The Death of Marchella Pierce: Collaboration, Conflict, and Accountability in Child Protective Services

CASE

Eighteen pounds was all she weighed. A four year-old girl so thin and frail that you could see her bones through her skin. Deep scars on her wrists and ankles, from the twine that bound her to her bed nearly each night.

Marchella Pierce’s life ended on the morning of September 2, 2010 in Brooklyn, New York. Her mother, Carlotta Brett-Pierce, found her unresponsive, her hands cold. When the police arrived at the apartment they found twine still tied to the headboard of the toddler bed where Marchella slept, and a video tape case, encrusted with dried blood that had been used to beat her. They found marijuana and crack, which neighbors would say Carlotta used regularly.

Marchella’s autopsy would reveal that she had been starved, force-fed ninety adult doses of antihistamines, and beaten. Carlotta and her mother, Loretta, with whom she and Marchella lived, were both arrested. In the following months, investigations were opened into the city’s role in the death, as well as that of the contractor that the city had entrusted to provide services to the family. The shocking nature of the death would unleash a demand for public accountability, triggering investigations, resignations, accusation and counter-accusation between contractors and the government charged with her care, and ultimately the prosecution of two social workers.

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Entering State Supervision

Neighbors remembered Carlotta for her fiery temper. A “troublemaker,” one recalled, “just evil.” She had been accused of throwing a padlock at the head of one of her neighbors and of cutting another with a razor blade. Neighbors frequently complained. The police were often called to her home. She had been arrested three times, twice for drug possession and once for assault.

Marchella’s father provided little stability. Tyrone Pierce’s trouble with the law began in his teens, around the same time he started seeing Carlotta. By age 16, he had been arrested twice on drug charges. By 18, he pled guilty to armed robbery and a string of thefts. After serving six years in prison, he was released on parole. Soon after, Carlotta was pregnant with their first child, a son. But before the child was born, Tyrone was back in prison for a parole violation. When he was released in 2005, Carlotta became pregnant again, with twins. On April 3, 2006, Marchella and her older sister, Miracle were born. Miracle died soon after birth.

Born 15 weeks premature, Marchella faced significant health problems. Her underdeveloped lungs required a tracheal tube to breathe. She spent her first year in an extended care facility. For the rest of her life, she divided her time between hospitals and long-term care facilities and living with her mother and grandmother, along with Carlotta’s grandmother, aunt, and two cousins in a small apartment.

In April, 2009, Marchella spent nearly 10 months at the Northwoods Rehabilitation Facility in Niskayuna, north of Schenectady, over one-hundred-seventy miles from home. Her parents would visit her at times, taking a cab from Brooklyn. While Marchella was at Northwoods, Carlotta became pregnant for a third time. During the pregnancy, she tested positive for marijuana and was reported to the Statewide Central Register, New York’s database of child abuse and neglect. Carlotta’s case was assigned to Child Development Support Corporation (CDSC), which was tasked with providing drug treatment, testing, and home visits. Marchella returned to her mother’s care in February, 2010. A month after the move, she returned to the hospital. Her tracheal tube was malfunctioning and she was having trouble breathing. Doctors tried to show Carlotta how to clean the tube but found her indifferent to the task. They were concerned enough to place a call to the Statewide Central Register. New York City’s Administration for Child Services (ACS) sent an investigator to the home the next day. The investigator raised concerns about Marchella’s home and her family, but ACS did not follow up.
The Nonprofit: Child Development Support Corporation

Carlotta had been referred to CDSC, a Brooklyn-based non-profit, for drug treatment. CDSC served families in three needy communities – Bed-Stuy, Fort Greene, and Clinton Hill – providing drug treatment, a Head Start center, employment programs, and a food pantry, among other community services. While New York City was ultimately responsible for the well-being of the children in ACS supervision, a broad coalition of nonprofits provided services to at-risk children and families.

