

**THOMAS R. SUOZZI**  
County Executive



**BONNIE GARONE**  
Commissioner

**NASSAU COUNTY**  
**COMMISSIONER OF INVESTIGATIONS**

**Report to the County Executive**  
**Concerning Child Protective Services**

June 13, 2008

## EXECUTIVE SUMMARY

Three children were killed in their home in February, and their mother has been charged with murder. News accounts reported that the mother confessed to the killings in a 911 call to police, then led the police to the three bodies. The deaths are tragic and incomprehensible.

Immediately after the murders, Nassau County Executive Thomas R. Suozzi ordered a review of the County's contacts with the mother and children, to determine what, if anything, went wrong with a system designed to protect children.

The County Executive directed that the investigation answer the following questions:

- A. Should the County have removed the children from the home at some point in the past?
- B. Should the County have offered the family additional services over the years?
- C. Should additional steps have been taken when the County received allegations about the mother's conduct and mental state, two days before the children died?

After thorough investigation, this report presents the following conclusions:

### A.

#### **There was no legal basis to remove the children from their home in the past.**

As discussed in Part A of this report, the children could not legally have been removed from their home in the past because there was no record of any conduct by the mother that would have risen to the stringent legal standard required by New York State law.

In response to every prior report of suspected maltreatment, CPS -- Child Protective Services, the unit of the Nassau County Department of Social Services responsible for investigating allegations of child abuse and neglect -- thoroughly investigated and found the children to be well cared for by their mother. In every past investigation the children were found comfortable and spontaneous with the mother and there were no signs of abuse, maltreatment or imminent danger.

More recently, CPS had received no reports of possible danger from those who interacted regularly with the family, and since early 2007 CPS had not been alerted by any court officials to look into the safety of the children.

Perhaps most tragically, before the last allegation about the mother's conduct, received two days before the children were killed, CPS had received no allegations of the mother acting strangely or irrationally.

**B.**

**An offer of additional services  
to the mother would have been appropriate,  
but the County could not have compelled her to participate.**

From the time the children were born, the Nassau County provided numerous benefits and services to the family.

Over the years the County provided for the family's basic needs, including financial benefits, medical care, day care, utilities, rent and furnishings.

The County also offered the mother services from five county departments and six outside agencies, which she utilized to a limited degree. In addition, the mother previously was enrolled in a year-long parenting program.

As discussed in Part B of this report, additional parenting support and counseling could have been offered, but the mother's participation could not have been compelled in the absence of abuse, maltreatment or neglect of the children. Any additional services thus would have been voluntary on the mother's part, and it is unknown whether she would have utilized them.

**C.**

**Additional steps should have been taken  
to investigate the allegations received on February 22, 2008 concerning the mother.**

When CPS received allegations that there was concern about the mother's mental state and the children's safety two days before the children were killed, two immediate attempts were made to visit the family. No contact was made, however, because no one was found at home.

The children were killed little more than a day later, before additional attempts were made to assess their safety.

This investigation made a number of troubling discoveries:

- The initial caseworker did not take sufficient steps to determine whether the family in fact was at home.
- The same caseworker apparently received a phone call from the mother on the afternoon the allegations were received, but did not report it or make any record of it.
- The supervisor on duty failed thereafter to ensure that timely efforts were made to locate the family, by scheduling follow-up visits or directing that contact be made with others who might have information about the safety of the children.

- An e-mail that could confirm that someone was assigned to visit the family over the weekend cannot be found.
- The weekend caseworker allegedly assigned to visit the family on Sunday, the day the children died, has refused to speak about his work for the County, asserting his Fifth Amendment right not to answer questions that might tend to incriminate him.

While we never can know whether the mother's actions could have been prevented, additional steps should have been taken to investigate the allegations as discussed in Part C.

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Finally, while this report concludes that certain CPS employees should have taken additional steps in this case, it would be remiss if it did not also acknowledge that the CPS staff performs a difficult and demanding job twenty-four hours a day, every day of the year, and performs with dedication, compassion and professionalism. In more than six thousand cases each year children are protected, and that fact should not be lost as we focus on this tragedy.

A.

**SHOULD THE COUNTY HAVE  
REMOVED THE CHILDREN AT SOME POINT IN THE PAST?**

In the wake of a horrific tragedy in which three young lives were lost, it is reasonable to ask whether the family was “known to” CPS and, if so, why the children had not been removed from their home in order to keep them safe. The short answer is that the legal standard for removing children is a high one, and it was not met in this case. The more complete answer is that, by all available accounts, the children had been well cared for at every CPS visit and inquiry, and there was no prior indication that they were in danger of harm by their mother’s hand.

**1. There was no legal basis to remove the children from their home during the course of the County’s involvement with this family.**

Legally, removal of children from their home is an action of last resort for the government. For that reason, a child may be taken from his or her home without the consent of a parent or guardian only if there is “reasonable cause to believe . . . that continuing in his or her place of residence or in the care and custody of the parent . . . presents an imminent danger to the child’s life or health.”<sup>1</sup> There must be evidence upon which a court can find that the “imminent danger” to a child is “near or impending, not merely possible.”<sup>2</sup> That legal standard must be met before “the state, through its family court, may intervene against the wishes of a parent on behalf of a child.”<sup>3</sup>

Because the children were found to be healthy and well cared for on every past occasion that they were evaluated, and any recent deterioration in the mother’s functioning had not been made known to the County, there was no basis, prior to the most recent allegations, upon which to remove them from their home and their mother.

**2. Prior CPS involvement with the family did not involve facts that would warrant removing the children from their home.**

Over the approximately five-year period spanning the spring of 2003 through the end of 2007, nine reports of suspected abuse or neglect of the subject children were made to the State Central Registry, which in turn transmitted the information to the Nassau CPS unit for investigation. Each of the allegations was fully investigated.

