Advisory Committee to the Court Appointed Special Advocate and Children's Justice Act Programs

AGENDA

In-Person Meeting
Virginia Department of Social Services
5600 Cox Road, Glen Allen, VA 23060
York River Room, 111B

October 25, 2024
10:00 AM – 12:00 PM

1. **Welcome, Roll Call and Introduction of Guests**

2. **Review and Approval of July 26, 2024, Minutes**

3. **Presentation of the Office of the Children's Ombudsman Annual Report –** Eric Reynolds, Director, Office of the Children's Ombudsman

4. **CJA Program Update**

5. **CASA Program Update**
   - CASA Expansion Study Report
   - FY24 Annual Report – Preliminary Review

6. **Citizen Review Panel**
   - Child Maltreatment Death Report FY23 – Carley Lansden, Child Fatality Specialist, Virginia Department of Social Services
   - Worker Training – Patrick Bridge, Director of Local Training and Development

7. **Adjournment**

DRAFT

Pursuant to § 2.2-3707.1 of the Code of Virginia this DRAFT of the minutes of the Court Appointed Special Advocate (CASA) and Children's Justice Act (CJA) Advisory Committee is available to the public. The public is cautioned that the information is provided in DRAFT form and is subject to change by the Advisory Committee prior to becoming final. Once the minutes have been finalized, they will be marked "FINAL" and made available to the public.

COURT APPOINTED SPECIAL ADVOCATE/CHILDREN'S JUSTICE ACT
PROGRAM ADVISORY COMMITTEE
MEETING MINUTES

July 26,2024

A meeting of the Advisory Committee to the Court Appointed Special Advocate and Children's Justice Act programs was held virtually on July 26, 2024.

Members Present
Judge Eugene Butler
Shamika Byars
Morgan Cox
Lana Mullins
Jeannine Panzera
Giselle Pelaez
Eric Reynolds
Lora Smith (for Shannon Hartung)
Judge Thomas Sotelo, Chair

Members Not Present
Randy Bonds
Jackie Robinson Brock
Davy Fearon
Katharine Hunter
Sandy Karison
Pat Popp, Vice-Chair
Ashley Thompson

Guests
Kirby Baughn (VDSS)
Denise Johnson (VDSS)
Rachel Miller (VDSS)

Staff Present
Jenna Foster
Melissa O'Neill

I. **Call to Order:** Judge Thomas Sotelo, Committee Chair, called the meeting to order at 10:04 AM. Members introduced themselves.

II. **Approval of Minutes:** The committee received and reviewed the draft minutes of the April 26, 2024, meeting. Giselle Pelaez noted her name was misspelled and needed to be corrected. Giselle Pelaez made a motion to approve the minutes with corrections. Eric Reynolds provided a second. The motion was approved.

III. Set Meeting Dates for Upcoming Year: The committee discussed the following meeting dates for the upcoming year.

Friday October 25, 2024
Friday January 24, 2025 – Virtual
Friday April 25, 2025
Friday July 25, 2025 – Virtual

Shamika Byars made a motion to accept the dates as presented and Eric Reynolds provided the second. The motion was approved.

IV. CASA Program Update: The committee was previously provided a written update regarding the Court Appointed Special Advocate Program. The following additional updates were discussed.

Draft Proposed Regulations Review: The draft proposed regulations were approved by the Criminal Justice Services Board at their meeting held on June 13, 2024. DCJS will continue to keep the Advisory Committee informed regarding the regulatory process.

CASA Expansion Legislative Study: Committee members were briefed on the CASA Expansion Legislative Study work group meeting held on July 10, 2024. The work group was directed to complete a study to determine the feasibility of requiring a local CASA program in every jurisdiction throughout the Commonwealth and to identify any obstacles regarding the establishment of programs. The report is due to the Governor and the General Assembly by November 1, 2024.

V. CJA Program Update

The CASA/CJA Advisory Committee was provided with a written report detailing significant activities of the CJA program this quarter. The following additional updates were provided.

Domestic Violence and Sexual Violence (DVSV) Children's Programming Workgroup: This workgroup, comprised of 17 participants from local DVSV housing programs, VDSS, and DCJS, meet monthly to identify and address areas of need for DVSV children's programming and services. Each quarter, the group meets in-person to tour a local program. The group is currently planning a breakout session at the upcoming DCJS Domestic Violence Conference that focuses on multidisciplinary teams and the importance of including DVSV child advocates in case review and continuing services for victims and families.

DCJS Domestic Violence Conference*:* Members were updated about the conference entitled *Building Bridges: Collaborative Approaches to Prevent Domestic Violence and Support Survivors*. that the DCJS Division of Programs and Services is planning. This conference, scheduled for October 7-9, 2024, at the Hampton Roads Convention Center, will have a child-focused track in addition to specific sessions for program leadership. Limited scholarships were made available.

VI. **Citizen Review Panel**

The committee received presentations and information on two Virginia Department of Social Services projects.

Kirby Baughn, Prevention and In-Home Program Manager with the Virginia Department of Social Services, provided an overview on the implementation of the Parental Child Safety Placement Program that went into effect as of July 1, 2024.

Denise Johnson, IT Portfolio Program Manager, Division of Family Services, with the Virginia Department of Social Services, provided an update on the implementation of the replacement data system for OASIS. The new system is CCWIS (Comprehensive Child Welfare Information System). VDSS has been working on this project since 2019 and plans to contract with a vendor in 2025.

VII. **New Business:** Members provided updates, information and news from their respective agencies and disciplines.

VIII. **Adjourn:** Eric Reynolds made a motion to adjourn the meeting and Giselle Pelaez provided the second. The motion carried and the meeting adjourned at 11:49 PM.

Next meeting dates:

Friday October 25, 2024
Friday January 24, 2025 - Virtual
Friday April 25, 2025
Friday July 25, 2025 – Virtual

CASA/CJA Advisory Committee Citizen Review Panel 2024 Recommendations

Prevention/FFPSA

The Virginia Department of Social Services (VDSS) should continue to focus timely prevention efforts that ensure safety and well-being of the child and support families in ways that provide support and enhance timely permanency. This includes providing services to prevent removal, and services to support adoptive and kinship families. VDSS should continue to build capacity for evidence-based practices and services and then work toward enhancing a robust and qualified workforce. Services should include respite for all members of the family including siblings in the home. Primary and secondary prevention efforts should focus on avoiding penetration into and continued need for tertiary services. Development and integration of best practices of the Science of Hope in working with children and families. Include education stability as a prevention strategy.

The VDSS should develop mechanisms for reporting on its prevention services model. This would include establishing criteria and definitions of the various levels of prevention interventions. Consideration should include reports on the number of prevention (pre-court intervention) cases served, length of time cases are served in prevention, outcomes of prevention efforts, interventions and services provided, how many prevention cases were non-compliant, and what steps the Department took when cases were non-compliant.

System Improvement

The Virginia Department of Social Services (VDSS) continues to focus on family engagement practices as a cornerstone of the child welfare system. To implement family engagement practices effectively, more trained workers are needed. Efforts should be expended to explore interagency collaboration regarding delivery of case management services and implementation of lived experience navigator services to guide parents. VDSS has experienced the impacts of a reduced workforce due to the pandemic, fiscal constraints, and vicarious trauma. Important to retain workers to maintain uniformity and strengthen the workforce.

VDSS should encourage local Departments of Social Services (LDSS) to improve communication and collaboration across jurisdictions when investigating child abuse and neglect and participate in a local multidisciplinary team (MDT), if available. Per Virginia Code § 15.2-1627.5, LDSS-Child Protective Services Unit representation is a required member on a local MDT.

VDSS should encourage LDS agencies to improve cross systems collaboration to support thorough investigations of child abuse and neglect. This should include cross

systems joint training opportunities. Upon commencement of dependency proceedings, VDSS should encourage inclusion of attorneys, relatives and other actors in service planning (i.e., family partnership meetings and team meetings).

The pandemic presented numerous challenges, especially for frontline workers. The VDSS should continue to examine the preparedness for the COVID19 pandemic and begin planning for the next pandemic that will inevitably strike. Included in this planning should be helping teachers and other mandated reporters to identify child abuse and neglect in a virtual environment. VDSS should continue to study trends in the reductions of the number of child abuse and neglect complaints and determine if the reduction in complaints trends actually equates to a reduction in harm to children.

VDSS in-home services practices align CPS ongoing practice, prevention services, and the implementation of the Family First Prevention Services Act. The Advisory Committee requests continued collection of data and information on the path to permanency for children and families involved in Alternate Living Arrangements.

As the Virginia Department of Social Services builds the new Child Welfare Information System (CWIS), the Committee requests updates and asks the Department to seek stakeholder input into the development of data points for the system.

The Virginia Department of Social Services will provide the Committee with a report on the impact and utilization of the Virginia Heals project.

Diversity, Equity and Inclusion in Child Welfare

The Virginia Department of Social Services (VDSS) should ensure equity in its response to child welfare including examination of data through an equity lens. The examination of child welfare practice should include practice implications for children and caregivers of color, children and caregivers that identify as LGBTQ, and children and caregivers with disabilities.

VDSS should ensure voices with lived experience are included in decision-making and policy considerations, with special consideration given to parents and caregivers.

The Committee would like an update on the impact of halting the Qualified Residential Treatment Placement (QRTP) designation for residential setting. The committee would like an update on the number of children in hospitals, hotels and offices (safe and sound task force efforts).

COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

October 10, 2024

Sent Electronically
Melissa O'Neill
CASA/CJA Citizen Review Panel Coordinator
Virginia Department of Criminal Justice Services
1100 Bank Street, Richmond, VA 23219

Dear Ms. O'Neill:

The Virginia Department of Social Services (VDSS) commends the Court Appointed Special Advocate Program and Children's Justice Act Committee for their work as an active Citizen Review Panel (CRP) as part of Virginia's Child Abuse Prevention and Treatment Act (CAPTA) Plan. The feedback for our Child Protective Service Program by our Citizen Review Panels is crucial to the improvement of our program for the citizens of the Commonwealth.

Child Protective Services (CPS) in Virginia is a continuum of specialized services designed to assist families who are unable to safely care for their children. CPS is child-centered, family-focused, and based on the belief that the primary responsibility for the care of children rests within their families. CPS encompasses the identification, assessment, investigation, and treatment of abused or neglected children. Virginia's specialized services are designed to:

- Protect children and their siblings;
- Prevent future abuse or neglect;
- Enhance parental capacity to provide adequate care; and
- Provide substitute care when the family of origin cannot remedy the safety concerns.

CPS will respond to valid child abuse or neglect reports by conducting a Family Assessment response or an Investigation response, also known as Differential response. The goals of both responses are: to assess child safety, strengthen and support families, and to prevent future child maltreatment. The track decisions are guided by state statute and local policy. In SFY 2023, there were 52,480 children reported as possible victims of child abuse or neglect in 33,679 completed reports of suspected child abuse or neglect. Of those children, 4,368 were involved in founded Investigations, 8,033 were involved in unfounded Investigations, and 40,079 in Family Assessments (differential response). In SFY 2023, Family Assessments accounted for 76% of all CPS reports accepted by local Departments of Social Services and 38 children died because of abuse or neglect. There were 26 children involved in 26 Human Trafficking Assessments, which are required when a report alleges a child is a victim of human trafficking, sex, or labor, and does not meet the validity criteria for an Investigation or Family Assessment.

Over the last year, VDSS continues to prioritize working towards meeting our federal outcomes related to child protection including responding to reports of abuse with a timely consistent response, providing ongoing services to for children who are at high or very high risk (In-Home services) and ensuring timely case closure. Additionally, VDSS is prioritizing family engagement through the use of Family Partnership Meetings, and Child and Family Team Meetings.

We have reviewed your recommendations for our CPS program and thank you for your input. VDSS offers the following responses to your recommendations:

1. **Prevention/FFPSA**

   In 2024, the General Assembly, through House Bill 27 and Senate Bill 39, established the Parental Child Safety Placement Program, a statutory framework for a parent, guardian, or legal custodian to arrange for a Parental Child Safety Placement for their child with relatives and fictive kin when a LDSS has determined that the child cannot remain safely in their home of origin. Regardless of where the child may temporarily or permanently reside, the framework ensures protections for parental rights, promotes placement with relatives or fictive kin, supports reunification efforts, and provides specific timeframes for permanency. Solidifying and enhancing tertiary prevention practice will let VDSS continue to partner and focus on earlier (primary and secondary) prevention activities, ensuring a well-resourced prevention continuum. In-Home Services also ensures that when children temporarily or permanently reside with relatives or fictive-kin caregivers, services are provided to ensure the safety and permanency of those living arrangements.

   Implementation of the Parental Child Safety Placement Program framework will establish collaboration across programs and focus on building relationships among the triad between caregivers, children, and LDSS. This framework represents a significant practice shift for all 120 LDSS and the full child welfare continuum: Prevention/In-Home, Child Protective Services, Foster Care, and Resource Family. VDSS is managing the process to implement necessary revisions to written practice guidance, regulatory actions, LDSS training and change management, and updates to the child welfare information system.

One of the key tenets of the establishment of the Parental Child Safety Placement Program is the Parental Child Safety Placement Agreement. The Parental Child Safety Placement Agreement codifies the guardrails needed to protect children and families by promoting family-driven decisions, ensuring the preservation of parental rights, establishing consistent practice among the LDSS, and enhancing the provision of In-Home Services to children and families.

VDSS will continue to focus on the use of data to drive decisions, support recommendations, and conduct thorough root-cause analysis in this practice area. Detailed data about Parental Child Safety Placements and services will offer insight into the circumstances leading to the use of these placements and the types of services and supports provided during the placement. This data will also assist VDSS to further explore whether disproportionalities and disparities exist in Parental Child Safety Placements statewide and how the practice affects the well-being and permanency of children and families over time. VDSS remains committed to prioritizing family-based support and decision-making to keep children with their parents in their own communities. Families are the experts of their lives, and practice will prioritize engaging families in a deliberate manner to develop and implement creative, individual solutions that build on their strengths to meet their identified needs.

2. System Improvement

VDSS remains a key partner in the Multidisciplinary Team (MDT) Stakeholder Group which is a collaborative partnership between Virginia Department of Criminal Justice Services, Children's Advocacy Centers of Virginia, Virginia Department of Social Services, and Commonwealth Attorney Services Council, and is committed to strengthening and sustaining MDTs throughout the state. The MDT Stakeholder Group believes that training, resources, and support targeted at MDTs at key points along their developmental pathway have the greatest potential to cultivate effective teams who are best equipped to help children and families impacted by abuse. The MDT Stakeholder Group developed two training courses to support MDTs across the Commonwealth.

The first training course, MDT 101 - Building a Strong Foundation for MDT Success, is designed to provide a comprehensive introduction to the Multidisciplinary Team model to leaders from new and developing MDTs. Participants will learn about the benefits of collaborative community response to child abuse allegations.
The second training course, Good To Great - Enhancing MDT Effectiveness and Functioning, is intended to support MDTs who have been operating in their current composition for 3-5 years. It is often at this point that we begin to see MDTs experience growing pains and encountering challenges around collaboration, engagement, and commitment to the model. This training seeks to empower teams to take responsibility for their own effective functioning and offers tools and approaches that support healthy collaboration. This training is designed to be attended by groups of team members from the same MDT.

So far in CY2024, the MDT Stakeholder Group, held two virtual MDT 101 training sessions that reached 117 individuals. There are two additional MDT 101 training

sessions scheduled for October 24th and December 10th. Additionally, at the DCJS Domestic Violence Conference scheduled to be held in October, there will be two sessions specifically on MDTs.

For CY2025, the MDT Stakeholder Group anticipates offering at least two in-person sessions that will likely include the Good To Great - Enhancing MDT Effectiveness and Functioning training content.

VDSS Division of Family Services (DFS) has selected a vendor to provide Human-Centered Design (HCD) services to inform the development of a federally compliant Comprehensive Child Welfare Information System (CCWIS). The VDSS provides semi-annual status updates to the General Assembly and weekly updates to the project team.

To prepare the workforce for a modern child welfare information system, this project, VDSS DFS HCD Consultant, will review and update established workflows, prepare journey maps for system users and for stakeholders in the community that they encounter, identify pain points in current processes, and provide a roadmap to improve current processes. The deliverables will facilitate the building of a state-of-the-art child welfare information system that is built with the end user in mind. This project will follow human centered design principles including, but not limited to, understanding the end users and stakeholders, engaging with end users and stakeholders throughout the process, and testing/revising processes based on end user feedback.

The Office of Trauma and Resilience Policy (OTRP) has been actively engaging with local partners and communities to promote resilience and healing among the children, families, and individuals being served. The OTRP strives to provide essential resources, training, and technical assistance to local agencies and organizations, with a focus on the Virginia HEALS Trauma-Informed Model of Service Delivery Virginia HEALS – Virginia HEALS. In support of these activities, the OTRP explores and implements various training and funding opportunities, fostering the adoption of trauma-informed and healing-centered policies, practices, and programs across the state.

The Virginia HEALS Trauma-Informed Model of Service Delivery, and the resources provided in the toolkit that supports it, continue to have a significant impact across systems. The OTRP provides on-going training and technical assistance related to Virginia HEALS to local service providers, with this past year seeing a particular focus on the Trauma-Informed Agency Self-Assessment (TIASA) and the Screening for Experiences and Strengths (SEAS). In SFY2024, the OTRP facilitated training sessions for 723 service providers across systems (child welfare, behavioral health, advocacy, etc.) on various components of the Virginia HEALS toolkit, and at least 132 child and family-serving providers participated in e-Learning modules.

The OTRP also contracted with and provided support and technical assistance to agencies within five of Virginia's multi-disciplinary Trauma-Informed Community networks to participate on a learning collaborative, Creating Healing-Centered Organizations. Using data from the Virginia HEALS Trauma-Informed Agency Self-Assessment, these

agencies engaged in a strategic planning and implementation process to become more healing-centered both internally, with their workforce, and externally, with the children, families, and individuals that they serve.

3. Diversity, Equity, and Inclusion in Child Welfare

VDSS and the DFS are committed to diversity, equity and opportunity in child welfare. While the DEI committee has disbanded temporarily, DFS is working on adding inclusive language in guidance across the continuum of programs using an equity lens. In addition, DFS has a Parent Advisory Council that includes parents who have experience with the child welfare system. DFS also manages the SPEAKOUT committee. This committee is comprised of current and former foster care and adopted youth. Both groups provide feedback and suggestions on policy and programs through their lens of lived experience. Both committees are managed by the Permanency team.

