The Rockbridge ADVOCATE
"INDEPENDENT AS A HOG ON ICE"
VOL. 25, NO. 5 $3.00 JULY 2016

Protect the children? Social Services failed!

A regional office's review of the local agency found indications of child abuse and neglect complaints being ignored, shredded, and swept under the rug.

In April, an infant from Alone Mill died on the way to the hospital. At some point prior to the death, the local Department of Social Services had received a complaint about the living conditions of the child. The infant was assessed as being at "high risk" by the Department. Such an assessment is supposed to trigger either the removal of the child or a set of services and monitoring to ensure that the risk is reduced. But law enforcement officials say that the Social Services did nothing for the family after making the assessment.

The death is being investigated by the Rockbridge County Sheriff's Department, which is waiting on autopsy results. Deputies obtained a search warrant shortly after the incident, and the application for the warrant says the condition of the house where the couple and child lived "appears to have been a danger to the child's health."

The death is cited in a blistering "Quality Management Review" of the local Department of Social Services dated May 2016.

In the wake of the report, the local department's director, Meredeth Downey, announced her retirement, and the woman who headed both the child and adult protective services sections of the department, Brenda Perry, has been forced out of her job.

And in the wake of the report, the sheriff's department has begun an investigation into the Child Protective Services branch of the local agency.

Both county sheriff Chris Blalock and his chief deputy, Tony McFaddin, say they won't hesitate to bring criminal charges if warranted.

Among the findings in the state's review of the local agency, which is dated May, 2016, are that complaints concerning the welfare of children were ignored, that reports may have been shredded, and that there was a "hostile workplace environment" for some of the employees.

One section of the review provides a summary of the major problems at the Child Protective division of the Social Services office in Lexington. Many of them point the finger at

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A letter from the editor:

The mess at our Department of Social Services

For years there have been complaints about the Rockbridge Area Department of Social Services, and in particular about the division charged with — and entrusted with — protecting children in need of protection.

Judges and people affiliated with the juvenile and domestic relations court system have complained to no avail.

Cops have complained to no avail.

Lawyers have complained to no avail.

Folks who have been caught up in the system, or involved with the system somehow, have complained to no avail.

And people who have worked for the Department have complained to no avail.

For years, the response of Social Services has been to ignore the complaints, bad-mouth those who have made them; circle the wagons; and bury its collective head in the sand.

The results have been tragic.

At least two children have died after the Department was notified of the horrible conditions in which the children lived and did nothing about it.

At least two may have been horribly sexually abused after the Department was notified of the horrible conditions in which the children lived and did nothing about it.

It's hard to imagine anything more shocking. An agency that is supposed to help keep our children safe instead left them in harm's way.

The recent review of the local office by its regional overseer spells out some of the details of what the agency was doing — or not doing — when it comes to protecting children.

During the past year, the department flat-out rejected more than half of the reports of abuse and/or neglect it received. The regional office looked at 30 of those rejected reports — about one out of five — and found that a dozen of them should have led to some sort of investigation.

It gets worse. The report contains allegations that some complaints and referrals were shredded before they were even entered into the computer system designed to track the status of the agency's response to complaints.

There are indications that dates were changed on some reports of abuse and neglect in order to make it appear that they were responded to in a timely fashion.

Emergency calls that came in late in the day or after hours were brushed aside because....well, it was getting close to quitting time, or after quitting time.

Employees who tried to do their jobs were bullied and browbeaten. Some kept their own copies of reports on the sly for fear they'd be shredded. Some complained, and their complaints fell on deaf ears. Some quit.

And the workers who tried to do their jobs — some of the most stressful, gut-wrenching, and difficult jobs in the world — were subjected to a hostile work environment.

That none of them filed suit in federal court is a miracle.

That none of them complained publicly is sad.

A few complained privately and nothing was done, which shows a complete failure of the system.

We'll probably never know what harm befell the children who were pushed through the agency's cracks.

It would be easy, and convenient, to blame the agency's problems on a couple of employees. But it goes beyond that.

The problems are a result of a culture at the agency that tolerated those problems, and by tolerating them sent a clear message to anyone who knew something was wrong. That message was, "Shut up. Go along. And if you do, you'll collect a nice pension."

There was a total disconnect at the agency between the management and the employees. A survey performed by the regional office tells the story.

The management tended to agree that morale at the agency is "generally high," while the rest of the staff in general said otherwise.

The management tended to think the agency's leadership was just swell, while the rest of the staff in general said otherwise.

The long and short of the survey is a clear indication that the agency's management was deluded. There's nothing rare about that. But when it comes to an agency that is supposed to protect children — and the elderly — such a delusion can lead to tragic consequences. There's every reason to think that it did so here.

