2025 ANNUAL REPORT

OFFICE OF THE CHILDREN'S OMBUDSMAN

RICHMOND, VIRGINIA

OFFICE of the CHILDREN'S OMBUDSMAN

Table of Contents

EXECUTIVE SUMMARY

Pursuant to paragraph G of Virginia Code § 2.2-447, 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 2025 (FY2025), which began on July 1, 2024, and ended on June 30, 2025.

Complaints and Investigations. In FY2025, the Office of the Children's Ombudsman (OCO) received 466 complaints. Of Virginia's 120 local departments of social services, 88 were the subject of the complaints we received during FY2025. The most common complaints were allegations that agency staff were biased against the complainant, inappropriate or inadequate support or services were offered to the complainant, improper child protective services (CPS) Investigation procedures, improper child removals, and lack of agency staff responsiveness.

The OCO initiated 32 formal investigations of complaints received in FY2025 or earlier. Common practice issues identified in our case reviews and investigations were related to:

1. Local department of social services participation in local child protection Multidisciplinary Teams.
2. Follow-up with mandated reporters.
3. Case transfers between local departments.
4. Permanency placement decisions.
5. Engagement with fathers.

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 and the family has had prior involvement with child protective services or foster care.

In FY2025, the OCO received 49 notifications of such child fatalities. Twenty-five of the 49 children (51%) were aged 6 months or younger. In 14 cases (29%), unsafe sleep practices or conditions were reported at the time of the child's death. In 9 cases (18%), the family had a history of domestic violence. In 13 cases (27%), the parents were reported to have had untreated or undertreated mental health conditions. In 12 cases (25%), the decedent child was reported as being born substance exposed.

In 25 cases (51%), the children's parents or caregivers were reported to have had a history of substance use. In 22 of these 25 cases (88%), the decedent children were 3 years of age or younger. Unsafe sleep conditions were reported in 9 of these 25 cases (36%). The substances most frequently reported to be used by parents in these cases were cannabis, cocaine, and alcohol.

Recommendations for System Changes.

1. Workforce Support.

Many local departments of social services continue to have difficulty attracting, hiring, and retaining qualified family service specialists. In addition, many local departments lost experienced long-term family services specialists and supervisors during the COVID-19 pandemic resulting in a significant loss of experienced senior workers. The combination of these two workforce challenges leads

directly to the majority of practice issues we see in our case reviews and investigations. We recommend that state and local leaders and policy makers take actions to (1) provide competitive compensation for local department staff; (2) establish equal pay scales across the state to prevent local staff from leaving one agency to work for another that can provide higher pay; (3) reinstitute in-person training for local department staff; (4) fund the Virginia Department of Social Services Office of Trauma and Resilience's Workforce Support Program; (5) create a state pool of emergency family services specialists; and (6) consider the consolidation of localities with smaller and less-resourced local departments under one combined local board and department of social services.

2. Child Protection.

We noted deficiencies in practices involving CPS and local departments' responses to reports of alleged child abuse and neglect, particularly with the very young children (age 3 years and younger) and medically fragile children that are extraordinarily vulnerable and lack protective capacity. We recommend that state leaders and policy makers consider (1) establishing centralized intake and validation of CPS reports; (2) amending law and regulation to require expedited responses to CPS reports involving children under age 3 years; and (3) developing targeted efforts to address parental substance misuse, including supporting a robust state plan for the implementation of Plans of Safe Care and providing multidisciplinary training focused on parental substance use and its effects on children.

3. State Oversight over Local Administration of Family Services.

Virginia has a delivery system of social services that is state supervised and locally administered. The Commissioner of the Virginia Department of Social Services has limited authority to enforce compliance with social services laws, regulations, and policies when the programs are not being administered properly. The following actions should be considered by state leaders to bolster the supervisory and oversight authority of the Commissioner over the delivery of social services programs: (1) authorize state intervention in the local administration of child protective services; and (2) clarify state laws governing the appointment, performance, and removal of directors of local departments of social services.

4. Quality Legal Representation in Child Dependency Cases.

To help improve the quality of legal representation and advocacy for parents and children involved in child dependency court proceedings, state leaders and policy makers should increase the rate of compensation paid to attorneys serving as court-appointed guardians ad litem for children; and provide funding to establish local or regional pilot programs offering a multidisciplinary model of legal representation and advocacy for parents.

5. Establishment of a Permanent Children's Cabinet.

Issues affecting children have gotten much more complex in recent years. An effective statewide response requires coordinated efforts by multiple executive branch agencies across administration secretariats to ensure that laws, regulations, and policies reflect the shared goal of keeping Virginia's children and youth on track developmentally, educationally, socially, and emotionally. Getting buy-in from the highest level of leadership at child-serving agencies is needed to make meaningful and lasting progress in filling gaps and solving complex problems within the systems that serve children and families. We recommend that state leaders and policy makers consider establishing a permanent Children's Cabinet by executive order or legislative action.

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 (LCPAs), 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 Virginia Code § 2.2-447, 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 2025, which began on July 1, 2024, and ended on June 30, 2025.

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 by Governor Ralph Northam and reappointed by Governor Glenn Youngkin in June 2025. 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 his employment with the Commonwealth, 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 in 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 for 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. Frank has over 16 years of experience in child welfare in the areas of therapeutic treatment, counseling, and conducting behavioral assessments. Frank is certified in Trauma Informed Advocacy through the Mitchell Hamline School of Law and is a Certified Fatherhood Group Facilitator. He is a graduate of Virginia State University and earned his Master of Business degree with a concentration in Public Administration from Strayer University.

Jamie Anderson, Senior Investigations Analyst. 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 in Virginia, Texas, and Oklahoma serving in a variety of roles across all programmatic areas including child protective services, prevention, training, foster care & adoptions. Jamie earned her Master of Social Work 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.

Acronyms you may find 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
FSS – family services specialist
FY – fiscal year
GAL – guardian ad litem
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, also referred herein as local department(s)
OCO – the Office of the Children's Ombudsman
OCS – the Office of Children's Services
SEI – substance exposed infants
VDSS – the Virginia Department of Social Services

2025 LEGISLATION

The OCO supported the following legislation that was passed by the General Assembly and signed into law by Governor Youngkin:

1. **House Bill 1777** and **Senate Bill 1406,** introduced by Delegate Richard Sullivan and Senator Saddam Azlan Salim, respectively, amended the statutes governing the OCO to (1) clarify that the OCO may receive and investigate complaints from participants in the Fostering Futures program; (2) require local departments of social services, licensed child placing agencies, and children's residential facilities to provide information to youth aged 12 years and older in foster care of the services and contact information of the OCO; and (3) permit the OCO to confidentially communicate with a child or youth who submits a complaint to the OCO. These bills went into effect July 1, 2025, and were introduced due to the advocacy of young adults who were formerly in foster care in Virginia but were never made aware of the services provided by the OCO.

2. **House Bill 1733** and **Senate Bill 1372,** introduced by Delegate Joshua Cole and Senator David Suetterlein, respectively, amended the statute governing petitions for the relief of custody. The legislation requires the local department of social services to refer petitioners to the local Family Assessment and Planning Team (FAPT) and to prepare a written report of the history of the child and family. The legislation also directs the OCO to convene a work group to provide recommendations to the Commission on Youth regarding the factors that courts should consider in determining whether good cause exists to grant the petition for relief of custody. The work group also must explore the potential benefits and considerations of raising the standard of evidence for granting temporary relief of custody to a clear and convincing standard. This legislation was a recommendation of the Commission on Youth as a result of its study of Relief of Custody petitions.

3. **House Bill 2457,** introduced by Delegate Jackie Glass directs the State Board of Social Services to amend its regulations by January 1, 2026, to (i) require local departments of social services to apply for federal benefits on behalf of children in foster care that they may be eligible for, (ii) prohibit the use of military survivor benefits to pay for the care and support of children in foster care that the Commonwealth is otherwise obligated to pay for, and (iii) require local departments of social services that are representative payees for children in foster care to conserve such military survivor benefits in an appropriate trust instrument or protected account that is exempt from federal asset and resource limits.

4. **Senate Bill 818**, introduced by Senator Barbara Favola, provides that, if the local department of social services serves as representative payee for a child in foster care that receives certain federal benefits, as specified in the bill, the local department of social services shall provide written notice, in person or by certified mail, that it is acting as the child's representative payee within 30 days after receiving the first benefit payment on behalf of the child to (i) the child, if the child is 12 years of age or older; (ii) the child's parent, prior guardian, or prior custodian, or, if there is no legal parent or prior guardian or custodian, the child's next of kin; (iii) the child's guardian ad litem, if applicable; and (iv) counsel appointed for the child, if applicable.

FY2025 OCO ACTIVITIES

OCO staff attended, presented, and otherwise participated in the following conferences, events, and project initiatives related to improving the child welfare system:

- Exhibitor - Mandatory Judicial Training for the judges of Juvenile and Domestic Relations District Courts; Office of the Executive Secretary, Supreme Court of Virginia – Roanoke, August 2024
- Attendee/Exhibitor – Building Bridges: Collaborative Approaches to Prevent Domestic Violence and Support Survivors Conference; Department of Criminal Justice Services – Hampton, October 2024
- Presenter – 13th Annual Children's Services Act Conference; Office of Children's Services – Roanoke, October 2024
- Attendee – Permanency Conference; Virginia Department of Social Services – Williamsburg, October 2024
- Presenter – Advisory Committee for the Children's Justice Act and Court Appointed Special Advocate Programs; Department of Criminal Justice Services – Richmond, October 2024
- Attendee/Planning Committee Member – Rural Summit; EO of Southwest Virginia – Abingdon, October 2024
- Co-Organizer/Presenter – Parental Child Safety Placement Program Webinar; Virginia Department of Social Services, Virginia League of Social Services Executives, Court Improvement Program of the Office of the Executive Secretary for the Supreme Court of Virginia – Online, November 2024
- Exhibitor – Youth Mental Health Summit; Secretary of Health and Human Resources – Richmond, November 2024
- Co-Presenter/Host – Manchester Middle School Student Field Trip to Capitol Square – Richmond, November 2024
- Presenter for Pennsylvania Child Services team; Virginia League of Social Services Executives – Richmond, December 2024
- Attendee – Transforming Mandated Reporting; Casey Family Programs – Austin, TX, December 2024
- Attendee – Re-Entry Council Meeting; Planning District 14 – Farmville, March 2025
- Attendee – 26th Annual International Families and Fathers Conference – Los Angeles, CA, April 2025
- Attendee – Prevention Conference; Virginia Department of Social Services – Williamsburg, April 2025
- Presenter – Home Visiting Conference; Early Impact Virginia – Richmond, May 2025
- Attendee – Safe Kids, Strong Families bill signing and planning events; Secretary of Health and Human Resources – Richmond, May 2025
- Participant – Parental Child Safety Placement Program listening session; Virginia League of Social Services Executives – Abingdon, June 2025
- Presenter – Parental Child Safety Placement Program; Fredericksburg-Area Best Practices Court Team – Fredericksburg, June 2025