VDSS made the decision to "pause" the designation of Qualified Residential Treatment Programs (QRTP) beginning April 1, 2023. This decision was made for several reasons including:

· Virginia shifted to Medicaid as the first payer for all children's Medicaid approved residential facilities beginning July 1, 2021 (the same date as the implementation of Family First and the QRTP designation). While VDSS incorporated this shift to Medicaid in planning for QRTP implementation, the actual impact of this shift was far greater than anticipated, resulting in significantly reduced IV-E claiming for children's congregate care placements.

· VDSS was aware that the process for accessing IV-E funds for QRTP placement was complicated and created a significant burden on LDSS staff.

· VDSS continued to see a significant number of case errors with QRTP placements, impacting IV-E funding as well as CSA funding, resulting in a significant cost to localities. These case errors appeared to stem at least partially from Virginia's outdated child welfare information system (OASIS.) In addition, because Virginia's complex congregate care system poses a barrier to requiring all residential facilities to become QRTPs, it proved challenging for workers to navigate when QRTP rules apply and when they don't.

· LDSS expressed concerns that the QRTP providers were not actually doing anything above and beyond what they had been doing prior to the designation so that youth in these placements were not receiving better quality care. The designation of QRTPs was largely based on the providers self-report which proved to be problematic.

Since the pause, the percentage of youth in congregate care has increased. In April 2023 11.2% of youth in foster care were placed in congregate care while in July 2024 13.3% of youth were placed in congregate care. The overall number of youth in foster care has also increased and there has been an increase in older youth entering care which likely

explains the increase in congregate care placements, not the pause of QRTP designation. It should also be noted that the percentage of children in kinship placements has increased over this same time period going from 11.6% to 15.3%. Although there has been in increase in placements in congregate care, there has been a greater increase in the more desirable placement of youth with relatives.

VDSS is committed to ensuring that children and youth who need a level of treatment that can only be provided in a congregate care setting receive quality care which is trauma informed and continues to explore bringing back the QRTP designation when it can be done successfully. Virginia will be undergoing a federal title IV-E review in 2025 and it would not be in the state's best interest to reinstate a process that would have such an impact on the review without sufficient time to perfect the process. Additionally, VDSS has noted the challenges with the current child welfare information system that does not allow any of the process to be automated. As VDSS works to replace the current system, many of these processes that can be automated will be built into the new system. The new system is estimated to be in place in 2026.

There has been an average of 20-22 youth on the VDSS Home Office High Acuity Team's active monitoring list for the last 90 days. This list includes youth who are currently without a placement and in the LDSS office/hotel as well as youth who are at risk of being without a placement within the next 30 days or so. Over the last 90 days there has been an average of one youth sleeping in the LDSS office/hotel. One notable trend this summer is that there have been many referrals for 17-year -old youth that are within six months of their 18th birthday. This is challenging for the LDSSs and the High Acuity Team as they still have a high level of need and very few congregate care providers are willing to consider youth at this age since they cannot remain in that placement once they turn 18. However, it continues to be evident that the NEW referrals (kids with no prior Safe and Sound/High Acuity Team involvement) are displaced for fewer days. Through June and July 2024 there was a significant decrease in TOTAL days of youth displacement statewide (in comparison with the previous quarter). Unfortunately, these trends do not necessarily mean that youth are displaced less often than they previously have been, as the High Acuity Team has been working diligently to streamline the process and approach to assisting LDSSs with displaced youth. In November 2023, VDSS hired a liaison who works at The Commonwealth Center for Children and Adolescents and assists local departments when youth in their custody are psychiatrically admitted to the hospital. This position provides support to the LDSS in discharge planning, identifying placements, and making referrals. A third High Acuity Placement Coordinator joined the team in July, also expanding capacity to support LDSS with high acuity youth. The expanded capacity has provided additional support to the LDSS but has not eliminated the issue of children and youth not having placements.

Sincerely,

Shannon Hartung

Shannon Hartung
Protection Program Manager

Cc: Kimberly Huhn Murphy, Children's Bureau

REPORT OF THE DEPARTMENT OF
CRIMINAL JUSTICE SERVICES

Report of the Court-Appointed Special Advocate (CASA) Program Work Group (2024 Appropriation Act, Item 394.B.3.c.)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 6

COMMONWEALTH OF VIRGINIA
RICHMOND
2024

COMMONWEALTH of VIRGINIA

Department of Criminal Justice Services

The Honorable Jackson H. Miller
Director

Tracy Louise Winn Banks, Esq.
Chief Deputy Director

Washington Building
1100 Bank Street
Richmond, Virginia 23219
(804) 786-4000
www.dcjs.virginia.gov

October 1, 2024

The Honorable Glenn Youngkin
Governor of Virginia
Patrick Henry Building
1111 East Broad Street
Richmond, Virginia 23219

Members of the Virginia General Assembly
C/O Division of Legislative Automated Systems (DLAS)
900 East Main Street W528
Richmond, Virginia 23219

Re: Report from the Court-Appointed Special Advocate Work Group

The 2024 Appropriation Act, as enacted by the Virginia General Assembly and the Governor in Chapter 2 during the Special Session (394.B.3.c), directed the Virginia Department of Criminal Justice Services (DCJS) to convene a work group to study and make recommendations on the feasibility of requiring the establishment of Court-Appointed Special Advocate (CASA) programs in every judicial district in the Commonwealth. DCJS was directed to include various stakeholders on the work group, identify any judicial districts in the Commonwealth where no local CASA program has been established, and to determine the feasibility, including analyzing any obstacles, of requiring the establishment of a local CASA program in every judicial district.

The Act provides that the work group shall complete its work and submit findings and recommendations to the Governor and General Assembly no later than November 1, 2024.

If you have any questions or require additional information, please contact Tracey Jenkins, Division Director, Division of Programs and Services, at tracey.jenkins@dcjs.virginia.gov or 804-225-0005.

Sincerely,

Jackson H. Miller
Director

Attachment

Report of the Court-Appointed Special Advocate (CASA) Program Work Group

November 1, 2024

Virginia Department of Criminal Justice Services
www.dcjs.virginia.gov

Report of the Court-Appointed Special Advocate (CASA) Program Work Group

Preface

The 2024 Appropriation Act, as enacted by the Virginia General Assembly and Governor (Chapter 2, Acts of Assembly, 2024 Special Session I), directs the Virginia Department of Criminal Justice Services (DCJS) to convene a work group to examine the feasibility of requiring the establishment of Court-Appointed Special Advocate (CASA) programs in every judicial district of the Commonwealth of Virginia. *(See Appendix A)*

Work Group Members

CASA Program Coordinator

Melissa O'Neill, *Virginia Department of Criminal Justice Services*

Representatives of Local CASA Programs

Kate Duvall
Piedmont CASA

Dionne Harrison
CASA of the New River Valley

Jeannine Panzera
Henrico CASA

Lorna Rexrode
CASA of Central Virginia

Brianna Taylor
28th Judicial District/Culpeper CASA

Kristi Wagner
29th Judicial District CASA

Volunteer Court Appointed Special Advocates

Kassie Gada
CASA of Central Virginia Volunteer

Merrily Main
Piedmont CASA Volunteer

Nicole Poulin *(Also Stakeholder)*
Richmond CASA

Judges in Judicial Districts Where a Local CASA Program is Established

The Honorable David Barredo
16th Judicial Circuit Court

The Honorable Chad Logan
Shenandoah and Page J&DR Court

The Honorable Thomas Sotelo
Fairfax J&DR Court

Judges in Judicial Districts Where No Local CASA Program has been Established

The Honorable Kimberly Athey
Frederick/Winchester J&DR Court

The Honorable Jay Dugger*
Hampton J&DR Court

The Honorable Nora Miller
Mecklenburg J&DR Court

The Honorable Joseph Teefey*
11th District Circuit Court

Virginia Department of Social Services

Shannon Hartung
Virginia Department of Social Services

Ina Fernandez*
Loudoun County Department of Social Services

* Invited and provided input, but not present at meeting

Invited Stakeholders

Morgan Cox
Guardian ad litem

Beth Coyne
Office of the Executive Secretary of the Supreme Court, Court Improvement Program

Nicole Poulin *(Also CASA Volunteer)*
Family and Children's Trust Fund

Eric Reynolds
Office of the Children's Ombudsman

Virginia Department of Criminal Justice Services

The Honorable Jackson H. Miller
Director

Tracey Jenkins
Director, Division of Programs and Services

Laurel Marks
Manager, Juvenile and Child Welfare Section

Melissa O'Neill
CASA Program Coordinator

Terry Willie-Surratt
CASA Grant Monitor and Quality Assurance Coordinator

Wyatt Jones
Intern

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Executive Summary

In accordance with the 2024 Appropriation Act, the Virginia Department of Criminal Justice Services (DCJS) convened a work group focused on identifying any judicial districts in the Commonwealth of Virginia where no local Court-Appointed Special Advocate (CASA) program has been established and determining the feasibility, including analyzing any obstacles, of requiring the establishment of a local CASA program in every judicial district. The work group must report its findings and recommendations to the Governor and the General Assembly by November 1, 2024.

The work group convened on July 10, 2024, in Richmond, Virginia. Prior to meeting, the work group was provided with comprehensive written materials, including an overview of CASA program history, current operations, and relevant data to foster a shared understanding of CASA program operations among participants.

There are 27 operational CASA programs in the Commonwealth. Twenty-four are nonprofit organizations, and of those, eight are under an umbrella nonprofit organization which provides other types of services to children, families, and individuals. The remaining 16 programs are stand-alone CASA nonprofit organizations. Three CASA programs are administered by a government agency.

There are 31 judicial districts in the Commonwealth. Of those, 19 are completely served by CASA programs. In eight, some but not all courts are served. There is one judicial district where a local CASA program has been established in only one court. There are three judicial districts where no local CASA program has been established. In total, there are 38 courts without services from a local CASA program.

Led by DCJS staff, the meeting included presentations and discussions aimed at examining the potential for CASA program expansion. Participants identified emergent themes, assessed the need for additional information, and leveraged their diverse experiences to highlight priority areas critical to the expansion of CASA programs in Virginia.

Findings and Recommendations

The work group concluded that requiring the establishment of local CASA programs in every judicial district is not feasible. Further, the group identified obstacles that informed the conclusion in the following areas.

Independence of Program Model: There is a need for flexibility in program implementation to suit local community needs.

Funding Challenges: Adequate financial resources at multiple levels (state, local, and donor) are essential for the sustainability of CASA programs.

The Volunteer-Based Nature of CASA Programs: Adequate number of trained volunteers is crucial for program effectiveness.

Judicial Support: Judicial support is crucial for program effectiveness.

Public Awareness and Education: Addressing misconceptions about CASA programs will improve community engagement and support.

Court-Appointed Special Advocate (CASA) Program Expansion Study Work Group Report

Introduction

Court Appointed Special Advocate (CASA) programs provide trained, citizen volunteers to speak for abused and neglected children who are the subject of juvenile court proceedings involving allegations of abuse and neglect. CASA volunteers advocate for safe, permanent homes for children and provide a consistent presence and a voice in court for children, helping to ensure the best possible outcome for child victims.

Virginia's CASA Program is established pursuant to Article 5, Chapter 1, of Title 9.1 of the *Code of Virginia* and administered by the Virginia Department of Criminal Justice Services (DCJS). The program, working with local programs also established pursuant to this article, provides "…services in accordance with this article to children who are subjects of judicial proceedings (i) involving allegations that the child is abused, neglected, in need of services, or in need of supervision or (ii) for the restoration of parental rights pursuant to § 16.1-283.2 and for whom the juvenile and domestic relations district court judge determines such services are appropriate. CASA volunteer appointments may continue for youth 18 years of age and older who are in foster care if the court has retained jurisdiction pursuant to subsection Z of § 16.1-241 or § 16.1-242 and the juvenile and domestic relations district court judge determines such services are appropriate."

DCJS promulgates regulations for local CASA programs in accordance with the *Code of Virginia* and monitors local programs for compliance. Regulations for local programs, codified in 6VAC20-160-10 through 6VAC-160-120, include the following topic areas: general definitions, program administration, volunteer administration, qualifications of volunteers, and training guidelines for volunteers. State general funding available through the Appropriation Act is also administered by DCJS to applicants seeking to establish and operate a local CASA program in their respective judicial districts. Only local programs operating in accordance with Article 5, Chapter 1, of Title 9.1 of the *Code of Virginia* are eligible to receive state funds.

CASA volunteers provide independent, unbiased information to the court regarding the best interest of the child. Local CASA programs are locally operated organizations (most are nonprofits), governed by a board of directors or a local unit of government. Each must raise the funds required to operate the program to supplement the grant funds provided by DCJS. DCJS grant funds make up only 36% of the annual aggregate statewide CASA budget. CASA programs are generally considered grassroots organizations, supported by local communities.

There are 27 operational CASA programs in the Commonwealth. Twenty-four are nonprofit organizations, and of those, eight are under an umbrella nonprofit organization which provides other types of services to children, families, and individuals. The remaining 16 programs are stand-alone CASA nonprofit organizations. Three CASA programs are administered by a government agency. Program budgets in FY23 ranged from $75,000 to $991,726, with a median budget of $205,700 and an average of $314,616.

There are 31 judicial districts in the Commonwealth. Of those, 19 are completely served by CASA programs. In eight, some but not all courts are served. There is one judicial district where a local CASA program has been established in only one of its courts. There are three judicial districts where no local

CASA program has been established. In total, there are 38 courts without services from a local CASA program.

CASA programs range in scope and size depending on the number of courts and localities served. In FY23, nine programs served up to 60 children, seven programs served up to 120 children, six programs served up to 180 children, and five programs served over 180 children. A total of 116 people were employed in the 27 programs statewide in FY23. The average staff size is four employees. Average salaries for full-time Executive Directors, Program Directors, and Volunteer Coordinators were $74,683, $59,040, and $49,180, respectively.

DCJS maintains a website with CASA information: www.dcjs.virginia.gov/juvenile-services/programs/court-appointed-special-advocate-program-casa.

Work Group Charge and Purpose

The charge and purpose from the General Assembly for the work group is "to study and make recommendations on requiring a local court-appointed special advocate (CASA) program to be established and available in every judicial district of the Commonwealth." Further, the work group is "to identify any judicial districts in the Commonwealth where no local CASA program has been established and determine the feasibility, including analyzing any obstacles, of requiring the establishment of a local CASA program in every judicial district."

The 2024 Appropriation Act as enacted by the Virginia General Assembly and Governor (Chapter 2, Acts of Assembly, 2024 Special Session I) may be found in Appendix A in this report. Pursuant to this directive, DCJS included membership for the work group as required.

Methodology

DCJS engaged in several activities prior to the workgroup meeting to assist in accomplishing the charge and purpose.

DCJS developed surveys for Juvenile and Domestic Relations District Court Judges (Appendix B) and CASA Program Directors (Appendix C) about the feasibility of CASA program expansion to every judicial district in the Commonwealth. The Office of the Executive Secretary of the Supreme Court of Virginia emailed the judicial survey to every juvenile court judge; the CASA Program Coordinator at DCJS emailed the survey to local CASA programs.

To benefit from lessons learned, DCJS facilitated three local CASA program focus groups centered on the feasibility, benefits, challenges, and obstacles of the proposed mandate to establish a local CASA Program in every judicial district of the Commonwealth. Participants were selected based on their past or current experience in program expansion into multiple jurisdictions (Appendix D).

Finally, DCJS developed a report identifying every judicial district in the Commonwealth where CASA program services are available. In an effort to present a complete picture of need, the report included data on judicial districts without CASA programs and judicial districts with CASA programs where existing programs do not have sufficient resources to serve all the children in need of CASA services. These areas are deemed to be "underserved" (Appendix E). DCJS used the number of abuse and neglect filings from the Office of the Supreme Court as a proxy for children who are eligible for CASA.

Work group members received the following materials in advance of the meeting for their review:

- Copy of CASA enabling legislation, Article 5 of Chapter 1 of Title 9.1, *Code of Virginia*
- CASA Program Overview
- FY23 CASA Program Report
- Juvenile and Domestic Relations District Court Judges Survey Report
- Local CASA Program Survey Report
- Local CASA Program Focus Group Report
- Need by Judicial District Report

DCJS staff led the work group in a comprehensive overview of CASA program history and a summary of current program operations, including a review of materials sent in advance, to create a shared understanding of CASA program operations in Virginia (see Appendix F).

The work group was divided into smaller groups for discussion purposes. Participants examined emergent themes, determined if additional information was needed, and based upon their respective experiences and expertise, identified priority areas having the greatest impact on CASA program expansion in Virginia.

The full work group reconvened to make an overarching recommendation and identify obstacles for the feasibility of requiring establishment of a local CASA program in every judicial district in the Commonwealth.

Work Group Recommendation on Requiring a Local CASA Program to be Established and Available in Every Judicial District of the Commonwealth

The work group concluded that it is not feasible to require the establishment of local CASA programs in every judicial district in the Commonwealth. They identified obstacles that informed the conclusion in several key areas and offered specific suggestions for each identified obstacle to enhance the overall capacity and infrastructure of local CASA programs in the Commonwealth. The areas were as follows: independence of the program model; funding challenges; the volunteer-based nature of CASA programs; judicial support; and public awareness and education.

Obstacle 1: Independence of the CASA Program Model

While CASA programs provide a service *to* the court, CASA programs in Virginia are independent entities *from* the court. CASA programs are either nonprofit entities or local government agencies, not directly under the court. This is a critical component of CASA programs. CASA volunteers provide independent, unbiased, factual information to the court regarding the best interest of the child.

Work Group Suggestions

- Rather than a mandate, build capacity and support for existing local programs focusing on underserved courts.
- Develop strategies to explore sustainable funding for CASA programs statewide, then consider expansion plans.
- Frame the benefit of the CASA program in child-centric terms when educating judges.

Obstacle 2: Funding

Currently, operations of existing CASA programs are not fully funded. CASA programs receive 36% of their annual funding from DCJS through a grant which is a combination of state general funds and federal Victims of Crime Act (VOCA) funds. The remaining 64% of funds are raised by local CASA governing authorities and CASA program staff. Federal VOCA funds are at risk of reduction given severe cuts to the VOCA fund nationwide. Sources of private, corporate, and business grant funding is also diminishing. Localities need to support existing communities before consideration of expansion.

