

L.J. v. Massinga Independent Verification Agent
CERTIFICATION REPORT FOR DEFENDANTS’
73rd COMPLIANCE REPORT
July 1 – December 31, 2024

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Note: Beginning with the 64th Report, Defendants’ Six-Month Compliance Reports, and the IVA’s Certification Reports can be found on the Maryland Department of Human Services website under the “Consent Decree” tab.

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**IVA CERTIFICATION REPORT FOR
DEFENDANTS' 73rd COMPLIANCE REPORT**

EXECUTIVE SUMMARY

This is the Independent Verification Agent's Certification Report ("IVA Report" or "IVA Response") for the Defendants' 73rd Compliance Report ("Defs.' Report") covering the July 1 – December 31, 2024 report period of the *L.J. v. Massinga* Modified Consent Decree (MCD). Defendants Baltimore City Department of Social Services (BCDSS) and Maryland Department of Human Services (DHS) provided their report to the IVA and Plaintiffs on October 13, 2025, more than nine months after the end of the report period. The ongoing delay in submitting reports has been raised repeatedly in prior IVA reports. Defendants have not explained why these delays occur, but it is clear that data collection and reporting does not explain it. Defendants still report 70% of the measures as "TBD."

There were 1,445 children in BCDSS foster care as of October 31, 2025. Between October 1, 2024, and September 30, 2025, the rate of entry of children into foster care¹ in Baltimore City was 4.44 per 1,000 children, an increase from the prior year entry rate of 3.65. Children in foster care in Baltimore City continue to remain in foster care substantially longer than the timeframes set out under federal permanency targets.

The IVA is unable to describe other important characteristics and needs of children in BCDSS foster care due to the unavailability of adequate accurate information and reports about the children in CJAMS (Child, Juvenile and Adult Management System), the statewide child welfare database. The problem and impact of poor documentation in CJAMS was highlighted in the 2025 report from Chapin Hall that was commissioned by the Defendants, "Maryland Social

¹ Throughout this report, the terms "foster care," "out-of-home care," and "out-of-home placement" ("OHP") are used interchangeably.

Services Administration Placement Needs Assessment” (hereinafter referred to as the “Chapin Hall Report”). This assessment, in addition to providing data and insight into the ongoing placement challenges experienced by children in BCDSS out-of-home care and across the state, raises concerns about how poorly CJAMS is documented in critical areas. The findings of the Chapin Hall Report align with many of the same data problems identified and reported by the IVA in the past.²

DEFENDANTS’ REPORT

Defendants’ Report Does Not Provide an Accurate Picture of the State of the System

In most other child welfare litigation, a monitor has been appointed to provide the Court with a true picture of the status of the system. *L.J.* has been unusual in relying on the Defendants to provide the court with that information and relying on an IVA for certification of the data provided by Defendants. It is therefore particularly important that Defendants’ reports accurately describe the status of the Baltimore City foster care system. Instead, the Defendants’ reports have been utilized to portray the system favorably and to minimize concerns about areas where the system is not meeting the needs of the children and families it is charged with serving.

For example, Defendants failed to report important data that was available to them when they provided their 73rd Report to the IVA and Plaintiffs in October 2025. By that time, data was available for 10 of the 15 MCD measures that had been designated as priorities for report development. However, Defendants provided data for only 3 of those 10 priority reports. This IVA Report provides that additional data for family involvement meetings, case plans, Youth Transition Plans, caseworker visits, ongoing health care for children, and caseloads and

² Discussion of these issues and citations are on pp. 15 - 19 of this report.

supervisory loads for not only the 73rd report period but also for the 74th report period (ending June 30, 2025) and 75th report period (ending December 31, 2025).

In April and September 2025, the Maryland Department of Legislative Services (DLS) issued audits of Defendant DHS' Local Department Operations and Social Services Administration (SSA) Operations. Those reports contained 18 findings of non-compliance including, among others, failure to implement effective oversight of local departments; failure to monitor foster care providers properly; failure to ensure accurate data in CJAMS; and failure to provide required medical and dental exams. DLS raised particular concerns that six of the eight audit findings in a 2021 audit of SSA were repeated in the 2025 audit. Defendants failed to mention either of these audits in their 73rd Report.

Of greater concern about Defendants' latest report is the presentation of information that Defendants have reason to know is inaccurate or misleading in the context in which it was presented. This report highlights four areas of particular concern:

(1) Reporting of erroneous maltreatment-in-care data. The correct data showed declining, not improving, performance from the 71st to the 73rd report periods.

(2) Reporting that children entering foster care received necessary health screenings and comprehensive assessments, when only 66.5% of children had received their comprehensive medical, dental, and mental health exams within the first 60 days in foster care.

(3) Limiting reporting of ongoing health care data to CFSR data which looks at a small set of 26 foster care case reviews in 2024, when less than 10% of all children in foster care actually received timely ongoing health care for this report period.

(4) Providing data for family engagement that is limited to meetings that take place within three days of a child's entry into foster care when available data demonstrates that family involvement in ongoing planning meetings was no greater than 20% for the report period.³

Ongoing Data Collection and Reporting Concerns

The MCD is divided into five substantive sections - Preservation and Permanency Planning, Out-of-Home Placement (OHP), Health Care, Education, and Workforce. There are 28 Outcomes spread across these five substantive sections. Compliance with the Outcomes is measured by a total of 40 Exit Standards. In order to exit the MCD, Defendants must be certified by the IVA as compliant with each of the Exit Standards for three consecutive report periods.

Prior IVA reports have summarized the history and challenges in developing measure instructions which are used to determine how an MCD requirement will be tracked and documented for reporting purposes. Upon the completion of all measure instructions in May 2021, the parties set a goal of January 1, 2022, for implementation of reporting for all of the *L.J.* measures. That goal has not been met for 70% of the MCD measures due largely to ongoing limitations in the CJAMS data and reporting system; poor data input practices; and delays in reinstating use of the Quality Service Reviews (QSR) for reporting on qualitative *L.J.* measures.

Defendants have repeatedly referred to the reporting requirements of *L.J.* as “extremely burdensome,” but the reality is that the reporting that *L.J.* requires is no more than Defendants need to be able to do to meet their basic responsibilities for managing a child welfare system. While a more streamlined set of required reports may make sense at this point in the history of *L.J.*, accurate reporting of important data points will always be a critical responsibility for Defendants.⁴

³ Discussion of these issues and citations are on pp. 19 - 29 of this report.

⁴ Discussion of these issues and citations are on pp. 29 - 35 of this report.

A Lack of Specific Compliance Plan Goals and Assessment of Outcomes for Improvement Efforts

It is difficult to know how much progress has been made in improving performance with MCD outcomes since Defendants continue to lack accurate, valid, and reliable baseline data. However, even without a full set of data on MCD measures, Defendants know where challenges exist. Defendants still have not provided compliance plans or set goals for progress for measures that they know are not in compliance.

In addition, Defendants continue to include in their reports discussions of various improvement efforts without any assessment of the value or effectiveness of those efforts. Effective practices and programs with measurable outcomes are essential if the Defendants hope to ensure safety, improve the health and well-being of children in foster care, and shorten the amount of time children spend in foster care.⁵

CRITICAL SAFETY, PERMANENCY AND WELL-BEING ISSUES

60th Report Cohort Update

This report includes an update on a group of children initially discussed in the IVA's Response to Defendants' 60th Report, subsequently referred to as the "60th Report cohort." This original cohort consisted of 36 children who entered foster care under the age of 13 and who experienced significant placement instability, lack of appropriate placements, and waiting lists for treatment programs. As of November 2025, six years later, 20 of these children remain in foster care. Many of the 60th Report cohort children continue to experience placement instability, appearing on the weekly Overstay/Waitlist, in runaway notices, and in hotel and Children in the Building (extended hours) reports. Some of the youth have stabilized but remain in congregate care placements, have not achieved permanency, and have no potential permanent placement

⁵ Discussion of these issues and citations are on pp. 35-36 of this report.

resource available. It appears likely that the older youth in the cohort will age out of the foster care system without ever achieving permanency. Two case examples in this report highlight the experiences and challenges of this cohort - all children who entered foster care at a young age for reasons not related to their behavior (a reason cited by Defendants for the challenges they face with finding appropriate placements for some children in their care).

What is clear from the tracking of this cohort is that Defendants must identify young children with placement disruptions early and work to identify and put into place the needed services to stabilize the child in a family setting. Otherwise, the risk for long stays in foster care with significant placement instability increases. A case with a similar history to those of the 60th Report cohort recently came to the attention of the IVA when a young girl began appearing regularly on the Overstay/Waitlist. The story of SM, a now 9-year-old girl who entered foster care at 2-years-old when her mother “aged out” of foster care, is also shared in this report.

Without intensive wraparound services, appropriate community-based placements, and where necessary, adequate short-term, effective, high-intensity placements, other young children are at risk of placement instability and long-term foster care.⁶

Caseloads Have Continued to Decrease

Reasonable caseloads are essential to both the provision of services to ensure safety, permanency and well-being, and to documenting those services in CJAMS. Under the MCD, OHP caseworkers may not have caseloads of more than 12 children. Over the past two years, BCDSS has steadily increased the percentage of caseworkers meeting the 12 children per caseworker caseload level - from 13% at the end of 2023 to 50% as of the end of October 2025. Defendants have credited focused recruitment, streamlined hiring processes, and an emphasis on retention for

⁶ Discussion of these issues and citations are on pp. 36 - 41 of this report.

these gains. These commendable efforts need to continue, even as improvements have been made. Although Defendant BCDSS has been able to replace staff leaving over the past year - an important improvement - staff turnover remains a serious problem. Staff turnover results in case transfers and new hires that frequently lack experience and require restricted caseloads for a period of time. From July 1, 2024 - June 30, 2025, not including transfers to and from family preservation or to specialty units, there were 587 case transfers within the OHP program. Case transfers impair the engagement with children and families needed to assist them in resolving problems and attaining reunification or other forms of permanency on a timely basis.⁷

Engagement and Case Planning are Critical Components of Child Welfare Practice

Case planning is a critical component of working with families involved in the foster care system. The MCD, as well as state and federal law, requires written case plans for all children placed by the local child welfare agency in out-of-home care. A key element in case planning is engagement with parents, families, and youth. In their report, Defendants highlight the engagement of parents at the point in time when their children enter foster care. However, for children in foster care, ongoing engagement with parents, youth and extended families is critical. Available data shows that Defendants' engagement after initial removal is significantly lower.

The failure to meaningfully engage with families will continue to impact the quality of case planning. Without improvement in parental engagement and case planning, it is unlikely that Defendants will be able to meet the federal targets for permanency for children in OHP.⁸

The Need for More Appropriate Placements and Services Continues

Children in Defendants' care continued to spend multiple nights in BCDSS' office buildings and hotels rather than in homes and other licensed settings during the 73rd report period;

⁷ Discussion of these issues and citations are on pp. 41 - 42 of this report.

⁸ Discussion of these issues and citations are on pp. 42 - 46 of this report.

72 children spent over 1,000 nights there. The frequency of the practice had increased in 2023 and throughout 2024 before starting to decrease in 2025.

While reports of youth staying in BCDSS office building during non-business hours has decreased over the past few months, and there have been no reports of children committed to BCDSS being placed in a hotel since May 2025, children continue to be placed on waiting lists for weeks and sometimes months to obtain an appropriate placement. Some, including children under 12 years old, remain in hospitals, diagnostic facilities or residential treatment centers (RTC) long after they are ready for discharge or for a “step-down” to a less restrictive placement.

Following the October 2025 death of a foster youth (not from Baltimore City) in a hotel and legislative hearings on the most recent Department of Legislative Services’ audit, DHS issued a directive prohibiting local departments from “facilitating the use of hotels or other unlicensed settings for youth experiencing out-of-home care.” While this directive makes it clear to staff that these settings are not acceptable, it does not provide a solution to the lack of appropriate placements that drives the problem, nor does it address the importance of placement stability for children with a history of complex mental health needs and placement disruption. As stated in the Chapin Hall Report, “there is an urgent need to develop placement options for children in foster care, particularly those who are older, have complex needs, or have experienced significant placement instability.”⁹

More Children Living with Kin Caregivers in Licensed Homes

Kinship care generally provides greater stability in placement; results in improved well-being as compared to children in non-relative care; limits the trauma of removal and the circumstances that led to removal; maintains sibling and other ties; and results in improved

⁹Chapin Hall Report, p. 69. Further discussion of these issues and citations are on pp. 47 - 52 of this report.

permanency outcomes. BCDSS has set a goal to place 50% of all children in foster care with kin and to have 90% of those kin licensed (and therefore receiving financial support comparable to non-relative foster parents). Progress has been made in this area, especially in the area of licensing, but there is still work to be done to reach 50% placement with kin. As of October 31, 2025, 40% of all children in Baltimore City OHP were placed with kin.

In 2024, 58% of children who entered care were placed with kin as their first placement. This is an important step in reducing trauma for children entering foster care. However, as important as the rate of kin placement is, children should not just be placed with kin but also stay safely with kin - for their foster care stay if reunification is the plan or, if reunification is not possible, permanently. It is critical that Defendants respond quickly if kin placements are in danger of disruption. Defendants should track the stability of these kin placements and whether they lead to shorter lengths of stay in foster care and improved permanency rates upon exit from foster care.¹⁰

Problems with Providing Timely Health Care Services Continue

Defendants' continuing poor performance in providing timely health care services to the children in OHP is an area of significant concern. While Defendants have continued to ensure initial health screenings when children first enter foster care at a rate nearing the *L.J.* requirement, other required exams have not come close to meeting the state's own requirements or *L.J.* compliance levels.

Foster children in Maryland are required to have comprehensive medical examinations within the first 60 days of entering OHP and comprehensive dental examinations within the first 90 days. During the 73rd report period, the compliance level for those examinations was 57%.

¹⁰ Discussion of these issues and citations are on pp. 53 - 54 of this report.

Over the past two years, no more than 25% of children in OHP have received their annual medical exams on time. Less than 16% of children received the required semi-annual dental examinations timely.¹¹

Adequate Mental Health Services and Data Are Still Lacking

High quality, culturally responsive mental health care is essential to the well-being of children and youth in foster care. The failure to provide this care exacerbates placement problems, and the complexity of mental health issues impacts the length of time a child spends in out-of-home care. BCDSS created the BCDSS Youth Wellness Program to contract directly with mental health providers for services for children and youth and continues to work with Behavioral Health Systems Baltimore (BHSB) to implement the program. The implementation of this program has faced and continues to face many challenges. As of November 2025, only 7 clinicians of the 20 that were anticipated are participating in the program. Furthermore, there continues to be a lack of information about the outcomes, including the quality and effectiveness, of the BCDSS Wellness Program.

There is an overall lack of accurate and complete data available around the mental health needs of children in BCDSS custody. This issue is also raised in the Chapin Hall Report and attributed in part to the lack of documentation in CJAMS. Without such data, it is difficult to identify and develop the mental health services that foster children and their families need for their well-being while in care and for successful exit from the foster care system.¹²

¹¹ Discussion of these issues and citations are on pp. 55 - 61 of this report.

¹² Discussion of these issues and citations are on pp. 61 - 63 of this report.

Data Chart and IVA Certification of Reported Data

In their 73rd Report, Defendants request certification of compliance for two Exit Standards - Measures 52 and 79. For the reasons set out in this report, the IVA denies certification.

