Richmond Office of the City Auditor

Office of the Inspector General

Fighting government waste, fraud and abuse

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Richmond City Auditor/Inspector General

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Honorable Members of the City Council

The Office of the Inspector General has completed an investigation in the Department of Social Services. This report presents the results of the investigation.

Allegations:

A member of the City Council informed the Office of the Inspector General that several employees approached him and alleged several significant issues with the operations of the Richmond Department of Social Services (RDSS). Independently, the Office of the Inspector General received numerous allegations from RDSS employees. The investigators met with the employees who made the following allegations:

- RDSS management made decisions that compromised the safety of children served by the Child Protective Service Unit (CPS).
- RDSS followed unfair hiring practices. This allegation was investigated by the City's Human Resources Department and was found to be unsubstantiated.

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.

Investigative Procedures:

- Interviewed RDSS employees, including CPS supervisors and caseworkers
- Reviewed case files
- Reviewed records kept by RDSS management
- Reviewed personnel files
- Reviewed e-mails for several DSS personnel
- Interviewed Virginia Department of Social Services (VDSS) management
- Interviewed former RDSS employees
- Examined the records room's procedures and reviewed the records retention policies

City's Actions to Investigate and Address RDSS Issues:

Several media organizations learned about the questionable practices in RDSS and the outcome of these practices, and they published a story regarding the allegations. The Deputy Chief Administrative Officer subsequently resigned. At the request of a City Council member, the Office of the Inspector General conducted this investigation. A seasoned professional, who recently retired from the State of Virginia was hired to replace the former Deputy Chief Administrative Officer. Subsequently, at the City's request, VDSS appointed a team of investigators to assess the current conditions in RDSS. This team has completed their investigation and will release their report in the near future. In addition, the Child Welfare League of America (CWLA), a non-profit group from Washington, DC specializing in social services matters, was retained to investigate the allegation and to issue policy recommendations.

Background:

RDSS introduced Virginia Children's Services Practice Model which is a state-wide initiative to reduce the number of children in foster care. The Virginia statewide initiative supported providing additional services to children and their families to reduce the need for removal of the children from their homes. This initiative emphasized on children's safety. Therefore, this initiative did not conflict with the need to remove the children to ensure their safety.

RDSS received recognition from VDSS for keeping more juveniles in their homes, which was the State's goal. RDSS was invited to share their accomplishments with the other social services departments in various jurisdictions in Virginia.

RDSS, encouraged by this recognition, decided to apply the philosophy of keeping vulnerable children, assisted by the CPS Program, in their homes. This Program helps by removing vulnerable children from an abusive home environment to a safer environment such as foster care.

Intimidation, Unrealistic Expectations and Lack of Guidance:

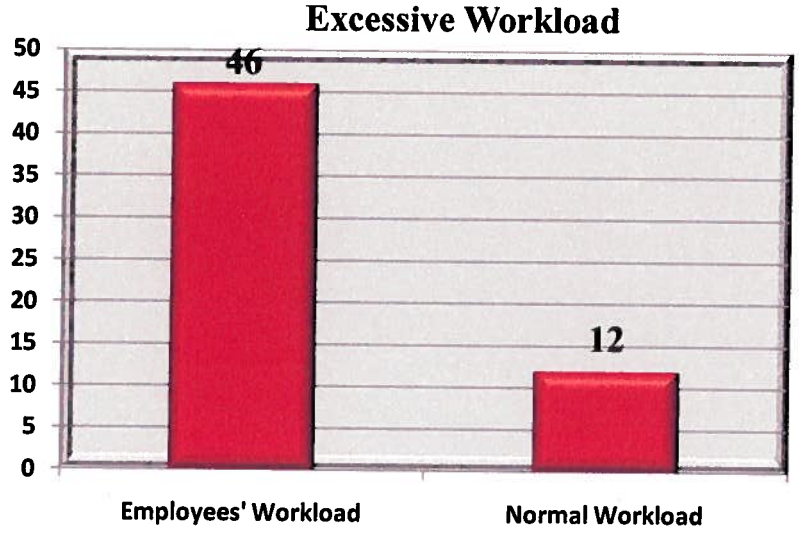
Many of the RDSS employees interviewed during this investigation collectively voiced that the Department had a hostile work environment. They further alleged that management was verbally abusive to employees and constantly moved employees who did not follow their instructions when employees thought it was not in the best interest of their clients. Employees felt intimidated by their immediate supervisors and upper management. Their observations and concerns are noted below:

- **Behavior:**
  - Rude behavior was exhibited by supervisors toward their subordinates.
  - Employees were publicly humiliated by reprimanding them in the presence of other employees.