It would be nice to think that as a result of the regional office's damning report, the long-standing problems at the local Department of Social Services will all be fixed. Maybe they will be. Maybe the Department will hire some intelligent, compassionate, diligent, and dedicated people to replace those who have left and who are leaving.

But it will take more than that to restore the community's faith in the agency. It will take a board and leadership team that will actually and actively listen.

Many of the details in the review of the Department are surprising. But the overall picture is the same one that court personnel, cops, lawyers, social workers, and folks involved with the system have complained about for years. And until the agency develops a method to hear those complaints and take them seriously, there's no reason to think that much of anything will change for long.

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Brenda Perry, who was the Services Supervisor at the agency. (Perry, who had been with Social Services for well over a decade, could not be reached for comment.)

The section of the review containing the summary reads as follows. (It has been edited slightly in the interest of clarity.)

The most serious and significant findings involve the Child Protective Services program. The findings … indicate that Child Protective Services [CPS] workers have not completed mandatory training necessary for their positions and they have indicated they have been denied permission to attend training.

The Services Supervisor [Brenda Perry] screens CPS reports [of possible child abuse or neglect] for validity — and almost 50% of the CPS reports that were screened out as invalid (and no action taken) were found to be valid and should have been investigated. No records reviewed indicated that … [those filing the complaints] had been notified that their report was ruled invalid. Mandated CPS contacts were not found in the agency's automated record system [OASIS], and documentation found did not show that safety and risk assessments were done correctly … .

Investigations and assessments are not being completed within mandatory timeframes in 79% of cases. Two cases that were to be pulled for review could not be located at the agency. Of utmost concern are reports by staff that the Services Supervisor shreds Child Protective Services reports and does not take any action or enter any information into OASIS [the agency's automated record-keeping system]. This was backed up by copies made of these reports before they were shredded.

It was also reported that the Services Supervisor sometimes does not allow them to respond to emergency calls saying "it is too late in the day," or, "law enforcement can handle it." At these times, it is reported that the Services Supervisor attempts to have mandated [child abuse] reporters (such as school personnel) take photographs of injuries — and this is a clear Child Protective Services function.

Services workers indicate that they use personal cell phones to keep in touch with community partners (i.e. law enforcement) because the Supervisor discourages communication and working relationships.

Some workers expressed that the Services Supervisor has told them they will not offer CPS Ongoing Services because the agency "doesn't have time" to do that. Workers state that sometimes they are so concerned about some cases, they offer services in secret.

Tragically, there was a recent child fatality in this jurisdiction where there had been a previous CPS report. During the initial report, the infant was assessed as "High Risk," but no services were offered.

After the fatality occurred, law enforcement had to call the Piedmont Regional Office because the Services Supervisor was refusing to assign a CPS investigator to investigate the case. After an investigator was assigned, law enforcement personnel had to call the Piedmont Regional Office twice to intervene because the Services Supervisor was refusing to turn over requested records for the investigation.

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The case involving the infant from Alone Mill is the only one specifically cited in the review. But the sheriff's department says it knows of others where it believes Child Protective Services dropped the ball, and a tragedy occurred.

In September 2014, according to Tony McFaddin, the county's chief deputy sheriff, the Rockbridge Area Department of Social Services received a complaint about the conditions inside a roach-infested trailer where two young children were living in Arnolds Valley. "Someone thought the welfare of the children should be checked," he says. But, he says, Social Services "did nothing." According to McFaddin, the agency noted that the report came in months after the person who filed it visited the trailer, and the agency said it needed something more recent before taking action.

A year later there was a second complaint, this one from an anonymous caller saying someone needed to check on the trailer. "The caller," McFaddin says, "said that they had reported it to Social Services and nothing had been done." The caller, McFaddin says, alleged that the mother of the children was heard yelling at them, threatening to knock their teeth down their throats.

A deputy did respond to the call in less than an hour. But Social Services, which is expected to handle such complaints, didn't.

Social Services did eventually get involved. But the children were not removed for some time. A guardian ad litem was appointed for the children, a three-year-old and eight-year-old girl. The guardian visited the home, was horrified by the conditions, and Juvenile and Domestic Relations District Court Judge Anita Filson ordered the children removed. One of the children subsequently disclosed to a social worker in Roanoke that she has been the victim of "multiple sexual acts" while living in the home.

Four adults living in two adjoining trailers were arrested last month on charges related to the alleged abuse of the two children. The four are: Robert Eugene Clark, 38; his parents, Robert Junior Clark, 67, and Beverly Clark Simmons, 65; and the younger Clark's half sister, Samantha Kay Simmons, 30. All of them were charged with two counts of felony child endangerment, and the younger Clark is charged with forcible sodomy of a child. County law enforcement officials say it is one of the worst cases involving children here that they've ever seen, and several more charges against some the adults are expected.