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1. N.Y. Soc. Svs. Law § 417(1)(a) and § 424(9); 18 NYCRR § 432.3(l).

2. Nicholson v. Scoppetta, 3 NY3d 357, 369, 820 NE2d 840, 845, 787 NYS2d 196, 201 (2004).

3. N.Y. Family Court Act § 1011; see §§ 1022 (preliminary orders of court for removal prior to filing of petition); 1024 (emergency removal without court order).

In order to investigate reports of child abuse, neglect or mistreatment, CPS caseworkers visit the home where the children reside, interview those with knowledge of their care, and observe the children in interactions with others. The subject of the report is interviewed, often several times, and the caseworker also reaches out to other adults in the children's lives, such as relatives, teachers and counselors. Where the children are old enough, the caseworker speaks with them as well, both with and outside the presence of their parents. Where appropriate, the caseworker checks the children for bruises or other evidence of abuse. Unannounced visits are made to the home, on different days and at various times, and health and safety factors within the home are reviewed. In addition, the children are observed interacting with siblings and the subject of the investigation, so that nonverbal information, such as the children's degree of comfort or apprehension around the subject, can be weighed.

All of these steps were taken by CPS caseworkers in investigating each of the nine reports.

After investigation, the majority of the reports -- six of the nine, and one of two allegations in the seventh -- were determined to be "unfounded." State law requires CPS to designate a report as "unfounded" when the investigation determines there is no credible evidence to support it.<sup>4</sup> The state is notified of all "unfounded" determinations.<sup>5</sup>

State law does not permit the details of the unfounded cases to be publicly discussed. For the purpose of this report, however, it is most important to note that the caseworkers who met and spent time with the family in every instance observed that the children interacted spontaneously with their mother and exhibited no apparent fear or apprehension in her presence.

The same was true in the remaining three reports, none of which involved any finding that the mother was harming or threatening to harm the children. Those reports, deemed "indicated" because caseworkers concluded there was credible evidence to support them, involved a domestic dispute in 2004 in which the mother was beaten, and findings in 2007 that the mother had left the children alone.

The 2004 incident triggered a CPS investigation because the children had been present in the home during an altercation in which the father of one of the children present beat the mother. The police were called and arrested the father, and the mother acted responsibly in obtaining an order of protection against him. There was no indication of harm to, or any threat of violence against, the children.

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4. N.Y. Soc. Serv. Law § 412(11), (12); 18 NYCRR § 432.1(f),(g).

5. Specifically, the information is reported to the State Central Registry, which may review the County's determination; upon review, it may request additional information, affirm the designation, or change it. 18 NYCRR § 432.9(d). None of the unfounded determinations for this family were questioned by the state.

The 2007 incidents both concerned instances of the children being left without adult supervision. The CPS investigation of the first instance, which involved the children playing in a park outside their mother's field of vision, concluded that the mother had accidentally fallen asleep while sitting in her car outside the park. At the conclusion of the investigation of the second incident, which involved the mother leaving the children alone in the family apartment, the mother was counseled about the need to make appropriate plans for someone to watch her children when she could not, and she agreed.

As in the unfounded cases, throughout these investigations, too, the children showed no signs of abuse; to the contrary, they were found in every instance to be well cared for and comfortable interacting with their mother.

**3. Prior police involvement with the mother did not involve facts that would warrant removing the children from their home.**

While the mother had a long history of involvement with Nassau County police, under the applicable legal standard, discussed above, none of the encounters created a basis to remove the children from her care. Among other reasons, from the time the first child was born in 2001:

- (a) The mother was most often the *complainant*, not the subject of the police reports; and
- (b) The children rarely were present during conduct that resulted in police involvement.

Between 2001 and 2007 she complained to the police seventeen times about the conduct of others, including family members with whom she argued, unknown persons allegedly using her benefit cards, a neighbor she accused of punching her, and a child she accused of hitting her daughter. Many of her complaints involved the father of her sons, whom she accused at various times of yelling at her, cursing at her, hitting her, damaging her property and forging her signature on a tax refund.

The mother was arrested twice in April of 2003 in connection with her dealings with the father: once for going to the father's home in violation of a protective order, and again when she cut his hand while trying to slash his tires after he slashed hers, and possessing marijuana; the arrests resulted in conviction for harassment in the second degree and a sentence of four days in jail and a \$125 fine. The children were not present in either instance. Arrests in 2000, before any of the children were born, resulted in convictions for assault in the second degree, disorderly conduct and criminal contempt in the second degree, for which the mother was sentenced, on June 26, 2002, to three years of probation, to include therapy as directed by the Probation Department. During the period of probation she was provided with a number of services that she utilized to varying degrees, and these are discussed in the next section of this report.

In the four instances in which the children *were* involved or present when the police responded -- in 2004, when the children were at home while their mother was beaten; in 2005, when she found them missing when she returned upstairs from doing laundry in the basement;

in 2006, when she was accused of slapping her daughter; and in 2007 when she complained to the police that her sons' father failed to return one of the boys after a visit -- reports were made by the police Juvenile Aid Bureau ("JAB")<sup>6</sup> to CPS, which thoroughly investigated them as discussed in the previous section of this report. Although police have the legal authority to remove children prior to a court order when immediate action is necessary to protect them,<sup>7</sup> JAB never found such danger present in the conduct of the mother.

**4. The County received no reports of irrational behavior in the weeks preceding the report made on February 22, 2008.**

If, as has been reported in the media, the mother had been manifesting signs of mental illness for weeks, that information was not known to CPS or to the police.

