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Richmond City Auditor

# Richmond City Council

The Voice of the People

Richmond, Virginia

## Office of the City Auditor

January 15, 2014

Mr. Byron Marshall, Chief Administrative Officer  
City of Richmond

The Office of the Inspector General (OIG) has completed an investigation in the Richmond Department of Social Services (RDSS). This report presents the results of the investigation.

### **Allegations:**

The OIG received several complaints from RDSS employees alleging a RDSS Program Manager advised Child Protective Services (CPS) Unit employees to close cases without conducting a proper investigation, which may have jeopardized the safety of the children.

### **Legal Requirements:**

In accordance with the Code of Virginia, §15.2-2511.2, the City Auditor is required to investigate all allegations of fraud, waste, and abuse. Also, City Code section 2-231 requires the Office of the Inspector General to conduct investigations of alleged wrongdoing.

### **Cooperation:**

The OIG wishes to thank the Interim DCAO for Human Services and the Interim RDSS Director for their cooperation and assistance during the investigation. The investigators were provided access to the records and relevant employees when requested.

### **Background:**

In May 2013, the OIG issued an investigative report related to RDSS management making decisions that compromised the safety of children served by the CPS Unit. RDSS applied the philosophy of keeping vulnerable children assisted by the CPS Program, in their homes in spite of compromising the safety of the children. Based on this action the effectiveness of the program appeared to be inflated and indicated a much higher performance.

In the current complaint, RDSS had cases that were out of compliance with State requirements for response and closure. Some RDSS employees are concerned about the cases being closed, without following proper practices that assures proper investigation and safety of children. If a significant number of cases are closed within a short period, it indicates superior performance on RDSS' CPS Unit.

**Findings:**

- The investigator obtained information that 774 CPS cases, which consisted of Family Assessments and Investigations, were closed by RDSS employees between July 1, 2013 and September 30, 2013. This number appeared to be excessive, as two other localities of similar size closed only 224 and 484 cases, respectively during the same time period.
- The Investigators reviewed a random sample of 100 closed cases from RDSS to determine if the cases were closed appropriately. The investigators forwarded these cases to the Virginia Department of Social Services (VDSS) with a request to conduct a detailed review. The detailed review was requested to determine the appropriateness of the closings. Trained VDSS professionals from two regions reviewed these cases and determined that 66% of these cases were closed inappropriately.
  - The findings for one of the regions indicated that, “While some CPS referrals reviewed were closed appropriately, at least 28 of the 50 referrals reviewed (56%) were closed inappropriately (without important additional information being obtained and/or services being provided to the family or child/children) and several others were questionable. For several of the referrals, the reason given for the closing of the referral was “not able to complete/information not obtainable.”
  - In the review of the cases, this region found that:
    - Three sexual abuse referrals in the 50 referrals reviewed were not conducted jointly with law enforcement, as required by CPS policy.
    - In 15 of the referrals reviewed (30%), the Structured Decision Making (SDM) risk assessment tool was not completed correctly. If the SDM tool had been used correctly by the RDSS CPS staff, the resulting risk category would have been higher for these referrals, triggering the need to have a case opened to CPS ongoing services.
    - Three referrals reviewed were closed with a “high” or “very high” risk rating, and no case was opened to CPS ongoing services, as required by CPS policy.

- In two other referrals, there were unexplained physical injuries to infants that should have been investigated due to the seriousness of the allegations.
  - In one referral, which had a prior CPS history with the RDSS, a report was made to the police for a criminal investigation, but there was no subsequent follow up by RDSS CPS staff prior to closure of the CPS referral.
  - Most of the safety assessments completed were determined to be “unsafe” or “conditionally safe”. However, there was no documentation of the safety plan on the Structured Decision Making (SDM) tool, as required by CPS policy.
  - 30% of the SDM risk assessment tools from this random sample were completed incorrectly and, since they were approved by a supervisor, this presents a major concern.
  - The lack of CPS case openings, and no services being provided to families, was a recurring theme heard from the CPS staff during the VDSS Quality Management Review (QMR) in early 2013. Based on the review of these 50 closed referrals, it appears that little, if anything has changed in CPS case practice and supervision, since the VDSS QMR was completed and the state report issued in June 2013.
- The second region that reviewed 50 additional 50 cases found that 38 cases involved a referral where there was a significant concern on how the referral was completed and/or closed. Out of the 50 referrals, which were randomly selected from a list of CPS cases, only 8 presented with minimal or no concerns. The remaining four cases were either purged from the State system or investigated by an agency other than the City of Richmond.