OCO staff also regularly participated in the following work groups, committees, and advisory groups:

- Advisory Work Group for the Commission on Youth Relief of Custody study
- Advisory Work Group to Develop Qualification and Performance Standards for Court-Appointed Counsel for Parents and Guardians in Child Dependency Cases
- Child Abuse and Neglect Committee, Family and Children's Trust
- Child Welfare Advisory Committee
- Children's Justice Act/Court Appointed Special Advocate Advisory Committee
- Children's Safety Citizen Review Panel
- Foster Youth to Independence Voucher Statewide Work Group
- Governor Youngkin's Safe Kids, Strong Families Initiative
- Governor Youngkin's Stand Tall – Stay Strong – Succeed Together Initiative
- Task Force on Maternal Health Data and Quality Measures
- VDSS Fatherhood Engagement Week Planning Committee
- VDSS/DCSE Fatherhood Steering Committee
- Virginia Department of Health Work Group for the Plan of Safe Care State Plan

COMPLAINTS AND INVESTIGATIONS

The OCO receives complaints from the public with respect to children who are (i) receiving child protective services (CPS), (ii) in foster care, or (iii) 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:

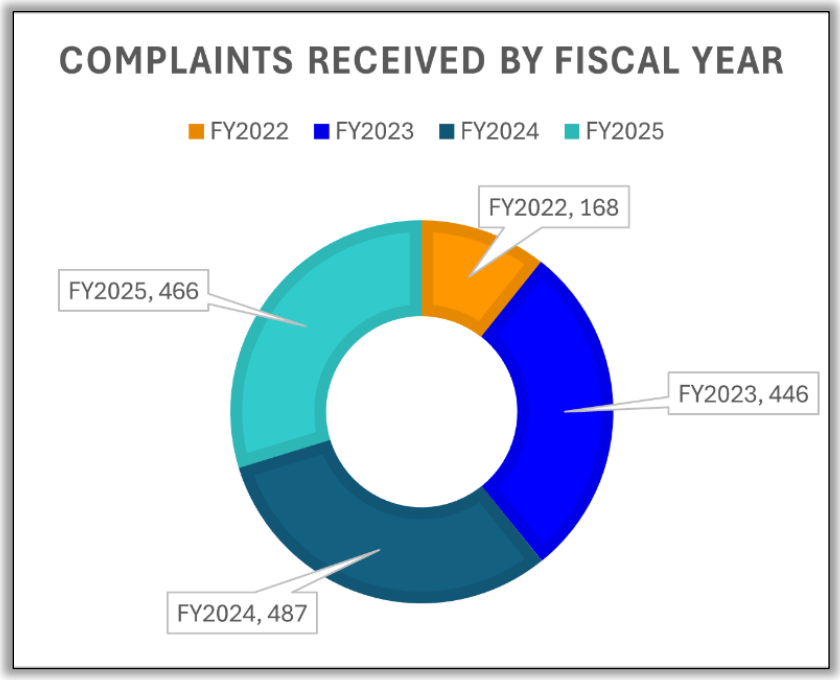
- contrary to law, rule, or policy;
- imposed without an adequate statement of reason; or
- based on irrelevant, immaterial, or erroneous grounds.

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

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

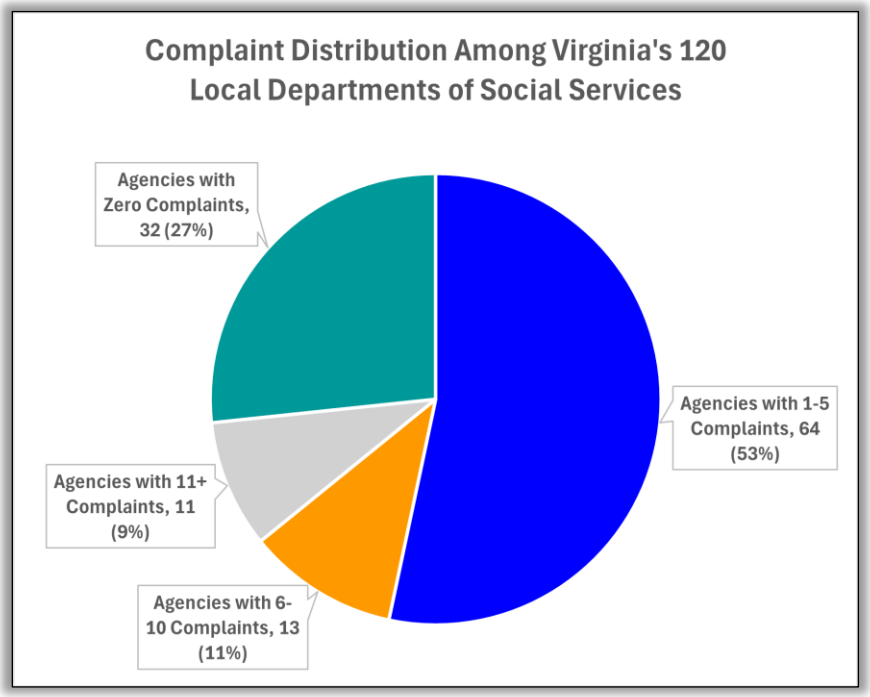
COMPLAINTS

The following data relates to complaints that were received during FY 2025.



In FY 2025, the OCO received 466 complaints, bringing the total number of complaints received since the OCO was established in June 2021 to 1,567.

Subject Agencies. Out of the120 local departments of social services in Virginia, 88 (73%) were the subject of the complaints we received during FY2025.



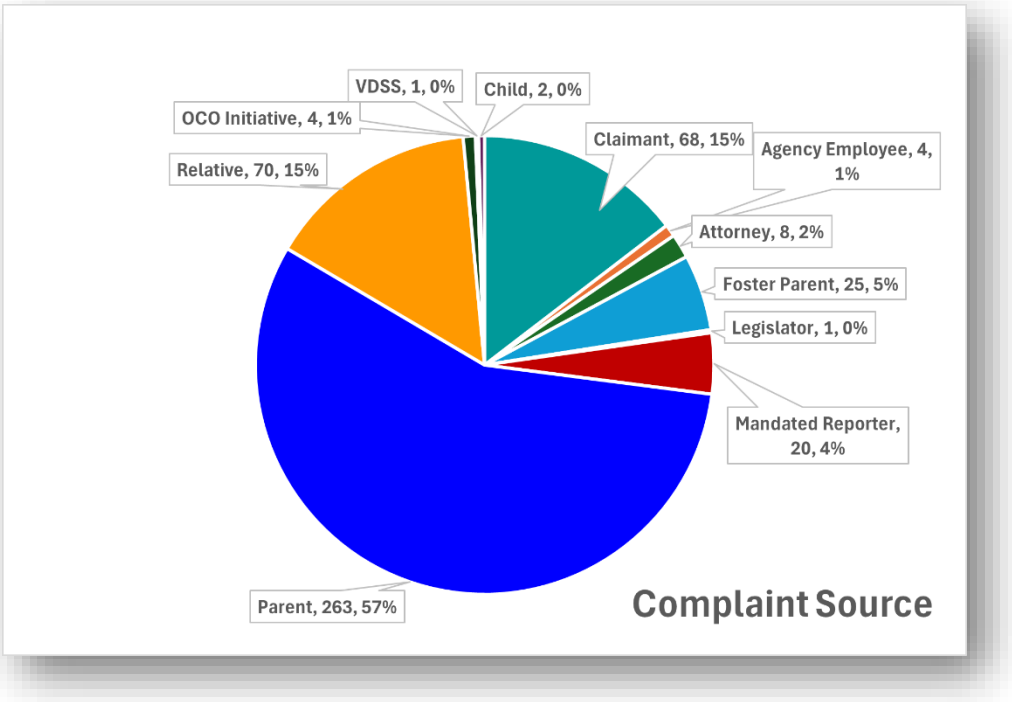
Complainants. A statutory complainant is any one of the following individuals as listed in Virginia Code § 2.2-441:

- 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 (57%). Relatives are the second most common source of complaints (15%).

Complaints can also be submitted by individuals who do not meet the definition of a statutory complainant. The OCO can investigate complaints submitted by such individuals, but we are limited in the amount of information provided to them at the conclusion of our investigation. We can inform

them of our recommendations and the investigated agency's response to our recommendations, subject to laws governing the disclosure of confidential information.



Disposition of Complaints (as of June 30, 2025):

- Preliminary Assessment Initiated (308)
- Open – Awaiting information from Complainant (16)
- Closed - Not Enough Information Provided by Complainant (97)
- Closed - Lack of Subject Matter Jurisdiction (38)
- Closed - OCO Discretion (3)
- Closed - Lack of Jurisdiction – No Active Cases (4)

PRELIMINARY ASSESSMENTS

The following data relates to preliminary assessments that were initiated during FY2025. Some preliminary assessments may have been initiated from complaints that were received during the prior fiscal year.

All complaints received are entered into the OCO's case management tracking system. If the complaint is determined to be related to a case involving a child or children receiving child protective services, in foster care, or placed for adoption and the claimant has provided the necessary information, these complaints move out of intake and into our preliminary assessment stage.

For preliminary assessments, OCO staff review the information submitted by the complainant and the case records in the statewide online database for child protective services and foster care cases. We may also request more information from the complainant or subject agency. If, based on our review of the information gathered, a complainant's allegations can be substantiated, we will seek to resolve them informally with the subject agency and complainant or initiate a formal investigation.