After the tragic events, *Newsday* reported the comments of a family member who said she had seen the mother a week earlier and thought the mother "'had gotten into her own little world,'" when the mother told her that a woman on television "'was talking about her and the kids,'" and that "'there was some lady following her'" when she went out of the house.<sup>8</sup> A second *Newsday* article reported that "[n]eighbors on Prospect Avenue had seen [the mother] outside in her pajamas, pushing an empty stroller."<sup>9</sup> The father of the boys was reported in the *New York Post* as saying that the mother told him in the past that she would "throw the kids out of the window," if he "failed to show up for scheduled visitations."<sup>10</sup>

Unfortunately, such behavior -- which clearly would have been relevant in weighing whether the children were in danger -- was not made known to CPS or the police.

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6. JAB is an investigative unit of the Nassau County Police Department, currently staffed with 13 detectives, which is contacted by patrol officers when they encounter situations in which children may be at risk. Where appropriate, JAB Detectives attempt to educate parents regarding the harm and detriment children experience when they witness or are subjected to domestic disputes. Where it appears that abuse or maltreatment may be present, JAB refers the matter to CPS for an appropriate investigation.

7. Section 1024 of the Family Court Act, titled "Emergency removal without court order," directs police officers, among others, to "take all necessary measures to protect a child's life or health including, when appropriate, taking or keeping a child in protective custody," when there is "reasonable cause to believe" that danger to life or health is imminent and there is insufficient time to apply for a court order.

8. *Newsday*, "Changes Seen in Young Mother," Feb. 25, 2008 at p. A2.

9. *Newsday*, "Social Workers Made Several Visits," Feb. 25, 2008 at p. A3.

10. *New York Post*, "Blown Chance to Save Kids," Feb. 26, 2008 at p. 17.

**5. The County received no reports from mandated reporters or court officials in the weeks preceding the report made on February 22, 2008** .

If indeed the mother had been acting dangerously in the weeks before the tragedy, it could not have been evident to the professionals in contact with her and the children given that no such reports were made to CPS by mandated reporters or court officials. While any person is permitted to report suspected child abuse or maltreatment, if he or she has reasonable cause to suspect it is occurring,<sup>11</sup> certain officials and professionals, such as teachers, guidance counselors and social workers, are required to do so. They are called “mandated reporters.”<sup>12</sup> No such reports, which would have triggered immediate investigation, were received by CPS in the months preceding the February 22<sup>nd</sup> report. Nor since early 2007 had any court official asked CPS to conduct any investigation in connection with matters involving the family that were pending in court.

**Conclusion**

As detailed above, there was no legal basis to remove the children from their home in the course of the County’s involvement with the family. Neither prior CPS involvement over the years nor prior police contacts involved facts that would have warranted or allowed removal, or that indicated the likelihood of future risk for the children.

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11. N.Y. Soc. Serv. Law § 414.

12. N.Y. Soc. Serv. Law § 413(1)(a). The following titles are listed in the law as mandated reporters: physician; registered physician assistant; surgeon; medical examiner; coroner; dentist; dental hygienist; osteopath; optometrist; chiropractor; podiatrist; resident; intern; psychologist; registered nurse; social worker; emergency medical technician; licensed creative arts therapist; licensed marriage and family therapist; licensed mental health counselor; licensed psychoanalyst; hospital personnel engaged in the admission, examination, care or treatment of persons; Christian Science practitioner; school official, which includes but is not limited to school teacher, school guidance counselor, school psychologist, school social worker, school nurse, school administrator or other school personnel required to hold a teaching or administrative license or certificate; social services worker; day care center worker; provider of family or group family day care; employee or volunteer in a residential care facility defined in subdivision seven of section four hundred twelve of this title or any other child care or foster care worker; mental health professional; substance abuse counselor; alcoholism counselor; peace officer; police officer; district attorney; assistant district attorney; investigator employed in the office of a district attorney; law enforcement official.

**B.**

**SHOULD THE COUNTY HAVE OFFERED THE FAMILY ADDITIONAL SERVICES?**

Whether additional services could have changed the course of events for the family is something we obviously can never know. What we do know is that from the time the mother's first child was born in 2001, the family received benefits and services from five county departments and the mother was offered the services of six outside agencies, which she utilized to varying degrees. Additional voluntary services could have been offered, but we will never know if they would have been accepted.

**1. The County provided for the family's basic needs.**

While a media account the day after the children died suggested that the mother recently had been "turned down for financial assistance,"<sup>13</sup> that is not the case:

From January 2002, when she was twenty-one years old and had a six-month-old daughter, the mother received assistance from the County for herself and her family. Each family member received comprehensive medical benefits, and food stamps were provided from shortly after the birth of her second child in 2003. The family also was enrolled in WIC -- "Women, Infants and Children" -- a supplemental nutrition program that provides foods essential for good growth and nutrition for young children as well as nutritional counseling and education. The family's financial benefits most recently were recertified in November 2007, to continue through March 31, 2008.

During the periods that the mother worked or attended various programs, the County paid for day care providers selected by the mother. As part of the recertification that took place last Fall, the day care benefits also were extended to March 31, 2008.

Finally, for much of this time the family resided with the mother's grandmother, but after she evicted them the County provided rental and other assistance.<sup>14</sup> When the mother found an apartment the County provided emergency funds to pay the first month's rent and a security deposit, and also purchased a refrigerator for the apartment as well as furniture and other necessary items. Thereafter the family's monthly benefits from the County included the apartment rent and utilities.

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13. *New York Post*, "Mom Drowns 3 Kids," Feb. 25, 2008 at p. 5.

14. The grandmother filed a Petition in First District Court in 2005, seeking the mother's eviction. The mother ultimately signed a "Stipulation of Settlement of Non-Payment" in September 2005 and agreed to vacate the grandmother's home. She found an apartment in 2006.

