Office of Children and Family Services

Oversight of Child Protective Services

Report 2021-S-17 | January 2023

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Office of Children and Family Services (OCFS) effectively oversees local departments of social services' investigation of reports of alleged child abuse or maltreatment, and ensures compliance with relevant laws, regulations, and procedures to promote the safety and well-being of affected children and families. The audit covered the period from January 2018 to November 2021, with subsequent information related to our sample cases through September 2022.

About the Program

The New York State Child Protective Services Act of 1973 was established to encourage more complete reporting of child abuse and maltreatment, provide for the swift and competent investigation of such reports, protect children from further abuse or maltreatment, and provide rehabilitative services. OCFS' mission is to serve New York's public by promoting the safety, permanency, and well-being of our children, families, and communities. OCFS is responsible for overseeing the locally administered child welfare system, including 58 local departments of social services (LDSSs) as well as the voluntary agencies that contract with LDSSs to provide child welfare services.

Suspected incidences of child abuse and maltreatment are received by OCFS through the Statewide Central Register of Child Abuse and Maltreatment (SCR) via phone calls, fax, and electronic submission (hereafter, suspected incidences of child abuse and maltreatment received by the SCR are referred to as "calls"). The SCR, established by New York Social Services Law, is available 24 hours a day, 7 days a week, 365 days a year, and received roughly 300,000 calls annually for the 2 years prior to the COVID-19 pandemic. Calls decreased to just under 270,000 in 2020. If a call is received and OCFS staff determine there is reasonable cause to suspect that a child (i.e., under the age of 18) has been impaired or is in imminent danger of impairment because of the failure of a parent or person legally responsible to exercise a minimum degree of care, this will result in an intake report if it is within the jurisdiction of the State and sufficient demographics (e.g., name, address) are provided to initiate an investigation. Calls with concerns that do not contain those elements result in a non-report. In such instances, the caller must be provided with a clear explanation of why the intake is not being registered as a report and given the option to receive a supervisory consultation. Examples of circumstances that would result in a non-report include, but are not limited to, those related to children 18 years of age or older and children residing outside of New York State. Calls received through the SCR that OCFS staff determine meet the threshold for a report are sent to the respective LDSS through CONNECTIONS – the computerized system of record used for recording child welfare information in the State.

In certain instances, reports of abuse or maltreatment involve the death of a child. OCFS is required by law to conduct a review and issue a summary report within 6 months of the death of the child. To improve practices within LDSSs, OCFS implemented a Program Quality Improvement (PQI) process in January 2020. The process involves case reviews by a dedicated team to improve consistency, with a goal of reviewing 2,400 cases in a 3-year cycle. Once reviews of the LDSS are completed, OCFS issues a report to the LDSS, which includes any findings. If needed, a program improvement plan is put in place and monitored by OCFS.

Key Findings

- OCFS generally has processes in place to oversee LDSSs' investigation of reports of alleged child abuse or maltreatment. However, we found improvements could be made to child fatality and PQI reviews. The prevalence of certain issues across multiple LDSSs indicates problems that should be addressed statewide rather than on a case-by-case basis. Officials had not yet developed a plan on how to address and rectify the deficiencies on a statewide basis.
- While OCFS is generally performing its required duties in receiving calls through the SCR and determining actions for the calls, we found closure codes for non-report calls could more accurately reflect the nature of closure and why the call did not result in a report. Additionally, the length of time OCFS maintains call recordings from the SCR may limit its ability to retroactively investigate whether non-report calls were properly handled.

Key Recommendations

- Evaluate and address deficiencies found in PQI and child fatality reviews on a statewide basis across all LDSSs.
- 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.