The regional experts noticed, “Most importantly, there is consistent evidence to suggest child safety was either never assessed or assessed at a point in time far after the validation process took place. In many other instances, assessments of risk were based on assumptions not supported by documentation where it seems children may have been left in vulnerable situations. .... There also seems to have been a lack of CPS staff to handle the large number of referrals vacated by exiting staff. In this case, it would seem assistance from the Regional Office should have been requested with the potential use of alternative departments to prevent pending referrals from lying idle for months with no interaction.”

Subsequent to the previous investigations conducted by the Inspector General's Office, the State of Virginia, and the Child Welfare League of America, it was determined that cases in excess of 800 were out of compliance. These cases had been open beyond the timeframe permitted by the State policies. The Interim Director desired to bring the Department in compliance with these policies and instructed the Program Manager over these cases to identify a mechanism for this purpose.

The Program Manager at this point assumed complete responsibility of bringing the cases in compliance. However, during this process the Program Manager did not inform the Interim RDSS Director, the Deputy Chief Administrative Officer over Human Services, and the VDSS representative assigned to the City of Richmond, about the methodology she followed for closing the cases.

The Program Manager developed a five point criteria methodology to close the cases, as follows:

1. It had been over four months since completion due date.
2. It was not sex abuse, Out of Family (OOF), or there was no indication of an unsafe condition at the time of initial contact.
3. There were either no new referrals, or the family is open to services in Family Preservation or CPS Ongoing.
4. There were no red flags indicating an unsafe or high risk situation.
5. Unusual circumstances - discussed with Program Manager.

The investigators noticed the Program Manager did not follow these criteria when she closed the cases. In addition, as a manager of this function, she did not evaluate if the criteria was used consistently for the cases closed during the above period.

The Program Manager did not consult the Interim RDSS Director or the state representative, regarding the appropriateness of these criteria for closing the cases. Subsequent inquiries by the investigator with the VDSS management revealed VDSS did not review or approve the above criteria for case closure by RDSS. Furthermore, these criteria do not meet CPS regulation or policy. In addition, the criteria used by RDSS were significantly limited, compared to the tool used by the City of Virginia Beach in similar situations (Exhibit A).

### ***Conclusion***

Based on the findings, the OIG concludes that the allegations are substantiated. It appears that in order to reduce the number of open cases that were out of compliance with the State Policy, the Program Manager made decisions that may have compromised safety of children.

The OIG recommends appropriate disciplinary action against the Program Manager.

The OIG found the allegation to be substantiated. If you have any questions, please contact me at extension 5616.

Sincerely,

*Umesh Dalal*

Umesh Dalal, CPA, CIA, CIG  
City Auditor/Inspector General

c: Mr. Stephen W. Harms, Interim DCAO, Human Services  
City Council Members  
City Audit Committee

**Child Welfare Supervisory Tool  
 CPS Investigations**

Reviewer: \_\_\_\_\_

Review Date: \_\_\_\_\_

**DEMOGRAPHICS**

**1. Case Name:** \_\_\_\_\_

**2. Referral #:** \_\_\_\_\_

**3. Assigned Worker:** \_\_\_\_\_

**Child and Family Services Review Outcomes**

**Safety Outcome 1:** Children are first and foremost protected from abuse and neglect- (1) Timeliness of response; (2) No reoccurrence of maltreatment

**Safety Outcome 2:** Children are safely maintained in their homes- (3) Prevention of removal; (4) Efforts to maintain safety and reduce risk