Although Defendants do not request certification of compliance, they do meet the compliance levels required for Exit Standards 121, 125, and 126. Compliance with Exit Standard is certified. Under the MCD, certification is no longer required for Exit Standards 125 and 126.¹³

The IVA's Data Chart, Appendix 1 to this Report, contains 73rd report period data available to but unreported by Defendants as well as the IVA's certification decisions on the accuracy, validity, and reliability of the data reported by Defendants for the MCD Exit Standards and Internal Success Measures.

Additional Commitments in the MCD are addressed in Appendix 2 to this Report.

¹³ Discussion of these issues and citations are on pp. 63 - 79 of this report.

**IVA CERTIFICATION REPORT FOR
DEFENDANTS' 73rd COMPLIANCE REPORT**

I. INTRODUCTION

This is the Independent Verification Agent's Certification Report ("IVA Report" or "IVA Response") for the Defendants' 73rd Compliance Report ("Def.' Report") covering the July 1 – December 31, 2024 report period. Defendants Baltimore City Department of Social Services (BCDSS) and Maryland Department of Human Services (DHS) provided their report to the IVA and Plaintiffs on October 13, 2025, more than nine months after the end of the report period.¹⁴ The delay in submission of reports has been raised repeatedly in the IVA reports with no response by Defendants. Data collection and reporting do not appear to be the reason; 70% of measures still remain "TBD" in Defendants' report.

Pursuant to the Modified Consent Decree (MCD), Part One, Section II. J,

Every six months, Defendants shall submit to the Court, with a copy to the Plaintiffs, a report addressing their performance under the Internal Success Measures and Exit Standards and compliance with the Additional Commitments of Part Two of this Decree, based on data reflecting performance for the six-month period covered by that report. The report shall contain a certification by the Independent Verification Agent as to the accuracy of the report or statement by the Independent Verification Agent of the portions of the report that are not certified and the reasons why they have not been certified.

The responsibilities and activities of the IVA are described in the MCD, Part One, Section

II. A - D. They read, in part:

B. Verification activities will have two key functions: (1) to provide accurate, independent information to the Court and the parties about system performance to implement the requirements of this Decree; and (2) to provide feedback to Defendants that supports self-correcting measures and ongoing quality improvement by Defendants.

¹⁴ While the MCD does not specify a timeline for Defendants' report, the length of time between the end of the report period and the submission of the report to the Plaintiffs and IVA continues to be excessive for a six-month reporting cycle. This delay results in the IVA reviewing data for certification that is over a year old when the IVA begins work on the certification report and well over a year when received by the Court.

...

C. The Independent Verification Agent shall be authorized to verify that: (1) the data and other information reported by Defendants are accurate, valid, and reliable; (2) the measures and methods used by Defendants to report data and other information are accurate, valid, and reliable; (3) Defendants have in place sufficient quality control and review processes to verify accurately and regularly the accuracy of data provided through its management information systems; and (4) Defendants' case review process is accurate, valid, and reliable.

The IVA has worked to fulfill these functions through these certification reports and by ongoing work with Defendants to improve access to accurate, valid, and reliable data and the creation of accurate, valid, and reliable data reports.

II. L.J. v. MASSINGA HISTORY, LEADERSHIP AND COMMUNICATION

L.J. history, Defendants' leadership, and communication between the parties and the IVA were discussed at length in the IVA's Response to the 72nd Report and will not be repeated here. DHS Principal Deputy Secretary Carnitra White retired at the end of 2025. Other than her departure, there have not been any notable changes in leadership at either DHS or BCDSS.

On May 8, 2025, presiding Judge Stephanie Gallagher referred the case to Magistrate Judge Susan Gauvey for "settlement/ADR purposes." At the time of the IVA's drafting of this report, the parties were still engaged in negotiations for a possible new modified consent decree. Upon request from Judge Gauvey and Plaintiffs, the IVA has provided input on a new MCD with fewer measures and reporting requirements that would address long-standing and still unresolved problems with the care and services provided to the children and families involved in the child welfare system. Based upon years of prior experience in child welfare and now the IVA role, the IVA has provided specific recommendations as to what agency services and activities are critical to the safety, permanency, and well-being of those children. A new, streamlined MCD with fewer measures could focus on the problems of children lingering in the foster care system; the failure

to ensure appropriate and timely health care of children in foster care; and the lack of adequate services and safe and appropriate placements, particularly for those children with complex health, developmental and mental health needs. Multiple other jurisdictions have successfully exited lawsuits. While these other lawsuits may differ somewhat in issues, scope, and remedies, they have ended with compliance, system improvement and exit (or an exit plan) that has resulted in child welfare systems that better serve children and their families. This can happen in the *L.J.* case as well.

III. CHILDREN IN DEFENDANTS' CARE

While the IVA is responsible for verifying that Defendants' data is accurate, valid, and reliable, it is essential to remember that behind the data are children who often have experienced neglect and abuse compounded by the trauma of removal from their homes and families. All of these children and families deserve a fully functioning child welfare system that works to ensure safety, permanency and well-being.

There were 1,445 children in BCDSS foster care¹⁵ as of October 31, 2025. Between October 1, 2024 and September 30, 2025, the rate of entry of children into foster care in Baltimore City was 4.44 per 1,000 children.¹⁶ This more recent data is an increase from the entry rate of 3.65 per 1,000 in the year ending September 30, 2024, which is the data cited by Defendants in their report.¹⁷

¹⁵ Throughout this report, the terms "foster care," "out-of-home care," and "out-of-home placement" ("OHP") are used interchangeably.

¹⁶ Att. 1, Headline Indicators through October 31, 2025, CJAMS data extract 11/15/25. Downloaded on 1/2/26 from Defs.' Intranet.

¹⁷ Defs.' 73rd Report, p.5.

Children in OHP as of October 31, 2025, by Age and Race¹⁸

Age Group (# children)	Total Children	Black/ African American	Multi- Racial¹⁹	White/ Caucasian	Other/ Unknown²⁰
0-4	446	293	44	94	15
5-12	397	328	16	48	5
13-17	348	286	14	43	5
18-20	254	208	11	30	5
All	1,445	1,115	85	215	30

Almost 79% of children and youth in BCDSS foster care reside in family settings. The percentage of children residing with kin has increased. The percentage of children residing in congregate care placements (group homes, diagnostic centers and residential treatment centers) has remained stable.

Children in OHP as of October 31, 2025, by Placement Type²¹

Placement Type	Percentage of Children in OHP
Non-Kin Family Home (foster families, treatment foster homes, pre-adoptive homes)	39%
Kin (all kin placements plus trial home visits)	40%
Congregate Care	10%
Independent Living (Includes college)	8%
Other (jail, runaway, hotels, offices, hospitals)	3%

¹⁸ Data calculated by IVA from Defs.' Foster Care Milestone Report, October 31, 2025.

¹⁹ "Multi-racial" includes children for whom more than one race is listed. All but 13 of these 85 children are listed as both "Black/African American" and "White/Caucasian." Those 13 children are American Indian and Black/African American (3 children); Asian and Black/African American (3 children); and Unknown and Black/African American (7 children).

²⁰ This category includes American Indian (1 child); Asian (1 child); Latino (3 children); and Unknown (25 children).

²¹ Foster Care Milestone Report, October 31, 2025.

Other than ensuring safety and well-being, the primary responsibility of a child welfare system is moving children to permanency as soon as possible. “Permanency” means that a child leaves the foster care system for (1) reunification with parents; (2) adoption; or (3) custody and guardianship by relatives or non-relatives. Children in foster care in Baltimore City continue to remain in foster care substantially longer than the timeframes set out under federal permanency targets.

Timely Permanency for Children in OHP November 1, 2024 - October 31, 2025²²

Children in foster care for:	Federal Permanency Targets	BCDSS Permanency Rates
Up to 12 months ²³	35.2%	17.1%
12 to 23 months	43.8%	33.9%
24+ months	37.3%	32.1%

Defendants report an average length of stay of 35 months for children in Baltimore City foster care during the 73rd report period. The average length of stay has not decreased in the last three years.²⁴

If the agency does not achieve permanency for a child, the child will “age out” of the foster care system in Maryland at age 21. From November 1, 2024 through October 31, 2025, 90 youth aged out of foster care when they turned 21, without having been reunified with parents or leaving foster care to become a permanent part of another family.²⁵

²² Att. 1, Headline Indicators, p. 2.

²³ For the Permanency Rate for Children in OHP for up to 12 months, the look-back period is actually one year earlier, i.e., November 1, 2023 - October 31, 2024.

²⁴ Defendants have reported as follows since 2021: 67th Report: 36 months; 68th Report: 34 months; 69th Report: 35 months; 70th Report: 35 months. Defendants reported this measure as “TBD” for the 71st and 72nd report periods.

²⁵ Data calculated by IVA from BCDSS Exits Report as of October 31, 2025.

The IVA is unable to share other important characteristics and needs of children in BCDSS foster care due to the unavailability of adequate accurate information and reports about the children in Maryland’s child welfare database, CJAMS. In 2024, Defendants contracted with Chapin Hall for a statewide placement needs assessment. The final report, “Maryland Social Services Administration Placement Needs Assessment” (hereinafter referred to as the “Chapin Hall Report”) was completed in January 2025.²⁶ This assessment provides further data and insight into the ongoing placement challenges experienced by children in out-of-home care in Baltimore City and across the state. It also raises concerns about how poorly CJAMS is documented in critical areas.²⁷ In the Chapin Hall Report, the researchers found many of the same data problems that the IVA has reported in the past: missing or inaccurate information in CJAMS regarding placement changes,²⁸ physical and mental health diagnoses,²⁹ and identification of pregnant and parenting youth,³⁰ to name a few. In order to effectively serve children in BCDSS care and to ensure that children spend as little time in foster care as possible, accurate information about each child’s needs and circumstances must be available.

IV. DEFENDANTS’ REPORT - LIMITATIONS AND CONCERNS

In most other child welfare litigation, a monitor (or more recently “co-neutrals”) has been appointed to provide the Court with a true picture of the status of the system.³¹ *L.J.* has been

²⁶ Defendants’ 72nd Report, Attachment A, Chapin Hall, “Maryland Social Services Administration Placement Needs Assessment” Final Report, (January 2025). (“Chapin Hall Report”). Chapin Hall is a policy research center focused on providing decision-makers with data analysis and solutions to support them in their work for children, families and communities.

²⁷ See, e.g., Att. 2, Chapin Hall, “Executive Summary to the Final Report,” (January 2025), p. 7. The IVA has attached the Executive Summary to this report because Defendants did not include it as an attachment to their report.

²⁸ Chapin Hall Report, p. 41

²⁹ Chapin Hall Report, pp. 35, 41, 44.

³⁰ Chapin Hall Report, pp. 31-34.

³¹ See, e.g., *Charlie H. v. Corzine*, 1:89-cv-01754 (U.S. District Court for the District of New Jersey) and *LaShawn A. v. Fenty*, 1:89-cv-01754 (U.S.D.C. District of District of Columbia) for which the Center for the Study of Social Policy (CSSP) acted as monitor until both cases were dismissed. More recently, in 2020, Judith Meltzer (CSSP) and

unusual in relying on the Defendants to provide the court with that information and relying on an “IVA” for certification of the data provided. As a result, it is particularly important that Defendants’ reports provide a true picture of the status of the Baltimore City foster care system. Instead, the Defendants have focused on using the report as an opportunity to show the system in its best light and rarely acknowledge the areas where the system is not meeting the needs of the children and families they are charged with serving.

A. What Defendants Have Omitted From Their Report

Defendants’ Report provides almost no data at all; 70% of the *L.J.* Measures remain unreported. While there are over 26 pages of narrative in the report, Defendants fail to address almost all of the data requirements of the MCD. Defendants fail to provide the Court with data that is available. By the time that Defendants provided the 73rd report to Plaintiffs and the IVA on October 13, 2025, they had finalized and validated as accurate the CJAMS reports for 10 of the 15 *L.J.* Measures that the parties had designated as priorities to be finalized.³² They provided data for only three of those 10 reports - Exit Standards 65, 75, and 82. Because Defendants did not provide all data that was available for the 73rd report period, the IVA is providing the Court that data, below.

In addition, because the 73rd report period ended over a year ago, the IVA is also providing data available from CJAMS for the 74th report period (January 1 - June 30, 2025) and the 75th report period (July 1, 2025 - December 31, 2025).³³

Kevin Ryan (Public Catalyst) were appointed as co-neutrals in Kevin S. v. Blalock, 1:18-cv-00896 (U.S.D.C. District of New Mexico).

³² Most of these measures have been prioritized because they measure requirements not only of the *L.J.* MCD but also of federal and state law and policy. Of the 15 priority reports, Defendants had completed Exit Standards 20, 24, 29, 65, 72, 75, 82, 83, 115, 116 and Internal Success Measure 9.

³³ Data from these reports downloaded from CJAMS on 1/26/26. The IVA waited until January 10 to download the reports for the 75th report period to allow for some time for data input to “catch up.” Under Maryland policy, most of the data for these reports should have been entered within five days of the activity. It is possible that compliance

L.J. Exit Standard		(73rd) July - Dec 2024	(74th) Jan - June 2025	(75th) July- Dec 2025	IVA Notes
20	For 85% of children, BCDSS had a family involvement meeting [FTDM] at each critical decision-making point.				Measure was divided into 4 sub-reports. Each report must reach 85% compliance for the Exit Standard to be certified as compliant.
	20A - For 85% of children, BCDSS had an FTDM within 72 hours (3 days) of the child's removal into OHP.	84.65%	81.08%	87.5%	
	20B - For 85% of children, BCDSS had an FTDM between 45 days before and 7 days after a placement change.	8.42%	7.21%	16.60%	
	20C - For 85% of children, BCDSS had an FTDM within 3 – 5 months prior to a permanency plan review hearing where DSS requested a plan change.	19.05%	0%	5.56%	
	20D - For 85% of children, BCDSS had a Youth Transition Team meeting every 180 days.	.88%	3.78%	1.74%	

levels will rise for some of these reports if they are re-run at a later date. However, given the continuing delays in Defendants' reporting, the IVA believes that it is important that the Court have data that is much closer to contemporaneous than Defendants have been providing.

<i>L.J. Exit Standard</i>		(73rd) July - Dec 2024	(74th) Jan - June 2025	(75th) July- Dec 2025	IVA Notes
24	90% of children had a case plan that was completed within sixty days of the child’s entry into OHP and which was updated every 6 months.	14.05%	16.95%	20.73%	
29a	90% of children aged fourteen and over had a transition plan included in the child’s case plan and timely received the services identified in the case plan.	22.07%	19.28%	32.12%	This is the quantitative portion of Exit Standard 29. The qualitative requirements are measured by QSR, discussed below at pp. 32-34 and 43, below. Compliance levels for both 29a and 29b must reach 90% for certification of compliance with this Exit Standard.
65	99.68% of children in OHP were not maltreated in their placement, as defined by federal law.	98.54%	99.58%	99.30%	Actual result for 73rd Report is 98.33% . Actual result for 74th Report is 99.21% . Actual result for 75th Report is 99% . See pp. 26-27 and pp. 68-69, below.
72a	95% of children had documented visits from their caseworker once monthly in the child’s placement.	95.4%	93.3%	96.4%	This is the quantitative portion of Exit Standard 72. The qualitative requirements are measured by QSR, discussed below at pp. 32-34, below. Compliance levels for both 72a and 72b must reach 95% for certification of compliance with this Exit Standard.