The allocation of state general fund dollars has not increased since 2008. The current funding formula by which grant amounts are determined, which includes a base amount of funds which serves up to 60 children and then an additional per child allocation for each child served over 60, was established by DCJS in 2007. It does not take account for the cost to sustain program expansions (i.e., real costs of serving multiple jurisdictions, larger geographic areas, and actual costs involved in program implementation across multiple courts). Due to the stagnant state general fund allocation, each new program established or new area served reduces the amount of funds that existing programs receive from DCJS.

There are significantly more children eligible for CASA services in localities served by CASA but without sufficient resources to meet the need (*underserved areas*) than in *unserved* areas. In CY2023, existing CASA programs were unable to serve children who were the subject of an estimated 3,403 abuse and neglect filings in underserved areas. In contrast, there were 329 abuse and neglect filings in unserved areas. Volunteer recruitment at state and local levels, program staffing support, and training resources were all identified as capacity needs for existing local programs. The work group emphasized the importance of strengthening infrastructure and capacity at both the local CASA program and state level before considering expansion to unserved areas.

Work Group Suggestions

- DCJS should revisit the CASA program funding formula.
- Increase the state general fund allocation for CASA programs; there has not been an increase since 2008.
- Create an ongoing funding strategy to provide incentives for expansion and which allows additional funding to supplement existing funding so existing programs and localities are not hurt by bringing on more localities, like, for example:
    - Exploring sources of ongoing support for CASA programs including court fees, Interest on Lawyers’ Trust Accounts (IOLTA), or Lottery funding.
    - Seeking to fund a statewide endowment for CASA programs.

Obstacle #3: The Volunteer-Based Nature of CASA Programs

The success of the CASA model is dependent upon the trained citizen volunteer advocate, assigned by a juvenile court judge to an individual child’s case. By definition, volunteers cannot be required or mandated to serve. Existing CASA programs struggle to recruit enough volunteers to meet the needs of courts served. The work group noted this as a significant obstacle to requiring CASA programs statewide.

Support for volunteer recruitment is a significant need across the Commonwealth. Finding diverse volunteers is a major challenge statewide. DCJS funded a statewide volunteer recruitment campaign in 2022 in collaboration with the Virginia CASA network using American Rescue Plan Act funding. The campaign was excellent; however, ongoing funding is needed to sustain the gains made. Ongoing public awareness and recruitment is necessary to grow and maintain the volunteer base to meet the need

statewide. Further focus on infrastructure and capacity building at the local CASA program and state level is required to meet this need.

According to a research summary by AmeriCorps, volunteerism declined by 7% in the United States during the COVID pandemic.[1] That was not the case with CASA volunteers. CASA volunteer retention in Virginia remained steady over the past five years. The stability of retention rates is attributed to the screening methods, training, supervision, and support provided by local CASA programs, which is in part driven by the regulations promulgated by DCJS. However, the need for additional CASA volunteers is great. Finding a more diverse volunteer base is needed to expand the broader pool of volunteers to serve Virginia's abused and neglected children.

Work Group Suggestions

- Provide support to local programs for recruitment, training, supervision, and retention of CASA volunteers.
- Allocate additional state resources in these vital areas of support to local programs.
- Specific recruitment suggestions:
  - Consider recruiting volunteers at events that solicit volunteers for other types of child serving opportunities (i.e., foster parents, mentoring).
  - Integrate recruitment efforts with other community organizations (e.g., churches, civic organizations).
  - Recruit volunteers from law schools in Virginia.

Obstacle #4: Judicial Support

Judicial support is required to establish a CASA program. Judge David Soukup founded the CASA program in 1977 in Seattle, Washington after observing in his court that the social services and legal systems were overburdened. He wanted more unbiased information on the children and families coming before him in order to inform the significant decisions that he made as a judge when children were before him with allegations of abuse and neglect. His idea was to engage and train community volunteers to fill in the gaps and support the overburdened system to provide the bench with the needed information to make those critical decisions

In Virginia, Judge Phillip Trompeter was a newly appointed juvenile court judge in Roanoke when he heard about the CASA program while at a conference in Reno, Nevada. Believing that CASA volunteers would make a tremendous difference in the cases before the court, Judge Trompeter helped shepherd the first CASA program into existence in 1985. Norfolk and Newport News courts soon followed, and thus began the CASA program movement in Virginia.

In 1990, the General Assembly passed legislation establishing the CASA program and directing DCJS to promulgate regulations for local CASA programs. At that time, there were 11 operational CASA programs in the Commonwealth. Today there are 27 operational CASA programs serving, at least in part, 28 of 31 judicial districts and 91 of 133 localities in Virginia.

The National CASA/GAL Association was founded in 1982 and provides technical assistance and support to local CASA programs. The CASA concept is endorsed by the American Bar Association and the National Council of Juvenile and Family Court Judges. In 2022, there were over 900 CASA/GAL

[1] https://americorps.gov/sites/default/files/document/volunteering-civic-life-america-research-summary.pdf

programs across the country, with nearly 88,000 volunteers advocating for 227,000 abused and neglected children.

Most juvenile and domestic relations district courts (67%) in Virginia have an established CASA program. According to the judicial survey conducted for this study, juvenile court judges with CASA programs recognize the value of the CASA program and specifically, find benefit in the information provided to the court by the CASA volunteer on behalf of the child. Judges valued the objectivity of the report and the unbiased recommendations offered and expressed appreciation for the support provided to the child and family by the CASA volunteer.

Judges have discretion when deciding to appoint CASA volunteers. Judges also have discretion when deciding to support the development of a new CASA program. Without judicial support, a CASA program cannot fulfill its mission and thus has no purpose.

Many of Virginia's 27 local CASA programs were started at the request of judges. Information provided to the work group indicated that while most juvenile court judges in the state are supportive of and endorse the CASA program, there are some judges that do not. These judges do not see the value added by the program and express satisfaction with the stakeholders and partners working on behalf of the abused and neglected children in their court. They do not see the need for a CASA program given that their systems are functioning. These judges believe that, for their courts, a CASA program would be a disruption and not a benefit. On the other hand, there are judges that do not have access to CASA program services and are very interested in the development of a program in their respective courts.

The work group noted a significant obstacle to requiring local CASA program expansion is where judicial support does not exist. A mandate impedes judicial discretion, and for those courts that are not supportive of the concept, the program would not be welcomed. A mandate also does not allow for the locality to determine its own best practices, including the development of a CASA program.

Work Group Suggestions

- Develop model protocol for judicial evaluation of CASA reports.
- Develop education and training for judges that emphasizes the benefits of the CASA program, specifically the benefits to the child. Include information during the training on children and families who have received CASA program services.
- Develop education and training to enhance CASA program partnerships with guardians ad litem (GALs) and local bar associations.

Obstacle 5: Public Awareness and Misperceptions of the CASA Program

It became evident in the preparation for and conversation at the work group meeting that not all stakeholders are familiar with CASA, and that some misperceptions exist. The importance of educating stakeholders, partners, and the public on the role and operations of CASA programs and CASA volunteers was evident during the work group discussion. The various partners and stakeholders with whom CASA programs routinely interface include juvenile and domestic relations district court judges, local departments of social services, guardians ad litem, court personnel, parent attorneys, mental health providers, school personnel, local government officials, the media, and various community funders.

The work group discussed several areas where there are notable *misperceptions* of the CASA program and CASA volunteers.

Misperception 1: Being a CASA volunteer takes a great deal of time, so you cannot be a volunteer and work full time.

Reality: Representatives on the work group offered unique perspectives on the time requirements for volunteering. The time commitment varies, but it is not as burdensome as it seems. CASA volunteers typically only take one case at a time, and the monthly time commitment fluctuates depending on the status of the case. CASA volunteers come from all walks of life and are genuinely interested in finding solutions to complex problems. Most work part- or full-time and still can meet the requirements as a CASA volunteer.

Misperception 2: CASA volunteers are not appropriately trained.

Reality: In 6VAC20-160-120, the CASA regulations set forth requirements for CASA volunteer training. These regulations require a minimum of 30 hours of pre-service training and provide instruction on the topics that must be included in the pre-service training. As a part of that training, volunteers learn how to interview children and stakeholders and write a comprehensive, objective, unbiased court report. The training for CASA volunteers is trauma informed and focuses on the importance of family preservation and maintaining family connections.

Further, volunteers must have 12 hours of continuing education annually. CASA programs are required to provide volunteers with training opportunities designed to improve the volunteer's level of knowledge and skill with special attention to changes in the law, policies, and practices of other agencies involved or any developments in the understanding of child development, child abuse and neglect, and child advocacy.

Most programs in Virginia require more than the minimum number of hours. In addition to the training, preservice requirements include court observation of cases like those that the volunteer will be assigned.

Misperception 3: Local programs receive no oversight or guidance.

Reality: Local CASA programs have oversight from numerous outside entities. DCJS has regulatory and administrative oversight of Virginia CASA programs. Programs that are nonprofit organizations must comply with state and federal requirements regarding their nonprofit status, including having oversight by their governing boards, and the three programs under local government supervision have additional requirements by local units of government. As members of the national CASA organization, all programs must meet standard requirements. For fundraising purposes, each must meet the state fundraising requirements with the Virginia Department of Agriculture and Consumer Services. All programs must meet requirements regarding financial accounting and local business practices. If there are regulatory concerns, local programs are accountable to DCJS.

Misperception 4: CASA reports are inadmissible because they contain hearsay.

Reality: The work group discussed the importance of demystifying CASA's role in judicial decision making. The Virginia Court of Appeals held in Holley v. Amherst County Department of Social Services that CASA reports are admissible, and the *Code of Virginia* § 16.1-274(A) sets forth requirements for the filing and distribution of CASA reports to attorneys for the parties in advance of all hearings.

These misperceptions can be clarified and perhaps eliminated through intentional training of stakeholders, including training on the role of the CASA volunteer.

Work Group Suggestions

- Emphasize the benefits for the child, as well as the value of information provided to the court, when training judges on the CASA program.
- DCJS and the Virginia Department of Social Services should work together to develop a best practices protocol for establishing guidelines for local departments of social services and local CASA program collaborative partnerships.
- Develop creative strategies for education of guardians ad litem (GAL) on the role of CASA volunteers and the collaborative relationship with GALs. Working with GALs is critical for CASA volunteers. This is the only defined partnership for CASA volunteers in the *Code of Virginia*. A major concern identified by the work group is the decline in the available number of GALs to serve across Virginia. Therefore, the partnership between CASA volunteers and GALs is even more critical. The work group suggested exploring strategies for improving education of GALs on the role of CASA volunteers and GALs.
- Explore partnerships between local CASA programs and local bar associations.
- Develop a comprehensive public awareness program for stakeholders on the CASA program including training, supervision, and CASA program management and oversight.
- Educate stakeholders on the current content of CASA training to alleviate misconceptions and mistrust as the training has significantly evolved from when the program began.

Other Obstacles:

The work group identified several other obstacles for statewide expansion. The remaining courts to be served in the state are mostly in rural localities and will likely benefit from existing CASA program expansion rather than development of a new CASA program. Multi-jurisdictional CASA programs experience unique challenges when working in multiple localities. The expansive geography, distinct cultural and social communities within jurisdictions, funding challenges, and small numbers of children to be served all present unique challenges.

The process for CASA program expansion typically takes approximately two years to complete. The process is driven by a locality, and there are many steps necessary to fully execute new program development.

Since CASA programs are locally operated, most often by a nonprofit organization, with oversight provided by a board or administrative authority, the oversight authority must approve any expansion project. If there is not an existing CASA program in place, a new program structure must be developed.

CASA programs are regulated by DCJS and are also members of the National CASA/GAL Association. As such, they must comply with Virginia regulations, DCJS grant conditions for funding purposes, and National CASA/GAL standards for local programs. When considering program expansion or new program development into an unserved area, DCJS can provide instruction as to what is required by the CASA program staff and governing board authority to meet the various requirements.

DCJS works collaboratively with the local program staff or constituent planning group to complete the steps required to establish an expansion or new program development project, providing technical assistance and support as needed. When resources are available, DCJS provides grant funding for expansion and new program development. Finally, DCJS ensures the program expansion meets regulatory requirements for operations.

Work Group Suggestions

- Develop an expansion project “playbook” or tool kit for Virginia CASA program expansion efforts.

Conclusion

The work group's comprehensive analysis and recommendations aim to enhance the capacity and infrastructure of local CASA programs throughout the Commonwealth of Virginia. While the establishment of mandatory programs in every judicial district may not be feasible, the suggestions provide a roadmap for strategic improvements that will bolster the effectiveness of CASA initiatives in Virginia.

Appendices

Please contact Melissa O'Neill, *CASA Program Coordinator,* at melissa.o'neill@dcjs.virginia.gov or 804-293-0473 if interested in receiving the complete appendix materials.

Appendix A: Legislative Mandate

Chapter 2, Acts of Assembly, 2024 Special Session I, (394.B.3.c): The Department of Criminal Justice Services (the Department) shall convene a work group to study and make recommendations on requiring a local court-appointed special advocate (CASA) program to be established and available in every judicial district of the Commonwealth. The work group shall include the CASA Program Coordinator, representatives of at least two local CASA programs, at least two volunteer court-appointed special advocates, at least two judges of a juvenile and domestic relations district court and one judge of a circuit court sitting in a judicial district where a local CASA program is established, at least two judges of a juvenile and domestic relations district court and one judge of a circuit court sitting in a judicial district where no local CASA program has been established, a representative from the Department of Social Services, and any other stakeholders deemed appropriate by the Department. The work group shall identify any judicial districts in the Commonwealth where no local CASA program has been established and determine the feasibility, including analyzing any obstacles, of requiring the establishment of a local CASA program in every judicial district. The work group shall report its findings and recommendations to the Governor and the General Assembly by November 1, 2024.

Appendix B: Juvenile and Domestic Relations District Court Judges Survey Report

In preparation for the work group meeting, Virginia Department of Criminal Justice Services (DCJS) developed a survey for Juvenile and Domestic Relations District Court Judges about the possibility of a CASA program expansion to every judicial district in the Commonwealth. The Office of the Executive Secretary of the Supreme Court of Virginia emailed the survey to every juvenile court judge; responses were received from 56 judges (39%), 47 with CASA programs and nine without.

Appendix C: Local CASA Program Survey Report

DCJS surveyed CASA Program Directors in May 2024 about the possibility of a CASA program expansion in every judicial district in the Commonwealth. Responses were received from 26 of 27 programs directors (96%).

Appendix D: Local CASA Program Focus Group Report

DCJS facilitated three local CASA program focus groups centered on the feasibility, benefits, challenges, and obstacles of the proposed mandate to establish a local CASA Program in every judicial district of the Commonwealth. The participants were selected to participate in the focus group based on their past or current experience in program expansion into multiple jurisdictions.

Appendix E: Need by Judicial District Report

Developed for this study, the report identifies every judicial district in the Commonwealth and where CASA program services are available. Additional data is included on the estimated number of underserved and unserved children in judicial districts.

Appendix F: Work Group Presentation

DCJS developed a presentation for the meeting which included a CASA program overview, requirements for CASA program development and sustainability, and CASA program data. The work group then reviewed the materials sent in advance. Finally, the presentation contained an approximation of the additional costs needed for potential expansion.

COMMONWEALTH of VIRGINIA
Office of the Governor

Office of the Children's Ombudsman
Eric J. Reynolds, Esq., Director

October 1, 2024

The Honorable Glenn Youngkin
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Members of the General Assembly
General Assembly Building
923 East Broad Street
Richmond, Virginia 23219

James Williams, Commissioner
Virginia Department of Social Services
5600 Cox Road
Glen Allen, Virginia 23060

Dear Governor Youngkin, Members of the General Assembly, and Commissioner Williams,

I am pleased to submit the 2024 Annual Report of the Office of the Children's Ombudsman in accordance with § 2.2-447 of the Code of Virginia. The statute requires me, as Director of the Office, to report on its activities each year, including any recommendations regarding the need for legislation or for a change in rules or policies.

If you need any additional information, please do not hesitate to contact me by email at eric.reynolds@governor.virginia.gov or by telephone at 804-225-4823.

Respectfully submitted,

Eric J. Reynolds, Director
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2024 ANNUAL REPORT

OFFICE OF THE CHILDREN'S OMBUDSMAN

RICHMOND, VIRGINIA

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EXECUTIVE SUMMARY

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

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

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

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

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

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

Recommendations for System Changes.

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

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

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

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

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

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

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

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

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

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

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

ABOUT THE OFFICE OF THE CHILDREN'S OMBUDSMAN

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

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

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

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

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

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

Staff:

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

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

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

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

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

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

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

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

Acronyms used in this Report:

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

FY2024 LEGISLATIVE ADVOCACY

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

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

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

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

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

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

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

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

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

FY2024 OCO ACTIVITIES

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

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

COMPLAINTS AND INVESTIGATIONS

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

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

Virginia Code § 2.2-441.