Non-profits have played a central role in the provision of social services since the beginning of the field. During the progressive era, when the role of city government expanded into the home, most social assistance programs were provided by reformers outside of government. The first child protective agency is widely considered to be the New York Society for the Prevention of Cruelty to Children, which was founded in 1874 in reaction to a particularly gruesome example of child maltreatment.¹ The society, founded and funded by New York philanthropists, pressed for legal changes that would defend children from harm. Good intentions notwithstanding, reformers carried with them the biases of their times, and support depended upon the race of the family as much any other factor. Furthermore, many non-governmental child protection organizations were operated by churches and made services available only to church members.

After the New Deal, as the role of the government in social services grew, child welfare became a greater public concern. Yet child welfare agencies and their non-governmental partners followed many of the same restrictive patterns that they had during the Progressive Era, providing aid only to those who were deemed “deserving.” This had a disproportionate impact on minority children. Throughout the 1970s and 1980s, advocates sought more equal treatment and a series of court cases restricted the role of religious nonprofits in New York City’s child welfare constellation. The city took on a larger role in child protection. In 1995 New York City established the Administration for Child Services to centralize its child protective functions and coordinate with the many nonprofits serving children and families.²

CDSC traced its roots to 1969 when a group of six single mothers created a parent support group for families in their Brooklyn neighborhood. The organization expanded throughout the 1960s and 1970s, incorporating in 1975. Since 1987, CDSC had held a contract with the city as part of the network of state and city agencies, and upwards of seventy non-profits that served

¹ Myers, 2008.
² Casey and Mehrotra, 2011.
to protect children and families from abuse, neglect, and deprivation. Families deemed lower risk, that is, unlikely to pose a direct threat to their children, were assigned to contractors like CDSC for services that they would need to avoid entering the foster care system. CDSC stressed that its programs were intended to help families become self-sufficient, by curtailing substance abuse, finding steady employment, and establishing family child-care routines.\textsuperscript{3}

The city’s contract with CDSC specified that contractor caseworkers were to contact families two to three times a week for the first four weeks after a referral, or until the client achieved sobriety. But even when a client had been referred to the contractor by the city, the terms of the contract stipulated that services were strictly voluntary. Carlotta could not be compelled to comply with the treatment.

In the seven months that Carlotta was under the supervision of CDSC, there is little record of her or Marchella, or either of her sons, having been seen by CDSC caseworkers. CDSC did not report to ACS that children were not being adequately cared for. Contractors could call a formal conference to raise concerns with ACS if they saw children to be at risk, and CDSC never used this tool at key points such as when Marchella was discharged from medical care, or when Carlotta failed drug tests. Nor did they make a State Central Registrar report on Carlotta’s continued use of drugs.

Beyond this individual case, CDSC had developed a reputation for its poor quality of service. In 2005, the city placed CDSC on a watch-list of underperforming contractors, placing the contract on corrective action status. A 2008 report by the city Comptroller listed several deficiencies in CDSC’s service, including a failure to make the contracted number of visits to clients. John Mattingly, the commissioner of ACS, testified before City Council that CDSC had begun to make necessary changes to its procedures by the time the Comptroller had released his report. ACS renewed the non-profit’s contract through 2010.

**The City: Administration for Child Services**

While CDSC was given primary oversight of the case, ACS was still obligated to monitor the family. The ACS and CDSC were expected to collaborate as part of the New York City’s stretched child protective services network. At ACS, the case fell under the responsibility of Chereece Bell. Bell, a ten-year veteran who supervised the Hospital/Sex Abuse Unit of ACS’s Zone B, a region that encompassed Bed-Stuy, Bushwick, Williamsburg, and Greenpoint.

Bell knew all too well the risks of failure. She watched as a co-worker and two supervisors lost

\textsuperscript{3} Child Development Support Corporation, 2009.
their jobs for failing to follow up on two calls to the Statewide Central Registry reporting the possible abuse of a girl named Nixzmary Brown. In 2006, the seven-year old Brown was found dead, bound to a chair, starved and badly beaten. Her death prompted the city to change the ACS system. The ACS hired several retired detectives to consult and train child welfare investigators, improved the process of reporting cases to ACS, and imposed stricter documentation requirements for caseworkers. John Mattingly, the commissioner of ACS, developed ChildStat, a performance measurement system modelled on the NYPD’s highly-praised CompStat program. Even before Brown’s death, the ACS was expanding, with hundreds of new caseworkers hired under Mattingly’s tenure.

