the Residents of the City of New York:

My office has audited the Administration for Children's Services (ACS) to determine whether it had adequate controls over the process for investigating allegations of child abuse and neglect. We perform audits such as this to increase accountability and to ensure that applicable policies are followed.

The audit found that ACS lacked sufficient controls over its processes for investigating allegations of child abuse and neglect. Although ACS has established formal guidelines that govern its investigations, the audit found limited evidence that supervisors and managers performed required case reviews on a consistent basis. In addition, the audit found that ACS has failed to create an effective mechanism to enable supervisors and managers to monitor whether staff consistently follow the required investigatory steps. ACS case records we reviewed provided limited evidence that directions from supervisors and other key required investigatory steps were performed in a timely manner. The audit also questioned whether ACS has applied sufficient resources to support the investigatory function.

To address these issues, the audit recommends that ACS formulate an efficient internal control system, including uniform policies and procedures that are distributed to its staff in a timely manner; ensure that case workers perform all key steps of an investigation; clearly document when managerial reviews are performed and ensure that Deputy Directors properly track them; and determine whether the agency is appropriately staffed to meet its current case load requirement and if not, seek additional funding from the City's Office of Management and Budget to hire additional case workers.

The results of the audit have been discussed with ACS officials, and their comments have been considered in preparing this report. Their complete written response is attached to this report.

If you have any questions concerning this report, please e-mail my Audit Bureau at audit@comptroller.nyc.gov.

Sincerely,

Scott M. Stringer

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MG15-061A

EXECUTIVE SUMMARY

The Administration for Children's Services (ACS) was created in 1996 to ensure the safety and well-being of children in the City of New York (the City). ACS' Division of Child Protection (DCP) is responsible for protecting children who are abused or neglected and for ensuring that they and their families are provided services specifically tailored to their needs. DCP's Child Protective Services Borough Offices (borough offices) are responsible for investigating reports of alleged child abuse and neglect. The borough offices investigate an average of roughly 60,000 reports of alleged child abuse and neglect each year.

An investigative team consisting of a Child Protective Manager (manager), a Child Protective Specialist Supervisor (supervisor), and a Child Protective Specialist (case worker) conducts the investigation. Deputy Directors of each borough office are responsible for overseeing investigations and are also responsible for ensuring that managers perform their required reviews. The investigative team must conduct a thorough assessment of the safety risk level of every child in the household. All of the details of each investigation must be documented by the case worker and supervisor in a timely manner within progress notes. Supervisors are supposed to regularly review the case workers' progress notes and make comments and suggestions there as needed. At the conclusion of the investigation, if no credible evidence exists, the report is deemed "unfounded." If the investigation reveals that "some credible evidence" of child abuse and neglect exists, the report is deemed "indicated."

The objective of this audit was to determine whether ACS has adequate controls over the process for investigating allegations of child abuse and neglect.

Audit Findings and Conclusions

ACS lacked sufficient controls over its process for investigating allegations of child abuse and neglect. Although ACS has established formal guidelines that govern the process, it has not developed sufficient controls to ensure that those guidelines are followed. We found limited evidence that supervisors and managers performed required case reviews on a consistent basis.

We believe that this is due in large part to management's failure to develop an effective mechanism to gauge compliance with investigatory guidelines. We also question whether ACS has applied sufficient resources to support the investigatory function. These weaknesses hinder ACS' ability to ensure that investigatory steps are conducted in a timely manner.

Insufficient oversight to ensure that ACS staff consistently follow guidelines and directives weakens any controls that may be established and increases the risk that investigatory results may be flawed. Consistent with this concern, our review of 25 sampled cases revealed multiple areas within each case where staff did not adhere to ACS guidelines and these issues were not detected during the course of the investigation.

At the exit conference for this audit, ACS officials stated that some of the investigatory procedures they previously supplied to us during the course of the audit were provided in error because they were outdated and no longer applicable. Consequently, the officials contended that a number of the findings in this report of inadequate controls are not significant or no longer valid. However, the newly provided information does not support their current assertions. To begin with, even if we accept their new claims at face value, the fact that agency officials originally provided inapplicable procedures to us thinking that they were current is itself evidence of a profound lack of controls over the agency's investigatory process. Moreover, ACS officials acknowledged that some of the information recently provided to us was not incorporated into current procedures available to staff. Other information dated from the year 2000 was identified as applicable to ACS staff responsible for working with families with histories of indicated cases receiving services from Protective, Preventive and Foster Care Providers, which is not the subject of this audit. Accordingly, it appears that rather than seeking to strengthen its policies and procedures and to better help the vulnerable children in its charge, ACS has resorted to trying to discredit our findings with irrelevant and possibly outdated procedures. This action raises significant concerns about the ability of ACS management to correct the weaknesses identified in this report.

Audit Recommendations

To address the issues raised by this audit, we make the following seven recommendations:

- ACS should formulate an efficient internal control system, including uniform policies and procedures that are distributed to its staff in a timely manner.
- ACS should ensure that managers and supervisors perform timely reviews during all stages of the investigation, as well as ensure that case workers perform all key steps of an investigation.
- ACS should develop a system that allows the recording of managerial reviews in a manner that can be clearly documented in terms of when they were performed.
- ACS should ensure that Deputy Directors properly track managerial random reviews so that they can be certain that all random reviews were performed and in the required time period.
- ACS should conduct a study to determine the adequacy of its current case load requirement to determine if it is appropriately staffed to perform thorough investigations. Depending on the study's findings, ACS should use this study as justification for seeking additional funding from the City's Office of Management and Budget to hire additional case workers.

- ACS should ensure its staff complies with all aspects of an investigation, including following supervisory directives, complying with guidelines and maintaining notebooks during the course of an investigation.
- ACS should ensure that case workers update progress notes in a timely manner and that this aspect is carefully monitored by the supervisors.

Agency Response

In their response, ACS officials agreed with six of the seven audit recommendations, stating that they have already taken action to begin implementing them. In addition, they stated they would take the remaining recommendation under consideration.

AUDIT REPORT

Background

ACS was created in 1996 to ensure the safety and well-being of children in the City. DCP is responsible for protecting children who are abused or neglected and for ensuring that they and their families are provided services specifically tailored to their needs.

The New York State (State) Office of Children and Family Services (OCFS) oversees ACS and operates the Statewide Central Register of Child Abuse and Maltreatment (SCR). SCR operates 24 hours a day, seven days a week and has a hotline to receive complaints of possible abuse and neglect from the public, mandatory reporters,[1] and OCFS, which refers all allegations of child abuse and neglect to the SCR hotline. OCFS enters all reports of alleged child abuse and neglect into CONNECTIONS (CNNX), a computer system developed and maintained by the State that contains information about families and children receiving child welfare services in the State and mandates that local social services districts, including the City, use CNNX.

DCP's Child Protective Services Borough Offices (borough offices) are responsible for investigating reports of alleged child abuse and neglect. The borough offices investigate an average of roughly 60,000 reports of alleged child abuse and neglect each year. ACS has 17 borough offices throughout the City: six in Brooklyn; three each in Queens and the Bronx; four in Manhattan; and one in Staten Island. Allegations are forwarded to the appropriate ACS borough office via CNNX; each borough office investigates those allegations of child abuse and neglect reported for families in its area. The state mandates that an investigation must be initiated within 24 hours of the receipt of a report and concluded (with a final determination on the allegation) within 60 days of receipt of the report.

An investigative team consisting of a manager, a supervisor, and a Child Protective Specialist case worker conducts the investigation.[2] On average, each manager oversees three supervisors and each supervisor oversees five case workers. Once the case is assigned to the borough office for investigation, the supervisor reviews the allegation, along with any prior intake reports and investigations pertaining to the family (if applicable), and schedules a pre-investigation conference with the case worker to review the case details and develop a preliminary investigation plan.[3] Deputy Directors of each borough office are responsible for overseeing investigations and are also responsible for ensuring that managers perform their required reviews.

Investigative steps that the case workers and supervisors are supposed to take and timeframes for their performance are detailed in State law and various ACS and OCFS directives, including

[1] Mandatory reporters are professionals who under the New York State law, are required to report suspected child abuse or maltreatment when they are presented with reasonable cause. Mandatory reporters include doctors, social workers, emergency room staff, police officers, school officials, day care workers and a host of others who are likely to come into contact with children and particularly children in crisis. http://ocfs.ny.gov/main/publications/pub1159.pdf

[2] In addition, an ACS Investigative Consultant is required to conduct a background check of all family members for arrests, warrants, and any other criminal history. The Investigative Consultants are also available to offer guidance and assistance to the case workers during the investigation.

