2024 ANNUAL REPORT

OFFICE OF THE CHILDREN'S OMBUDSMAN

RICHMOND, VIRGINIA

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EXECUTIVE SUMMARY

Pursuant to paragraph G of § 2.2-447 of the Code of Virginia, the Children's Ombudsman "shall submit to the Governor, the director of the Department, and the General Assembly an annual report on the Ombudsman's activities, including any recommendations regarding the need for legislation or for a change in rules or policies." This Annual Report covers our work during State Fiscal Year 2024, which began on July 1, 2023, and ended on June 30, 2024.

Legislative Advocacy. In FY2024, the OCO advocated for legislation and state budget appropriations in two major areas of Virginia's child welfare system: kinship care and legal representation for parents involved in child dependency cases. Senate Bill 39 and House Bill 27 created a program to support relatives and close family friends to care for children who would otherwise enter foster care. The bills were amended to create a more robust and comprehensive plan for at-risk children to be placed with relatives within and without the foster care system. House Bill 893 included provisions increasing the maximum amount of compensation for attorneys appointed to represent parents and directing the Judicial Council to develop and adopt standards of qualification and performance for such attorneys.

Complaints and Investigations. The OCO receives complaints with respect to children who (i) are receiving child protective services (CPS), (ii) are in foster care, or (iii) are awaiting adoption. The OCO can investigate complaints that allege that administrative acts taken regarding such children were contrary to law, rule, or policy; imposed without an adequate statement of reason; or based on irrelevant, immaterial, or erroneous grounds.

In FY2024, the OCO received 487 complaints. Ninety-two of Virginia's 120 local departments of social services were the subject of the complaints we received during FY 2024. We received one complaint about a licensed child placing agency. The OCO initiated 28 formal investigations.

Child Fatalities. Pursuant to subsection B of Va. Code § 2.2-443, the OCO may investigate child fatality cases that occurred or are alleged to have occurred due to child abuse or child neglect and the family has had prior involvement with child protective services or foster care.

In FY2024, the OCO received 54 notifications of such child fatalities. Thirty of the 54 children (56%) were aged 6 months or younger. In 24 cases (44%), unsafe sleep practices or conditions were reported at the time of the child's death. In 17 cases (31%), the family had a history of domestic violence. In nine cases (17%), the parents were reported to have had untreated or undertreated mental health conditions. In 16 cases (30%), the decedent child was reported as being born substance exposed. In 25 cases (46%), the children's parents or caregivers were reported to have had a history of substance use, including at the time of the child's death. In all but one of these 25 cases, the decedent children were 4 years of age or younger. Unsafe sleep conditions were reported in 12 of these 25 cases.

Recommendations for System Changes.

1. Foster Care Placement Changes. Since this Office opened three years ago, we continually receive complaints alleging that local departments are often making foster care placement decisions with little to no planning and for questionable reasons. In these cases, we find that the local departments failed to comply with the state policy guidance for placement changes, which promotes a shared decision-making process to ensure that the children's best interests are protected, to establish case participants' expectations for the transition, and to mitigate the trauma and loss the children and foster family will suffer from the placement change. We recommend that local departments establish strict protocols and supervisory review when placement changes are being contemplated. We also recommend that VDSS regional permanency consultants provide additional oversight over local departments' placement decisions to ensure compliance with the state policy guidance.

2. Children entering Foster Care due to behavioral health challenges. We reviewed several cases in which the primary reason the child entered foster care was the child's own behavioral health issues. Practices in such cases need to acknowledge the parents' role in achieving permanency instead of treating them as if they maltreated the child. We recommend that VDSS and local departments establish policy guidance addressing best practices and protocols for managing these cases to ensure that parents are included in service planning, placement decisions, and discharge planning when children are admitted in residential treatment. Visitation arrangements should be commensurate with the circumstances of the child's treatment and not limited in frequency or duration as if contact with the parent was a safety risk. No decisions regarding the child's treatment, services, or placement should be made without the parents' involvement.

3. Communication with families. We investigated several cases in which communication problems between the agencies and parents or relatives created unnecessary conflict or detrimentally affected the outcome of the case. We recommend that local departments establish clear expectations for communication with parents and other parties by CPS and foster care workers and family services specialists. Workers should respond to families in a timely manner and with communication that is clear and tailored to the recipient's role and level of understanding of the case. Local departments should establish specific protocols for workers' use of text and email communications to ensure meaningful responsiveness, timeliness, and clarity.

4. MDTs and Joint Child Abuse Investigations. In our review of cases, we found that several jurisdictions' Multidisciplinary Teams for the investigation of child sexual abuse cases required by statute were not functioning effectively or at all. As a result, there was very little collaboration between the local child protective services staff and law enforcement in investigations of child sexual abuse.

We recommend that local departments of social services review their policies regarding MDTs, forensic interviews of children, and joint investigations with law enforcement and take affirmative steps to ensure that proper procedures are in place and that a Memorandum of Understanding or Agreement has been developed with law enforcement and the Child Advocacy Center serving the locality that sets out the expectations and responsibilities of each when jointly investigating child abuse cases; and to work with the local Commonwealth's Attorney to ensure that the locality's MDT is functioning effectively according to statute. Local departments should also ensure that its CPS workers are aware of and familiar with the policies and procedures related to MDTs and joint investigations.

5. Housing Support for Families and Youth Aging out of Foster Care. State leaders and policy makers should consider taking legislative or administrative action to facilitate access to housing vouchers available under the HUD's Family Unification Program and Foster Youth to Independence initiative for DSS-involved families with housing challenges and youth aging out of foster care. Considerations should be made to designate VDSS as the entity that can enter Memoranda of Understanding on behalf of the 120 local departments of social services with the several local Public Housing Authorities throughout the Commonwealth to help address the challenges identified by the VDSS work group studying the issue.

6. Substance Exposed Infants and Plans of Safe Care. Substance exposed infants and parents with a history of substance use present in an alarming number of cases in the child fatality notifications we receive. From our discussions with key stakeholders, including local departments of social services and health care professionals, and from our reviews of child fatality cases, it is evident that there is significant confusion about our current laws and policies for the reporting of substance exposed infants to CPS and that implementation of Plans of Safe Care is inconsistent throughout the state. The Virginia Department of Health has resumed statewide efforts to ensure the robust implementation and development of Plans of Safe Care. This work must continue with the engagement of all necessary stakeholders, including state and local social services representatives, state and local behavioral health agencies, state and local health agencies, private health and mental health care providers, and private family/early childhood serving agencies.

7. Safe and Sound Task Force Initiatives. The Safe and Sound Task Force was convened to address the issue of children in foster care with high acuity behavioral health needs sleeping in social services offices, hospital emergency rooms, and hotels because there were no approved placements available. The OCO recommends that state leaders take the following measures to sustain the Task Force's interagency and cross-Secretariat collaborative efforts and to fill the gaps in the state's array of approved foster care placements: (i) Designate DBHDS as the lead agency to collaborate and enter into interagency agreements with the VDSS, DMAS, DJJ, and the Office of Children's Services. (ii) Create a Children's Cabinet that can be authorized to direct agencies to take preventative measures for emergent issues and

to quickly mobilize agencies and stakeholders into action to address systemic crises. (iii) Direct state and local agencies to take necessary steps to make Sponsored Residential homes more accessible for foster care purposes and to increase providers' capacity to accept children in foster care with behavioral health needs. (iv) Appropriate additional funding to support the Enhanced Treatment Foster Care model of foster homes. (v) Explore program models for the establishment of a state-run program that can provide supportive and safe housing for youth in foster care on a temporary basis as a step-down from PRTFs and to give local departments time to identify an appropriate family and access to necessary wrap-around services.

8. Legal Representation in Child Welfare Cases. To improve the quality of legal representation for parents and children involved in child welfare cases, the OCO recommends the following: (i) Establish a state-level Parents Advocacy Commission with similar functions as the Virginia Indigent Defense Commission to provide oversight and training for attorneys that are appointed to represent parents. (ii) Implement a system of providing legal counsel for parents involved in CPS matters prior to the initiation of court proceedings. (iii) Consider legislative and budgetary measures to address the rate of compensation for guardians ad litem for children and to review the GAL Standards of Qualification and Performance for any needed revisions to improve the quality of representation for children.

9. Investments in Prevention and Protection. Federal funding for prevention and child protection programs is set to be significantly reduced. State leaders should consider making appropriate budgetary investments to ensure that these programs can continue and expand their important work: (i) Family Resource Centers support families' ability to safely raise healthy children by providing supports and resources in the areas of parenting education, workforce development, assisting with concrete needs like food and housing, health services, transportation, and other community services. (ii) Court Appointed Special Advocate programs provide specially trained volunteers appointed by the courts in child welfare cases to gather and report valuable information to assist the court in making decisions supporting children's best interests. (iii) Child Advocacy Centers provide a safe space for children to be forensically interviewed for criminal and civil abuse and neglect investigations. They also provide therapeutic services to help children heal and help families navigate the criminal and CPS processes.

ABOUT THE OFFICE OF THE CHILDREN'S OMBUDSMAN

The Office of the Children's Ombudsman (OCO) was created by the General Assembly in 2020 "as a means of effecting changes in policy, procedure, and legislation; educating the public; investigating and reviewing actions of the Virginia Department of Social Services (VDSS), local departments of social services (LDSS), licensed child-placing agencies, or child-caring institutions; and monitoring and ensuring compliance with relevant statutes, rules, and policies pertaining to child protective services and the placement, supervision, and treatment of, and improvement of delivery of care to, children in foster care and adoptive homes." The statutes creating and governing the OCO are found in Chapter 4.4 of Title 2.2 of the Code of Virginia.

Pursuant to paragraph G of § 2.2-447 of the Code of Virginia, the Children's Ombudsman "shall submit to the Governor, the director of the Department, and the General Assembly an annual report on the Ombudsman's activities, including any recommendations regarding the need for legislation or for a change in rules or policies." This Annual Report covers our work during State Fiscal Year 2024, which began on July 1, 2023, and ended on June 30, 2024.

To ensure best practices in fulfilling our statutory responsibilities, the OCO abides by the following principles:

Independence: The OCO is dedicated to remaining free from outside control, limitation, or influence to ensure that our investigations, findings, and recommendations are based solely on a review of the facts and law. We operate within the Office of the Governor but are not under any Secretariat so that we can maintain our independence from the authorities that oversee the agencies that are subject to our investigative authority.

Impartiality: The OCO is dedicated to reviewing each complaint in an impartial and fair manner free from bias and conflicts of interest. We treat all parties without favor or prejudice.

Confidentiality: The OCO is dedicated to protecting the confidentiality of all information and records obtained in the performance of our duties. We limit disclosure in accordance with applicable law.

Staff:

Eric Reynolds, Director. Eric was appointed Director of the OCO in June 2021. He previously served as staff attorney for the Court Improvement Program in the Office of the Executive Secretary for the Supreme Court of Virginia and was an Assistant Attorney General with the Virginia Office of the Attorney General in Richmond, representing and advising the Virginia Department of Social Services, the State Executive Council for Children's Services and the Office of Children's Services, the Department of Aging and Rehabilitative Services, and the Department of Medical Assistance Services. Prior to working for the state, he was in private

practice, focusing on family law and serving as a court-appointed guardian ad litem for children and counsel for parents in child custody and child welfare cases. He is a graduate of the University of Richmond School of Law.

Jane Lissenden, Policy Analyst. Jane joined the OCO in August 2021. As policy analyst, she participated the development and implementation of policies and procedures for the Office. She is engaged in case reviews and outreach efforts and assists with special projects and reports. Prior to this role, Jane served for 15 years as Training Coordinator with the Court Improvement Program in the Office of the Executive Secretary at the Supreme Court of Virginia. Jane is a graduate of James Madison University, with a Bachelor of Science degree in Public Administration and a minor in Criminal Justice.

Destiny Allen, Investigations Analyst. Destiny served as a School Social Worker for Chesterfield County Public Schools where she worked closely with students and their families, school personnel, and community partners to meet students' academic needs, issues, or concerns. She is a graduate of the University of Virginia's College at Wise, with a Bachelor of Science degree in Sociology, and a minor in Administration of Justice. Destiny earned her Master of Social Work degree with a concentration in Administration, Planning, and Policy from Virginia Commonwealth University, School of Social Work.

Frank L. Green II, Investigations Analyst. Frank served as a Management Analyst with the City of Richmond Department of Social Services in the Child, Families, and Adults Division. In this role, he ensured that families and children were safe, and stable in their own homes, while promoting family reunification and support for youth in foster care, and the community. He accomplished this critical mission by managing state and federal grants to ensure compliance with funding regulations, while also developing, interpreting, and maintaining policies and guidelines to ensure the effective oversight and implementation of recipient grant programs. Frank has over 16 years of experience in the Child Welfare field in areas of therapeutic treatment, counseling, and conducting behavioral assessments. Frank is certified in Trauma Informed Advocacy through Mitchell Hamline School of Law, and a Certified Fatherhood Group Facilitator. He is a graduate of Virginia State University with a Bachelor of Art in Political Science. Frank has also earned his Master of Business with a concentration of Public Administration from Strayer University.