Allegations. The following chart lists the allegations submitted by complainants, whether they were substantiated or not, and practice issues we independently identified in our case reviews. Complaints are sorted by category with the number of complaints received for each type of allegation. Allegations are grouped in the following categories:

- Agency Issues: general internal agency practices
- Alternative Living Arrangements: issues specific to ALA practices (informal temporary custody arrangements for safety planning)
- Child Protective Services: issues specific to CPS Reports, 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
- Miscellaneous Items – Outside the scope of OCO jurisdiction

		Complainant Allegation	OCO Allegation
Agency Issues	Agency staff were biased against the complainant	69	5
	Records contain false information	9	6
	Agency culture	11	1
	Inaccurate information presented in court by agency	12	0
	Documentation	5	41
	Worker changes	6	5
	Lack of responsiveness from agency staff	6	0
	Communication/collaboration with LCPA	4	0
	Supervision Deficiencies	0	4
Alternate Living Arrangements (In-Home Services)	Inappropriate or inadequate support or services to parent	18	0
	Placement decision	16	4
	Inappropriate or inadequate support or services to child	4	4
	Inappropriate or inadequate support or services to ALA caregiver	4	4
	Visitation Issues	4	4
	Service Plan Issues	2	3
	Incomplete or Insufficient Safety Plan	1	1
Child Protective Services	Investigation process	142	69
	Removal process	83	27
	Agency lack of responsiveness	57	29
	Family Assessment process	56	45
	Inadequate services	56	12
	Validation process	53	33
	Safety plans	22	11
	Inappropriate services	9	8
Family Engagement	Inadequate relative contact	16	10
	Family Partnership Meetings	8	8
	Inadequate trauma informed care/practices	5	4
	Engagement/communication with parents (foster care)	6	2
	Engagement/communication with relatives or fictive kin (foster care)	6	2
	Engagement/communication with child (foster care)	1	4
	Agency lack of responsiveness	43	0
	Inadequate services	43	20

Foster Care	Inadequate case management	41	29
	Placement decision	37	18
	Visitation issues	34	15
	Inadequate reunification efforts	29	14
	Inadequate permanency efforts (for non-reunification permanency goal)	13	4
	Inappropriate services	10	2
	Abuse by Foster Parent	8	0
	Service Plan issues	6	5
	Sibling placement	6	4
	Confidentiality of Records	6	3
	Permanency goal	6	3
	Adoption	6	0
	Worker Visits	5	6
	Foster Care licensing	5	5
	Interstate Compact on the Placement of Children	5	2
	Foster parents' expectations	4	3
	Parent Evaluations	4	0
	School issues	3	0
	Kinship Guardianship Assistance Program (KinGap)	2	1
	Adoption Subsidy	2	0
	Normalcy	2	0
	Virginia Enhanced Maintenance Assistance Program (VEMAT)	2	0
	Child's evaluations	1	0
	Fostering futures	0	1
Miscellaneous Items – Beyond the Scope of OCO Jurisdiction	Contested custody	15	0
	Guardian Ad Litem concerns	12	0
	Judicial concerns	8	0
	Law Enforcement concerns	7	0
	Family Assessment and Planning Team/Children's Services Act	5	0
	Inadequate Parents' legal representation	3	0
	Freedom of Information Act (FOIA)	1	0

For cases that do not rise to the level of investigation, we attempt to resolve the concerns raised by the complainant with a more informal approach. If we identify agency practices that could be improved but were not deemed systemic or detrimental to the outcome of the case, we provide practice recommendations to the agency. Most complaints received by the OCO in FY2025 were resolved at the preliminary assessment stage without having to initiate a formal investigation.

Disposition of Preliminary Assessments:

- Information was provided to the complainant about the agency's actions (106)
- Assistance was provided to resolve the complaint or practice recommendations were made to the agency (34)
- Investigation Initiated (25)
- Complainant was referred to another agency (6)
- Closed – No active cases (66)
- Closed – Complainant did not respond to our request for an intake call (34)

- Closed - Requested by Complainant (5)
- Closed - Other (7)

INVESTIGATIONS

The following data relates to investigations that were initiated during FY 2025. Some investigations may have been initiated from complaints we received in the prior fiscal year.

A formal investigation is initiated when we substantiate the complaint's allegations and identify practice concerns that may potentially affect the outcome of the case or the safety and well-being of the child or children. We may also initiate a formal investigation if we identify a pattern of practice concerns within the same agency or among multiple agencies.

The OCO initiated 32 formal investigations involving the following local departments of social services:

- Alleghany-Covington Department of Social Services (1)
- Carroll County Department of Social Services (2)
- Chesterfield/Colonial Heights Department of Social Services (1)
- Danville Division of Social Services (6)
- Franklin County Department of Social Services (1)
- Henry-Martinsville Department of Social Services (1)
- Nelson County Department of Social Services (5)
- Norfolk Department of Human Services (1)
- Patrick County Department of Social Services (1)
- Roanoke City Department of Social Services (2)
- Russell County Department of Social Services (10)
- Virginia Beach Department of Human Services (1)

The following chart lists the practice areas for which we substantiated allegations made by complainants or identified practice issues in our case reviews and either made findings or provided recommendations to the local department to improve their agency practices:

Practice Areas	Allegations	Findings/ Recommendations	Percent of Substantiated Allegations
Adoption/Adoption Assistance	8	1	12.50%
Agency - Bias	74	2	2.70%
Agency – Confidentiality of Records	9	3	33.33%
Agency - Culture	12	4	33.33%
Agency - Documentation	46	23	50.00%
Agency - Lack of Responsiveness	6	6	100.00%
Agency – Inaccurate information presented in court by agency	12	1	8.33%
Agency - Supervision Deficiencies	4	1	25.00%

Agency - Worker Changes	11	1	9.09%
ALA - Inappropriate or Inadequate Support or Services to ALA Caregiver	8	3	37.50%
ALA - Inappropriate or Inadequate Support or Services to Child	8	2	25.00%
ALA – Placement Decision	20	3	15.00%
ALA - Service Plan Issues	5	1	20.00%
CPS – Agency Lack of Responsiveness	86	2	2.33%
CPS - Inadequate Services	68	8	11.76%
CPS – Inappropriate Services	17	1	5.88%
CPS - Investigation Process	211	55	26.07%
CPS - Safety Plan	33	6	18.18%
CPS - Validation Process	86	12	13.95%
CPS - Family Assessment Process	101	32	31.68%
CPS – Removal Procedures	110	2	1.82%
Family Engagement – Engagement/Communication with Child	5	2	40.00%
Family Engagement – Engagement/Communication with Relatives or Fictive Kin	8	1	12.50%
Family Engagement – Family Partnership Meetings	16	4	25.00%
Family Engagement - Inadequate of Relative Contact	26	4	15.38%
Family Engagement - Lack of Trauma Informed Care	9	2	22.22%
Foster Care – Fostering Futures	1	1	100.00%
Foster Care - Inadequate Reunification Efforts	43	10	23.26%
Foster Care – Inadequate Permanency Efforts (non-reunification)	17	1	5.88%
Foster Care - Inadequate Services	63	9	14.29%
Foster Care – Kinship Guardianship Assistance	3	2	66.67%
Foster Care – Foster Care Licensing	10	5	50.00%
Foster Care – Normalcy	2	1	50.00%
Foster Care - Placement Decisions	55	3	5.45%
Foster Care – Service Plan Issues	11	2	18.18%
Foster Care – Sibling Placement	10	3	30.00%
Foster Care - Visitation issues	49	5	10.20%
Foster Care - Worker Visits	11	8	72.73%
Interstate Compact for the Placement of Children	7	1	14.29%

NOTEWORTHY PRACTICE ISSUES

LDSS participation in local Multidisciplinary Teams. "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." (From the Department of Criminal Justice Services' Children's Justice Act website.) Virginia law authorizes the establishment of MDTs for child abuse investigations and prosecutions. Virginia Code §§ 15.2-1627.5, 63.2-1503(K).

- We found that several localities' MDTs were not functioning due to the lack of cooperation, collaboration, and information sharing by the LDSS.
- In these localities, community MDT partners, such as law enforcement, Commonwealth's Attorneys, and Child Advocacy Centers, reported that the LDSS representatives on the MDTs did not participate in discussions of child abuse investigations and refused to share any information with the MDT. The resulting lack of coordination between law enforcement and the LDSS often caused delays in prosecution, increased risk of child-witness tampering, and delayed forensic interviews of children.
- LDSS staff in these localities reported that they were prohibited from disclosing confidential information. This is contrary to law: "The local department may disclose the contents of records and information learned during the course of a child-protective services investigation or during the provision of child-protective services to a family, without court order and without the consent of the family, to a person having a legitimate interest when in the judgment of the local department such disclosure is in the best interest of the child who is the subject of the records. Persons having a legitimate interest in child-protective services records of local departments include… any person who is responsible for investigating a report of known or suspected abuse or neglect or for providing services to a child or family that is the subject of a report, including multidisciplinary teams…" Virginia Code § 63.2-105(A). See also Virginia Code § 63.2-1503(J) and (K).

Follow-up with mandated reporters. In CPS cases we reviewed, we noted varying practices among local departments in their engagement with individuals who submit reports of child abuse or neglect and are mandated reporters under Virginia Code § 63.2-1509, such as school staff, medical providers, and law enforcement officers.

Information provided by a mandated reporter in their initial submission of a report of child abuse or neglect is used by the agency to determine the report's validity, the response time, and whether a CPS Investigation or Family Assessment will be opened. In too many cases after a report was validated, we noted that the assigned CPS workers did not reach back out to the mandated reporters to get more information or clarification about the alleged abuse or neglect, or to gather more information about the reporters' involvement with the children and families. This information would have been valuable and relevant to the agency's assessment of the families' safety needs and risk of future harm.

We found this to be particularly problematic when a child discloses abuse to a teacher or school counselor but then denies any abuse when speaking with the CPS worker. We noted that in some cases, the CPS workers would document that the report of abuse or neglect would be unsubstantiated because the "child did not disclose abuse" or a similar statement, which is not necessarily true since the child did disclose it to someone, just not the CPS worker, perhaps out of fear of parental retaliation or because of unfamiliarity with the CPS worker. Regardless, it would have been helpful for the CPS worker to get more information from the teacher or school counselor about the context in which the child's disclosure was given, the child's demeanor while disclosing, and the experiences the teacher or school counselor has had with the child and family.

In most cases, mandated reporters will have particular knowledge about the child or family and some level of expertise from which the CPS worker could get more insight into the child's situation. The CPS worker may be able to find out what preventative services had been attempted or offered to the family prior to the submission of the report. In other cases, the mandated reporter may indicate that they were unsure whether to make the initial report but did so out of an abundance of caution. In any case, information gathered from further engagement with the mandated reporter can assist the CPS worker in assessing safety and risk more effectively. The practice of regularly following up with mandated reporters by local departments could also improve the working relationships and collaboration among them and hopefully break down any silos or barriers that hinder the community's ability to collectively respond to child maltreatment.

Case transfers between LDSS. One disadvantage of having a state-supervised/locally administered system of delivering social services is the inherent complexity and unpredictability in CPS case transfers between local departments when families move from one locality to another, a family lives in one locality but the abuse occurred elsewhere, or when the child lives in one locality and the parents or prior caregivers live in another.

Jurisdiction and case transfers are governed by state law, regulation, and policy. Virginia Code § 63.2-1508(D); 22VAC40-705-40(I); VDSS Child and Family Services Manual, Part C, Section 3.5.2.4. Despite this authority, staff from several local departments expressed frustration with neighboring local departments who were unresponsive and unwilling to discuss and agree to case transfers, even when the neighboring local department should take jurisdiction. Staff also expressed concern that other local departments would often refuse to assist in a secondary role to provide support when families moved into the other locality.

