



# Office of Children and Family Services

KATHY HOCHUL  
Governor

SUZANNE MILES-GUSTAVE  
Acting Commissioner

July 21, 2023

Attn: Thomas DiNapoli, State Comptroller  
Office of the State Comptroller  
110 State St.  
Albany, NY 12236

## Re: Audit 2021-S-17 – 180-Day Response to the Report

Dear Mr. DiNapoli:

On behalf of the New York State Office of Children and Family Services (OCFS) and pursuant to Executive Law § 170, please find a 180-day update pertaining to OCFS's response to the Office of State Comptroller's (OSC) three recommendations detailed in Audit Report 2011-S-17 entitled "Oversight of Child Protective Services." OSC's stated objective was to determine whether OCFS adequately monitors Child Protective Services (CPS) activities to protect vulnerable children. The audit period under review was January 2018 to November 2021, and contained two key findings and recommendations.

**Recommendation 1:** Evaluate and address deficiencies found in Program Quality Improvement (PQI) and child fatality reviews on a statewide basis across all LDSSs.

- **OCFS Response 1:** OCFS has implemented and continued multiple activities to strengthen child protective practice statewide. Please see the following:
- The Bureau of Oversight and Monitoring- The compliance unit in CWCS home office continues to systemically review Preventive/Protective cases as part of the oversight and monitoring process for each LDSS. Typically, five to seven Preventive/Protective cases are reviewed and scored utilizing the OSRI tool for each district. The findings are shared with the LDSS after the review to ensure awareness of strengths in their practice and areas identified as needing improvement. These findings are also compared to rest of state at the debrief meeting with each LDSS, to provide a lens of their practice in comparison to other districts across the state. The LDSS review cycle was previously conducted approximately every three and a half years but, with recent process changes, is now on track to be conducted every two years. This will allow for more frequency of reviews as well as the opportunity for more comparative analyses to gauge practice improvement.
- PQI Executive Team – The Performance Improvement Plan (PIP) workgroup, which consists of members from the PQI executive team, meets biweekly. The workgroup has created processes, resources and training to guide state and agency staff in how to develop and implement quality improvement strategies that improve practice consistently across the state. In addition, the workgroup has developed a revised PIP template, standard language, a PIP closure process and created PIP approval/closure letters. The Regional Offices will pilot the new processes and forms during the 3rd quarter (July-September 2023).

- Plan of Safe Care (POSC) – Inconsistencies in practice across the state have been identified regarding standards, presumptions of timing and circumstances for completing the POSC and how to use it most effectively to support child safety and caregiver well-being. Clarifying guidance is being researched.
- Grand Rounds – OCFS created a mailbox where exceptional casework is collected. These cases are presented at live meetings along with best practice and how it relates to current PQI trends and is open to both LDSS and state child welfare staff. The most recent session was Promising Practice Adoption, held in November of 2022. Another session, Working with Substance Misuse, will be held on July 26, 2023.
- Guidance Documents – OCFS published 23-OCFS-ADM-09, New Mandated Reporter Training, which is part of OCFS' Statewide Central Register Reform. The ADM provides guidance to mandated reporters regarding revisions to mandated reporter training. The revisions to the training were made to comply with the current statutory requirements and to strengthen the skills of mandated reporters in making informed decisions about identifying potential abuse or maltreatment of a child. The new training will also help mandated reporters identify when concerns do not rise to a level legally requiring a report be made to the Statewide Central Register (SCR). The training will help mandated reporters determine whether a family could instead be supported by directing them to culturally responsive, effective and community-based programs through OCFS' new Help, Empower, Advocate, Reassure and Support (H.E.A.R.S.) family line. Another key focus of the new training is an implicit bias training component to explore the impact of implicit bias on decision-making and to reduce the number of SCR reports influenced by bias about race or poverty.
- Data Leaders Team (DLT) – The DLT designed a monthly one-page report for LDSS that monitors the status of CPS investigations by workers and units per district. The team continues to find ways to monitor and track CPS reports and communicate findings with LDSS during monitoring visits. Ideas are brought to the DLT for cross-region discussion and brought back to the members' offices to build data capacity statewide. The DLT met in December 2022 as well as March and May 2023. Another meeting is planned for September 2023. Discussion items included the following:
  - Acquiring and applying data from various sources including the state's Data Warehouse
  - Chapin Hall and PQI reviews to inform oversight and monitoring activities with LDSS

Regarding child fatality review, the following strategies continue:

- Statewide Child Fatality Review Team – OCFS continues to chair a Statewide Child Fatality Review Team that meets quarterly and with smaller workgroups that push forward initiatives between quarterly meetings. The team last met in June 2023 and is currently working on several child fatality prevention initiatives to reduce the number of infant unsafe sleep deaths as well as initiatives to reduce the number of teenage suicides. Members of the team include high-level decision-makers at both the state and local levels, along with other pertinent stakeholders.

- Child Fatality Reports – OCFS continues to issue child fatality reports for deaths where there is a suspicion that maltreatment or abuse contributed to the death or where the deceased child was in an open child welfare case. These reports continue to be publicly posted to the OCFS website on a quarterly basis. Only reports where OCFS determines it is contrary to the best interest of surviving siblings to release the report are withheld from being posted to the OCFS website.

**Recommendation 2:** Establish procedures to more accurately reflect the nature of the calls determined to be non-reports and the reason why the call did not result in a report; this may include, but not be limited to, adjusting the retention period for the call recording and updating closure codes.

**OCFS Response 2:** OCFS has reviewed the existing closure codes for Non-Report Closures as agreed and is implementing the following additional codes to better distinguish the reason for a Non-Report:

- 1) Disconnected before providing adequate information
- 2) Information Technology (IT) issues
- 3) Caller was interrupted and will call back
- 4) Law enforcement referral processed
- 5) Completed in backup system

OCFS appreciates the opportunity to provide an update regarding our continued work in these areas. Please contact me by email at [Gail.Geohagen-Pratt@ocfs.ny.gov](mailto:Gail.Geohagen-Pratt@ocfs.ny.gov), or by phone at (518) 474-3377 with any questions regarding this response.

Sincerely,



Gail Geohagen-Pratt, Acting Deputy Commissioner  
Division of Child Welfare and Community Services

cc: Suzanne E. Miles-Gustave, Esq., Acting Commissioner, Office of Children and Family Services  
Kendra Sena, Esq. Acting General Counsel  
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