After Brown’s death, ACS caseworkers faced more documentation requirements than before, and more referrals. Improving the case reporting process led to a steady growth in the number of families under ACS supervision. Stronger documentation requirements meant longer hours for caseworkers. On top of this, the precedent had been set that supervisors would be held accountable for a case that turned tragic. Bell, who had been promoted to a supervisory role as a reward for her thoroughness, committed herself to her new job, against the advice of friends who reminded her of the Brown case.

Bell pushed herself and her workers hard. She compiled family histories, assigned cases, and decided how a caseworker should proceed with a family. In the past, the unit had had a second supervisor. While Bell had asked for additional help, she was left to manage the supervision herself. She oversaw four or five caseworkers, each responsible for as many as twelve open investigations and many more cases going through the courts. Bell’s unit might be responsible for the welfare of as many as 400 children at a time. She pressed her employees on the need to document their contacts with families. “Don’t you think you should go make a visit to that family tonight,” she would ask, “you’re not going to make me lose my job.” Many would stay until seven or eight at night, and then would continue the work from home. Yet, they were often weeks behind on paperwork. The pace never relented.

The Last Year

Carlotta had been enrolled in CDSC’s drug treatment program since November 2009. While the family was under the nonprofit’s supervision, CDSC fell well short of their contracted standards for contacting Carlotta: from the time Marchella returned to her mother’s home in February 2010 through June of that year, CDSC reported three home visits where Marchella was seen. On one of these visits, near the end of February, CDSC’s caseworker recorded that Carlotta was not complying with the drug treatment. But CDSC did not notify ACS or the statewide central
registry. The communication that the network was built to provide was not happening. Days later, Carlotta would bring Marchella to the hospital for breathing problems.

Cases assigned to Bell’s unit – those that involved children who had been admitted to the hospital, like Marchella, and victims of sexual abuse – were among the toughest that ACS was responsible for. Yet compared to the rest of these cases, Marchella’s didn’t seem out of the ordinary. “In comparison to all the others, that case did not jump out at me. . . . That was not the one that I was afraid something would happen,” Bell would later say. Marchella’s case only noted that she had been hospitalized. The call from hospital officials after Carlotta’s visit had been referred to ACS as an “additional information” call – one which reported an update to a family’s file, rather than reporting a new case of abuse or neglect.

The nature of the phone call would turn out to be pivotal. “Additional information” calls did not require that supervisors open a new investigation; the choice lay with Bell. On the decision of whether or not to open an investigation, one caseworker claimed, “you ask yourself, if I don’t do a visit, will this child die?” As far as Bell knew, nothing about the call seemed any more troublesome than any other call that came in to her office. She asked caseworker Damon Adams to pay the family a visit.

When Adams asked Carlotta about the hospital visit, she told him that she already knew how to operate a tracheal tube, and she was agitated because Marchella was hungry and she had to return home to her other children. The explanation seemed reasonable to Bell. Adams’s report raised questions about Carlotta’s parenting ability but Bell declined to open an investigation—after all, CDSC was already supervising the family due to Carlotta’s drug use, and there was no allegation of the type of abuse that was common in many of Bell’s cases. ACS still maintained an open case on the family, but without a formal investigation, Adams was not required to file regular reports or visit as frequently. In an overburdened ACS unit, the presence of CDSC helped make the workload manageable.

And so Marchella’s case – at first glance, an ordinary case of a needy child in a difficult situation, the likes of which ACS dealt with every day – was placed on the back burner. Meanwhile, CDSC reported four more contacts between Carlotta’s March hospital visit and the end of their contract with the city on July 1st. In those four visits, Marchella was seen only once, on March 10th. Each time Carlotta was recorded as being non-compliant with her drug treatment. ACS was never notified.