We acknowledge that local departments continue to have staffing challenges that affect their capacity to accept more cases, but the lack of responsiveness and refusal to consider case transfers or whether they can assist is unacceptable and can leave children in vulnerable situations. Local departments should consider developing memoranda of understanding and establishing protocols with neighboring localities to facilitate collaboration and timely communication.

Permanency placement decisions. We continue to see varied practices regarding the following situation:

- Child enters foster care at or shortly after birth. Reunification efforts are made to work with the parents to allow the child to safely return home but are unsuccessful. Appropriate

relatives may not have been identified or were reluctant to interfere with the efforts to reunify the child with the parents. The LDSS seeks a change in the permanency plan goal to adoption. At this point, the child has been in foster care for an extended period of time. The LDSS begins working with the foster family to become the adoptive home.

Conflict arises when a relative expresses interest in being a placement option, causing concern that the child may be removed from the family in which he or she has been raised since birth. We have received complaints from both the relatives and the foster families in this scenario. The heartbreak felt by foster families is tremendous, but state law prioritizes kinship care, requiring local departments to "first consider placement with a kinship foster parent." Virginia Code § 63.2-900.1(A). The LDSS should weigh whether the disruption, trauma, and loss to which we subject the child by removing them from the foster home trumps the state policy to pursue kinship care and the benefits, actual or perceived, of placing the child with the particular relative.

We noted that some local departments take necessary steps to make sure their decision is in the child's best interest: they consult with the other stakeholders and professionals involved with the child and assess all the child's needs, including potential future contact with the parents (whether good for the child or not); ability to meet the child's special needs, if any; and the extent to which the child will maintain his or her cultural and familial ties in either placement. On the other hand, we have noted that other local departments did not take these steps and based their decision on arbitrary factors (e.g. disdain for the foster parents, skepticism of the relatives) or strict adherence to the kinship care policy without determining whether it was in the child's best interest.

Virginia policy requires local departments to use concurrent planning to ensure that if "Plan A" - usually reunification - is not successful, efforts have already been taken to work towards "Plan B" - usually placement with relatives. While concurrent goals are routinely listed on foster care service plans, actual work towards achieving the secondary goal varies greatly by local department. Some relatives express hesitancy to become involved early in a foster care case because they do not want to interfere with the parents' efforts to achieve reunification. Others are not notified early in the case, or do not understand the ways in which relatives can be engaged throughout the life of the case, i.e. visiting with the children, participating in normalcy activities, or serving as a placement option. The delay in engaging these relatives can lead to incorrect expectations on the part of the foster parents who have been led to believe that if reunification is not successful, that adoption by the foster family is the next likely outcome.

Because local departments have the final authority regarding the placement of the child, it is difficult for anyone – foster parents, the guardian ad litem, parents, and even children themselves – to object to the local departments' decisions. Courts have been reluctant to review these decisions, despite their authority to do so under the law. We acknowledge that placement decisions in this situation are dependent on the particular facts and circumstances and must be judged on a case-by-case basis, but interested parties should be permitted to challenge the placement decision, whether informally with the local department or within the judicial process.

Engagement with fathers. In our review of cases, we noted some agencies' reluctance to engage fathers in the CPS process when the father was not part of the child's household, was perceived as being "not involved" in the case or was accused of being abusive. Certainly, concerns about

domestic violence and abusive behavior should be considered as factors in decision making. In general, local departments should attempt to engage the father and his side of the family to better understand the circumstances of his involvement and relationship with the children prior to and during child welfare system involvement. Engaging the child's father and the paternal side of the family can help maintain family connections, limit the amount of time a child is in foster care, and restore family relationships that may have been severed or frayed due to prior conflicts between the parents regarding finances, contentious custody proceedings, or other divisive matters.

The benefits of fathers' involvement in children's lives have been researched and documented over the past 20 years. In 2006, the Urban Leadership Institute found that 63% of youth who committed suicides, 85% of youth who exhibited behavioral disorders, and 90% of homeless and runaway youth came from fatherless homes. In 2018, the Administration for Children, Youth, and Families encouraged states to bolster father engagement efforts noting the important role fathers have in child development and family stability which can lead to better outcomes for children.

In our case reviews, we noted the following practices regarding father engagement:

- Fathers who are known to the agency but are not being contacted during a CPS Family Assessment or Investigation
- Local departments scrutinizing fathers more than mothers or other caregivers
- Safety plans that did not take into consideration any rights or visitation arrangements (court-ordered or otherwise) of noncustodial fathers
- Fathers being held accountable for complying with safety plans they did not sign
- Disproportionate delays in service referrals or service delivery for the father
- Limited financial assistance provided to fathers being considered as a placement option for the child (e.g. assistance for housing, daycare, utilities, and transportation)
- Delayed visitation between fathers and children in foster care

Once the father has been identified, agencies should begin engaging him and conduct an independent assessment rather than rely solely on others' representations of his situation or relationship with the child. Agencies should also discuss with the child, when age-appropriate, what the father's role was and what it could be, and what relationships the child may have with paternal relatives. If paternity is in question, agencies should seek to establish paternity as quickly as possible to prevent any delay in services.

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 was notified of 229 child deaths that occurred in the Commonwealth during FY2025 in which there was suspicion of child maltreatment. Of those, 162 were validated and opened for Investigation by child protective services. The OCO was notified of 49 child deaths in which there was suspicion of child maltreatment and the families had involvement with child protective services or foster care that met the statutory criteria listed above.

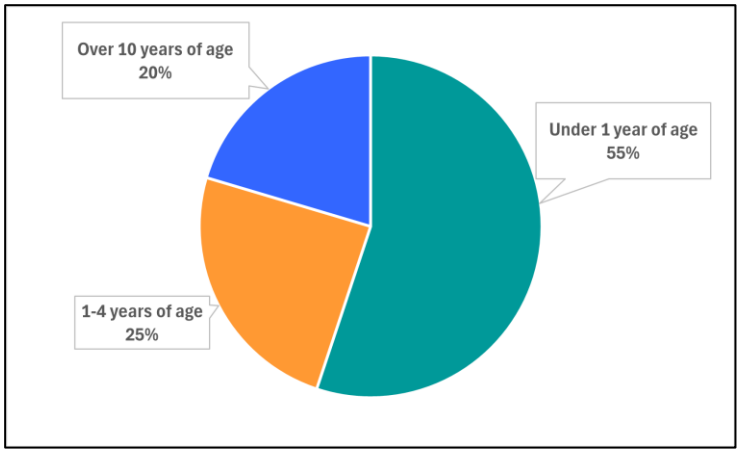
The OCO reviewed each child fatality case and the records related to all CPS and foster care cases associated with the child's family that were documented in the state child welfare information system online database. The following information about these 49 child fatality cases was gathered solely from these child welfare case records.

Localities in which child fatalities were reported. The 49 child fatalities occurred in the following localities:

Bedford County
Chesapeake (3)
Chesterfield County (2)
Clarke County
Danville
Dickenson County
Fredericksburg
Harrisonburg-Rockingham County (2)
Henrico County (6)
Henry County-Martinsville
Loudon County
Lynchburg (2)
Nelson County
Newport News
Norfolk
Northampton County
Orange County
Petersburg
Portsmouth
Prince Edward County
Prince William County
Roanoke (2)
Roanoke County
Rockbridge County
Scott County
Shenandoah County
Spotsylvania County
Staunton-Augusta County-Waynesboro
Suffolk
Tazewell County
Virginia Beach (4)
Warren County (3)
York County

Demographics. The ages, gender, and race of the 49 children were reported as follows:

Age	Number of Children
≤1 month	7
1 – 2 months	4
2 months	4
3 months	3
4 months	1
5 months	3
6 months	3
7 months	1
8 months	1
1 - 2 years	7
2 – 3 years	2
3 years	1
4 years	2
10 years	1
11 years	2
13 years	1
15 years	1
16 years	1
17 years	4



Gender	Number of Children
Female	20
Male	27
Not Reported	2

Race	Number of Children
Black	14
Multi-racial	8
White	27

Conditions at the time of death/family history.

Unsafe Sleep. For 14 children (29%), unsafe sleep practices or conditions were reported at the time their death. Such practices and conditions include 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.

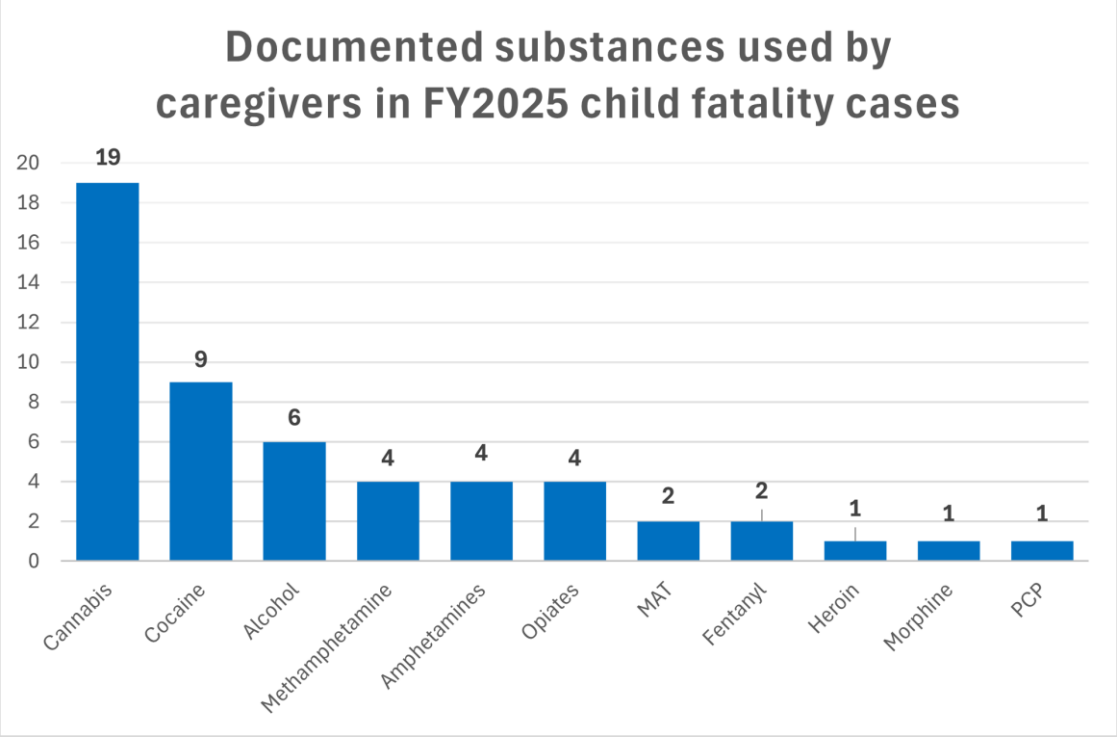
Substance-Exposed Infants. Twelve children (25%) were reported as having been born substance exposed - the mother used substances during pregnancy or tested positive for substances at birth, or when the child tested positive for substances at birth. All 12 children were under the age of 2 years at the time of death, with 10 of them being 6 months of age or younger (83%).