Jamie Anderson, Senior Investigations Analyst (began July 1, 2024). Jamie served sixteen years with the Henrico County Department of Social Services as a Senior Social Worker and Supervisor in Foster Care. Jamie has over twenty years of experience in public child welfare across Virginia, Texas, & Oklahoma serving in a variety of roles across all programmatic areas including CPS, prevention, training, foster care & adoptions. Jamie earned her Master of Social Worker degree from The University of Texas at Arlington and is a Licensed Clinical Social Worker in Virginia.

Denise Dickerson, Intake Analyst. Denise was the Program Manager for the Interstate Compact on the Placement of Children (ICPC) and the Interstate Compact on Adoption and Medical Assistance (ICAMA) at the Virginia Department of Social Services. She also served as the Director of Operations at the Richmond Redevelopment and Housing Authority, the Director of Social Services in the City of Petersburg, the Assistant Director of Administration at the Richmond Behavioral Health Authority, and Assistant to the Deputy City Manager in the City of Richmond. She has a Bachelor of Arts degree in Sociology from Iona College in New Rochelle, New York and a Master's degree in Public Administration from Virginia Commonwealth University.

Dara Hechter, Virginia Management Fellow. Prior to coming to the office, Dara was a fellow with the Office of the Secretary of Health and Human Resources. Dara graduated with her Bachelor's in Political Science and International & Global Studies from Brandeis University in 2023.

Acronyms used in this Report:

ALA – alternative living arrangement(s)
CAC – Child Advocacy Centers
CASA – Court Appointed Special Advocates
CHINS – Child in Need of Services
CPS – child protective services
CSA – the Children's Services Act (Virginia Code §§ 2.2-5200 *et seq*.)
DBHDS – the Department of Behavioral Health and Developmental Services
DCJS – the Department of Criminal Justice Services
DJJ – the Department of Juvenile Justice
DMAS – the Department of Medical Assistance Services (Virginia Medicaid)
FC – foster care
FUP – the Family Unification Program
FY – fiscal year
FYI – the Foster Youth to Independence housing initiative
GAL – guardian ad litem
HUD - the United States Department of Housing and Urban Development
ICPC – the Interstate Compact for the Placement of Children
ICWA – the Indian Child Welfare Act
LCPA – licensed child placing agencies
LDSS – local department(s) of social services
OCO – the Office of the Children's Ombudsman
OCS – the Office of Children's Services
SEI – substance exposed infants
THC – tetrahydrocannabinol (cannabinoid found in cannabis/marijuana)
VDSS – the Virginia Department of Social Services

FY2024 LEGISLATIVE ADVOCACY

The OCO advocated for legislation and state budget appropriations in two major areas of Virginia's child welfare system: kinship care and legal representation for parents involved in child dependency cases.

1. Kinship Care. Bills introduced by Senator Barbara Favola and Delegate Katrina Callsen – Senate Bill 39 and House Bill 27, respectively – created a program to support relatives and close family friends to care for children who would otherwise enter foster care. The bills were amended to create a more robust and comprehensive plan for at-risk children to be placed with relatives within and without the foster care system. These amendments were requested by Governor Youngkin as part of his legislative agenda and were strongly supported by Senator Favola and Delegate Callsen as well as by several legislators from both parties.[1] The amended bills created the Parental Child Safety Placement Program, which establishes a roadmap for local departments of social services to place children with relatives instead of having them enter foster care and to prioritize kinship care for those children who must enter foster care.

   The Parental Child Safety Placement Program was developed to address the significant operational and legal issues inherent in the use of informal "alternative living arrangements" by local departments of social services whose practices varied from jurisdiction to jurisdiction. The OCO highlighted these issues in its 2022 Annual Report. This legislation was accompanied by a proposed item in the Governor's introduced budget for increased funding to provide financial support for kinship caregivers. This funding also received bipartisan support from the General Assembly.

2. Parental Legal Representation in Child Dependency Cases. Delegate Adele McClure introduced House Bill 893 which incorporated the recommendations made by the Work Group convened by the OCO pursuant to Senate Joint Resolution No. 241 (2023 Session of the General Assembly) that reviewed Virginia's system of providing legal counsel for parents involved in child dependency cases. The final version of the bill passed with wide bipartisan support and included the following provisions:

   - The bill increased the maximum amount of compensation from $120 per case to $330 per case. For termination of parental rights petitions, the maximum amount of compensation was increased to $680 per case. These rate increases become effective on January 1, 2025.

[1] Senators Jennifer Carroll Foy, Ryan McDougle, Mark Obenshain, Christopher Head, and Angelia Williams Graves co-sponsored SB39 with Senator Favola. Delegates Adele McClure, Chris Runion, Betsy Carr, Jackie Glass, Karen Keys-Gamarra, Marty Martinez, Irene Shin, and Anne Ferrell Tata joined Delegate Callsen as co-patrons on HB27.

- The bill directs the Judicial Council, in conjunction with the Virginia State Bar and the Virginia Bar Association, to develop and adopt standards of qualification and performance for attorneys that are appointed to represent parents in child dependency cases.
- The bill includes language that authorizes the establishment of multidisciplinary law offices that can pilot the interdisciplinary model of legal representation by which the attorney is assisted by a social worker or parent peer support to provide more holistic advocacy for parents. Such model of representation has been shown to improve timely outcomes for children in foster care.

State Budget. The OCO supported and advocated for the following budget items that were passed by the General Assembly:

1. Kinship Care support for relatives taking care of children to prevent children from entering foster care, passed in conjunction with the kinship legislation passed under House Bill 27 and Senate Bill 39.
2. Funding for House Bill 893 to increase the maximum amount of compensation for court-appointed counsel for parents involved in child dependency cases.
3. Funding to implement the Foster Youth Driver's License Program recommended by the Virginia Commission on Youth to facilitate foster youths' ability to obtain their driver's licenses.
4. The establishment of a Training Academy for department of social services employees.
5. Funding to support Healthy Families America and Early Impact Virginia home visiting programs, Child Advocacy Centers, and implementation of the Two-Generation/Whole Family Pilot Project by Community Action Agencies, local departments of social services, and Division of Child Support Enforcement offices throughout the Commonwealth.

FY2024 OCO ACTIVITIES

OCO staff regularly participated in various workgroups, advisory committees, conferences, and project initiatives related to improving the child welfare system, including:

- SJR241/SB1443 Child Dependency Legal Representation work groups
- The CSA Annual Conference in Roanoke - October 2023
- Planning Committee for the 2023 Rural Summit in Abingdon - October 2023
- The Center for Advancing Policy on Employment for Youth (CAPE) collaboration meeting with the Department of Aging and Rehabilitative Services, the Department of Education, and VDSS in Richmond - October 2023
- Regulatory Advisory Panel for Licensed Child Placing Agencies - October 2023
- Kin First Kick Off Meeting - October 2023
- Tour of Shenandoah Valley Juvenile Center in Staunton – October 2023
- Department of Juvenile Justice Juvenile Detention Center Repurposing work group
- Office of Children's Services CHINS work group
- VDSS Citizens Review Panel work group
- VDSS Tribal Roundtable
- VDSS Child Welfare Advisory Committee
- Virginia League of Social Services Executives Child and Family Services Committee
- Virginia League of Social Services Executives Legislative Committee
- Children's Justic Act/Court Appointed Special Advocate State Advisory Committee
- Family Resource Center tours: Chesapeake (CHIP of South Hampton Roads) - December 2023; Richmond (Liberation Center)
- The Commission on Youth's Study on Relief of Custody - May 2024 – present
- Governor's Fatherhood/Reentry Initiative
- Conference Presentations/Speaking Engagements:
    - Families Forward - July 2023
    - Virginia Mountain and Valley Lawyers Association Conference in Winchester - October 2023
    - Virginia Family Network (Peer/Parent Support) - February 2024
    - CASA (Court Appointed Special Advocate) College - March 2024
    - Family and Children Trust Child Abuse and Neglect Committee Lunch and Learn - April 2024
    - Child Abuse Awareness Month Presentation for the Catholic Diocese of Richmond - April 2024

COMPLAINTS AND INVESTIGATIONS

The OCO receives complaints from the public with respect to children who (i) have been alleged to have been abused or neglected, (ii) are receiving child protective services (CPS), (iii) are in foster care, or (iv) are awaiting adoption. The OCO can investigate complaints that allege that administrative acts taken regarding such children by VDSS, local departments of social services, child-placing agencies, or children's residential facilities were:

- contrary to law, rule, or policy;
- imposed without an adequate statement of reason; or
- based on irrelevant, immaterial, or erroneous grounds.

Virginia Code § 2.2-441.

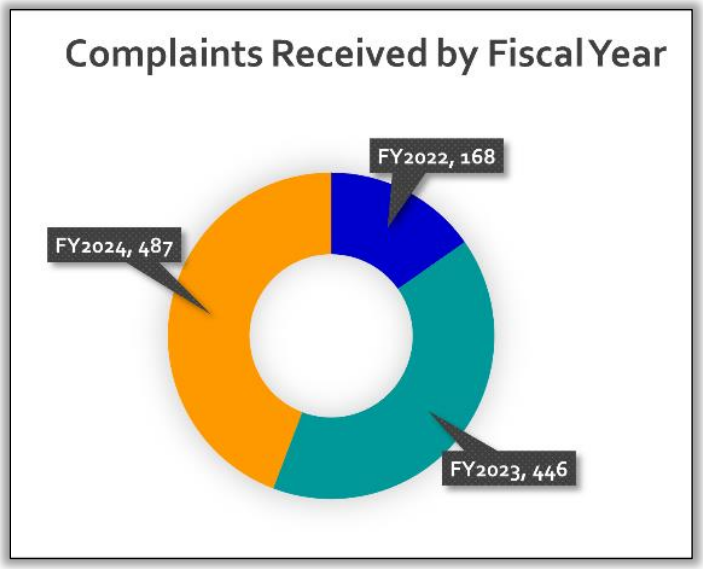
The OCO is required to prepare a report of the factual findings of an investigation and make recommendations to the agency being investigated if we find any of the following:

1. A matter should be further considered by the Department, local department, or child-placing agency.
2. An administrative act or omission should be modified, canceled, or corrected.
3. Reasons should be given for an administrative act or omission.
4. Other action should be taken by VDSS, the local department, children's residential facility, or child-placing agency.

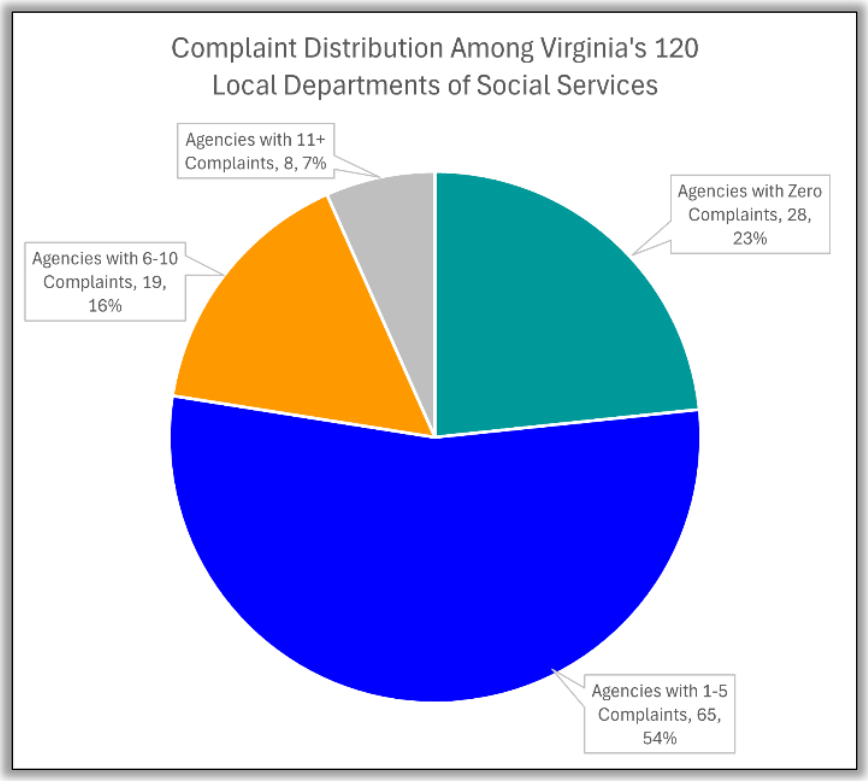
Virginia Code § 2.2-447(A).

COMPLAINTS

In FY2024, the OCO received 487 complaints, bringing the total number of complaints received since the OCO was established in June 2021 to 1,101.



Subject Agencies. Ninety-two of Virginia's 120 local departments of social services were the subject of the complaints we received during FY 2024. We received one complaint about a licensed child placing agency.