In 2009, the city’s budget cuts slashed the number of slots for families in preventative services. Facing severe funding gaps, and citing serious deficiencies, ACS allowed CDSC’s contract to
lapse in July 2010. In May, the city began close-down procedures, working with CDSC to identify which families could be removed from supervision and which should be transferred to ACS caseworkers. At the beginning of the process, CDSC recommended that Carlotta’s case be closed. After Carlotta failed yet another drug test, ACS decided to keep the case open.

At the end of the CDSC contract, Damon Adams was the only caseworker monitoring the family. Adams, who had graduated with a Masters from Tufts University, had worked for ACS for four years. When profiled by the Tufts student paper as a 20 year old, Adams described his plans to “go back to my old neighborhood and maybe work as a social worker, to help underprivileged kids.” Adams’s imposing figure – he stood over six feet tall and had been captain of his college football team – disguised a tenderness and an ability to connect with the traumatized children. Families praised him for his warmth and dedication. Long after their cases were closed, parents would continue to call Adams for advice and children would sneak into the office to play with him.

At ACS the unrelenting pace of calls and demands for documentation made it hard for Adams to provide extra help to families. Like many caseworkers, he was chronically late on paperwork. To catch up, he worked weekends and sometimes requested vacation time to give him a chance to file reports without being assigned new cases. His compassion, however, sometimes rankled Bell, who told him to stop counseling of families with closed cases who reached out to him. “He just wants to do social work; he just wants to counsel you and encourage you. And that’s wonderful,” said Bell, “but … in that kind of unit, there’s no room for it.”

When the call came that Marchella was dead, ACS began a process that caseworkers dread. Senior officials started to sort through the documentation on the case since it had first come to the city’s attention, nearly a year before. They needed to understand if the proper protocols had been followed, and if any caseworkers had failed to do their job.

Bell remembered that every time she had asked Adams about the Pierce family, he told her that he had just visited the family, that they were eating dinner, that everything appeared normal. When Bell received the phone call, she immediately asked Adams about the case. He told her that he had done five home visits since Marchella and Carlotta’s March visit to the hospital that had brought the family to ACS’s attention. He had recorded these visits – on March 3rd, April 6th, June 9th, July 23rd, and August 12th – in ACS’s computer system. But his handwritten case notes didn’t mention any of these visits and only contained a few scant details on Marchella’s case. There were almost no notes from Bell.
The lack of supporting documentation raised the question of whether the visits had actually happened. Without such evidence, Adams’s word was insufficient. Bell would often remind her caseworkers that “if it isn’t written, it didn’t happen.” Caseworkers privately complained that ACS leaders cared more about paperwork than home visits. But even if ACS officials believed Adams about his reported visits, it was still clear that five visits in six months fell far short of ACS standards.

**Blame and Accountability**

The day after Marchella’s death, the *New York Daily News* headline read “Child Death Horror. B’Klyn Girl, 4, Weighed 15 Lbs. and May Have Been Tied to Crib.” A spokesperson for ACS pointed out that Marchella’s case had been assigned to CDSC and that the non-profit failed to visit the family two to three times each week, as was legally required. A pattern of blame shifting – from ACS to its contractor, and back again – had begun.

The *New York Post* put ACS in the crosshairs. Its headline that Friday blared “4-Year-Old, 15-Lb. Girl Found Dead; ‘Starved’ & ‘Tied to Bed’ in Home ACS Probed.” The article reported that CDSC had failed to make the required visits. However, it quoted Martha Rowe-Riddick, CDSC’s Executive Director: “We did the required number of visits and we did the required work.” The *Post* article also pointed out that CDSC’s contract had expired. The city was responsible for Marchella’s well-being since July.

Early reporting would soon shift from ACS’s failures to CDSC’s. On September 8th, the *New York Times* published an article, titled “Audit Assailed Group Hired to Aid Family in Abuse Case,” that detailed a scathing 2008 New York City audit of the non-profit. In addition to CDSC’s failure to make required visits to the families under its supervision, the article described how the contractor could not show whether or not individuals under supervision had passed drug tests, or even whether or not its own employees had passed criminal background checks. The audit of CDSC revealed that it had been unable to show that it had “helped families obtain the preventive services needed to become stabilized so that the children are not placed in foster care.”