Office of the New York State Comptroller
Division of State Government Accountability

January 24, 2023

Suzanne E. Miles-Gustave, Esq.
Acting Commissioner/Executive Deputy Commissioner
Office of Children and Family Services
52 Washington Street
Rensselaer, NY 12144

Dear Acting Commissioner Miles-Gustave:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit entitled *Oversight of Child Protective Services*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms 5

Background 6

Audit Findings and Recommendations 10

SCR Documentation of Non-Reports 10

Oversight of Investigations 11

Recommendations 14

Audit Scope, Objective, and Methodology 15

Statutory Requirements 16

Authority 16

Reporting Requirements 16

Agency Comments 17

Contributors to Report 20

Glossary of Terms

Term	Description	Identifier
OCFS	Office of Children and Family Services	*Auditee*
Calls	Suspected incidences of child abuse and maltreatment received by the Statewide Central Register of Child Abuse and Maltreatment	*Key Term*
CDC	Centers for Disease Control and Prevention	*Federal Agency*
CPS	Child Protective Services	*Program*
LDSS	Local department of social services	*Key Term*
Manual	Child Protective Services Manual	*Key Term*
PIP	Program Improvement Plan	*Key Term*
PQI	Program Quality Improvement	*Key Term*
SCR	Statewide Central Register of Child Abuse and Maltreatment	*Key Term*
SSL	New York Social Services Law	*Law*

Background

The New York State Child Protective Services (CPS) Act of 1973 was established to encourage more complete reporting of child abuse and maltreatment, provide for the swift and competent investigation of such reports, protect children from further abuse or maltreatment, and provide rehabilitative services. The Office of Children and Family Services' (OCFS) mission is to serve New York's public by promoting the safety, permanency, and well-being of our children, families, and communities. OCFS is responsible for overseeing the locally administered child welfare system, including 58 local departments of social services (LDSSs) and the voluntary agencies that contract with LDSSs to provide child welfare services.

Suspected incidences of child abuse and maltreatment are received by OCFS through the Statewide Central Register of Child Abuse and Maltreatment (SCR) via phone calls, mail, fax, and electronic submissions (hereafter, suspected incidences of child abuse and maltreatment received by the SCR are referred to as "calls"). The SCR, established by New York Social Services Law (SSL), is available 24 hours a day, 7 days a week, 365 days a year, and received roughly 300,000 calls annually for the 2 years prior to the COVID-19 pandemic. Calls decreased to just under 270,000 in 2020.

Mandated reporters are individuals legally required to make a report, or cause a report to be made, when they have reasonable cause to suspect child abuse or maltreatment during their professional or official capacity. Mandated reporters often have frequent contact with children and have an early opportunity to help them get the intervention, support, and services they need to stay safe and well. Under SSL, mandated reporters include, but are not limited to, teachers, school nurses, police officers, and directors of children's summer day camps.

The SCR is operated by OCFS staff who receive specific training in how to handle suspected incidences of child abuse or maltreatment fielded by the SCR. Staff supervisors conduct assessments of calls, on a sample basis, to verify they were handled correctly. Further, OCFS has a quality assurance unit that conducts additional assessments to ensure calls are handled correctly. If a call is received and OCFS staff determine there is reasonable cause to suspect that a child (i.e., under the age of 18) has been impaired or is in imminent danger of impairment because of the failure of a parent or person legally responsible to exercise a minimum degree of care, this will result in an intake report if it is within the jurisdiction of the State and sufficient demographics (e.g., name, address) are provided to initiate an investigation.

Calls with concerns that do not contain those elements result in a non-report. In such instances, the caller must be provided with a clear explanation of why the call is not being registered as a report and given the option to receive a supervisory consultation. Examples of circumstances that would result in a non-report include, but are not limited to, those related to children 18 years of age or older and children residing outside of New York State. Select information, including closure codes denoting the reason calls were closed, is entered into a digitally logged call record, which OCFS officials stated is maintained for 365 days in CONNECTIONS – the computerized system of record that is used for recording child welfare information in

the State. However, the recording with the entire call detail is only maintained for 75 days.

Calls received through the SCR that meet the threshold for a report are sent to the respective LDSS through CONNECTIONS. LDSS staff must begin an investigation within 24 hours of receiving the report, complete a preliminary safety assessment within 7 days of the receipt of the report of abuse, and complete a full investigation within 60 days of receiving the report. At the conclusion of the investigation, LDSS staff must determine whether the evidence gathered finds the report to be "indicated" (i.e., one or more substantiated allegations) or "unfounded." Case activity is documented in progress notes within CONNECTIONS. All aspects and requirements of CPS cases in the State, established by statute and regulations, are described in the Child Protective Services Manual (Manual). According to the Manual, progress notes should be entered as timely as possible after the event they describe – but no more than 30 days after the event.