[3] The staff of the agency's Applications Unit retrieves intake reports from CNNX, provides clearances, and assigns the case to the investigative units in the appropriate borough office.

the Child Protective Services *Casework Practice Requirements Manual*. Key steps are described in Table I below:

Table I

Key Steps in the Process for Investigating
Allegations of Child Abuse and Neglect

Step	Description	Time Frame
Contact the source of the allegation	Verify the information contained in the allegation.	Within 24 hour receipt of allegation
Pre-investigative conference	Conference between supervisor and case worker to review allegation and form a plan of action.	Prior to the initial home visit
Initial face- to-face meeting	Initial visit to assess the safety of the child or children.	Within 24 Hours of receipt of high priority case and within 48 hours for all other cases
Face to face contact with the child or children	Intended to ensure the safety of the child throughout the investigation	On a bi-weekly basis or twice per month
Follow key investigate steps, such as: (a) review prior allegations, (b) interview all parties separately, (c) interview collateral sources and school officials.	Evidence collection guidelines are set forth by ACS for case workers to use when conducting an investigation.	Early on during the course of an investigation
Two Safety Assessments	Intended to support the child welfare goal of safety, permanency and well-being for children and their families.	Initial report - by the 7th day of the investigation. Second report - by the 55th day or within seven days of closing the investigation
Risk Assessment Profile (RAP)	Designed to assist in making informed decisions regarding whether additional services, such as anger management and drug treatment programs, are needed based on the level of risk.	By the 40th day of the investigation.
Domestic Violence Screening Tool	To assess for possible domestic violence. If there are signs, an additional protocol must be completed.	In all cases. If signs of domestic violence is evident after first visit then a protocol is to be completed by the end of the investigation.
CPS' Compliance with Supervisory Directives	Instructions and guidelines offered by the supervisor	Throughout the entire course of the investigation
Concluding an Investigation	Forming a determination of indicated or unfounded	By the 60th day of the investigation

The investigative team must conduct a thorough assessment of the safety risk level of every child in the household. All of the details of each investigation must be documented by the case worker and supervisor in a timely manner within the progress notes section of CNNX. Supervisors are supposed to regularly review the case workers' progress notes in CNNX and make comments and suggestions there as needed.

Throughout the investigation, supervisors issue directives (supervisory directives) regarding certain steps that the case worker should follow during the investigation.[4] If no credible evidence exists, the report is deemed "unfounded." If the investigation reveals that "some credible evidence" of child abuse and neglect exists, the report is deemed "indicated." A determination of

[4] ACS considers the directives to be instructions and guidelines for the case worker to follow during the investigation.

"indicated," however, does not automatically require that a child or children be removed from the home; only those children who cannot remain safely at home are placed in foster care. Many families receive preventive services through ACS that enable children to remain safely in the home while their parents or caregivers obtain additional support.

Objective

To determine whether ACS has adequate controls over the process for investigating allegations of child abuse and neglect.

Scope and Methodology Statement

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. This audit was conducted in accordance with the audit responsibilities of the City Comptroller as set forth in Chapter 5, §93, of the New York City Charter.

The scope of this audit was July 1, 2013, through May 31, 2015. The audit looked only at cases that had been investigated by DCP and resulted in an "indicated" determination.[5] The audit did not test any aspects of ACS-provided preventive or foster care services subsequent to those investigations, nor did the audit examine the investigative process for cases deemed to be "unfounded." Please refer to the Detailed Scope and Methodology at the end of this report for the specific procedures and tests that were conducted.

Discussion of Audit Results with ACS

The matters covered in this report were discussed with ACS officials during and at the conclusion of this audit. A preliminary draft report was sent to ACS and discussed at an exit conference held on May 17, 2016. We submitted a draft report to ACS on May 27, 2016, with a request for comments. We received a written response from ACS on June 13, 2016. In their response, ACS officials agreed with six of the seven audit recommendations, stating that they have already taken action to begin implementing them, and stated that they would take the seventh recommendation under consideration. Throughout its response, ACS cites a number of procedural changes and reforms that it has developed to address the deficiencies we identify in this audit. We commend ACS for taking our audit findings seriously and recognizing the need for an overhaul in its investigation process. However, ACS' response also includes a number of assertions that must be addressed.

In connection with the audit's methodology, ACS suggests that our audit findings are based only on an examination of a very small sample of case records. This is incorrect. As we explained to ACS officials at the exit conference for this audit, our findings are based on reviews of ACS' internal control structure for the areas pertaining to our audit and through those reviews, we identified deficiencies and weaknesses, acknowledged by ACS staff and officials during the course of our audit. Subsequent to our review of the agency's internal controls, we conducted an

[5] Based on State confidentiality law embodied in a confidentiality agreement with the State, we were not permitted to have access to cases that were determined to be unfounded.

in depth review of 25 case records to determine if any of the control deficiencies pertaining to ACS' overall investigative process were evident in these cases and to examine what the impact might be if they did.

In addition, ACS misinterprets our use of the term "corrective actions," believing that we are referring to disciplinary actions taken against ACS personnel. Rather, our use of the term refers to actions taken by ACS with regard to the investigations themselves to ensure that required investigatory steps are executed.

Regarding the audit's findings, ACS argues that the findings relating to three of the cases analyzed in our audit were incorrect due to certain limitations and misinterpretations. However, one of the cases cited by ACS (in which the alleged abuser died) was not mentioned in the draft report submitted to ACS for comment. Rather, it was preliminarily discussed with ACS officials and, based on information we received from them, was not included in the draft report. We urge ACS to carefully review our final audit report, which reflects consideration of all of the information the agency has provided us.

In one of the remaining two cases (in which we cite a case worker for failing to follow up with a pediatrician treating a child with asthma), ACS argues that the contact was noted in the redacted medical records to which we had limited access. However, this assertion is inconsistent with statements made by the case supervisor, who acknowledged that contact with the child's pediatrician was not made. Furthermore, ACS' policies require case workers to note all interviews with collateral sources (e.g., physicians) in CNNX and so any contact made with a physician should have been noted there as well as in medical records.

In the remaining case (involving an allegation of domestic violence), ACS argues that no Domestic Violence (DV) screening was required because the alleged perpetrator was arrested and referrals for counseling had been made. However, ACS' policy specifically requires a DV screening to be conducted for all allegations, without exception. This policy makes sense because, absent a DV screening, ACS cannot demonstrate that it appropriately assessed the situation and determined that (1) there are no remaining signs of domestic violence, and (2) it identified all of the service needs of the family.

After carefully reviewing ACS' arguments, we find no basis to change any of the findings of this report.

Finally, we note that most of the procedural changes cited by ACS in its response were not in effect during the scope of our audit, with many of them still in the developmental stage. Consequently, we cannot assess the degree to which these efforts adequately address the issues discussed in this report.

The full text of the ACS response is included as an addendum to this report.

FINDINGS AND RECOMMENDATIONS

ACS lacked sufficient controls over its process for investigating allegations of child abuse and neglect. Although ACS has established formal guidelines that govern the process, it has not developed adequate controls to ensure that those guidelines are followed. We found limited evidence that supervisors and managers performed required case reviews on a consistent basis. We believe that this is due in large part to management's failure to develop an effective mechanism to gauge compliance with investigatory guidelines. We also question whether ACS has applied sufficient resources to support the investigatory function. These weaknesses hinder ACS' ability to ensure that investigatory steps are conducted in a timely manner.

Our review of 25 cases did find that initial home visits, 7-day and closing safety assessments and supervisory conferences were all conducted on time, and cases were mostly concluded within the required 60-day timeframe. In addition, for the most part, prior allegations were reviewed and collateral sources were interviewed. However, these positive actions are mitigated by the deficiencies discussed throughout the report. Specifically, we found significant failures to follow guidelines for each of the cases reviewed. Furthermore, we found no evidence that supervisors reminded the case workers to take specific actions required by the guidelines, thereby leaving unresolved the question of whether key investigative steps required by the guidelines had been taken. (Appendix I contains a breakdown of the issues found in all 25 cases).

Insufficient oversight to ensure that ACS staff consistently follow guidelines and directives weakens any controls that may be established and increases the risk that investigatory results may be flawed. Consistent with this concern, our review of 25 sampled cases revealed multiple areas within each case where staff did not adhere to ACS guidelines and these issues were not identified by supervisors during the course of the investigation. While not intended to be a statistically significant sample, we reviewed these randomly selected cases to assess the degree to which ACS's procedures, designed to ensure effective investigations and oversight, were implemented in a small sample of cases deemed "indicated." (That is, where the investigations resulted in determinations that there was evidence of abuse or neglect.)

At the exit conference for this audit, ACS officials stated that some of the investigatory procedures they supplied to us during the course of the audit were provided in error because they were outdated or no longer applicable. Consequently, according to officials, the significance of a number of the findings in this report are minimized or no longer valid. However, documentation subsequently provided by ACS officials does not support their contention. Rather, as discussed in more detail below, it appears that in an attempt to discredit our findings, ACS has resorted to citing irrelevant and possibly outdated procedures as its current guidelines. The details of our findings are discussed in the following sections of this report.