And there's another case in which McFaddin is convinced Social Services dropped the ball. Three years ago a seven-month-old infant stopped breathing in a home

on Rosemary Lane. The place was described as unbelievably filthy, infested with cockroaches, and smeared with feces. The child died.

There had been reports of the filthy conditions before the child's death, according to McFaddin. Social Services, he says, did go out there. But, he says, there were no follow-up visits to ensure that the place had been cleaned up.

"They're supposed to be caretakers of children," McFaddin says. And generally speaking, he says, the Child Protective Services workers here "genuinely care. But it seems like they were constantly thwarted. I find it appalling."

"There's a system set up there [—OASIS —] so that everything's documented. If someone keeps reports from being entered into the system, there's something wrong with that," he says.

And Perry, according to the review of the local office, was doing just that.

Sheriff Chris Blalock has made no secret of his concerns about the office for years. He was sent a copy of the review when it was completed. "It's one thing to wonder what's going on," he says. Still, he says, he was surprised with "the extent of documents being shredded and cases disregarded, and that the social workers were being hindered to the extent that they were."

According to the review, during the 12 months ending March 1, 2016, Child Protective Services received 271 reports alleging abuse and/or neglect. Of the total, 158 were screened out, meaning they were deemed invalid.

The review team went over a sample of 30 of the "screened out" complaints.

The team found that nearly 50% of those rejected complaints "contained allegations meeting the requirements of validity and should have been assigned as either an investigation or family assessment."

And the team found that not a single one of the 30 sampled files had documented notification to the person who filed the complaint of the department's decision not to pursue the matter.

Of the total number of reports, 113, that weren't rejected — "screened out" — 99 were assigned for family assessment, and 14 were assigned to be investigated for possible abuse or neglect. But 28 of the family assessments had not been done by the time the review team finished its work.

The agency is currently in the process of poring through the rest of the reports that were screened out in order to determine which ones were valid and what, if anything, should be done in those cases.

The review was conducted by a team from Social Services' Piedmont Regional Office, which oversees the local department. The review itself says it was initiated "following an expression of concern by Rockbridge Area Department of Social Services staff members, Rockbridge County law enforcement, Virginia Department of Social Services Specialists, and an incident in which the Program Specialist from the Department of Aging and Rehabilitative Services had to involve the Piedmont Regional Office in order to have program issues resolved." ➢

And the review is of the entire Social Services operation here, not just the Child Protective Services division.

What follows are some excerpts from various sections of the 38-page review.

■ Staff interviews indicate the process of Child Protective Services [CPS] intake is impractical and does not ensure every report received is added to the [Department's] OASIS database. Statements from staff allege the shredding of some CPS referrals by the CPS supervisor [Brenda Perry] before the information is placed into the database. Statements from staff also indicate dates of reports received are sometimes changed by … [Perry] in order to meet response priority guidelines. …

■ Staff interviews have determined CPS calls of an emergency nature coming in — not only during regular business hours, but also during times of on-call and after-hours — are not being responded to in an emergency nature. Reasons given indicate … [Perry] indicates it is either "too late in the day," "there is not currently enough staff to cover office functions," or "law enforcement can handle the situation."

■ Staff interviews indicate they are told by the CPS supervisor to have mandated [child abuse] reporters, such as school personnel, photograph alleged injuries for a CPS worker to respond at a later time. This is impractical as a key CPS function, the [child] safety assessment, would need to be created before a child returns to or remains in an unsafe environment. It is not up to other entities to perform CPS functions of assessing and ensuring safety of an alleged abused and/or neglected child.

■ According to the interviews with staff who complete Child Protective Services functions, agency morale is extremely low in a working environment of what could easily be considered hostile with reports of workers and clients being bullied by the CPS supervisor. Allegations that these concerns have been taken to the agency director [Meredeth Downey] and dismissed have also been made.

■ The CPS files reviewed have shown the agency does not have a practical method of storing or maintaining CPS records. Records are inconsistent with included documents in no understandable arrangement or order. Of the family assessments and investigations reviewed, two files were unable to by located by the agency.

■ Family Services workers voice complaints that they were often denied permission to attend training sessions offered by the Virginia Department of Social Services.

■ Statements made by staff indicate ongoing services are sometimes provided without initiating a case. In other words, if the family needs assistance, the agency will work with the family in an unofficial capacity. This is sometimes done without the knowledge of the Child Protective Services Supervisor, who would forbid the offering of any services to the family.