Prior to making a determination of whether to indicate or unfound a report, the investigation must include, but is not limited to:

- One home visit with face-to-face contact with the subject(s) and other persons named in the report to evaluate the environment of the child named in the report as well as other children in the same home.
  - If not already identified by the SCR, staff must add any non-custodial parent, if known, as an "other person named in the report."
  - A notice must be sent to the non-custodial parent, named as an "other person named in the report," that an investigation is occurring.
  - If a child has contact with the non-custodial parent in the non-custodial parent's home, reasonable efforts must be made for staff to have face-to face contact with the non-custodial parent in the non-custodial parent's home.
  - The efforts to make face-to-face contact must be documented in CONNECTIONS, and if not achieved, the reasons such contact was not made must also be documented.
- An assessment of the current safety of all children in the home or named in the report.
- An assessment of the risk of future abuse and maltreatment of the child(ren).
- Documentation of such assessments in the form and manner specified by OCFS.
- A determination of the nature, extent, and cause of any condition cited in the report.

Additionally, when a call is categorized as a non-report but it is believed that the alleged acts or circumstances may constitute a crime or an immediate threat to the child's health or safety, OCFS is required to convey the information to the appropriate law enforcement agency, district attorney, or other public official empowered to provide the necessary aid or assistance.

When reports of abuse or maltreatment involve the death of a child, OCFS is required by law to conduct a review and issue a summary report within 6 months of the death of the child. According to OCFS, there were 134,401 calls that proceeded to investigation during the 2020 calendar year, and 368 of those involved a child fatality, as outlined in Table 1.

Table 1 – SCR Calls, Reports, and Fatality Allegations

Year	SCR Calls	Change From Prior Year	Reports	Change From Prior Year	Reports Involving Fatality Allegation	Change From Prior Year
2018	304,713		165,898		365	
2019	315,807	3.64%	162,211	(2.22%)	410	12.33%
2020	268,926	(14.84%)	134,401	(17.14%)	368	(10.24%)
2021*	269,428	0.19%	107,676	(19.88%)	264	(28.26%)

*Only includes data through November 2021.

Calls, reports, and reports involving fatality allegations all decreased during the year the COVID-19 pandemic began (2020) compared to the prior year. The Centers for Disease Control and Prevention (CDC) noted similar decreases nationally, with allegations of suspected child abuse decreasing by 20% to 70% in 2020 compared to the same period in 2019. However, the CDC also found an increase in hospitalizations due to child abuse for the same period, partially attributing this to reduced interaction between children and mandated reporters rather than an actual decrease in cases of child abuse. Due to the potential effects of the decreased interaction with mandated reporters, coupled with the pervasive stress experienced by parents or guardians during the pandemic that the CDC cited, the importance of CPS staff's and the State's oversight of the child welfare system was increasingly critical.

OCFS' child fatality reviews encompass not only the circumstances that resulted in the child's death but also any CPS history, including previous investigations conducted by the LDSS relating to that child. When the review of an investigation of a child fatality finds statutory or regulatory compliance failures and deficiencies in practice, the LDSS must develop a Program Improvement Plan (PIP) and submit it to OCFS for approval. The objective of a PIP is to correct the behaviors and/or conditions that caused the non-compliance issues identified in OCFS' review. As part of the PIP, OCFS identifies the applicable regulatory or statutory citations (i.e., failures to comply with aspects of State law or regulation). The PIP should describe specific corrective strategies, detailing actions and activities that will help the LDSS resolve the identified issue(s). OCFS should then conduct quarterly reviews to ensure the LDSS' compliance with the PIP.