Lack of Consistent Representations from ACS Management Of Applicable Policies and Procedures

At the exit conference for this audit, ACS officials stated that some of the investigatory procedures they supplied to us during the preceding year while we were conducting the audit had been provided in error and that they were no longer applicable. As a result, officials argued, a number of the findings in this report are not significant or no longer valid. However, the documents the ACS officials provided subsequent to the exit conference do not support their contention that ACS procedures have been changed.

As described in detail in the Scope and Methodology section of this report, during the course of this audit, we had numerous meetings with ACS officials pertaining to its investigation process, conducted staff interviews, and were in frequent email communication with the agency in order to learn specific aspects of ACS' policies and procedures and how they were implemented. Our interviews included staff and managers in a wide variety of positions, including case workers and supervisors responsible for the day-to-day investigations. We conducted our audit tests using the criteria and documentation provided by ACS itself. To ensure that our understanding of required procedures was correct, we asked in writing that ACS officials confirm our understanding of those procedures, and provided officials the opportunity to correct any statements related to their process that they viewed to be factually inaccurate. Near the conclusion of our audit fieldwork, prior to the issuance of a preliminary draft report, we met with ACS management and verbally presented our findings. At no time up to that point did ACS indicate the procedures we were provided were invalid.

Nonetheless, for the first time at the May 17, 2016, exit conference, ACS officials asserted that they had mistakenly provided us with procedures that had not actually been in effect during our scope period. ACS officials claim that some of the procedures were modifications to prior procedures. However, we found no practical evidence to support this new assertion as we describe below in the relevant sections of this report. The fact that these supposedly controlling policies and procedures were brought to our attention more than a year and a half after we commenced this audit raises serious questions about ACS's management. At best, these late-produced rules illustrate that ACS is so disorganized that its senior officials and line staff are not in agreement with regard to the policies and procedures governing various aspects of its operations, which would in part explain the deficiencies we found in this audit. However, the last minute production of supposedly controlling rules could also reflect a breach of the good faith and cooperation that are essential to the audit process. Under present circumstances, we fear that the weaknesses we found will persist unless management changes its operating philosophy and refocuses away from trying to build defenses for its actions to addressing agency weaknesses.

Control Weaknesses

Supervisory Case Reviews Not Conducted on a Consistent Basis

Supervisor Case Reviews

We found that supervisors did not conduct the required supervisory case reviews on a consistent basis. Even when the reviews took place, supervisors failed to consistently note when certain key investigation steps were not performed. In the cases where required steps were not completed, supervisors rarely reminded the case workers that such steps were necessary or ensured that corrective actions took place.

Our review of 25 randomly selected cases found that supervisors in those 25 cases had to perform a total of 75 case reviews. However, 20 of the reviews (associated with 14 cases) were not performed in a timely manner. Of these, we found no evidence that eight supervisor reviews associated with six cases were done at all.[6]

[6] 12 cases had at least one late review, 4 cases had at least one missing review and 2 cases had a combination of missing and late reviews, as indicated in the Appendix.

According to DCP's *Casework Practice Requirements Manual*, supervisors must review all cases by days 5, 25, and 50 of an investigation to determine whether the required steps were taken. These reviews are described in more detailed in the chart below:

Type of Supervisory Case Review	General purpose
5-Day	To determine whether the required face-to-face contact was made with the children in the household and whether the children's initial safety assessments were submitted for approval.
25-Day	To determine whether, among other things, interviews of all family members and collateral sources were conducted, children's needs were assessed, and any dangerous conditions addressed.
50-Day	To determine whether there are any additional activities that need to be completed to support the determination of the allegations prior to closing the investigation.

We selected for review a random sample of 25 cases of reports of alleged child abuse and neglect that ACS received during the period of July 1, 2013, through May 2015. Based on our review of the case records recorded in CNNX, we found that only 47 of the 75 required supervisor reviews took place within the required timeframes. Of the 28 reviews that were not conducted within the required timeframes, 20 were conducted late and 8 were not conducted at all. The case breakdown is as follows: for 12 cases, one or more of the reviews were late—one 29 days late—for four cases, one or more of the required reviews did not take place at all and two cases had a combination of late reviews, as well as reviews that did not take place at all.

High Priority Cases

We found that the majority (67 percent) of manager reviews of high priority cases were not conducted or were not conducted within the time frames mandated by ACS in its guidelines. The timeliness requirement is particularly significant in child protective cases where the case workers are working under a mandate to take all necessary steps to conclude an investigation within 60 days and so they need immediate timely feedback from their supervisors and managers. While applicable to all of ACS's child protective investigations, it is all the more the critical in those cases designate high priority.

As noted above, cases that involve fatalities or families with a history of four or more prior cases are considered high priority by ACS.[7] Cases involving a fatality are coded as High Priority 1 and cases with a prior history of four or more cases are coded as High Priority 13. The *Casework Practice Requirements Manual* requires managers to review all High Priority 1 and 13 cases on days 5, 30 and 55 of the investigation. The milestone reviews are intended to ensure that both the case worker and supervisor assigned to the investigation proceed in accordance with ACS guidelines. Our sample of 25 cases included 12 cases that were coded as High Priority 13.[8] Based on the guidelines provided by ACS at the time of our review, these cases should have received a total of 36 manager case reviews. Our review of CNNX found that only 12 (33 percent)

[7] The four or more prior cases can be either indicated or unfounded cases or a combination of both.

[8] Our randomly selected sample did not include any High Priority 1 cases.

of those reviews were conducted in a timely manner. Eleven of the 12 cases had at least one review that either did not take place or took place late. For two of these 11 cases, there was no evidence that any manager reviews were ever conducted.

ACS officials at the exit conference claimed that the policy had been changed to only require managerial reviews on days 7 and 55 of the investigation and that no reviews on the 30th day were required. They acknowledged that this policy had not yet been included in the *Casework Practice Requirements Manual*, which is supposed to contain authoritative guidance on case work requirements for staff and managers. In fact, five of the 12 managers with High Priority 13 cases did conduct the 30-day reviews, in accordance with the agency's formal guidelines. When we asked for documentation that this requirement had been disseminated to ACS staff, ACS officials at the exit conference provided us with a memo dated 2006, entitled Managerial High Priority Reviews. However, this memo predates the more current 2013 requirements included in the *Casework Practice Requirements Manual* that had previously been provided. Thus, we found no basis upon which credit the May 17th claim that the standards had been changed and communicated to the staff and managers.

The failure to conduct timely manager reviews significantly undermines ACS' efforts to ensure that complete and thorough investigations are conducted, including the ability of the Deputy Directors at each borough office to carry out their responsibilities and ensure that managers are performing their required reviews. Timely managerial reviews provide an important control, letting managers assess investigations' progress and the ability offer guidance and directives to supervisors and case workers at key points in an investigation. In addition, since only high priority investigations require managers to give their final approval prior to closing the investigation, these managerial reviews take on added importance. Accordingly, failure to perform all of the required reviews increases the risk that some investigations may not be handled in accordance with established guidelines, and that such occurrences may go undetected.

Other Manager Case Reviews

In addition to high priority case reviews, managers must perform weekly random case reviews. However, currently, ACS is not able to ensure that such reviews are being conducted. Failure to conduct the required manager case reviews increases the risk that in instances where required investigatory steps have not been followed, corrective action may not be taken timely or at all, which could compromise the quality of the investigation.

According to ACS' Managerial Random Review Policy, managers must perform random reviews of three cases per week. These reviews intended to ensure that managers assess the supervisors' oversight of investigative team case work. Each Monday, managers must access the agency's Automated Case Reference System (ACRS) to retrieve three cases randomly selected by ACRS for review. For one random week of the month, ACRS does not select any cases for review; instead, managers select three cases on their own for review purposes. This review policy requires that the three cases chosen must be completed by the Friday of the same week and that a report be completed at the end of the review. The Deputy Director of each office must verify and review the cases that have received a managerial review. The reviews are integral to ensuring that cases are investigated properly. Managers use the random review reports as a basis of their discussion with supervisors to identify areas that need improvement.

We randomly selected 15 managers and attempted to determine whether they conducted required managerial reviews from April 5, 2015, through May 24, 2015. However, ACS could not provide us with the cases reviewed. Although ACS procedures state that managers are to save the

reviews on the agency's internal computer system (the S drive), this requirement is not enforced. Our review of the agency's computer system revealed that managers inconsistently saved the reviews performed. Furthermore, managers did not indicate the dates they conducted reviews for those they saved. In the absence of evidence documenting these reviews, we have limited assurance that managers are performing them and that the Deputy Directors have ensured that they take place.

