

**New York State  
Citizen Review Panel  
for Child Protective Services  
in New York City**

**2006 Annual Report  
and Recommendations**

January 1, 2006 to December 31, 2006

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## Recommendations to the New York State Office of Children and Family Services

*The following ten numbered recommendations were developed in conjunction with the Eastern and Western Citizen Review Panels for a joint Annual Report. However, after the New York City Panel adopted the dissent recommendation on page 8, the Eastern and Western Panels decided to submit a separate report.*

Federal law requires the New York State Citizen Review Panels to offer recommendations to the Office of Children and Family Services for improvements leading to better outcomes for the children who come to the attention of the system. The Office of Children and Family Services serves New York's public by promoting the well-being and safety of our children, families and communities and must meet federal goals of achieving child safety, permanency, and well-being. In 2006 much attention was given to those cases in which a child's safety was of grave concern. New legislation was passed to address gaps and to make revisions in existing legislation that will allow the child protection system to respond to those serious cases where a child's life is at stake. New funding was included in the budget targeted towards improved training, expanded capacity, and other improvements. While panel members applaud this increased attention to child protection, they remain concerned that inadequacies still exist and that the system fails many families in fundamental ways.

The recommendations that follow build on the recommendations the panels made in their 2005 report. The 2006 Recommendations were formulated by the panels based in part from input provided by local departments of social services, OCFS staff, child welfare experts, and others. They are not meant to be comprehensive in scope but address those issues which have been brought to the attention of panel members over the course of the year. One calls for a fundamental change in the way the system operates. Others address workforce issues and restraints. Panel members are particularly interested in seeing increased preventive services offered to families, services which can give families needed support without the fear of losing their children. All are designed to continue the important progress made over the years.

### 1. Community Child Protection

*Develop a system of community child protection throughout the state. Specifically:*

- *Offer a differential response for reports made to the State Central Register, for those cases which have not risen to a severity where children's safety is in question.*
- *Offer increased neighborhood-based, preventive services before engagement with the child protection system.*
- *Offer increased use of family engagement strategies throughout casework practice, aiming to work with family members as partners in their children's future.*

- *Develop and implement a marketing campaign that emphasizes the fragility of families when crisis becomes overwhelming. The campaign budget should afford both continual outreach to families, and be of a size and scope to reach each of its target population segments. It should include parenting education as one of its strategies.*

Underlying these recommendations is our view that child protection systems alone cannot keep all of our children safe. It is the responsibility of the entire community.

Once a report is accepted by the State Central Register, the current system requires an investigation and a decision as to whether or not the report is “unfounded” or “indicated.” If indicated, the case may stay open and the family may be given the opportunity to receive services or the case may be closed with no services offered. In 2004, over 140,000 reports were accepted with over 40,000 of them indicated; of those 41% received services.

In 2006, the state expects to accept more than 150,000 reports. When cases are “unfounded” it appears that the reports were either baseless or did not rise to the level of concern to be indicated. Yet these families endured the same investigation as those conducted for the most serious cases where children are at risk and only 4% received any service beyond the investigation.

Of particular concern is that many of the unaided families are either struggling to survive or facing an immediate and overwhelming crisis, or both. The child welfare system must offer these children and their families useful developmentally appropriate services as needed, helping them move toward stability.

We need a new approach; an approach offering families with complex needs access to an array of developmentally appropriate preventive services and supports *before* their circumstance reaches a crisis point and before they warrant a call into the State Central Register and an investigation by Child Protective Services. Child Protective Services should be a service of last resort rather than an entry point for the help families need. Also, for families reported to the State Central Register, whose children are safe, a differential approach is more effective than an investigative approach for encouraging family members to join efforts to move forward, while still assuring child safety. To this end, the panels support legislative change permitting local departments of social services to offer a differential response. The panels call on the state to provide the funding needed to carry out and evaluate these efforts.