The following substances were documented as those to which the 12 children were exposed prenatally (some children were exposed to more than one substance):

- Cannabis (4 children)
- Amphetamine (4 children)
- Medication Assisted Treatment, including Suboxone, Methadone, and Buprenorphine (3 children)
- Opiates (3 children)
- Cocaine (2 children)
- Fentanyl (2 children) (1 child's mother was given fentanyl during birth)
- Methamphetamine (1 child)
- Nicotine (1 child)

Parental Substance Use. For 25 children (51%), the child's parents or caregivers were reported to have had a history of substance use, including at the time of the child's death. Twenty-two of these 25 children (88%) were 3 years of age or younger. Five of them were 1 month or younger (20%). Unsafe sleep conditions were reported in 9 of these children's cases (36%). The substances reported to have been used by the parents and caregivers were:

- Cannabis (19 cases)
- Cocaine (9 cases)
- Alcohol (6 cases)
- Methamphetamine (4 cases)
- Amphetamines (4 cases)
- Opiates (4 cases)
- MAT (2 cases)
- Fentanyl (2 cases)
- Heroin (1 case)
- Morphine (1 case)
- PCP (1 case)



For the 19 children in whose cases parental use of cannabis was reported, 12 of them were aged 6 months and younger (63%); 3 were 6 to 12 months old (16%); and 3 were 1 to 3 years old (16%).

Domestic Violence. In 9 cases (18%), the family had a history of domestic violence.

Parental Mental Health. In 13 cases (27%), the parents were reported to have had untreated or undertreated mental health conditions.

Children 6 months of age and younger. Particularly noteworthy is that 25 of the 49 children (51%) were aged 6 months or younger when they died. For these children, the following information was reported and documented:

Gender	Number of Children
Female	9
Male	14
Not Reported	2

Race	Number of Children
Black	7
Multiracial	3
White	15

Conditions/Family History	Number of Children
Unsafe Sleep	11
Substance-Exposed Infants	10
Parental Substance Use	17
Domestic Violence	4
Parental Mental Health Diagnoses	7

CPS Investigations. All 49 child fatalities were investigated by CPS. As of the writing of this report, 10 of the Investigations concluded with a finding of child abuse or neglect; 23 were unfounded; and 16 Investigations were still pending.

Manner of Death. In 34 of the child fatality cases we reviewed, the LDSS documented receipt of the OCME's medical report as of the writing of this report. With regard to the manner of death for each of those cases, we noted the following:

Manner of Death	Number of Cases
Undetermined	10
Natural	6
Accidental	5
Suicide	4
Homicide	4
Unreported	4
Drowning	1

Staff from some LDSS have reported to us that they are reluctant to make a finding of abuse or neglect in the death Investigation if the manner of death is undetermined. It was also reported to us that some law enforcement agencies will close their criminal investigations of the child's death due to an undetermined manner of death. However, as the Office of the Chief Medical Examiner (OCME) explained to the OCO, an undetermined manner of death means that more investigation is needed because the death was unnatural, i.e. they were unable to identify a natural or other explanation for the circumstances that led to the child's death. Instead of closing investigations or making no

findings of abuse and neglect, LDSS and law enforcement should step up their investigations when the manner of death is undetermined.

Recommendations related to child fatalities.

Multidisciplinary Training for child fatality investigations. Training is currently offered by VDSS and DCJS for CPS workers, law enforcement, and Commonwealth's Attorneys' offices. Staff from the OCME should be involved in the development and presentation of these training opportunities. We recommend that VDSS collaborate with DCJS and the OCME to ensure that local CPS and criminal child fatality investigators are provided training focused on improving their understanding and interpretation of medical examiners' reports.

Data collection and availability. Timely access to reliable data and information about child deaths is required for state and local leaders and policy makers to develop effective prevention strategies. The preceding analysis only covers 49 children's deaths in FY2025. As noted above, VDSS was notified of 229 total child deaths in FY2025, of which 162 were opened for investigation due to suspected child maltreatment.[1]

Based on an analysis by the Family and Children's Trust Fund of Virginia (FACT) of data collected by VDSS and the Virginia Department of Health (VDH), accurate and comparable data necessary for meaningful analyses and development of effective preventative strategies is difficult to obtain. FACT stated in its recent *Child Fatality Investigation & Review in Virginia* report:

> Child fatality data in Virginia is scattered across various agencies and not readily comparable. One of the most glaring examples of this is that the OCME and VDH collect and release data on a calendar year basis while DSS collects and releases data on a fiscal year basis. Multiple data requests to different agencies were needed to achieve the comparisons in this report and there is no available comparable data available to the public. . . .Even with the retrospective nature of fatality review data, Virginia lags massively behind, in some cases nearly a decade, in what the public is able to review. The most timely public notification of child fatalities often comes from news sources which do not have complete information and usually only involve "sensational" cases where an individual has been arrested, or a tragic accident occurred. The general public is unaware of the rate of child fatalities occurring in Virginia. Finding the data for those who seek to understand the issue is a challenge. (p. 41).

We recommend that state leaders and policy makers amend state laws, regulations, or policies to establish protocols for the collection of case-specific data and for the public disclosure of child death data, subject to applicable federal confidentiality laws. The availability of data allows localities "to identify trends faster and make changes to policies and procedures without having to wait for a state level report to be completed." (FACT, *Child Fatality Investigation & Review in Virginia*, p. 41.)

[1] VDSS annually publishes information and data for child maltreatment death investigations. The latest report was released covering the child death investigations conducted during FY2024.

Child fatality reviews. Virginia currently has a state Child Fatality Review Team, chaired by the OCME in accordance with Virginia Code § 32.1-283.1(B), and five Regional Child Fatality Review Teams. Virginia also had a Fetal and Infant Mortality Review Team that reviewed natural deaths of infants under the age of 12 months, but state funding for this team was terminated by the General Assembly in 2014.

According to the OCME's website, the Virginia Child Fatality Review Team "does not review every child death every year, but instead chooses a specific type of child death on which to focus its review. Reviews typically cover child deaths from certain causes or manners of death or injury patterns. The Team is tasked with developing recommendations for prevention, education and improved child death investigation."

The Regional Child Fatality Review Teams "convene to examine deaths that local departments of social services (LDSS) investigated. CFRTs focus on identifying risk factors, trends, and patterns, developing recommendations, and creating action plans." (*Child Maltreatment Death Investigations in Virginia During State Fiscal Year 2024*, p. 12.) These regional teams, however, only review child fatality investigations that meet the OCO's criteria for child fatality case reviews and investigations. Thus, not all child deaths of suspected child maltreatment are reviewed by the regional teams.

Given the parameters of the reviews conducted by the state and regional child fatality review teams, many cases in which child maltreatment is suspected are not being reviewed each year (e.g. 113 in FY2025). As noted in the FACT report, "This results in missing some of the most vulnerable children, those who never came to the attention of the agency at all [due to their age, lack of exposure to mandated reporters, or the abuse or neglect was subtle enough to go unidentified by outsiders]. Such data would provide useful insights into the prevention of abuse and neglect deaths that are currently flying under the radar." (*Child Fatality Investigation & Review in Virginia*, p. 38.)

In addition to the recommendations made by FACT in its report, we recommend that state leaders and policy makers consider:

(i) reviewing the operations of the State and Regional Child Fatality Review Teams to determine whether current parameters for child death reviews facilitate the development of effective prevention strategies and identification of child welfare agency practice improvements; and

(ii) reestablishing the Fetal and Infant Mortality Review Team, authorizing it to develop and implement procedures for analyses of fetal and natural infant deaths for the purpose of identifying factors contributing to such deaths and recommending strategies to prevent future occurrences. This Team should be authorized to access necessary data and information about fetal and natural infant deaths and be directed to coordinate with the Virginia Child Fatality Review Team, the Regional Child Fatality Review Teams, and the Maternal Mortality Review Teams for the development of policy and programmatic recommendations for the prevention of fetal, infant, and child deaths.

SAMPLE INVESTIGATION FINDINGS

Investigation 1. The LDSS opened a CPS Investigation after receiving a report that an infant was hospitalized with acute respiratory failure and non-accidental head trauma. We made the following findings regarding agency practices:

- The LDSS did not timely validate the report.
    - The CPS report was made to the LDSS on Day 1. The case record reflected that the report was entered on Day 4; the Structured Decision Making screening tool was completed indicating an R1 response time (requiring face to face contact with the alleged victim child within 24 hours of receipt of the report) on Day 5; and the report was finally validated on Day 6.
- The LDSS did not meet face to face with the alleged victim child within the 24 hour (R1) response time required by law for reports involving children age two years and younger.
    - The case record documented a "face-to-face" contact with the child and hospital staff on Day 6, the day the report was validated. To be timely, this contact should have been completed by day 2, within 24 hours of receipt of the report. Also, the documented notes of the contact indicated that it was a telephone call with hospital staff, not an in-person visit as is required. LDSS staff reported to us that they relied on the hospital staff, as mandated reporters, to make the initial face-to-face contact on the CPS worker's behalf, which is contrary to regulation and policy.
    - There was no documentation that the LDSS made *any* face-to-face contact with the child during the 30 days the child was hospitalized.
- The LDSS did not timely develop or implement an appropriate safety plan or take timely legal action to protect the alleged victim child.
    - The alleged abusers had unlimited and unrestricted access to the child while the child was hospitalized despite the evidence of serious non-accidental injuries. The LDSS claimed that no safety plan would be entered because the child was deemed safe in the hospital. The LDSS suggested that hospital staff could take whatever action they thought was necessary to ensure the child's safety.

The LDSS acknowledged our findings and recommendations and made significant internal changes to address the practice issues identified.

Investigation 2. We investigated two cases handled by the LDSS involving two different families but identified the same practice issues in both cases so the investigations were consolidated. Both children were infants born premature who tested positive for cocaine at birth. We made the following findings:

- The LDSS did not make timely face-to-face contact with the victim children within the 24 hours required by law for reports involving children aged two years and younger.
    - LDSS staff stated that they requested the mandated reporter that called the CPS reports in to complete the initial face-to-face contact on the LDSS' behalf. They also stated that the children were newborns and "could not be interviewed anyway."
- The LDSS did not adequately assess the parents for substance misuse in accordance with state policy.