After we raised these deficiencies regarding the manager case reviews with ACS management, they stated that the agency was in the process of working on a solution to address this issue, although they were unable to provide an estimated time for completion. In the meantime, officials said that Deputy Directors have been instructed to create individual files to track each of their managers' completion of reviews.

ACS Does Not Have an Effective Mechanism to Monitor Compliance with Investigatory Procedures

We found that ACS has failed to create an effective mechanism to enable supervisors and managers to monitor whether staff consistently follows the required investigatory steps. The lack of an effective tracking mechanism significantly hinders ACS' ability to ensure that: (1) there is sufficient monitoring and oversight of the investigation; and (2) all of its policies and procedures are carried out in the course of an investigation. This failure increases the risk that investigative results may be based on incomplete, insufficient information or that cases may improperly be deemed unfounded, leaving children in potentially dangerous situations.

As noted above, ACS has developed formal guidelines that govern their process for investigating allegations of child abuse and neglect. These guidelines are designed to ensure that thorough investigations are conducted in a manner that best addresses the children's needs and safety concerns. To accomplish this objective, staff must follow these guidelines on a consistent basis.

Among other things, the guidelines mandate that all of the details of an investigation, including the supervisor's directives, be entered into a repository of notes within CNNX, known as progress notes. In order to ascertain whether the case worker adhered to the supervisory directives, performed the required number of home visits, and took any other required action, supervisors must read through each individual progress note, which is a narrative written by the case workers in which the case worker chooses what information to include. ACS employees told us that the supervisory review process is time-consuming and cumbersome. They noted that there is no tracking mechanism within CNNX that would allow the supervisor to determine whether key investigative steps had been carried out or whether they had been done in a timely manner, nor has ACS developed a system for its supervisors and managers to use outside of CNNX.

The lack of an effective tracking mechanism is further exacerbated by the fact that during our scope period, case workers were assigned 10 to 12 investigations at any given time, which translated to 50 to 60 cases per supervisor. When we interviewed supervisors, they stated that it was not reasonable to expect them to be able to review all case details within the progress notes, given their caseload. Supervisors stated that is why, to a great extent, they rely on face-to-face interactions with case workers to discuss case details. The lack of an effective tracking system increases the risk that important steps may not be followed, and that such omission may go undetected.

After we raised these deficiencies regarding the supervisor and manager case reviews with ACS management, they stated that the agency was in the process of working on a solution to address

this issue, with the intention that the new system will be operational between September and December 2016. However, until that time, ACS cannot be assured that all required steps of an investigation are complied with. According to ACS officials, this weakness is mitigated by the fact that supervisors are in daily contact with case workers, with the expectation that the case workers will address any issues noted during their investigation. However, this informal method does not ensure that all required steps are followed. This control weakness is evidenced by our in-depth review of the progress notes and available supporting documentation for a sample of 25 cases in which we found that a significant number of required steps were not completed timely, if at all, and that there is no record that the persons overseeing the case workers reminded them to complete the required steps if the investigation. This issue is discussed in more detail below.

Staffing Resources May Be Insufficient

ACS employees repeatedly raised concerns that staffing resources are inadequate during our audit. A review of the scope of work required of ACS case workers and the magnitude of their responsibilities suggests a basis for such concerns.

While investigating an allegation, the case worker carries the primary responsibility for whatever actions are deemed necessary for ensuring the safety of the children. Thus, case workers' responsibilities include the following:

- conducting safety assessments in response to allegations and meeting with families within 24 to 48 hours;
- contacting the source of the allegation;
- interviewing the alleged subject, the alleged victim, parents/caregivers, other household members, and collateral contacts (e.g., school staff, health care providers, police officers, etc.);
- making safety assessments within seven days and then again within seven days of closing the investigation;
- conducting home visits with the children; and
- participating in family meetings or conferences with the family or other support systems.

Furthermore, for cases deemed "indicated" where the family has ongoing service needs, case workers must assess the risk to children of future abuse or maltreatment. In instances where the case workers determine that additional services are required for the duration of the investigation, the case workers are responsible for arranging the services and for working with the family to address the possible risks to the child. When required, case workers also work with ACS legal staff to file petitions with Family Court for supervisory oversight of the family or for the children's removal. They also work collaboratively with contract agencies to provide preventive or foster care when appropriate and they enter and maintain computerized records of case information.

We discussed staffing resources with supervisors and ACS upper management. Supervisors we spoke with expressed concern about the workloads maintained by each case worker. We were told that case workers would be better equipped to perform detailed and thorough investigations if they had fewer cases assigned and that five to six cases per case worker would be ideal. This lower case worker case load would also translate to approximately 25 to 30 cases per supervisor. Currently case workers handle 10 to 12 cases and supervisors handle 50 to 60 cases.

ACS upper management stated that the current caseload is adequate and provides case workers with the ability to perform a thorough investigation and allows supervisors to engage in adequate oversight.[9] However, ACS had no evidence that it has calculated the approximate amount of time needed to satisfactorily conduct an investigation and other supplementary steps and compared that time to the sufficiency of its staff levels in regards to its current caseload. For example, ACS management was unable to provide us with any benchmarks regarding the amount of time that a case worker is expected to spend on areas such as initial home visits, bi-weekly contact with children, entering progress notes into CNNX and other tasks, stating that "ACS does not have a formula relating to these tasks/time spent on tasks." In the absence of such an analysis, neither we nor ACS can be assured that current staffing levels are sufficient to perform thorough investigations of the roughly 60,000 allegations it receives annually.

Recommendations

1. ACS should formulate an efficient internal control system, including uniform policies and procedures that are distributed to its staff in a timely manner.

   ACS Response: ***"***DCP has a policy for disseminating new policies and procedures, which was developed and distributed to DCP staff in April 2013. The current practice for policy distribution is as follows: all draft DCP policies are distributed to the division's executive team at least two weeks before they are finalized in order for senior leadership to review and give feedback that informs the final policy. Once finalized, the policy is shared electronically with all DCP staff. . . .

   …DCP is working with the ACS Division of Policy, Planning and Measurement (DPPM) to strengthen oversight of and improve access to policies and procedures. This includes a comprehensive review and cataloguing of DCP's current and historical policies and procedures which is currently underway."

   Auditor Comment: While ACS states that its practice for disseminating policies and procedures to staff was developed in 2013, as noted earlier in this report, officials at the exit conference acknowledged that the agency had significant deficiencies in this area. Therefore, we are pleased that ACS is working to improve staff's access to policies and procedures.

2. ACS should ensure that managers and supervisors perform timely reviews during all stages of the investigation, as well as ensure that case workers perform all key steps of an investigation.

   ACS Response: "DCP has a supervisory/managerial structure which is intended to ensure timely reviews are completed at all key steps of an investigation. Each unit within DCP has a Supervisor Level II (CPSSII) who reports to a Child Protective Manager (CPM), who in turn reports to a Deputy Director (DD). Child Protective Managers are required to ensure that the Supervisor II complete all required reviews. There are controls in place which allow the CPM's to ensure such compliance. Reports in both Connection (CNNX) and ACRS track and control compliance with the supervisor's review of the 5 Day/25 Day/50 Day

[9] However, as discussed below in connection with our finding that case workers did not routinely maintain notebooks, ACS management stated that due to a shortage of staff, ACS is unable to send out two case workers to conduct the interviews.

investigatory milestones. Deputy Directors are required to review that the CPMs have performed reviews and compliance is controlled during their one-on-one supervision. . . .

Looking ahead, ACS will institute a 'dashboard' that will draw from and complement Connections (CNNX). The dashboard will support Risk Management, flagging key issues and identifying triggers on a micro and macro level to help supervisors and managers better identify cases that require their close attention and supervisory reviews."

Auditor Comment: ACS officials do not indicate when the capability to produce reports that allow for tracking compliance with required investigatory steps was developed. However, these reports were not in effect as of the conclusion of our audit fieldwork. While we are pleased that ACS plans to institute a new system to allow for better oversight, it should ensure that its "dashboard" incorporates a mechanism for the tracking of supervisory and managerial reviews as well.

3. ACS should develop a system that allows for the recording of managerial reviews in a manner that can be clearly documented in terms of when they were performed.

   ACS Response: "DCP is working on short-term and long-term initiatives to strengthen the Random Review (RR) process and archiving. First, as discussed with auditors during the audit, DCP has recently clarified instructions for saving Random Reviews in an online folder. Second, ACS is reviewing the RR process whereby cases are selected, and also modifying the instrument that is completed during the Random Review in order to reflect the milestone dates of "pulled for review", "review date" and "e-save date." Finally, ACS is upgrading IT systems to improve tracking of case assignments and controls over managerial reviews. A new automated Case Assignment System (CAS) under development will replace the older, outdated ACRS system."

4. ACS should ensure that Deputy Directors properly track managerial random reviews so that they can be certain that all random reviews were performed and in the required time period.