**2. The County provided the mother with the opportunity to utilize a wide range of services.**

Through both her period of probation and her contacts with other county agencies, including when she applied for benefits, the mother was screened for and provided with a wide range of services that she utilized to varying degrees.

One of the first programs to which she was referred was the Women's Opportunity Resource Center ("WORC"), run by the Educational and Assistance Corporation ("EAC") in Hempstead.<sup>15</sup> The program offered GED classes in the morning and general business classes in the afternoon, and she attended, at times sporadically, during 2002 and 2003.

Shortly after she completed the WORC program and throughout her term of probation, the mother was directed by the Probation Department to attend several additional programs that offered counseling and other services. State and federal privacy laws preclude identifying those programs here. Although her attendance again was sporadic and she chose to leave one of the programs in order to work, she was not charged with violating the terms of probation, which could have resulted in incarceration. Instead, Probation personnel worked with her, attempting to find a counseling program with which she would engage, until her term of probation ended on June 25, 2005.

One program with which it appears the mother *did* engage at times was the Family Ties program conducted by the Family and Children's Association, to which CPS referred her after the first, unfounded CPS investigation. This program, in which she participated from September 2003 until December 2004, was a voluntary, preventive service program designed to help keep families together through counseling and other services. During those sixteen months, a caseworker visited the family regularly, checked with day care providers about the children, spoke with the mother on the phone about particular problems as they occurred, and generally counseled her about issues with which she was dealing.

**3. Additional communication among agencies could result in more coordinated services .**

Although various agencies were speaking with the mother over the years and directing her to services, it appears that insufficient mechanisms existed to coordinate those efforts. In addition to the service referrals made by Probation and CPS, screening was done for employment and substance abuse needs each time the family was recertified for public assistance benefits, as

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15. According to the website for WORC, it "is an alternative to incarceration program for women," with the goals of "self-sufficiency and the prevention of recidivism." It is described as "a full day on-site program consisting of computer skills training, business skills development, adult basic education, GED preparation, personal living skill development, and counseling." <http://www.eacinc.org/p-worc.htm>

required by state law.<sup>16</sup> Thus on ten separate occasions, spanning 2001 to 2008, the mother completed self-reporting Alcohol and Drug Abuse Screenings required of applicants for financial assistance.<sup>17</sup> She also was referred for assessment of her employment skills on numerous occasions.

Because she did not always inform other agencies of the requirements being imposed on her by Probation, at times the mother simultaneously was directed by Probation and others to attend different appointments and programs. The first instance occurred in 2003, when she was advised that she would be sanctioned for failing to report for an employment assessment when in fact she already was required to attend a daily program mandated by Probation. Her record was corrected once confirmation of her attendance was secured, but similar problems occurred again in both 2004 and 2005.

To avoid such instances, which waste both staff and client time and can result in relevant information being missed and services being duplicated, additional protocols for coordinating and sharing information should be established among the County's service agencies, within the confines of the confidentiality requirements of state and federal law.

That applicable confidentiality restrictions can be hard to decipher was starkly illustrated in the course of preparing this report, when it was discovered that the Lexis electronic legal research service<sup>18</sup> was displaying an outdated -- and incorrect -- version of the New York legal requirements for the confidentiality of probation records. In March 2008, the language displayed by Lexis for the relevant regulation -- 9 NYCRR § 348.4 -- stated only that probation records "shall be accessible, in whole or in part, only by those authorized by law, court order and/or the Division of Probation and Correctional Alternatives." This language provided little, if any, guidance as to whether a local probation department could share an individual's records with a unit such as CPS.

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16. See 18 NYCRR § 385.6(a); 18 NYCRR § 351.2(i)(1). As stated in the Temporary Assistance Sourcebook ("TASB"), which is published by the New York State Office of Temporary and Disability Assistance "to provide Temporary Assistance staff with authoritative information to do their job effectively" (p. 1-1 (12/27/07)): "[l]ocal districts must screen all heads of household and all adult applicants and recipients of TA . . . for alcoholism or substance abuse." TASB at p. 445 (10/27/03). In addition, at recertification "[t]he employment, potential employability, availability for employment, or need for training or retraining shall be reviewed and established." TASB (2/27/08) at p. 6-3. [www.otda.state.ny.us/main/ta/TASB.pdf](http://www.otda.state.ny.us/main/ta/TASB.pdf)

17. The screening forms are dated February 5, 2008; February 14, 2007; (date illegible) 2007; September 6, 2006; November 13, 2003; November 14, 2002; June 14, 2001; and September 11, 2001. One additional screening form has an illegible date, and one is undated.

18. The Lexis service is an electronic database, commonly used by attorneys, government agencies and courts, that includes statutes, regulations and legal decisions of every state and many countries.

At the same time, the website of the state Probation agency<sup>19</sup> contained a very different version of the same regulation, which turned out to be the correct version. There, the correct regulation listed four instances in which local probation agencies *must* release information, and additional circumstances in which they *may* do so; in this version of the law, CPS investigations were listed as one of the situations that *require* probation offices to share their records:

Upon a determination by a probation director . . . that probation records regarding an individual presently under the supervision of the department are relevant to an investigation of child abuse or maltreatment conducted by a child protective service agency . . . he/she shall provide the records, or portions thereof, determined to be relevant to the child protective service conducting the investigation. . . .

9 NYCRR § 348.4(b)(3) (emphasis added). Once the state agency confirmed that its version of the law was the current one, and provided Lexis with supporting documentation, Lexis promptly corrected the regulation published in its database.

It seems clear that probation officials may -- indeed, must -- share with CPS any information in probation records that would be relevant to a CPS investigation. But the fact that Lexis, one of the country's foremost legal authorities, could evidence confusion about the law demonstrates just how difficult it can be to ensure seamless communications among agencies.