- In one of the cases, the mother reported using cocaine 24 hours prior to giving birth and that she regularly used cannabis during pregnancy. Relatives reported concerns with the mother's continued substance misuse after giving birth.
- Both infants were not only born substance exposed but born prematurely and with little to no prenatal care, further increasing their risk for developmental delays. Both could have potentially benefited from preventive services offered through an early intervention program.

The LDSS acknowledged our findings and recommendations and made significant internal changes to address the practice issues identified.

Investigation 3. We investigated the death of a newborn. The infant stopped breathing and became unresponsive while being fed. The infant died shortly after being admitted to the hospital. The infant had been born substance exposed. The LDSS opened a Family Assessment and referred the family to Healthy Families, Infant and Toddler Connection, and In-Home Services. This Family Assessment was still open at the time of the infant's death.

The infant lived with the parents and multiple siblings. The family had multiple CPS referrals prior to the infant's death: several CPS Family Assessments, a CPS Investigation, and several invalidated (screened out) CPS reports. We reviewed all referrals and found multiple practice issues that were contrary to law, rule, and policy.

- In several Family Assessments, the LDSS did not make face-to-face contact with the alleged victim child within the assigned priority response time.
- In a Family Assessment opened when one of the decedent child's older siblings was born substance exposed, there was no documentation that the CPS worker saw the parents or the child in person at any point during this Family Assessment.
- In several cases in which parental substance misuse was alleged, the LDSS did not assess the parents' substance use, confirm parents' compliance with substance use treatment, or require the parents to undergo any drug tests.
- In several cases, required interviews were inadequate, incomplete, and not conducted in accordance with state laws, rules, and policies. In one Family Assessment, the LDSS did not interview the other children in the home or any collateral witnesses, such as school personnel.
- The LDSS opened a Family Assessment that should have been opened as an Investigation as the CPS report was the third valid report received within 12 months.
- In at least two cases, the Structured Decision Making (SDM) Family Risk Assessment was not created until the case was closed. When completed, it contained incorrect information regarding the number of prior Family Assessments and Investigations, which skewed the results.
- The LDSS opened a CPS Investigation on a report alleging sexual abuse. Very little information about the Investigation was documented. The LDSS rated this with a response time of R3, requiring face to face contact with the alleged victim child within five business days. This should have been rated at least R2 given the sexual abuse allegations and the age of the alleged victim child.

- The LDSS failed to consider the significant CPS history with the family, a critical component of the overall assessment and decision-making process for all cases.
- The LDSS did not conduct thorough safety assessments, develop proper safety plans to address potential risks, collaborate with collaterals, or conduct any drug testing when warranted. In multiple referrals, the agency expected others – particularly law enforcement and the medical community – to take protective measures instead of exercising its own authority to do so, such as seeking court intervention or providing foster care prevention services.
- There was a consistent pattern with the LDSS not responding to CPS reports within the mandated time frames when referrals were received on Fridays or Saturdays. Initial contact with the family did not occur until after the weekend.

In the CPS Investigation of the infant's death, medical testing revealed multiple skull fractures that were deemed nonaccidental. The cause and manner of death were undetermined. Inexplicably, the LDSS did not make any findings of abuse or neglect against the parents but made a founded disposition of physical abuse against an "unknown abuser."

The LDSS acknowledged our findings and recommendations and made significant internal changes to address the practice issues identified.

Investigation 4. We received a notification of the death of an infant. Two LDSS had been involved with the family. The child's mother was a minor who had been kicked out of her parent's home in Locality 1. The mother and child resided in the home of a friend in Locality 2.

The family's DSS history included the following:

- LDSS 1 in Locality 1 invalidated (screened out) a CPS report alleging that the child's mother had the child around firearms.
- LDSS 2 in Locality 2 screened out another CPS report alleging that the child and the mother were homeless. The mother's parents did not respond to phone calls. LDSS 2 noted that LDSS 1 had jurisdiction and documented that staff attempted to contact LDSS 1 but was unsuccessful.
- LDSS 2 received a subsequent CPS report alleging that the child had been left with different caregivers and that the mother was unable to be located. The report also alleged substance use in the home where the mother and child were residing.
    - LDSS 2 opened a Family Support case because they did not think they had jurisdiction to validate the CPS report.
    - LDSS 1 staff reported to us that because the child and the mother lived in Locality 2 and that LDSS 2 opened the Family Support case, they did not see the need to validate the CPS report or open a Family Assessment or Investigation.

The Family Support family services specialist assigned by LDSS 2 quickly identified and documented serious safety concerns and risk of harm for both the child and the teenage mother. Neither of the maternal grandparents provided any financial support for the mother or the child. The mother was not making appropriate decisions for the care of the child and was not able to financially support herself and her child. The FSS was unable to prepare a safety plan because the case was only a Family Support case and not a CPS Family Assessment or Investigation.

The FSS met with agency leadership and requested that the case be elevated to a Family Assessment or Investigation to take more protective measures for the child and the mother. LDSS 2 leadership denied this request, reporting to us that the only issue the FSS raised was the mother's inability to financially provide for the child, which they claimed did not warrant opening a Family Assessment or Investigation.

LDSS 2 staff attempted to conduct an unannounced visit, but no one answered the door. Four days later, the child died while in the care of another individual with whom the mother left the child.

The OCO found the following:

- Jurisdictional confusion and the absence of interagency cooperation between LDSS 1 and LDSS 2 resulted in the child being left in unsafe conditions and at great risk of future maltreatment.
- The decisions by both agencies to invalidate the CPS reports, and the refusal by LDSS 2 to elevate the Family Support case to a Family Assessment or Investigation, were contrary to law, rule, or policy and were made without adequate statements of reason given the increased vulnerability of the child and her minor mother.
- Either LDSS could have exercised jurisdiction: state regulation states that the local department of jurisdiction is "the local department in the city or county in Virginia where the alleged child resides or in which the alleged abuse or neglect is believed to have occurred." (22VAC40-705-10.)

LDSS 1 did not provide a response to our findings and recommendations. LDSS 2 had already reviewed its actions after the death of the child and made significant changes in their policies and practices as a result of their own findings but also acknowledged and considered the recommendations we made in our report of investigation.

Investigation 5. The complainants, who were relatives of a child in foster care, alleged that the LDSS did not engage with them during the first eleven months the child was in foster care, and that once they were engaged, appropriate steps were not taken to evaluate their household as a permanent placement option for the child. After completing an investigation, we made the following findings:

- Relatives were not notified of the child's placement in foster care in accordance with state law and policy.
    - The case record did not include any documentation that relatives were notified of the child's placement in foster care.
    - The case record indicated that some out-of-state relatives contacted the LDSS several months after the child entered foster care. They were provided with information about petitioning for custody and the ICPC process. In each of these circumstances, it was the family member who initiated contact.
- Diligent efforts were not made to identify relatives to achieve the concurrent goal of relative placement.
    - The initial foster care services plan submitted to the court by the LDSS had a goal of "return to own home" with a concurrent goal of "relative placement." Notably, this FCSP did not include any information about attempts to engage relatives.
    - The complainants petitioned for custody once they learned that the child was in foster care. Despite the filing of this petition and their expression of interest in being a placement option, the LDSS did not initiate the ICPC process.
- The LDSS did not adequately manage the foster parents' expectations, which led to an unrealistic

expectation that they would be able to adopt the child, prior to exploring relative placement options.

- Less than one month after the child entered foster care, FSS documented "Foster parents are beginning to become frustrated with the process and are trying to dictate what happens regarding contact with parents."

The LDSS did not respond to our findings and recommendations.

Investigation 6. A Family Assessment was opened by the LDSS due to concerns that an infant was hospitalized for failure to thrive. The child had complex medical needs and was medically fragile. This was the child's third hospitalization for failure to thrive. The LDSS found that the parents missed medical appointments for the child and that they could not keep up with the child's medical needs. A safety plan was entered stating that a relative would temporarily move into the home to assist with the care of the child. The LDSS closed the Family Assessment and referred the family to parenting education and counseling. The LDSS documented that an In-Home Services case would be opened to continue providing services to the family.

- The LDSS did not open the In-Home Services case until one month after the Family Assessment closed, contrary to state policy which requires In-Home Services cases to be opened "without delay" (VDSS Child and Family Services Manual, Part B, Section 2.4.1). The delay was concerning given the child had significant medical needs and was extraordinarily vulnerable; the parents were not following through with the child's medical appointments during the Family Assessment; and there appears to have been no actual assessment of the relative's ability to ensure the child's medical needs were consistently met. Agency staff were unable to explain why there was a delay in opening the In-Home Services case.

During the In-Home Services case, medical providers continued to report missed appointments and the LDSS staff were unsuccessful in scheduling home visits with the family to check on the child's care due to the family's unresponsiveness and uncooperativeness. The LDSS sought and was granted an emergency removal order.

- The child was placed in foster care but the case records and information from agency staff confirm that the agency did not provide the foster parents with any information about the child's complex medical needs, the plan of care or treatment, or how to administer the child's medication or the medical equipment.

The LDSS acknowledged our findings and recommendations and took steps to address the practice issues identified.

Investigation 7. Over a two-year period, we received complaints concerning multiple CPS and foster cases managed by a particular LDSS. We investigated the complaints and identified significant practice issues. Some of the issues concerned the agency's responses to CPS referrals and appeared to be systemic, so we reviewed all CPS referrals received by the LDSS in a two-month period.

We identified the following practice issues in our investigations and reviews of CPS referrals:

- Lack of proper supervision of family services specialists (FSS).

- FSS were not engaging in fundamental practices required by state policies for CPS and foster care cases, such as interviewing key parties for an investigation or making appropriate service referrals for parents in foster care cases.
- Case record documentation of supervisory case staffing meetings between FSS and their supervisors provided no information as to what was discussed or what directives were provided by the supervisor to the FSS and often contained notes that were copied and pasted from month to month.

- Child protective services.
  - Most referrals alleging parental use of cannabis, including those reporting a child born substance exposed, were invalidated with a notation that "THC is legal in Virginia" and without any consideration of how parental substance use may put children, especially the very young children, at risk.
  - Documentation of some CPS Investigations was insufficient. In one Investigation, the lack of proper documentation resulted in the reversal of a finding of abuse.
  - One CPS Investigation was concluded in three days with an unfounded disposition despite the mother leaving the young children home alone with her paramour who was a Tier III sex offender. The statutory definition of "abused or neglected child" in Virginia Code § 63.2-100 includes a child "whose parents or other person responsible for his care creates a substantial risk of physical or mental injury by knowingly leaving the child alone in the same dwelling, including an apartment as defined in § 55.1-2000, with a person to whom the child is not related by blood or marriage and who the parent or other person responsible for his care knows has been convicted of an offense against a minor for which registration is required as a Tier III offender pursuant to § 9.1-902." Agency staff reported that they relied on misinformation they received from law enforcement.
  - In several cases, LDSS staff did not observe the alleged victim children face-to-face within the required response times in accordance with state regulation.
- Foster care.
  - In several cases, we found very little documentation of engagement with parents or of any reasonable efforts to work with the families to achieve reunification. Some parents felt that they were coerced into signing entrustment agreements to voluntarily terminate their parental rights.
  - In multiple cases, visitation between parents and children in foster care was delayed, inconsistent, and not set out in specific visitation plans as required by law.
  - Parents were not meaningfully involved in the development of Foster Care Service Plans.
  - In two cases, LDSS did not properly prioritize kinship care and relative placements over adoption by unrelated and non-kinship caregivers in accordance with law and policy.