CDSC was unwilling to accept its designated role as scapegoat. In late September a spokesperson for CDSC told the *New York Times* that the contractor had only briefly been responsible for the Pierce family’s case. CDSC also pointed out that they were contracted to assist Carlotta with drug counseling and compliance. Martha Rowe-Riddick again, incorrectly, challenged ACS’s contention that the contractor had failed to contact the family as routinely as required.
On September 24th, ACS acknowledged that there had been “lapses in frontline protective practice” of its own employees. Adams and Bell were suspended without pay. An article in the *New York Times* was unsparing in its criticism, frequently referring to the “city’s failure,” “the agency’s missteps,” and questioning why ACS had initially blamed CDSC after its contract had ended with the nonprofit.

ACS tried to control the damage. On October 5th, the agency released a preliminary report outlining its role in the Pierce family’s case and ameliorative actions taken. Again, ACS pinned most of the blame on CDSC, saying “The analysis of CDSC’s actions in the case shows that the preventive agency’s involvement in ensuring that the mother received drug treatment and making certain that the children were safe and adequately cared for was woefully inadequate.”

On the first page of a press release announcing the report, the agency reiterated that CDSC had failed to make the required number of contacts with the family, had alerted neither the State Central Registry nor ACS that Carlotta was not in compliance with her treatment, and that CDSC caseworkers had only seen Marchella three times in the four months before the end of their city contract. Their argument, essentially, was that if CDSC had done its job, ACS would have stepped in more quickly. Again, CDSC pushed back. “It’s unbelievable that they continue to throw us under the bus in this case when they had responsibility for it the last two months,” said CDSC’s Martha Rowe-Riddick. Again, she claimed that “when [CDSC was] in the home there was nothing going on and the child was still alive.”

The press release acknowledged ACS’s own missteps. ACS should have conducted an assessment of Marchella and her brothers’ well-being when doctors reported on Carlotta’s continued drug use, instead of simply enrolling Carlotta in a drug treatment program. The report also criticized Chereece Bell’s decision not to open a new investigation after receiving a call from the hospital. Most glaringly, the ACS reported that “it is simply not in the record that ACS representatives visited the family at all after June 2010.”

**Agency Reforms**

ACS also announced a series of reforms. The agency investigated ways to better monitor its contractors’ compliance with agency rules, including better monitoring and enforcement mechanisms. ACS pointed out that while CDSC had been placed on “corrective” status after its 2008 audit of the contractor, the agency had had no indication that CDSC’s performance had been so negligent.

Recognizing that monitoring and enforcement could only go so far, ACS announced that it would strengthen its contract termination process. The agency would improve the process of
assessing cases still open at the end of a contract. Under the new rules, there would be stronger lines of communication between the closedown team responsible for transitioning cases from the contractor and the agency bureau to which the cases were assigned. ACS determined that had such a process been in place when CDSC’s contract ended, ACS caseworkers would have been more aware of the acute needs of Pierce. ACS also promised to review all cases that CDSC had open when its contract ended. In addition, ACS would, with the help of the state, assess all “additional information” calls that had been made to the city or to the State Central Registry in the prior ten months. Reviewing these cases, the agency hoped to identify any calls that had been misclassified and required extra attention. To prevent future calls from being incorrectly classified, the city announced that it required more detailed note-taking and other documentation practices. Finally, ACS and the Public Advocate, the city’s elected ombudsman, announced that they would create a Children’s Services Planning Group to further investigate the issue and identify possible reforms that ACS could institute.