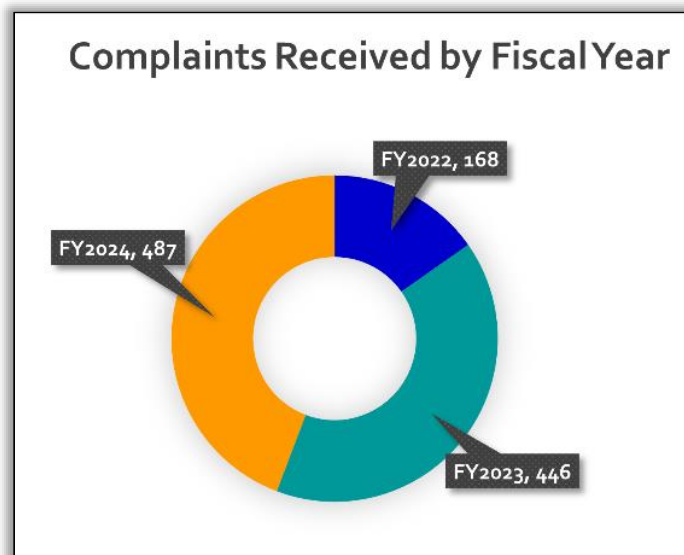
The OCO is required to prepare a report of the factual findings of an investigation and make recommendations to the agency being investigated if we find any of the following:

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

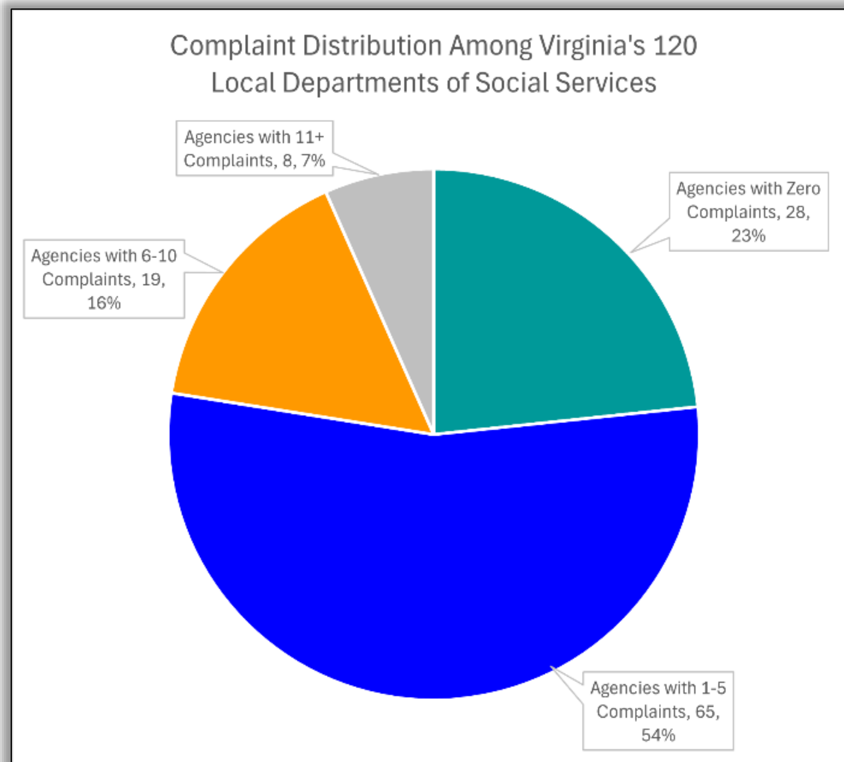
Virginia Code § 2.2-447(A).

COMPLAINTS

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



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

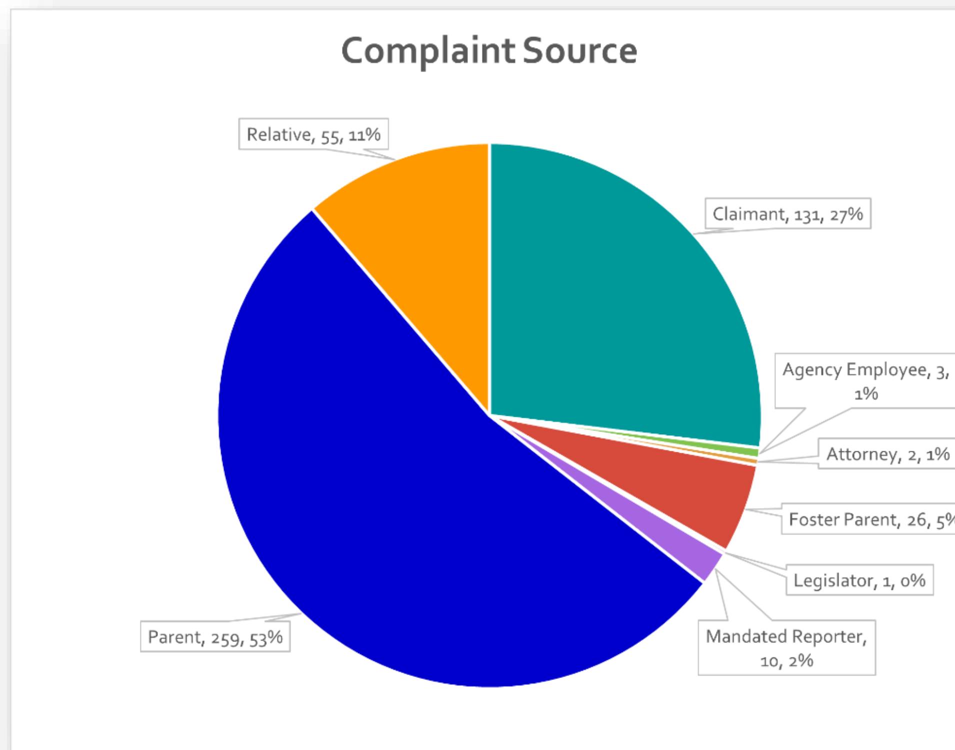


Complainants. A statutory complainant is any one of the following individuals as listed in Virginia Code § 2.2-441:

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

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

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

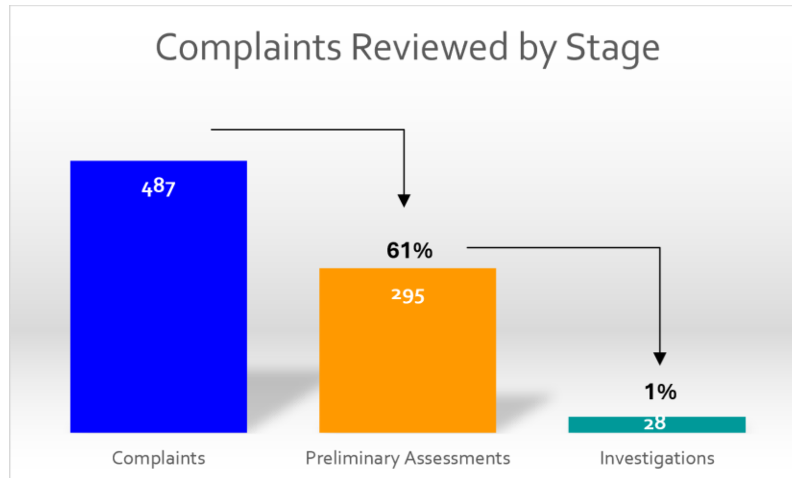


Disposition of Complaints (as of June 30, 2024):

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

PRELIMINARY ASSESSMENTS

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



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

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

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

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

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

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

Disposition of Preliminary Assessments:

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

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

INVESTIGATIONS

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

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

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

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

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

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

Case 1

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

Findings:

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

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

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

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

Case 2

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

Findings:

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

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

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

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

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

Case 3

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

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

Findings and recommendations:

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

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

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

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

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

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

Case 4

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

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

Case 5

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

Findings:

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

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

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

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

Case 6

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

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

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

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

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

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

Case 7

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<u>Case 8</u>

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

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

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

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

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

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

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

Case 9

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

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

Findings:

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

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

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

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

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

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

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

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

Case 10

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

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

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

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

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

Case 11

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

Findings.

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

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

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

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

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

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

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

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

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

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

CHILD FATALITIES

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

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

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

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

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

Gender	Number of Children
Female	24
Male	30

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

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

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

Conditions at the time of death/family history.

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

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

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

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

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

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

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

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

Gender	Number of Children
Female	15
Male	15

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS FOR SYSTEM CHANGES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[10] VDSS Child and Family Services Manual, Part C, Section 10.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Child Maltreatment Death Investigations

In Virginia During State Fiscal Year 2023

Prepared by:

Child Protective Services Program

June 2024

VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

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Child Death Investigations
During State Fiscal Year 2022

EXECUTIVE SUMMARY

This is a report on child deaths that were reported to local departments of social services (LDSS) and investigated during State Fiscal Year (SFY) 2023. This report includes a synopsis of data for all child abuse or neglect fatalities for SFY 2023, including demographic information pertaining to the victims, alleged abuser/neglector(s) and households impacted by those fatalities. It also highlights changes or trends from previous years. The information is used to evaluate and modify Virginia Department of Social Services (VDSS) policies, guidance, procedures, and best practices where warranted.

The purpose of this report is to provide information on all child deaths that were investigated, with an emphasis on those deaths that occurred as a result of substantiated abuse or neglect. This report includes two appendices. Appendix A provides details for investigations that resulted in a founded disposition; Appendix B provides details of investigations that resulted in unfounded dispositions. A founded disposition means that a preponderance of the evidence demonstrates that child maltreatment occurred. This determination is based primarily upon first source, or direct evidence. A disposition of unfounded means there was not a preponderance of the evidence to warrant a founded disposition.

PRELIMINARY SUMMARY OF FINDINGS

In SFY 2023:

- LDSS investigated 173 child deaths suspected of being caused by abuse or neglect.
- Five child deaths suspected of being caused by abuse or neglect occurred in an out-of-family setting.
- There were 38 children whose deaths were the result of abuse or neglect.
- There were 107 investigations that resulted in an unfounded disposition; twenty-six investigations were pending at the time of this report and the dispositions for two investigations were appealed.
- Sixty-four LDSS conducted at least one child death investigation.
- The Eastern Region and the Northern Region investigated the most child deaths (50), while the Western Region experienced the highest rate of child deaths (4.7 deaths per 100,000 children).
- Children who died as a result of abuse or neglect ranged in age from birth to 16 years with 75% who were three and under.

- More male children (21) died from abuse or neglect than female children (17).
- The race of the children who died as a result of abuse or neglect included 45% who were White; 39% who were African American and 10% who were multi-racial.
- Fifty-five caretakers were determined to be responsible for the death of 38 children; thirty-five of the caretakers were female and 20 were male.
- Thirty-six (65%) of the 55 caretakers were biological parents, and 24 (44%) of them were between 30 and 39 years old.
- Twenty-eight (74%) of the 38 abuse-or-neglect-related child deaths involved physical neglect, and 9 (24%) child deaths involved physical abuse. Some children died from more than one type of abuse and/or in combination with physical neglect or medical neglect.
- Twenty-seven families (71%) had prior or active child welfare involvement.
- Twenty-seven families had other children living in the home at the time of the fatality.

I. CHILD DEATHS

LDSS conducted 171 investigations involving 173 child deaths suspected of being caused by child maltreatment in SFY 2023. LDSS determined that 38 children died as a result of abuse or neglect; 107 children were in unfounded reports; twenty-six reports were pending at the time of this report; and two reports were appealed.

The Eastern (50) and Northern (50) Regions investigated the most reports followed by Piedmont (37), Central (22), and Western (12).

As highlighted in Table 1, 64 (53%) of the 120 LDSS investigated at least one child death. Virginia Beach (12), Norfolk (9) and Prince William (9) had the highest number of investigations, not all of which were founded.

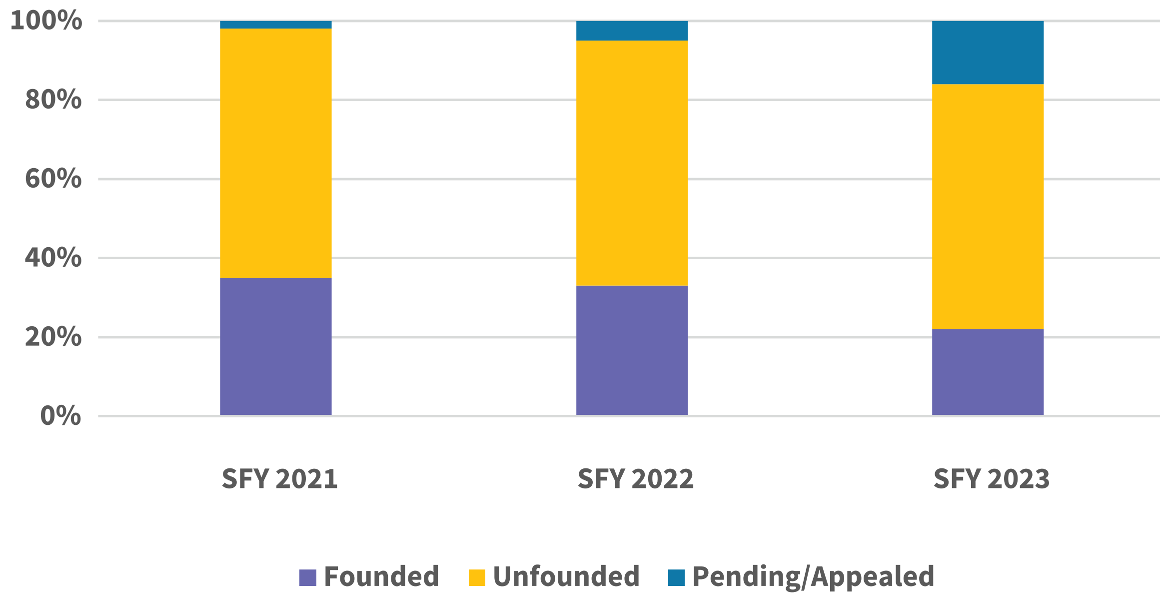
Table 1: Dispositions of CPS Complaints with a Child Death by Locality

LDSS	Founded	Unfounded	Pending/ Appeal	Grand Total
Albemarle		2		2
Alexandria		2		2
Arlington	1	3	2	6
Augusta	1	1	2	4
Bedford County	1			1
Botetourt			1	1
Buckingham		1		1
Chesapeake	1	4	1	6
Chesterfield		1	1*	2
Culpeper		1		1
Danville		2		2
Fairfax County	1	3	4	8
Fauquier		1		1
Franklin County	1			1
Franklin City		1		1
Frederick		1		1
Fredericksburg	1			1
Giles		2		2
Halifax			1	1
Hanover	1			1
Hampton	1	1		2
Harrisonburg		1	1	2
Henrico	1	5		6
Henry	1	1		2
Hopewell		1		1
Isle of Wight		1		1
James City	2	1		3
King George	1	1		2
Lee		2		2
Loudoun	1	2		3
Louisa	1			1
Lunenburg	1			1
Lynchburg	2	1	1	4
Manassas		2		2
Mecklenburg	1	3		4
Newport News	2	1		3
Norfolk	2	4	3	9
Northumberland		1		1
Norton		1		1
Petersburg		1		1
Pittsylvania		3		3
Portsmouth	2	5		7
Prince Edward		1		1
Prince William	1	8		9
Pulaski	1			1
Richmond City		6		6
Roanoke County		1	3	4
Roanoke City	1	1	3	5
Rockbridge			2	2
Scott	1	1		2
Shenandoah County		2		2
Smyth	2			2
Spotsylvania	2	4		6
Stafford		1		1
Staunton		1		1
Suffolk	1	1		2
Sussex		1		1
Tazewell	1			1
Virginia Beach	1	10	1	12
Warren		1		1
Westmoreland		1		1
Winchester		1		1
Wise		1		1
York	1	2		3
GRAND TOTAL	**38**	**107**	**26**	**171**

Sources: VDSS, June 2024. Information obtained from LDSS
*One investigation involved the deaths of three children

As exhibited in Table 2, the percentages of **founded** versus **unfounded** dispositions involving child fatalities decreased for founded (22%) dispositions.

Table 2: Dispositions of Child Death Investigations



Sources: VDSS, June 2023. Information obtained from LDSS.
One investigation was unable to be completed.

As shown in Table 3, the death rate for children who died from abuse or neglect decreased from SFY 2022. According to the National Child Abuse and Neglect Data System (NCANDS) 2022 Child Maltreatment Report the national estimate of child deaths due to maltreatment has increased 12.7% since FFY 2018. Due to the relatively low frequency of child fatalities, the national rate is sensitive to which states report this data and changes in the child population estimates produced by the U. S. Census Bureau.[1]

Table 3: Death Rate of Children in Virginia Due to Abuse or Neglect SFY 2011- SFY 2023

SFY	Death Reports Investigated	Deaths Due to Abuse/Neglect	Death Rate (per 100,000)	National Death Rate**
2011	86	30	1.6	2.0
2012	107	37	2.0	2.1
2013	105	33	1.8	2.2
2014	124	47	2.5	2.0
2015	131	52	2.8	2.1
2016	129	46	2.5	2.3
2017	124	46	2.5	2.3
2018	118	40	2.1	2.3
2019	144	51	2.7	2.4
2020	139	42	2.2	2.5
2021	171	59	3.2	2.4
2022	164	54	2.7	2.4
2023	**171**	**38**	**2.0**	**2.7**

*Death rate is calculated as number of deaths due to abuse/neglect divided by the state child population (2022 = 1,866,910)
Sources: VDSS, June 2024, Kids Count Data Center from the Annie E Casey Foundation
** Source: *Child Maltreatment 2022.* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

[1] Source: *Child Maltreatment 2022*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

As exhibited in Table 4, there were twenty-six pending investigations in SFY2023. The Code of Virginia, specifically § 63.2-1505 B5, grants certain exceptions to the time frame for completing child death investigations, when such investigations require reports or records that are generated outside of the local department, such as an autopsy report. The time needed to obtain these reports or records is not counted towards the 45/60/90-day timeframes. The records must be necessary to complete the investigation and not available due to circumstances beyond the control of the local department.

Table 4: Child Fatality Investigations and Outcomes by Region

	Founded		Unfounded		Pending		Appealed		Total	
	#	%	#	%	#	%	#	%	#	%
Central	3	13.6	18	81.9	1*	4.5	0	0.0	22	100.0
Eastern	13	26.0	32	64.0	3	6.0	2	4.0	50	100.0
Northern	9	16.0	34	70.0	7	14.0	0	0.0	50	100.0
Piedmont	8	22.0	16	43.0	13	35.0	0	0.0	37	100.0
Western	5	42.0	7	58.0	0	0.0	0	0.0	12	100.0
Statewide	**38**	**21.0**	**107**	**63.0**	**24**	**14.0**	**2**	**1.0**	**171**	**100.0**

Sources: VDSS, June 2024. Information obtained from LDSS.
*One investigation involved the deaths of three children.
.

VDSS also reports by region the ratio of child deaths to the population of children less than 18 years of age, as well as examines the number of child deaths and the percentages of founded investigations.

As exhibited in Table 5, the rate of child deaths per 100,000 children has decreased in the Central and Western Regions since SFY 2021. It should be noted that an increase of one or two child deaths would have a more significant impact on regions with a low child population (i.e. the Western Region) versus a region with a high child population (i.e. the Eastern Region).