   ACS Response: "As noted above, DCP has clarified instructions for documenting and saving the RR in an online folder and work is currently underway on a new automated system that will support tracking and managerial controls. Deputy Directors are required to review that the CPMs have performed reviews and compliance is controlled during their one-on-one supervision."

5. ACS should conduct a study to determine the adequacy of its current case load requirement to determine if it is appropriately staffed to perform thorough investigations. Depending on the study's findings, ACS should use this study as justification for seeking additional funding from the City's Office of Management and Budget to hire additional case workers.

   ACS Response: "We will take this recommendation into consideration. As outlined above, ACS already has one of the lowest child protective caseload in

the United States, and been approved to hire additional staff in the Division of Child Protection which will greatly strengthen the current workforce."

Auditor Comment: Without knowing whether the responsibilities of ACS case workers are comparable to those of case workers throughout the country, it is not possible to evaluate the significance of ACS' claim that it has the lowest child protective caseload in the United States. Furthermore, such a comparison does not address the key issue of whether the resources allocated by ACS are appropriate given the tasks required of ACS case workers. Consequently, we urge ACS to implement our recommendation.

Investigations for Sampled Cases Were Not Consistently Performed in Accordance with Established Guidelines

We found limited evidence that supervisory directives and other key required investigatory steps were performed in a timely manner. Further, we found limited evidence that supervisors and managers identified and addressed such failures.

Our review of the progress notes and other available supporting documentation for the 25 cases we sampled indicate that each case had one or more deficiency in case worker, supervisor and/or manager compliance with supervisory directives or the completion of other required investigatory steps. These deficiencies are discussed below.

Supervisory Directives

We found overall that the progress notes contained no evidence that any supervisors noted any case workers' failure to comply with any of the 130 directives mentioned below. According to the supervisors we met with concerning these cases, they all agreed that ACS needed a better system for tracking compliance with the directives, expressing concern that the current system, which requires that supervisors read through a case's many progress notes to assess compliance, did leave room for negligence and errors.[10] However, according to ACS guidelines, "Supervisory directives serve as a framework for the investigation; supervisory directives are instructions and guidelines which reflect/outline/document core case issues, case decisions and case actions." The supervisors we interviewed stated that they considered the supervisory directives an integral tool to ensure that case workers conduct thorough and conclusive investigations.

For the period reviewed (July 2013 through May 2015), we looked at the status of the 354 supervisory directives issued in 10 of the sampled cases. Our review of the progress notes revealed that case workers failed to comply with 130 (37 percent) of the supervisory directives. The breakdown by case is shown in Table II below.

[10] One of the six supervisors had been in charge of two cases. Two supervisors had refused to meet with us and one supervisor was no longer with ACS by the time of our review.

Table II

Percentage of Non-Compliance with
Supervisory Directives

	Case #1	Case #2	Case #3	Case #4	Case #5	Case #6	Case #7	Case #8	Case #9	Case #10	Total
# of Directives issued	47	45	40	47	53	16	28	5	31	42	354
# of Directives Not in Compliance	20	9	13	21	19	6	10	3	10	19	130
% of Directives Not in Compliance	43%	20%	33%	45%	36%	38%	36%	60%	32%	45%	37%

* **These cases correlate to case numbers 2-11 in the Appendix of the report**

In one case (#8) concerning an allegation that the father was physically abusing the mother in front of their three children (ages 8, 10 and 16), the case worker received a directive to ask the children how they felt about not residing with their father. The case worker also received another directive, to interview all the adults residing in the household, as required by ACS policy. Though the case progress notes reported that the children were in emotional distress, there was no evidence that the case worker noted in the progress notes that he/she followed either directive. Further, we found no supervisory note reminding the case worker to comply with the directives; the lack of such compliance may increase the risks to the children. The deficiencies also raise the concern that the supervisors are not adequately ensuring that their directives are being followed and that the case workers' actions are properly documented as required.

In another case (#2) that involved an allegation of educational neglect, the mother stated that the child's asthma had caused the child's absence from school. The supervisor issued a directive for the case worker to verify the severity of the child's asthma with the child's pediatrician. We found no evidence in the progress notes that the case worker complied with the directive and no evidence of the supervisor's follow-up.

Bi-weekly Face-to-Face Contact

According to the process outlined in ACS' Child Protection Case Flow,[11] during the investigative stage, case workers must have "[b]i-weekly face to face contact with the maltreated children." This process was confirmed to us when we met with supervisors and case workers. However, in all of the cases we sampled where bi-weekly face-to-face contact was required, (24 of the 25 we sampled),[12] only once did the case worker perform the face-to-face bi-weekly contact with the child/children in a timely manner.[13] The progress notes for only three cases had explanations as

[11] The Child Protection Case Flow is an internal document created by ACS to outline the process and required steps to be conducted during an investigation.

[12] In one of our 25 sampled cases, the child was removed from the home; therefore, visits were not required.

[13] In reviewing the bi-weekly contact, we gave the case workers credit in instances where they noted that an attempt was made but was unsuccessful due to other circumstances beyond the case workers' control, such as a child was not home or family refused a case worker's request to visit, etc.

to why the contacts did not occur bi-weekly. For one case lacking an explanation for the delay, the case worker had no contact with the children for 31 days. The progress notes contained no evidence that supervisors reminded the case workers to conduct the bi-weekly face-to-face contact in a timely manner in 11 (48 percent) of the 23 cases.

ACS officials informed us that face-to-face contact allows the case worker to gauge and oversee the child's safety and well-being during the investigation and to assess the child's ongoing needs. They stressed the importance of this type of contact on a bi-weekly basis, specifically to ensure the children's safety. Our audit findings reinforced the ACS officials' statements that bi-weekly contact with the child plays a key role in the investigation process and in ensuring the child's safety. For example, in one case, the father allegedly had been intoxicated, grabbed his 15-year-old daughter by the hair and slapped her across the face. He allegedly also threw the mother to the floor, slapping and choking her, causing both daughter and mother to sustain various injuries. However, 26 and 28 days passed between a case worker's visits (12 and 14 days late, respectively) to inquire about the child's well-being. We did not see any explanations in the progress notes for the late visits, nor did we see reminders from supervisor to conduct the visits.

In our May 17th exit conference, ACS officials stated that the requirement for face-to-face visits was bi-monthly (i.e., twice a month) and not bi-weekly, once every two weeks. However, the documentation they provided to support this contention was a memo dated April 7, 2000, entitled "Family Casework Contact Requirements and Safety Assessments for Families with Histories of CPS Indicated Cases Receiving Services from Protective, Preventive and Foster Care Providers." However, this memo by its title is applicable to cases that have already gone through the investigations process and are receiving services. Our audit is of the investigations process itself and so this protocol does not appear applicable. In addition, the April 2000 memo refers to having face-to-face contact with the child's parent or caregiver, whereas the purpose of the home visits during the course of an investigation involving allegations of abuse or neglect is to ensure the safety of the child. Accordingly, we find no basis to alter this finding.

Domestic Violence (DV) Screenings

According to ACS policy, a Domestic Violence (DV) "screening is required for all families with Children's Services involvement, regardless of the allegations." Every family must be screened for DV and if specific conditions apply, the case worker must continue with the DV protocol worksheet, which outlines the specific steps that must be followed to ensure the children's safety.

However, we found problems related to DV screenings with 16 (64 percent) of the 25 cases we reviewed. Specifically, six cases in our sample had no evidence of DV screenings and the other 10 that required the protocols were incomplete. While these screenings are integral to any case investigation, they are critical for cases where domestic violence issues have been observed at the start. Nevertheless, 11 of the 16 cases—including four with no evidence of DV screenings—involved some form of domestic violence. One case lacking a DV screening had been coded as a high priority domestic violence case. The allegation stated that the parents had fought in front of their infant child, which escalated to the father "severely hitting" the mother in front of the infant. However, the progress notes contained no evidence that the supervisor reminded the case worker to complete the DV screening.

The 10 cases with incomplete screenings lacked details such as the "Overall Case Assessment," which flags any immediate danger to the children and any adult victim. Also lacking was the "Suspected Batterer's Interview," which contains the suspect's version of events and which can be compared to what the alleged victim and children have conveyed during their interviews.

Case workers must perform and complete the screenings and the supervisor reviewing their cases must ensure that case workers have completed them. Only in 25 percent of the cases did the progress notes contain evidence that case workers receive supervisory reminders to complete the DV screenings. Even in these cases, the notes contained no evidence that case workers corrected the deficiencies or that supervisors followed up.