RECOMMENDATIONS FOR SYSTEM CHANGES

Based on the complaint reviews and investigations we conducted and the advocacy work in which we participated this year, we recommend the following actions be considered by state leaders and policy makers to improve Virginia's child welfare system:

1. Workforce Support.

We continue to hear about difficulties local departments are experiencing in attracting, hiring, and retaining qualified family service specialists. We also know that many local departments lost experienced family services specialists and supervisors during the COVID-19 pandemic resulting in a significant loss of institutional knowledge and skilled employees. As a result, many local departments had no choice but to promote family services specialists with less experience and knowledge into supervisory positions.

The combination of these two workforce challenges leads directly to the majority of practice issues we see in our case reviews and investigations. The state laws, regulations, and policies that govern the practice areas where we see most dysfunction are not being followed as they should. We will not see significant systemic improvements in Virginia until we meaningfully address these challenges to make sure local departments can attract, hire, and retain qualified employees and can provide proper supervision and support.

State regulation requires that family services specialists and supervisors have a bachelor's degree in the human services field or a bachelor's degree in any field accompanied by a minimum of two years of appropriate and related experience in a human services related area. 22VAC40-670-20. Yet the average annual base salary for family services specialists is only $45,760 (or $22 per hour), with many localities reporting that they can only offer a starting annual base salary of $37,000 to new employees. These figures are tragically low in light of the challenging work inherent in child protective services and foster care cases in addition to the extra responsibilities placed on local department staff, such as having to be on-call during off hours and weekends and being ready to serve their communities whenever a state of emergency is declared.

These base salaries vary from locality to locality. The inconsistency across the Commonwealth gives rise to family services specialists transferring to other local departments or other community agencies - such as schools, community services board, or court services units - that can offer more pay.

Family services specialists leave not only for compensation deficiencies, but also due to burnout and job dissatisfaction, which may be a result of poor supervision and lack of support within the local department. Some family services specialists reported to us that agency culture played a significant role in their decision to leave the local department when agency leaders and supervisors forced them to take actions contrary to state policies or that they felt were not in the best interests of a child or a family.

According to data from the VDSS Office of Research and Planning and the VDSS Office of Trauma and Resilience Policy, new family service specialists remain at their local department for an average of 11 months before leaving. The average turnover rate for Family Service Specialists I was 40% for calendar years 2022-2024. First-year turnover costs the Commonwealth over $11 million annually.

State leaders and policy makers should consider the following:

a. Competitive Compensation for Family Services Specialists and Family Services Supervisors. The base salaries for new and existing family services specialists should be competitive with other professions requiring similar educational qualifications and job responsibilities and expectations. This will require the state to appropriate sufficient funds to support localities' ability to provide this increased level of compensation.

b. Equal pay scales across the state to prevent employees from leaving one local department to work for another. The pay scales for the different levels of family services specialists within the Family Services Occupational group should be consistent across localities. For example, compensation for an FSS II in one locality should be the same for an FSS II in other localities, with a few exceptions for the local departments located in areas having higher costs of living.

c. Reinstitute In-Person Training for Local Staff. Prior to the COVID-19 pandemic, most required training for local family services staff offered by VDSS was in-person. Much of that training moved to a virtual platform during the pandemic and has stayed virtual since. Over the past few years, we have heard from many local directors who would like to have their employees attend in-person training. Such training, they said, was more effective in helping their employees understand the material and provided their new employees with the opportunity to get to know others from around the state to create informal networks of peers, fostering lasting relationships that were supportive and helped prevent employee burn-out. VDSS should again offer in-person required training for family services staff.

d. Fund the VDSS Office of Trauma and Resilience's Workforce Support Program, which includes a Statewide Peer Support Line that would be staffed by part-time retired family services specialists and would provide peer support and on-site crisis response after critical incidents such as child deaths or threats to local staff. This will require hiring one full-time employee and appropriating approximately $600,000 to implement this program.

e. Create a state pool of emergency CPS and foster care family services specialists. Over the past four years we noted that some local departments experienced such staff shortages that they were unable to timely respond to CPS reports or serve children in foster care, resulting in children being left in potentially unsafe situations and in one case, parents not being able to visit their children in foster care for months at a time. Having a pool of qualified CPS and foster care workers that can be deployed to assist local departments during staffing crises could prevent children and families from falling through the cracks. This will require sufficient appropriations for the hiring of staff.

f. Consolidation of Local Departments. More districts of two or more localities – particularly smaller localities with fewer resources – should be authorized to establish a combined local board of social services and one local department, as permitted by state law in Virginia Code § 63.2-306. This would allow the participating localities to combine their resources to provide more effective support and supervision of local workers. This will require authorization by the State Board of Social Services after receiving the Governor's consent and consultation with and an election by the affected local governing bodies.

2. Child Protection.

Much attention has been paid recently to the foster care side of child welfare. Over the past few years, robust state policies were implemented to promote kinship care and achieve more timely permanency for children and youth in foster care. As demonstrated by the investigation summaries highlighted earlier in this report and in our review of child fatality cases, however, we noted deficiencies in practices involving child protective services (CPS) and local departments' responses to reports of alleged child abuse and neglect, particularly with the very young children (age 3 years and younger) and medically fragile children that are extraordinarily vulnerable and lack protective capacity.

We recommend that state leaders and policy makers consider the following:

a. Centralized Intake and Validation of CPS Referrals. We noted wide variances in practices and inconsistencies across the Commonwealth in local departments' documentation and decisions regarding the validation of CPS referrals. CPS reports alleging similar acts of abuse or neglect may be validated in one locality but screened out in another. We also noted that some validation decisions are unduly influenced by internal agency bias based on a local department's history with subject families.

VDSS currently operates a State Hotline and an online Mandated Reporter Portal for individuals to call in or submit reports of child abuse or neglect. The State Hotline office receives reports, enters all information into the state CPS database, and contacts the local department having jurisdiction to forward the report to local staff, who then determine whether the report will be validated, the response time, and whether a Family Assessment or CPS Investigation will be opened if the report is validated.

State law should be amended to expand the authority of the VDSS to receive and make the validity determinations for all reports of child abuse and neglect. Consideration should be given to allow local departments that have dedicated intake staff and robust intake processes that regularly meet state standards to maintain their authority to validate CPS reports. A budget item will be required to cover the cost of this expansion.

b. Expedited response to CPS reports involving children under age 3 yrs. Enact legislation and amend state regulation at 22VAC40-705-80(A)(1) to require local departments to make first contact with children under three years of age within 24 hours of receipt of the validated CPS report. Currently, this response time is required for reports involving children under the age of two years.

c. Focused efforts to address parental substance misuse. Parental substance misuse is one of the most common reasons for CPS involvement and intervention. After the 2021 decriminalization of recreational use and possession of cannabis in the home, its use increasingly has become normalized. As a result, we often hear parents make statements such as, "It's only weed" and "It's ok, it's legal" to justify their substance use. We have also heard them say, "I only smoke it outside" or "I use it only after the kids go to bed." We have also noted CPS reports get screened out on the basis that cannabis use is legal at home. These misperceptions minimize the effect cannabis use has on parents' ability to keep children safe and provide proper supervision, especially of the younger children.

Moreover, the prevalence of parental substance misuse noted in child fatality cases is alarming. While substance misuse may not have directly caused children's deaths, it may have played a role in the fatalities caused by unsafe sleep practices or conditions where better supervision may have prevented the child's death. For the children born substance exposed, substance use by the mother during pregnancy has shown to affect the child's health and development. They are extraordinarily vulnerable and deserve better protection. As one noted expert pediatrician has put it, "These children are unwell."

State leaders and policy makers should consider supporting the following initiatives:

- Plans of Safe Care. The Virginia Department of Health (VDH), along with relevant state and local agencies, nonprofit organizations, and members of the medical community, has been developing the state plan for the implementation of Plans of Safe Care, as required by federal law under the Child Abuse and Prevention Treatment Act (CAPTA) Reauthorization of 2010 and the Comprehensive Addiction and Recovery Act (CARA) of 2016, that address "the health and substance use disorder treatment needs of the infant and affected family or caregiver." 42 U.S.C. § 5106a(b)(2)(B)(iii)(I).

  State guidance at VDSS Child and Family Services Manual, Part C, Section 10 sets forth the procedures and protocols for local departments to follow when they receive a CPS report alleging that a child was born substance exposed. The guidance contemplates that a Plan of Safe Care has been developed or will be developed for the parents and child. However, these plans require the collaboration of other parties, including the local community service boards and the family's private medical providers, to be most effective in ensuring the baby is safe and the family is getting the supportive services they need to properly parent and supervise the child. Unfortunately, local departments have reported a lack of collaboration, particularly from the community services boards, in ensuring that the Plans of Safe Care are implemented.

  We are hopeful that the VDH's development of the state plan and its work with multiple state and local stakeholders, which includes DBHDS and local community service boards, will help alleviate some of these issues. Responsibility in ensuring these infants' safety rests not just with the local departments but with the greater community under a properly implemented Plan of Safe Care. To that end, state leaders should provide necessary legislative and financial support so that localities have the resources available to serve these families, such as robust substance use treatment and parenting services, home visiting programs, and affordable childcare.

- Training. State leaders and policy makers should consider a multiagency initiative to develop and provide training opportunities, specifically addressing parental substance use and its effects on children, for professionals and government agencies that work directly with families with children. These training opportunities should be regularly updated and provided periodically to keep up with the everchanging landscape of substance misuse and related research and include topics covering parental cannabis and alcohol use and their effects on children and parental capacity, neonatal abstinence syndrome, substance exposed infant protocols, Plans of Safe Care, and the consumption of and exposure to substances by

children and adolescents. The intended audience for these training opportunities should include:

- Public and private medical providers (OB/GYNs, Pediatricians, Public Health Nurses, Nurse Practitioners, Hospital staff, Medication Assisted Treatment providers)
- LDSS staff, including CPS and foster care workers
- Community Service Boards and Behavioral Health Offices staff
- Private mental and behavioral health providers
- Home visiting program staff
- Private attorneys who are certified to be appointed to represent parents and children and to serve as guardians ad litem for children
- Judges from the Juvenile and Domestic Relations District and Circuit Courts
- Court Appointed Special Advocates program and volunteer staff
- Court Services Unit and Department of Juvenile Justice staff
- Local school division staff
- Local law enforcement staff

The following state agencies should be involved in planning, developing, funding, and convening the training opportunities: VDH, VDSS, DBHDS, DJJ, DCJS, VDOE, OCS, the Virginia Alcoholic Beverage Authority, the Virginia Cannabis Control Authority, and the Virginia Opioid Abatement Authority.