**4. An offer of additional services to the mother would have been appropriate, but the County could not have compelled her to participate.**

With the acuity of hindsight, it is easy to say that additional support services probably should have been offered to the mother after the second finding that she had left the children unsupervised, in 2007. What we can see now is that the mother had difficulty in relations with others at times, particularly the father of her sons; needed assistance in meeting the needs of her children; and had difficulty holding a job. Moreover, in 2006, after being evicted from her grandmother's house, she moved from living quarters with other family members to an apartment alone with a young son and daughter. Shortly after that, in August 2006, she gave birth to her third child. Two successive reports of leaving the children unsupervised were found "indicated" in 2007.

While the two indicated reports each provided a small snapshot of the mother's functioning at a point in time, the larger and more vivid picture comes into focus when the reports are viewed against the background of the family's entire history.<sup>20</sup> So although the

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19. The Division of Probation and Correctional Alternatives is the state Probation agency.

20. Presumably that is why, within one business day of receiving a report of suspected child abuse or maltreatment, CPS is required to review the State Central Register record of prior reports involving family members, including legally sealed, unfounded reports, and within five

2007 indicated cases contained no evidence to indicate that the children were in danger of future harm, the whole picture suggests that an offer of additional services, especially in the areas of counseling and parenting skills, would have been appropriate at the time of the last indicated case. It is important to understand, however, that participation in such services would have been voluntary for the mother.<sup>21</sup> Whether participation would have been helpful -- and whether the mother would have participated fully, sporadically, or not at all -- is something we cannot know.

### Conclusion

While the County provided for the family's basic needs over the years, and offered the mother the services of six outside agencies, including a fifteen-month program designed to help families stay together through counseling and other services, hindsight suggests that additional services, especially in the areas of counseling and parenting skills should have been offered. While no single investigation required it, an offer of such voluntary services in 2007, after the mother twice was found to have left the children alone, would have been appropriate.

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business days CPS must review its own files that apply to the prior reports. 18 NYCRR § 432.2(b)(3)(i).

21. CPS may “offer to the family of any child believed to be suffering from abuse or maltreatment such services for its acceptance or refusal, as appear appropriate for either the child or the family or both; provided, however, that prior to offering such services to a family [CPS must] explain that it has no legal authority to compel such family to receive said services.” N.Y. Soc. Serv. Law § 424(10); 18 NYCRR § 432.3(p). While CPS may seek court intervention to compel a family to accept particular services, there must be a sufficient evidence to demonstrate that such an order is necessary and in the best interests of the child. See 18 NYCRR § 432.2(b)(4)(iv).

C.

**SHOULD ADDITIONAL ACTION HAVE BEEN TAKEN  
IN RESPONSE TO  
THE ALLEGATIONS RECEIVED ON FRIDAY, FEBRUARY 22, 2008?**

On the afternoon of Friday, February 22<sup>nd</sup>, CPS received a report that a caller to the state child abuse hotline had expressed concern about the mother's behavior and the safety of the children. A Nassau caseworker called the source of the allegations and conducted an interview by phone, then contacted a caseworker in the field to go immediately to the home to check on the children. After no one was found at home in the afternoon, a second caseworker visited the home Friday night. Beyond those efforts, however, no additional steps were taken to assess the safety of the children.

**1. Additional steps should have been taken to investigate the allegations received on February 22, 2008 concerning the mother.**

On February 22<sup>nd</sup>, at 12:26 p.m., a call was made to the state hotline expressing concern about the mother's mental state and the safety of the children. The allegations made to the state were forwarded to Nassau County CPS, and the CPS registry unit properly received them. According to the state, the following is what was said by the hotline caller:

“MOTHER IS SMOKING MARIJUANA IN THE PRESENCE OF SEVEN YEAR OLD [REDACTED], FIVE YEAR OLD [REDACTED] AND EIGHTEEN MONTH OLD [REDACTED]. MOTHER IS DOING COCAINE, TOO. MOTHER LEAVES THE CHILDREN HOME ALONE. THE LAST TIME THIS HAPPENED WAS ABOUT TWO MONTHS AGO. MOTHER IS FAILING TO PROVIDE PROPER SUPERVISION. MOTHER HAS MENTAL HEALTH ISSUES. SHE IS HAVING HALLUCINATIONS AND DELUSIONS. MOTHER IS THREATENING TO PUT THE CHILDREN OUTSIDE. MOTHER'S MENTAL STATE IS PLACING THE CHILDREN AT IMMINENT RISK OF HARM.”

“[REDACTED] DIDN'T HAVE A PHONE NUMBER FOR THE MOTHER. A CONTACT PERSON IS THE GRANDMOTHER. SHE CAN BE REACHED AT 516-[REDACTED]. THE LAW GUARDIAN'S NAME IS [REDACTED], AND HER PHONE NUMBER IS 516-[REDACTED]. MOTHER HAS NO BEDS, AND THE CHILDREN ARE SLEEPING ON THE FLOOR.” 22

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22. Names and other identifying information have been omitted from the allegations.

While state law prohibits the County from revealing the source's identity,<sup>23</sup> news reports have stated that the allegations were made by the father of the two youngest children.<sup>24</sup>

**Contact with the source of the allegations.** -- After the allegations were received by the Nassau CPS registry unit, they were given to a caseworker in the office. That caseworker immediately contacted the source of the allegations by phone in an attempt to clarify them and/or obtain additional information. The source indicated that the allegations sent to CPS by the state accurately reported what he had said when he called the hotline. The source explained that he had not personally seen the mother using drugs in the presence of the children, but thought the mother had sounded "high" on the phone two months before. The source also reported that the mother had an order of protection against him, and that he and the mother were scheduled to be in court on the upcoming Monday concerning a visitation issue. Finally, the source stated that the mother's mental state was such that she believed that people on television and the internet were "doing voodoo on her." The source also supplied the full name, address and phone number of the mother's maternal grandmother. The caseworker who spoke to the source promptly typed up notes of the conversation, and sent them by e-mail to the caseworker assigned to the case.