To improve practices within LDSSs, OCFS implemented a Program Quality Improvement (PQI) process in January 2020. The process involves case reviews (CPS, foster care, and preventive cases) by a dedicated team to improve consistency, with a goal of reviewing 2,400 cases, including 1,200 CPS cases, in a

3-year cycle. Once reviews of the LDSS are completed, OCFS issues a report to the LDSS, which includes any findings identified. If needed, a PIP is put in place and monitored by OCFS. OCFS established a PQI administrative team that is intended to meet annually to review the findings of the PQIs, identify statewide issues, issue an annual report, and make recommendations for statewide policy and procedural changes.

Audit Findings and Recommendations

Children who are abused or maltreated, or at risk of such, are some of the most vulnerable members of our community. We found OCFS generally has processes in place to oversee LDSSs' investigation of reports of alleged child abuse or maltreatment. However, we found improvements could be made to child fatality and PQI reviews. Although certain issues are prevalent across multiple LDSSs, OCFS did not identify these problems at a statewide level. Rather, OCFS identified them on a case-by-case basis. Such issues included: failure to review prior SCR records involving members of the family within 1 business day; issues with reaching out to all necessary case contacts, child engagement, and/or making home visits; and inadequate assessments of the family's needs. Officials have not yet developed a plan to address and rectify the deficiencies found across LDSSs on a statewide basis – although they have taken action to address them on a case-by-case basis at each LDSS. Further, the PQI administrative team, which was developed in part to make policy and procedural changes to address problems identified at a statewide level, hasn't met since April 2021, nor has it issued an annual report as intended.

We also found several investigations lacked evidence to support the completion of required steps. We found issues with progress notes, timely completion of the 7-day safety assessment, and providing notification of reports to all appropriate persons. Additionally, while OCFS is generally performing its required duties in receiving calls through the SCR and determining actions for the calls, we found closure codes for non-report calls could more accurately reflect the nature of closure and why the call did not result in a report. Further, the length of time OCFS maintains call recordings from the SCR may limit its ability to retroactively investigate whether allegations were properly handled.

SCR Documentation of Non-Reports

Between September 2021 and November 2021, the SCR received 69,844 calls. Of those, 45,225 (65%) moved to report, 13,841 (20%) were determined to be non-reports, and the remaining 10,778 (15%) were not unique calls but provided additional or supplemental information on a previously received call, complaints, general information for LDSSs, etc.

We selected a sample of 50 of the 13,841 calls determined to be non-reports. For the 50 calls, OCFS could not provide information to support the determination staff had made. The only information recorded in OCFS' digitally logged call record data was the date of the call, whether the call came from a mandated reporter, and a general reason for the determination of non-report (e.g., child over 18, lives outside of New York State, insufficient demographic information). Additionally, no assessment was completed by the staff's supervisor or OCFS' quality assurance unit on any of the 50 calls to determine if staff made the appropriate determination.

OCFS only maintains recordings of calls for 75 days; therefore, if there is subsequently a concern that the call was mishandled, OCFS can only investigate, using information in the call recording, for up to 75 days. For example, we reviewed one instance where OCFS received a complaint regarding the mishandling of a

call made to the SCR. OCFS reviewed the call recording, determined that the call should have been considered a report, and subsequently completed the report as a result. OCFS was able to investigate this instance because the original call recording had not yet been deleted. However, if the complaint had been made after 75 days, the call recording would have been deleted, and the data maintained outside the recording in the digitally logged call record may not be adequate to determine whether the call was handled properly. In such an instance, the call may not have been able to be reclassified from a non-report to a report, resulting in the potential abuse or maltreatment going uninvestigated. Consideration of a longer retention period or improved documentation of non-report determinations and calls could improve OCFS' capability to retroactively determine whether calls were handled appropriately.

Additionally, we found that the closure code for the determination of non-report was not always the actual result of the call, due to the limited choices of closure codes. Of the 13,841 calls determined to be non-reports, 3,656 (26%) documented the reason for categorization as a non-report was "refused to report" – including 573 calls (16%) from mandated reporters. OCFS staff initially stated that this closure code is used when the caller describes a scenario that would rise to the level of a report, but the caller refuses to give the necessary information to register the report (i.e., details such as names or addresses). However, after further analysis of the calls made by mandated reporters, we determined that the "refused to report" disposition is not always the actual reason of the non-report.