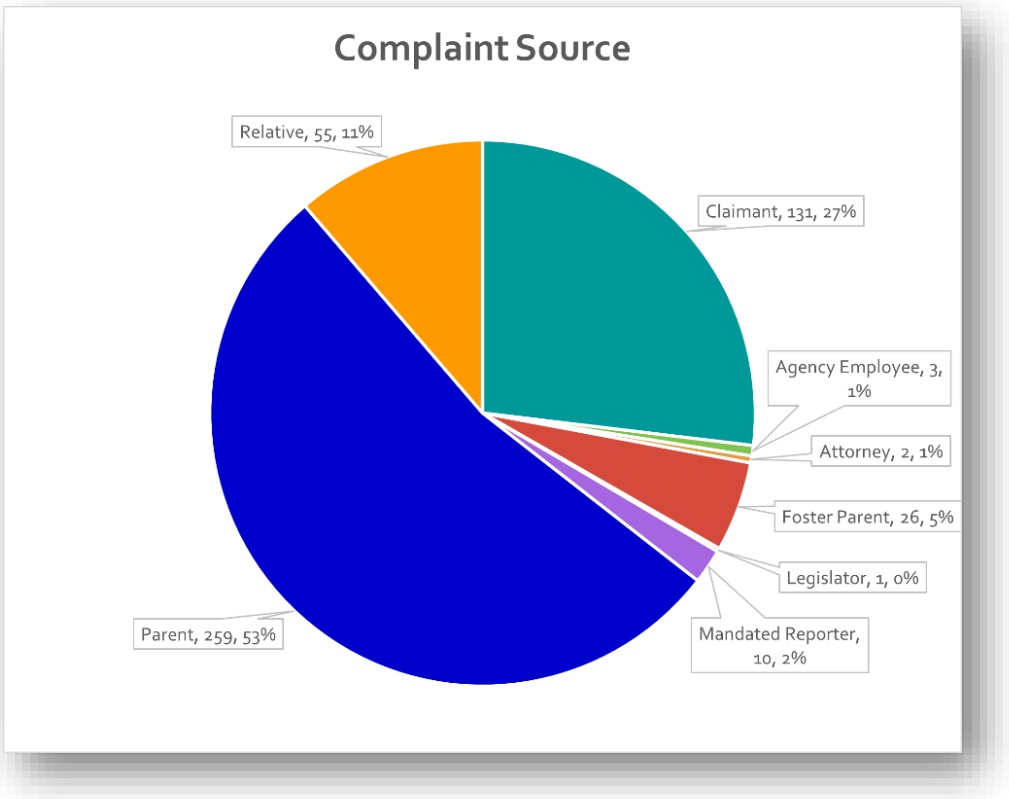


Complainants. A statutory complainant is any one of the following individuals as listed in Virginia Code § 2.2-441:

- the child,
- a biological parent of the child,
- a foster parent of the child,
- an adoptive parent or prospective adoptive parent of the child,
- a legally appointed guardian of the child,
- a guardian ad litem for the child,
- a relative of the child or any person with a legitimate interest as defined in Virginia Code § 20-124.1,
- a Virginia legislator,
- a mandated reporter of child abuse or neglect, and
- an attorney for the child, a biological parent, a foster parent, adoptive parent, guardian of the child, or relative or person with a legitimate interest.

As in previous years, most of the complaints received by the OCO came from parents (55%). Relatives are the second most common source of complaints (11%).

Complaints can also be submitted by individuals who do not meet the definition of a statutory complainant. By statute, the information we provide such individuals from our complaint reviews or investigations must be limited to protect confidentiality of the OCO's records.

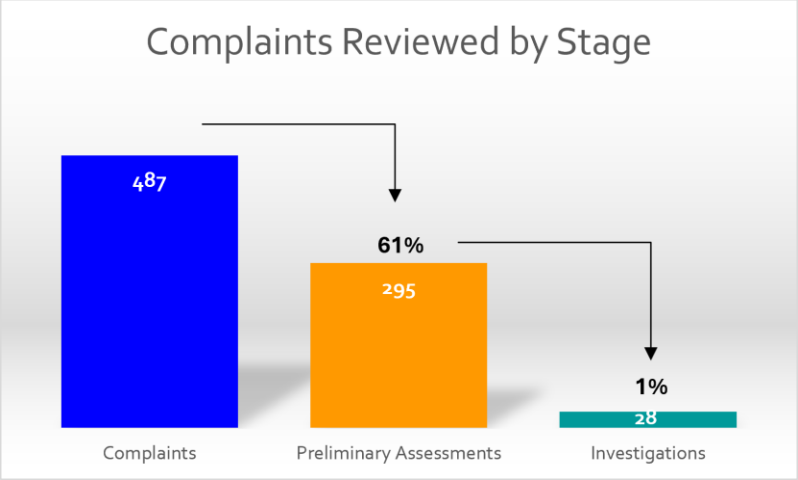


Disposition of Complaints (as of June 30, 2024):

- Preliminary Assessment Initiated (282)
- Open – Awaiting information from Complainant (27)
- Closed - Not Enough Information Provided by Complainant (112)
- Closed - Lack of Subject Matter Jurisdiction (62)
- Closed - OCO Discretion (1)
- Closed - Lack of Jurisdiction – No Active Cases (2)
- Closed - Requested by Complainant (1)

PRELIMINARY ASSESSMENTS

Of the complaints received, 61% moved beyond the intake stage to become a preliminary assessment. This means that the allegations in the complaint related to a case involving a child who was receiving child protective services, was in foster care, or placed for adoption.



All cases that became a preliminary assessment were reviewed to determine whether the complainant's allegations could be substantiated. This assessment included a review of the information submitted by the complainant and a review of the case records in the state's Child Welfare Information System (OASIS), the statewide online social services database, and, if necessary, a request for more information from the complainant or local department.

Complainants' Allegations. The following chart lists the allegations submitted by complainants, sorted by category, with the number of complaints received for each type of allegation, whether they were substantiated or not. The allegations are grouped in the following categories:

- Agency Issues: general internal agency practices
- Alternative Living Arrangements: issues specific to ALA practices
- Child Protective Services: issues specific to CPS Investigations, Family Assessments, In-Home Services, and Family Support cases
- Family Engagement: practices regarding engagement with families, including family finding and family partnership meetings
- Foster Care: issues specific to foster care cases

Agency Issues	Agency staff were biased against the complainant	42
	Communication/collaboration with LCPA	3
	Communication/collaboration within the LDSS (FC, CPS, IHS, etc.)	3
	Agency culture	4
	Documentation	32
	Lack of responsiveness from agency staff	23
	Records contain false information	12
	Inaccurate information presented in court by agency	3
	Supervision deficiencies	5
	Worker changes	6
Alternate Living Arrangements (In-Home Services)	Inappropriate or inadequate support or services to ALA caregiver	16
	Inappropriate or inadequate support or services to child	9
	Inappropriate or inadequate support or services to parent	25

	Incomplete or Insufficient Safety Plan	3
	Placement decision	17
	Service Plan Issues	5
	Visitation Issues	8
Child Protective Services	Family Assessment process	53
	Inadequate services	23
	Inappropriate services	9
	Investigation process	161
	Removal process	47
	Safety plans	37
	Validation process	45
Family Engagement	Family Partnership Meetings	37
	Inadequate relative contact	43
	Inadequate trauma informed care/practices	11
Foster Care	Abuse by Foster Parent	5
	Adoption	5
	Adoption Subsidy	
	Child's evaluations	4
	Child's Social Security Benefits	1
	Foster Care licensing	1
	Foster parents' expectations	20
	Permanency goal	5
	Inadequate case management	23
	Inadequate permanency efforts (for non-reunification permanency goal)	10
	Inadequate reunification efforts	28
	Inadequate services	49
	Inappropriate services	10
	Kinship Guardianship Assistance Program (KinGap)	1
	Normalcy	4
	Post-Adoption Contact and Communication Agreement (PACCA)	2
	Parent Evaluations	3
	Placement decision	34
	School issues	5
	Service Plan issues	6
	Sibling placement	3
	Virginia Enhanced Maintenance Assistance Program (VEMAT)	4
	Visitation issues	39
	Worker Visits	6
Miscellaneous Items – Beyond the Scope of OCO Jurisdiction	Confidentiality of Records	7
	Contested custody	13
	Freedom of Information Act (FOIA)	5
	Guardian Ad Litem concerns	15
	Inadequate Parents' legal representation	6
	Judicial concerns	5

For cases that did not rise to the level of investigation, we made every attempt to help or provide clarification to the complainant about the allegations that were raised. Any recommendations for improved practice that we identified in our preliminary assessments were provided to the local department.

Disposition of Preliminary Assessments:

- Information was provided to the complainant about the agency's actions (135)
- Investigation Initiated (28)
- Assistance was provided to resolve the complaint (20)
- Complainant was referred to another agency (11)
- Closed – No active cases (25)
- Closed – Complainant did not respond to our request for an intake call (9)
- Closed - Requested by Complainant (1)
- Closed - Other (2)

Most complaints received by the OCO were resolved at the preliminary assessment stage without having to initiate an investigation by providing additional assistance and information to the complainant to address their concerns and/or consulting with the local department to find a resolution.

INVESTIGATIONS

The OCO initiated 28 formal investigations involving the following local departments of social services and licensed child placing agency:

- Botetourt County
- Carroll County
- Chesterfield-Colonial Heights
- Dinwiddie County
- Franklin City
- Frederick County
- Lynchburg
- Mecklenburg County
- Patrick County
- Portsmouth
- Prince William County
- Roanoke City
- Roanoke County
- Rockbridge-Buena Vista-Lexington Area
- Russell County
- Shenandoah County
- Shenandoah Valley (Augusta County, Staunton, Waynesboro)
- Sussex County
- Washington County
- Westmoreland County
- York County-Poquoson
- Intercept Health

Investigations are initiated when the complainant's allegations have been substantiated and we identify practice concerns that may potentially affect the outcome of the case or the safety and well-being of the child. We may also initiate investigations if we identify a pattern of practice concerns within the same agency or among agencies.

The following chart lists the practice areas for which we made findings and provided recommendations to improve agency practices:

Adoption/Adoption Assistance	7
Agency - Communication/Collaboration with another LDSS	1
Agency - Documentation	13
Agency - Internal CPS-FC Collaboration	1
Agency - Lack of Responsiveness	4
Agency - Records contain inaccurate information	1
Agency - Supervision Deficiencies	1
Agency - Worker Changes	3
ALA - Inappropriate or Inadequate Support or Services to ALA Caregiver	1
ALA - Inappropriate or Inadequate Support or Services to Child	1
ALA - Inappropriate or Inadequate Support or Services to Parent	1
ALA - Service Plan Issues	1
CPS - Inadequate Services	4
CPS - Investigation Process	31
CPS - Safety Plan	9
CPS - Validation Process	2
CPS - Family Assessment Process	10
CPS – Removal Procedures	2
CPS – Validation Process	2
Family Engagement – Family Partnership Meetings	14
Family Engagement - Lack of Relative Contact	6
Family Engagement - Lack of Trauma Informed Care	3
Freedom of Information Act	1
Foster Care - Foster Parent Expectations	1
Foster Care - Inadequate Case Management	7
Foster Care - Inadequate Reunification Efforts	1
Foster Care - Inadequate Services	4
Foster Care – Kinship Guardianship Assistance	1
Foster Care - Placement Decisions	5
Foster Care – Sibling Placement	1
Foster Care - Visitation issues	6
Foster Care - Worker Visits	2
Interstate Compact for the Placement of Children	1
Inadequate Services (general)	4
Lack of Agency Response	1
Lack of Trauma Informed Care	1
Placement Decision	1
VEMAT	1

The following are summaries of findings and recommendations from some of the investigations that were closed by the OCO in FY 2024:

Case 1

The OCO received a complaint from a foster parent who was caring for children who were eligible to be members of a federally recognized Indian tribe. Because the children were considered Indian children under the Indian Child Welfare Act (ICWA), the local department was obligated to comply with ICWA's provisions governing foster care.

Findings:

1. The local department of social services notified the Tribe that the children were in foster care. The Tribe, however, declined jurisdiction as it did not have a tribal court or a department of social services. Nonetheless, the local department still needed to comply with the provisions in ICWA for cases involving Indian children in foster care being handled by state courts:

- After the Tribe declined jurisdiction, the local department should have taken steps to ensure that the Tribe was given notice of all court hearings and the opportunity to join in and intervene in the case as a party. (25 U.S.C. §§ 1911(b) and 1912(a).)
- Under ICWA, removal of the children requires a finding that active efforts were made to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family and that these efforts were unsuccessful. (25 U.S.C. § 1912(d).) This finding was not made. Instead, removal was granted upon the finding that *reasonable* efforts to prevent removal were made and were unsuccessful, which is the finding required under state law for cases involving non-Indian children.
- Under ICWA, an Indian child's placement in foster care must be ordered upon a "determination, supported by clear and convincing evidence, including testimony of qualified expert witnesses, that the continued custody of the child by the parent or Indian custodian is likely to result in serious emotional or physical damage to the child." (25 U.S.C. § 1912(e).) No qualified expert witness testified in this case and the children's placement in foster care was made upon the lower preponderance of the evidence standard used under state law for non-Indian children.
- The local department did not comply with the foster and adoptive placement preferences required under ICWA. (25 U.S.C. § 1915(a) and (b).) Federal regulation states that, "The placement preferences must be applied in any foster-care, preadoptive, or adoptive placement unless there is a determination on the record that good cause under § 23.132 exists to not apply those placement preferences." (25 C.F.R. § 23.129(c).)