## 2. Home Visiting

*Increase funding for home visiting programs in the 2007-2008 budget across New York State. Further, develop a strategy that leads to a comprehensive home visiting system across New York State and increased coordination between OCFS, the NYS Department of Health and local services.*

Programs such as Healthy Families New York, Nurse Family Partnership and the Community Health Worker Program are effective in preventing child abuse and neglect,

improving health and cognitive outcomes, and improving bonding between mother and child. The Rand Corporation has named the OCFS-funded Healthy Families New York program a proven best practice. The 2006-2007 budget added \$7.5 million for Healthy Families New York, bringing the total to \$25 million. The Nurse Family Partnerships receive funding through counties and the Community Health Worker program receives its funding from the NYS Department of Health. Statewide there are only 83 sites in total for these three models. Many areas have no programs available and the existing sites are not able to handle current needs in their communities.

We specifically encourage OCFS to continue to meet with the Department of Health, prevention advocates, and other interested parties to identify gaps in eligibility, funding and services; to develop recommendations; and to develop a strategy leading to a comprehensive home visiting system that includes universal screening and prenatal care throughout the state. It is important for families that New York State brings these programs to scale. We also encourage OCFS to assure these programs are accessible and culturally sensitive to immigrant, Native American, and ethnic populations of children and families.

### 3. Home and Community Based Services Waivers

*Provide for a single joint quality assurance team for Home and Community Based Waiver slots funded through the Office of Mental Health and the Office of Children and Family Services.*

Home and Community Based Services Waivers allow communities flexibility in providing mental health and support services to children with behavioral and emotional disorders, and their families. The services give children the best chance of recovery by helping them to remain in their homes. These cost-effective waivers allow more children to receive these needed services.

Funding increases in the 2006-2007 state budget allowed the Office of Mental Health (OMH) to increase the number of slots by 300 and OCFS to increase slots by 150, for a total increase of 50% in the number of slots available throughout the state. OMH and OCFS will both distribute slots to local communities. Local communities will be responsible and accountable to both agencies on the use of these funds. Having one joint quality assurance team for both agencies will increase efficiencies, reduce duplication of services, and reduce administrative costs for the state and local communities.

### 4. Children and Family Trust Fund

*Include \$2 million in funding for the Children and Family Trust Fund within the Office of Children and Family Services budget.*

Panel members appreciate the \$2 million for these programs included in the 2006-2007 budget. In 2000, no funding was appropriated for the Trust Fund. In 2005, the Trust Fund received \$677,700 through a legislative member item.

The Trust Fund supports innovative approaches for primary prevention of abuse and neglect. The Trust Fund has been reliant on strong advocacy efforts for too long and needs more secure funding. Inclusion of Trust Fund dollars within the OCFS budget will give the important programs supported by the fund the financial security they need to continue their services to families.

## 5. Child Welfare Workforce

*Review and evaluate standards of performance, minimum qualifications for workers, content and effectiveness of training offered to caseworkers and supervisors, and workload levels for child welfare employees. Set state standards for workload and accountability and offer recommendations to local districts on how to implement improvements.*

The child welfare workforce is integral to both offering quality child welfare services and to encouraging families to accept and access services. Quality is reflected in the workforce's ability to engage families, make good decisions in the field, and keep thorough and accurate records. The work is becoming increasingly difficult as families face ever more complex problems. Decisions made in brief time spans can affect families and children for the rest of their lives. Yet there is variability across districts in the state on worker qualifications and wide variability on workloads, supervision, and local district training of child welfare workers.

We encourage the Office of Children and Family Services (OCFS) to adopt recommendations on child welfare caseworker workloads based upon the report and recommendations from the Walter R. MacDonald & Associates study with additional input necessary to address the variance in practice that exists in local districts across New York State. We ask that these recommendations set measurable standards for performance, increase supervisor training, and offer mechanisms for ensuring the transfer of training into the practice arena. In particular, we encourage the state to focus on improving caseworker understanding of family dynamics, decision-making skills, developmentally appropriate practice, and techniques for engaging families as partners in moving forward.