For example, in one instance, a law enforcement officer called to report concerns but had to end the conversation due to an incoming high-priority call. The initial call was interrupted and was categorized as a "refused to report." While the officer called back, and a report was registered on a separate call, the initial call's categorization is misleading. Generally, OCFS officials stated staff may select the closure code "refused to report" due to limited options in the system and when no other option is immediately apparent as appropriate. OCFS staff could not confirm this was the case for all instances logged as "refused to report" or whether the disposition was correct or not because the retention period limited OCFS' ability to obtain details for calls older than 75 days. Based on our findings, OCFS officials stated they are exploring the possibility of adding additional closure codes, which would better identify the true reason such a determination was made.

Oversight of Investigations

PQI

We reviewed OCFS' PQI process and found that it is generally successful in identifying deficiencies with the performance at each individual LDSS. Also, each LDSS is developing PIPs to address the issues identified as part of their PQI review. Identifying issues through monitoring processes is critical; however, the greatest benefit from monitoring functions can be achieved by fixing deficiencies in procedures and practices so that they do not recur. The prevalence of certain

issues across multiple LDSSs indicates there are problems that should be addressed statewide, possibly through procedural or policy change, rather than on a case-by-case basis.

As of November 2021, OCFS officials reported that over 1,000 investigations at 12 LDSSs have gone through the PQI review process. Of those investigations, 550 were related to reports of abuse or maltreatment. In approximately half of the 12 LDSS reviews, OCFS found issues related to safety and risk decision making as well as case planning. Table 2 breaks out OCFS' findings by type of deficiency and the percentage of cases in which OCFS identified the issue.

Table 2 – Prevalent Deficiencies

Deficiency	Percent of Cases
Issues with case contacts, child engagement, and/or home visits	84%
Failure to review prior SCR records involving members of the family within 1 business day	70%
Did not offer needed services prior to closure of the investigation	36%
Had significant gaps in casework activity that caused a concern for the safety of the child(ren) and/or were deemed detrimental to the progress of the investigation	32%
Failure to gather sufficient information to assess risk to all children in the household	32%
Missing certain documentation to support supervisory oversight	28%
Lacked an adequate assessment of the family's need for services	24%
Did not have an adequate assessment of immediate or impending danger to all children named in the report and in the household within 24 hours	16%

We reviewed a sample of 50 of the investigations OCFS reviewed to determine if OCFS' findings were supported, if there were additional findings, and if the deficiencies identified were addressed. We did not identify any additional issues that PQI may have overlooked. However, the prevalence of the deficiencies identified across cases and LDSSs suggests that OCFS needs to develop solutions that have statewide reach. Officials have not yet developed a plan on how to address and rectify the deficiencies across LDSSs. Further, the PQI administrative team, which was developed in part to make policy and procedural changes to address problems identified at a statewide level, hasn't met since April 2021, nor has it issued an annual report as intended.

Investigative Support

We selected a sample of 50 cases requiring an investigation – excluding those that needed a fatality review – to determine if the LDSSs took appropriate steps during their case review. Similar to what OCFS identified in its PQI reviews, we found that several investigations lacked evidence to support the completion of required

steps. For example, we found one case that did not have evidence that the child's environment was assessed. Additionally, we found issues with progress notes (16), timely completion of the 7-day safety assessment (16), and providing notification of reports to all appropriate persons (i.e., every parent, guardian, or person legally responsible for the care of the children named in the report) (8). Progress notes, which document the activities staff take during an investigation as well as efforts by both LDSS staff and family to promote safety and reduce risk to the child, were also not always complete or entered timely. For example, one case had notes entered almost 7 months after events occurred and after we requested support for this investigation. Another had incomplete notes documenting the beginning of the investigation, did not document whether necessary additional assessments were completed, and did not support that the allegation was properly vetted. OCFS should work with LDSSs to ensure staff perform and document the required steps of each investigation to ensure the safety of children involved and the accountability of the LDSS over the investigation conducted.