**Attempt to visit the family Friday afternoon.** -- The available information was communicated by phone to the assigned CPS caseworker, who was in the field, and sometime between approximately 2:15 and 3:30 p.m. that caseworker (the "Day Caseworker") made an unannounced visit to the home of the mother and children in Westbury. The time of the visit is estimated because the Day Caseworker made no record of it and subsequently could not recall what time she arrived at the house.<sup>25</sup>

The Day Caseworker approached three doors at the house, which contained several apartments: the front door was locked, the side door opened directly into the apartment of another tenant, and a knock on the back door was answered. In response to the Day Caseworker's questions, the woman who answered the door confirmed that the family lived upstairs, but stated that neither the mother nor the children were home. A flight of stairs was visible from the doorway, leading to what looked like the door to an upstairs apartment, but the Day Caseworker did not walk up the stairs and knock on the door, or ask the woman for permission to do so. Instead, the Day Caseworker left a note with her phone number, asking the mother to call her, and returned to the office.

Upon returning to the office the Day Caseworker prepared paperwork to pass the case to the night staff, so that another visit could be made in the evening. She included with the

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23. The source of the allegations is confidential by law. N.Y. Soc. Serv. Law § 422-a(4).

24. *Newsday*, "How Could This Happen?" Feb. 26, 2008 at p. A2; 24. *New York Post*, "Blown Chance to Save Kids," Feb. 26, 2008 at. p. 17.

25. According to the Child Protective Services Program Manual, promulgated by the New York State Office of Children and Family Services, all progress notes made by the caseworker are to include, among other details, the date and time of each contact.

paperwork for the night staff a copy of the initial allegations, but did not include the e-mail that described the phone conversation with the source of the allegations, or a description of the attempted visit to the home. She did not attempt to contact the grandmother or the law guardian mentioned in the allegations.

**Mother's call to CPS late Friday afternoon.** -- The Day Caseworker's case notes include nothing about receiving a call from or having a phone conversation with the mother. But the investigation conducted for this report included a review of the mother's telephone records for the last three days of the children's lives, and only then was it discovered that the mother had phoned the Day Caseworker late in the afternoon of Friday, February 22<sup>nd</sup>. Specifically, the phone records show that a call was made from the mother's phone to the Day Caseworker's phone at 4:18 p.m. that Friday, presumably in response to the note left at the house. Based on the duration of the call, and the fact that voice-mail capability had not yet been established for the Day Caseworker's phone, there can be little doubt that the mother's call was answered.

Throughout two separate interviews concerning the phone call, the Day Caseworker never denied that the mother called her and that they spoke on that Friday afternoon. Rather, she stated that "maybe" she spoke to the mother, but insisted that she "can't recall" a conversation.

The reasonable conclusion is that the conversation took place. Did the mother appear to be lucid and calm, or were there indications that something was seriously wrong? Because the Day Caseworker failed to make any notes about the call,<sup>26</sup> or even let anyone know that it had taken place when it was fresh in her mind, we do not know.

**Attempt to visit the family Friday evening.** -- A second visit was made to the home, on Friday evening, but again no one was found at home. This visit was made by a part-time caseworker (the "Night Caseworker") who was assigned by the supervisor on duty Friday night to make the visit. He arrived at the mother's address at approximately 7:39 Friday night. The Night Caseworker took a flashlight to the back of the house, where the doorbells were located, and twice pressed the bell for the family's apartment. After receiving no response, and having already completed his one other assigned case for the night, the Night Caseworker returned to the CPS night office in Westbury to complete paperwork. By approximately 8:30 p.m., the Night Caseworker had completed both of his assignments and his paperwork. He was given no further assignments Friday night.

**No further attempts made Friday evening.** -- The supervisor on duty Friday night (the "Night Supervisor") did not instruct the Night Caseworker, or any other caseworker, to return to the Westbury home later in the shift, to check again whether the mother or children were home, despite that the Night Supervisor, Night Caseworker and others were on duty until 11 p.m. that night. Nor did the Night Supervisor direct anyone to phone the grandmother or the law guardian, to determine if they had current information about the family, although both names and phone numbers were included with the allegations. Thus, although he had a copy of the allegations, which described the mother's mental state and expressed concern about the safety of

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26. The Child Protective Services Program Manual directs that "each contact" be entered in the case record as part of the "Progress Notes."

the children, the Night Supervisor did not make further attempts to contact the family or otherwise assess the children's safety Friday night.

**No Saturday contact scheduled.** -- According to the Night Supervisor, who assigns cases for weekend visits before leaving Friday night, the next visit to the home was scheduled for Sunday. The Night Supervisor states that the visit was assigned to a caseworker who was working on both Saturday and Sunday (the "Weekend Caseworker"), with the visit for *this* case, and one other, left for Sunday. Specifically, the Night Supervisor stated, the Weekend Caseworker was told Friday night that cases would be left for him to pick up on Sunday, and this was one of those cases.

The Night Supervisor initially stated that there was insufficient staff on duty to assign the case for a Saturday visit, but later conceded that was not accurate. Rather, the Night Supervisor chose not to assign a visit for Saturday although there was sufficient Saturday staff to do so. According to the record kept by the Night Supervisor, he had *seven caseworkers* working that Saturday, and a total of *nineteen cases* that he assigned for weekend visits. All nineteen cases -- including this case -- easily could have been assigned for visits on Saturday.