In sum, the ACS argued that errors by two caseworkers and the negligence of the contractor were to blame for the Marchella’s death – not agency-wide failures. At the same time, it put in place new caseworker procedures and contractor policies to prevent future tragedies. The ambiguity of their response invited further investigation. New York’s Public Advocate (and later Mayor) Bill de Blasio stated that “the suspension of [Adams and Bell] reinforces concerns about whether ACS’s handling of cases and lack of resources have left thousands of children in jeopardy.” Child advocates pointed out that the reforms the agency had instituted after the death of Nixzmary Brown had the unintended effect of overburdening ACS caseworkers. “It was inevitable that families were going to get lost in the shuffle,” said one child welfare advocate.

In the months after ACS released its preliminary report, the agency deflected the worst of the criticism. But it was soon back in the spotlight. On March 23, 2011, Charles J. Hynes, the Brooklyn District Attorney, announced that he would convene a grand jury to investigate systemic failures at ACS. Just a week later, the Children’s Services Planning Group report was released. The report was based on a review of ACS policies and practices, and analysis of several families’ cases. While ACS concluded that “that the manner in which the Marchella Pierce case was handled was not the result of overall systemic failure,” the media coverage focused on the relatively few failures in the process to suggest a deeper problem. A New York Times story was headlined “Report Says New York City Overlooked More Children in Danger.”

The article explained that ACS had found at least ten additional cases in which caseworkers failed to recognize conditions that put children in danger. In addition, the ACS found that more than 50 (out of 2,095) cases had been closed despite evidence that the families were still in
need of the city’s help. The Times article did not mention that only 5 percent of closed cases needed the kind of attention that Marchella’s required.

Despite the critical coverage in the press, ACS’s commissioner, John Mattingly, was sanguine: “this report is a fair representation from experts outside ACS to show what needed to be done to make this kind of situation less likely in the future.” However, simply reforming policies and practices would not go far enough to placate the agency’s critics.

**Legal Accountability**

Soon after Damon Adams and Chereece Bell were suspended without pay they were forced to resign from ACS. Bell had been warned countless times that “you’re only as good as your last case.” While her diligence had won her promotions, awards, and supervision of the toughest cases, it offered little protection now. Adam’s approach to child services casework – one that focused on connecting with children but neglecting documentation and paperwork – won him praise from families, but made him appear negligent to investigators.

In July of 2011 Mattingly resigned after 7 years as head of ACS. He received generally positive reviews from child welfare advocates for reforms he had pursued after the death of Nixzmary Brown. During his tenure, he presided over the hiring of 600 additional caseworkers. The turnover rate among caseworkers dropped. But the deaths of children like Brown and Pierce defined his tenure. “I think he was so personally affected by the horror-story cases that he lost sight of the fact that the majority of the cases are not horror cases,” said one child advocate.

The President of a local civic organization wrote “John Mattingly stayed for the long haul in what is probably the most thankless position in city government. You get into the news only when a child under your protection is murdered, usually by the mother’s boyfriend, or when the child starves to death after months or years of neglect and abuse. The more grotesque the death, the more attention it receives in the media, and the more people are shocked by the tragedy, which can often be traced to the negligence or incompetence of employees of the Administration for Children’s Services.”

While Mattingly could retire, the prospects for Bell and Adams were grimmer. They soon became the focus of a legal investigation. Their union organized a protest outside their offices and in front of the District Attorney’s, chanting “Stop the blame,” “Who’s next?”, “The D.A. doesn’t know.”
What didn’t the DA know? Even as the Bloomberg administration boasted that the average ACS caseload was ten per worker, caseworkers noted this number only captured official investigations, not court cases, and did not reflect ever-increasing documentation standards which took time away from working with families. With 60,000 unique calls coming into the State Central Registry each year, the work kept piling up, especially in high-poverty areas. The recession-driven budget cuts required ACS to take on cases previously supported by contractors like CDSC.

Adams, co-workers agreed, had many more needy families than average. Many of his cases needed more attention, and were more likely to end up in court, requiring him to make three or four court appearances per week. When he was interviewed after Pierce’s death, Adams estimated he was working with 40 families.