## 6. Case Records

*Conduct a review of case record practices to assure clarity, organization and completeness, and quality casework practice.*

The case record is intended to help workers collect information, organize it, analyze it and make good decisions. Therefore, case records must accurately communicate a family's story, the decision-making process, services provided, and outcomes for children and their family. In 2006, the Western panel reviewed child fatality reports and the New York City panel reviewed case records.<sup>1</sup> In reviewing those records, both panels found it difficult to

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<sup>1</sup> Federal law specifically allows Citizen Review Panels to review case records in order to evaluate the extent to which the state is effectively performing its child protective responsibilities.

understand what had taken place, decision-making rationale, whether the involvement with the families was helpful, and what interventions improved outcomes for children.

Reform should ensure that case records provide fast access to key specifics, including relevant dates, people, actions, services offered, and rationale for decision-making. Case records turned over to third parties as allowed by law should arrive in a uniformly organized manner. Also, the panels request that local departments of social services begin producing official summaries of each case as a standard practice for all case files.

#### 7. Child Advocacy Centers (CACs) and Multidisciplinary Teams (MDTs)

*Increase funding for these important services to support operating costs and to provide education, outreach, and training to encourage full participation by potential team members. Also, set statewide standards for CACs and MDTs which provide uniform definitions, practices, and eligibility criteria.*

Much-needed funding for these services was provided in the 2006-2007 state budget, for improving and increasing services at existing locations and for expansion to new locations. It will take time to assess the funds distribution and to tally the impact they have on services levels and how far those services go to meet the growing need. Far too many Child Advocacy Centers devote staff time to fund-raising for their operating budgets, detracting from the staff time available for service provision.

Although standards for CACs and MDTs exist, there is a need to promote uniformity of definitions, practices, and eligibility across the state. Education programs will help the responders statewide better understand the work of Child Advocacy Centers, the potential for successful investigations using multidisciplinary teams, and their roles, responsibilities, and protocols. In addition, CACs and MDTs should make their records available to all parties, including parents.

#### 8. Federal Bureau of Investigation Checks

*Support OCFS's budget request for an increase in funding covering the costs of FBI checks on prospective foster care and adoptive parents.*

Legislation passed in the 2006 session authorizes FBI checks for adults interested in becoming foster parents or adopting a child. Currently, New York only performs state checks, leaving unanswered questions about a prospective foster or adoptive parent's conduct while living in another state. The FBI check will provide added screening and offer further protection to our children.

The legislation requires these checks but did not cover the costs for conducting an added 17,000 checks across the state. OCFS needs an estimated \$687,000 in added state funding to cover the costs of the checks, staffing, and systems changes needed to implement the new legislation effectively.

## 9. Child Fatality Review Teams

*Provide the funding and other support necessary to create a Statewide Child Fatality Review Team to support local and regional teams across the state. With this, develop uniform protocols for operations, reporting, and data collection and analysis. Also, publish and disseminate a New York State report on child deaths with recommendations for prevention of child deaths in the future.*

Legislation passed in 2006 changed the scope and composition of locally based Child Fatality Teams across the state, and included added money to support the operations of these teams. The legislation did not provide for a state Child Fatality Review Team.

As many local communities assess their capacity to convene Child Fatality Teams and make changes linked to the new legislation, a statewide team of experts would offer much needed technical support to local communities. The state team would also review all fatality reports produced locally, looking for commonalities that could lead to recommendations for change to prevent future deaths. Such reviews have led to new practices and warnings, spanning SIDS, water safety, the dangers of co-sleeping, and related topics. The State Team should be linked to New York State's overall effort and national efforts on child death surveillance and injury prevention.

## 10. Disproportionality

*The Panels request that OCFS conduct a study and issue a report evaluating the extent to which racial and ethnic disproportionality and disparities exist in child welfare practices across the state. Further, the report should offer recommendations as needed to remove practices identified as contributing to disparate treatment and disproportionality.*

The issue of disproportionality in child welfare services is a national concern. Studies show that race and ethnicity are factors affecting the handling of CPS and child welfare cases and that it can exist at critical stages, such as reporting, determination, placement, and outcomes experienced by certain children and families of color. The panels are concerned that disproportionality and disparate treatment exists in New York State and ask that OCFS undertake such a study to understand which child welfare practices contribute to disproportionality or disparate treatment. Such a study should also offer recommendations as needed to remove practices identified as contributing to disparate treatment and disproportionality.