**Well-Being Outcome 1:** Families have enhanced capacity to provide for their children's needs- (17) Needs and services of child's parents and foster parents (18) Child and family involvement in case planning (19) Caseworker visits with the child (20) Caseworker visits with the parents

**Well-Being Outcome 2:** Children receive appropriate services to meet their educational needs- (21) Educational needs of the child

**Well-Being Outcome 3:** Children receive adequate services to meet their physical and mental health (22) Physical health of the child (23) Mental/behavioral health of the child

<b>SDM Assessments</b>		<b>Comments</b>
S1 (1)	Intake tool and response time	
S1 (1) S2 (3/4) WB1 (17,19,20)	Safety Assessment (Safe, Conditionally safe, Unsafe)	
S1 (1) S2 (3/4)	Safety Assessment entered timely	
S2 (3/4) WB1 (17,18,19,20)	Safety plan and/or protective agreement completed with the family and entered in safety assessment	

S2 (3/4) WB1 (17) WB3 (23)	Risk Assessment (Low, Moderate, High, Very High)			
<b>Prior History</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
S1 (1/2) S2 (3/4)	Prior CPS/Foster Care/Agency history obtained, reviewed and documented?			
S1 (1/2) S2 (3/4)	How many referrals were received?			
Comments:				
S1 (1/2) S2 (3/4)	Results of mandatory screenings obtained, reviewed and documented? (Spider, Accurint, CPS checks of other individual in the home, Court checks, sex offender registry, SNAP benefits, etc.).			
Comments:				
S1 (1/2) S2 (3/4) WB1 (17)	CPS/Foster Care history obtained from other states, reviewed and documented? (If applicable).			
Comments:				
<b>Environment</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
S2 (4) WB1 (19,20)	Documentation of home visit and condition: If no, was reason given?			
S2 (4) WB1 (19,20)	Documentation of observation of where abuse occurred: If no, was reason given?			
Comments:				
<b>Interviews/Documentation</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
S1 (1/2) S2 (3/4) WB1 (17,18,19,20)	Was case completed and closed within the 45 day timeframe as required by CPS policy?			
S1 (1/2) S2 (3/4)	Was an extension requested?			
S1 (1/2) S2 (3/4)	Was case completed in the extension timeframe?			
Comments:				
S1 (1/2) S2 (3/4) WB1 (17,18,19,20)	Are all the mandated contacts clearly documented in OASIS?			
Comment:				
S1 (1/2) S2 (3/4)	Are all monthly face to face contacts documented within 72 hours as required by VBDHS agency policy?			
Comments:				
S1 (1,2)	Was the complainant contacted to discuss the allegations further?			

S1 (1/2) S2 (3/4) WB1 (17,18)	Was the non-custodial parent contacted?			
S1 (1/2) S2 (3/4) WB1 (17,18)	If the parent is not involved, what were the attempts to engage the parent?			
Comments:				
S2 (4) WB1 (19) WB3 (22)	Were all children (ages 0-8) in the home photographed?			
Comments:				

<b>Interviews/Documentation</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
S1 (1/2) S2 (3/4) WB1 (17,19) WB3 (22)	If child is under age 2, allegations of physical abuse and/or nonverbal, is there clear documentation to support that child was observed to assess, injury, safety and risk?			
S1 (1/2) S2 (3/4) WB1 (17) WB3 (22)	If child is under age 1, was safe sleep addressed and outcome documented?			
Comments:				
S1 (1/2) S2 (3/4) WB1 (17,18)	Is there documentation to support a discussion around the available supports to the family (neighbors, relatives, etc.)?			
Comments:				
S1 (1/2) S2 (3/4) WB1 (17,18,19,20) WB2 (21) WB3 (22,23)	Is there documentation to support that the SDM factors were discussed with the family?			
Comments:				