Child Fatality Reviews

When OCFS conducts child fatality reviews, staff generally successfully identify deficiencies in the investigation relating to the child's death and those in prior investigations relating to that child. However, similar to the PQI reviews, PIPs address issues only on a case-by-case basis and fail to make recommendations to fix systemic problems occurring statewide. Crucially, in the case of fatality reviews, while the identification of deficiencies after the fact may provide useful information and areas for improvement, ultimately the worst outcome has already occurred. Therefore, it is critical that solutions are found to these deficiencies to address them proactively rather than after the incident has occurred.

According to OCFS officials, they received approximately 1,407 reports of abuse or maltreatment to children between calendar years 2018 and 2021 that involved an alleged fatality. OCFS' child fatality review of such cases between January 1, 2018 and November 15, 2021 identified 2,752 citations to LDSSs resulting from 641 investigations (46%). The number of citations varied by LDSS, with Bronx (317), New York (248), Kings (240), Onondaga (228), and Erie (137) being the five with the highest number of identified citations.

Additionally, a significant number of the citations related not only to the investigation occurring at the time of the fatality but to previous report investigations involving that child. Of the 3,085 citations noted between 2018 and 2021, 843 (27%) were related to the investigation occurring at the time of the fatality, while 2,242 (73%) were related to previous report investigations that involved the child – indicating deficiencies occurred in investigations prior to the investigation directly pertaining to the child's death. Table 3 shows the overall trend in citations during the period.

Table 3 – Citation Trends

Time of Citation	2018	2019	2020	2021	Totals
At the time of fatality	321	200	164	158	**843**
CPS review of history	612	556	576	498	**2,242**

While there is a noticeable downward trend in the number of citations per year, we note that there was also a drop in reports, especially in 2020 and 2021, which may possibly be attributed in part to the COVID-19 pandemic. There was also a significant decrease in the number of reported fatalities and fatality-related investigations. However, not all LDSSs experienced a drop from year to year. For example, Schenectady, which had only 15 citations in 2019, had 49 in 2020. Also, Ulster had four citations in 2019 but 43 in 2020. Overall, 25 LDSSs saw an increase in citations from 2019 to 2020, and 13 LDSSs saw an increase from 2020 to 2021.

We reviewed a sample of 52 child fatality reviews and found that OCFS, in all cases, identified deficiencies and that a PIP was put into place to address the deficiencies for 51 of the 52 reviews; for one review, OCFS could not locate the PIP. Further, for all but three cases, we found evidence that OCFS conducted quarterly reviews to ensure the PIP was met. However, there was little consistency in how PIPs addressed deficiencies, and OCFS could not easily monitor deficiencies or corrective action among LDSSs or even within regional areas.

For example, some LDSSs, such as the Bronx, outlined the PIP by individual investigation, whereas Erie outlined the PIP by type of issue. While a one-size-fits-all approach may not work across the State, OCFS should determine beneficial strategies for addressing deficiencies and develop systemic solutions as monitoring is done case by case and not collectively.

Recommendations

1. 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.
2. Evaluate and address deficiencies found in PQIs and child fatality reviews on a statewide basis across all LDSSs.
3. Work with LDSS staff to improve investigation file documentation, including ensuring case notes are sufficiently detailed and entered timely.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine if OCFS effectively oversees LDSSs' investigation of reports of alleged child abuse or maltreatment, and ensures compliance with relevant laws, regulations, and procedures to promote the safety and well-being of affected children and families. The audit covered the period from January 2018 to November 2021, with subsequent information related to our sample cases through September 2022.