- Employees challenging upper management practices were disciplined by removal, and transferring to other service areas.

- **Lack of proper guidance**
  - The employees received initial training upon employment with the City. RDSS did not provide on-going training to stay abreast of the latest record retention and destruction requirements.
  - RDSS did not have comprehensive policies and procedures to provide appropriate guidance for CPS workers to carry out their job duties.
  - Supervisors were often not available for team development meetings.

- **Unrealistic Expectations**
  - Employees were negatively evaluated for minor performance issues without considering the employees' excessive workload. For example, an employee received a negative performance evaluation due to missing phone calls. The demand for the employee's time for competing case load priorities was not considered. Due to staff turnover, many of the remaining employees currently have an unmanageable case workload.
  - According to CWLA standards the recommended caseload per caseworker is 10 to 12 active cases per month. However, CPS had 599 active cases that transpired into 46 cases per employees. This issue is depicted in the following graph:



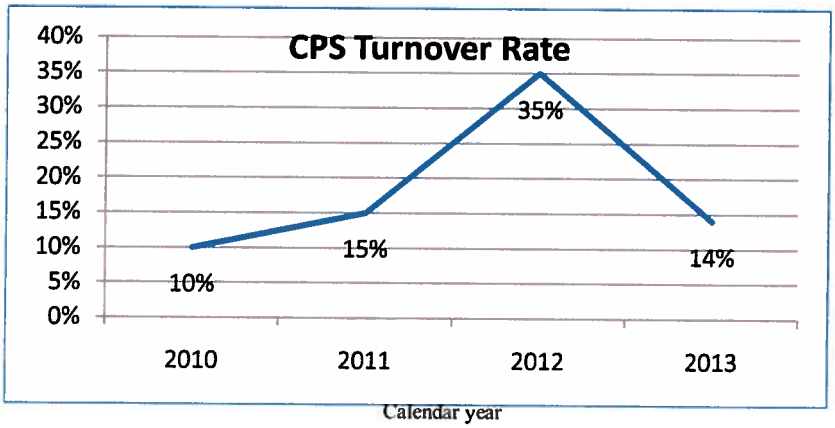
  - RDSS did not meet the deadlines established by VDSS for certain tasks such as ensuring timely contacts per the State's Safe Measure Requirement Policy. The investigators were informed that when RDSS could not comply with the State mandates, VDSS offered to help and show the willingness to grant time extensions. However, RDSS did not accept VDSS's assistance.

Employee Morale:

- Concerned employees expressed their lack of confidence in the administration and RDSS Management to address their concerns to resolve workplace issues. These employees were not able to meet with the RDSS Director to discuss the issues identified while performing their duties. Based on a memo dated November 13, 2012, six CPS caseworkers communicated their concerns to the Director in writing. The Director did not take any actions or offer to meet with the employees to resolve their concerns.
- During the interview, the RDSS Director indicated that she was not aware of intimidation and change of direction in the CPS Unit. Accordingly, the Director did not take any action or get involved in resolving the issues. In order to manage the department, the director is expected to be knowledgeable about changes in the department and the potential impact of such changes. In this case, the consequences of the changes were significant and did impact health and safety of children who were in abusive homes.
- The Chief Administrative Officer offered to speak with the RDSS employees to hear their concerns. During interviews, employees expressed that CAO refused to accept anonymous communications from employees. The employees indicated that this offer did not encourage them to candidly discuss their concerns.