<b>Collateral Contacts</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
S1 (1/2) S2 (3/4) WB1 (17) WB2 (21) WB3 (22,23)	Does the documentation support that the frequency and quality of contacts with knowledgeable and credible collaterals, professional providers of service and/or resource providers were sufficient to thoroughly assess safety and risk?			
S1 (1/2) S2 (3/4) WB1 (17) WB2 (21) WB3 (22,23)	<b>Number of Collateral contacts</b>			
Comments:				
S1 (1/2) S2 (3/4) WB1 (17)	Quality of collateral contacts to thoroughly assess safety and risk:			



<b>Assessing Safety and Mitigating Risk</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
S1 (1/2) S2 (3/4) WB1 17,18,19,20)	Was the safety decision on the Safety Assessment appropriate?			
Comment:				
S1 (1/2) S2 (3/4) WB1 (17,18)	Was a Safety Plan made?			
S1 (1/2) S2 (3/4) WB1 (17,18)	Was a protective agreement completed and did it address safety and risk factors?			
Comments:				
S1 (1/2) S2 (3/4) WB1 (17,18)	If Safety plan was utilized, were the appropriate screenings (CPS, Criminal Background, Sex Offender registry, and Home Assessment) completed?			
Comments:				

<b>Educational</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
WB1 (19,20) WB2 (21)	Does documentation support that the educational needs of age appropriate children were assessed (i.e., IEP, SST, attendance, tutoring needs)?			
Comments:				
WB2 (21)	Did worker obtain appropriate educational documentation?			
Comments:				

<b>Physical Health</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
WB1 (19,20) WB2 (22)	Does documentation support that the physical health and dental needs of the children were assessed?			
Comments:				
WB3 (22)	If identified as a well-being need, does the documentation support that the child's physical health needs were satisfactorily addressed by the provision of services to meet those needs (i.e., immunizations, periodic health & dental screenings, hygiene)?			
Comments:				

<b>Mental Health</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
WB3 (23)	Does documentation support that the children's mental health needs were assessed (i.e., discussions with mental health professionals, psychologists, counselors)?			
Comments:				
WB3 (23)	If identified as a well-being need, does documentation			

	support that the mental health needs are being met?			
Comments:				
<b>Substance Abuse</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
WB1 (19,20) WB3 (22)	Does documentation support that the substance abuse issues of the child or issues of substance exposed infant were assessed? (i.e., drug testing, substance abuse evaluation).			
WB1 (17,18,20)	Does documentation support that the substance abuse issues of the caretakers were assessed? (i.e., drug testing, substance abuse evaluation).			
WB (17,18) WB3 (22)	If identified as a need, does the documentation support that the child/caretaker's substance abuse treatment was satisfactorily addressed by the provision of services and/or drug testing?			
Comments:				

<b>Case Staffing</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
S1 (1/2) S2 (3/4)	Are the required supervisory staffings documented?			
Comments:				
S1 (1/2) S2 (3/4)	Was the City Attorney staffing documented appropriately?			
Comments:				
<b>Court Action and Intervention</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
S1 (1/2) S2 (3/4)	Was court action taken and appropriately documented to keep the children safe? (PO, Petitions, ERO).			
Comments:				
S1 (1/2) S2 (3/4) WB1 (17,18)	Were interventions done to reduce or remove risk to the children? (i.e., safety plans, removal of alleged abuser, in-home services, etc.).			
Comments:				
<b>Family Partnership Meeting/Teaming</b>		<b>Yes</b>	<b>No</b>	<b>N/A</b>
S1 (1/2) S2 (3/4) WB1 17,18,19,20)	Was a FPM held on high risk cases to attempt to prevent removal?			
Comments:				
S1(1/2) S2(3/4) WB1(17,18,19,20)	Was a Family Teaming held at closure to address safety and provide supports to the family?			
Comments:				

<b>Steps to completion:</b>	<b>Date To Be Completed</b>	<b>By Whom</b>	<b>Actual Date Completed</b>
1.			
2.			
3.			
4.			
5.			

\_\_\_\_\_  
 Signature of Supervisor/Reviewer

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Family Services Specialist

\_\_\_\_\_  
 Date