L.J. Exit Standard		(73rd) July - Dec 2024	(74th) Jan - June 2025	(75th) July- Dec 2025	IVA Notes
75	95% of new entrants to OHP received an initial health screen within five days of placement.	91.93%	93.23%	96.15%	
82	90% of children entering OHP received timely periodic EPSDT examinations, and all other appropriate preventive health assessments and examinations, including examinations and care targeted for adolescents and teen parents.	70.71%	70.74%	59.6%	
83	90% of children in OHP received timely periodic EPSDT examinations, and all other appropriate preventive health assessments and examinations, including examinations and care targeted for adolescents and teen parents.				Measure was divided into 4 sub-reports. Each sub-report must reach 90% compliance for the Exit Standard to be certified as compliant.
	83A 90% of children in OHP received Timely Annual Exams.	24.63%	23.14%	15.76%	
	83B 90% of children in OHP received Timely Semi-Annual Dental Exams.	15.74%	15.57%	10.3%	

L.J. Exit Standard		(73rd) July - Dec 2024	(74th) Jan - June 2025	(75th) July- Dec 2025	IVA Notes
	83C 90% of children in OHP ages 48 months and less received Timely EPSDT exams.	48.46%	51.5%	32.86%	
	83D Summary combining results for each child from 83 A – C.	9.58%	8.29%	7%	
115	90% of case-carrying staff was at or below the standard for caseload ratios.				Measure was divided into 3 sub-reports. Each sub-report must reach 90% compliance for the Exit Standard to be certified as compliant.
	115A - 90% of OHP caseworkers had between 3 - 12 cases	30.3%	45.2%	50.9%	
	115B-1 - 90% of Resource & Support continuing care caseworkers had no more than 36 cases.	97.7%	96.7%	87.9%	
	115B-2 - 90% of Resource & Support new application caseworkers had no more than 10 cases.	100%	99.4%	100%	

L.J. Exit Standard		(73rd) July - Dec 2024	(74th) Jan - June 2025	(75th) July- Dec 2025	IVA Notes
116	90% of case-carrying teams were at or below the standard for ratio of supervisor to worker.				Measure was divided into 2 sub-reports. Each sub-report must reach 90% compliance for the Exit Standard to be certified as compliant.
	116A - 90% of OHP Supervisor to Caseworker Ratios were no more than 1:5.	98.9%	93%	95.4%	
	116B - 90% of Resource & Support Supervisor to Caseworker Ratios were no more than 1:5.	85.1%	78.9%	95.1%	

B. DLS' Repeat Audit Findings

In April and September 2025, the Maryland Department of Legislative Services (DLS) issued audits of Defendant DHS Local Department Operations and Social Services Administration (SSA) Operations.³⁴ Combined, those reports contained 18 findings of non-compliance including failure to implement effective oversight of local departments; failure to monitor foster care providers properly; failure to ensure accurate data in CJAMS; and failure to provide required medical and dental exams. DLS raised particular concerns that 6 of the 8 audit findings in a 2021 audit of SSA were repeated in the 2025 audit. Defendants fail to mention either of these audits in

³⁴ Att. 3, DLS Audit of DHS Local Operations (April 2025) and Att. 4, DLS Audit of DHS SSA Operations (September 2025).

their report nor did they provide copies of these reports to Plaintiffs and the IVA as required by the MCD. See further discussion below at pp. 75-77.

C. Inaccurate and Misleading Data in Defendants' Report

Perhaps the greatest concern about Defendants' report is the presentation of information which Defendants have reason to know is inaccurate or misleading in the context it was presented.

1. Maltreatment-in-Care performance (Defs.' Report, p. 3): While Defendants claim that "for the past four reporting periods [70th - 73rd], BCDSS has exceeded or been very close to meeting the Exit Standard [65 compliance standard] of 99.68 percent of children not maltreated in their placement," the actual results show that assertion to be inaccurate. Rather than getting closer to meeting the required compliance percentage, Defendants' performance actually declined from the 71st to the 73rd report period and, while it rose from the 73rd to the 74th report period, fell again from the 74th to the 75th report period. Defendants' incorrect reported results and the IVA-corrected results for the 71st - 75th report periods are set out in the chart, below. In each of those reports, and on p. 69, below, the IVA has provided detailed information as to why Defendants' reported percentages are incorrect. Defendants have never provided any information refuting the IVA's analysis.

L.J. Measure 65 – Maltreatment-in-Care³⁵

<i>L.J. Court Report #</i>	Data from <i>L.J. Court Report</i>		Actual Data Validated by IVA	
	# Cases of Maltreatment in Care	% Children in OHP Not Maltreated	# Cases of Maltreatment in Care	% Children in OHP Not Maltreated
71 (July-Dec 2023)	6	99.64%	8	99.52%
72 (Jan-Jun 2024)	6	99.63%	10	99.39%
73 (July-Dec 2024)	23	98.54%	27	98.33%
74 (Jan-Jun 2025)	7	99.58%	13	99.21%
75 (July-Dec 2025)	12	99.30%	17	99%

While the numerical discrepancies may seem small, they represent significant reporting errors - having failed to account for 25%, 40%, 15%, 54% and 29% of the total maltreatment in care cases for the 71st, 72nd, 73rd, 74th and 75th report periods, respectively.

2. Initial Health Performance (Defendants' Report, pp. 3 and 17): Defendants claim that children entering foster care are receiving necessary health screenings and comprehensive assessments. In fact, the only health care that children entering foster care received in numbers close to the *L.J.* requirements is the Exit Standard 75 requirement of initial health screenings within five days of placement. (For the 73rd report period, compliance was at 91.63%; the Exit Standard requires 95% compliance). Defendants' inclusion in this section of the report of the 98.5% compliance data for "comprehensive health assessment" is misleading. What Defendants cite as "CHA" is just a document, not any actual health exam or assessment. The CHA is based upon *L.J.* Exit Standard 79 which requires that Defendants compile a written summary of any health care data about a child

³⁵ Data downloaded for Measure 65 from CJAMS on 4/24/25 for the 71st and 72nd report periods and on 1/26/26 for the 73rd, 74th, and 75th report periods.

that is available to BCDSS in the first 60 days the child was in OHP and mail it to the caregiver, caseworker and child's doctor. (MCD, pp. 29-30). Exit Standard 79 does not address whether or not the child received any of the comprehensive medical, dental or mental health care exams required within the first 60 days the child is in OHP. In other words, a child could have a timely completed CHA but only have received one, two or none of the required exams. Exit Standard 82 is the measure which requires the timely exams. For the 73rd report period, only 70.71% of children entering foster care received their comprehensive medical, dental and mental health exams in the first 60 days.³⁶ The failure to include this data in their discussion of initial health performance is misleading to the reader who is not aware of the distinction between the CHA as a document and the actual completion of required health exams.

3. Ongoing Health Care (Def.' Report, p. 17). Besides repeating the compliance rate for the written health assessment (CHA), the only data provided in the "ongoing health care" section in the Defendants' 73rd Report is the citation of the Child and Family Services Review (CFSR) case review data for 2024 which gives "strength" ratings of 71% for physical health and 78.3% for mental health. This data is unconvincing for three reasons: (1) use of the CFSR for compliance purposes was not agreed to by the parties; (2) a 71% compliance rate is still nearly 20 percentage points lower than the required 90% for ongoing health care; and, most significantly, (3) these ratings are based upon case reviews of only 26 foster care and 11 in-home services cases reviewed for the CFSR for all of 2024.³⁷ In contrast, the reports for Exit Standard 83 measuring ongoing preventative health and dental care are based upon 100% of the cases of children due during the

³⁶ Data for Exit Standard 82 downloaded from CJAMS on 1/26/26.

³⁷ Defs.' 73rd Report, Att. A., 2024 Baltimore City CFSR, pp. 2-3 and pp. 11-12. Physical health was a "strength" in 17 foster care cases; mental health was a "strength" in 13 cases.

report period. For the 73rd report period, only 9.58% of children received timely all of the ongoing health care they were due.³⁸

4. Family Engagement (Defs.' Report, p. 4). According to Defendants' report, BCDSS "excels at engaging families when children enter care," with 85.02% of children newly placed in foster care having a family involvement meeting (also called "FTDMs") within 72 hours of placement. However, the report provides no substantiation for its further claim that after that initial meeting, it is regularly holding meetings with families, in addition to the required family involvement meetings, referring the reader to Section IV "for additional details." There is nothing in that section or anywhere else in the report to support that statement. In fact, the data now available for other types of required family involvement meetings shows that those meetings were not being held regularly - timely placement change FTDMs at 8.42%; timely permanency plan FTDMs at 19.05%; and Youth Transition team meetings at .88%.³⁹

The Court should have a full and accurate picture of the child welfare system in this case. That requires that Defendants report all available data for the MCD measures and provide the data accurately and in the context of the MCD requirements.

V. MEASURES, DATA COLLECTION AND REPORTING

The MCD is divided into two parts: Part One addresses the scope of the case and the procedural requirements, including the role of the IVA, data access, reporting requirements, communication and dispute resolution and the process for obtaining court review and case exit.

Part Two of the MCD is divided into five substantive sections - Preservation and Permanency Planning, Out-of-Home Placement (OHP), Health Care, Education, and Workforce.

³⁸ Data for Exit Standard 83D downloaded from CJAMS on 1/26/26.

³⁹ Data for Exit Standards 20B, 20C, and 20D downloaded from CJAMS on 1/26/26.

There are 28 Outcomes spread across these five substantive sections. Compliance with the Outcomes is measured by a total of 40 Exit Standards.⁴⁰ Additionally, there are 59 Internal Success Measures (ISMs) which provide for additional data reporting agreed to by the parties.⁴¹

In order to exit the MCD, Defendants must be certified by the IVA as compliant with all of the Exit Standards for each of the MCD Outcomes for three consecutive report periods.

Prior IVA reports have summarized the history and challenges in developing measure instructions which are used to determine how an MCD requirement will be tracked and documented for reporting purposes.⁴² The measure instructions provide that the reports for approximately one-half of the measures be drawn from CJAMS; one-fourth of the measures from Quality Service Reviews (QSRs); and one-fourth from other sources such as Legal Services and Quality Assurance (QA) reports.⁴³ Upon the completion of all measure instructions in May 2021, the parties set a goal of January 1, 2022, for implementation of reporting for all of the *L.J.* measures. That goal has not been met.

A. Status of *L.J.* Reports

The IVA has detailed in prior reports the history of attempts to produce accurate, valid and reliable reports for *L.J.* compliance.⁴⁴ Despite four years of intensive work, and specific deadlines

⁴⁰ See Att. 5, *L.J. v. Massinga* Modified Consent Decree - Outcomes and Exit Standards Only (October 9, 2009).

⁴¹ While the decree includes 86 ISMs, 27 of them are duplicates of Exit Standards without the compliance goals, e.g., Exit Standard 72 requires that “95% of children have a monthly caseworker visit in their residence;” while ISM 71 requires reporting on the “% of children who have monthly caseworker visits in their residence.” In this IVA report, where there is both an Exit Standard and ISM with the same requirements, only the Exit Standard is cited.

⁴² See, e.g., IVA Response to Defs.’ 66th Report, p. 19.

⁴³ Because Defendants no longer include it on their data chart, the data sources for each of the reports is listed on the IVA’s Data Chart, Apx. 1 to this report. While the data for most of the measures come from either quantitative or qualitative sources, the parties and the IVA have agreed that four of the measures (Exit Standards 3, 29, 72, and 88) require both quantitative and qualitative measurement. For these measures, there are subparts “a” and “b” for quantitative and qualitative compliance levels, respectively. Both of these subparts must meet the required compliance levels for certification.

⁴⁴ See, e.g., IVA Response to Defs.’ 69th Report, pp. 8-12; IVA Response to Defs.’ 72nd Report, p. 17.

set more than a year and one-half ago for a limited set of “priority” reports, 70% of the *L.J.* measures continue to be reported by Defendants as “TBD.”

Defendants have repeatedly referred to the reporting requirements of *L.J.* as “extremely burdensome,”⁴⁵ but the reality is that the reporting that *L.J.* requires is no more than Defendants need to be able to do to meet their basic responsibilities for managing a child welfare system. While a more streamlined set of required reports may make sense at this point in the history of *L.J.*, accurate reporting of important data points will always be a critical responsibility for Defendants.⁴⁶

In March 2024, Defendants and Plaintiffs agreed upon 15 priority measures for which they felt data was most urgently needed. As of the filing of this report, Defendants have completed 10 of the 15 reports. Most of the other CJAMS reports, while completed at one time, have been found to have defects or need enhancements to be accurate. Defendants have prohibited MDTHINK⁴⁷ staff from working on any of the other *L.J.* CJAMS reports, even if only small changes need to be made for the report to be accurate and reliable.⁴⁸ In so doing, Defendants do not just deny Plaintiffs, the IVA and the Court access to the data, they also deny themselves the opportunity to

⁴⁵ See, e.g., Defs.’ 72nd Report, p. 3; Defs.’ 73rd Report, p. 2.

⁴⁶ See 45 C.F.R. 1355.52 for the federal requirements for data quality and reporting capabilities for child welfare data systems (CCWIS). See Fam. Law Art. 5-1300 et seq. for some of the Maryland state law reporting requirements. Although state law requires reporting on many child welfare data points, there are no consequences built into the law for failure to comply. While consequences for violation of the federal reporting requirements exist in law, the likelihood of their enforcement is exceedingly small. See IVA Resp. to Defs.’ 72nd Report, p. 38.

⁴⁷ In July 2025, it was announced that MDTHINK was being rebranded as “Maryland BENEFITS.” Governor Wes Moore, Press Release, July 15, 2025. <https://governor.maryland.gov/news/press/pages/governor-moore-announces-streamlined-benefits-access-for-marylanders-through-maryland-benefits-one-application.aspx> (date last accessed 1/10/26). Because Defendants continue to use “MDTHINK” in their report, this report also will continue to use that term.

⁴⁸ This includes the other seven Exit Standards requiring CJAMS reports - 3, 36, 70, 79, 88, 93, and 94. The IVA has agreed with Defendants and Plaintiffs that the new kinship regulations and policies have rendered the requirements of Exit Standard 48 (and ISM 45) obsolete. As a result, the CJAMS reports for those measures are no longer needed.

show measurable improvement in practice and, potentially, compliance or substantial compliance with *L.J.* requirements.

B. Data Sources

1. CJAMS

For the Court to be able to determine if the Defendants have met the requirements of the *L.J. MCD*, Defendants must improve their ability to extract data accurately and efficiently from CJAMS.

The following elements are needed in order to be able to extract that data:

1. The CJAMS application must have the necessary fields to collect the data and sufficiently straightforward interfaces to permit staff to input the data with a minimum amount of time and expertise.
2. Staff must have the training, supervision and time to input the data accurately.
3. There must be a mechanism to create needed reports without the need to cede all report writing to highly trained individuals who have the ability to write computer code.