Employee Turnover:

During this time, employee turnover increased substantially. The normal turnover for the CPS unit, prior to the above changes, was 10%. Turnover increased up to 35% subsequent to the changes which are depicted in the following graph:



Unsound Management Practices

The investigators noted the following management practices:

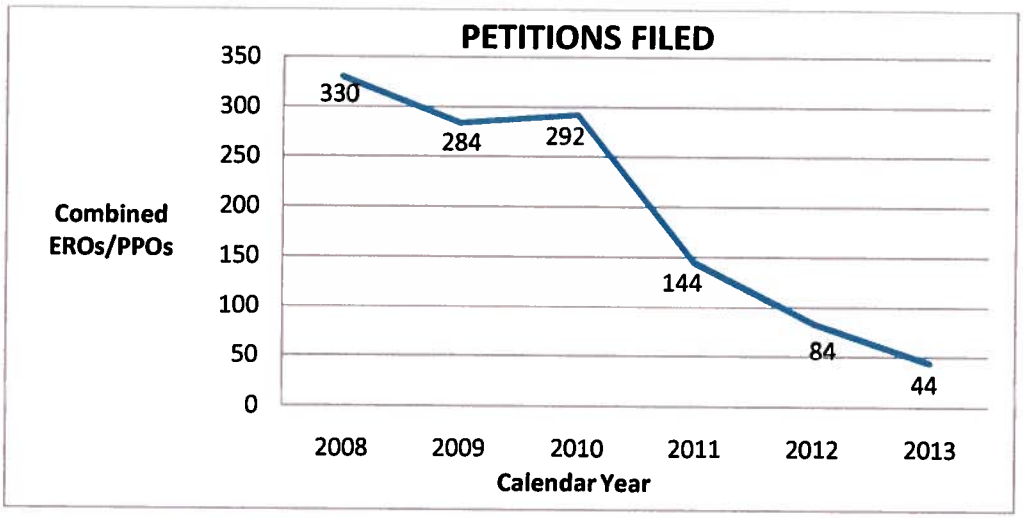
- The caseworkers were leaving children in an unsafe environment. Until May 2011, the supervisors were authorized to initiate the removal of a child from unsafe conditions. Since that date, they have been required to obtain approval from the Program Manager and the Deputy Director. The caseworkers were directed by management not to prepare the Personal Protective Orders (PPO) and Emergency Removal Orders (ERO).
- Management edited prepared PPOs and EROs to change the content in order to minimize the impact so that the Court would not fully understand the facts reported. These actions minimized the caseworkers' findings prior to filing them with the Court and made it less likely to result in the removal of a child from an abusive home.
- It has been a long standing practice to remove unattended children from their homes. Management's instructions prevented caseworkers from discharging the duties of emergency removals. They were directed to wait at each home until the parent/custodian arrived instead of immediately (timely) removing the children.

  The investigators were informed that, in one case, two toddlers were found roaming in their neighborhood by themselves at about 2:00 am. The RDSS Second Responder caseworker initially attempted to locate the caregiver unsuccessfully. RDSS management instructed the caseworker to continue looking for the caregiver and not to take the children into custody. The caseworker visited more than 100 residences and finally located the caregiver. The caseworker was instructed to release the children in the custody of the caregiver and not to prepare documentation such as a PPO or ERO. In addition, since RDSS did not open a case for the incident, RDSS did not follow up on the well-being of the children.

- Management prohibited timely removals which were warranted by observations of the CPS On-Going Unit caseworkers. Although the staff possessed the authority to conduct emergency removals, they were instructed to call the CPS Hotline. This process may have delayed the needed removal and exposed the children to unsafe conditions and abuse.
- Caseworkers routinely operate in an environment where they need to consult the City Attorney's Office while conducting their work. RDSS management directed caseworkers not to confer with their assigned City Attorney's staff to obtain legal advice. The caseworkers were directed not to release any information to the City Attorney's Office until it had been approved by RDSS management. This action prevented the City Attorney's Office from rendering opinions on potential removal of children from abusive homes. Several e-mails indicated that employees must forward any verbal or written communication related to the cases for management approval prior to submitting it to the City Attorney's Office. Before the new management changed the direction of the Department, the caseworkers were able to get legal consultation whenever it was necessary.

- Management ignored professional medical recommendations for client care. In one of the cases discussed subsequently, the medical professional was of the opinion that the caregiver did not demonstrate the capacity to adequately meet her children's needs. The caregiver was struggling with drug addiction and had clinically significant symptoms of anxiety and depression. The caregiver did not have the cognitive or emotional skills to provide an adequate or healthy home environment. RDSS management did not agree with the City Attorney's Office and the medical professional's opinion and left the child in the custody of the caregiver.