To accomplish our objective, we became familiar with and assessed the adequacy of internal controls related to our audit objective. We also assessed the reliability of available data. We reviewed relevant laws and regulations as well as OCFS policies and guidance related to investigation of reports of abuse and maltreatment. We also interviewed OCFS as well as LDSS officials. We requested records for a random sample of 50 of the 13,841 calls that resulted in a non-report between September 1, 2021 and November 30, 2021. We reviewed records for a judgmental sample of 52 child fatality cases. We selected this sample based on district size, geographic region, and number of citations. Two of the cases, which were later added to our initial sample of 50, were selected due to specific issues with those cases. We also selected a judgmental sample of 50 cases reviewed by OCFS' PQI process. We selected this sample based on geographic region and length of the investigation under review, while avoiding districts that we selected in our child fatality sample. We also selected for review a judgmental sample of 50 investigations that occurred during November 2021 and that did not involve a fatality allegation. We considered the volume and types of allegations in selecting this sample and used the time period of November 1, 2021 and November 5, 2021 as it was the only available data during the time of our sample selection. None of the results of our samples can be projected to their respective populations as a whole. We were able to directly test the accuracy of the data in CONNECTIONS but not its completeness. However, based on our audit work, we determined that the data from CONNECTIONS regarding calls received and cases investigated was sufficiently reliable for the purposes of this audit.

There were several instances during the audit when OCFS took lengthy periods of time to provide data or documents during the audit. For example, it took 124 days to receive the entire sample of PIPs we requested regarding PQI reviews, 142 days to receive the complete population of PIPs we requested, and 176 days to provide complete investigation data for our sample that excluded fatality investigations. Despite efforts to obtain the requested information, the delays persisted. OCFS officials stated that these delays were largely a result of difficulty extracting information from CONNECTIONS, the retrieval of documents across the State that were not available in a centralized system, and the subsequent redactions officials made for confidentiality purposes. Officials also attested that at no time did OCFS make any attempts to alter, manipulate, or withhold information related to the audit. These delays were considered by auditors when evaluating the appropriateness of the evidence provided.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our 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, notwithstanding the delays we experienced in obtaining certain information.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of OCFS' oversight of Child Protective Services.

Reporting Requirements

A draft copy of the report was provided to OCFS officials for their review and comment. Their comments were considered in preparing this final report and are attached in their entirety at the end of it. In general, OCFS officials agreed with our recommendations and indicated actions they would take to implement them.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office of Children and Family Services shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Agency Comments

KATHY HOCHUL
Governor

SUZANNE MILES-GUSTAVE, ESQ.
Acting Commissioner

December 27, 2022

Nadine Morrell, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street - 11th Floor
Albany, NY 12236-0001

Re: Audit 2021-S-17 – Response to the Draft Report

Dear Ms. Morrell:

The New York State Office of Children and Family Services (OCFS) has prepared this letter in response to the Office of the State Comptroller's (OSC) December 2022 Draft Report for Audit 2021-S-17 (draft report). 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. OSC had two key findings and recommendations:

Finding 1: "OCFS generally has processes in place to oversee LDSS' investigation of reports of alleged child abuse or maltreatment. However, we found improvements could be made to child fatality and in [Program Quality Improvement] (PQI) reviews. The prevalence of certain issues across multiple [Local Departments of Social Services] (LDSSs) indicates problems that should be addressed statewide rather than on a case-by-case basis. Officials had not yet developed a plan to on how to address and rectify the deficiencies on a statewide basis."

Recommendation 1: Evaluate and address deficiencies found in PQI and child fatality reviews on a statewide basis across all LDSSs.

OCFS Response 1: OCFS appreciates OSC's acknowledgement of OCFS' successful oversight and monitoring activities by which OCFS has identified CPS investigation deficiencies. OCFS' implementation of child fatality reviews and PQI monitoring activities, along with resulting Program Improvement Plans (PIP), are key tools which have helped to strengthen CPS practice statewide. As to a statewide review system, OCFS has several existing structures that allow for statewide information-sharing and reflection of case practice, and which consider the information from both child fatality reviews and PQI outcomes to inform practice improvement across New York State.

Regarding PQI, there are several statewide strategies that have been developed to address the areas needing improvement identified during case practice reviews. These include:

- PQI Executive Team – This team consists of members of statewide OCFS senior leadership, bureau managers, regional office staff, and training staff. The team reviews data from PQI case record reviews and identifies statewide themes for LDSS reflection of case practice. These include topics such as improving investigation case file documentation and ensuring case notes are sufficiently detailed and

entered timely. Additionally, there are two subgroups; a Program Improvement Plan (PIP) workgroup tasked with building statewide consistency in the creation and use of PIPs, and a Plan of Safe Care (POSC) workgroup created to develop additional guidance on the development and implementation of POSC with qualified families.