3. State Oversight over Local Administration of Family Services.

Virginia is one of nine states that have a delivery system of social services that is state supervised and locally administered. VDSS implements regulations and policy guidance but the administration of social services programs, such as foster care, child protective services, and public benefits, is the responsibility of the 120 local departments of social services in the Commonwealth. VDSS has some authority to enforce compliance with social services laws, regulations, and policies when the programs are not being administered properly, but VDSS Commissioners have historically been reluctant to exercise their full authority. The following actions should be considered by state leaders to bolster the supervisory and oversight authority of VDSS over the delivery of social services programs.

a. Authorize state intervention in the local administration of child protective services. State law currently authorizes the VDSS Commissioner to issue corrective action plans and to temporarily assume control of a local department's administration of foster care services when the local department fails to provide those services in accordance with law, regulation, and policy. Virginia Code. § 63.2-904.1. This law was enacted at the recommendation of the Joint Legislative Audit and Review Commission in its 2018 *Improving Virginia's Foster Care* System report. State leaders should consider amending state law to grant the VDSS Commissioner similar authority over local departments' administration of child protective services.

b. Clarify state laws governing the appointment, performance, and removal of directors of local departments of social services. Current law provides for the following:

- The local director shall be appointed by the local board of social services or, if applicable, other designated appointing authority "from a list of eligibles furnished by the Commissioner." (Virginia Code § 63.2-325.)
- The VDSS Commissioner may remove any director "who does not meet the personnel standards established by the" State Board of Social Services. (Virginia Code § 63.2-327.)
- The local director acts "as agent for the [VDSS] Commissioner in implementing the provisions of federal and state law and regulation." (Virginia Code § 63.2-333.)

First, the State Board of Social Services should consider establishing regulations or protocols for the furnishing to localities by the VDSS Commissioner the list of eligible candidates that can serve as directors of the local departments. It is our understanding that this process is currently administered by the VDSS human resources division, which merely determines whether a prospective candidate submitted by a locality meets the minimum requirements to serve as a local director. Neither the Commissioner nor his or her deputy commissioners are involved directly in this process. More robust qualifications than just the minimum requirements should be the measure for candidates' inclusion on the Commissioner's list.

Second, state leaders should consider amending the laws to clarify the VDSS Commissioner's authority over supervising local directors' administration of social services programs. The VDSS Commissioner's current authority to "remove any director" is limited to directors who do not meet the State Board's "personnel standards." It is not clear whether this includes the directors' performance in administering social services programs in accordance with law and policy. State leaders should also consider authorizing a streamlined process for the VDSS Commissioner to order the immediate removal of directors when appropriate for their failure to properly administer social services programs in accordance with federal and state law, regulation, and policy.

4. Legal Representation for Parents and Children Involved in Child Dependency Proceedings.
The courts play a fundamental role in the child welfare system as the arbiter of local departments' interventions within a family. The courts decide whether court-ordered child protection measures sought by local departments are necessary and sufficient to maintain the proper balance between protecting children and preserving families. Lawyers for the parties involved must ensure that the proper evidence is before the court so that the judge can make informed decisions and is in the best position to provide that necessary oversight over government actions.

In Virginia, parents are provided with court-appointed attorneys after a local department files a petition alleging a child is abused or neglected. The courts also appoint an attorney to serve as the child's guardian ad litem to advocate for the child's best interests. Unfortunately, the number of attorneys willing and becoming qualified to serve in these court-appointed roles has decreased significantly over the past several years. As a result, many parents and children are not receiving the legal representation and advocacy they need and deserve. Our current system of providing legal counsel in child dependency cases is insufficient. State leaders should consider the following actions to steer the Commonwealth in the right direction for providing quality legal representation in child dependency cases.

a. Funding for increased compensation to court-appointed guardians ad litem for children. According to data from the Office of the Executive Secretary of the Supreme Court of Virginia (OES),

the number of attorneys qualified statewide to be appointed as guardians ad litem for children dropped 29% from a monthly average of 1,171 in 2020 to 828 in 2025. In parts of the Hampton Roads and the Shenandoah Valley areas, the decrease was as much as 37%. The situation has been described repeatedly by judges and attorneys as a crisis.

Guardians ad litem (GALs) report burnout and being overwhelmed with heavy caseloads, and an increase in conflicts of interest as fewer remaining attorneys have previously represented one of the parties. In addition, experienced attorneys are retiring while newer ones are declining to join the list of qualified GALs or quickly leave it. Attorneys cite the low hourly rate and insufficiency of the recent pay increase[2] in relation to the work required as the underlying reason. With law firms billing from $250 - $500 per hour or more, depending on the jurisdiction, attorneys cannot afford to do court-appointed work, and some report accepting salaried positions, for example in Commonwealth's Attorneys' and Public Defenders' offices. A geographically representative group of 12 judges offered that an increase in guardian ad litem fees would help to improve the current situation.

State leaders should consider providing a more reasonable rate of compensation for the attorneys advocating for Virginia's children. According to OES, it is estimated that increasing the pay rate of GALs by approximately 13.5% to $65 per hour for time spent out of court and $90 per hour for time spent in court would have an adjusted total cost to the Commonwealth, offset by federal Title IV-E reimbursements, of $3 million annually.

b. Collaboration with Virginia's law schools. To increase law students' awareness of and interest in child welfare law and practice, state leaders and policy makers should consider collaborating with Virginia's law schools to establish courses of study and law clinics dedicated to child dependency law. Law clinics could offer advocacy for parents involved with CPS or in foster care cases, or partner with existing qualified guardians ad litem to assist in the advocacy for children. State agencies and the judicial branch could partner with law schools to provide low cost continuing legal education to help support attorneys who agree to accept court appointments to represent parents and children in child dependency cases.

c. Funding for Pilot Program for Multidisciplinary Advocacy for Parents involved in Child Dependency Cases. In the multidisciplinary model of legal representation, an attorney's legal services are supplemented by a social worker and a peer support to provide comprehensive advocacy for parents involved in child dependency cases. This model has been shown in other states and localities to decrease the amount of time children remain in foster care due to more robust advocacy that promotes achieving more timely permanency. These pilot programs could also provide pre-petition legal advocacy for parents who may be asked to enter a Parental Child Placement Agreement as a means to prevent children's entry into formal foster care.

In 2024, the following enactment clauses were passed with House Bill 893 to authorize the establishment of programs to pilot this model of representation:

> *2. That up to two multidisciplinary law offices or programs may be established for the purpose of representing parents in child dependency court proceedings or, prior to*

[2] In its 2025 Session, the General Assembly approved an increase in the hourly rates paid to GALs from $55 per hour for time spent out of court and $75 per hour for time in court to $57.50 and $78.85, respectively.

the initiation of such proceedings, pursuant to a child protective services assessment or investigation in localities, jurisdictions, or judicial districts that affirm they have met criteria developed by the work group established by Chapter 305 of the Acts of Assembly of 2022. Such multidisciplinary law offices shall utilize the Interdisciplinary Practice Model developed by the American Bar Association and the Family Justice Initiative and develop such protocols, goals, and outcome measures as are consistent with those required for federal financial participation for legal representation under Title IV-E of the Social Security Act, 42 U.S.C. § 673 (Title IV-E). Any private or local public entities establishing any such multidisciplinary law office may enter into an agreement with a local department of social services or the Department of Social Services to receive Title IV-E funding for eligible administrative costs of providing legal representation for a child who is a candidate for Title IV-E foster care or in foster care and his parent to prepare for and participate in all stages of foster care legal proceedings, including court hearings related to the child's removal from the home.

3. That any multidisciplinary law office or program established pursuant to the second enactment of this act shall, in any calendar year that such multidisciplinary law office or program is in effect for at least six months, submit a report that includes information on program outcomes, expenses, recommendations, and any other information pertinent to the measurement of how the program impacts the progression of child dependency cases. Such report shall be submitted annually to the Office of the Children's Ombudsman established by Chapter 4.4 (§ 2.2-438 et seq.) of Title 2.2 of the Code of Virginia and the Chairmen of the House Committees for Courts of Justice and on Health and Human Services and Appropriations and the Senate Committees for Courts of Justice and on Education and Health and Finance and Appropriations by November 1.

Teams of stakeholders in two Virginia localities have expressed an interest in establishing a pilot program in their communities. State leaders should appropriate sufficient funds to launch these pilots in accordance with this legislation to determine their efficacy and potentially expand them if outcomes improve in child dependency cases. A budget item for approximately $550,000 per fiscal year is required to fund each pilot program. Federal Title IV-E funds would be available to help offset some of the operating costs of these programs.

5. Establishment of a Permanent Children's Cabinet.

Issues affecting children have gotten much more complex in recent years. An effective statewide response requires coordinated efforts by multiple executive branch agencies across administration secretariats to ensure that laws, regulations, and policies reflect the shared goal of keeping Virginia's children and youth on track developmentally, educationally, socially, and emotionally. Collaboration among state and local child-serving agencies is essential to addressing current needs and to sustaining efforts on a long-term basis. Getting buy-in from the highest level of leaders at 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. As noted by the Family and Children's Trust Fund of Virginia:

> A permanently staffed Children's Cabinet would serve as a policy-coordinating body to focus comprehensively on children and their families beyond the silos that often exist between agencies and Secretariats within government. Many other states have adopted this model to create a shared vision, goals and strategies across government and state and local stakeholders groups to address the comprehensive needs of children.[3]

Recent executive branch initiatives, such as Right Help Right Now and Safe and Sound, have benefited from a multiagency approach to solving complex problems within Virginia's child welfare and behavioral health systems. Future initiatives of a Children's Cabinet could include the coordination for the multidisciplinary substance use training recommended herein; coordination of efforts targeting children and adolescent behavioral health challenges arising in homes, schools, and community settings; and expected challenges awaiting low income families due to cuts in federal funding for key safety net programs. We recommend that state leaders and policy makers consider establishing a permanent Children's Cabinet by executive order or legislative action.

[3] Letter to William A. Hazel, Jr. M.D., member, Glenn Youngkin Transition Team, January 3, 2022.