The above strategy paid off for management in what they wanted to accomplish. The number of PPO and ERO petitions dropped significantly as depicted in the following graph:



Note: 2013 statistic represents filings up to May 3, 2013

Under normal circumstances, this performance would enhance the Department's accomplishments and give them state-wide recognition. In addition, this type of recognition would promote members of RDSS management. However, this practice came with a high price as discussed throughout the report.

The Inspector General's Office Review of Case Files:

The investigators learned that 35% (37 of 107) files requested by the State investigators for their review were missing. The Inspector General's Office requested 250 additional files to determine if this ratio of missing files was prevalent for the entire population of active files.

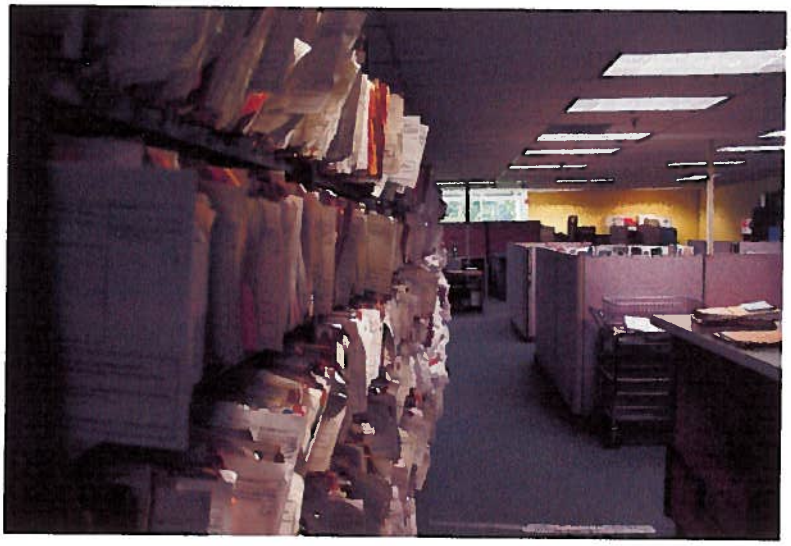
During the case file reviews, the investigators noted the following in the 250 files requested for review:

- The total population of files requested included 155 investigations and 95 family assessments.

- 24 case files, which were unfounded investigations, had been purged in the State System (Oasis). DSS was not required to maintain these files therefore; these files were not available to the investigators.
- Of the remaining 226 case files, 34% or 77 files were missing. The Program Manager admitted that the files were recreated by printing the information contained in Oasis. The documents in the files were printed between March 13, 2013 and March 19, 2013. These files did not contain any original documentation such as medical reports, assessments, etc. In addition, one file did not contain any documentation. Based on this observation, 452 files are expected to be missing in the entire population of 1,225 cases.
- Several of the other 149 files were missing key documentation. A large number of files contained documentation that was augmented with Oasis information rather than the original documents.
- The investigators noted that several "Level I" substantiated investigative files, which require a retention period of 18 years, did not contain any original documentation. This means that the documents were either missing or destroyed.

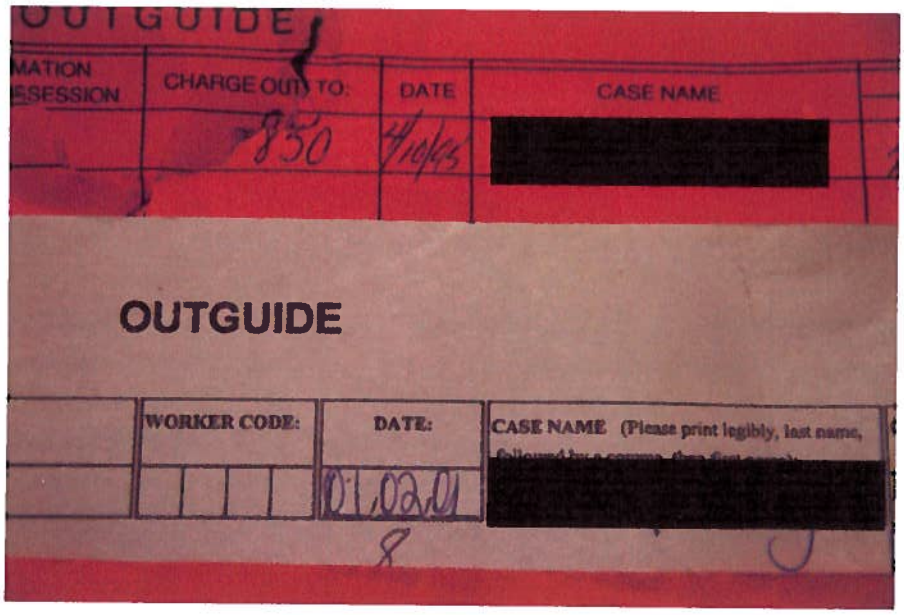
The above discrepancies are a result of lack of records management as described below:

The investigators visited the RDSS records room. This room is expected to hold closed case files. Periodically, RDSS caseworkers and their supervisors remove files from the file room if they receive an additional complaint on a closed case. The investigators observed that more than 50% of the files were removed from the records room as indicated by "out-cards" inserted in place of the files removed. The following picture depicts the condition of the records room:



The investigators found that the caseworkers who removed some of the files are no longer employed by the City. Some files were checked out a significantly long time ago. For example, the investigators found that one of the files was checked out in 1995. The whereabouts of some

of the files are not known. RDSS must manage the records more effectively. The following picture depicts the point:



Conditions that Warranted Removal of Children

The investigators learned of the following conditions during their case files review that contributed to an abusive environment:

- Caregivers (parent, guardian) who lacked the cognitive skills to care for the children
- Caregivers with systemic drug addiction and on-going psychiatric challenges
- On-going history of abuse by the caregiver
- Homelessness and/or lack of stability
- Caregivers with their own history of abuse which affected their care for their children

RDSS went too far in its quest to reduce the number of removals; this puts vulnerable children in an unsafe environment as discussed below:

Case File Review

Based on the information received during interviews, the investigators selected four cases for further review. The following discussion provides details of the review.

Case I

Background:

This case pertains to a family where one of the caregivers had mental health challenges. The family had a history of:

- *Physical child abuse*: One of the children went to school bleeding and bruised. According to the records, the caregiver had beaten the child with a blunt object. In addition, a toddler was also discovered by the RDSS caseworker to have severe burns.

- *Poor hygiene*: One of the children was observed wearing soiled clothing that smelled like mildew and sewage.

- *Inadequate Nutrition, Shelter and Clothing*: Before the family moved to Virginia, another state DSS had found the following:
    - Inadequate supervision,
    - medical neglect,
    - Inadequate food, shelter, and clothing. A family of seven resided with the maternal grandmother in addition to her own family. The house was deemed to have been overcrowded to a point that it was not considered safe.

- *Lack of Proper Medical and Mental Health Care*:

  Medical Health Care:

    - The Caregivers did not seek routine medical care for their children. RDSS caseworker observed:
        - Severe diaper rash
        - Skin burns
        - Lack of immunizations
        - Bruises
        - Two of the children had not been seen by a pediatrician for a year since moving to Virginia in 2011

  Mental Health Care:

    - Caregiver - One of the caregivers had been hospitalized twice for psychiatric care in another state. The caregiver failed to follow up with the mental health care professional upon coming to the State of Virginia. In addition, the caregiver failed to take prescribed medication for mental well-being.

    - The Caregiver with mental health issues was excluded from the home due to a criminal court order for assaulting the mentally challenged child. The spouse allowed this caregiver to move back into their home without RDSS' permission or knowledge. RDSS did not take any actions upon learning of the caregiver's return to the home.

- Children – The caregivers did not seek needed mental health care for the children. Some of the children exhibited aggressive violence towards each other. They also exhibited attention deficit disorder, suicidal ideations, etc.

RDSS did not file a PPO, an agreement for the caregivers to comply with certain requirements, until five months after the initial incident. In this case, the children continued to be exposed to physical and mental abuse. Therefore, removing the children from their home would have been beneficial.