[ This report, originally submitted as a dissent by one panel member, was later adopted by a majority of the NYC panel as part of its 2006 Annual Report. ]

**Dissent to 2006 Annual Report  
New York State Citizen Review Panels  
For Child Protective Services  
Respectfully submitted by panel member Gerard J. Papa**

The 1999 NYS statute creating Citizen Review Panels (CRP) assigns each panel two responsibilities: (1) “evaluate the extent to which the agencies are effectively discharging their child protection responsibilities” and (2) prepare an annual report. *[In New York City, child protective services are administered by the City Administration for Children’s Services (ACS) under supervision of the State Office of Children and Family Services (OCFS).]*

As an original member of the New York City CRP, in good conscience I cannot approve the annual report submitted in the name of our panel; and I apologize to the children and families of our City for having failed to dissent in past years. Here is my brief report.

**1. ACS and OCFS are in over their heads in New York City and are incapable of effectively discharging their overly broad mandate.** Don’t believe (as I naively believed until this year) the reports, statistics, and assurances of agency leadership. When the rubber meets the road, ACS intervention is as capable of causing grievous harm to struggling families as it is of leading to a good result. The Biblical account of King Solomon demonstrates his legendary wisdom with a story of intervention in a child protection case. The ACS employee who knocks on your door will not possess the Wisdom of Solomon – he or she will be a fallible human capable of the same mistakes and sins as the rest of us. But that ACS employee will nevertheless be endowed with the extraordinary powers of a King, powers which our Constitution would never allow to a state agent in any other circumstance. A family, whatever its circumstance, is a sacred institution. A government toys with this institution at everyone’s peril. We must reconstruct and reign in our child protective system to take proper account of the inevitable fallibility and human frailties of those charged with implementing our best intentions.

**2. The solution is not the predictable “more training, more money, more reporting, more procedures, more laws, more everything.”** A fundamental bottom-up reevaluation must be made of what society can and should reasonably expect from a child protective system – right down to the most basic applicable state laws – in a city as large as New York. This can only succeed if, unlike past efforts of this type, it is undertaken by individuals with absolutely no professional ties to the multi-billion-dollar child protection industry (including both public and state agencies). In off-the-record conversation among themselves, professionals often excuse some typical horror story with, “Well, you know, that’s ACS.” But the public does not know,

our lawmakers do not know, our Mayor and Governor do not know. Yet few professionals dare to criticize publicly, clearly, or completely. Too much money, too many careers, too many professional friendships are at stake.

**3. The New York City CRP (I cannot speak for the other two state CRP panels) is a waste of taxpayer dollars, doomed to ineffectiveness as constituted by statute and as administered to date.** (Statewide, about \$1,000,000 of taxpayer money has so far been expended on these panels).

*>>> I thought it best to confine my dissent to a single page. I remain willingly available to address any or all of the above in complete detail with all who may be interested. Feel free to contact me. <<<*

### **Comments from individual NYC Panel Members**

From Eric Brettschneider: I support the recommendations offered by the Eastern and Western Panels in this report. While the dissent offered by Gerard Papa and adopted by the New York City panel for inclusion in this report raises many legitimate concerns and represents popular public sentiments, in my view, is too extreme and full of exaggeration to support in its present form.

From Eric Brettschneider and David Lansner: The statement in paragraph 3 of Gerard Papa's dissent, about the administration of the panel, should not be construed as a criticism by us of the Schuyler Center, which has provided excellent assistance to the Panel within the limitations of the state's contract.

From David J. Lansner: comments regarding the Eastern and Western Panels' recommendations:

- 5. Child Welfare Workforce: Far too many of the ACS casework staff and supervisors are not competent to handle their duties. They lack sufficient education, investigative skills, and even simple spelling and grammar skills. They are grossly ignorant of social work and legal concepts. For many, even extensive training would not qualify them to be adequate caseworkers or supervisors. In addition, there is a pervasive attitude among line staff and supervisors that training is something to be endured but then ignored. Finally, management has failed to take disciplinary action against even the most incompetent staff.
- 7. Child Advocacy Centers: CAC's should be impartial and should share their information with all parties in a case. Currently, they often view themselves as part of the prosecution team and refuse to give parents information about their own children's health.
- 9. Child Fatality Review Teams: The emphasis on fatalities deflects attention from the much more widespread problem of unnecessary removals and detentions of children. Teams should be set up to study removals.