2. The local department did not engage in family finding in accordance with state law and guidance. (Virginia Code § 63.2-900.1(A) and Section 3.9.2.3 of the VDSS Child and Family Services Manual, Part E.) Ongoing efforts were not made to engage with relatives or potential caregivers within the children's tribal community until two years after the children were placed in foster care.

Recommendations: The OCO recommended that the local department make efforts for staff to review ICWA resources and to seek out training that is specific to managing cases governed by ICWA.

Case 2

A mother whose child was in foster care complained to the OCO about the actions of the local department of social services alleging that neither she nor the child's father were involved in the development of the foster care service plan and that the local department made placement decisions that were not in the child's best interests. Due to a lack of documentation in the local department's case record, an investigation was initiated so that the OCO could evaluate the mother's allegations.

Findings:

1. With regard to the development of the foster care service plan, the local department attempted to convene a family partnership meeting when the child was first removed from the home to discuss the service plan, but the mother refused to participate. The local department instead held a phone conference with the mother to develop the plan. The father was incarcerated and was unable to participate in the phone conference, but the local department reviewed the plan with him upon his release.

2. The local department placed the child with a relative, consistent with state law and policy prioritizing kinship care. The relative became an approved kinship foster home and was available as a permanency option for the child.

3. The local department did not document important events and contacts in the case record, including the following:

- CPS Process and Procedures
    - Observations of the home environment where the alleged victim child resides
    - Mandated contacts with the alleged victim child, the child's sibling, and the parents
    - Forensic interview of the child
- Foster Care
    - Family partnership meeting notes
    - Consultation with the mother in the development of the foster care service plan
    - Efforts to identify and contact the child's relatives
    - Monthly visits with the child by the case worker

Recommendations: The OCO recommended that the local department document all contacts and events that take place during CPS and foster care cases and to provide training for CPS and foster care staff in the use of the official state mobile app that can facilitate proper and timely documentation.

Case 3

The child entered foster care after the parents had sought help with the child's behavioral health issues. The child exhibited violent behaviors that the parents were not able to handle, creating an unsafe environment for the family. A trial home placement was attempted after the child was discharged from a psychiatric residential treatment facility, but the trial home placement was unsuccessful, causing the child to be removed again from the parents. The local department then sought termination of parental rights due to the parents' inability to provide a safe home for the child.

The parents contacted the OCO expressing confusion as to why the local department was no longer seeking reunification and frustration that the local department assigned a parent coach with whom they did not have a productive relationship and who hindered their progress. The parents were also frustrated that the local department seemed to keep "moving the goal post" for them which made it difficult for them to achieve the goal of reunification. After reviewing the case records, the OCO identified additional practice concerns.

Findings and recommendations:

1. The case records were unclear as to whether the child entered foster care on a petition alleging abuse or neglect or a petition alleging the child was a child in need of services (CHINS), as both petitions were referenced. After interviewing local department staff, we learned that the local department filed a CHINS petition after discussing it with the parents. However, the guardian ad litem was very concerned about the information contained in the petition and recommended that the child enter foster care. The local department then decided to file an abuse and neglect petition to request an emergency removal and to let the judge decide which petition to grant. The parents were not told about the removal request until the court hearing. The court dismissed the CHINS petition and ordered the child's entry into foster care on the abuse and neglect petition. We found that the local department should have notified the parents of their decision to file the abuse and neglect petition prior to the court hearing.

We also found that the parents were not offered the option of entering a Non-custodial Foster Care Agreement with the local department. In these arrangements, the child is voluntarily placed in the care of the local department while the parents retain legal custody. These agreements are intended to provide non-punitive assistance in accessing services for parents with children having behavioral health needs without the agency having to file a petition alleging abuse or neglect. With a Non-custodial Foster Care Agreement, the child is considered to be in foster care, but with the parents' retaining legal custody, they should have more say in the decisions regarding the child's placement and services.

2. Regarding the parents' allegation that the assigned parent coach was ineffective, it was clear from the information we received that the provider was not a good fit for the parents. The relationship lacked trust and did not provide the assistance the family needed. Services

provided to families to help them achieve reunification with their children should not create additional barriers. We encouraged the local department to seek alternative providers for parents and children when it becomes clear that the services are ineffectual. In this case, the parents were able to form a better relationship with their subsequent parent coach.

3. Key stakeholders that we interviewed stated that they believed the transition for the trial home placement was rushed and did not properly prepare the family for the child's return home. The residential treatment facility where the child was admitted prior to the trial home placement had given notice to the local department that the child had to be discharged. The local department was unable to find a step-down placement, so the trial home placement occurred earlier than planned. Some services were not put in place, particularly regarding the child's school environment, which previously triggered the child's behaviors. The trial home placement began during the child's summer break from school and was going well until school resumed. The family was receiving intensive in-home services, but they were not in place long enough to be effective. The family could have benefited greatly from proper discharge planning, an appropriate intermediate step-down placement, High Fidelity Wraparound services, and more accommodations at the child's school.

4. After the trial home placement failed, the child was placed back in residential treatment and the local department sought termination of the parents' rights. At the time of our investigation, the child remained in residential treatment with no permanent placement identified. We expressed grave concerns with the local department's decision to terminate parental rights and to cut the child off legally from the parents who demonstrated a deep commitment and love for the child throughout the duration of the case. Many children and youth in foster care who exhibit similar behavioral health issues have languished in foster care bouncing from placement to placement, often becoming displaced in hospital emergency departments, hotel rooms, or sleeping in agency offices because no approved foster placement will take them, and often age out of foster care without connecting to any supportive adult. Terminating parental rights can unnecessarily limit the opportunity for the children to remain connected to supportive family members and relatives.

Case 4

The OCO received a complaint from a medical professional with concerns that the local department of social services was not responding to multiple CPS reports alleging that a child was abused and neglected. The child had had four near-fatal overdoses within a 6-month period. Medical and mental health professionals had significant concerns for the child's safety if discharged to the parents. The local department invalidated the CPS referral. Upon review of the family's CPS history, which included a family assessment opened due to another child being born substance exposed, we found that other CPS reports were inexplicably screened out and the history indicated that the child remained at serious risk of further harm. The OCO notified the local department's director and the VDSS regional office

of our concerns with the multiple screen-outs. The local department took immediate steps to address the safety needs of the child and our concerns with its CPS intake process.

Case 5

The local department opened a family assessment upon a validated CPS report alleging abuse by the child's father. When the mother took the child to receive medical care for a cough and a fever after the child returned from the father's home, medical staff noted healing cuts around the child's wrists and bruising on other parts of the child's body. After conducting the family assessment, the local department concluded that the family needed no additional services and rated the risk assessment as low for future child abuse or neglect. The mother contacted the OCO with concerns that the local department did not conduct the family assessment properly. Specifically, the mother alleged that CPS did not review the child's medical records, did not put a safety plan in place to ensure the child's safety, and did not respond to her request for the CPS records.

Findings:

1. Contacts, observations, and other pertinent information were not documented, updated, or entered into the case records within the appropriate timeframe required by state policy. In our initial review of the case records, we found only one page of case records for the family assessment that was opened. Due to the significant lack of case records, we were unable to assess and identify whether proper steps for the family assessment were taken, whether preventative actions were attempted to ensure the child's safety, and whether services were identified. The lack of records prevented us from being able to substantiate the complainant's concerns.

One day after we initiated the investigation, the case records were updated and continued to be updated regularly. Upon our final review, the information added to the case record was clear and concise describing all aspects of the agency's work with the family and the events that took place throughout the life of the case. Information gathered from our interviews with agency staff was consistent with the documentation and confirmed that the actions taken and decisions made by the agency were substantially in accordance with applicable laws, rules, and policies.

2. The family assessment, however, was not completed within 60 calendar days of the receipt of the complaint report as required by state policy. The Code of Virginia requires local departments of social services to complete and document the family assessment within 60 calendar days of receipt of the complaint or report. During our interviews with staff, we learned that the agency was experiencing staff shortages, which impacted the management of their CPS cases. It was reported that their CPS workers had a caseload of about thirty cases. It was also reported that only five of fourteen CPS investigator positions were filled at the time, which resulted in the agency having to recruit agency workers from other family service units to provide support.

The agency acknowledged the untimeliness of their case documentation but advised that their main priority is to be responsive and take the time to properly assess children's safety and to make suitable plans for children and their families. It was noted that case documentation was made a secondary priority for the agency as they continued to work through their staffing challenges. Information gathered from the updated case records and our interviews with agency staff confirmed that efforts were made to ensure that the presenting concerns were addressed, the family was engaged throughout the family assessment process, and that services were identified and implemented, when applicable.

Case 6

The OCO received a complaint from the mother of a foster parent who was taking care of a child with special medical needs. The child's grandmother was identified by the local department as the permanency placement and had started the process to become an approved foster kinship care provider. The grandmother was already taking care of the child's older siblings and was willing to be the permanency placement for the child to ensure the siblings could remain together but had expressed concerns to the local department that she would not be able to manage the child's extraordinary medical needs. The local department told her that if she was not able to care for the child, then they would seek out other kinship caregivers.

The grandmother and the child's mother maintained a close relationship with the foster parent, who had supported the child's relationships with the siblings and with both the grandmother and mother. The foster parent's own mother also was very involved with the family and provided much support to the child's mother during and after her periods of incarceration. The grandmother and mother reported to the local department that the foster parent was very much a part of their family and felt that the child's interests would best be served if the foster parent could adopt the child.

The local department disagreed, however, and started the process of identifying another relative who could serve as the permanency placement. The local department reported that they were concerned that the foster parent would cut the child's family out altogether after adoption. The local department also cited to state policy prioritizing kinship care over terminating parental rights and adoption.

Out of fear that the child would no longer have contact with her and the siblings, the grandmother filed a petition for custody. At the permanency planning hearing, the court granted the grandmother custody. The local department closed the foster care case thereafter. Within a short period of time, the foster parent filed a petition for custody with the support of the child's mother and grandmother. The court granted custody to the foster parent. Unfortunately, because the child was not adopted from foster care, the child was ineligible for adoption assistance.

Recommendations: The local department was encouraged to reconsider its policies regarding kinship care. Generally, kinship care is preferred over adoption by a non-relative.

However, each case and each child's needs are different and broad policies encouraging kinship care should not be blindly adhered to and applied at all costs. Local departments should consider the particular facts and circumstances of each case and how the child's interests will best be served. Here, the child's adoption by the foster parent was supported by the child's mother and grandmother. The foster parent had built a strong relationship with the child's family, including the child's siblings, such that their families were integrated. As a result, the child was able to retain a strong bond with the mother, grandmother, siblings, and other extended family members, even while in the care of the foster parent.

Case 7

The OCO was contacted by the grandmother of children who were in foster care. The grandmother, who lived in another state, complained that the local department did not properly or timely engage the Interstate Compact for the Placement of Children (ICPC) process to place the children with her. The OCO reviewed the case records and interviewed the local department staff. We found that the foster care worker worked diligently through the ICPC process but was met with some barriers with the internal protocols in the state in which the grandmother lived.

Findings: Although we did not identify that any of the local department's acts regarding the ICPC process and placement of the children with the grandmother violated law, rule, or policy, we did identify some issues regarding the CPS cases involving the children that led to the children's entry into foster care:

1. New allegations of abuse and neglect of the children were received during an active family assessment, but the local department did not address these new allegations appropriately under state policy. Agency staff reported to us that their agency practice is that if there is an open case and there is already an assigned worker, the local department adds the new concerns to their open case. It was explained that this is due to some families having multiple CPS complaints being made against them during open cases and the number of workers that would have to be assigned to cover each complaint.

Agency staff acknowledged guidance set forth in the VDSS Child and Family Services Manual, Part C, Section 3.4.3.1, but expressed that if followed, the agency would have an array of cases opened with families that receive several complaints against them. The OCO acknowledges the challenge agencies experience in receiving multiple complaints or reports concerning children and families within their community; however, it is important for each referral to be addressed separately to ensure that (i) each new concern brought to the agency's attention is assessed or investigated appropriately, (ii) that cases are managed within the required timeline per state policy, (iii) and that case dispositions are made when applicable.

Recommendation: We recommended that agency staff make efforts to document all CPS reports and concerns in the child welfare information system to ensure that well-informed

decisions can be made when receiving these multiple reports. Documentation of new referrals received during pending cases and responses to such referrals should be in accordance with state guidance in VDSS Child and Family Services Manual, Part C, Section 3.4.3.

The agency should also be mindful that state policy requires that if there is a third valid CPS report within 12 months, it must be opened as an investigation. VDSS Child and Family Services Manual, Part C, Section 3.9.1. This should assist the agency in determining track decisions and managing multiple complaints and reports that are received by the agency concerning the family.

2. Contact with the alleged victim child was not made within the assigned response priority time in accordance with state policy at VDSS Child and Family Services Manual, Part C, Section 4.5.6.2. The CPS referral was assigned an R2 response priority level, which requires contact to be made with the alleged victim child within 48 hours of the referral. The agency did not contact the child until seven days after the referral was received.