Case II

Background:

A child had a severe medical condition that needed constant care. The child was in the hospital numerous times for weight loss. He had a feeding tube due to an illness. The child has Failure to Thrive Syndrome and has kidney problems leading to kidney failure. He has a catheter that needs to be drained every four hours. He gains weight while in the hospital and loses weight when he goes home.

Doctors at the hospital thought the mother wasn't doing enough to appropriately care for the child's medical needs. According to the State representative, RDSS acted appropriately. There was no evidence that the mother did anything wrong.

Case III

Background:

One of the caregivers had a history of drug use and mental health issues and did not have cognitive skills to learn and to retain how to care for the child. The other caregiver was capable of providing appropriate care but worked long hours to support the family. The child was left to the care of the caregiver who had mental health issues.

Caregiver's History:

The caregivers' two oldest children were removed and placed in the custody of their maternal grandmother. RDSS had removed two other children due to being severely underweight. The older of the two children removed by RDSS had old femur fractures on both legs and significant developmental delays. The other child also was malnourished and had scalp burns.

The caregiver had a fifth child. When the caregiver gave birth to the fifth child, the hospital notified RDSS of the child's premature birth, exposure to drugs prior to birth, and a condition that needed constant medical care as the child:

- Was hospitalized numerous times for weight loss due to the Failure to Thrive Syndrome illness. The child gained weight while in the hospital but lost weight upon returning to the home.
- Required a feeding tube due to the medical condition.

Doctors at the hospital thought that the mother wasn't doing enough to appropriately care for the child's medical needs. The caregiver with mental health issues was not able to learn care giving procedures due to her limitations. This caregiver consistently missed doctor's appointments for the child.

The City Attorney's Office, after learning the family's history, rendered a written opinion to remove the fifth child from the custody of the caregivers. RDSS made a decision to keep the child in the caregivers' custody despite of attorney's advice.

Based on caseworkers' interviews and documentation in various e-mails, the RDSS Deputy Director over CPS programs suggested on several occasions that additional services be provided to keep the child at home. RDSS's decision not to remove the child immediately from the home exposed the fifth child to undue risks.

Case IV

Background:

This case pertains to a homeless caregiver who had mental health issues. The caregiver had six children, one of whom was an adult and lived on its own. This case was brought to the attention of RDSS through a hospital notification of a child who had an old injury that was possibly the result of abuse and neglect. The pertinent facts are as follows:

- An adult sibling of the injured two-year old child took the child to the hospital to seek medical attention. During preliminary examination, the doctors suspected that the child had a broken leg. However, the child's mother retrieved the child before medical treatment had been rendered.
- The caregiver was located by Richmond Police convinced the caregiver to return the child to the hospital. The doctors found that the child had a broken femur which had occurred two and a half weeks prior to the examination.
- The broken femur began to heal incorrectly and resulted in making the injured leg about two inches shorter than the other leg.
- The medical professionals described the injury as the result of blunt force trauma which was not consistent with information received from the caregiver.

RDSS conducted an emergency removal and also removed all minor children living with the caregiver. During the investigation, RDSS concluded that the case was unfounded due to their inability to determine the identity of the abuser. Not knowing the identity of the abuser did not negate the fact that the abuse occurred. Therefore, the case should have been founded

with an unknown abuser. The Deputy Director over CPS programs instructed the caseworker not to file a petition to remove the children from the household even though she was aware of the history in this case. Ultimately, the child was returned to the caregiver. Leaving the child in the environment where the abuse occurred would further expose the child to abuse.

Conclusion

The recognition received by RDSS from adopting the Virginia Children's Services Practice Model encouraged management to leave vulnerable children in an abusive environment. In contrast, the State initiative emphasized the safety of the children. The Initiative did not encourage compromising the children's safety. However, RDSS management's actions and their intimidation of caseworkers resulted in children being left in homes where the caregivers did not have cognitive or emotional skills to take care of the children. Often, the caregivers had drug addiction and/or severe mental health issues. In some cases, children with severe health conditions needed additional care which the caregivers could not provide. In these cases, the health and safety of the children were compromised.

If you have any questions, please contact me at extension 5640.

Sincerely,

Umesh Dalal

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City Auditor/Inspector General

Cc: Byron C. Marshall, Chief Administrative Officer
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