Table 5: Child Deaths Due to Abuse or Neglect and Rates by Region

	SFY 2021		SFY 2022		SFY 2023	
	Deaths	**Rate** (Per 100,000)	**Deaths**	**Rate** (Per 100,000)	**Deaths**	**Rate*** (Per 100,000)
Central	12	4.0	10	3.4	3	**1.0**
Eastern	16	3.9	11	2.7	13	**3.2**
Northern	7	0.8	16	2.0	9	**1.1**
Piedmont	14	5.9	8	3.4	8	**3.3**
Western	10	9.5	9	8.5	5	**4.7**

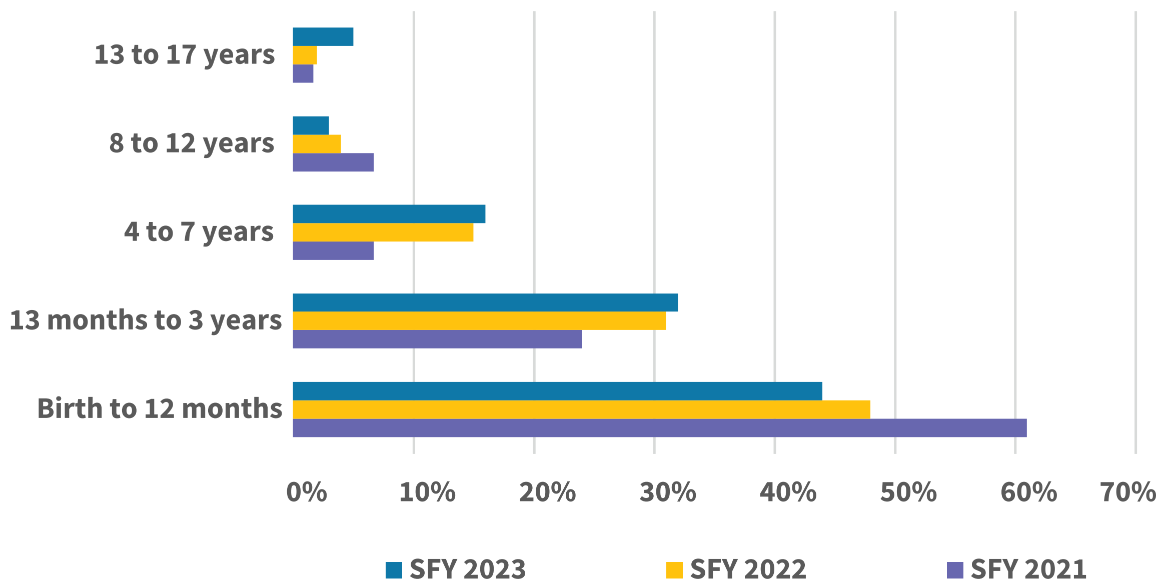
Sources: VDSS, June 2024. Information obtained from LDSS. Kids Count Data Center from the Annie E Casey Foundation. *The population data used to determine rate per 100,000 for children <18 years of age by region are: Central: 294,304; Eastern: 408,211; Northern: 801,031; Piedmont: 236,312; Western: 105,704.

II. CHILDREN

LDSS investigated the deaths of 173 children in SFY 2023; and 38 children were found to have died as a result of abuse or neglect. This section provides detailed demographic information and trends for the children involved in child death investigations and whose deaths were determined to be the result of abuse or neglect.

As highlighted in Table 6, children under the age of three continue to be the most vulnerable to die as a result of abuse or neglect. Virginia's percentage for SFY 2023 was 76%, which is higher than the percentage throughout the country. Nationally, 66.1% of all child fatalities in FFY 2022 were children younger than three years of age.[2]

Table 6: Children Who Died From Abuse or Neglect by Age



Sources: VDSS, June 2024. Information obtained from LDSS.

[2,3,4] Source: *Child Maltreatment 2022*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

As shown in Table 7, there were more male child deaths than female in SFY 2023. This is consistent with the national data which indicates that boys experienced a higher fatality rate (3.26 per 100,000) than girls (2.25 per 100,000).[3]

Table 7: Children Who Died From Abuse or Neglect by Gender

	SFY 2021			SFY 2022			SFY 2023		
	#	%	Rate (per 100,000)	#	%	Rate* (per 100,000)	#	%	Rate* (per 100,000)
Female	25	42.4	2.7	23	42.6	2.5	17	45.0	1.8
Male	34	57.6	3.5	31	57.4	3.2	21	55.0	2.1
Total	**59**	**100.0**	**3.1**	**54**	**100.0**	**2.9**	**38**	**100.0**	**2.0**

Sources: VDSS, June 2024. Information obtained from LDSS. Kids Count Data Center from the Annie E Casey Foundation. *The population data used to determine rate per 100,000 for children <18 years of age was females: 909,967 and males: 956,943.

As exhibited in Table 8, 46% of the children who died as a result of abuse or neglect in Virginia were White and 41% were African American. The disproportionate rate of African American child deaths in Virginia is slightly below the national data.[4]

Table 8: Children Who Died From Abuse or Neglect by Race

	SFY 2021		SFY 2022		SFY 2023		
	Number	Percent	Number	Percent	Number	Percent	Rate* (per 100,000)
African-American	16	38.0	19	32.2	18	33.0	4.8
White	20	48.0	29	49.2	32	59.0	3.2
Multi-racial	5	12.0	9	15.3	3	6.0	2.5
Asian	0	0.0	1	1.7	0	0.0	0.0
Unknown	1	2.0	1	1.7	1	2.0	N/A
Total	**42**	**100.0**	**59**	**100.0**	**54**	**100.0**	**2.8**

Sources: VDSS, June 2024. Information obtained from LDSS. Kids Count Data Center f/t Annie E Casey Foundation. *The population data used to determine rate per 100,000 for children <18 years of age was African American: 374,628; White: 979,043; multi-racial: 116,030; Asian: 129,217; total: 1,886,910.

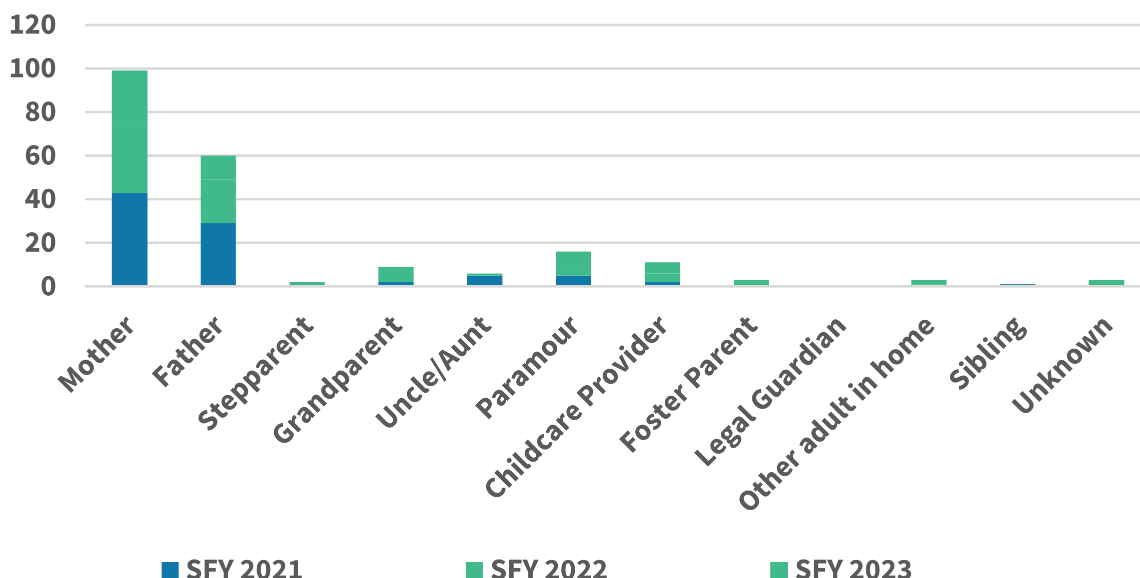
[3,4] Source: *Child Maltreatment 2022.* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

III. CARETAKERS

CPS investigates child fatalities that are suspicious for abuse or neglect committed by a caretaker **only**.

As shown in Table 9, LDSS determined that there were 55 caretakers responsible for the deaths of 38 children due to abuse or neglect in SFY 2023. Sixteen victims were abused or neglected by two different caretakers and one victim was abused or neglected by three different caretakers. The majority of caretakers (65%) were the biological parents, which is less than the national data (81.8%) that indicates the parents acted alone, together or with other individuals.[5] Caretakers also include regulated (licensed) childcare providers.

Table 9: Caretakers in Child Deaths from Abuse or Neglect



Source: VDSS, June 2024. Information obtained from LDSS.

Nationally, more than 10 percent (13.2%) of fatalities did not have a parental relationship to their perpetrator.[6] Sometimes the identity of a caretaker is unknown. Unknown is used when an investigation reveals that the child was physically abused or neglected, but the LDSS is unable to establish the identity of the responsible caretaker. If new information is received regarding the identity of the caretaker, a new investigation may be conducted.

[5, 6] Source: *Child Maltreatment 2022*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

As highlighted in Table 10, the race of the caretakers was primarily White (56%) and African American (40%).

Table 10: Race of Caretakers in Child Deaths from Abuse or Neglect

	SFY 2021		SFY 2022		SFY 2023	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
African-American	26	30.0	21	29.0	22	40.0
White	52	60.0	41	58.0	31	56.0
Asian	1	1.1	0	0.0	0	0.0
Unknown	4	4.6	9	13.0	2	4.0
Multi-racial	4	4.6	0	0.0	0	0.0
Total Caretakers	**87**	**100.00**	**71**	**100.0**	**55**	**100.0**

Source: VDSS, June 2024. Information obtained from LDSS.

As shown in Table 11, there are typically more female perpetrators of child maltreatment than male perpetrators.

Table 11: Gender of Caretakers in Child Deaths from Abuse or Neglect

	SFY 2021		SFY 2022		SFY 2023	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Female	54	62.0	37	52.0	35	63.6
Male	33	38.0	31	44.0	20	36.4
Unknown	0	0.0	3	4.0	0	0.0
Total Caretakers	**87**	**100.0**	**71**	**100.0**	**55**	**100.0**

Source: VDSS, June 2024. Information obtained from LDSS.

As exhibited in Table 12, the ages of caretakers ranged from 18 to 63 years in SFY 2023. The majority of the caretakers (44%) were between 30 and 39 years of age.

Table 12: Age of Caretakers in Child Deaths from Abuse or Neglect

	SFY 2021		SFY 2022		SFY 2023	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Under 20 years	8	9.1	3	4.0	1	2.0
20 to 29 years	38	44.0	36	51.0	19	35.0
30 to 39 years	27	31.0	18	25.0	24	44.0
40 to 49 years	9	10.3	3	4.0	4	7.0
50 or older	4	4.6	5	7.0	7	12.0
Unknown	1	1.1	6	9.0	0	0.0
Total	**87**	**100.0**	**71**	**100.0**	**55**	**100.0**

Source: VDSS June 2024. Information obtained from LDSS.

IV. CATEGORIES OF ABUSE AND NEGLECT

In SFY 2023, 38 children died as a result of at least one type of abuse or neglect. Some children were abused or neglected in more than one way and by more than one caretaker. Of the children who died, 28 (74%) had been physically neglected and 9 (24%) had been physically abused. One child (2%) was medically neglected.

The type of abuse or neglect is not necessarily the *cause of death* for the child. For example, a child accidentally, fatally shot himself. The cause of death (determined by the medical examiner) would be gunshot wound of the head; the type of abuse or neglect (determined by CPS) would be neglect (failing to do something on behalf of the child).

As highlighted in Table 13, 27 (73%) of the child deaths involved some type of physical neglect. The two most prevalent types of neglect were Inadequate Supervision and Other/Unspecified sub-type. When determining the validity of a report, the alleged inaction by the caretaker may not clearly fit into the pre-defined sub-categories but still encompasses physical neglect so the Other/Unspecified sub-type is utilized by the LDSS.

Table 13: Types of Neglect in Child Deaths

	SFY 2021	SFY 2022	SFY 2023
Abandonment	0	0	0
Inadequate Supervision	15	12	10
Inadequate Shelter	1	0	1
Inadequate Food	0	0	0
Failure to Thrive	0	0	0
Medical Neglect	0	0	0
Other/Unspecified sub-type	22	23	17

Source: VDSS, June 2024. Information obtained from LDSS

Medical neglect directly caused or contributed to the death of one child (3%). Medical neglect involves a caretaker's failure to obtain a child's necessary medical care or to follow doctor-recommended medical regimen for the child.

As illustrated in Table 14, 9 (24%) children died as a result of physical abuse in SFY 2023.

Table 14: Types of Abuse in Child Deaths

	SFY 2021	SFY 2022	SFY 2023
Asphyxiation (accidental or intentional	3	0	0
Bone Fracture	1	1	1
Burns	0	0	0
Bruises	1	0	0
Gunshot	0	1	0
Poisoning	2	3	2
Abusive Head Trauma	0	1	0
Stabbing	0	0	0
Internal Injuries	1	0	0
Head Injury	3	3	0
Chronic Physical Abuse[1]	0	0	0
Other or Unspecified Type	8	7	6

Source: VDSS, June 2024. Information obtained from LDSS.
[1] Chronic Physical Abuse, formerly known as Battered Child Syndrome.

V. FAMILIES AND THE CHILD WELFARE SYSTEM

When initiating a response to a child fatality report, CPS assesses immediate harm or threat of harm toward any sibling(s) or other child(ren) in the home. Based on this initial safety assessment, a safety plan may be developed with the family for a course of action to mitigate any danger(s) or threat(s) of harm. The following information identifies those families and the resulting protective action taken by the LDSS.

As shown in Table 15, there were 38 households that involved 38 child death investigations resulting in founded dispositions for SFY 2023; 27 (71%) of those households had other children for whom initial safety was assessed. All of the remaining households had no other children in the home.

Table 15: Initial Safety Outcomes for Other Children in the Household

	SFY 2021	SFY 2022	SFY 2023
	# Families	# Families	# Families
Safety plan with family	10	12	14
Safety plan with relatives/family friends	25	25	11
Emergency removal/foster care	7	0	2
Total Families	**42**	**37**	**27**

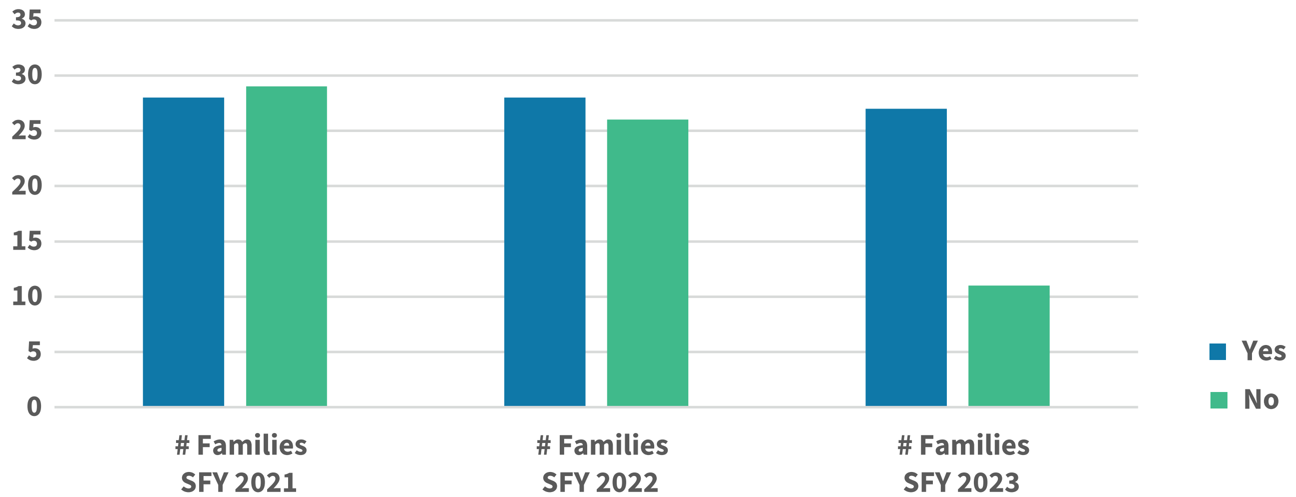
Source: VDSS, June 2024. Information obtained from LDSS.

In SFY2023, a plan was developed with 14 households that allowed the siblings to remain in their own homes. An additional 11 households placed their children in alternate living arrangements with relatives or family friends, while maintaining legal custody of their children.

As a result of CPS involvement, families were provided services that include grief counseling; burial assistance; home visiting; parent education and mental health services; substance use assessments and treatment; intimate partner violence services; and protective orders.

As exhibited in Table 16, there were 38 victims (38 households) in founded CPS fatality investigations for SFY 2023; 27 families (71%) had prior or active child welfare involvement.

Table 16: Prior Family Child Welfare Involvement in Child Deaths from Abuse or Neglect



Source: VDSS, June 2024. Information obtained from LDSS.

Prior involvement means that the alleged abuser, victim child or siblings were previously the subject of a family assessment, an investigation, in-home services, or foster care case. It does not include any caretaker's history of abuse or neglect that occurred as a child or any reports of suspected child abuse or neglect that did not meet validity criteria. Prior involvement also includes any open family assessment, investigation, or case at the time of the child's death. It may also have occurred in more than one locality or a locality different from where the child died. See the Table of Founded Child Deaths in Appendix A for further details.

VI. REGIONAL CHILD FATALITY REVIEW TEAM ANALYSIS

Regional Child Fatality Review Teams (CFRT) 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. The Code of Virginia, specifically §32.1-283.2 provides the authority for the work of CFRT.

There is a CFRT, which is multidisciplinary in structure, in each of the five VDSS regions. As of January 1, 2024, the regional review teams were restructured in order to enhance the quality of the review process, enhance the quality of the recommendations that are developed during the meetings, and

to increase capacity across programs within the Virginia Department of Social Services (VDSS) to strengthen prevention work. Historically, regional review teams reviewed every child death that was investigated by Child Protective Services. The regional review teams will only review the child fatality investigations that meet the following criteria:

1. Current open DSS referral/case at the time of the fatality
2. Valid or invalid CPS report within last 12 months
3. Child died while in foster care (not from natural death and no complaint in foster home)
4. Child died in foster care on a trial home placement
5. Foster care case involving decedent or decedent's siblings was closed within the last 24 months

This is the same criteria that requires VDSS to notify the Office of the Children's Ombudsman when an LDSS validates a CPS referral involving a child fatality.

Each Regional Child Fatality Review Team reports annually the significant findings and themes from the reviews as well as recommendations or initiatives that result from the team's discussion of that year's child death cases. Highlights of SFY 2022's regional recommendations:

- Enhance public awareness campaigns related to safe sleep practices while continuing to target under reached populations such as the recovery community, fathers, grandparents, older siblings, and non-familial caretakers.
- Improve local and state partnerships with community resources to promote safe sleep messaging to ensure families are receiving safe sleep education prior to child welfare involvement.
- Provide more educational materials in multiple languages.