Agency staff reported that when complaints are reported to the state office through the mandated reporter portal and the state hotline, there is often a delay in the time they receive them by as much as several hours, which causes them to be behind in responding to the complaints. The OCO looked further into the reported delays between the time a CPS referral is received from the mandated reporter portal or state hotline and the time the referral is sent to the local agency. We found that most local departments were notified of the CPS referral within 20-30 minutes of receipt by the state hotline staff.

Recommendation: We recommended that agency supervisors take measures to ensure that staff contact victim children within the appropriate response times.

3. A CPS investigation was not completed within 45 calendar days of the receipt of the referral and was extended without documenting the reason or notifying the alleged abuser(s) of the extension in accordance with state law and regulation.

Agency staff acknowledged that this was an oversight by the agency worker assigned to the case at the time and reported that the case was opened longer because the alleged victim child's whereabouts were unknown at the time the agency received the complaint. The child was eventually located during the investigation and court action was initiated.

We noted, however, that during the time the child could not be located, the local department received a separate CPS referral when the child presented at the emergency room of a local hospital. The referral was screened out and the CPS investigator was not immediately notified and was too late in responding to the hospital to locate the child.

Recommendation: We recommended that agency staff should review the statutory requirements for conducting investigations and request assistance from supervisors when circumstances may prevent timely completion. Agency supervisors should ensure that staff

comply with the timelines and notifications required by statute for completing and extending investigations.

4. Three family assessments were not completed within 60 calendar days of the receipt of the CPS complaint.

Recommendation: Agency staff should review the statutory requirements for conducting family assessments and request assistance from supervisors when circumstances may prevent timely completion. Agency supervisors should ensure that staff comply with the timelines required by statute for completing family assessments.

5. Contacts, observations, and other pertinent information were not documented, updated, or entered into the case record within the appropriate time frame required by state policy. During the time the alleged victim child could not be located for the CPS investigation, the case record did not reflect whether diligent efforts were made to locate him, and periodic checks were not completed nor documented as required by state policy. Staff reported that efforts were made to locate the child, including making Accurint and Clear searches, issuing CPS Alerts, and periodic home visits with and phone calls to the child's relatives who may have had knowledge of the child's whereabouts. However, none of these efforts were documented.

Recommendation: We recommended that agency workers make efforts to timely document and update case records that reflect the actions and decisions made throughout the life of the case. This is not only required by state policy, but is necessary on a practical basis for supervisors, newly assigned workers, and others having a need to review the record to understand the case history.

Case 8

The OCO received a complaint from fictive kin caregivers who had been caring for two children via a safety plan in an in-home services case. While caring for the children, these caregivers also completed the process to become a licensed foster home. The children presented with significant medical needs that were likely to continue for years due to in utero substance exposure. The caregivers had voiced their concerns about being able to provide for these children financially because private insurance and their employer's family benefits would not be available unless the children were adopted.

The local department did not give the caregivers the option to serve as a foster care placement and said that if the children entered foster care, they would be separated. Although the local department held a family partnership meeting, we found that the kinship caregivers were not being provided with the appropriate information or options for supporting the children in the long term.

After the kin caregivers expressed concern about their ability to care for the children on a permanent basis, the local department began planning for a change in placement, which

was scheduled to take place the day after the OCO received the complaint. The OCO notified the local department immediately of the investigation and requested that the VDSS Regional Office provide technical assistance and guidance to ensure that consideration would be given to formalizing the arrangement with the fictive kin through foster care. After consultation, the local department petitioned for an emergency removal of the children, who were then placed in the home of the caregivers as a formal foster care placement.

The OCO reviewed similar cases where the local department was resistant to approve kinship caregivers as foster homes. Often, caregivers are suspected of being driven by financial gain to get foster care maintenance stipends that are more than the relative maintenance payments. In multiple cases, the families reported to us that they were told that by going to court for formal foster care, the children would end up being placed far away or that siblings would be separated.

In this case, a note in the case records stated, "*the team acknowledged the dangerous precedence set by Alternate Living Arrangement providers seeking additional funding creating a situation in which the Department must assume custody, and children enter foster care, in order for the caregivers to be paid more than the Relative Maintenance Payment, particularly in this case where there are…other children that could theoretically enter foster care.*"

The OCO strongly disagrees with this viewpoint and encourages local departments to reconsider how best to support kinship caregivers who are caring for children and to increase the children's likelihood of achieving permanency within the family.

Case 9

The OCO received a complaint from a mother about a CPS investigation that was initiated upon receipt of a report of an incident of domestic violence between the mother and father in the presence of the youngest child. Police had been called, the father was arrested, and an emergency protective order was entered. The mother subsequently did not request for the protective order to be extended and reportedly minimized the domestic violence incident.

A safety plan was initially put in place whereby the father was not to have any contact with the children. The safety plan also stated that, "Services will be implemented by the family to move towards reunification. FSS [] will ensure services are implemented and participation is taking place. FSS will monitor adherence to the safety plan." The father's criminal charge was subsequently adjudicated with a deferred disposition, to be dismissed upon his compliance with services and no further acts of domestic violence and other conditions.

Findings:

1. The decision to safety plan with the mother for the father to have no contact with the children was based solely on information provided by the initial reporter prior to any contact, interviews, or discussions with the family members.

2. The CPS interview with the mother occurred with the children present and was not conducted using trauma-informed practices. The mother was highly emotional, and the children created distractions and were privy to some of the sensitive discussion. No other home visit is documented nor any further assessment of the family's needs. There were no documented interviews of the children.

3. There was no documentation of any Family Partnership Meetings being held or planned to involve the family in determining appropriate services.

4. There were no documented referrals for services. The mother was provided information about early childhood intervention services weeks later with no documented explanation as to why this service was being recommended to the family.

5. Staff contacts with the family were not documented. There was no documented discussion with the mother about why counseling was needed and whether any other supports could assist her in accessing those services around her and the children's schedules and obligations.

6. The documentation suggested that the mother was not being treated as a victim of domestic violence. There was no documentation of what domestic violence services were offered or suggested to the parents as a couple. There was no documentation of any discussion with the Commonwealth's Attorney's office or the father's assigned probation officer regarding the services and conditions with which he had to comply to dispose of his criminal case.

7. The 45-day investigation period lapsed with no documentation of cause to extend the timeframe.

Recommendation: We were concerned that the agency's intervention was not supportive of family restoration but was more punitive. The lack of referrals for meaningful domestic violence services, lack of trauma-informed practices and engagement, and perceived unresponsiveness of the agency sowed serious distrust in the agency by the family. We recommended that the local department staff familiarize themselves and comply with state guidance at VDSS Child and Family Services Manual, Part H dealing with Domestic Violence in Child Welfare.

Case 10

The OCO received a complaint from a parent who was subject to a CPS referral. The parent's concerns related to the drug screens conducted by the local department, the safety plan, and the local department's authority to meet with the child. We could not substantiate the parent's allegations but did identify practice concerns of our own:

1. The CPS referral was accepted as a family assessment. The allegation related to illegal drug use by the caregiver and the local department correctly completed the intake tool, which did not determine that an investigation was mandatory. However, after the child tested positive for methamphetamine and THC, the decision was made to petition the court for an emergency removal order. State regulation at 22 VAC 40-705-60 3b requires that when circumstances warrant a child be taken into emergency custody during a family assessment, the report shall be reassigned immediately as an investigation. There is no indication that the local department changed the track of the family assessment to an investigation. The family assessment was closed substantiating the initial allegations but there was no finding in this matter because of the failure to change the track to an investigation.

2. The child entered the local department's custody on October 31st and was returned home on a trial home placement on November 7th. The court transferred custody back to the parents on November 14th. Case records indicated that a family partnership meeting (FPM) was not convened until November 30th. A timely held FPM may have helped prevent the child from entering foster care.

The local department should hold FPMs at the major decision points during a case to build trust, establish clear expectations, and engage family supports. State guidance in the Virginia Department of Social Services Child and Family Services Manual, Part C, Section 4.5.11.1 states:

> *The LDSS should schedule a [family partnership meeting] FPM when the worker assesses the child's safety to be in jeopardy or at risk of removal or out of home placement. However, safety concerns are paramount and necessary action to address safety issues shall not be delayed. The FPM should be scheduled within 24 hours after safety issues have been identified and the agency is considering removal, and occur before the five-day court hearing in cases after the emergency removal. Emergency removal prompts the need to convene a FPM and changing the track from a family assessment to an investigation. This meeting provides the opportunity for family and community participation in the decision-making process for the child. Engaging the relatives and natural support of the family will be crucial to a successful meeting.*

Case 11

The OCO received a complaint from a mother whose child was placed in an alternative living arrangement with a relative pursuant to a safety plan while the local department conducted its investigation of alleged physical abuse by the mother's spouse. The mother's complaint alleged that the local department intimidated her to sign the safety plan, forced the spouse out of the home, illegally prohibited contact between her and the child, and kept the child away from the family for three months unnecessarily, causing the family to miss out on important family events and holidays.

Findings.

1. At the time of the CPS referral alleging abuse, the child was visiting a relative for the weekend. The relative resided in a different county than the mother. The local department sent one team of CPS staff to the relative's home and a second team to the mother's home. Both teams completed two conflicting safety plans. The safety plan signed by the relative stated that the child would remain with the relative. The safety plan signed by the mother stated that there would be no contact between the child and the stepparent. It did not require the child to reside anywhere else. Moreover, although neither safety plan prohibited contact between the child and the mother, the local department staff told the mother that no contact was allowed. When interviewed, staff confirmed that they did not consult with each other when drafting the safety plans.

2. The safety plan signed by the relative was invalid because it was not signed or consented to by the parent having legal custody. This safety plan called for the child to remain in the physical custody of the relative. The parent having legal custody has the right to determine where the child resides. The relative had no such right. Safety plans that affect custody should be signed by parents or guardians having legal custody.

3. The separation of the family was imposed without an adequate statement of reason and based on erroneous grounds. The local department prohibited contact between the stepparent and the other children in the home, who had not been reported as abused. No safety assessment was conducted to determine whether the other children would be at risk if they had contact with the stepparent.

The local department also relied on inaccurate information provided by the relative, who alleged that the mother had taken steps to keep the victim child out of day care to prevent anyone from seeing bruises on the child. The local department staff did not discuss these allegations with the mother nor did they review the daycare records to substantiate these allegations.

4. Continued family separation under the safety plan was contrary to state policy. The child did not return home until thirteen days after the conclusion of the CPS Investigation. State policy at Section 4.6.22.2 of Part C of the VDSS Child and Family Services Manual states that the actions under a safety plan are in effect until a new safety plan is developed or the investigation or case is closed, whichever comes first. The child should have been able to go home earlier. Following the conclusion of the CPS Investigation, if further conditions were required to ensure the child's safety, the local department could have (i) developed a new safety plan and opened an In-Home Services case, or (ii) sought court action in the event the family was noncompliant.

5. No services were provided the family. Despite the safety plan provision stating that services would be offered the mother and stepparent, no services were offered or referred. Local department staff reported that they had concerns with domestic violence but acknowledged that the family was not provided any referrals to address these concerns.

6. The CPS investigation was not conducted in accordance with state regulations and policies. State regulation at 22VAC40-705-80 requires certain actions to be taken during CPS Investigations, including the following:

- The victim child's interview must be recorded.
- Interviews of the other children residing in the home must be conducted.
- The site of the incident where the alleged abuse occurred must be observed.
- Interviews of collaterals must be conducted.

The first interview of the child was not recorded and was conducted in the presence of the relative. The child and the alleged abuser reported that the child had been wrestling with one of his siblings at the time of the alleged incident, yet that sibling was not interviewed. There is no documentation of any observation of the bedroom in which the incident allegedly took place. Daycare and hospital staff were not interviewed. The child's forensic interview is noted but not fully documented in the case record.

7. State policy at Section 4.6.21.1 of Part C of the VDSS Child and Family Services Manual states that a family partnership meeting should be scheduled "when the worker assesses the child's safety to be in jeopardy or at risk of removal or out of home placement." No family partnership meetings took place. This could have assisted local department staff and the family in making important decisions, such as the child's place of residence, contact and visitation, and the actions and services needed to address the child's safety. The holding of a family partnership meeting could have facilitated better coordination among the various local department staff and supervisors involved and could have established appropriate expectations between the local department and the family.

CHILD FATALITIES

Pursuant to subsection B of Virginia Code § 2.2-443, the OCO may investigate child fatality cases that occurred or are alleged to have occurred due to child abuse or child neglect in the following situations:

1. A child died during an active child protective services investigation or open services case, or there was a valid or invalid child protective services complaint within 12 months immediately preceding the child's death.
2. A child died while in foster care, unless the death is determined to have resulted from natural causes and there were no prior child protective services or licensing complaints concerning the foster home.
3. A child was returned home from foster care and there is an active foster care case.
4. A foster care case involving the deceased child or sibling was closed within 24 months immediately preceding the child's death.