From Sania Metzger: I join with David Lansner's comments related to #7 recommendation on Child Advocacy Centers.

From Yvonne Hutchins Plummer:

- I join with David Lansner's comments related to #7 recommendation on Child Advocacy Centers.
- Regarding #5 Child Welfare Workforce: From our work conducting case record reviews, it is evident the child welfare workforce requires improvement in documentation, correct spelling and grammar.

From Mathea C. Rubin: I do not believe that the NYC CRP is "doomed to ineffectiveness" nor is it "a waste of taxpayers dollars" as long as ACS and OCFS are willing to fully respond effectively to panel concerns whether by implementing necessary investigations or evaluations or actively taking necessary corrective measures regarding the apparent problems that the panel brings to light.

NYC CRP members whose professions bring them to the front lines of the child welfare system contribute a variety of insights and information to the panels' work. Their input is a valuable asset.

I believe the administrative support provided to the panel has been efficient and professional. What most concerns me is whether or not ACS is open to review.

## **Summary of 2006 New York City Citizen Review Panel Meetings and Activities**

For minutes from any of the follow meetings, go to [www.citizenreviewpanelsny.org](http://www.citizenreviewpanelsny.org).

### **January 26, 2006**

Ronald Richter, ACS Deputy Commissioner for Family Court Legal Services, and Jeanette Ruiz, Deputy Commissioner for Out of Home Placements, met with the panel. They discussed their work in reforming ACS practices in bringing cases to court and proposals under consideration in the aftermath of Nixzmary Brown's death. Panel members learned of a spike in the number of reports made to the SCR. The panel received updates on FBI legislation and the Governor's proposed budget. They approved plans to hold a meeting with OCFS staff and guests to discuss the panels' 2005 recommendations. Panel members expressed concern over the number of vacancies on the panel.

### **March 2, 2006**

ACS Commissioner John Mattingly, with staff members Zeinab Chahine, Jennifer Rojas, and Jennifer Mulhern, joined the panel for a discussion on the reforms and activities since Nixzmary Brown's death. ACS experienced a 70%-80% spike in the number of reports and found it a challenge to keep up with those reports. They reported adding new staff and redeploying other staff, adding resources and equipment to support the increased workload. Panel members agreed to support legislation in the 2006 session that supported their 2005 recommendations. The panel discussed plans for their meeting in May with OCFS staff and guests.

### **May 19, 2006**

The panel held a two-part meeting with OCFS staff and invited experts in the field to discuss their 2005 recommendations and to receive further input. The meeting began with a private discussion between OCFS staff and panelists. Guests with expertise in child welfare attended the second half of the discussion to give their input.

### **September 7, 2006**

Panel members met for a regularly scheduled meeting to discuss procedures for conducting case reviews. With only four panel members present, the members discussed a process for the case reviews aiming for presentation to the rest of the panel for decision-making at the panel's next meeting.

### **September 28, 2006**

Panel members discussed the proposed procedures for conducting case reviews and agreed on a process. Panel members received a briefing on, and invitation to, the October 13 meeting in Syracuse.

**November 7, 2006**

Panel members devoted their meeting to a review of three child protective services cases. Their discussion focused on the need for family services, as shown in the case records. Members expressed concern over the lack of key information in the records and lack of organization of the information provided. They expressed the concern that these issues make the case records difficult to understand. The panel intended to finish the case reviews and inform their 2006 recommendations from the discussions that followed.

**December 7, 2006**

Panel members continued their discussions of the case reviews they conducted. They discussed their 2006 recommendations for their annual report. The panel decided to sign on to several of the recommendations worked out by the Eastern and Western Panels, and offered additional recommendations for the other two panels to consider.