- Grand Rounds – To provide technical assistance regarding best practices, OCFS hosts statewide "Grand Rounds" meetings. This strategy facilitates statewide peer to peer learning to improve practice areas that have been identified as part of the PQI process.

- Guidance Documents – When areas for improved practice are identified across districts, OCFS reviews existing manuals and guidance documents to determine if there is a need to clarify, update, and/or issue new guidance statewide.

- Data Leaders Team –A statewide Data Leaders Team, comprised of key, regionally based OCFS staff, and led by the Director of the Bureau of Continuous Quality Improvement, provide regional support to staff working with each LDSS to improve case practice. Using data analysis and reporting, the members work with LDSSs to improve internal monitoring and to build statewide capacity and consistency.

Regarding child fatality reviews, the following strategies are fully implemented:

- Child Fatality Review Teams – OCFS leads a Statewide Child Fatality Review Team (SCFRT). This cross-system team is comprised of professionals from multiple disciplines, representing multiple state and local agencies, who are engaged in researching the causes of preventable child deaths, as well as in developing strategies to prevent such tragedies from occurring. OCFS established the statewide team to build upon the work of the county and regional local child fatality review teams (CFRTs) statewide. During the statewide reviews of individual fatalities, system and practice issues are identified and discussed in order to develop strategies to reduce the occurrence of child fatalities statewide.

- Child Fatality Reports - OCFS is required by statute to conduct a review of each child fatality investigation when that fatality allegedly resulted from abuse or maltreatment, as well as issue a summary report. The OCFS child fatality reports are an assessment of the local district's CPS practice. After a determination by OCFS that public disclosure of the report would not harm the child's surviving siblings or other children in the household, the fatality report is publicly posted on the OCFS website. These reports are posted to share findings of practice gaps or areas of needed improvements.

Finding 2: "While OCFS is generally performing its required duties in receiving calls through the [Statewide Central Register] (SCR) and determining actions for the calls, we found closure codes for non-report calls could more accurately reflect the nature of closure and why the call did not result in a report. Additionally, the length of time OCFS maintains call recordings from the SCR may limit its ability to retroactively investigate whether non-report calls were properly handled."

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 agrees that the addition of more specific non-report closure codes may help clarify and improve accuracy in documenting why a call to the SCR did not result in an accepted report. OCFS plans

to review the existing closure codes and determine whether additional or replacement codes would be appropriate to better distinguish the reason for a non-report. OCFS contends that its SCR call retention timelines are appropriate to meet system needs.

Once again, thank you for meeting with us to discuss the draft report and for the opportunity to respond. Please contact me by email at Lisa.GharteyOgundimu@ocfs.ny.gov, or by phone at (518) 474-3377 with any questions regarding this response.

Sincerely,

Lisa Ghartey Ogundimu, Esq.
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
Brendan G. Schaefer, CPA, Director, Office of Audit and Quality Control

Contributors to Report

Executive Team

Andrea C. Miller - *Executive Deputy Comptroller*
Tina Kim - *Deputy Comptroller*
Ken Shulman - *Assistant Comptroller*

Audit Team

Nadine Morrell, CIA, CISM - *Audit Director*
Heather Pratt, CFE - *Audit Manager*
Brandon Ogden - *Audit Supervisor*
Stephon Pereyra - *Examiner-in-Charge*
Chelsey Fiorini - *Senior Examiner*
Christina Frisone - *Senior Examiner*
Jacqueline Keeys-Holston - *Senior Examiner*
Kelly Traynor - *Senior Editor*

Contact Information
(518) 474-3271
StateGovernmentAccountability@osc.ny.gov
Office of the New York State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

Like us on Facebook at facebook.com/nyscomptroller
Follow us on Twitter @nyscomptroller
For more audits or information, please visit: www.osc.state.ny.us/audits/index.htm