The Virginia Department of Social Services notifies the OCO when a child fatality that meets the above statutory criteria occurs. In FY2024, the OCO received 54 notifications of such child fatalities. The OCO reviewed each child fatality case and the records related to all CPS and any foster care cases associated with the child's family that were documented in the state child welfare information system online database. The following information about these 54 child fatality cases was gathered solely from these child welfare case records.

Demographics. The ages, gender, and race of the 54 children were reported as follows:

Age	Number of Children
1 month	10
6 weeks	1
2 months	8
3 months	2
4 months	7
5 months	1
6 months	1
7 months	2
8 months	1
9 months	2
1 year	1
2 years	4
4 years	3
5 years	2
8 years	3
12 years	3
14 years	1
16 years	2

Gender	Number of Children
Female	24
Male	30

Race	Number of Children
Asian	1
Black	18
Multiracial	9
White	26

Localities in which child fatalities were reported. The 54 child fatalities occurred in the following localities:

Alexandria
Alleghany Co.
Arlington Co.
Bedford Co.
Carroll Co.
Craig Co.
Emporia
Fairfax Co. (3 cases)
Fauquier Co.
Franklin Co.
Frederick Co.
Hampton (2 cases)
Hanover Co.
Henrico Co. (3 cases)
Hopewell (2 cases)
Lynchburg
New Kent Co.
Newport News (2 cases)
Norfolk (4 cases)
Orange Co.
Page Co.
Petersburg
Pittsylvania Co. (2 cases)
Portsmouth (3 cases)
Prince William Co.
Richmond
Roanoke (2 cases)
Rockbridge Co.
Smyth Co. (2 cases)
Spotsylvania Co. (3 cases)
Stafford Co.
Staunton
Tazewell Co. (2 cases)
Virginia Beach
Washington Co.
York Co.

Conditions at the time of death/family history.

Unsafe Sleep. In 24 cases (44%), unsafe sleep practices or conditions were reported at the time of the child's death. Such practices and conditions included children sleeping face-down; co-sleeping with adults or other children, including falling asleep while breastfeeding; sleeping on adult-sized beds; sleeping in baby swings; and sleeping in bassinets, cribs, or pack-n-plays with blankets, pillows, and stuffed animals.

Substance-Exposed Infants. In 16 cases (30%), the decedent child was reported as being born substance exposed when it was reported that the mother used substances during pregnancy or tested positive for substances at the birth of the child, or when the child tested positive for substances. The following substances were documented as those to which the 16 children were exposed prenatally:

- THC (9 children)
- Medication Assisted Treatment, including Suboxone, Methadone, and Buprenorphine (4 children)
- Cocaine (2 children)
- Methamphetamine (1 child)
- Heroin (1 child)
- Fentanyl (1 child)

Parental Substance Use. In 25 cases (46%), the children's parents or caregivers were reported to have had a history of substance use, including at the time of the child's death. In all but one of the 25 cases where parental substance use was documented, the decedent

children were 4 years of age or younger. Unsafe sleep conditions were reported in 12 of the 25 cases. The substances reported to have been used by the parents and caregivers were:

- THC (18 cases)
- Cocaine (8 cases)
- MAT (6 cases)
- Methamphetamine (4 cases)
- Heroin (2 cases)
- Fentanyl (2 cases)
- Amphetamines (2 cases)
- Morphine (1 case)
- MDMA (1 case)
- Kratom (1 case)
- Alcohol (1 case)
- Gabapentin (1 case)
- Benzodiazepines (1 case)

Domestic Violence. In 17 cases (31%), the family had a history of domestic violence. In nine cases (17%), the parents were reported to have had untreated or undertreated mental health conditions.

Children 6 months of age and younger. Particularly noteworthy is that 30 of the 54 children (56%) were aged 6 months or younger. For these children, the following was reported and documented:

Gender	Number of Children
Female	15
Male	15

Race	Number of Children
Asian	0
Black	12
Multiracial	5
White	13

Conditions/Family History	Number of Children
Unsafe Sleep	22
Substance-Exposed Infants	12
Parental Substance Use	16
Domestic Violence	11
Parental Mental Health Diagnoses	6

Cause/Manner of Death. In 24 of the 54 child fatality cases reported to the OCO, as of the writing of this Annual Report, the local departments of social services investigating the child fatalities still had not received the final medical examiner's report, so the causes and

manners of death for those children are still unknown. Autopsies were not done for several cases due to the nature of the death, with some directly resulting from the children's serious medical conditions and two children having died from gunshot wounds. For cases that documented receipt of the medical examiner's report, the causes and manners of death were documented as follows:

Cause of Death	Manner of Death
Sudden unexpected infant death	Undetermined
Food asphyxiation from choking	Choking tonsillar hypertrophy
Accidental homicide	Unsafe sleep condition
Myocarditis and intussusception	Natural
Sudden unexpected infant death	Undetermined
Seizure disorder and respiratory syncytial virus	Undetermined
Undetermined	Undetermined
Sudden unexpected infant death associated with co-sleeping/soft bedding	Undetermined
Unsafe sleep and fractures indicate accidental and non-accidental causes	Undetermined
Sudden unexpected infant death associated with cocaine and fentanyl and unsafe sleep	Not documented
Acute bacterial meningitis	Not documented
Acute necrotizing encephalitis and influenza	Not documented
Acute appendicitis	Not documented
Suffocation due to unsafe sleep	Not documented
Suffocation	Not documented
Sudden unexpected infant death associated with unsafe sleep and coronavirus	Undetermined
Blunt force trauma to the head; fentanyl toxicity and cocaine exposure	Homicide
Sudden unexpected infant death associated with unsafe sleep environment and lymphocytic interstitial pneumonitis of the lungs.	Undetermined
Congenital cytomegalovirus and a brain cyst	Not documented
Suffocation	Accidental
Undetermined	Undetermined
Undetermined	Undetermined
Sudden unexpected infant death with bronchopneumonia with unsafe sleep on an adult bed while co-sleeping	Not documented

Case Summaries. The following summaries are of some of the cases in which the CPS child fatality investigations were completed.

Case 1. The child was 4 months old at the time of death. It was reported that the baby co-slept with the mother. The cause of death was Sudden Unexpected Infant Death (SUID), and the manner of death was Undetermined. The CPS investigation of the fatality resulted in an Unfounded disposition (there was no preponderance of the evidence that the child's death was caused by abuse or neglect).

Prior DSS involvement: A CPS referral was made when the child was born. The reported concern was the mother's ability to care for the newborn given her hostile behavior in the hospital and reported mental health diagnoses. The child tested positive for THC at birth. The referral was invalidated but a Family Support case was opened.[2] The local department's Family Services Specialist (FSS) assigned to the case assisted the mother with accessing resources for employment, childcare, housing, and mental health care. The FSS discussed safe sleep with the mother and referred her to Healthy Families, but she declined to follow through with the services.[3] The FSS also referred the mother to domestic violence resources when the child's father made threats against her, but the mother declined these services as well. The Family Support case was still open at the time of the child's death.

Case 2. The child was 1 year old and had preexisting medical conditions, including seizures, that may have contributed to the child's death. The mother reported that the child was unresponsive when she checked on him after she woke up. The medical examiner's report concluded that the child died of Seizure Disorder and a respiratory virus. The CPS investigation concluded with an Unfounded disposition as "[t]here was no evidence obtained which would link the alleged victim's death to any abuse/neglect created, inflicted, threatened, or allowed to be inflicted to the child by a caretaker."

Prior DSS involvement: The child and an older sibling were both reported as substance-exposed infants when the mother tested positive for THC at their births. The referral for the sibling was screened out. For the SEI referral for the decedent child, the local department opened a Family Assessment. The mother received some prenatal care and reported that she used THC during the pregnancy, but no Plan of Safe Care was documented. When the child was two months old, a CPS investigation was initiated when it was reported that the child fell out of the father's arms causing the child's head to hit a desk. The CPS investigation resulted in an Unfounded disposition. The parents reportedly were continuing to use THC at the time of that investigation. The medical examiner's report expressed uncertainty as to whether the head injury from the fall caused the child to experience seizures.

[2] Family Support cases are less restrictive interventions than In-Home Services and other prevention services offered by local departments of social services. See VDSS Child and Family Services Manual, Chapter B, Section 2.4.5.1.

[3] Healthy Families is a network of non-governmental organizations that provide in-home support to parents with young children.

Case 3. The child was 16 years old and died of a gunshot wound after the child had been playing with the gun in a bedroom with friends. The mother reported that she was not aware that the child had the gun. The CPS Investigation concluded with an Unfounded disposition.

Prior DSS involvement: A CPS referral was screened out the day before the child's death. The reported concern was that there was a shooting and other illegal activity in the home while the child and the child's siblings were present. The referral was screened out because the shooter was arrested "and law enforcement did not report any concerns for the children."

Case 4. Two different local departments of social services were involved with this family. The child was 2 years old and had been co-sleeping with another child in the household. A caretaker covered the child with a weighted blanket but woke up later to find the child to be unresponsive. The medical examiner's report cited in an Undetermined cause and manner of death. The CPS investigation resulted in an Unfounded disposition.

Prior DSS involvement: A CPS investigation was initiated 12 days prior to the child's death by the local department in another locality and was still open when the child died. The child had presented at the hospital with various bruises, marks, and fractures that medical staff concluded were consistent with non-accidental trauma. There is no documentation of any follow-up with the medical staff by CPS. A safety plan was in place that required "sight and sound" supervision of the child "at all times" by relatives but the safety plan was unclear as to any restrictions on contact between the child and the child's mother or her boyfriend. The safety plan was presumably in place at the time of the child's death, but the relatives were not present at the location where the child died providing supervision. This investigation concluded with a Founded disposition against an unknown abuser. This disposition was made two and a half months after the child fatality investigation was concluded by the other local department in the locality where the fatality took place.

Case 5. The child was 3 months old and was found unresponsive in the pack-n-play where the child slept on a nursing pillow. The medical examiner's report stated that a definitive cause of death was not determined but may have included accidental asphyxiation due to unsafe sleep, a viral infection, and dehydration. The medical examiner also noted that multiple suspicious fractures "with high degree of specificity for abuse without any adequate explanation in at least two different stages of healing raises the suspicion for a homicidal manner of death, possibly intention[al] smothering." The CPS investigation concluded with a Finding of physical abuse and neglect by the parents.

Prior DSS involvement: A family assessment was opened on a report that the child's older sibling was born substance-exposed to THC. An In-Home Services case was opened following the Family Assessment. The FSS discussed safe sleep practices with the family and had the parents enter a safety plan stating that they would not use THC while in a caretaking role or in the presence of the child and would practice safe sleep.

The following year, a Family Assessment was opened on a CPS referral that alleged domestic violence in the home. The mother reported using THC edibles "for insomnia" and vaping a Delta 8 pen. The FSS observed her wearing the vape pen on a lanyard around her neck and a bong on the living room floor. Both the mother and the older sibling tested positive for THC. The decedent child was born a month after this Family Assessment was opened and was reported to be substance exposed to THC. The referral was screened out because the child did not experience withdrawal symptoms. The mother reported to DSS staff that she was getting services from Healthy Families, but there is no documentation of any follow up by the FSS to confirm this. The decedent child was observed during a home visit to be asleep, wrapped in a thick blanket in a baby swing. Staff discussed safe sleep practices with the parents. The Family Assessment was closed and assessed the family as being at moderate risk with services needed.

One month later, another Family Assessment was opened on a CPS referral alleging that the family was homeless and living in their car. The parents tested positive for THC at the time of the referral. The family identified a friend with whom they could live. A safety plan was in place whereby the parents agreed not to use THC in a caretaking role and to ensure that the children had a sober caretaker at all times. They also agreed to not engage in any violence with or around the children, to notify DSS if their living arrangement changes, and to comply with DSS and recommended services. The family subsequently moved into an extended stay hotel but did not notify DSS. During a home visit, the FSS noted that the child was laying on the adult bed with a blanket almost to the child's nose. The FSS discussed safe sleep with the parents and instructed them to use the play pen that the local department had bought for them. On a follow up home visit, the FSS noted that the child was laying down in the play pen with stuffed animals. The FSS again discussed safe sleep with the parents. The parents tested positive for THC at this home visit. The FSS referred the parents for domestic violence, substance use, anger management, and housing services. The mother followed up with the provider, the father did not. The child died while this Family Assessment was still open.

Case 6. The child was 3 months old and was found unresponsive after sleeping on a couch. The child tested positive for cocaine and fentanyl at the time of death. The medical examiner concluded that the cause of death was SUID associated with cocaine and fentanyl and unsafe sleep, and the manner of death was undetermined. The mother left the child in the care of a friend. The CPS investigation concluded with a Finding of physical neglect against the caretaker and the mother.

Prior DSS involvement: A Family Assessment was opened when the child was born substance exposed to cocaine and showing signs of Neonate Abstinence Syndrome. The mother reported that she used cocaine during pregnancy. A safety plan was entered whereby the child would be discharged from the hospital to the care of a relative and requiring the mother's contact with the child to be supervised. No follow up with the family was documented after the child was discharged from the hospital. The mother subsequently

placed the child with the friend without notifying DSS. The Family Assessment closed four months after the child died – eight months after the Family Assessment was opened.