The investigation identified no legitimate reason for leaving *any* cases to be visited on Sunday. The Night Supervisor has stated that based on the initial allegations available to him, he viewed the case as a "classic" custody dispute carrying little risk for the children, notwithstanding the allegations of hallucinations, delusions, and the threat of putting the children outside on what was a snowy day in February. But even if there had been no allegation of an imminent risk of harm, all of the cases should have been assigned for Saturday in any event, because there were sufficient caseworkers on duty. The *only* identified benefit of leaving two cases for Sunday was to provide an additional day of work for a part-time caseworker who was paid by the hour and who could then be scheduled to work on both Saturday and Sunday (the "Weekend Caseworker").

In addition to failing to supply a credible reason why the case was not assigned for a Saturday visit, the Night Supervisor has asserted that it was "not required." The law, however, does not support that assertion. State law requires CPS to commence an appropriate investigation within 24 hours of receiving a report of possible abuse or neglect.<sup>27</sup> This means that, under the law, within 24 hours there should be actual contact with the subject, or with someone else in a position to know whether the children are in danger. The applicable regulation states this very clearly:

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27. After receiving a report of suspected child abuse or maltreatment, CPS shall "commence . . . within twenty-four hours, an appropriate investigation." NY Social Services Law § 424(6). The applicable regulation further explains that CPS must commence the investigation within 24 hours and "in accordance with the provisions of section 432.2(b)(3)." 18 NYCRR § 432.3(i).

Investigation/assessment. (i) The child protective service must commence . . . within 24 hours after receiving a child abuse and/or maltreatment report, an appropriate investigation of each report of suspected child abuse and/or maltreatment. Within 24 hours of receiving a child abuse and/or maltreatment report, the child protective service . . . must conduct a face-to-face contact or a telephone contact with the subjects and/or other persons named in the report or other persons in a position to provide information about whether the child may be in immediate danger of serious harm. . . . 28

The Child Protective Services Program Manual, which is issued to every caseworker and every supervisor, also spells this out:

A child protective investigation must be initiated within 24 hours of the receipt of the report in one of the following ways:

- face-to-face contact with the child and/or family.
- significant telephone contact with the child and/or family.
- significant face-to-face or telephone contact with the source of the report if (s)he is in a position to provide information about whether the child may be in immediate danger of serious harm.
- significant face-to-face or telephone contact with another person in a position to provide information about whether the child may be in immediate danger of serious harm.

Program Manual, Ch. IV, sec. D-.2.a at p. 1.

That the allegations were extremely serious in nature should have flagged the need for aggressive follow-up. The Night Supervisor thus should have ensured that additional attempts were made Friday night and Saturday to contact the family and the other potential sources of information to assess the children's safety.

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28. 18 NYCRR § 432.2(b)(3) (emphasis added).

**2. Some questions remain unanswered,  
and will be referred to the District Attorney.**

We have not been able to learn all of the facts concerning certain steps that were taken, not taken, and why:

As a threshold matter, it has been impossible to confirm that the case in fact *was* assigned for any weekend visit, because the only contemporaneous record of the assignment -- an e-mail message that the Night Supervisor states was sent Friday night, February 22<sup>nd</sup> -- mysteriously has disappeared. Every Friday night that he is on duty, the Night Supervisor prepares a chart showing which cases each caseworker is assigned to handle over the weekend, and the chart is sent by e-mail to the CPS Assistant Director who is his supervisor. That e-mail message for the Friday in question thus would confirm whether the case in fact had been assigned to the Weekend Caseworker to make a visit over the weekend. No such e-mail has thus far been located.

In addition, the Weekend Caseworker's actions remain a mystery for additional reasons:

First, it appears the Weekend Caseworker had not made any attempt to visit the family by Sunday *evening*, when he apparently first learned that the children had died.

Second, when he was questioned the Weekend Caseworker invoked his Fifth Amendment rights and refused to provide any information about his work for the County, making it impossible to obtain any direct answers about his actions.

By way of example, at a deposition on April 1, 2008, the Weekend Caseworker testified in relevant part as follows:

Q: Turning to the weekend of Friday, February 22<sup>nd</sup> through Sunday, February, 24<sup>th</sup>, did you do any work for the county that weekend?

A: (Attorney) I'm directing my client not to answer any questions, on the grounds that the answers to those questions may tend to incriminate him.

As I said, that stands for any and all future questions of him, period. . . .

. . . .

Q: It is my understanding that you intend to invoke your Fifth Amendment right, if I ask you any questions about your work for the county on Sunday, February 24<sup>th</sup>; is that correct?

A: Yes.

Q: It is my understanding that you invoke your Fifth Amendment right, if I ask you any additional questions about your work for the County of Nassau; is that correct?

A: Yes.

Transcript pp. 28-30.

The Weekend Caseworker thus refuses to confirm even that the case was assigned to him as the Night Supervisor reports. Nor has there been any explanation why, if a visit *was* planned for Sunday, the Weekend Caseworker had not attempted to visit by Sunday evening. These issues will be referred to the District Attorney.<sup>29</sup>

### Conclusion

It is clear that additional action should have been taken in response to the allegations received by the County on Friday, February 22, 2008. During the first attempt to visit the family on Friday afternoon, the Day Caseworker should have directly confirmed that the mother was not at home by knocking on the upstairs apartment door, or at least seeking to do so, before leaving the premises. Given the conclusion of this report that the Day Caseworker received a phone call from the mother upon returning to the office, she should have used the opportunity to attempt to determine the mother's mental state, made a record of the call, and informed a supervisor in a timely manner that the call had occurred. After the second attempt to visit the home was unsuccessful Friday evening, the Night Supervisor should have required an additional visit to take place, later in the shift, and assigned a caseworker to contact the grandmother and law guardian. If those efforts were unsuccessful, the Night Supervisor should have required that additional visits to the family take place beginning Saturday morning.