In response to these recommendations, VDSS implemented the following projects and initiatives:

- Created infographics around safe sleep practices, gun safety, and water safety that were made available for LDSS staff and the public. All three resources are available on the VDSS public website and are available in multiple languages.
- VDSS developed and distributed two brochures *Guide for Using Recreational Marijuana While Parenting and Parent's Guide for Safe Storage of Marijuana* to local agencies and community partners to educate parents on safe marijuana use and storage.
- Highlighted LDSS staff/units who are doing prevention work within their own communities. Agencies have included Washington County, Winchester, and Lynchburg for their work around safe sleep education in collaboration with their community partners.
- Participation in the Safely to Their First Birthday affinity group which is led by the National Partnership for Child Safety (NPCS). The affinity group works to develop consistent, equitable, and compassionate child welfare responses to sudden unexpected infant deaths (SUIDs), as well as the identification of upstream practices for SUID prevention.

The following are highlights of SFY 2023's regional recommendations:

- Increase safe sleep education and messaging for parents/caregivers with a history of substance use, as substance use continues to be a risk factor in many child fatality investigations.
- Collaborate with community health providers to create educational materials for parents/caregivers on the impact of substance use while pregnant, with an emphasis on the long-term impact and increased risk to infants who are born substance exposed.
- Create a public awareness campaign on gun safety and proper storage of firearms and ammunition.

VII. UNFOUNDED REPORTS

In SFY 2023, there were 107 (62%) child fatality reports and investigations with an unfounded disposition. An unfounded disposition does not mean the abuse or neglect did not occur. An unfounded disposition means the investigation lacked a preponderance of the evidence to warrant a disposition of founded.

Of the 107 unfounded reports:

- Seventy-four of the reports (69%) involved a child less than one year of age.
- Fifty-five of the 107 reports (51%) were sleep related. This means the actual surface the child slept on, with whom the child was sleeping, or how the child was sleeping. This includes children who suffocated or accidently asphyxiated due to their sleep environment.

Many of the sleep-related child deaths resulted in a determination by a medical examiner that the cause of death was Sudden Unexplained Infant Death (SUID). SUID is a diagnosis of exclusion, made when there is an absence of pathological findings revealing injury, violence, disease, or other fatal medical condition. A SUID diagnosis recognizes a host of confounding factors, most importantly, the presence of unsafe sleep factors and/or medical problems such as pneumonia, prematurity, or congestion[7].

VIII. PATTERNS AND TRENDS

VDSS tracks additional data to identify trends or patterns that inform prevention initiatives throughout the state. In addition to demographic information on the victim children and the families impacted by those fatalities, factors that influence family health and functioning are collected when such information is available. This specific information is sensitive to which LDSS capture this information throughout the life of their investigation.

[7] Excerpt from Sleep-Related Infant Deaths in Virginia, a report from the Virginia State Child Fatality Review Team.
http://www.vdh.virginia.gov/medExam/childfatality-reports.htm

In SFY2023, a substance use component was present in 62 (36%) of all fatality investigations. This could mean that substance use was occurring in the home at the time of the fatality, or the parent(s)/caregiver(s) has a documented history of substance use. This percentage also includes the 22 victim children who were born substance exposed. In 10 investigations, exposure to substances either contributed to or directly caused the child's death as determined by a medical examiner.

Because substance use remains prevalent across many fatality investigations, VDSS participates in a monthly collaborative of key state stakeholders, including Department of Medical Assistance Services, Department of Behavioral Health and Developmental Services, and the Department of Health, to improve the statewide response to Substance-Exposed Infants. Additionally, VDSS serves on the Steering Committee of a statewide workgroup, Pathways to Coordinated Care, led by the Virginia Department of Health (VDH). The workgroup consists of over sixty diverse members including public and private stakeholders and partners. The workgroup is focused on the needs of substance-exposed infants and their caregivers. The pandemic created some delays, but VDH has hired a new position to assist in resuming this workgroup and the work should resume in fall 2024.

Data is also collected around which families have experienced intimate partner violence (IPV). Twenty-eight (16%) families had a documented incident(s) of intimate partner violence prior to the child fatality. This could mean that CPS was previously involved with the family due to IPV or law enforcement reports prior IPV after the LDSS is notified about the child fatality.

IX. NEAR-FATALITIES

CAPTA (Child Abuse Prevention and Treatment Act) defines a "near fatality" as *an act that, as certified by a physician, places the child in serious or critical condition (22VAC40-705-10). "Life-threatening condition" means a condition that if left untreated, more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.*

There were 38 near-fatalities reported and investigated by the LDSS for possible abuse or neglect. Twelve of the 38 children were under the age of one, fifteen were between 13 months old and 3 years old, and the remaining eleven children ranged in age from four to 17 years old. Fifty percent (19) of the children were male and 50% (19) were female. The race of the children was 34% African American; 50% White; 3% Asian; 8% Unknown; and 5% Multi-Racial. Twenty-two of the 38 investigations (58%) were founded for abuse or neglect; sixteen of the families had prior child welfare involvement.

X. APPENDICES

A. TABLE OF CHILD DEATH INVESTIGATIONS WITH A FOUNDED DISPOSITION

Locality	"Date of Death"	Date of Birth	Age (years)	Child Sex	Race	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
York	7/7/2022	8/23/2020	1.9	Female	W	father mother grandfather	Physical Abuse Physical Neglect Physical Abuse	In September 2020, York DSS opened a Family Assessment due to the decedent being born substance exposed and experiencing significant withdrawal symptoms. The assessed risk was high and an in-home case was opened with the family; services were provided.	Child was found unresponsive in the home. Cause of death is acute combined overdose with tobacco exposure and laboratory evidence of SARS-COVID-19 viral infection.
Lynchburg	7/16/2022	12/12/2021	0.6	Male	AA	father	Physical Abuse	None.	Child was found unresponsive in the home. Cause of death is undetermined.
Smyth	7/19/2022	1/28/2022	0.5	Male	W	mother	Physical Neglect	In November 2021, Smyth DSS opened a Family Assessment due to the decedent being born substance exposed. Services were provided.	Child was found unresponsive in the home. Cause of death is suffocation with methamphetamine exposure contributing.
Virginia Beach	8/1/2022	3/22/2020	2.4	Female	AA	mother	Physical Abuse	None.	Child was found unresponsive in the home. Cause of death is acute diphenhydramine toxicity.
Loudoun	8/3/2022	6/11/2022	0.1	Female	AA	mother father	Physical Neglect Physical Neglect	None.	Child was found unresponsive in the home. Cause of death is undetermined.
James City	8/9/2022	3/24/2022	0.4	Male	W	childcare worker (unreg)	Physical Neglect	None.	Child was found unresponsive in the babysitter's home. Cause of death is SUID associated with unsafe sleep.
Newport News	9/4/2022	9/23/2021	0.9	Male	AA	mother mother's paramour	Physical Neglect Physical Neglect	None.	Child was found unresponsive in the home. Autopsy report not documented.
Bedford County	9/11/2022	4/16/2022	0.4	Male	AA	foster parent foster parent	Physical Neglect Physical Neglect	The mother and her two oldest children had ongoing CPS involvement since 2020 due to substance use and inadequate shelter. Lynchburg DSS conducted four family assessments on the family between March of 2020 and April 2022. They opened an In-Home Services case in July 2022 and sought a Child Protective Order (CPO). In August 2022, Lynchburg DSS executed a removal of all three children when the CPO was violated. Services were provided.	Child was found unresponsive in the foster home. Autopsy results not documented.
Henry	9/18/2022	11/25/2019	2.8	Female	W	mother	Physical Neglect	Between 2013 and 2014, Patrick County DSS conducted four CPS Investigations on the family for allegations of physical neglect and substance-exposed infant. The investigations resulted in one Founded Level 1 disposition, one Founded Level 2 disposition, and two Founded Level 3 dispositions. The risk on all four investigations was very high. Patrick County DSS had an In-Home Services case on the family from February 2005 until March 2006. The children were in foster care in Patrick County from 2013 to 2014 and 2014 to 2017. Services were provided.	Child was found unresponsive in a bath tub. Cause of death is complications of drowning.
Louisa	10/3/2022	9/3/2022	0.1	Female	W	mother	Physical Neglect	In September 2022, Louisa opened a Family Assessment after the decedent as born substance exposed to the mother's prescribed Methadone. This Family Assessment was open at the time of the fatality.	Child was found unresponsive in the home. Cause of death is SUID associated with co-sleeping in an adult bed, soft bedding, and a cluttered sleep environment.
Hanover	10/20/2022	5/15/2020	2.4	M	Multi	mother mother's paramour	Physical Abuse Physical Abuse	None.	Child was found unresponsive in the home. Cause of death is blunt force trauma to the head, neck, torso, and extremities.

A. TABLE OF CHILD DEATH INVESTIGATIONS WITH A FOUNDED DISPOSITION

continued

Locality	"Date of Death"	Date of Birth	Age (years)	Child Sex	Race	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Norfolk	10/22/2022	4/28/2022	0.5	M	W	mother father	Physical Neglect Physical Neglect	In September 2022, Virginia Beach DSS received a report alleging a history of domestic violence with the parents and concerns for the mother's ongoing legal issues. A Family Support case was opened with the family, but was closed shortly after opening due to the agency being unable to make contact with the family.	Child was found unresponsive. Cause of death is SUID associated with co-sleeping in an adult bed, methamphetamine exposure, and viral respiratory infection.
James City	10/30/2022	5/22/2021	1.4	F	W	childcare worker (unreg)	Physical Neglect	In June 2018, James City County opened a Family Assessment after allegations that the babysitter had physically abused her niece. The allegations were not substantiated. In December 2019, James City County opened a Family Assessment due to concerns about the babysitter's stepchildren while they were in the care of their biological mother. The babysitter was not an alleged abuser/neglector in this referral. Services were provided.	Child was found unresponsive in the babysitter's pool. Cause of death is drowning.
Fredericksburg	11/6/2022	9/20/2022	0.1	F	W	mother	Physical Neglect	None.	Child was found unresponsive in the home. Cause of death is SUID associated with unsafe bed/bedding and co-sleeping.
Spotsylvania	11/7/2022	9/23/2017	5.1	M	AA	mother mother's paramour	Physical Abuse Physical Abuse	None.	Child was found unresponsive in the home. Cause of death is undetermined.
Mecklenburg	11/13/2022	8/14/2021	1.2	F	AA	mother	Physical Neglect	In June 2022, Mecklenburg DSS opened a Family Assessment after an incident of intimate partner violence between the mother and father where the children were present. Services were provided.	Child became unresponsive and passed in a hospital setting. Cause of death is complications of thermal injury.
Smyth	12/6/2022	8/21/2022	0.3	M	W	mother	Physical Neglect	None.	Child was found unresponsive in the home. Cause of death is accidental suffocation.
Spotsylvania	12/16/2022	9/6/2016	6.3	F	W	mother mother's paramour	Physical Neglect Physical Neglect	In 2022, Spotsylvania DSS received two invalid reports involving the family.	Child was found unresponsive in the home. Cause of death is fentanyl toxicity.
Portsmouth	12/19/2022	7/15/2017	5.4	M	W	mother grandmother	Physical Neglect Physical Neglect	The family had significant involvement with Portsmouth and Virginia Beach DSS between 2017 and 2022 due to ongoing parental substance use; services were provided.	Child was found unresponsive in the home. Cause of death is acute fentanyl toxicity.
Arlington	1/10/2023	9/29/2020	2.3	M	AA	mother father	Physical Neglect Physical Neglect	In August 2022, Arlington DSS opened a Family Assessment after an incident of intimate partner violence between the mother and father in front of the children. The father was under the influence of PCP and alcohol, and was subsequently arrested. Services were provided.	Child was found unresponsive in the home. Cause of death is fentanyl toxicity.
Portsmouth	1/17/2023	11/19/2022	0.2	F	W	mother	Physical Abuse	In 2022, Portsmouth DSS received two invalid reports involving the family.	Child was found unresponsive in the home. Cause of death is SUID associated with acute methamphetamine exposure, possible asphyxia due to an unsafe sleep surface, and mild respiratory viral infection.
Norfolk	1/18/2023	10/1/2008	14.3	F	AA	mother father	Medical Neglect Medical Neglect	In 2014, Norfolk DSS received numerous reports alleging medical neglect of the decedent and physical neglect of other siblings in the home. Norfolk DSS opened a dual in-home and foster care case in 2014 after the decedent was removed from the biological family's home due to the parent's inability to meet the child's medical needs. She was returned to the parent's home in 2015. In August 2016, Portsmouth DSS received a referral alleging similar concerns regarding medical neglect of the decedent. Portsmouth attempted to open an In-Home case with the family, but were unable to locate them to provide services.	Child found unresponsive in the home. Autopsy results not documented.
Roanoke	1/24/2023	3/16/2018	4.9	F	Multi	mother's paramour	Physical Abuse	In February 2022, Roanoke City DSS received a report alleging concerns for the mother's now 7-year-old child. This referral was screened out, but a Family Support case was attempted with the family. The mother declined services.	Child became unrepsonsive in the home. Cause of death is not documented.

A. TABLE OF CHILD DEATH INVESTIGATIONS WITH A FOUNDED DISPOSITION

continued

Locality	"Date of Death"	Date of Birth	Age (years)	Child Sex	Race	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Tazewell	2/3/2023	1/14/2021	2.1	M	W	father mother	Physical Neglect Physical Neglect	From 2015 to 2021, Tazewell received multiple reports related to parental susbtance use and the fatality of another sibling. Services were provided.	Child was found unresponsive in a river. Cause of death is hypothermia and drowning.
King George	2/21/2023	9/13/2022	0.4	M	Unk	child care worker (reg) child care worker (reg)	Physical Neglect Physical Neglect	None.	Child was found unresponsive at his childcare facility. Cause of death is complications of COVID 19 and Adenovirus.
Lynchburg	2/24/2023	3/22/2010	12.9	F	AA	mother	Physical Neglect	In July 2020, Amherst DSS opened a Family Assessment after receiving a report that the mother was dating a 16-year-old (the mother was 31 at the time) who was selling drugs, the mother was using drugs, and all parties were mishandling firearms. Services were provided.	Child became unresponsive in the home. Cause of death is gunshot wound to the abdomen.
Scott	3/23/2023	1/27/2023	0.2	M	W	foster parent	Physical Neglect	In January 2023, Bristol opened a Family Assessment after the decedent's birth due to the biological mother being unable to care for the decedent. Ultimately, the mother signed a temporary entrustment and the decedent was placed in foster care. Services were provided.	Child was found unresponsive in the foster home. Cause of death is SUID.
Chesapeake	3/30/2023	4/21/2020	2.9	F	AA	mother's paramour	Physical Abuse	Between 2020 and 2022, multiple agencies received reports due parental substance use and physical abuse. Services were provided.	Child became unresponsive in the home. Cause of death is blunt head and abdominal trauma, with smothering as an additional significant factor.
Augusta	4/1/2023	9/7/2022	0.6	M	Multi	mother father	Physical Neglect Physical Neglect	In November 2022, Harrisonburg DSS received an invalid report regarding the child and family.	Child was found unresponsive in the home. Cause of death is SUID.
Lunenburg	4/4/2023	2/28/2017	6.1	F	W	mother father	Physical Neglect Physical Neglect	In March 2022, Lunenburg DSS opened a Family Assessment after receiving a report that there was drug use in the home, a lack of supervision, and poor home conditions. Services were provided.	Child became unresponsive following an ATV accident. Autopsy results not documented.
Prince William	4/6/2023	9/6/2017	5.6	F	Multi	mother's paramour	Physical Abuse	The family has extensive history dating back to 2012. The allegations ranged from physical abuse, physical neglect, substance use, mental health, and housing instability. The family has history across multiple jurisdictions to include Fredericksburg, Warren, Fairfax County, and Prince William. Services were provided.	Child was pronounced deceased following a motor vehicle accident. Cause of death is multiple blunt force injuries.
Newport News	4/6/2023	2/1/2020	3.2	M	AA	father	Physical Neglect	In February 2020, Newport News DSS opened an In-Home case after receiving a referral alleging concerns about the decedent being in the care of his biological mother. Services were provided.	Child was found unresponsive in the home. Cause of death is self-inflicted gunshot wound to the head.
Franklin County	4/21/2023	1/12/2023	0.3	F	W	child care worker (unreg)	Physical Neglect	None.	Child was found unresponsive in the childcare provider's home. Cause of death is suffocation.
Suffolk	5/9/2023	12/2/2022	0.4	M	AA	mother	Physical Neglect	None.	Child ws found unresponsive in a vehicle. Cause of death is hyperthermia.
Hampton	6/6/2023	10/25/2006	16.6	M	AA	other other	Physical Neglect Physical Neglect	In January 2007, Norfolk opened an in-home cause due to substance use concerns with the decedent's biological mother. In June 2012, Norfolk opened a short-term intake to assist the decedent's grandmother (who had full custody of the decedent) with utility bills.	Child became unresponsive at a community pool. Cause of death is drowning.
Pulaski	6/11/2023	5/10/2021	2.1	M	W	mother	Physical Neglect	In September 2020, Wythe opened a Family Assessment after receiving a report that the family's home was covered in urine, feces, and bugs and that the decedent's sibling had a strong odor to him. An in-home case was opened; services were provided.	Child was found unresponsive in a pool. Cause of death is drowning.

A. TABLE OF CHILD DEATH INVESTIGATIONS WITH A FOUNDED DISPOSITION

continued

Locality	"Date of Death"	Date of Birth	Age (years)	Child Sex	Race	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Fairfax	6/15/2023	1/28/2023	0.4	M	Unk	father	Physical Neglect	In January 2023, Fairfax opened a Family Assessment after the decedent was born. The decedent was having trouble feeding and the feeding difficulties were attributed to substance exposure in utero. It was also reported that the father shook the infant's head to keep him awake for a feeding while in the hospital. Services were provided.	Child was found unresponsive in the home. Cause of death is undetermined.
Henrico	6/27/2023	5/5/2020	3.1	M	AA	mother	Physical Neglect	In July 2022, Richmond City received an invalid report regarding the child and family.	Child was found unresponsive in the home. Cause of death is fentanyl toxicity.