The parties are aware of the ongoing problems with meeting these requirements, and the IVA has provided recommended solutions in prior IVA Reports.⁴⁹

2. Quality Service Reviews (QSR)

Due to the qualitative nature of many of the measures, the parties agreed that the data for approximately one-quarter of the *L.J.* reports would be drawn from the QSR process. QSR provides a case-based appraisal of frontline practice created for human services agencies to

⁴⁹ See, e.g., IVA Response to Defs.' 72nd Report, pp. 27-32.

improve results.⁵⁰ Although QSR is primarily designed for internal practice improvement rather than monitoring, it has been used successfully in other jurisdictions, e.g., Washington, D.C and New Jersey, to measure compliance with discrete consent decree requirements. Those particular jurisdictions have successfully met their Consent Decree requirements and exited their decrees.⁵¹ Cases for review using the QSR system are selected through a stratified random sampling process.⁵² The QSR uses a standardized protocol with a number of indicators to measure and rate the current status of a child and the child's family in key life areas and to appraise performance of key system practices for the same child and family.⁵³

The IVA notified Defendants in early 2024 that BCDSS's QSR data was not valid due to changes that had been made to program which had resulted in problems including lack of fidelity to the original QSR validated model; a significantly extended time to complete a full case review; and a failure to apply the QSR protocol as written. The IVA explained that this could be remedied through retraining and proper application of the protocol. The IVA also shared that updates could be made to the QSR protocol, instrument and ratings system that would reduce the amount of time spent on each case; better identify practice strengths; and show better progress towards compliance with the MCD.⁵⁴

Without prior discussion with Plaintiffs or the IVA, DHS counsel, at the July 2024 court hearing, raised the possibility of not using QSR for *L.J.* compliance purposes. Although Defendant

⁵⁰ The QSR process was developed by the Child Welfare Policy and Practice Group, Quality Service Review Institute, Montgomery, AL and Tallahassee, FL. In 2014, it was adapted to the needs of BCDSS and implemented with a newly created QSR Unit.

⁵¹ The New Jersey litigation, *Charlie H. v. Corzine*, 1:89-cv-01754 (U.S. District Court for the District of New Jersey) was dismissed in April 2023. The Washington, D.C. litigation, *LaShawn A. v. Fenty*, 1:89-cv-01754 (U.S. District Court for the District of Columbia) was dismissed in June 2021.

⁵² The number of cases to sample per report period was established through consultation with the University of Baltimore's Jacob France Institute which specializes in statistical information and research and its Director, Richard Clinch, PhD. BCDSS has used U.B.'s recommended sample numbers since BCDSS began use of QSR for *L.J.* report purposes in 2015.

⁵³ Detailed discussions of QSR and its application can be found in prior IVA reports.

⁵⁴ Att. 6, IVA QSR Report emailed to BCDSS and Plaintiffs' counsel on 2/27/24.

BCDSS subsequently indicated to the IVA that they planned to continue using QSR for practice improvement, they then provided the IVA with proposed alternative data collection methods for the *L.J.* measures for which QSR currently is used. The IVA rejected that proposal on October 1, 2025, and provided detailed reasoning why the new measurement method was not only insufficient but also would be significantly more labor-intensive and time-consuming for Defendants.⁵⁵

The QSR unit has continued to work with Florence Racine, former head of New Jersey's statewide QSR program and a trainer for BCDSS QSR staff from 2014 - 2019 and again since 2024. According to Ms. Racine, the process for each case review has been returned to the QSR model process. In addition, staff has been retrained on appropriate application of the QSR protocol to individual case facts and will continue to be trained as to-be-agreed-upon changes to the QSR protocol are implemented. Additionally, the Plaintiffs and IVA have agreed to lower the indicator ratings needed for *L.J.* compliance purposes.⁵⁶

The IVA has offered her assistance in making any necessary changes to the QSR protocol and rating collection tool. As soon as those materials are updated, active use of QSR for *L.J.* measure data collection should resume promptly, with an estimated start date in early 2026.

3. Other Data Sources

The third source of reports for the *L.J.* measures are the BCDSS Legal Services Unit⁵⁷ and the Innovations Unit (sometimes called "QA").⁵⁸ The data for those reports is gathered in a variety

⁵⁵ See Att. 7, IVA Resp. to DSS Proposed BRD and QSR protocol changes, emailed to Brandi Stocksdales on 10.1.25.

⁵⁶ The BCDSS Director at the time that the parties agreed to use QSR for certain *L.J.* measures decided that a rating of "5" or "good" should be required for compliance purposes. Defendants have proposed, and the IVA and Plaintiffs' counsel have agreed, that a rating of "4" or "fair" be considered compliant when QSR is re-implemented for *L.J.* data collection.

⁵⁷ Legal Services reports include Exit Standard 66, and ISMs 10, 13, 23, and 28.

⁵⁸ Innovations Unit ("QA") reports include Exit Standards 52, 68, 121, 122, 125, and 126, and ISMs 27, 46, 47, 49, 50, 51, 67, 100, 117, 118, 119, 120, 123, and 124.

of ways, including surveys, CJAMS milestone reports, review of individual cases in CJAMS, logs kept by other agency staff members, notations made by attorneys from court hearings, and others.

In IVA reports and in meetings with BCDSS, the IVA has requested changes in practices of data-gathering and reporting to ensure that these reports comply with the requirements of the MCD and measure instructions. Some of those changes have been implemented, allowing certification of those measures, but, as explained in Part VII, below, and in the IVA's Response to the 73rd Report Data Chart, Apx. 1 to this report, others of those reports still are not certifiable as accurate, valid and reliable.⁵⁹

C. Compliance Plans/Strategies for Improvement

It is difficult to know how much progress is being made in improving performance with MCD outcomes since Defendants continue to lack accurate, valid, and reliable baseline data. However, even without a full set of data on MCD measures, Defendants know where challenges exist. Defendants still do not provide compliance plans for measures that they know are not in compliance. Defendants can and should develop plans and set goals for progress in important outcome areas.

Defendants continue to include in their reports discussions of various improvement efforts without setting any goals for achievement or any assessment of the value or effectiveness of those efforts. For example, they provide seven pages of detailed description of the components of the Youth Wellness Program, now in place for nearly three years. However, all of the data provided is "process" data, e.g., how many referrals were made, how many support team meetings were held, and how many navigator assessments were done. At this point, more information about the

⁵⁹ In addition, without explanation and despite the fact that they have the data available to them, Defendants continue not to report results for Exit Standard 66 (timely provision of maltreatment-in-care reports and dispositions).

program - how many children are actually receiving therapy from the program, what types of therapy and for how long, and what the outcomes have been for those children - should be collected and available for reporting. In another example, Defendants have repeatedly written about Permanency Roundtables and Permanency Review Action Plans (PRAP) to increase the rates of permanency and reduce the length of time children remain in foster care. They provide no data at all about that process, not even the number of such roundtables or PRAPs held or what impact they have had on increasing the rates of timely permanency.

Effective practices and programs with measurable outcomes are essential if the Defendants hope to achieve safety, permanency and well-being for the children in BCDSS foster care.

VI. CRITICAL CHILD WELFARE POLICY AND PRACTICE ISSUES FOR SAFETY, PERMANENCY AND WELL-BEING

A. 60th Report Cohort Update

The IVA's Response to the 60th Report (January 1 - June 30, 2018), included the results of an extensive review of the cases of 36 children under the age of 13 who had experienced significant placement instability, lack of appropriate placements and waiting lists for treatment programs. (Referred to hereafter as "60th Report cohort").⁶⁰ There were updates for the 60th Report cohort in the IVA's Response to the 66th, 70th, 71st, and 72nd Report. These reviews found that a majority of the youth remained in foster care and many continued to experience placement instability. All of these children entered foster care before the age of 13; a majority of them entered when even younger - between the ages of 5 and 10 years old. A previous review of their Juvenile (CINA) Court records showed that these children entered foster care due to a multitude of reasons: parental substance abuse; untreated parental mental health issues; physical

⁶⁰ See Att. 8, IVA Certification Report for Defendants' 60th Report (filed June 25, 2019), pp. 16-24.

abuse; abandonment; and unstable housing. Rarely was the reason for entry into foster care a parent's inability to manage the behavior of their child.

As of November 21, 2025, six years later, 20 of these 36 children remain in foster care. All of these children have been in foster care for at least seven years. One youth has been in foster care for more than 12 years. These 20 children are in the following placements: 9 are in congregate care (group homes, therapeutic groups home and residential treatment centers), 4 are in kinship/family-of-choice placements, 3 are in therapeutic foster homes, 3 are in corrections/detention centers, and one has no placement listed in CJAMS following a hospital overstay. Determining placement for some of these youth was complicated by differing information in the Placement sections and Contact Notes sections of CJAMS for these children.⁶¹ This failure to document case files accurately and timely has been raised repeatedly by the IVA and was also a significant concern noted in the Chapin Hall Report.

Many of the 60th Report cohort children continue to experience placement instability, appearing on the weekly Overstay/Waitlist, in runaway notices, and in hotel and Children in the Building (extended hours) reports. Of the four kin placements, one is unstable, one is temporary (youth is on waitlist for new placement), and one is fairly new. Some of the youth have stabilized but remain in congregate care placements, have not achieved permanency, and have no potential permanent resource available. It appears likely that these older youth will age out of the foster care system without ever achieving permanency.

⁶¹ In tallying the placement types for these youth, the IVA used the Placement section in CJAMS to determine placement type even if the contact notes indicated a different placement. It is essential that the Placement section include accurate information so that the location of a child can be determined without having to search through contact notes.

In earlier IVA reports, the stories of several of these 60th Report cohort of children have been shared. Below are two other case examples highlighting the challenges faced by these youth, all who entered foster care at a young age for reasons not related to their own behavior.

KJ

KJ, 5 years old at the time, and her younger sibling entered care in June 2018 due to their mother's neglect and mental health issues. KJ's placement instability was concerning from the start - five different regular foster homes in the first six months of foster care. Why there were so many placement changes and whether there were any efforts made to avoid placement disruption is unclear due to a lack of information in CJAMS.

In December 2018, a sixth placement, this time with a therapeutic foster care (TFC) provider failed after only a month. KJ was moved to yet another TFC home. Fortunately, KJ stabilized with her new TFC parent, and in 2021, parental rights were terminated for KJ and her sibling. Unfortunately, KJ's foster parent was not willing to become a permanent placement for KJ and had made it known to DSS that she was not an adoptive resource. Meanwhile, KJ's sibling was adopted by his foster parent.

After nearly five years in her TFC home, in September 2024, KJ was emergently hospitalized at a local hospital and then transferred to Sheppard Pratt (Psychiatric) Hospital ten days later. She was ready for discharge less than two weeks later, and Sheppard Pratt recommended a TFC home with in-home support services. However, KJ was not returned to her last TFC home (for reasons that are not readily discernable from a review of CJAMS), and DSS was unable to locate a new TFC home for her.

KJ was forced to stay at Sheppard Pratt for more than two additional months, until the end of December 2024, when she was placed at St. Vincent's Villa diagnostic program. Then, after the 90-day limit for diagnostic programs passed, she was required to wait an additional four months until the end of July 2024 when she was placed at St. Vincent's Villa residential treatment center (RTC), the only RTC in Maryland that accepts children under the age of 13. KJ remains at the RTC as of the writing of this report.

It is difficult to know how KJ is doing in this most recent placement. There is no current treatment plan and only one "Monthly Psychiatric Note" in her CJAMS file for the entire five months since placement. Her case plan does not provide additional information either. After seven years and 11 placements (including hospitalizations), KJ, now 12 years old and with no legal parent, remains in the care of BCDSS without an adoptive resource or any prospects for permanency.

JG

JG entered care for the first time in 2016 when she was 8 years old due to allegations of neglect by her mother. She returned home to her mother but was removed two more times, in 2017 and 2021 for neglect and physical abuse by her mother. After a brief and unsuccessful attempt to place JG with her father in 2023, she entered foster care for a fourth time in April 2024. Now 17 years old, she has spent seven of the last nine years of her life in foster care.

JG has experienced significant placement instability during her seven years in foster care - at least 26 placements since 2016, including kinship placements, regular foster care, therapeutic foster care, group homes, residential treatment centers and trial home visits.⁶² In addition to the more than 26 placements, JG has attended at least 10 different schools from ages 8 to 17.

In May 2024, JG was sent to a for-profit out of state residential treatment center program in Arkansas.⁶³ When she was ready for discharge in September 2024, a placement had not been identified for her in Maryland, and, upon her return from Arkansas, JG was placed in a hotel for six days before being placed in a group home. Five more placements have followed. In September 2024, the BCDSS consulting psychiatrist recommended neuropsychiatric testing and a speech/development assessment. There is no readily available information in CJAMS to know if these referrals were made or testing completed.

In November 2025, JG was psychiatrically hospitalized. This is the last update in the Placement section of CJAMS. However, a review of contact notes indicates that JG was discharged from the hospital in early December, and she was placed in a family home. No provider name or address is listed in the Placement section of CJAMS as of December 15, 2025.⁶⁴ Although there is a case plan approved by a supervisor on November 3, 2025, most of the questions are unanswered, and the youth transition plan attached to the case plan is completely blank, leaving much unknown about plans for JG.

⁶² It is likely that she has had more than the 26 placements documented in CJAMS. Several of her placements were with TFC agencies, and she may have been placed in more than one TFC home through each of these providers. (Until recently, this information was often not included in the child welfare case management system.)

⁶³ Riverview Behavioral Health is listed on the Acadia Healthcare network of programs. <https://www.acadiahealthcare.com/acadia-locations/search/>. Acadia was one of the Residential Treatment Facility (RTF) companies investigated by the United States Senate, in “Warehouses of Neglect” (June 2024). https://www.finance.senate.gov/imo/media/doc/rtf_report_warehouses_of_neglect.pdf (last downloaded January 4, 2026).

⁶⁴ A change in placement notice was found after a search of the documents folder in CJAMS indicating that youth is placed with a kinship provider. This lack of readily available placement information is a serious safety issue and an ongoing concern regarding proper documentation in CJAMS.

These two children's histories are not dissimilar to the other children in the 60th cohort.⁶⁵ What is clear from the tracking of this cohort is that Defendants must identify young children with placement disruptions early and work to identify and put into place all the needed services to stabilize a child in a family setting. Otherwise, the risk for long stays in foster care with significant placement instability increases. A case with a similar history to those of the 60th cohort recently came to the attention of the IVA when a young girl began appearing regularly on the Overstay/Waitlist.

SM

SM, a 9-year-old girl, entered care in September 2018 when she was just two years old. Her mother, a former foster youth who had aged out of foster care less than a month before her daughter entered foster care, was unable to locate housing and brought SM to DSS for placement.

In 2022, after nearly four years in a regular BCDSS foster home, SM was ejected from her placement due to reported behavior problems. Despite her young age, SM has been placed in at least seven different homes through BCDSS and four different therapeutic foster care (TFC) agencies, as well as being hospitalized for 17 days. In an ejection notice from one of the TFC agencies, they stated the ejection was due to "critical safety concerns that stem from incomplete and inaccurate information provided during the referral process" and that the lack of accurate information "directly impacted [their] ability to plan for and ensure [SM's] safety." As a result of this placement instability, SM has already attended four different schools despite being in only the 4th grade.

Beginning October 24, 2025, SM has been on the weekly BCDSS waitlist for a new placement with a diagnostic program. Given the very limited resources for children as young as SM, BCDSS does not anticipate that she will be placed until mid- January 2026, almost 3 months after first appearing on the waitlist.

Appropriate community-based placements and intensive wrap-around services are needed to reduce the risk of placement instability and long-term foster care. Additionally, with lower

⁶⁵ See, e.g., IVA Response to Defs.' 71st Report at 22-25 and Defs.' 72nd Report at pp. 43-44.

caseloads, Defendants should be able to identify and intervene more quickly with these intensive services in the cases of children experiencing significant placement instability.