Risk Assessment Profiles (RAP)

According to ACS policy, case workers should complete a Risk Assessment Profile (RAP) no later than by the 40th day of the investigation or before a case is submitted for closure if less than 40 days. Creating a RAP helps the case worker make an informed decision whether to request additional services for a case, depending on the level of risk for abuse and maltreatment. The RAP helps the case worker classify and accurately determine the level of risk in a family in conjunction with good professional judgment and supervision. However, this policy is not always enforced in a timely manner. While all 25 cases that we reviewed had a completed RAP, in only 6 had it been completed by the 40th day. The remaining 19 (76%) were completed up to 34 days late. In only 11 percent of the cases with late RAPS did we find evidence of supervisory reminders that they needed to be completed.

ACS officials at the May 17th exit conference stated that it was not mandatory to conclude the RAP by the 40th day of the investigation, as long as it was concluded before the investigation was closed. However, this assertion is contrary to express ACS guidelines, as well as with the written confirmation obtained from ACS, which states that the RAP "can be completed no later than 40 days from the date of intake." Moreover, at the exit conference ACS officials had also stated that the completion of the RAP could be delayed beyond 40 days if the case worker was waiting to receive additional information that may be relevant to the assessment of the case. It should be noted that none of the 19 cases with late RAPs had evidence that the case workers were waiting to receive additional information. Accordingly, we find no basis to alter this finding.

DCP Notebooks

According to ACS's policy, "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." Further, ACS policy expressly provides that interviews and home visits must be recorded in the notebooks. The policy also states that, "[e]ach page must be clearly marked with the first name and last initial of the case name, and CNNX case number assigned to the case." In light of the case workers' workload, notebooks are a critical tool to help ensure that all pertinent details of a case get recorded.

However, based on our interviews with supervisors, we found that ACS does not enforce this policy and does not ensure that case workers are utilizing required notebooks to capture all relevant information during the various stages of an investigation. One supervisor told us that she reviewed the notebooks on an "as needed basis," mainly when she found issues with the progress notes. Another supervisor told us that she consistently asked to see the notebooks and compared the entries to the progress notes and three other supervisors told us that they never asked to see the notebooks and "trusted" the case worker to record the required information. All five supervisors confirmed that ACS does not require that the supervisors review the notebooks, so it is left to the discretion of each case worker to comply with the notebook usage policy to capture the details of an investigation.

However, we found that the case workers for 20 of the 25 cases we reviewed (80 percent) did not have notebooks pertaining to the investigations we had sampled, though 460 progress notes were entered in CNNX. Further, for the the five cases where the case workers did have notebook entries, the entries were not clearly labeled with the case name and number as required. Instead, all of the entries were comingled among the case worker's different cases, with conflicting dates between the notebooks and entries made into CNNX. In addition, with only 12 entries in the notebook compared to 120 progress notes entered into CNNX, there were insufficient entries to support the progress notes pertaining to interviews and home visits.

ACS management acknowledged that the failure of case workers to maintain the required notes in notebooks is a problem and stated that in order to properly engage with the individuals being interviewed, it was important to have two case workers present at the time of the interview – one to ask questions and interact with the interviewee and one to take notes. However, due to a shortage of staff, ACS is unable to send out two case workers to conduct the interviews, possibly hindering the quality of the interview and investigation.

Progress Notes Are Not Updated in Timely Manner

According to ACS' policy, "Division of Child Protection staff are required to document all case-related events in CNNX within 5 business days of such events." The policy also states that, "Specific time frames for recording entries in Connections (CNNX) guide and support good case practice by assuring recall of case actions and assessments, continuity of work done with the case, and ongoing maintenance of CNNX records." Progress notes are an integral investigative tool that allow the case worker to capture critical information for making a case determination and that allow the supervisor to review the investigation status to assess its progress.

Updating CNNX promptly preserves the investigation's integrity and ensures that details are recorded accurately. Recording of events late can lead to case workers' entering inaccurate or incomplete information and can also interfere with the supervisors' ability to adequately oversee investigations and offer meaningful directives.

Our review of 25 sampled cases consisted of 580 progress notes, of which 119 (21%) notes—pertaining to 24 of the 25 cases—had late CNNX entries, one 37 days late. The late entries raise further concerns because none of the case workers investigating these 24 cases had any notebook entries corresponding to these progress notes, meaning that the case workers relied solely on memory when recording the details into CNNX. The progress notes contained evidence of supervisory reminders to record entries in a timelier manner for only 33 (28 percent) of the 119 cases with late entries.

Recommendations

6. ACS should ensure its staff complies with all aspects of an investigation, including following supervisory directives, complying with guidelines and maintaining notebooks during the course of an investigation.

   ACS Response: ***"***DCP continues to reinforce our policies and systemic controls to ensure full compliance with all investigatory guidelines and practices."

7. ACS should ensure that case workers update progress notes in a timely manner and that this aspect is carefully monitored by the supervisors.

ACS Response: "Compliance is currently at 80% and we continue to make documentation a priority. As discussed above, ACS is introducing dictation software to support documentation efforts, which will enable CPS to speak their progress notes into the computer to allow for more efficient entry of progress notes. . . .

Longer term…ACS is examining the feasibility of electronic tablet devices for staff to update progress notes while in the field."

DETAILED SCOPE AND METHODOLOGY

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. This audit was conducted in accordance with the audit responsibilities of the City Comptroller as set forth in Chapter 5, §93, of the New York City Charter.

The scope of this audit was July 1, 2013, through May 31, 2015. It also focused exclusively on cases that were investigated by DCP and resulted in a determination of "indicated." The audit did not test any aspects of preventive or foster care services provided by ACS or its contracted agencies subsequent to those investigations, nor did the audit look into the investigation process for cases that were determined to be unfounded at the conclusion of the investigation.

To accomplish our objective and to obtain an understanding of ACS' controls over child abuse and neglect investigations, we conducted meetings with various ACS officials, including a DCP Deputy Director; two Child Protectives Managers; eight supervisors; six case workers; and investigative staff at the Emergency Children's Unit.[14] To gain an understanding of how allegations are received and distributed to the appropriate units for investigation, we interviewed a manager from the Applications Unit. To assess the adequacy of ACS' internal controls as they relate to our audit objective, we evaluated information obtained from these interviews, as well as various supporting documents ACS provided to us.

To obtain an understanding of the guidelines governing the investigation of child abuse and neglect reports, we reviewed various DCP policies and procedures, flowcharts of the investigation process, ACS internal reports, and other relevant information obtained from the ACS website and other sources (such as the Fiscal Year 2009 *Mayor's Management Report*). The criteria for our audit included the following: (1) Division of Child Protection *Casework Practice Requirements Manual* (fifth edition, dated December 2013); (2) Child Protective Services *Field Operations Manual* (issued December 15, 1991); (3) Child Protection Case Flow; and Managerial Random Review Policy (dated May 9, 2011); and (4) CONNECTIONS Step-by-Step Guide. We also reviewed a Joint Report issued in August 2007 by the New York City Department of Investigation (DOI) and ACS that examined 11 child fatalities and 1 near fatality that occurred between October 2005 and July 2006.

To gain an understanding of the way that the various steps of the investigation process are recorded in CNNX, we conducted a walkthrough of the system. We obtained an electronic file from CNNX listing 36,613 cases for the period July 2103 through May 2015, and containing data of the intake reports received and subsequent investigations of child abuse and neglect allegations for cases determined to be "indicated" during our scope. We performed limited testing of the data provided to assess its reliability. We sorted the population and reviewed each field to ensure that all fields contained reasonable data.

We randomly selected 25 cases to test whether the case workers carried out their responsibilities during an investigation in accordance with ACS guidelines. We randomly selected 10 of the 25

[14] For allegations that are received after 4:30 pm on weekdays and during all hours on weekends, ACS' Emergency Children's Unit is responsible for conducting an initial home visit to ensure the safety of the children. The case is then handed over to the borough office for investigation.

cases to determine whether the case workers complied with the directives given by the supervisors during the course of the investigation.[15] We met with the supervisors to whom these cases had been assigned to discuss certain deficiencies uncovered during our testing.[16] In addition, as part of our tests, we reviewed the progress notes for these 25 cases to determine whether there is a record of compliance with key steps of the investigation. The tests included, but were not limited to whether case workers:

- Reviewed all prior allegations before to the start of an investigation; conducted separate interviews with all parties involved in the allegation and, if not possible, visited the schools that the child(ren) attended to conduct an interview; and interviewed collateral witnesses.
- Made face-to-face contact with the children involved in the allegation within 24 hours of receipt of the report for the 12 high priority cases in our sample and within 48 hours for the 13 non-high priority cases.
- Made bi-weekly contact with the children involved in the investigation and, in instances where the bi-weekly visits were not timely, whether they detailed the reasons for the delay in the progress notes.
- Completed the DV screening and/or DV protocol worksheets and Risk Assessment Profiles in a timely manner.

We also determined whether major milestones were conducted in a timely manner. Milestones included the following: holding a pre-investigative conference between the supervisor and case worker, conducting the initial home visit; completing the 7-day and closing safety assessments; and making the case determinations within 60 days.