## New York City Citizen Review Panel Members

<b>Name</b>	<b>Organization</b>	<b>Appointment</b>
Eric Brettschneider, Co-chair	Agenda for Children Tomorrow	Executive
Jocelyn Brown, MD	Child Advocacy Center of NY	Executive
Yvonne Hutchins-Plummer	Elmhurst Hospital Center	Senate
David J. Lansner, Esq., Co-chair	Lansner & Kubitschek	Assembly
Margaret M. Magnus, Ph.D.	Hunter College	Senate
Sania Andrea Metzger, Esq.	Casey Family Services	Assembly
Gerard J. Papa, Esq.	Flames Youth Association	Executive
Mathea C. Rubin	Parent	Senate
Marion White	Child Abuse & Prevention Program, Inc.	Executive

## Federal Law and the Citizen Review Panels

The 1996 amendments to the federal Child Abuse Prevention and Treatment Act (CAPTA) mandate that states receiving federal funding under that legislation create volunteer Citizen Review Panels. The purpose of these panels is to decide whether state and local agencies are effectively carrying out their child protective responsibilities. Under the legislation, each state must set up citizen review panels. The federal statute broadly defines the work of the Citizen Review Panels.

The panels must meet not less than once every three months and produce an annual public report containing a summary of their activities. They must evaluate the extent to which the state is fulfilling its child protective responsibilities under its CAPTA State Plan by:

1. Examining the policies, procedures, and practices of state and local agencies.
2. Reviewing specific cases, when warranted.
3. Reviewing other matters the panel may consider important to child protection, consistent with Section 106(c) (A) (iii) of CAPTA.

Following the order of federal CAPTA Amendments of 1996, the New York State Legislature passed Chapter 136 of the Laws of 1999, setting up no less than three Citizen Review Panels, with at least one in New York City. The other panels are in Eastern and Western New York.

Each panel has up to thirteen members; the Governor appoints seven, with the Senate President and Assembly Speaker appointing three each.

## 2006 Legislative Review

Source: New York State Office of Children and Families web site  
<http://www.ocfs.state.ny.us/main/legal/leg2006.asp#cps>

### **Termination Parental Rights for Homicide (TRP) - Chapter 460 of the Laws of 2006 (S.5392-B/A.11582-B). Effective November 14, 2006.**

Authorizes launch of a TPR proceeding against a person convicted of homicide where the victim was another child for whom the person was legally responsible or another parent of the child. The legislation provides a possible exception to the TPR requirement for homicide of another parent where the convicted parent was a victim of domestic violence.

### **Expansion of Child Fatality Reviews and Teams - Chapter 485 of the Laws of 2006 (S.6703-B /A.10023-B). Effective December 14, 2006.**

Expands the scope, role, and composition of child fatality review teams (CFRT).

- Along with investigating the death of a child in foster care or whose death was reported to the Statewide Central Register of Child Abuse and Maltreatment (SCR), OCFS must investigate and issue a report on the fatality of any child for whom the social services district has an open child protective or preventive services case. Where there is a local CFRT that issues reports, the local CFRT may assume this role. The law also provides the CFRT access to records, addresses confidentiality, and provides members of the team immunity from liability in relationship to their participation on the team.
- A CFRT also has permissive authority to investigate any unexplained or unexpected death of a child.
- Expands the required members of a CFRT to include local health officials, the coroner or medical examiner, the county attorney's office, the district attorney's office, and local and state law enforcement.
- Tightens applicable time frames for receipt of a coroner's report on all such fatalities within the scope of the CFRT or OCFS requiring preliminary report issuance within sixty days from the date of death, absent extraordinary circumstances.

### **Dual Investigation/Multidisciplinary Teams - Chapter 494 of the Laws of 2006 (S.7042-A/A.11854). Effective December 14, 2006.**

- Requires local child protective services (CPS) to alert its multidisciplinary team (MDT) (or law enforcement in counties without a MDT) about all received SCR reports of suspected child abuse or maltreatment that allege physical or sexual abuse, or the death of a child. Also mandates the launch of a dual investigation in consort with the MDT (or law enforcement).