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29. The investigation also discovered certain discrepancies in time sheets submitted by the Weekend Caseworker that are not directly relevant to this report.

## **ACTIONS AND RECOMMENDATIONS**

Over the past three months a number of measures have been continued/expanded or initiated by CPS to increase the tools available to its staff and ensure the highest level of service to the public. Those steps are summarized below, together with additional recommendations.

### **1. Staff Performance**

The CPS staff accomplishes a difficult and demanding job twenty-four hours a day, every day of the year, and performs with dedication, compassion and professionalism. Through their efforts, children are protected in more than 6000 cases every year. At the same time, where there is a question of whether an individual staff member is performing his or her duties properly, investigation of complicated facts may be necessary. When that happens, as in this case, difficult decisions about the deployment of staff may need to be made immediately, before all of the facts are available.

Toward that end, the Night Supervisor and Weekend Caseworker were suspended from their duties while this investigation was being conducted, and the Day Caseworker later was placed on desk duty. While the Night Supervisor initially was suspended without pay, vacation pay was permitted to be utilized, to avoid undue financial hardship, once it appeared that the investigation could not be completed within 30 days as originally envisioned.

With the completion of the investigation, individual recommendations have been made to the Department of Social Services as to appropriate disciplinary measures based on the findings in this report.

### **2. CPS Case Review**

CPS workers have an enormous volume of information to assimilate, particularly in complex cases. Providing additional checks on these cases will help to ensure that appropriate decisions are made.

- Immediately after this tragedy, CPS, with assistance from Children's Services and Behavioral Health, conducted an intensive review of more than 200 pending cases with characteristics similar to this case in terms of multiple prior contacts with the County. This review utilized a form that was developed by NYC ACS to assist in their case review. NYS OCFS also participated by providing experienced caseworkers that conducted some of the reviews.
- CPS also instituted a multidisciplinary "Case of the Week" program to review and assess high risk cases for quality management.

**RECOMMENDATION:** It is recommended that CPS impose an additional level of approval, by an Assistant Director, for the final disposition of two types of cases: (a) cases determined to be "indicated" and recommended to be closed, and (b) cases with substantial CPS history. For the latter, the number of prior cases triggering review should be determined by CPS leadership.

### **3. Education and Training**

The staff development efforts for CPS staff have been continually updated.

- As the facts and history of this case were reviewed, refresher training was conducted on two requirements important in the development of every case: the commencement of the CPS investigation within 24 hours of receiving a report of possible maltreatment, and the review of the CPS history and records when a new case is received.
- Additional training also has been offered in the areas of mental health and substance abuse.
- Refresher training also is scheduled on the importance of contacting collateral sources as part of a complete investigation.

RECOMMENDATION: It is recommended that supervisors be asked to confirm with their caseworkers, in their individual case conferences, that the caseworker has documented every contact they have made, and that caseworkers be reminded of the importance of noting the time of each contact and visit, so that the information is available to be entered in their case notes.

RECOMMENDATION: It is recommended that CPS develop and offer advanced training in interview and investigation techniques, including “tips” from detectives or others highly skilled in this area.

RECOMMENDATION: It is recommended that CPS discuss with the State Office of Children and Family Services (“OCFS”) whether available technology will allow the “time of event” field in Connections to be changed to a mandatory field that requires an entry.

### **4. Necessary “Tools”**

There are a number of changes that the department has instituted that would improve the tools that CPS caseworkers have available to them in the investigation of child abuse and neglect allegations.

- CPS is continuing to ensure that basic items contributing to efficiency and safety, such as cell phones, laptops with wireless capability and cameras, are available to all caseworkers.
- To meet the growing need for bilingual assistance, the department has initiated the process to hire five bilingual caseworkers.

RECOMMENDATION: It is recommended that CPS explore the feasibility of digitally recording phone contacts with clients. This would enable caseworkers to more easily seek consultation/assistance in appropriate cases and also facilitate quality management.

RECOMMENDATION: It is recommended that cell phones and wireless laptops be made available to supervisors of investigative units as well as to caseworkers.

## **5. Interoperability**

Information sharing between various departments and units of local government can help to enhance the information available to CPS in the investigation of child abuse and neglect allegations.

- Over the past three months, CPS has organized a series of meetings at which the many agencies touched by CPS issues have discussed methods to facilitate the exchanges of information needed in investigating child abuse and neglect allegations. These meetings have included representatives of CPS, Family Court, the Integrated Domestic Violence Court, the Nassau County Police Department, the County Attorney, the Department of Mental Health, Chemical Dependency and Developmental Disability Services, the Probation Department and others. These discussions are expected to result in additional protocols for sharing information.
- Behavioral health staff have been added to CPS and are available for consultation with caseworkers and to make visits with them to assist in assessing risk in appropriate cases.
- CPS also is working with the Juvenile Aid Bureau of the Nassau County Police Department to streamline the process of obtaining criminal history information in connection with pending cases; at the same time, CPS is exploring methods to obtain authority to access criminal history records directly, including the support of pending legislation in New York State.
- CPS is working with the Courts to expand access to family court records. This will require changes in legislation.

RECOMMENDATION: It is recommended that CPS leadership explore whether greater use can be made of confidentiality waivers, which are signed voluntarily by the subject of an investigation, to facilitate securing necessary information.

## **6. Public Education**

Mandated and community reporters are an integral component of the system that protects children. The reminder publicized by the MTA -- If You See Something, Say Something! -- rings true in the area of child abuse as well, and CPS recognizes the importance of educating those who interact with children on how to recognize child abuse and neglect

- CPS regularly offers educational sessions for those mandated to report their concerns.
- CPS staff also are continuing to speak regularly to community groups that seek guidance in this area.