To determine whether case workers recorded the details of their investigation in accordance with ACS guidelines, we requested notebook entries for the 25 sampled cases. We compared the number of entries made in the notebooks to the number of progress notes recorded in CNNX. We also reviewed the notebook entries to determine whether they were detailed enough to support the progress note to which they pertained. To determine whether case workers updated the progress notes in CNNX within five days of the relevant event/activity as required, we compared the event date to the entry date noted in the progress notes and calculated the number of days that elapsed.

We reviewed whether supervisory reviews had been performed within established timeframes for our randomly selected sample of 25 cases. For the 12 cases that were coded as high priority, we also determined whether the required number of managerial reviews had been conducted. To determine whether ACS ensured that managers were conducting the required number of random reviews and whether the deputy directors were reviewing them, we attempted to obtain a listing of all cases that were pulled by ACRS for review. In addition, we reviewed the content of the supervisor and managerial reviews to determine whether reminders were given to the case workers in instances where key components of an investigation were missing.

[15] Due to the deficiencies found during our testing, we concluded our review after 10 cases.
[16] It should be noted that we met with six supervisors to review seven of the ten cases (one of the six supervisors had been in charge of two cases, two supervisors had refused to meet with us and one supervisor was no longer with ACS by the time of our review).

APPENDIX

Issues Found with the Review of the 25 ACS Cases

	Oversight	Case workers Responsibility During Investigation											
Case #	Supervisory Reviews Were Not Performed or They Were Performed Late	CPM Reviews Were Not Performed or They Were Performed Late (**High Priority Cases Coded 1 & 13 Only)	*Supervisory Directives Not Complied With	Bi-Weekly Home Visits Are Not Performed	RAP Not Timely	Domestic Violence Screenings Are Not Complete or Are Missing	Prior Allegations Were Not Reviewed	All Parties Involved Were Not Interviewed Separately	Collateral Sources Were Not Interviewed	School Officials Were Not Interviewed	Missing or Incomplete Notebook Entries	Untimely Entry of Progress Notes	Total # of Issues Per Case
1				X							X	X	**3**
2	X	X	X	X	X	X				X	X	X	**9**
3	X		X	X	X	X					X	X	**7**
4	X		X	X				X	X		X	X	**7**
5		X	X		X	X	X		X		X	X	**8**
6	X	X	X	X	X						X	X	**7**
7			X								X	X	**3**
8	X		X	X	X	X			X		X	X	**8**
9	X		X	X		X					X	X	**6**
10			X	X	X	X					X	X	**6**
11		X	X	X	X						X	X	**6**
12	X			X	X						X	X	**5**
13	X	X		X	X	X				X	X		**7**
14	X	X		X	X	X					X	X	**7**
15	X			X	X	X					X	X	**6**
16	X	X		X	X	X				X	X	X	**8**
17	X			X	X						X	X	**5**
18	X	X		X	X	X					X	X	**7**
19	X			X	X	X			X	X	X	X	**8**
20	X	X		X							X	X	**5**
21			`	X		X					X	X	**4**
22	X	X		X	X	X					X	X	**7**
23	X	X		X	X						X	X	**6**
24	X			X	X	X					X	X	**6**
25				X	X	X					X	X	**5**
TOTAL	**18/25**	**11/12**	**10/10**	**23/25**	**19/25**	**16/25**	**1/25**	**1/25**	**4/25**	**4/25**	**25/25**	**24/25**	

* **We reviewed Compliance with Supervisory Directives for Cases 2-11**

**** Managerial Reviews are required for High Risk Cases Only: Case #'s 2, 5, 6, 11-14, 16, 18, 20, 22, and 23**

Administration for Children's Services

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June 13, 2016

Office of the Comptroller
1 Centre Street
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Attn: Marjorie Landa, Deputy Comptroller for Audit

Dear Ms. Landa:

Thank you for the opportunity to review and comment on the *Office of the Comptroller's Audit Report on the Administration of Children's Services' Controls Over Its Investigations of Child Abuse and Neglect Allegations*. ACS has carefully considered the audit findings and recommendations; our comments and responses to the recommendations are outlined below.

The ACS Division of Child Protection (DCP) staff investigates over 60,000 reports of child abuse and neglect every year involving more than 80,000 children. One constraint on this review was that the Comptroller reviewed a very small sample – only 25 cases – to determine whether ACS has adequate controls over the processes for investigating allegations of child abuse and neglect. While ACS agrees with the Comptroller's recommendation that administrative processes can be strengthened, it is important to note that in each of the 25 cases reviewed - even those in which a supervisory review occurred after the required timeframes - the children involved are safe, the families have been offered appropriate services and ACS has not received additional SCR reports for 24 of the 25 families to date. For the one case in which we received a subsequent report, ACS filed a neglect petition, immediately removed the child from the home and placed the child in a kinship foster care placement.

Another constraint on the review was the practical limitations around some of the documents requested. Auditors reviewed only the case records, documented in Connections (CNNX), associated with the 25 DCP investigations. However, staff corrective action and discipline matters are not referenced or documented in Connections – Connections is the official record for the family, not for the staff member. Disciplinary records are maintained outside of Connections. The absence of these types of records within Connections does not necessarily mean that a Child Protective Specialist was not disciplined appropriately as necessary.

In addition, even within the case record, certain documents were not legally permissible to share because of their confidential nature, including education documents protected under the Family Educational Rights and Privacy Act (FERPA) and medical documents protected under the Health Insurance Portability and Accountability Act (HIPAA). As a result, auditors reviewed case files which had been redacted (and marked as such) to protect the family's and child's privacy rights. In one

investigation referenced in the report, auditors cite a worker's failure "to verify the severity of the child's asthma with the child's pediatrician." While federal law precludes us from providing the documentary proof, ACS can assure the auditors that the case file contains information that ACS contacted the child's pediatrician with appropriate timeliness and was able to elicit appropriate information to inform the safety assessment.

The auditors also misinterpreted the timelines associated with the completion of various checklists and case practice tools. For example, in some cases the auditors cite ACS for failing to document a Domestic Violence Screening. The auditors highlight one case which had been coded as a high priority domestic violence case because the allegation stated that the father was "severely hitting" the mother in front of their child, but where the routine steps of a domestic violence screening were not documented. However, by the time the child protective investigation received that case, the child's father has already been charged in the criminal justice system with assault, was incarcerated, and was subject to an order of protection which prevented any contact with the child's mother. Due to the complainant's cooperation with criminal justice authorities, referrals for counseling have already been made and documented. In a similar case cited by the auditors, the perpetrator of domestic violence was already deceased. In these cases, there was no need to duplicate efforts and complete checklists merely to demonstrate ACS diligence. The Domestic Violence Screening is a questionnaire is designed to capture the possible nuances of abuse in the home: "Would you describe your partner as jealous?", "has your partner made you feel unsafe?" and "has your partner threatened you?" are among the queries. The Domestic Violence Screening was designed to identify possible service needs, but if those needs are being met and are documented, the screening is no longer relevant.

Despite these constraints, ACS agrees with the Comptroller's recommendation that DCP administrative processes can be strengthened, and several initiatives are already underway to do so. In January 2015, the Mayor's ACS Reform Plan provided significant funding to improve the child welfare system in New York City, a major component of which called for ACS to strengthen and support frontline staff and supervisors across the child welfare system in order to improve outcomes for the children and families we serve.

As a result of this $14.6 million annual investment, ACS developed the ACS Workforce Institute, a collaboration with CUNY School of Professional Studies that draws from the latest research in adult learning and child welfare practice to support the ongoing professionalization and improvement of frontline staff in DCP and among our provider-agency partners. By the end of June 2016, we will have provided training to 3,000 front line staff and supervisors through the Workforce Institute's programs. These include a course on "Building Coaching Competencies" for front line DCP supervisors and managers, which provides supervisors with skills to help their direct reports expand their critical thinking skills and continue learning on the job; and a course on strengths-based family engagement skills designed for all front line staff. Both include simulated real-life experiences and extensive feedback from trainers with expertise in the field.

Several other substantial reform efforts are underway in DCP with the support of the ACS systems-improvement units and other agency infrastructure. These include:

- The development of a newly expanded quality assurance and continuous quality improvement process for Child Protection. ACS will expand its current quality monitoring teams to create statistically valid samples of data from comprehensive case record reviews, and combine these with analyses of outcomes and other

performance in order to assess the strengths and needs of each borough office. That analysis will inform priority areas and the development of continuous strategic improvement action plans at the borough and zone level.

- Hiring and training new child protective staff for DCP to ensure that ACS is able to backfill positions as they become vacant, while also recovering from recent attrition. During FY 2017, ACS has secured funding and intends to hire an additional 475 Child Protective Specialists and 25 Child Protective Specialist Supervisors Level I.