B. TABLE OF CHILD DEATH INVESTIGATIONS WITH AN UNFOUNDED DISPOSITION

Locality	"Date of Death"	Date of Birth	Age (years)	Child Sex	Race	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Albemarle	7/1/2022	6/9/2022	0.1	F	AA	Mother	Physical Neglect	No	Child found unresponsive in the home. Cause of death is SUID associated with unsafe sleep conditions and neonatal jaundice.
Mecklenburg	7/2/2022	4/28/2022	0.2	M	Multi	Mother Father	Physical Neglect Physical Neglect	Yes	Child found unresponsive in the home. Cause of death is SUID associated with co-sleeping.
King George	7/6/2022	5/30/2022	0.1	F	AA	Mother	Physical Neglect	Yes	Child found unresponsive in the home. Cause of death is SUID associated with co-sleeping, unsafe sleep surface, SARS-COV-2 Positive.
Norfolk	7/6/2022	6/24/2022	0.0	M	AA	Mother Father	Physical Neglect Physical Neglect	No	Child found unresponsive in the home. Autopsy not documented.
Petersburg	7/7/2022	5/30/2022	0.1	M	AA	Mother	Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is SUID associated with co-sleeping and soft bedding.
Virginia Beach	7/9/2022	4/6/2018	4.3	M	W	Father Mother	Physical Abuse Physical Abuse	No	Child became unresponsive in the home. Cause of death is blunt head impact, contributing, laboratory evidence of SARS Covid 19 Infection.
Wise	7/11/2022	6/15/2022	0.1	M	W	Mother Father	Physical Abuse	No	Child was found unresponsive in the home. Cause of death is accidental suffocation.
Buckingham	7/11/2022	10/16/2015	6.7	M	W	Father Mother	Physical Neglect Physical Neglect	No	Child was found unresponsive in a pond. Cause of death is drowning.
Harrisonburg	7/13/2022	4/20/2022	0.2	M	Unk	Mother	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is Sudden Unexpected Death in Infancy.
Newport News	7/16/2022	3/27/2022	0.3	M	AA	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID associated with viral infection (rhinovirus and possible cytomegalovirus), unsafe sleep surface, and premature birth with history of intraventricular hemorrhage and hydrocephalus.
Shenandoah	7/17/2022	2/4/2022	0.5	M	W	Mother Mother's paramour	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is Sudden Unexpected Death in Infancy.
Portsmouth	7/26/2022	6/22/2022	0.1	F	AA	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death was SUID associated with an unsafe sleep environment with enterovirus and rhinovirus infections.
Lee	7/26/2022	2/27/2022	0.4	F	W	Child care worker-unreg Child careworker-unreg	Physical Neglect Physical Neglect	Yes	Child was found unersponsive in the home. Cause of death is accidental suffocation.
Roanoke County	7/27/2022	4/10/2022	0.3	M	AA	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cauase of death is SUID associated with unsafe sleep environment.
Henrico	7/28/2022	7/14/2022	0.0	M	W	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID with prone positioning.
Danville	8/4/2022	5/13/2018	4.2	F	W	Mother Father Sibling	Physical Neglect Physical Neglect Physical Abuse	Yes	Child was found unresponsive in the home. Cause of death is complications of anoxic brain injury (brain injury resulting from a lack of oxygen) of uncertain etiology.

B. TABLE OF CHILD DEATH INVESTIGATIONS WITH AN UNFOUNDED DISPOSITION
continued

Locality	"Date of Death"	Date of Birth	Age (years)	Child Sex	Race	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Virginia Beach	8/7/2022	6/15/2022	0.1	F	Multi	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is accidental asphyxia in an unsafe sleep situation.
York	8/9/2022	5/6/2018	4.3	M	W	Mother	Physical Neglect	No	Child was found unresponsive in a pool. Cause of death is complications of near-drowning.
Prince William	8/11/2022	7/12/2022	0.1	M	W	Mother	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is Sudden Unexpected Death in Infancy.
Fairfax	8/12/2022	3/14/2022	0.4	M	Unk	Unknown	Physical Abuse	No	Child was found unresponsive in the home. Cause of death is Sudden Unexpected Death in Infancy.
Winchester	8/24/2022	2/16/2022	0.5	M	W	Father	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID associated with unsafe sleep.
Prince William	8/24/2022	5/3/2022	0.3	F	W	Unknown	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is undetermined.
Prince William	8/24/2022	12/10/2019	2.7	M	W	Mother	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is choking.
Chesterfield	8/25/2022	3/26/2022	0.4	M	W	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Autopsy report not documented.
Frederick	8/25/2022	5/14/2022	0.3	M	Unk	child care worker-unreg	Physical Neglect	No	Child was found unresponsive in the babysitter's home. Cause of death is asphyxia due to an unsafe sleep environment.
Norfolk	8/27/2022	8/8/2008	14.1	M	W	Mother	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is delayed death followed by hanging.
Loudoun	8/28/2022	4/25/2022	0.3	M	Unk	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is Sudden Unexpected Death in Infancy.
Chesapeake	9/1/2022	8/13/2022	0.1	F	W	Mother	Physical Neglect	Yes	Child passed away in the hospital following a pre-mature birth. An autopsy was not coducted.
Virginia Beach	9/1/2022	8/8/2022	0.1	F	Unk	Foster Parent Foster Parent	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the foster home. Cause of death is complications from Larsen Syndrome.
Pittsylvania	9/3/2022	8/11/2016	6.1	M	W	Father Mother	Physical Neglect Physical Neglect	No	Child was found unresponsive following a motor vehicle accident. Cause of death is blunt injuries to the head and chest.
Augusta	9/3/2022	7/9/2013	9.2	M	W	Mother	Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is complications of Kernicterus.
Culpeper	9/7/2022	3/31/2022	0.4	F	Unk	Unknown	Medical Neglect	No	Child became unresponsive in the community. Cause of death is complications from dilated cardiomyopathy.
Fairfax	9/19/2022	9/5/2022	0.0	F	W	Unknown	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is Sudden Unexpected Death in Infancy.
Richmond City	9/25/2022	4/27/2011	11.4	M	AA	Mother Father	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is suicide by hanging.
Suffolk	9/25/2022	2/12/2018	4.6	M	AA	Stepparent	Physical Abuse	Yes	Child was found unresponsive in the home. Cause of death is gunshot wound.
Loudoun	9/25/2022	2/9/2005	17.6	F	W	Mother Father	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is acute intoxication due to the combined effects of fentantyl, bupropion, and fluoxetine.

B. TABLE OF CHILD DEATH INVESTIGATIONS WITH AN UNFOUNDED DISPOSITION
continued

Locality	"Date of Death"	Date of Birth	Age (years)	Child Sex	Race	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Virginia Beach	9/26/2022	10/7/2021	1.0	M	W	Father	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID associated with respiratory infection, possible asthma, preterm birth with good catch-up growth, enlarged liver, and possible asphyxia.
Warren	9/27/2022	1/25/2022	0.7	F	W	Mother Father	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is SUID associated with unsafe sleep and viral infection.
Danville	9/28/2022	6/15/2022	0.3	M	AA	Mother	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is suffocation.
Isle of Wight	9/30/2022	8/15/2022	0.1	F	AA	Mother	Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is undetermined.
Richmond City	10/1/2022	9/21/2020	2.0	M	AA	Mother	Physical Neglect	Yes	Child was found unresponsive in the home. An autopsy was not conducted.
Arlington	10/6/2022	8/17/2022	0.1	M	W	Unknown	Physical Abuse	No	Child was found unrepsonsive in the home. Cause of death is complications of asphyxia due to unsafe sleep environment.
Norfolk	10/7/2022	5/30/2022	0.4	M	AA	Mother Father	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is SUID associated with unsafe sleep surface with additional significant factors; SARS Covid 19, parainfluenza virus III, and congenital renal disease.
Fauquier	10/10/2022	6/24/2022	0.3	M	W	Grandmother	Physical Neglect	No	Child was found unresponsive in the grandparent's home. Cause of death is undetermined.
Norfolk	10/20/2022	6/18/2008	14.3	F	AA	Mother	Physical Neglect	No	Child was found unresponsive in a relative's home. An autopsy was not conducted.
Manassas	10/23/2022	6/2/2022	0.4	F	AA	Mother	Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is undetermined.
Mecklenburg	11/7/2022	9/8/2022	0.2	F	W	Father Mother	Physical Abuse Physical Abuse	Yes	Child was found unresponsive in the home. Cause of death is SUID associated with co-sleeping.
Prince William	11/7/2022	6/23/2019	3.4	M	AA	Father Mother	Physical Abuse Physical Abuse	No	Child was found unresponsive in the home. An autopsy was not conducted.
Spotsylvania	11/22/2022	11/16/2022	0.0	F	Multi	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is blunt and sharp force injuries to torso.
Henrico	12/3/2022	9/8/2022	0.2	M	AA	Mother	Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is SUID with prone positioning and unsafe bedding.
Franklin	12/4/2022	6/6/2006	16.5	M	AA	Father Great Grandparent	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is self-inflicted gunshot wound.
Henry	12/11/2022	8/9/2022	0.3	M	AA	Mother	Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is SUID.
Richmond City	12/12/2022	7/7/2021	1.4	F	AA	Father Father's paramour	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is undetermined.
Virginia Beach	12/16/2022	8/9/2022	0.4	M	AA	Father	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID associated with prone position, anomalous coronary artery and atrial septal defects.
James City	12/18/2022	11/19/2022	0.1	M	W	Mother	Physical Neglect	Yes	Child was found unresponsive in the home. Autopsy report not documented.

B. TABLE OF CHILD DEATH INVESTIGATIONS WITH AN UNFOUNDED DISPOSITION
continued

Locality	"Date of Death"	Date of Birth	Age (years)	Child Sex	Race	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Arlington	12/30/2022	11/12/2009	13.1	F	AA	Unknown	Physical Abuse	Yes	Child was found unresponsive in the home. Cause of death is suicide by hanging.
Alexandria	1/5/2023	11/26/2022	0.1	M	AA	Other	Physical Neglect	Yes	Child was found unresponsive in caregiver's home. Cause of death is SUID.
Spotsylvania	1/7/2023	12/27/2022	0.0	M	W	Unknown	Physical Neglect	No	Child was found unresponsive in the home. Autopsy report not documented.
Spotsylvania	1/11/2023	12/14/2022	0.1	M	Multi	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID associated with co-sleeping and soft bedding.
Norton	1/12/2023	10/15/2022	0.2	M	W	Foster Parent Foster Parent	Physical Abuse Physical Abuse	Yes	Child was found unresponsive in the foster home. Cause of death is undetermined.
Chesapeake	1/12/2023	7/27/2021	1.5	M	W	Mother	Physical Neglect	No	Child became unresponsive at a relative's home. Cause of death is head trauma due to auto-pedestrian accident.
Staunton	1/15/2023	1/12/2023	0.0	M	AA	Mother Father	Physical Neglect Physical Neglect	No	Child died following a home birth. Cause of death is undefined for fetal deaths.
North-umberland	1/18/2023	12/29/2022	0.1	M	W	Mother Father	Physical Abuse Physical Abuse	Yes	Child was found unresponsive in the home. Cause of death is SUID associated with co-sleeping.
Prince William	1/19/2023	7/1/2007	15.6	M	AA	Mother Father Aunt	Physical Neglect Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is self-inflicted gunshot wound to the head.
Henrico	1/20/2023	11/12/2022	0.2	M	AA	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID associated with unsafe bed/bedding, co-sleeping, and prone positioning.
Prince William	1/22/2023	6/2/2001	21.6	M	W	Mother Father	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death due to natural causes.
Virginia Beach	1/26/2023	2/25/2005	17.9	M	Multi	Other Other	Physical Neglect Physical Neglect	No	Child became unresponsive on a school bus. Cause of death is attributed to sepsis, cardiogenic shock, presumed septic shock, urinary tract infection, pulmonary hemorrhage and status epilepticus.
Richmond City	2/10/2023	1/13/2023	0.1	M	AA	Mother Sibling	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is undetermined.
Hopewell	2/14/2023	12/8/2022	0.2	F	AA	Mother	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is overlay associated with co-sleeping.
Henrico	2/12/2023	7/16/2021	1.6	M	Unk	Father Mother	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is anoxic encephalopathy due to ligature strangulation.
Giles	2/16/2023	10/27/2021	1.3	M	W	Mother	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is complications of Waterhouse-Friderichsen Syndrome due to staphylococcal sepsis with respiratory syncytial virus superinfection.
Manassas	2/18/2023	12/26/2022	0.1	M	W	Mother Father	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is undetermined.
York	2/22/2023	10/31/2022	0.3	M	W	child care worker-unreg	Physical Neglect	Yes	Child was found unrepsonsive in the childcare provider's home. Cause of death is SUID associated with viral infection and mild hepatic steatosis.

B. TABLE OF CHILD DEATH INVESTIGATIONS WITH AN UNFOUNDED DISPOSITION
continued

Locality	"Date of Death"	Date of Birth	Age (years)	Child Sex	Race	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Arlington	2/28/2023	9/6/2022	0.5	F	W	Mother	Physical Neglect	Yes	Child ws found unresponsive in the home. Cause of death is sudden unexpected death in infancy.
Chesapeake	3/3/2023	12/19/2022	0.2	M	W	Child care worker-unreg Child careworker-unreg	Physical Neglect Physical Neglect	No	Child was found unresponsive in the childcare provider's home. Cause of death is SUID associated with an unsafe sleep surface and laboratory evidence of viral infection.
Lee	3/5/2023	7/13/2022	0.6	M	W	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is accidental suffocation.
Richmond City	3/8/2023	10/17/2021	1.4	F	AA	Mother Father	Medical Neglect Medical Neglect	Yes	Child was found unresponsive in the home. Cause of death is complications of genetic epilepsy, human rhinovirus/enterovirus and coronavirus infection.
Westmoreland	3/13/2023	2/3/2023	0.1	M	W	Mother	Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is SUID associated with unsafe sleeping arrangements.
Fairfax	3/17/2023	9/7/2021	1.5	M	Asian	Unknown	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is undetermined.
Shenandoah	3/22/2023	10/9/2021	1.5	F	W	Unknown	Medical Neglect	Yes	Child was found unresponsive in the home. An autopsy was not conducted.
Mecklenburg	3/22/2023	2/15/2023	0.1	F	AA	Mother Father	Physical Abuse Physical Abuse	No	Child was found unresponsive in the home. Cause of death is SUID associated with prone positioning.
Prince William	3/25/2023	2/17/2023	0.1	F	W	Father	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID.
Richmond City	3/27/2023	6/14/2022	0.8	F	AA	Mother	Physical Neglect	No	Child was found unresponsive in bathtub. Cause of death is drowning.
Portsmouth	3/30/2023	1/27/2023	0.2	F	Multi	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID associated with co-sleeping and unsafe sleep surface.
Scott	3/31/2023	11/23/2022	0.4	F	W	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID associated with unsafe sleep environment.
Chesapeake	4/1/2023	11/28/2022	0.3	F	AA	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID associated with unsafe sleep surface, mild acute pneumonia, and focal pulmonary lymphangiectasia/lymphangiomatosis.
Portsmouth	4/3/2023	5/3/2019	3.9	M	AA	Father	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is gunshot wound of the head.
Pittsylvania	4/3/2023	8/11/2022	0.6	F	W	Grandmother Grandfather	Physical Neglect Physical Neglect	No	Child was found unresponsive in the grandparent's home. Cause of death is suffocation.
Virginia Beach	4/9/2023	1/5/2023	0.3	F	AA	Mother Father	Physical Abuse Physical Abuse	Yes	Child was found unresponsive in the home. Cause of death is undetermined.
Lynchburg	4/15/2023	1/10/2023	0.3	M	AA	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is suffocation due to co sleeping.
Prince Edward	4/17/2023	4/7/2023	0.0	M	AA	Mother Father	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is SUID associated with co-sleeping and soft bedding.
Spotsylvania	4/21/2023	1/6/2021	2.3	M	W	Father	Physical Neglect	No	Child became unresponsive in the home. Cause of death is blunt force trauma to the head.

B. TABLE OF CHILD DEATH INVESTIGATIONS WITH AN UNFOUNDED DISPOSITION

continued

Locality	"Date of Death"	Date of Birth	Age (years)	Child Sex	Race	Abuser (s)	Abuse Type	Previous History	Summary (SUID stands for Sudden Unexpected Infant Death)
Pittsylvania	4/28/2023	4/28/2023	0.0	F	W	Mother	Physical Neglect	Yes	Child passed away in the hospital following birth. An autopsy was not coducted.
Prince William	4/29/2023	2/1/2023	0.2	F	Asian	Unknown	Physical Neglect	No	Child became unresponsive in the home. Cause of death is cardiopulmonary arrest with an underlying cause of Netherton syndrome.
Stafford	5/4/2023	1/25/2020	3.3	F	Asian	Mother	Physical Neglect	No	Child was found unresponsive in a river. Cause of death is drowning.
Portsmouth	5/5/2023	4/7/2023	0.1	F	AA	Mother	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID associated with unsafe sleep.
Portsmouth	5/10/2023	4/7/2023	0.1	F	AA	Mother	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID.
Hampton	5/14/2023	12/23/2022	0.4	F	W	Mother	Physical Abuse	No	Child was found unresponsive in the home. Cause of death is SUID associated with unsafe sleep surface, viral respiratory infection, and history of slow weight gain.
Virginia Beach	5/28/2023	2/7/2023	0.3	F	AA	Mother Father	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is SUID associated with unsafe sleep and co-sleeping.
Roanoke	5/29/2023	5/9/2023	0.1	M	AA	Mother	Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is SUID.
Virginia Beach	6/5/2023	10/2/2022	0.3	M	AA	Father Father's paramour	Physical Neglect Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is undetermined.
Virginia Beach	6/14/2023	3/14/2021	2.3	M	Unk	Mother Mother	Physical Neglect	No	Child was found unresponsive in the home. Cause of death is sudden explained death in childhood associated with epiglottitis, tracheobronchitis, and possible anaphylaxis.
Sussex	6/19/2023	10/26/2013	9.6	F	AA	Stepparent	Physical Neglect	No	Child was found unresponsive in a relative's pool. Cause of death is drowning.
Giles	6/21/2023	6/21/2023	0.0	M	W	Father	Physical Neglect	Yes	Child was born and deceased on the same date. Cause of death is extreme prematurity due to complication of acute chorioamnionitis.
Henrico	6/24/2023	6/23/2023	0.0	M	W	Mother	Physical Neglect	No	Child passed away in the hospital following birth. The cause of death is complications of prematurity.
Alexandria	6/28/2023	4/14/2020	3.2	M	W	Mother Aunt	Physical Neglect Physical Neglect	No	Child was found unresponsive in the home. Cause of death is multiple blunt force injuries.
Albemarle	6/28/2023	4/20/2010	13.2	M	W	Mother	Physical Neglect	Yes	Child was found unresponsive in the home. Cause of death is self-inflicted gunshot wound.