B. Caseloads

Reasonable caseloads are essential to both the provision of services to ensure safety, permanency and well-being, and to documenting those services in CJAMS. Under the MCD, OHP caseworkers may not have caseloads larger than 12 children.⁶⁶

Over the past two years, BCDSS has steadily increased the percentage of caseworkers meeting the 12 children per OHP worker caseload level - from 13% at the end of 2023 to 50% as of the end of October 2025.⁶⁷

Caseload Data as of:	3 - 12 children	13 - 15 children	16 - 24 children
December 31, 2023	13%	14%	73%
June 30, 2024	27%	13%	60%
December 31, 2024	44%	20%	36%
June 30, 2025	47%	31%	22%
October 31, 2025	50%	32%	18%

Defendants have credited focused recruitment, streamlined hiring processes, and an emphasis on retention for these gains. Those efforts need to continue, even as improvements have

⁶⁶ Under the MCD, Part Two, section V.D.1, caseloads are required to be “15 children (or any lower ratio required by Maryland state law).” In 2006, pursuant to state law, the Child Welfare League of America (CWLA) performed a study to develop a methodology for calculation of child welfare case-to-worker ratios. See Att. 9, DHR [now DHS] Letter to Gen. Assembly with CWLA Study (October 2006). CWLA determined that, for Maryland, 12 children per foster care worker was a more appropriate caseload than 15 children due to the administrative demands placed upon the caseworkers in addition to their responsibilities to the children and families in their caseloads. To the IVA’s knowledge, worker administrative demands have not been diminished with the 2021 implementation of CJAMS. DHS conducted a caseload study in late 2025; no results have been released.

⁶⁷ Caseload data for 2023 calculated from Foster Care Milestone Reports. Caseload data for 2024 and April 2025 from *L.J. Measure 115A* monthly reports, downloaded 5/16/25. Caseload data for June and October 2025 from *L.J. Measure 115A* monthly reports, downloaded 11/24/25.

been made. 50% of caseworkers having 13 - 20 cases still results in 63% of the children and youth in OHP having caseworkers with caseloads above the prescribed level.⁶⁸ Although Defendant BCDSS has been able to replace staff leaving over the past year - an important improvement - staff turnover remains a serious problem. Staff turnover results in case transfers and new hires that frequently lack experience and require restricted caseloads for a period of time. Case transfers impair the engagement with children and families needed to assist them in resolving problems and attaining reunification or other forms of permanency on a timely basis. From July 1, 2024 - June 30, 2025, not including transfers to and from family preservation or to specialty units, there were 587 case transfers within OHP; 75 of those children were transferred to new caseworkers twice; eight children were transferred three times; and one child was transferred four times in that one year.⁶⁹ The combination of high caseloads and frequent case transfers make it more difficult to resolve many of the issues discussed in this report.

C. Family Engagement and Case Planning

Case planning is an essential part of working with families involved in the foster care system. The MCD, as well as state⁷⁰ and federal law⁷¹ require written case plans for all children placed by the local child welfare agency in out-of-home care. Guidance for case planning in Maryland is also provided in SSA/CW Policy #13-02 (revised February 28, 2023) and for Youth Transition Plans in SSA/CW Policy #25-10 (revised eff. October 1, 2025).⁷²

The “Case Plan” comprises four parts - Social History, Permanency Progress Plan, Service Plan, and, for children 14 years and older, a Youth Transition Plan (YTP). The Social History is

⁶⁸ Data for Exit Standard 115A for October 2025 downloaded from CJAMS on d 11/23/25.

⁶⁹ Defendants’ Case Transfers Reports for July - December 2024, downloaded 6/10/25, and for January - June 2025, downloaded 11/24/25.

⁷⁰ MD Code, Family Law, § 5-525; COMAR .07.02.11.13.

⁷¹ Adoption Assistance and Child Welfare Act, P.L. 96-272, 42 U.S.C. Section 675.

⁷² Defendants’ Child Welfare Policies can be found on the DHS public website at <https://dhs.maryland.gov/business-center/documents/child-policy-directives> (last accessed 1/10/26).

completed only once, at the time of the child’s removal. The Permanency Progress Plan must be completed every 180 days and is designed to reflect the status of the child in the 180 days prior to its completion. The Service Plan and Youth Transition Plan (YTP) are required to be developed collaboratively with the parent (Service Plan) or youth (YTP) and should set out what both the parent/youth are expected to do and what the agency is expected to do over the next 180 days to achieve their goals.

The initial case plan is due 60 days after removal; case plan reviews are due at 180 days after removal and every 180 days thereafter. Exit Standard 24 measures the timeliness of case plans for all children in OHP. Defendants are far from the required compliance levels for this measure.

L.J. Exit Standard 24 - Timeliness of Case Plans⁷³

Report Period	Timely Case Plans
73rd (July – December 2024)	14.05%
74th (January – June 2025)	16.95%
75th (July – December 2025)	20.73%

Furthermore, compliance with the MCD requires both a quantitative and a qualitative assessment of case plans. A simple quantitative percentage of case plans completed in the CJAMS system is insufficient to know if the case plans include all required elements. To be meaningful, case plans must also be individualized to the circumstances, strengths and needs of children and families. Exit Standard 15 uses the QSR process to report on the qualitative assessment of case plans. As discussed above at pp. 32-34, the QSR data is not currently being reported. The need

⁷³ Data for Exit Standard 24 downloaded from CJAMS on 1/26/26.

to understand not just whether but how well case plans are being done underlines the importance of getting BCDSS' QSR program back to the point of *L.J.* reporting. (See QSR discussion above.)

The IVA has reviewed many case plans over the years, including a number of them in the past year. Time and again, the IVA has seen case plans approved by supervisors where the majority of questions in the Permanency Progress Plan and Youth Transition Plans are unanswered. As examples, the most recent case plans for the children whose cases are highlighted in the 60th Cohort Update section of this report show:

- **KJ.** For the most part, the only sections completed in the plan are those which CJAMS automatically completes with data from other areas of the database, e.g., placements, schools, medical appointments. While some of the Permanency Progress Plan questions are answered, the most critical questions, regarding efforts to promote permanency and to provide services for safety and well-being, are unanswered. The answer to the question about how the caseworker is meeting the child's needs is clearly "cut and pasted" from a prior case plan in that it describes services provided in a TFC home even though the child was in a residential treatment center for the entire Permanency Progress Plan time period.
- **JG.** Only 4 of the 23 questions in the "Caseworker's Services and Plan" section of the Permanency Progress Plan are answered. The "Education" section contains only the names of the school she had attended in the prior 180 days; there was nothing in that section about school attendance, behavior, grades, strengths or needs. There was nothing in the "Mental Health" section. In the Youth Transition Plan attached to JG's case plan, nothing was completed.
- **SM.** The Permanency Progress Plan is much like that of J.G.; only 4 of 23 questions answered in the "Caseworker's Services and Plan" section, and no substantive information is provided in any other section other than dates of placements, schools, and caseworker visits. In addition, although SM's father is seeking to have SM placed with him and is having overnight visits, there is no Service Plan.

CJAMS has very few mandatory fields in either the Permanency Progress Plan or Youth Transition Plan, a fact which allows caseworkers to submit the plans to their supervisors with little

substance. However, even without mandatory fields, supervisors should not be approving case plans and transition plans that fail to address each of the questions and fields in those plans. Given that almost every supervisor has no more than five caseworkers to supervise,⁷⁴ this critical function should not be difficult to accomplish.

A key element in case planning is engagement with parents/guardians. In their report, Defendants highlight the engagement of parents at one point in time when their children enter foster care, stating that “BCDSS excels at engaging families when children enter care, with 85.02% of children newly placed in foster care having a family involvement meeting within 72 hours of placement.”⁷⁵ The pre-removal or immediately post-removal family involvement meeting (also called an “FTDM”) is an important step at the beginning of a foster care case. However, for children in foster care, ongoing engagement with parents, youth and extended families is critical. That engagement is significantly less.

Exit Standard 20 is divided into four sub-reports for the four types of facilitated mandatory family involvement meetings.

L.J. Exit Standard 20 - Family Involvement Meetings for Critical Decision-Making⁷⁶

<i>L.J. Compliance Report</i>	20A. Removal FTDMs within 72 hours of removal	20B. Timely Placement Change FTDMs	20C. Timely Change in Permanency Plan FTDMs	20D Timely Youth Transition Plan FTDMs
73rd (Jul-Dec 2024)	84.65%	8.42%	19.05%	.88%
74th (Jan-June 2025)	81.08%	7.21%	0%	3.78%
75th (July-Dec 2025)	87.5%	16.70%	5.56%	1.74%

⁷⁴ BCDSS has maintained a ratio of one supervisor for every five caseworkers in OHP. See Exit Standard 116A results for the 73rd, 74th and 75th report periods on p. 25, above.

⁷⁵ Defs.’ 73rd Report, p. 4.

⁷⁶ Data for Exit Standards 20A, 20B, 20C, and 20D downloaded from CJAMS on 1/26/26.

This case plan and meeting data is reflected in the findings of the Baltimore City 2024 CFSR Report. Engagement with families continued, as in prior CFSR reports, to be identified as Areas Needing Improvement.

- *Item 12B: Needs Assessment and Services to Parents* - “The review demonstrated the agency was not consistent in its practice of engaging biological parents and/or legal guardians to assess their needs and provide services during the review period.”⁷⁷
- *Item 13: Child and Family Involvement in Case Planning* - “The CFSR showed that the agency was not consistent in its practice of engaging biological parents to include them in regular discussions around developing case goals or monitoring progress towards achieving case goals.”⁷⁸
- *Item 15: Caseworker Visits with Parents* - “The review revealed the agency did not consistently engage biological parents in frequent, quality face-to-face visits to discuss the safety, permanency, or well-being of their children or to promote the achievement of case goals.”⁷⁹

The failure to meaningfully engage with parents will continue to impact the quality of case planning. And without improvement in parental engagement and case planning, it is unlikely that Defendants will be able to meet the federal targets for permanency, as reflected in the chart on p. 18, above. Given the importance of case plans in guiding permanency, whether it be the child’s return home or to an alternative permanent placement if a child is unable to return home safely, Defendants need to prioritize improvement of poor parent engagement and poor case planning.

⁷⁷ Defs.’ 73rd Report, Att. A. Child and Family Services Review (CFSR) Results Report for 2024, p. 9.

⁷⁸ Ibid, p. 10.

⁷⁹ ibid , pp. 10-11.

D. Placement Needs and Challenges

Following the death of a foster youth (not from Baltimore City) in a hotel and legislative hearings on the most recent Department of Legislative Services' audit,⁸⁰ on October 22, 2025, DHS issued a directive prohibiting local departments from "facilitating the use of hotels or other unlicensed settings for youth experiencing out-of-home care."⁸¹ While this directive makes it clear to staff that these settings are not acceptable, it does not resolve the problem of a lack of appropriate placements and raises additional questions. Does this directive discourage youth from seeking help from BCDSS? Are youth choosing to remain in unsafe, unapproved placements or worse yet, on the streets? While the directive prohibiting the use of hotels and office buildings may be well-intended, without practical and easily accessible alternatives, there are likely to be negative unintended consequences.

The number of youth spending four hours or more in an office building has decreased over the past few months and the IVA is not aware of any youth being placed by BCDSS in a hotel since May 2025. However, children continue to be placed on waiting lists for weeks and sometimes months to obtain an appropriate placement. Some remain in hospitals, diagnostic facilities or residential treatment centers long after they are ready for discharge or step-down to a less restrictive placement. The Chapin Hall Report provides further data and insight into the ongoing placement challenges experienced by children in BCDSS out-of-home placement and across the state. In Baltimore City specifically, additional evidence of these ongoing problems is contained in the weekly Overstay/Waitlists, and until recently, in the daily Children in the Building

⁸⁰ See Att. 4.

⁸¹ Att. 10, DHS Memorandum, "Directive-on-the-Use-of-Unlicensed-Settings" (10/22/25).

Reports (CITB), and daily Hotel Reports as well as in some of the runaway and critical incident reports.

Overstay/Waitlists

As required by the MCD, Defendants compile a weekly list of children on a waiting list for placement or in a temporary placement which is sent to Plaintiffs' counsel and the IVA each week.

A sampling of the weekly Overstay/Waitlists reports from the past six months:

Date	# on hospital Overstay (beyond medical need)	# on waiting lists (for new placements)	Notes
6/27/25	5	19	13 y.o. remains on hospital overstay report 6 weeks after ready for discharge; 2 youth on waitlist have been placed temporarily in the care of biological parents due to lack of placement availability
7/25/25	3	22	10 y.o. on hospital overstay list has been awaiting placement for 5 weeks
8/29/25	2	24	10 y.o. remains on hospital overstay list; 11 y.o. on waitlist in need of diagnostic placement but no beds available until October.
9/26/25	2	23	15 y.o. ready for discharge from RTC, awaiting new placement for 6 weeks
10/31/25	4	21	9 y.o. on overstay at diagnostic center, waiting for RTC placement since mid-August; another 9 y.o. in need of a diagnostic placement but due to lack of availability in Maryland, an out-of-stand placement has been requested.
11/26/25	1	19	13 y.o. on hospital overstay has been ready for discharge since July 2025; 11 y.o. awaiting diagnostic placement due to lack of available homes.

As noted in the chart, many of these youth remain on the Overstay/Waitlist for weeks and months. Hospital overstay cases include some of the most challenging youth, some of whom will likely experience periods of stability and improvement punctuated by periods of crisis. The Defendants must be prepared to meet the needs of these children despite these challenges.

No child - and certainly no 9-year-old - should have to be placed out of the state of Maryland. There have been multiple reports of serious safety concerns, even death, in the for-profit institutions that often provide such placements.⁸² Out-of-state placement means that caseworkers and placement contract monitors cannot visit unannounced to check on children's safety; unless the placement is close by in a neighboring state regular (or any) visits by family are prohibitive; effective, in-person family therapy or transitional visits home (or to a new family placement) will not occur. Placement options should not be limited to institutional and congregate care placements but also include family settings when appropriate. Defendants should work to recruit and train kin and foster families who understand the complex needs of youth in foster care, particularly teenagers, and, most importantly, ensure that the necessary community-based services are available to support these caregivers and stabilize youth.

Hospital overstays are harmful to children's well-being, causing disruption to a child's educational and therapeutic services, as well as a lack of recreational and social activities. The hospital environment - often loud, bright, and at times chaotic - particularly in an emergency department where children may be housed pending an opening in a psychiatric hospital, can further traumatize an already traumatized child.

⁸² E.g., Pro Publica, "Thousands of Foster Children were Sent to Out of State Mental Health Facilities Where Some Faced Abuse and Neglect" (2020), downloaded from <https://www.propublica.org/article/illinois-dcfs-children-out-of-state-placements> on 12/14/25.

Children in the Building

Children in Defendants' care continued to spend multiple nights in BCDSS' office buildings rather than in homes and other licensed settings during the 73rd report period and into the 74th and 75th report periods. This chart demonstrates that the frequency of the practice increased in 2023 and throughout 2024 before starting to decrease in 2025.⁸³

Report Period	# Youth staying in office building	Total nights those youth spent in office building	# Youth staying more than 3 nights in office building in the report period
Jan - June 2023	21 youth	45 nights	2 youth
July - Dec 2023	51 youth	205 nights	11 youth
Jan - June 2024	61 youth	233 nights	18 youth
July - Dec 2024	69 youth	314 nights	22 youth
Jan - June 2025	50 youth	257 nights	16 youth
July - Dec 2025	33 youth	165 nights	8 youth

The Chapin Hall Report reviewed office, hotel and hospital stays in Baltimore City. Two of the notable findings included in the Chapin Hall Report: a significant portion of the children with office stays had multiple prior foster care episodes,⁸⁴ and youth aged 14-17 are “disproportionately represented in office stays, which suggests underlying issues in the availability of foster care placements for older youth.”⁸⁵ These findings align with the IVA’s review and logging of hundreds of “Children in the Building” (CITB) reports provided to the IVA and Plaintiffs’ attorneys by the Defendants. The issuance of the October 2025 directive to prohibit

⁸³ This chart is compiled from daily “Child in the Building” reports listing the children who spent four or more hours in an office building overnight, and the BCDSS Extended Hours Archive.