As the Brooklyn D.A. investigated failures and lapses at ACS, people within the agency questioned such an approach. Would a cop be arrested for arriving too late to the scene of a crime? But public outrage demanded a response. The fact remained that Adams could not prove that he had visited the Pierce family in the six months between the end of CDSC’s contract and Marchella’s death. Bell had almost no documentation on the family. And so, on March 22, 2011, Bell and Adams were arrested.

The District Attorney charged Bell and Adams with criminally negligent homicide, saying “baby Marchella might be alive today had these ACS workers attended to her case with the basic levels of care it deserved.” Bail was set for each of them at $25,000. Six months after they had left the agency, they were news again, featured everywhere from local TV to the *New York Times*. The DA’s case centered on the argument that the caseworkers should have acted on the danger signs. Bell should have launched a full investigation after the call from the hospital. Adams was alleged to have falsified visits: if he had made them, surely he would have seen Marchella’s dire condition. These were the same failings identified by ACS itself, but now elevated to criminal behavior.

Meanwhile CDSC continued to operate and received public funding for programs such as Head Start childcare and food pantries. None of its employees faced legal action. In the months after Marchella’s death, the only indication of the tragedy that appeared on the contractor’s website was the removal of any mention of drug testing or preventative treatment.4

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4 Archived versions of CDSC’s website show that the nonprofit removed mention of drug testing, preventative services, and other services that ACS had contracted for between August 2010 and February 2011.
The grand jury impaneled for the case was much less sympathetic to the ACS than the Children’s Services Planning Group report. The grand jury report charged that 11 children had died under ACS supervision because of agency failures. It argued that little new funding was needed, but called for the agency to drop a distinction between “social work and law enforcement investigatory standards and techniques.” The emphasis on investigations echoed changes made after Nixzmary Brown’s death, which had led caseworkers to complain they were doing less and less actual social work.

The case had implications beyond Adams and Bell. When a child dies, legal liability usually rests on the primary caregiver. Marchella’s mother was charged with second-degree murder, receiving a sentence of 32 years to life. Her grandmother was sentenced to serve up to 15 years on manslaughter charges. But these punishments were not deemed sufficient. By charging Bell and Adams, the case created a precedent where caseworkers (and potentially other public employees with oversight of vulnerable populations) who are judged to have knowledge that an individual is at risk criminally liable for that risk.

“I do not want to go to work every day afraid that I’m going to be arrested for doing my job, and right now that’s how everybody feels and it’s really scary” said a co-worker of Adams. Social work remains a profession characterized by high stress, long hours, emotional labor, and low pay. The burnout rate is high. “The child welfare system in this country struggles to find good people and struggles to keep good people,” said Bryan Samuels, a former commissioner of federal Administration on Children, Youth and Families. “When you have something like what happened in New York happen, it has a chilling effect on a system’s ability to get and keep good people.” In 2016, four Los Angeles Department of Children and Family Services workers faced criminal charges for negligence in the 2013 death of Gabriel Fernandez at the hands of his mother and boyfriend. The legal precedent that social workers face such charges now seems firmly established in two different settings.

In December of 2013, Bell and Adams took plea deals. The felony charges were dropped, and they instead accepted misdemeanor charges of endangering the welfare of a child, with Adams also pleading guilty to falsifying records and official misconduct. They faced community service, and the prospect that the case would be sealed if they were not re-arrested. Adam’s lawyer described the pleas as a “fiction to accomplish a goal” and a way to save face for a DA that had overreached. Bell remained silent when the judge first asked her how she pled in the case, quietly offering a guilty plea only after being asked a second time.
### Timeline

April 23, 2006: Marchella Pierce is born 15 weeks prematurely; will spend the next year in hospitals until moving in with her mother. Her twin sister, Miracle, dies.

March 2008: CDSC, a contractor with ACS since 1987, previously on a city watchlist for poor performance in 2005, criticized by the city Comptroller for failing to make sufficient visits to families and not testing parents in substance abuse treatment. ACS still renews contract to June 30, 2010.

Mid 2009: Marchella enters Northwoods Rehabilitation and Extended Care Facility at Hilltop, near Schenectady, N.Y., about 170 miles from Brooklyn.