- The new law requires CPS also to assess whether it must make a notice to law enforcement in the circumstance where a report made by a mandated reporter alleges physical harm to a child, and two other pending or indicated SCR reports were made in the previous six months involving the same child, a sibling, or another child in the same household. If notice is given, CPS must jointly investigate the report with its MDT (or law enforcement in counties without a MDT).
- The law allows CPS and law enforcement to develop different local protocols on joint investigations of SCR reports. Such local protocols must receive OCFS approval.

**CHAMP - Chapter 516 of the Laws of 2006 (S.7643-A/A.11636-A). Effective August 16, 2006.**

Adds a new section 422-c to the Social Services Law (SSL) requiring OCFS to contract with the Upstate Medical Center at the State University of New York in Syracuse for a child abuse medical provider program (CHAMP) designed to improve access to quality medical services for child abuse victims. CHAMP provides information, training and mentoring on child abuse and maltreatment identification and treatment to mandated reporters in medical professions.

**Child Advocacy Centers - Chapter 517 of the Laws of 2006 (S.7644-B/A.11188-A). Effective February 12, 2007.**

- Adds new SSL §423-a establishing child advocacy centers (CACs) to deal with cases of child victims of sexual abuse and serious physical abuse.
- CACs must meet the minimum standards established in SSL §423-a.
- Requires OCFS to oversee creation of CACs in every region of New York State.

**Child Protective Service Supervisors Qualifications and Training for Caseworkers and Supervisors - Chapter 525 of the Laws of 2006 (S.7816/A.11574). Effective November 14, 2006.**

- Establishes minimum qualifications and training requirements for CPS supervisors.
- Current CPS supervisors must be trained within a year of the effective date of the legislation. Newly appointed CPS supervisors must complete the training on their appointment.
- Establishes continuing annual training requirements for all CPS supervisors and workers.

**Child Abuse Public Information Campaign - Chapter 539 of the Laws of 2006 (S.8131/A.11635). Effective August 16, 2006.**

Requires OCFS, assuming necessary budget appropriations, to conduct a public information campaign stressing zero tolerance for child abuse. The public information campaign must include information about the signs of child abuse and maltreatment, the child abuse hotline, and the services available to help at-risk families.

**Educational Neglect Reports - Chapter 543 of the Laws of 2006 (S.8183/A.11571-A).  
Effective August 16, 2006.**

- Requires OCFS with the State Education Department (SED) to develop model policies and practices for local departments of social services (LDSS) and school districts covering reporting and investigation of educational neglect. OCFS and SED must post the model policies and practices on their respective web sites by September 1, 2007.
- Each LDSS, in consort with school districts located within that LDSS's jurisdiction, must develop policies and procedures for reporting and investigating educational neglect based on the OCFS/SED model policies and practices. The LDSS must submit policies and procedures to OCFS for review by January 1, 2008.
- OCFS must approve or disapprove the proposed policies and procedures within 60 days of receipt.

**Hospital Protocols - Child's Death - Chapter 632 of the Laws of 2006 (A.11666/ S.8082).  
Effective August 16, 2006.**

Requires the Department of Health (DOH) to address protocols for medical review of unnatural child deaths at a hospital or while a child is being transported to a hospital. The protocols must include reporting appropriate cases to the SCR and law enforcement. DOH is required to consult with OCFS, LDSS, child fatality review team coordinators, law enforcement, and appropriate medical experts when developing the protocols.

**Child Protective Services Access Warrants - Chapter 740 of the Laws of 2006  
(S.8344/A.11852-A). Effective January 18, 2007.**

- Establishes a procedure to enable a CPS unable to locate or denied access to a child who is the subject of a report, to obtain a warrant permitting immediate access where the CPS has reason to believe the life or health of the child is endangered.
- The CPS may contact law enforcement to escort CPS staff and enforce the warrant.
- Law enforcement personnel, if contacted, must respond and remain at the location where the child may be present.
- Such a warrant may be obtained before a petition initiating a child protective proceeding is filed.

Requires 24-hour a day access to family court to obtain the warrant.