Case 7. Two different local departments of social services were involved with this family. The child was 3 months old and had been placed in bed on a u-shaped pillow. The child was in the care of a relative who had temporary custody because the mother was incarcerated. When the relative woke up in the morning, the child was unresponsive and not breathing. The medical examiner's report concluded that the cause of death was SUID associated with unsafe sleep environment and a lung condition, and the manner of death was undetermined. The CPS investigation concluded with an Unfounded disposition against the relative due to the medical examiner's report and the relative "not being provided with full information on safe sleep for infants."

Prior DSS involvement: A CPS referral reporting that the child was born substance exposed was called into a neighboring jurisdiction's department of social services. The referral stated that the mother disclosed that she had used heroin, fentanyl, and morphine five days prior to giving birth. The report also stated that the mother was serving a period of incarceration at the time and would be returning to jail upon her discharge from the hospital. The father was also incarcerated at the time. The mother had asked a relative, who had a history of substance use but was reportedly receiving Medication Assisted Treatment (MAT), to take care of the child. This referral was screened out because, "At this point, the infant is not having any withdrawals or showing any symptoms of being affected by the mother's drug use. The mother has a plan for [the relative] to take the child once…released from the hospital and this agency has no reason to not allow that. The call will be screened invalid and the hospital has been asked to please notify this agency if the infant starts showing symptoms of withdrawal."

The following day, the child started showing signs of withdrawal and another CPS referral was made, which was validated. A Family Assessment was opened. A safety plan was entered for the child to be discharged to the relative until further notice. The relative filed a petition for custody, which was heard by the court a month later and temporary custody was awarded the relative. The Family Assessment was closed prior to the final hearing. The case record does not include any documentation of a drug screen of the relative, confirmation of whether the relative was complying with the MAT, or any follow-up with whether the child needed any special medical treatment due to the substance exposure. There is also no documentation of any safe sleep discussion with the relative.

Case No. 8. The child was 2 months old at the time of death. The child was reported to have been found in cardiac arrest at the home and was transported to the hospital where the child died. It was reported that the child had bruising on the forehead and had slept on a circular pillow. The parents had methamphetamines in the house. The father admitted to using THC the day before the child died and cocaine two weeks prior. The cause of death was

suffocation, and the manner of death was accidental. The CPS investigation resulted in an Unfounded disposition against the parents.

Prior DSS involvement. A Family Assessment was opened when the child was born on a report that the child was born substance exposed. The child tested positive for amphetamines and THC at birth. The mother had limited prenatal care. The father tested positive for THC and amphetamines at the first home visit made by CPS staff. A safety plan was entered whereby a relative would be the primary caretaker for the child and the child's siblings and the parents would have supervised visits with the children. The relative subsequently returned the children to the parents without notifying the local department, in violation of the safety plan. The child died a week later.

Three years prior to the birth of the decedent child, a CPS investigation was opened on a report that the mother was not providing proper supervision of the older sibling, who was eight months old at the time. This investigation was Unfounded. There is no documentation of any drug screens being conducted. Documentation of the investigation was minimal.

Two years later, another CPS investigation was initiated on a report that the mother left another sibling in a car seat unaccompanied at the father's outdoor job site. The mother denied the allegation, but she tested positive for methamphetamine and amphetamines. The father tested positive for THC. The investigation was concluded with an Unfounded disposition.

RECOMMENDATIONS FOR SYSTEM CHANGES

Based on the complaints we received, the investigations we conducted, and the advocacy work in which we participated this year, we recommend the following actions be considered by local departments of social services and state policy makers to improve Virginia's child welfare system:

1. **Foster Care Placement Changes.** State law gives local departments "the final authority to determine the appropriate placement" for children in foster care.[4] Since this Office opened three years ago, we have continually received complaints alleging that local departments are abusing that authority, often making foster care placement decisions with little to no planning and for seemingly arbitrary reasons, such as personal conflicts between agency staff and foster parents, unsubstantiated safety concerns, or reasons of convenience for agency staff.

   Foster parents report that they are being notified of the local department's placement decision the day of, or in some cases, hours before the transition takes place. Foster parents tell us that they will send the children to school or day care in the morning, then receive a call from the foster care worker telling them not to pick the children back up at the end of the day. In most cases, a closing visit is not scheduled so the children are not able to say goodbye to the foster family. In some cases, the children are not given an opportunity to retrieve their personal belongings from the foster family.

   In these cases, we find that the local departments failed to comply with the state policy guidance for placement changes. This guidance promotes a shared decision-making process to ensure that the children's best interests are protected, to establish case participants' expectations for the transition, and to plan the transition so as to mitigate the expected trauma and loss the children and foster family will suffer from the placement change. We found that local departments would make the claim that emergency circumstances existed such that following the policy guidance would have jeopardized the child's safety. However, we rarely found that the facts supported that position.

   Children experience trauma and loss when they are initially removed from their families and placed in foster care. We need to be more diligent in preserving their foster care placements to prevent imposing additional trauma and loss on them. When changes do need to occur, there should be careful planning and collaboration to minimize disruption to the child's daily life. These changes should be handled as emergencies only when absolutely necessary due to immediate safety concerns. We recommend that local departments establish strict protocols and supervisory review when placement changes are being contemplated. We also recommend that VDSS regional permanency

[4] Virginia Code §§ 16.1-278.2(A)(4) and (5)(c); *See also* 16.1-278.4(5) and (6)(c) and 16.1-278.8(A)(13)(c).

consultants provide additional oversight over local departments' placement decisions to ensure compliance with the state policy guidance. Alternatively, the OCO would support legislation mandating adherence to proper practices regarding placement changes and statutory measures that clarify the authority of the court to review such placement decisions.

2. **Children entering Foster Care due to behavioral health challenges**. We reviewed several cases in which the primary reason the child entered foster care was the child's own behavioral health issues. In such cases, the child engaged in dangerous behaviors that posed harm for themselves or for their parents or siblings. The child was removed because the parents or guardians were "unable to care safely for the child."

   For children entering care due to their behavioral health issues, practices need to acknowledge the parents' role in achieving permanency instead of treating them as if they maltreated the children. Services and case management for these cases should reflect the families' circumstances. We found, however, that agencies did not handle these cases any differently than they did cases in which the parents were alleged or found to have abused or neglected the children. Visitation was unnecessarily limited. Some parents were excluded from key decision-making determinations or not notified of medical or mental health treatment and appointments. In some of these cases, the parents' rights were terminated because it was determined that the children would not be able to return home within the statutory foster care timeline.

   We recommend that VDSS and local departments establish policy guidance addressing best practices and protocols for managing foster care cases in which the primary reason for the child's entry into foster care is the child's behavioral health challenges. This guidance should also cover cases in which the parents have entered into a Noncustodial Foster Care Agreement with the local department by which the parents retain legal custody of the child, but the child enters foster care in order to access services not otherwise available to the family.

   Guidance should direct local departments to actively include the parents in service planning, placement decisions, and discharge planning when children are admitted to residential treatment. Visitation arrangements should be commensurate with the circumstances of the child's treatment and not limited in frequency or duration as if contact with the parent was a safety risk. No decisions regarding the child's treatment, services, and placement should be made without the parents' involvement.

3. **Communication with family**. We investigated several cases in which communication problems between the agencies and parents or relatives created unnecessary conflict or detrimentally affected the outcome of the case. In one case, relatives from out-of-state were not given information as to why their visits with the child were suspended. In another, an agency did not give a parent the opportunity to explain evidence that was

used to support the agency's petition to terminate the parental rights. In multiple cases we reviewed, agency workers' unresponsiveness to parents' and relatives' phone calls and emails caused delays in services and visits with the children which affected the progress toward achieving permanency. In several cases, the use of text messaging, while convenient and timely, often created more conflict as messages were misconstrued or unclear.

We recommend that local departments establish clear expectations for communication with parents and other parties by CPS and foster care family services specialists. Workers should respond to families in a timely manner and with communication that is clear and tailored to the recipient's role and level of understanding of the case. Local departments should establish specific protocols for workers' use of text and email communications to ensure meaningful responsiveness, timeliness, and clarity.

4. **MDTs and Joint Child Abuse Investigations.** State law requires the Commonwealth's Attorney in each jurisdiction to establish a multidisciplinary child sexual abuse response team that "shall conduct regular reviews of new and ongoing reports of felony sex offenses in the jurisdiction involving a child and the investigations thereof and, at the request of any member of the team, may conduct reviews of any other reports of child abuse and neglect or sex offenses in the jurisdiction involving a child and the investigations thereof."[5] According to the Department of Criminal Justice Services ("DCJS"):

> A multidisciplinary team (MDT) is a group of professionals with representation from law enforcement, child protective services, prosecution, mental health, medical, victim advocacy and child advocacy center staff (if available) who work collaboratively from the point of report of abuse to assure the most effective coordinated response possible. Interagency collaboration and written protocols are critical for coordinating intervention to reduce potential trauma to children and families and improve services, while preserving and respecting the rights and obligations of each agency to pursue their respective mandates.[6]

In our review of cases, we found that several jurisdictions' MDTs were not functioning effectively or at all. As a result, there was very little collaboration between the local child protective services staff and law enforcement in investigations of child sexual abuse. The lack of coordination for interviews of alleged abusers, child victims, and collateral witnesses led to children being left in unsafe situations and being interviewed multiple times, exposing them to re-traumatization.

[5] Virginia Code § 15.2-1627.5(A).
[6] https://www.dcjs.virginia.gov/juvenile-services/programs/childrens-justice-act-cja

We also found a similar lack of collaboration in some localities for cases not requiring an MDT's participation but for which both law enforcement and CPS are investigating child abuse or neglect. The "siloing" of both agencies from each other unnecessarily hampers each agencies' ability to carry out its duties to the children and families. In one case, the lack of collaboration and communication in the coordination of the forensic interviews of the children conducted by the local Child Advocacy Center led to CPS staff being absent from the interviews and the alleged abuser having contact with the children during the interview, a violation of forensic interview protocols.

We recommend that local departments of social services review their policies regarding MDTs, forensic interviews of children, and joint investigations with law enforcement and take affirmative steps to ensure that proper procedures are in place and that a Memorandum of Understanding or Agreement has been developed with law enforcement and the Child Advocacy Center serving the locality that sets out the expectations and responsibilities of each when jointly investigating child abuse cases; and to work with the local Commonwealth's Attorney to ensure that the locality's MDT is functioning effectively according to statute. Local departments should also ensure that its CPS workers are aware of and familiar with the policies and procedures related to MDTs and joint investigations.

5. **Housing Support for Families and Youth Aging out of Foster Care.** The United States Department of Housing and Urban Development (HUD) offers housing support for eligible families and youth aging out of foster care through its Family Unification Program (FUP) and Foster Youth to Independence initiative (FYI).

   Under FUP, public housing authorities (PHA) partner with public child welfare agencies (in Virginia, the local departments of social services) to provide housing vouchers for two populations:

   1. *Families for whom the lack of adequate housing is a primary factor in:*
      a. *The imminent placement of the family's child or children in out-of-home care, or*
      b. *The delay in the discharge of the child or children to the family from out-of-home care; and*
   2. *Eligible youths who have attained at least 18 years and not more than 24 years of age and who have left foster care, or will leave foster care within 90 days, in accordance with a transition plan described in section 475(5)(H) of the Social Security Act, and is homeless or is at risk of becoming homeless at age 16 or older.* (From the FUP website.)

   FYI housing vouchers are available to eligible "*Youth at least 18 years and not more than 24 years of age (have not reached their 25th birthday) who left foster care, or will leave foster care within 90 days, in accordance with a transition plan described in Section*

475(5)(H) of the Social Security Act, and are homeless or are at risk of becoming homeless at age 16 or older." (From the FYI website.)

In Virginia, several local departments of social services have entered memoranda of understanding (MOU) with their local PHA to access the FUP and FYI housing vouchers. During FY2024, VDSS convened a work group consisting of foster youth advocates, nonprofit organizations, and staff from local departments of social services and PHAs to discuss FYI implementation and the challenges that localities have experienced in accessing the housing vouchers.

Virginia's state-supervised/locally administered social services infrastructure poses challenges to accessing these housing programs that other states do not experience, including (1) voucher availability for youth who were in the care of one local department but living in a different jurisdiction; and (2) the need for separate MOUs between the PHAs and each of the 120 local departments of social services, a particularly cumbersome burden for the Virginia Housing Authority, which serves as the PHA for 81 localities.

State leaders and policy makers should consider taking legislative or administrative action to facilitate access to the FUP and FYI housing vouchers for DSS-involved families with housing challenges and youth aging out of foster care. Considerations should be made to designate VDSS as the entity that can enter MOUs on behalf of the 120 local departments of social services with the PHAs throughout the Commonwealth to help address the challenges identified by the VDSS work group.