- Expanding the Family Assessment Response (FAR) initiative, which is a model for more effectively addressing reports of child neglect that are determined to be low-risk. Through the FAR approach, the family partners with staff and community organizations to create and act on a plan for the family and children, addressing concerns identified in the report and in the initial phase of the investigation. Since FAR was launched in Queens in 2013, more than 1,500 families have worked successfully in partnership with DCP. Throughout 2016, ACS is expanding FAR to Brooklyn and will expand citywide starting in 2017.

- Expanding the use of "Teaming", which began in 2015 in four units in the Staten Island DCP Borough Office. Teaming is an innovative approach to casework practice that re-structures individualized casework to a team-based model. Teaming helps child welfare leadership support line staff and supervisors and helps unit members collaborate and support each other in every aspect of their work, which in turn allows for better support for children and families. When a team reviews a case, accountability, insight, and case practice is improved. The units that have implemented Teaming describe an increase in morale, better casework practice and lower attrition. The Workforce Institute will support expansion of the model throughout the Staten Island office, and plan for scaling its use more widely.

- Strengthening technical support for frontline child protective staff. ACS is introducing dictation software that will enable CPS to speak their progress notes into the computer, allowing more efficient and quicker entry of progress notes, a key concern in the audit report. DCP is also exploring portable tablets to replace the traditional and cumbersome "black books" recording; portable tablets would help streamline and simplify storage and archiving of field notes.

- Strengthening risk assessment and service-matching for DCP. ACS is developing a comprehensive risk assessment tool for use in all investigations and at set points throughout our involvement with each family. This tool will draw on aggregate data from hundreds of thousands of child welfare cases to help determine which ACS involved families are most likely to experience a future substantiated report of abuse or neglect and what services are best for the family. It will support critical decision-making and will be backed up by training, protocols, supervision and coaching. This project includes a new "dashboard" for frontline workers, supervisors and managers that will draw from existing systems of record to track fundamentals of case practice and highlight family needs and risks.

It is also important to acknowledge that ACS has among the lowest child protective caseloads in the United States. At 10.2 cases per CPS worker, our 2015 average caseload remained under our internal target caseload of 12 cases per CPS worker. This target was set

in accordance with a research-based and widely acknowledged standard developed by the Child Welfare League of America.[1]

We appreciate the Office of the Comptroller's insight, and will use the recommendations to further improve oversight and monitoring within DCP. Our responses to the individual recommendations follow below.

Audit Recommendation 1: ACS should formulate an efficient internal control system, including uniform policies and procedures that are distributed to its staff in a timely manner

ACS Response to Recommendation 1:

DCP has a policy for disseminating new policies and procedures, which was developed and distributed to DCP staff in April 2013. The current practice for policy distribution is as follows: all draft DCP polices are distributed to the division's executive team at least two weeks before they are finalized in order for senior leadership to review and give feedback that informs the final policy. Once finalized, the policy is shared electronically with all DCP staff. DCP leadership then discusses the policy with their managerial team during biweekly leadership meetings. DCP deputy directors (along with their managers) discuss the policy and its practice implications with supervisors during monthly supervisory forums and also with the CPS during monthly debriefings. Debriefings are attended by all staff in the zone/program and facilitated by the zone/program deputy director.

As noted above, DCP is working with the ACS Division of Policy, Planning and Measurement (DPPM) to strengthen oversight of and improve access to policies and procedures. This includes a comprehensive review and cataloguing of DCP's current and historical policies and procedures which is currently underway. DPPM is the lead in this work in order to ensure that policies follow a standardized format, are not duplicative or contradictory, and are accessible to the intended audience. The DPPM policy unit will verify compliance with OCFS directives and other state guidance documents, as well as other ACS policies, and will move new and revised policies through the appropriate review channels. The DPPM policy unit will also work with ACS' Office of Information and Technology to ensure easy access, both internally and externally, to relevant policies.

Audit Recommendation 2: ACS should ensure that managers and supervisors perform timely reviews during all stages of the investigation, as well as ensure that case workers perform all key steps of an investigation.

ACS Response to Recommendation 2:

DCP has a supervisory/managerial structure which is intended to ensure timely reviews are completed at all key steps of an investigation. Each unit within DCP has a Supervisor Level II (CPSSII) who reports to a Child Protective Manager (CPM), who in turn reports to a Deputy Directory (DD). Child Protective Managers are required to ensure that the Supervisor II complete all required reviews. There are controls in place which allow the CPM's to ensure such compliance. Reports in both Connections (CNNX) and ACRS track and control compliance with the supervisor's review of the 5 Day/25 Day/50 Day investigatory milestones. Deputy Directors are required to review that the CPMs have performed reviews and compliance is controlled during their one-on-one supervision.

[1] For more information on this standard see http://66.227.70.18/newsevents/news030304cwlacaseload.htm

In July 2011, DCP implemented Supervisory Journaling. Supervisors, Managers and Deputy Directors have a regulated structure for their one-on-one supervision and must conduct these supervisory sessions on a bi-weekly basis. These sessions, which are not recounted in Connections, are then documented in an electronic journal and stored on a shared drive. Deputy Directors must ensure these sessions are completed on a monthly basis. During these sessions, there are discussions regarding practice trends and issues, including ensuring that all reviews are conducted timely.

DCP also reinforces policies and procedures through training. For example, as mentioned above, the Workforce Institute has a training course in coaching that builds supervisory skills for frontline supervisors and managers.

Looking ahead, ACS will institute a "dashboard" that will draw from and complement Connections (CNNX). The dashboard will support Risk Management, flagging key issues and identifying triggers on a micro and macro level to help supervisors and managers better identify cases that require their close attention and supervisory review.

Audit Recommendation 3: ACS should develop a system that allows for the recording of managerial reviews in a manner that can be clearly documented in the terms of when they were performed.

ACS Response to Recommendation 3:

DCP is working on short-term and long-term initiatives to strengthen the Random Review (RR) process and archiving. First, as discussed with auditors during the audit, DCP has recently clarified instructions for saving Random Reviews in an online folder. Second, ACS is reviewing the RR process whereby cases are selected, and also modifying the instrument that is completed during the Random Review in order to reflect the milestone dates of "pulled for review", "review date" and "e-save date". Finally, ACS is upgrading IT systems to improve tracking of case assignments and controls over managerial reviews. A new automated Case Assignment System (CAS) under development will replace the older, outdated ACRS system.

Audit Recommendation 4: ACS should ensure that Deputy Directors properly track managerial random reviews so that they can be certain that all random reviews were performed and in the required time period.

ACS Response to Recommendation 4:

As noted above, DCP has clarified instructions for documenting and saving the RR in an online folder and work is currently underway on a new automated system that will support tracking and managerial controls. Deputy Directors are required to review that the CPMs have performed reviews and compliance is controlled during their one-on-one supervision.

Audit Recommendation 5: ACS should conduct a study to determine the adequacy of its current caseload requirement to determine if it is appropriately staffed to perform thorough investigations. Depending on the study's findings, ACS should use this study as justification for seeking additional funding from the City's Office of Management and Budget to hire additional case workers.

ACS Response to Recommendation 5

We will take this recommendation into consideration. As outlined above, ACS already has one of the lowest child protective caseloads in the United States, and been

approved to hire additional staff in the Division of Child Protection which will greatly strengthen the current workforce.

Audit Recommendation 6: ACS should ensure its staff complies with all aspects of an investigation, including supervisory directives, complying with guidelines and maintaining notebooks during the course of an investigation.

ACS Response to Recommendation 6:

DCP continues to reinforce our policies and systemic controls to ensure full compliance with all investigatory guidelines and practices.

Audit Recommendation 7: ACS should ensure that caseworkers update progress notes in a timely manner and that this aspect is carefully monitored by the supervisors**.**

ACS Response to Recommendation 7:

Compliance is currently at 80% and we continue to make documentation a priority. As discussed above, ACS is introducing dictation software to support documentation efforts, which will enable CPS to speak their progress notes into the computer to allow for more efficient entry of progress notes.

DCP has corrective action processes in place if staff are not documenting cases in a timely fashion. Staff not in compliance are first put on field restriction to allow him or her to update documentation. If documentation remains a concern, Corrective Action Plans are formulated and evaluations are performed based on CAP compliance. If performance does not improve, progressive discipline is initiated. As previously mentioned, it is important to recognize that staff corrective action and discipline matters are not referenced or documented in Connections – Connections is the official record for the family, not for the staff member. Disciplinary records are maintained outside of Connections.

Longer term, as referenced above, ACS is examining the feasibility of electronic tablet devices for staff to use to update progress notes while in the field.

Thank you for the opportunity to respond to the draft report. We appreciate the Comptroller's support in our work for the children and families of New York City.

Sincerely,

Gladys Carrión, Esq.

Gladys Carrión, Esq.
Commissioner