⁸⁴ Chapin Hall Report, p. 73.

⁸⁵ Chapin Hall Report, p. 75.

children staying in office buildings overnight does not address the importance of placement stability for children with a history of complex mental health needs and placement disruption.

While the significant decrease in children sleeping in BCDSS offices is promising, the Defendants do not provide any information in their report as to *how* this significant reduction was achieved, particularly for a problem that has been so intractable for multiple report periods. Have more placements become available? Have youth been moved to an appropriate placement or just to any placement that was available? Have the youth stabilized in these placements? Without an understanding of the needs of these youth and the full availability of appropriate placement at the time they are needed, Defendants risk another recurrence of the problem.

Hotels

Hotels, which are not approved placements, continued to be used during the 73rd and 74th report periods to house children, particularly children and youth with mental health issues, teenagers with a history of running away, and other difficult to place children. The practice is exorbitantly expensive, raises serious safety concerns, and is inappropriate for any long-term use. This practice saw a significant decline during 2025 and the last BCDSS-committed youth residing in a hotel was moved to a group home on May 9, 2025, after living in a hotel for more than one year and 4 months. This chart⁸⁶ summarizes hotel usage during the 73rd and 74th report periods:

Report Period	# Youth staying in hotels	Total nights those youth stayed in hotels	# Youth staying more than 30 nights in hotels in report period
July – Dec 2024 (73rd)	19 youth	687 nights	7 youth
Jan- June 2025 (74th)	2 youth	141 nights	1 youth

⁸⁶ IVA compilation of “Youth in Hotel Daily Reports.”

The IVA is not aware of any children placed by BCDSS in hotels after May 9, 2025.

Unfortunately, a number of the youth who previously resided in hotels have now been ejected (some more than once) from their post-hotel placements, are on runaway, or have spent nights in the BCDSS Extended Hours office. On January 7, 2026, just before the completion of this report, the IVA learned that Rite of Passage, a 24-bed program for boys ages 14-18 just opened in 2024 has not been permitted to accept new placements and will be closed. BCDSS currently has six teen boys in this placement, and all must be moved to new placements by March 1.

While the youth who appear on overstay and waiting lists or spend nights in an unapproved placement often present with more complex needs and may be a particularly challenging population, the Defendants must be prepared to meet the needs of all children who are in their care, including providing appropriate placements and intensive services when needed. As stated in the Chapin Hall Report, “there is an urgent need to develop placement options for children in foster care, particularly those who are older, have complex needs, or have experienced significant placement instability.”⁸⁷

The Chapin Hall Report includes 24 recommendations across key findings of the assessment that would benefit children in foster care across Maryland including children in Baltimore City.⁸⁸ Defendants compiled these recommendations into a document titled “Chapin Placement Assessment Recs and DHS Planned Actions” (February 2025). (Defendants’ 72nd report, Att. B). DHS had planned actions, targeted completion dates and targeted implementation dates for only 3 of the 24 recommendations as of February 2025. The IVA has not been provided with any updates regarding DHS’ response to Chapin Hall’s recommendations.

⁸⁷ Chapin Hall Report, p. 69.

⁸⁸ Chapin Hall Report, pp. 112-116. Additional recommendations based on the qualitative portion of the assessment are included in the Chapin Hall Report, Appendices I and J.

E. Kinship Care

Multiple past IVA reports have addressed in detail the importance of kinship placements and encouraged Defendants' strengthened efforts to increase the percentage of children and youth in kinship care. Kinship care provides greater stability in placement; results in improved well-being as compared to children in non-relative care; limits the trauma of removal and the circumstances that led to removal; maintains sibling and other ties; and results in improved permanency outcomes.

Defendants have provided a detailed update in their 73rd Report on the actions they have taken to increase placement rates with kin, the licensing of kin and additional supports for kin caregivers. BCDSS has set a goal to place 50% of all children in foster care with kin and to have 90% of those kin licensed (and therefore receiving financial support comparable to non-relative foster parents). There is still work to be done to reach 50% placement with kin. As of October 31, 2025, 40% of all children in Baltimore City OHP were placed with kin.⁸⁹

The December 2024 implementation of new regulations reducing the requirements for kin licensing has led to an increase in the number of kin caregivers who are licensed in Baltimore City. While there still must be criminal and child abuse background checks, home health assessment by caseworkers, and caseworker assessment of the kin caregiver for suitability of placement, kin caregivers are no longer required to complete foster parent training or meet a number of other non-relative foster parent licensing standards. 92% of kin caregivers were licensed as of the end of October 2025, an increase from 88% at the end of April 2025.⁹⁰

In their 73rd report, p. 15, Defendants state that between 2020 and 2024, the percentage of children whose first placement in foster care is with kin rose from 37% to 58%. This is an

⁸⁹ BCDSS Foster Care Milestone Report for October 31, 2025.

⁹⁰ April 30 and October 31, 2025 Foster Care Milestone Reports.

important step in reducing trauma for children entering foster care. Even brief stays in foster care can be traumatizing to children, and immediate placement with kin rather than “stranger care” can ease the impacts of this experience. However, as important as the rate of initial kin placement is, children should not just be placed with kin but also stay safely with kin - for their foster care stay if reunification is the plan or, if reunification is not possible, permanently. It is critical that Defendants respond quickly if kin placements are in danger of disruption. Defendants should track the stability of these kin placements and whether they lead to shorter lengths of stay in foster care and permanency upon exit from foster care.

One barrier that should be addressed as soon as possible is the current rate of pay for licensed kinship caregivers. Under the recent changes in the law, kinship caregivers receive the same payment rate as licensed public foster homes. However, this rate is insufficient, as there has been no increase in the public foster care board rate since FY2019 when there was a 1% rate increase. Yet, the cumulative rate of inflation has been 27% between 2019 to 2025.⁹¹ The timing for any future rate increase has not been announced.

F. Rate Reform

The development and implementation of a new rate structure for foster care providers in Maryland has been long-delayed. It was not until October 2024 that rate reform was implemented, and then for residential (congregate care) facilities only. The rate reform effort now includes proposed increased Child Placement Agency (CPA) rates for treatment foster care homes, independent living providers and “mother/baby” placements as well as a proposed Medicaid State Plan Amendment to use Medicaid funds to pay for behavioral health services in contractual

⁹¹ [usinflationcalculator.com](https://www.usinflationcalculator.com), accessed 11/14/25

placements such as group homes.⁹² There is no set date for implementation of rate restructuring for CPA providers. According to Defendants, any increase in kinship/foster home rates is tied to future board rate increases for CPA providers. As a result, problems with rates and service provision identified more than a decade ago continue to go unresolved.

G. Health

Defendants' continuing poor performance in providing timely health care services to the children in OHP is an area of significant concern. Defendants contract with HCAM (Health Care Access Maryland) for the MATCH (Make All the Children Healthy) program, which is tasked with management of the health care needs of the children in OHP. BCDSS retains the ultimate responsibility for the child's attendance at health appointments and receiving all necessary care.

Quantitative Data: Timeliness of Required Examinations

The required health care examinations for children in OHP in Baltimore City are the same as the requirements for children in OHP statewide based upon state regulations:⁹³ an initial health screening immediately after the child enters OHP; comprehensive medical examinations within 60 days of entering OHP;⁹⁴ and periodic medical examinations according to the requirements of

⁹² More information regarding rate reform: "Answers to Frequently Asked Questions (FAQ) about the Maryland Children's Quality Service Reform Initiative (QSRI)," updated January 8, 2024, <https://marylandpublicschools.org/programs/Documents/Special-Ed/IRC/FAQ-Maryland-Childrens-Quality-Service-Reform-A.pdf> (last accessed June 16, 2025).

⁹³ COMAR .07.02.11.08.

⁹⁴ While *L.J.* requires all of the comprehensive exams (medical, dental, and mental health) be completed in the first 60 days in OHP, Maryland policy allows for 90 days after entry into OHP (or the child turning age 1, whichever is later) for an initial dental exam, and a comprehensive mental health assessment is not required. See SSA/CW #25-08, Health Care Services Oversight and Monitoring (December 1, 2025), pp. 16-17. Defendants' policies are available on its website at <https://www.dhr.maryland.gov/documents/?dir=SSA%20Policy%20Directives/Child%20Welfare> (last accessed 1/10/26).

Maryland's Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines⁹⁵ along with periodic dental examinations.⁹⁶

BCDSS met the 95% requirement for Initial Health Screening under *L.J.* Exit Standard 75 for the most recent report period.⁹⁷ However, other required exams have not come close to meeting the state's own requirements or *L.J.* compliance levels.

MATCH has asserted over past years that a major reason why the compliance levels appeared so low is that it was not permitted to enter into CJAMS the date of a child's medical or dental appointment until MATCH had received the examination report from the provider, and those reports were often delayed. In the summer of 2025, BCDSS granted MATCH the authority to enter appointments if they had been at least verbally confirmed without waiting for the written reports. As such, the data for the current (75th) report period, July 1 - December 31, 2025, should show substantially higher compliance levels for Exit Standards 82 and 83. As shown in the charts below, they do not. At this time, it does not appear that the new system is producing better results.

Comprehensive Health Examinations

All foster children in Maryland are required to have comprehensive medical examinations within the first 60 days of entering OHP and comprehensive dental examinations within the first 90 days. *L.J.* Exit Standard 82 requires that 90% of children entering OHP in Baltimore City have comprehensive medical, dental and mental health examinations in the first 60 days. Compliance requires that all three exams are completed timely. The compliance level for those exams has not exceeded 71%, well below the required 90% compliance level.

⁹⁵ Att. 11, Maryland Health Kids Preventive Health Schedule (January 1, 2024) (downloaded from MD Department of Health website). "The Schedule reflects the minimum standards required for all Maryland Medicaid recipients from birth to 21 years of age."

⁹⁶ Att. 12, American Association of Pediatric Dentistry, Recommended Dental Periodicity Schedule 2022, downloaded from https://www.aapd.org/globalassets/media/policies_guidelines/bp_chart.pdf, 6/16/25.

⁹⁷ Data for Exit Standard 75 downloaded from CJAMS on 1/26/26.

L.J. Exit Standard 82 - Comprehensive Exams at 60 days⁹⁸

Report Period	Timely Comprehensive Exams
July - December 2024	70.71%
January - June 2025	70.74%
July - December, 2025	60%

Annual Health Examinations

All foster children in Maryland are required to have annual medical examinations. The *L.J.* measure instructions and report (and DHS guidelines) require that children have an annual medical exam within 13 months of the prior exam, allowing an extra 30 days for those exams to account for unexpected delays. The MCD requires a 90% compliance rate; over the past two years, compliance has not exceeded 25%.

L.J. Exit Standard 83A - Timely Annual Health Exams⁹⁹

Report Period	Timely Annual Health Exam
July - December 2024	24.63%
January - June 2025	23.14%
July - December 2025	15.76%

Semi-Annual Dental Examinations

All foster children in Maryland are required to have semi-annual dental examinations. Over the past two years, less than 16% of children have received a semi-annual dental exam within

⁹⁸ Data for Exit Standard 82 downloaded from CJAMS on 1/26/26.

⁹⁹ Data for Exit Standard 83A downloaded from CJAMS on 1/26/26. Another way of looking at timely receipt of required annual medical exams is the Foster Care Milestone Report snapshot of how many children eligible for annual medical exams had had that exam within the past 13 months. The October 31, 2025 Milestone Report showed that only 40% of the children who should have received an annual medical exam within the past 13 months had one. More than half of the 60% of children who had not had that exam were under the age of 18.

seven months of the prior dental exam. (As with annual exams, an additional month is allowed to account for unavoidable delays.)

L.J. Exit Standard 83B - Timely Semi-Annual Dental Exams)¹⁰⁰

Report Period	Timely Semi-Annual Dental Exams
July - December 2024	15.74%
January - June 2025	15.57%
July - December 18, 2025	10.3%

Early Periodic Screening, Diagnostic and Treatment (EPSDT) Exams for Children 48 months and Younger

Young children require physical examinations more frequently than once a year in order to ensure their proper development, their receipt of all necessary vaccinations, and early detection of any health problems. The importance of young children receiving these periodic examinations on the required schedule raises particular concern about these compliance rates remaining at or below 50% over the past two years.

L.J. Exit Standard 83C - EPSDT Exams for Children 48 Months and Younger¹⁰¹

Report Period	Timely EPSDT Exams
July - December 2024	48.46%
January - June 2025	51.5%
July - December 2025	32.86%

¹⁰⁰ Data for Exit Standard 83B downloaded from CJAMS on 1/26/26. Another way of looking at timely receipt of dental care is the Foster Care Milestone Report snapshot of how many children eligible for semi-annual dental exams had had that exam within the past seven months. The October 31, 2025 Milestone Report showed that only 45% of the children who should have received a dental exam within the past seven months had a dental exam.

¹⁰¹ Data for Exit Standard 83C downloaded from CJAMS on 1/26/26.

All Preventative Examinations Beginning 60 days After Removal

L.J. Exit Standard 83D provides a summary of the timeliness of all preventative exams due after the first 60 days after the child’s entry into OHP. It measures for each child whether all of the medical and dental preventative exams due during the report period took place, e.g., a two-year-old might have a nine-month EPSDT exam, an annual EPSDT exam, and a dental exam due during the report period. Exit Standard 83D measures whether the child received all of those examinations timely. Less than 10% of all children due exams have been receiving all required exams timely.

***L.J.* Exit Standard 83D - Preventative Exam Summary¹⁰²**

Report Period	Timely All Preventative Exams Due
July - December 2024	9.58%
January - June 2025	8.29%
July - December 2025	7.0%

Qualitative Review of Health Services

Five of the *L.J.* health measure instructions - Exit Standards 79, 82, 83, 88 and 94 - require qualitative review by an independent health care management expert. Besides assisting BCDSS and MATCH with feedback on the quality of health care management services, the qualitative review is designed to assist the IVA in ensuring that the qualitative as well as quantitative requirements of the MCD are met. Over the past four years, Kathy Maddock, BSN, MSA, FACMPE, LGBSS, has completed six such reviews. The report for the 73rd report period from July - December 2024 is attached.¹⁰³

¹⁰² Data for Exit Standard 83D downloaded from CJAMS on 1/26/26.

¹⁰³ See Att. 13, Maddock, “BCDSS Health Services and MATCH Oversight Report,” July – December 2024 (October 1, 2025).

For compliance with the EPSDT and dental exam requirements (Exit Standards 82 and 83), a subsample of children's EPSDT and dental reports are reviewed in detail. Ms. Maddock has reviewed at least 350 such reports and has found that, with two areas of exception, most providers are meeting the EPSDT requirements in their examinations.¹⁰⁴ The results for the other three Exit Standards have not been as favorable.

While MATCH staff is following the format requirements for the Comprehensive Health Assessment (CHA)¹⁰⁵ (Exit Standard 79) and for Health Plans¹⁰⁶ (Exit Standard 94), the content of many of these documents has been found to be insufficient. For example, for the 73rd report period, Ms. Maddock found that 37% of the CHAs had been completed for new entrants without obtaining documentation of all three comprehensive health care examinations that were to provide the basis for those CHAs.¹⁰⁷ For ongoing care, she found that 71% of annual Health Plans did not "address all unmet health needs and contain plans to address those needs promptly."¹⁰⁸

As to Exit Standard 88a, the requirement that children in OHP have "all health needs met," Ms. Maddock has found that no more than 53% of the children in continuing care had "all health needs met" due to lack of medical exam documentation in CJAMS and overdue or completely missed exams.¹⁰⁹

¹⁰⁴ See, e.g., Att. 13, pp. 12 and 18. The areas of underperformance have been in "risk assessment by questionnaire" and, for new entrants, "risk assessment by lab testing."