6. **Substance Exposed Infants and Plans of Safe Care.** Federal law requires states to have in place "policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants."[7]

   States also must develop Plans of Safe Care for infants "born and identified as being affected by substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant[s] following release from the care of healthcare providers."[8]

   As noted in this Report and in our FY2023 Annual Report, substance exposed infants and parents with a history of substance use represent an alarming number of cases in the

[7] 42 U.S.C. § 5106a(b)(2)(B)(ii).
[8] 42 U.S.C. § 5106a(b)(2)(B)(iii).

child fatality notifications we receive.[9] From our discussions with key stakeholders, including local departments of social services and health care professionals, and from our reviews of child fatality cases, it is evident that there is significant confusion about our current laws and policies for the reporting of substance exposed infants to CPS and that implementation of Plans of Safe Care is inconsistent.

While there is state guidance for local departments of social services in handling reports of children born substance exposed,[10] the responsibilities for the protection of these children and prevention of maltreatment must be shared among several agencies and stakeholders. Obstetricians and local community services boards/behavioral health authorities should be developing Plans of Safe Care with families during pregnancy before the child is born. Private organizations, such as Healthy Families, can provide meaningful in-home supports for parents before and after the child is born. Health care providers need to know the CPS reporting laws and understand what information is necessary to make such reports. If Plans of Safe Care are implemented properly, CPS may not have to intervene. Statewide coordination of these stakeholders' efforts in implementing Plans of Safe Care is much needed.

In FY2024, the Virginia Department of Health resumed statewide efforts to ensure the robust implementation and development of Plans of Safe Care. This work must continue with the engagement of all necessary stakeholders, including state and local social services representatives, state and local behavioral health agencies, state and local health agencies, private health and mental health care providers, and private family/early childhood serving agencies.

7. **Safe and Sound Task Force Initiatives.** In April 2022, Governor Youngkin's Safe and Sound Task Force was convened to address the issue of children in foster care sleeping in social services offices, hospital emergency rooms, and hotels because there were no approved placements available. Local departments of social services are continuing to experience challenges in finding approved placements for children who have high acuity behavioral health needs. Related to this issue, the Governor's *Right Help, Right Now* initiative, begun in 2023, is working on filling the systemic gaps in the provision of mental health services throughout the Commonwealth. Ongoing efforts are being made to develop long-term solutions to prevent children in foster care from being displaced due to high acuity behavioral health needs. The OCO recommends that state leaders consider the following actions to continue these efforts and to address the needs of these children:

[9] Of the child fatality notifications we received, 54% in FY2023 and 46% in FY2024 involved children reported as SEI at birth or had parents or caretakers with a history of substance use.
[10] VDSS Child and Family Services Manual, Part C, Section 10.

1. Interagency/Cross-Secretariat collaboration. The collaboration among child-serving agencies is essential to addressing the current need and to sustaining efforts on a long-term basis. Such collaboration has been successful for Safe and Sound, *Right Help, Right Now*, and the Governor's ALL IN educational initiative.

The executive branch child-serving agencies span multiple Secretariats: Health and Human Resources (Departments of Social Services, Health, Behavioral Health and Developmental Services, Medical Assistance Services, and the Office of Children's Services); Public Safety and Homeland Security (Departments of Juvenile Justice and Criminal Justice Services); and Education (Department of Education and the Virginia Early Childhood Foundation). Getting buy-in from the highest level of these agencies is needed to make meaningful and lasting progress in filling gaps and solving complex problems within the systems that serve children and families.

The development of interagency agreements and the establishment of a Children's Cabinet are two options that should be given serious consideration in promoting collaboration, institutionalizing best practices, and implementing solutions that can be sustained beyond Administrations.

To continue the work of the Safe and Sound Task Force, the Virginia Department of Behavioral Health and Developmental Services should be designated as the lead agency to collaborate and enter into interagency agreements with the Departments of Social Services, Medical Assistance Services, and Juvenile Justice and the Office of Children's Services. The agreements should set forth the roles, responsibilities, and expectations of each agency in addressing the needs of children in foster care experiencing high acuity behavioral health challenges who are displaced or facing imminent disruption from approved foster care placements.

To address the issues that inevitably arise due to the complexity of systems that serve children and families, state leaders should consider creating an entity such as a Children's Cabinet. Such an entity could be authorized to direct agencies to take preventative measures for emergent issues and to quickly mobilize agencies and stakeholders into action to address systemic crises.

2. Gaps in the Array of Approved Placements. Currently, approved placements for children in foster care include: (i) foster families approved by local departments of social services; (ii) treatment/therapeutic foster families ("TFCs") licensed by private licensed child placing agencies; (iii) group homes; (iv) therapeutic group homes; (v) children's residential facilities; and (vi) psychiatric residential treatment facilities ("PRTFs").

With the high-acuity behavioral health needs many of these children have, the implementation of a full array of wrap-around services, including crisis intervention, is necessary for family-based placements to be successful and permanent. Unfortunately,

the availability and quality of such services varies across the Commonwealth. The build out of child crisis services, including mobile crisis response, community stabilization, 23-hour crisis stabilization, and residential crisis stabilization units specifically are needed as a priority, particularly in DBHDS Regions 1 and III.[11]

In many cases, children go from PRTF to PRTF without successfully transitioning into a family-based setting. Some children end up being placed in PRTFs out of state, which are more difficult to monitor. Placement decisions are being made merely to find the child a bed, rather than to achieve their permanency goals. Local departments need more options.

Efforts have been made to utilize Sponsored Residential homes licensed under the Department of Behavioral Health and Developmental Services (DBHDS).[12] Some local departments of social services have been successful in placing displaced foster youth with Sponsored Residential providers, but barriers still exist regarding stakeholder expectations, payment for services, and licensing questions. Top-down direction from the governing state agencies is needed to make Sponsored Residential homes more accessible for foster care purposes and to increase providers' capacity to accept children in foster care with behavioral health needs.

The Virginia Department of Social Services is currently piloting a "professional foster parent" model whereby a foster parent is paid a livable salary to provide full-time foster care to children on a temporary basis. For this Enhanced Treatment Foster Care model, three licensed child placing agencies were contracted to provide such families to care for children with high-acuity needs. Consideration should be made to appropriate additional funding to expand the program to allow more children to be placed in family-based settings.

Currently, children are sleeping in social services offices and hotel rooms. These are unapproved placements and are often under the supervision of unqualified staff. These conditions pose significant safety concerns for the children and staff. To give local departments an alternative, state leaders should explore program models for the establishment of a state-run program that can provide supportive and safe housing for these youth on a temporary basis as a step-down from the PRTFs and to give local departments time to identify an appropriate family or relative with whom the child can be

[11] DBHDS Regions I and III refer the most children to the Commonwealth Center for Children and Adolescents as compared to the other DBHDS Regions.

[12] "Sponsored residential services (SRS) means residential services that consist of skill-building, routine supports, general supports, and safety supports provided in the homes of families or persons (sponsors) who provide supports under the supervision of a DBHDS-licensed provider. This service enables individuals to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to live a self-directed life in the community." Provider Manual: Developmental Disabilities Waivers (DMAS 8/28/2024), p. 185. *See also state regulations at* https://law.lis.virginia.gov/admincodefull/title12/agency35/chapter105/partVI/article4/ *and* https://law.lis.virginia.gov/admincode/title12/agency30/chapter122/section530/.

placed, along with the wrap-around services needed to support that family or relative. The program should be sufficiently staffed with qualified individuals licensed to provide care for foster youth with services that support normalcy for children educationally, socially, and physically. As with other long-term solutions, this initiative will require the collaboration of multiple state child-serving agencies necessitating top-down direction and coordination to overcome licensing, oversight, administrative, and cost barriers.

8. **Legal Representation in Child Welfare Cases.** The judicial system plays an important role in Virginia's child welfare system when a government agency gets involved with a family for the purpose of protecting children. The courts provide the checks and balances that help hold the government accountable and to prevent it from overstepping and infringing on the rights of parents and children. This helps maintain the delicate balance that must be struck between the interests of preserving families and protecting children. In our adversarial judicial system, attorneys for parents and children must ensure that the proper evidence is before the court so that judges can make informed decisions and are in the best position to provide necessary oversight over government actions while ensuring children's safety.

   In its 2024 Session, the General Assembly, with the Governor's approval, took the first step in improving Virginia's system of providing legal representation in child welfare cases by increasing the rate of pay court-appointed attorneys receive for representing parents. This rate had not changed in over 20 years. It is hoped that this rate increase will result in more attorneys signing up to accept these appointments. The legislation also directed the development of qualification and performance standards for these attorneys so that parents are provided robust legal representation. Further steps should be considered to help improve the quality of representation in child welfare cases:

   1. Parents Advocacy Commission. State leaders should consider establishing a state level Parents Advocacy Commission. This Commission would function similarly to the Virginia Indigent Defense Commission, providing oversight, accountability, and training support for attorneys. Local or regional offices could employ attorneys that could offer specialized representation for parents involved in child welfare cases within their jurisdiction, much like the existing Public Defender offices provide in criminal matters.

   2. Pre-petition Legal Representation. Virginia leaders should also consider implementing a system of providing legal representation for parents involved with CPS prior to the initiation of court proceedings. Parents are often at a disadvantage when confronted by CPS and rarely understand their rights or CPS procedures. Many key decisions affecting the lives of their children are made in this stage of child welfare involvement. Attorneys can provide assistance and advocacy to mitigate any safety concerns for the children to prevent them from unnecessarily entering foster care. The implementation of a pre-petition legal representation model will complement the landmark Kinship Care

legislation that was passed in 2024 that encourages the placement of children with relatives when they are deemed unsafe to remain in their home.

3. Improving the advocacy provided by guardians ad litem for children. Fewer and fewer attorneys are being qualified to serve as guardians ad litem for children ("GALs") each year. The rates of pay for GALs have not changed in decades even though child welfare cases have grown more complex. GALs are required to comply with the Standards of Performance but the compensation is not commensurate with the amount of time and effort required to meet those standards. State leaders should consider legislation and budgetary measures to address GAL compensation. State leaders should also consider directing a review of the Standards of Qualification and Standards of Performance for GALs for children to determine whether any amendments or revisions are necessary to improve the quality of representation and advocacy for children involved in court matters.

9. **Investments in Prevention and Protection.** Virginia receives federal funds through programs such as the Children's Justice Act, the Victims of Crime Act, and the Temporary Assistance for Needy Families (TANF) program that are used to support important programs for the prevention of child maltreatment and for the protection of children. Unfortunately, the amount of federal funds states receive under these federal programs is set to be significantly reduced in coming years. State leaders should consider making appropriate budgetary investments to ensure that our Virginia programs can continue their important prevention and protection work despite the reduced federal support. The following programs are important to Virginia's child welfare system, have been highly effective in the communities in which they operate, and should receive the necessary support to maintain and increase their capacity to serve Virginia's children and families:

1. Family Resource Centers. During FY2024, the OCO had the opportunity to visit three of Virginia's seven Family Resource Centers ("FRC"): the Liberation Center in Richmond, the Sankofa Center at CHIP of South Hampton Roads in Chesapeake, and Family Matters in Louisa. Families Forward Virginia received American Rescue Plan Act funds through the Virginia Department of Social Services to help establish the seven pilot centers. FRCs provide families with community and resource referrals, workforce development, parent education and support groups, concrete supports, health services, living skills and life coaching, transportation, and civic engagement and outreach. One key element of FRCs is the leadership role that people with lived experience have in the centers' programming and engagement with the community. The FRC model is an important part of Virginia's child welfare system as a primary prevention measure to support families and help them safely raise their children. As we heard from one parent:

> *There are caring and kind individuals at the DHS office, and parent leaders at the Family Resource Center who truly understand what we're going through and try to make opportunities available. The genuine humanity of*

others reminds us that we are not alone and that people are willing to do their best to help.

2. Court Appointed Special Advocate Programs. Virginia currently has 27 Court Appointed Special Advocate ("CASA") programs throughout the Commonwealth. "CASA is a child advocacy organization that seeks to provide trained volunteers to speak for abused and neglected children who are the subjects of juvenile court proceedings. CASA volunteers advocate for safe, permanent homes for children."[13] CASA volunteers provide valuable information to the court about a child's case so that the judge can make sound decisions that are in the best interests of the children. Volunteers undergo intensive training on foster care, the court processes for child welfare cases, and how to properly engage with the children, families, and professionals involved in the case. CASA program staff supervise and guide volunteers to ensure that their case participation is appropriate and that their reports to the court are accurate and promote the children's best interests.

3. Child Advocacy Centers. Effective investigation and prosecution of child abuse and neglect cases by law enforcement and CPS are needed to protect children from further abuse. Investigators rely heavily on forensic interviews of children, which must be done properly in order to be used meaningfully in gathering evidence and determining whether a child was abused or neglected. Virginia currently has 19 Child Advocacy Centers (CAC) and five satellite offices that adhere to the National Standards of Accreditation for Children's Advocacy Centers. CACs also provide therapeutic services to help children heal and help families navigate the criminal and CPS systems. "A children's advocacy center is a child-friendly facility in which law enforcement, child protection, prosecution, mental health, medical and victim advocacy professionals work together to investigate abuse, help children heal from abuse, and hold offenders accountable."[14]

[13] https://www.dcjs.virginia.gov/juvenile-services/programs/court-appointed-special-advocate-program-casa
[14] https://www.cacva.org/about-us/.