November 2009: Carlotta Brett-Pierce gives birth to second son, found to have tested positive for drugs; ACS puts the case with Child Development Support Corporation; by contract 2-3 visits are required until sobriety is achieved.

February 9, 2010: Marchella returns to the care of her mother.

February 11, 2010: CDSC case planner reported that she saw Marchella.

February 17, 2010: CDSC case planner reported that she saw Marchella.

February 26, 2010: CDSC home visit; supervisor records Carlotta as non-compliant with drug program, and raises concerns about home state. ACS are not informed.

March 2, 2010: Marchella brought to hospital because of malfunctioning tracheal tube. Officials report concerns because of Carlotta’s unwillingness to learn how to clean tube. ACS employee visits; raising concerns about Carlotta, but a new investigation was not ordered by Chereece Bell, the ACS supervisor.

March 3 and March 17, 2010: Carlotta reported as noncompliant in drug treatment program to CDSC; CDSC did not contact ACS.

March 10, 2010: CDSC provides only home visit where Marchella is seen since February 26 and until June 3, reports mother as cooperating with program. After the death, they will report three additional visits where Marchella was seen, but they were not recorded at the time.
May 2010: CDSC and ACS prepare for end of CDSC contract by reviewing open cases and deciding which cases to close. CDSC recommended that the Pierce case be closed, saying the home was stable and the children were safe. When Carlotta tested positive again for marijuana, ACS decided to keep the case open.

June 2, 2010: CDSC case planner records a visit, saying home is safe and stable, requesting case to be closed.

June 16, 2010: CDSC case planner notes Carlotta fails a drug test; last CDSC entry.

July 1 2010: CDSC contract expires, ACS employee Damon Adams now the only caseworker overseeing the case. Adams records one visit to the home with no one there; after death reports three additional visits, but it is unclear if these were falsified.

September 2 2010: Marchella Pierce dies; medical examiner finds signs of acute drug poisoning (antihistamines), blunt impact injuries, malnutrition and dehydration.

September 3 2010: ACS press statement claims that reports that ACS workers “visited the family throughout the summer.”

September 8 2010: Press gains access to earlier audit of CDSC.

September 24 2010: Media reports that Adams and his supervisor Bell were suspended without pay the previous week. Soon forced to resign.

October 5 2010: ACS press release that Child Development Support Corporation, had made “far less” than the two to three weekly visits but also that two employees have been suspended for not following procedures.

November 2010: ACS and Public Advocate create Children’s Service Planning Group of outside experts to examine ACS policies and practices for at-risk children.

November 9 2010: Carlotta charged with murder. Loretta Brett, Marchella’s grandmother, will later be charged with second-degree manslaughter, criminally negligent homicide, unlawful imprisonment, and endangering the welfare of a child. Sentenced June 6, 2012.
March 23 2011: Charles J. Hynes, the Brooklyn district attorney, convenes grand jury to explore what he called “evidence of alleged systemic failures.” ACS employees Adams and Bell charged with criminally negligent homicide, official misconduct and endangering the welfare of a child.

March 31 2011: Children’s Service Planning Group releases report; focuses on resources for preventative services; suggest problems with Pierce case not because of systemic failure; makes suggestions for better monitoring medically fragile children.

July 26 2011: John Mattingly, Commissioner of ACS, resigns. Though praised by Mayor’s and stakeholders in New York, the Pierce case becomes part of his legacy.

December 17 2013: Damon Adams and Chereece Bell plead guilty to misdemeanor charges, avoiding prison and a felony conviction.
Source Material

The case draws heavily from excellent investigative reporting from several sources. To enhance the readability of the case, we did not cite every source about the case in text, but we draw quotes and facts about the case from the following stories and reports.


The following sources provided additional background on ACS and the US child welfare system.


[Archived versions of CDSC’s webpage.](#)

[Children’s Services Planning Group Final Report,](#) March 31, 2011.

[Grand Jury Report of Marchella Pierce’s Death.](#)