¹⁰⁵ A CHA is created and provided to the child's caregiver and medical provider within 70 days of the child's entry into foster care and should include basic background on the child including the child's medical history, a summary of the medical, dental and mental health exams that have taken place since entry into OHP, and the recommendations from those exams.

¹⁰⁶ Also called "Health Passports" in the MCD, Health Plans must be created and provided to the child's caregiver and caseworker within 70 days of the child's entry into foster care and every year thereafter and should include an update of the child's physical and mental health since the last Health Plan, upcoming appointments, a plan for obtaining any needed care, and medications.

¹⁰⁷ Att. 13, p. 10.

¹⁰⁸ Att. 13, p. 16.

¹⁰⁹ Even if an examination took place, it is not possible to determine if the child had any needs identified in the examination without receipt of documentation from the provider.

In each of her reviews, Ms. Maddock has made recommendations to both BCDSS and MATCH on improvements that can be made to health care management.¹¹⁰ Defendants' continuing poor performance on important health measures makes implementation of those recommendations critical.

H. Mental Health

High quality, culturally responsive mental health care is essential to the well-being of children and youth in foster care. The failure to provide this care exacerbates placement problems, and the complexity of mental health issues impacts the length of time a child spends in out-of-home care. BCDSS created the BCDSS Youth Wellness Program to contract directly with mental health providers for services for children and youth and continues to work with Behavioral Health Systems Baltimore (BHSB) to implement the program. It was anticipated that this program would be particularly beneficial for children who experience placement instability because their therapeutic provider would be separate from their placement, thereby allowing the child to continue with their Wellness Program provider even in the case of a placement disruption.

The Defendants provide detailed information about the program in their report (Defs' 73rd Rep., pp. 18-23). The implementation of this program has faced and continues to face challenges. Referrals to the Wellness Program were delayed from a planned launch date in October 2022 to February 2023 due to the four contracted providers experiencing delays in hiring qualified therapists. Provider and clinical staff retention problems also have ensued. Of the four original providers awarded contracts, only two remain. A third provider was added to replace one of the providers who separated from the program, and a fourth is still being sought. As a result of these retention challenges, the referral portal has had to close periodically so that cases could be

¹¹⁰ Att. 13, p. 19.

reassigned to the remaining clinicians until a new provider was brought on or new clinicians could be hired. As of November 2025, only 7 clinicians of the 20 that were anticipated are participating in the program.

There continues to be a lack of information about the outcomes - including the quality and effectiveness - of the BCDSS Wellness Program. The Defendants list the goals of the program in their 73rd report,¹¹¹ but have not shared any data or analysis that assesses whether the program is meeting many of these goals. For example, has placement stability improved? Have hospitalizations and use of congregate care settings decreased? Defendants provide detailed information about the number of referrals and various other processes as part of the Wellness Program but have not yet reported on whether or how the program is meeting its identified goals.

Defendants should consider expanding the Wellness Program to include alternatives to the traditional one-to-one therapist client modality such as group therapy; art, music and dramatic arts therapy; yoga; peer support; and mindfulness and other activities to make it truly a “wellness” program responsive to the needs of the youth it is to serve. It may have the effect of creating a more stable service provider cohort as well as encouraging participation by youth who are declining to participate in the one-to-one therapy modality currently being offered.

The availability of crisis services is essential to the safety and well-being of youth in Defendants. Without a “24/7” crisis service available, youth may be at greater risk for police involvement, hospitalization and placement instability. What crisis services are available should be included in Defendants’ reports.

Lastly, there continues to be an overall lack of accurate and complete data available around the mental health needs of children in BCDSS custody. This issue is also one that was shared in

¹¹¹ Defs.’ 73rd Report, p. 18.

the Chapin Hall report: “Generally, the administrative, quantitative data in CJAMS is limited when it comes to *direct* measures or mentions of child behavioral and/or mental health needs. For example, there are many children placed in settings (like a facility approved or licensed by the Developmental Disabilities Administration) or whom have characteristics (like prescribed medications) which would require a diagnosis, but the diagnosis information in CJAMS is blank.”¹¹² Information such as the percentage of children and youth in need of mental health services, percentage of children and youth receiving mental health services, common diagnoses, frequently prescribed medications, and treatment outcomes, is essential to ensuring that the most appropriate services are available to meet the needs of children and their families and caregivers.

VII. DATA CHART AND IVA CERTIFICATION DISCUSSION

Part Two of the MCD contains five sub-sections: Preservation and Permanency Planning; Out-of-Home Placement; Health Care; Education; and Workforce. Each of these contains Outcomes with Definitions, Internal Success Measures (ISMs), Exit Standards and Additional Commitments. Compliance with those Outcomes is measured through compliance with 40 Exit Standards. In addition, Defendants must provide data for the ISMs. The IVA is responsible for review of Defendants’ assertions of compliance and may certify compliance only after verifying that the Defendants' reported data, and the measures and methods used to collect and to report that data are accurate, valid, and reliable.

“Certification” of individual measures involves (1) determining if the measure instruction for preparing and extracting the reported data meets the requirements of the MCD; (2) investigating the way the reported data was obtained to determine if it meets the requirements of the measure instruction; (3) verifying the reported data to determine if what is reported as the level

¹¹² Chapin Hall Report, p. 13.

of compliance is accurate, valid, and reliable; and (4) for Exit Standards only, determining if the verified compliance level meets the MCD requirements.

Defendants have been certified as compliant for at least three consecutive report periods for only 3 of the 40 Exit Standards:

Measure 121, 95 percent of caseworkers met the qualifications for their position title under Maryland State Law;

Measure 125, 90 percent of cases were transferred with required documentation within five working days; and

Measure 126, 90 percent of cases had a case transfer conference within ten days of the transfer.

Defendants request certification for two Exit Standards - Measures 52 and 79 - and state for Exit Standards 121, 125, and 126, that “Certification was granted by the IVA in *L.J.* submission 71.” The relevance of that statement is unclear. The reported compliance levels for Exit Standards 125 and 126 for the 73rd report period meet the required MCD compliance levels, but a certification decision is no longer required under the MCD. (See discussion below.) The IVA can certify compliance with Exit Standard 121 but not Exit Standards 52 and 79 for the reasons discussed below.

Defendants’ Data Chart is Attachment F to their report. The IVA has provided a copy of that Data Chart, annotated with the IVA’s findings, attached as Appendix 1 to this IVA report. More than 16 years after the entry of the MCD, 70% (87 of 126) of the required measures remain “TBD.” The IVA’s Data Chart includes the data for the 73rd report period for additional measures which Defendants did not report - Exit Standards 20, 24, 29a, 72a, 83, 115, and 116, and ISM 9.¹¹³

¹¹³ Because of the complexity of some of the *L.J.* measures, their CJAMS reports were broken down into sub-reports. For certification purposes, all sub-reports will have to meet the required compliance levels for the Exit Standard.

Given the number of years that Defendants have failed to report any data for most of the measures, it is important that any available validated data not be excluded any further.

A. Measures Certification Discussion

The IVA reviews the status of the measures for each substantive section of the MCD below. Where Defendants have provided data for and asserted compliance with an Exit Standard, the rationale for the IVA's decision about certification of compliance is included in this report on the following pages. Where Defendants have provided data for an Exit Standard but not asserted compliance or where they have provided data for an Internal Success Measure, the rationale for the IVA's decision about whether the data reported can be certified as accurate, valid, and reliable is included in the IVA's Data Chart.

1. Preservation and Permanency Planning

The Preservation and Permanency Planning section of the MCD includes five Outcomes containing a total of 7 Exit Standards and 22 Internal Success Measures (ISMs).

Defendants do not provide data for nor claim compliance with any of the Exit Standards in this section. The IVA's Data Chart contains available report data for Exit Standards 20, 24 and 29a.

Defendants provide data for seven of the ISMs (5, 10, 13, 18, 23, 27, and 28). The IVA's Data Chart also contains available report data for ISM 9. ISMs 5, 18, and 28 are certified as accurate, valid, and reliable. ISMs 10, 13, 23, and 27 are not certified as accurate, valid, and reliable for the reasons set out in the IVA's Data Chart, pp. 4-7.

2. Out-of-Home Placement (OHP)

The OHP section of the MCD includes 12 Outcomes containing a total of 14 Exit Standards and 29 Internal Success Measures.

Defendants provide data for three of the Exit Standards in this section - Measures 52, 65, and 68 (part 1). The IVA's Data Chart also contains the available report data for Exit Standard 72a. Although Exit Standards 57, 58, and 60 were designated as priority measures, Defendants have not completed the reports for those Exit Standards.

Defendants request certification for Exit Standard 52. Certification is denied for the reasons set out below. Exit Standards 65 and 68 are also discussed below.

Defendants provide data for eight of the ISMs (30, 38, 46, 47, 49, 50, 51, and 67). ISM 30 is certified as accurate, reliable and valid. ISMs 38, 46, and 47 are not certified as accurate, valid, and reliable for the reasons set out in the IVA Data Chart, Apx. 1, pp. 9-10. Because ISMs 49, 50, and 51 are linked to Exit Standard 52, and because ISM 67 is linked to Exit Standard 68, respectively, the reasons for denying certification are discussed with those Exit Standards, below.

Discussion of OHP Measures 49-52, 65, and 67-68

Internal Success Measure 49: *Number of Special Support team positions funded by the Department, by type.*

Internal Success Measure 50: *Number of Special Support positions filled, by type.*

Internal Success Measure 51: *MCDSS MS-100 22(job descriptions for all positions)*

Defs.' Report: Developmental Disabilities - 1; Education - 5; Housing and Employment - 2; Independent Living - 1; Mental Health - 3; Substance Abuse - 1 contractor through October; 2 in November and December; Ready by 21 - 1; SSI Supports - 1; Care Coordinator - 1; Family Investment/Foster Care Liaison - 1; SSI/SSA Benefits - 1; MATCH -1. Total: 19.

IVA Response: The data reported by Defendants is inaccurate. From information provided by Defendants, the highest number of Special Support team positions documented is 17, and the actual number of specialist positions filled for the entire report period is 14. The MS-22 for two of the

listed areas does not provide that the person holding the position has the expertise or responsibility to provide technical assistance in that area to caseworkers and supervisors . There is no MS-22 or job description provided for the positions of “Care Coordinator” or “MATCH.”

Exit Standard 52: *BCDSS employed a staff of non-case carrying specialists to provide technical assistance to caseworkers and supervisors for cases that require specialized experience and/or knowledge.*

Defs.' Report: Requests certification.

IVA Response: Defendants’ compliance is not certified. Defendants have not met the substantive requirements of Exit Standard 52 for the same reasons set out in multiple previous IVA reports. Defendants have not addressed the IVA’s concerns in any of their reports.

Exit Standard 65: *99.68 percent of children in OHP were not maltreated in their placement, as defined in federal law.*

Defs.’ Report: 98.54%.

IVA Response: Not certified as accurate. The actual compliance percentage is **98.33%**.

The parties to the MCD chose a compliance level of “99.68% of children in OHP not maltreated in their placement” for the MCD because, in 2009 when the MCD was entered, it was the standard used by the federal government. A footnote to Exit Standard 65 provides:

The measurement for maltreatment in foster care in this Decree is the measurement used by the United States Department of Health and Human Services in Child and Family Services Reviews, which means the percentage of children who were found to be victims of indicated maltreatment by perpetrators who are relative foster parents, non-relative foster parents, and group home or residential facility staff. “Relative foster parents” include unlicensed kinship care providers with whom BCDSS placed children in OHP.¹¹⁴

¹¹⁴ Prior to the third round of CFSR (in 2018 in Maryland), the measurement for maltreatment-in-care was changed to “of all children who were in foster care in a 12-month period, what was the rate of maltreatment per 100,000 days in

Defendants' reported compliance level for the 73rd report period is not accurate. There are at least four additional cases of maltreatment that should have been but were not included in the report for Measure 65. Therefore, there were a total of 27 (rather than 23, as reported) cases of confirmed maltreatment-in-care by caregivers during the report period. When those cases are included, the actual compliance rate is 98.33%.

The four cases which are missing from Defendants' report are not included because the caseworker who input the data and the supervisor who approved the report failed to mark "yes" for the field asking if the case was "provider involved" even though the maltreators clearly were in the role of caregiver when the maltreatment occurred.

The IVA has met with and communicated in writing with Defendants on multiple occasions over the past 15 years to demonstrate the problems which have led to every one of their reports for this Exit Standard being erroneous. It appears that Defendants have made the necessary changes to permit the correct data to be entered into CJAMS. The solution at this point relies on proper training of caseworkers and accountability by supervisors to do a careful review prior to approval of the caseworker's recommended disposition of the case.

Internal Success Measure 67: *Number of children who spent four hours or more in an office, motel, or unlicensed facility.*

Defs.' Report: 69 children.

care?" In addition, unlike for Measure 65, all occurrences of maltreatment are included, regardless of the relationship between the perpetrator and the child. The new national standard is less than 9.07 victimizations per 100,00 days in care during the 12-month period. For the year ending October 31, 2025, Baltimore City's rate was 11.3 victimizations per 100,000 days, (Att. 1, p. 2), although some of the underreporting for Measure 65 may also apply to the Headline Indicators calculation.

IVA Response: Defendants have established a process for capturing and reporting the information about children spending more than four hours in office buildings and hotels. However, the results they have reported are not accurate. The actual result for the 73rd report period is 72 children. This is calculated by adding the unique number of children who spent more than four hours in office buildings and those who spent nights in hotels. There were 53 children who spent nights in office buildings only; 13 children who spent nights in office buildings and hotels; and 6 children who spent nights in hotels only, for a total of 72 children (53+13+6). Those 72 children spent 1,001 nights in office buildings and hotels from July 1 to December 31, 2024.

Exit Standard 68: *99.8 percent of children in OHP were not housed outside regular business hours in an office, motel, hotel, or other unlicensed facility. If any child is so housed, BCDSS shall notify Plaintiffs' counsel within one working day of the reasons for the placement, the name of the child's CINA attorney, and the steps that BCDSS is taking to find an appropriate placement. Barring extraordinary circumstances, no child may be housed in an office for consecutive nights.*

Defs.' Report: 95.73%.

IVA Response: As set out above, the reported number of unique children either staying in office buildings more than four (non-business) hours or being placed in hotels is inaccurately reported for the 73rd report period as 69 when the actual number is 72. When the correct number of children is divided by the 1,616 children in OHP during the report period, Exit Standard 68 should be reported as **95.54%**.

3. Health Care

The Health Care section of the MCD includes five Outcomes containing a total of 7 Exit Standards and 15 Internal Success Measures.

Defendants provide data for three of the Exit Standards in this section - Measures 75, 79, and 82. The IVA's Data Chart also contains the available report data for Exit Standard 83.

Defendants claim compliance with and request certification of one Exit Standard, Measure 79. Certification is denied for the reasons discussed below.

Defendants provide data for six of the ISMs (73, 74, 76, 80, 91, and 92). ISMs 73, 74, 80, 91, and 92 are certified as accurate, valid, and reliable. Because ISM 76 is linked to Exit Standard 79, the reasons for denying certification are discussed with that Exit Standard, below.