■ Prior to the Quality Management Review, the Adult Services/Adult Protective Services Specialty from the Department of Aging and Rehabilitative Services performed an Adult Services Program Review. Many deficiencies were identified and a corrective action plan was required by that agency. The specialist performed a review at the end of six months which revealed the program had more serious deficiencies than in the original report. The Services Supervisor refused to meet with the Adult Services specialist to discuss the report. The Department of Social Services Piedmont Regional Director was asked to intervene and did so with the agency director, who was also unable to compel the Supervisor to meet with the specialist. The Piedmont Regional Director had to intervene with the Chairperson of the Rockbridge Area Department of Social Services board before the Supervisor was finally compelled to attend the meeting regarding the Adult Services Program.

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(This publication has submitted a Freedom of Information request in order to obtain the reviews of the Adult Protective Services Division, and will publish what they contain once they are delivered.)

The review outlines problems found in nearly every other branch of the Social Services office.

One notable exception is the administration of the Food Stamp program. Another is the child care program designed to improve the affordability, quality, and supply of available child care, and to increase the number of low-income family children in high quality child care settings.

What follows are some of the other findings and observations contained in the review.

■ Employee Surveys: The survey results are significant in that those in administration/management scored items much higher than other employees. This may indicate a lack of understanding of the severity of issues within the agency. Employee comments during interviews and accompanying the surveys indicate very low morale among agency staff and that most staff feel they are working in a "hostile work" environment. The comments from within the entire agency appear to center around one supervisory staff person and the fact that management has not acted on this person's intimidating behavior.

■ Out of 30 staff members, only fifteen positions are up-to-date on performance evaluations.

■ Background checks on employees at this agency have not been done in the last eleven years. Records show that the last time any sort of background check was done on staff was 2005 [and that one was incomplete]. The non-performance of these required background checks puts the agency in jeopardy of having staff members or volunteers who could potentially [have] a criminal history, Child Protective Services findings [of abuse or neglect], or multiple driving infractions.

■ The agency does not have a leave policy and no guidance is posted for staff reference.

■ There are clearly some performance issues within the Medicaid program [administered by the agency]. The agency has not met the performance target for application processing in any of the last six months for Medicaid applications. The goal is that 97% of all Medicaid applications be processed within 45 days or receipt of the application. Rockbridge Area Department of Social Services has processed at an average of 78.9% over the last six month period. The agency also has 273 Medicaid cases overdue for renewal as of March 2016. The number of overdue renewals has remained consistently high over the last six

months, but the number has been reduced from 700 overdue in March 2015. These performance measures have an impact on the citizens being served … .

■ A sample review of twenty individual Medicaid cases was conducted … . Of the twenty cases, six were correct with no technical or benefit errors. Of the other fourteen cases reviewed, three contained benefit errors and all contained technical errors. Benefit errors mean that someone who is not eligible might receive benefits, or someone who is eligible may not receive benefits for which they qualify. The technical errors were due to information present in the file not being evaluated, missing documentation, and income information not entered into the case management system … .

■ Self Sufficiency Programs — Temporary Assistance for Needy Families [TANF] and the Virginia Initiative for Employment not Welfare [VIEW] …

■ The agency recently had a worker resign from the Benefit Programs Unit, and her caseload was left in disarray. This has led to a backlog of work which has affected the morale of the entire unit. The Benefit Program Supervisor is not knowledgeable regarding the VIEW and TANF programs and staff members expressed that they cannot always go to her for appropriate guidance.

■ The timeliness in which TANF applications are processed within 30 days is measured against a goal of 97%. The agency failed to meet the timeliness goal of 97% four of the six months reviewed.

■ A total of 20 TANF and VIEW cases were reviewed. Out of the 20 cases, approximately 50%, (11) cases had errors ranging from incorrect coding, missing or outdated forms, and missing verifications.

■ It is concerning that a majority of employees both in services and in benefits programs reported during interviews and/or written survey comments that the Services Supervisor fosters an atmosphere of "bullying," "harassment," and "intimidation." Benefit programs staff reported that they are afraid to go into the kitchen because of the Services Supervisor and have created a make-shift kitchen for themselves in a storage room. Employees indicated that they have made multiple complaints to the agency director and the situation has not been corrected.

The local agency's retiring director, Meredeth Downey, says that a Child Protective Services specialist from the Piedmont Regional Office is working to straighten out the problems cited in the review. "When certain things came to our attention, we dealt with them."

"The majority of the employees are pulling together as a team," says Susan Reese, the Piedmont Regional Director. "I very much believe they have the youth of the community at heart, and I think the community can put faith in them."

"The employees are very much invested in making this agency a top agency," she says.

"For the most part, the social workers have been trying to do a good job," says Sheriff Blalock. "They care. And folks should have confidence in their desire to help."