Report to the CASA/CJA Advisory Committee

October 25, 2024 10 a.m. – 12 p.m.

Children's Justice Act (CJA)

Prepared by: Jenna L. Foster, Children's Justice Act Coordinator - DCJS

I. Domestic and Sexual Violence (DVSV) Children's Programming Workgroup

DCJS has identified that domestic violence / sexual violence (DVSV) child advocates working with these young secondary victims and their non-offending caregivers throughout the Commonwealth are often overlooked as a stakeholder group. To address the needs of this group of professionals working with child victims, DCJS convened a Workgroup of seventeen DVSV child advocates from housing and community programs across the Commonwealth, ensuring regional representation, to meet routinely to identify and address priorities.

To address the challenges and support the needs of this under-resourced professional population, DCJS is exploring the possibility of building foundational uniformity in service delivery within the child advocacy spaces (in housing programs) and promoting best practices in the field.

II. One-Time Grants for Existing Child-Treatment Programs

DCJS anticipates offering CJA funds through a one-time six-month grant solicitation exclusively for child-treatment programs. Applying programs must clearly explain their purpose and need for funds as well as how the use of funds directly correlates to the CJA mandate. Their purpose of funds must also align with specific categories to support DVSV programs, equipment, support group assistance, and volunteer recruitment. The anticipated funding period is April 1-September 30, 2025.

III. Child Advocates Attend DCJS Domestic Violence Conference

DCJS provided 19 child advocates, CPS workers, and CASA volunteers scholarships to attend the *Building Bridges: Collaborative Approaches to Prevent Domestic Violence and Support Survivors* conference in Hampton, Virginia, October 7-9, 2024.

IV. CJA Program to Support Ongoing Child Trafficking Efforts

DCJS is prioritizing awareness, training, and technical assistance related to child sex trafficking, specifically after the recent legislative changes effective July 1, 2024. The CJA program is working with the Human Trafficking team at DCJS to support child sex trafficking work related to § 15.2-1627.6 - Coordination of multidisciplinary response to human trafficking.

DRAFT

The Court Appointed Special Advocate/Children's Justice Act Advisory Committee (CASA/CJA)
POLICY FOR THE REMOTE PARTICIPATION OF MEMBERS

1. AUTHORITY AND SCOPE

a. This policy is adopted pursuant to the authorization of Va. Code § 2.2- 3708.3 and is to be strictly construed in conformance with the Virginia Freedom of Information Act (VFOIA), Va. Code §§ 2.2-3700—3715.

b. This policy shall not govern an electronic meeting conducted to address a state of emergency declared by the Governor or the Board of Supervisors. Any meeting conducted by electronic communication means under such circumstances shall be governed by the provisions of Va. Code § 2.2-3708.2. This policy also does not apply to an all-virtual public meeting.

2. DEFINITIONS

a. "Advisory Committee" means the Court Appointed Special Advocate/Children's Justice Act Advisory Committee (CASA/CJA Advisory Committee) or any committee, subcommittee, or other entity of the CASA/CJA Advisory Committee.

b. "Member" means any member of the CASA/CJA Advisory Committee.

c. "Remote participation" means participation by an individual member of the CASA/CJA Advisory Committee by electronic communication means in a public meeting where a quorum of the CASA/CJA Advisory Committee is physically assembled, as defined by Va. Code § 2.2-3701.

d. "Meeting" means a meeting as defined by Va. Code § 2.2-3701.

e. "Notify" or "notifies," for purposes of this policy, means written notice, such as email or letter. Notice does not include text messages or communications via social media.

3. MANDATORY REQUIREMENTS

Regardless of the reasons why the member is participating in a meeting from a remote location by electronic communication means, the following conditions must be met for the member to participate remotely:

a. A quorum of the CASA/CJA Advisory Committee must be physically assembled at the primary or central meeting location; and

b. Arrangements have been made for the voice of the remotely participating member to be heard by all persons at the primary or central meeting location. If at any point during the meeting the voice of the remotely participating member is no longer able to be heard by all persons at the meeting location, the remotely participating member shall no longer be permitted to participate remotely.

4. PROCESS TO REQUEST REMOTE PARTICIPATION

a. On or before the day of the meeting, and at any point before the meeting begins, the requesting member must notify the CASA/CJA Advisory Committee Chair (or the Vice-Chair if the requesting member is the Chair) that they are unable to physically attend a meeting due to (i) a temporary or permanent disability or other medical condition that prevents the member's physical attendance, (ii) a family member's medical condition that requires the member to provide care for such family member, thereby preventing the member's physical attendance, (iii) their principal residence location more than 60 miles from the meeting location, or (iv) a personal matter and identifies with specificity the nature of the personal matter.

b. The requesting member shall also notify the CASA/CJA Advisory Committee staff liaison of their request, but their failure to do so shall not affect their ability to remotely participate.

c. If the requesting member is unable to physically attend the meeting due to a personal matter, the requesting member must state with specificity the nature of the personal matter. Remote participation due to a personal matter is limited each calendar year to two meetings or 25 percent of the meetings held per calendar year rounded up to the next whole number, whichever is greater. There is no limit to the number of times that a member may participate remotely for the other authorized purposes listed in (i)— (iii) above.

d. The requesting member is not obligated to provide independent verification regarding the reason for their nonattendance, including the temporary or permanent disability or other medical condition or the family member’s medical condition that prevents their physical attendance at the meeting.

e. The Chair (or the Vice-Chair if the requesting member is the Chair) shall promptly notify the requesting member whether their request is in conformance with this policy, and therefore approved or disapproved.

5. PROCESS TO CONFIRM APPROVAL OR DISAPPROVAL OF PARTICIPATION FROM A REMOTE LOCATION

When a quorum of the CASA/CJA Advisory Committee has assembled for the meeting, the CASA/CJA Advisory Committee shall vote to determine whether:

a. The Chair’s decision to approve or disapprove the requesting member’s request to participate from a remote location was in conformance with this policy, and

b. The voice of the remotely participating member can be heard by all persons at the primary or central meeting location.

6. RECORDING IN MINUTES

a. If the member is allowed to participate remotely due to a temporary or permanent disability or other medical condition, a family member’s medical condition that requires the member to provide care to the family member, or because their principal residence is located more than 60 miles from the meeting location the CASA/CJA Advisory Committee shall record in its minutes (1) the CASA/CJA Advisory Committee’s approval of the member’s remote participation; and (2) a general description of the remote location from which the member participated.

b. If the member is allowed to participate remotely due to a personal matter, such matter shall be cited in the minutes with specificity, as well as how many times the member has attended remotely due to a personal matter, and a general description of the remote location from which the member participated.

c. If a member's request to participate remotely is disapproved, the disapproval, including the grounds upon which the requested participation violates this policy or VFOIA, shall be recorded in the minutes with specificity.

7. CLOSED SESSION

If the CASA/CJA Advisory Committee goes into closed session, the member participating remotely shall ensure that no third party is able to hear or otherwise observe the closed meeting.

8. STRICT AND UNIFORM APPLICATION OF THIS POLICY

This Policy shall be applied strictly and uniformly, without exception, to the entire membership, and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting. The Chair (or Vice-Chair) shall maintain the member's written request to participate remotely and the written response for a period of one year, or other such time required by records retention laws, regulations, and policies.

COMMONWEALTH of VIRGINIA

Office of the Governor

Office of the Children's Ombudsman
Eric J. Reynolds, Esq., Director

October 1, 2024

The Honorable Glenn Youngkin
Governor of Virginia
Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Members of the General Assembly
General Assembly Building
923 East Broad Street
Richmond, Virginia 23219

James Williams, Commissioner
Virginia Department of Social Services
5600 Cox Road
Glen Allen, Virginia 23060

Dear Governor Youngkin, Members of the General Assembly, and Commissioner Williams,

I am pleased to submit the 2024 Annual Report of the Office of the Children's Ombudsman in accordance with § 2.2-447 of the Code of Virginia. The statute requires me, as Director of the Office, to report on its activities each year, including any recommendations regarding the need for legislation or for a change in rules or policies.

If you need any additional information, please do not hesitate to contact me by email at eric.reynolds@governor.virginia.gov or by telephone at 804-225-4823.

Respectfully submitted,

Eric J. Reynolds, Director
Office of the Children's Ombudsman

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2024 ANNUAL REPORT

OFFICE OF THE CHILDREN'S OMBUDSMAN

RICHMOND, VIRGINIA

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EXECUTIVE SUMMARY

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

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

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

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

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

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

Recommendations for System Changes.

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

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

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

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

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

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

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

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

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

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

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

ABOUT THE OFFICE OF THE CHILDREN'S OMBUDSMAN

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

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

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

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

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

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

Staff:

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

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

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

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

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

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

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

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

Acronyms used in this Report:

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

FY2024 LEGISLATIVE ADVOCACY

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

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

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

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

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

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

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

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

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

FY2024 OCO ACTIVITIES

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

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

COMPLAINTS AND INVESTIGATIONS

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

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

Virginia Code § 2.2-441.

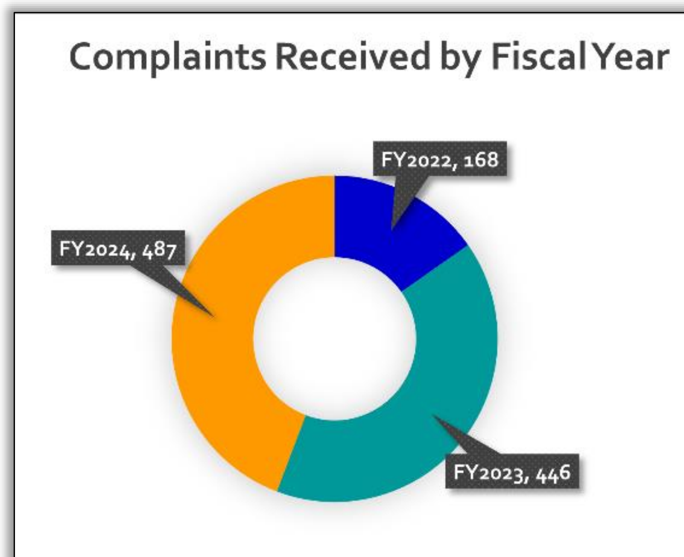
The OCO is required to prepare a report of the factual findings of an investigation and make recommendations to the agency being investigated if we find any of the following:

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

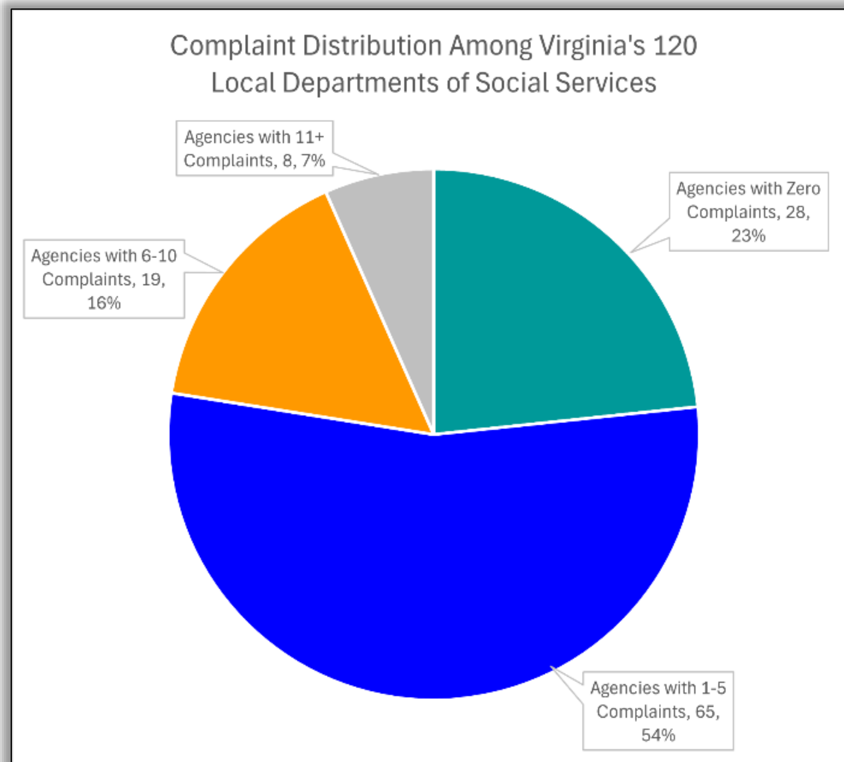
Virginia Code § 2.2-447(A).

COMPLAINTS

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



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

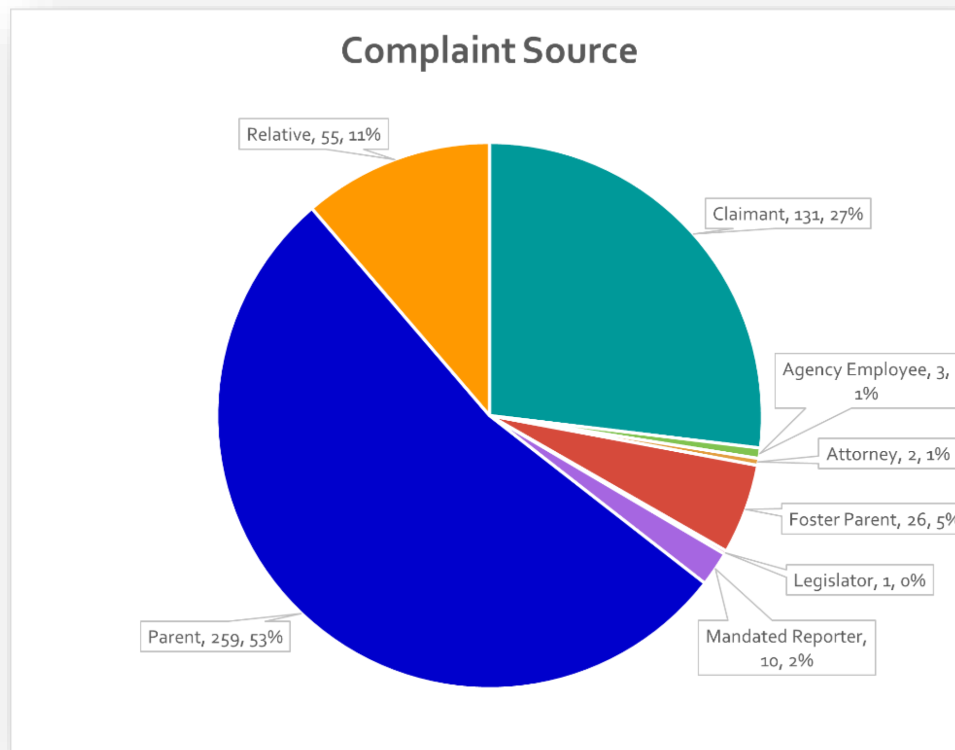


Complainants. A statutory complainant is any one of the following individuals as listed in Virginia Code § 2.2-441:

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

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

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

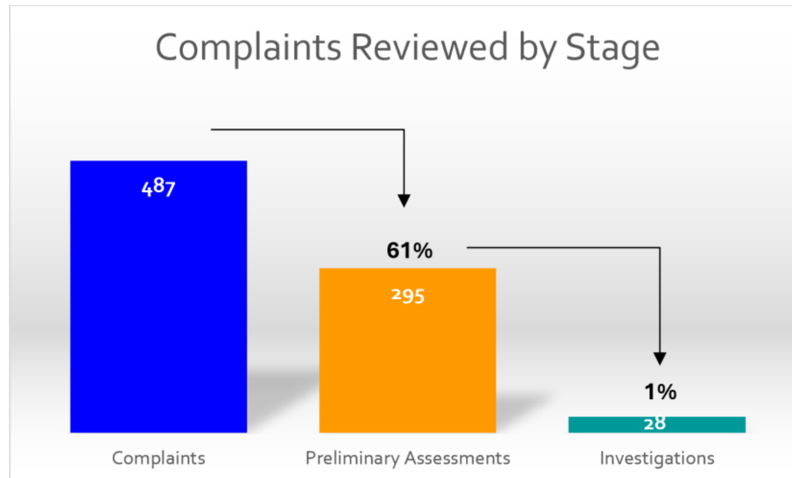


Disposition of Complaints (as of June 30, 2024):

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

PRELIMINARY ASSESSMENTS

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



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

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

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

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

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

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

Disposition of Preliminary Assessments:

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

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

INVESTIGATIONS

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

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

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

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

Adoption/Adoption Assistance	7
Agency - Communication/Collaboration with another LDSS	1
Agency - Documentation	13
Agency - Internal CPS-FC Collaboration	1
Agency - Lack of Responsiveness	4
Agency - Records contain inaccurate information	1
Agency - Supervision Deficiencies	1
Agency - Worker Changes	3
ALA - Inappropriate or Inadequate Support or Services to ALA Caregiver	1
ALA - Inappropriate or Inadequate Support or Services to Child	1
ALA - Inappropriate or Inadequate Support or Services to Parent	1
ALA - Service Plan Issues	1
CPS - Inadequate Services	4
CPS - Investigation Process	31
CPS - Safety Plan	9
CPS - Validation Process	2
CPS - Family Assessment Process	10
CPS – Removal Procedures	2
CPS – Validation Process	2
Family Engagement – Family Partnership Meetings	14
Family Engagement - Lack of Relative Contact	6
Family Engagement - Lack of Trauma Informed Care	3
Freedom of Information Act	1
Foster Care - Foster Parent Expectations	1
Foster Care - Inadequate Case Management	7
Foster Care - Inadequate Reunification Efforts	1
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The following are summaries of findings and recommendations from some of the investigations that were closed by the OCO in FY 2024:

Case 1

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

Findings:

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

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

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

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

Case 2

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

Findings:

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

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

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

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

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

Case 3

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

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

Findings and recommendations:

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

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

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

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

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

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

Case 4

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

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

Case 5

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

Findings:

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

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

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

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

Case 6

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

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

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

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

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

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

Case 7

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case 8

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

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

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

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

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

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

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

Case 9

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

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

Findings:

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

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

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

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

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

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

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

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

Case 10

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

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

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

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

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

Case 11

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

Findings.

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

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

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

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

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

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

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

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

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

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

CHILD FATALITIES

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

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

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

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

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

Gender	Number of Children
Female	24
Male	30

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

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

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

Conditions at the time of death/family history.

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

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

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

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

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

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

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

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

Gender	Number of Children
Female	15
Male	15

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS FOR SYSTEM CHANGES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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