Discussion of Health Care Measures 76 and 79

Internal Success Measure 76: *% of new entrants into OHP who received a comprehensive health assessment within 60 days of placement.*

Exit Standard: *90% of new entrants into OHP received a comprehensive health assessment within 60 days of placement.*

Defs.' Report: 98.5%.

IVA Response: Not certified. This measure looks for the completion of a written document that summarizes the three comprehensive health exams that are to occur within 60 days of a child entering foster care. The quantitative data from CJAMS showing that Defendants timely created and mailed the written comprehensive health assessment (CHA) in 98.5% of cases is accurate, valid and reliable. However, only 67% of the CHAs met the qualitative requirements of the MCD. As discussed at pp. 59-61, above, Measure 79 is one of the five health measures for which a qualitative examination by an independent health expert is required. For her qualitative assessment of CHAs, the expert, Kathy Maddock, rated the sample of cases for six requirements. The averaged score for those requirements for the CHAs was 67%; in only 50% of the sample of cases were all

required documents uploaded and the recommendations and referrals from each provider summarized clearly. Exit Standard 79 is not certified as compliant.

4. Education

The Education section of the MCD includes three Outcomes containing 6 Exit Standards and 11 Internal Success Measures (ISMs).

Defendants do not provide data for nor claim compliance with any of the Exit Standards in this section. As of the time of this report, the only measure designated as a priority measure, Exit Standard 99 (timely school enrollment), has not been completed.

Defendants provide data only for ISM 100. The IVA has insufficient information with which to determine if the reported data for ISM 100 is accurate, valid, and reliable.

5. Workforce

The Workforce section of the MCD includes three Outcomes containing 6 Exit Standards and 9 Internal Success Measures (ISMs).

Defendants provide data for four of the Exit Standards in this section - Measures 121, 122, 125, and 126. The IVA's Data also contains the available report data for Exit Standards 115 and 116.

Although Defendants have reached certification-level numerical compliance for three Exit Standards: Measures 121, 125, and 126, only Exit Standard 121 (and related ISMs 117 and 118) need be addressed here. Because Exit Standards 125 and 126 comprise the only two Exit Standards for the final Outcome of the MCD, and those two Exit Standards have been certified as compliant for three consecutive report periods, compliance with that Outcome can now be and is certified under Part One, Section V. A. of the MCD. Unless Defendants report a decline in the compliance

level, the IVA need not verify the reported data for those Exit Standards (and linked ISMs 123 and 124) again.¹¹⁵

However, Exit Standard 121 is only one of two Exit Standards for its Outcome, and the other Exit Standard, 122, has not yet reached compliance levels. Therefore, the IVA cannot certify compliance with that Outcome and will continue to review the reported data for Exit Standard 121 for certification of compliance.

Defendants provide data for six of the ISMs (117, 118, 119, 120, 123, and 124). ISMs 117 and 118 are certified as accurate, reliable and valid for the reasons set out in the discussion of linked Exit Standard 121, below. Exit Standard 122 and ISMs 119 and 120 are not certified as accurate, reliable and valid for the reasons set out in the IVA's Data Chart, p. 20.

Discussion of Workforce Measures 117, 118, and 121

Internal Success Measure 117: *Percent of caseworkers who qualified for the title under Maryland State Law.*

Defs.' Report: 100%

Internal Success Measure 118: *Percent of case-carrying workers who passed their competency exams prior to being assigned a case.*

Defs.' Report: 100%

Exit Standard 121: *95 percent of caseworkers met the qualifications for their position title under Maryland State Law.*

Defs.' Report: 100%

¹¹⁵ "Once certified compliance with an Outcome has been achieved, the periodic reports required by subsection J of Part One, Section II, "Verification Activities," will no longer be required, nor will verification by the Independent Verification Agent of compliance with the Outcome be required. Instead, the Defendants will continue to measure compliance with the Outcome and will incorporate reporting on the Outcome in quarterly public management reports. Defendants shall notify the Independent Verification Agent, with a copy to Plaintiffs, if their compliance with an Outcome or the methodology for reporting on an Outcome changes." MCD, p. 8.

IVA Response: Based upon the documentation provided by Defendants, Defendants' reports for this Exit Standard and for Internal Success Measures 117 and 118 are found to be accurate, valid, and reliable.

Exit Standard 121 requires reporting on newly hired caseworkers during the report period in which they are first assigned a case. For all of those caseworkers, Defendants provided (1) documentation of either an MSW in social work or related field or a bachelor's degree in an "appropriate behavioral science," and (2) proof of completion of the mandatory pre-service training and passage of the competency examination prior to assignment of a first case. For those new caseworkers without a social work license, they also provided documentation of their supervisors' social work license. The IVA reviewed all of the degrees and proof of passage of compliance exam letters and randomly checked OHP milestone reports for the period between when the new caseworkers were hired and when they passed their competency exams and found no instances where staff were assigned cases during that period of time. The IVA finds that the procedures used by Defendants to collect this information, and the data provided are accurate, valid and reliable.

Based on this review, the IVA certifies that Defendants' reported compliance level of 100% for Exit Standard 121 is accurate, valid and reliable and surpasses the MCD-required compliance level of 95%.

B. Additional Commitments

Four of the five subsections in Part Two of the MCD also have Additional Commitments included. These 22 Additional Commitments are included in the MCD to address issues of importance to the welfare of the children served by BCDSS which do not fit neatly into the Internal Success Measures/Exit Standards format. Defendants are required to report on compliance with

the Additional Commitments in each six-month compliance report. The IVA's response to Defendants' report on compliance with those Additional Commitments is found in Appendix 2 to this report.

C. Other Reporting Requirements

Defendants report on five additional MCD reporting requirements.

1. MCD Part One, Section II. Verification Activities and Information Sharing

F. The Plaintiffs shall have access to the following: ... 4. Within one working day, Plaintiffs' counsel shall be notified of the serious injury or death of any class member and shall be provided timely the incident report, any reports of the investigative outcomes, and access to the child's case file.

Defendants have reported no fatalities in OHP in 2024 and one fatality in OHP in 2025.

From January 1 - October 31, 2025, Defendants provided 143 Critical Incident Reports.

Many of those reports were connected to a CPS maltreatment report.

The IVA has no record of any follow-up reports being provided.

Defendants no longer provide regular reports of children running away from placements.

The IVA is unable to determine whether Defendants are compliant with this reporting requirement. In order to do so, the IVA needs to examine the data for the report for Measure 61, which should report all safety-related Critical Incident Reports. That report was completed by MDTHINK but is no longer accurate due to changes in the CJAMS application.

2. MCD Part One, Section II. Verification Activities and Information Sharing

F. The Plaintiffs shall have access to the following: ... 5. Defendants shall promptly provide to the Independent Verification Agent and to Plaintiffs' counsel all publicly

available reports that Defendants receive indicating that they are not in compliance with a requirement of this Decree.

Defendants report receiving no such publicly available reports during the 73rd report period. The IVA knows of no such reports. However, Defendants did not provide relevant reports available during the 74th report period or the 75th report periods, which have already passed.

On April 11, 2025, the Maryland Department of Legislative Services (DLS) issued an audit of DHS Local Department Operations including findings from the DHS Inspector General's office that child abuse and neglect investigations often were not completed timely; that monthly visits with children were not documented timely; that foster care trust accounts were not maintained properly; and that foster care providers were not properly monitored. Of the 98 sampled child welfare-related findings of violations, 10 were from Baltimore City.¹¹⁶

On September 12, 2025, DLS issued an audit of DHS Social Services Administration (SSA) Operations including 14 findings of non-compliance. Those most relevant to *L.J.* include:

Finding 1. SSA had not implemented comprehensive quality assurance processes and effective oversight of the State's Local Departments of Social Services (LDSSs) administration of child welfare programs.

Finding 2. SSA did not have comprehensive procedures to ensure individuals with disqualifying criminal backgrounds did not interact with children under its care. As a result, SSA did not identify multiple individuals with disqualifying convictions that were in positions to interact with children.

Finding 3. SSA did not have a process to periodically reconcile the Maryland Sex Offender Registry to its records of SSA providers and vendors to identify any sex offenders with potential access to children.

Finding 4. SSA did not ensure that data on CJAMS used to monitor the LDSSs was accurate and supported.

¹¹⁶ Att. 3, MD Department of Legislative Services, Audit DHS Local Operations (April 2025). The relevant findings and the number of cases found to be non-compliant for Baltimore City are on pp. 11 - 13 and 18, respectively.

Finding 5. SSA did not ensure the LDSSs provided foster care children the required medical and dental exams. We identified numerous foster children who did not receive exams within the timeframes required by State regulations.

Finding 6. SSA did not ensure the LDSSs placed foster care children in settings authorized in State law. We identified 280 children placed in hotels under the supervision of providers that were not licensed and at a significantly higher cost to the State.

Finding 7. SSA did not ensure the LDSSs established and maintained required trust accounts for foster children.

Finding 9. SSA did not meet federal foster care service performance requirements resulting in penalties totaling \$698,296 being assessed on the State.

Finding 10. SSA did not sufficiently address instances when LDSSs did not conduct child abuse and neglect investigations timely.

Finding 11. SSA did not report child abuse and neglect investigations that were not completed within 60 days to the General Assembly as required by State law. In addition, SSA could not support its explanations for untimely investigations, certain of which appeared questionable.

In addition, the audit found that 6 of the 8 findings in a 2021 Audit of SSA were repeated in this audit.¹¹⁷

3. MCD Part One, Section III, Communication and Problem-Solving

E. By December 31, 2009, Defendants, after consultation with the Internal Verification Agent, Plaintiffs' counsel and stakeholders, shall establish a standardized process for resolving issues related to individual class members. ... Records shall be kept of the issues raised and their resolutions, and summary reports shall be provided to the Internal Verification Agent and Plaintiffs' counsel every six months.

On December 9, 2025, Defendant BCDSS provided the summary report for the report period ending December 31, 2024.¹¹⁸ Based upon the complaint summary provided, BCDSS is found to be in compliance with this requirement of the MCD. In the future, rather than the IVA

¹¹⁷ Att. 4, DLS Audit, pp. 4-6, 11-12.

¹¹⁸ Att. 14, Complaint Process Summary Report for 73rd Report, received on December 9, 2025.

having to request this summary report, it should be provided automatically to the IVA and Plaintiffs' counsel after the end of each report period.

4. MCD Part Two, Section II. Out-of-Home Placement

D 1. a. (4) Plaintiffs' counsel will be notified within ten working days of any child being placed on a waiting list or in temporary placement.

BCDSS has continued to send a weekly list of children who have overstayed the period of medical necessity in hospitals, who are waiting for new placements to be located for them, or who are on waiting lists to be placed in new settings to which they have been admitted. The IVA acknowledges the efforts of the Defendants to create and share this information as required by the MCD.

For verification purposes, in the IVA Response to the 70th Report, the IVA had requested information describing the process for compiling this list and how BCDSS ensures that all children awaiting an appropriate placement are included on the list. Subsequently, in an email dated July 17, 2024, in a meeting on October 30, 2024, in a follow-up email on November 6, 2024, and again on January 21, 2025, the IVA requested a log of all requests for placement to the Child Placement Resource Unit (CPRU) and their resolution. Defendants have failed to respond to any of these requests, making it impossible for the IVA to determine whether Defendants are complying with this requirement of the MCD.

5. MCD Part Two, Section II. Out-of-Home Placement

D. 9. a. (1) (b) ... Within five business days of receipt of a [maltreatment in care] report, BCDSS shall notify the attorney for the child, the child's parents and their attorneys ..., Plaintiffs' counsel An unredacted (except the name of and identifying information

about the reporter and privileged attorney-client material) copy of the report must be provided to the child's attorney and Plaintiffs' counsel. The completed unredacted ... disposition report must be provided to the child's caseworker, child's attorney and to Plaintiffs' counsel within five business days of its completion. ...

Defendants are not in compliance with this requirement. Once again, Defendants report that “Work has been underway to develop a more compliant system to report all incidents for which notice is required.” (p. 28). Unfortunately, this has been a continuous problem since the first years of the MCD. Defendants complain of the burdensome nature of this task, even though state law already requires notice within five days of the report and disposition to the child's attorney. COMAR .07.02.11.23.A(2)(c) and E(1)(c).

This reporting requirement is also found in Exit Standard 66. Defendants have failed to provide data for Exit Standard 66 for the last four *L.J.* reports even though Exit Standard 66 relies on neither CJAMS nor QSR for data. Defendant BCDSS' Legal Services Unit is responsible for providing copies of all maltreatment-in-care reports and dispositions to Plaintiffs' counsel and the children's CINA attorneys. Defendants have not provided any justification for failing to provide this data.

The IVA keeps detailed records of every maltreatment report and disposition provided by Defendants. During the 73rd report period, Defendants received at least 43 reports of maltreatment that were opened for investigation; 26 of those reports were provided to the child's attorney, Plaintiffs' attorneys and the IVA within five business days,¹¹⁹ 3 were provided late, and 14 were not provided at all, for a 61% compliance rate. This is a steep decline from the 72nd report period's 92% compliance rate.

¹¹⁹ In calculating whether or not the report or disposition was provided timely, 10 calendar days have been allowed to account for weekends and, in some cases, holidays.

During the 73rd report period, Defendants issued at least 55 dispositions; 16 were provided to Plaintiffs' attorneys and the IVA within five business days, 15 were provided late, and 28 were not provided at all, for a 29% compliance rate. The total compliance rate for providing timely maltreatment reports and dispositions for the report period was 43%.

Respectfully Submitted,

_____/s/_____
Rhonda Lipkin
Independent Verification Agent

Lisa Mathias
Assistant to Independent Verification Agent

Copies provided on January 26, 2026, by email to:

Rafael López, Secretary, DHS
Brandi Stocksdale, Director, BCDSS
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Stephanie Franklin, Attorney for Plaintiffs
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David Beller, Attorney for Defendants
Ann Sheridan, Attorney for Defendants
Barry Dalin, Attorney for Defendants
James Becker, Attorney for Defendants
Judy Meltzer, Forum Facilitator
Kathleen Noonan, Forum Facilitator

LIST OF ATTACHMENTS

- Att. 1. Performance on SSA Headline Indicators (Baltimore City) as of October 31, 2025, downloaded January 2, 2026.
- Att. 2. Chapin Hall, Executive Summary to “Maryland Social Services Administration Placement Needs Assessment, Final Report” (January 2025).
- Att. 3. MD Department of Legislative Services, Audit Report, DHS Office of the Secretary and Related Units (April 2025).
- Att. 4. MD Department of Legislative Services, Audit Report, DHS Office of the Secretary and Related Units (September 12, 2025).
- Att. 5. *L.J. v. Massinga* Modified Consent Decree - Outcomes and Exit Standards Only (October 9, 2009).
- Att. 6. IVA QSR Report emailed to Plaintiffs and BCDSS on February 27, 2024.
- Att. 7. IVA Letter re: *L.J.* QSR measures, emailed to BCDSS on October 1, 2025.
- Att. 8. DHR Letter to Gen. Assembly with CWLA Study (October 2006).
- Att. 9. IVA Certification Report for Defendants’ 60th Report (filed June 25, 2019), pp. 16-24.
- Att. 10. DHS Memorandum, “Directive on the Use of Unlicensed Settings” (October 22, 2025).
- Att. 11. Healthy Kids Preventive Health (EPSDT) Schedule (January 1, 2024).
- Att. 12. American Association of Pediatric Dentistry, Dental Periodicity Schedule (2022).
- Att. 13. Maddock, BCDSS Health Services and MATCH Oversight Report, January - June 2024 (October 1, 2025).
- Att. 14. Complaint Process Summary Report for the 73rd Report, received December 9, 2025.