Center *for the* Study *of* Social Policy
Ideas into Action

Paul Vincent

Michelle H., *et al.* v. McMaster Progress Report: South Carolina Department of Social Services

October 1, 2024 – March 31, 2025

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I. Introduction

This report assesses the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA) in *Michelle H., et al. v. McMaster and Catone*, for the period of October 1, 2024 through March 31, 2025. This report has been prepared by court-appointed independent Co-Monitors Judith Meltzer and Paul Vincent, with the assistance of co-monitor staff, and is presented to the Honorable Richard M. Gergel, U.S. District Court Judge, the Parties to the lawsuit, and the public.[1]

A. Summary of Litigation and Settlement Agreement

The *Michelle H. v. McMaster and Catone* lawsuit was filed in the United States District Court for South Carolina in January 2015 on behalf of a Class of children in foster care against the Governor of South Carolina and the State's Department of Social Services (DSS).[2] The suit alleged DSS failed to maintain an adequate number of foster homes and other appropriate living placements for children; did not provide basic monitoring of children's safety due to excessive case manager caseloads and an unstable foster care workforce; and failed to provide basic health care services to children in foster care. The Parties negotiated a Final Settlement Agreement (FSA) that was approved by the Court on October 4, 2016.[3,4]

The FSA outlines South Carolina's obligations to significantly improve the experiences of, and outcomes for, "all children who are involuntarily placed in DSS foster care in the physical or legal custody of DSS now or in the future" and reflects an agreement by the State to address long-standing problems in the operation of its child welfare system (FSA II.A.). State leaders and Plaintiffs crafted the FSA to guide a multi-year reform effort to address:

- Appropriate placements for children in foster care
- Workloads of case managers and team leaders, and case manager contacts with children
- Investigations of allegations of abuse and/or neglect of children in the State's custody by a caregiver
- Family connections – visits between children and their parent(s), the placement of children with their siblings and visits between siblings who are not placed together
- Access to timely physical and mental health care

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[1] Mr. Vincent sadly passed away on July 27, 2025. He was active as Co-Monitor for the entire monitoring period and some time thereafter. Although he did not participate in the writing/editing of this report, his views are represented in the analysis and assessment. We mourn his passing.
[2] *Michelle H., et al. v. McMaster and Catone*, 2:15-cv-00134, (D.S.C.) (originally filed as *Michelle H., et al. v. Haley and Alford*).
[3] Final Settlement Agreement (October 4, 2016, Dkt. 32-1).
[4] The Final Settlement Agreement incorporates provisions ordered in a September 2015 Consent Immediate Interim Relief Order (hereafter Interim Order or IO) (September 28, 2015, Dkt. 29).

Since the development of the FSA, implementation plans for key bodies of work – which are also tracked by the Co-Monitors – have been approved and ordered by the Court.[5]

B. Role of Co-Monitors and Methodology

The Final Settlement Agreement appoints Judith Meltzer and Paul Vincent as independent and equal Co-Monitors.[6] The Co-Monitors function in an impartial capacity and are responsible for conducting the factual investigation and verification of data and documentation necessary to compile and issue semi-annual public reports on the State's progress and performance in meeting the terms of the FSA (FSA III.).

To determine the State's performance on the FSA requirements, the Co-Monitors and their staff utilized a range of sources and activities to collect information and to inform the overall assessment of the State's progress.[7] These include, among others, analysis of quantitative data provided by DSS including data extracted from DSS's Child and Adult Protective Service System (CAPSS) and other sources; review of case records in CAPSS; analysis and validation of qualitative data collected by DSS and co-monitor staff through structured reviews; observations and discussions from county office site visits; information provided through focus groups; data and information provided in DSS's reports to the Court; discussions with case managers and other DSS staff, private providers, and community members; meetings with leaders from DSS and other state leaders; and discussions with Plaintiffs' counsel.[8]

Additionally, this report draws on information provided through the Co-Monitors' engagement with the Richland County Child Welfare Improvement Task Force.[9] The Task Force was created at the direction of the Court in October 2024 and charged with the development and implementation of an improvement plan to urgently address the placement instability crisis in Richland County as well as problems related to the physical condition of the Richland County DSS office.[10] During the monitoring period, and continuing as of the writing of this report, the work of the Richland County Task Force has been a primary area of focus for DSS. This report discusses the work of the Richland County Task Force as it relates to the FSA requirements.[11] To this end, *Section*

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[5] To view Implementation Plans and Addendums for the *Michelle H.* Final Settlement Agreement, see: https://dss.sc.gov/child-welfare-transformation/

[6] Judith Meltzer is former President and now Senior Fellow of the Center for the Study of Social Policy (CSSP) and is supported by co-monitor staff including Molly Dunn, Lisa Mishraky-Javier, and Shira Davidson. More information about CSSP can be found at https://cssp.org/

[7] Appendix B includes a list of specific activities the Co-Monitors used to assess DSS's performance during this period.

[8] CAPSS is DSS's State Automated Child Welfare Information System (SACWIS).

[9] The Co-Monitors' engagement includes, review of improvement plans, monthly reports produced by DSS to the Court, and meeting presentations; and participating in Richland County Task Force workgroup meetings.

[10] Order directing the prompt creation of a task force to prepare and implement a plan to address issues relating to overnight stays in the Richland County DSS office (October 18, 2024, Dkt. 331).

[11] Letter from J. Michael Montgomery with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 364).

III of this report includes a brief overview of the Richland County Task Force, and throughout this report, county-level data are provided, as relevant, with a focus on Richland County. County-level data are included within the body of the report for the nine DSS county offices with the largest number of children in foster care on March 31, 2025 (this includes Richland County). For each of these data points, complete data for all 46 South Carolina Counties can be found in Appendix D.

C. Report Structure

This report assesses the State of South Carolina's progress toward meeting the requirements of the *Michelle H.* Final Settlement Agreement during October 1, 2024 – March 31, 2025 (Monitoring Period 17 or MP17).[12] This report is presented in four sections:

- Section I outlines the *Michelle H.* FSA and describes the role of the Co-Monitors, and the methodology used to assess performance.
- Section II summarizes the State's progress toward meeting the FSA requirements during MP17.
- Section III provides an overview of the child welfare system in South Carolina, including a brief overview of the Richland County Task Force and a description of the State's fiscal resources supporting child welfare activities. It also includes demographic information about children in the State's foster care system during MP17.
- Section IV details the State's performance toward meeting each FSA requirement during MP17.

[12] This report refers to monitoring periods by number (e.g., MP17) and/or date range (e.g., October 2024 – March 2025). Guideposts to time frames and monitoring periods are provided throughout this report and a table of monitoring periods is provided in Appendix A.

II. Areas of Improvement and Challenge

The six-month monitoring period of October 1, 2024 through March 31, 2025 (Monitoring Period 17) was marked by new leadership with State DSS Director Tony Catone and Deputy and State Director of Child Welfare Services Dawn Barton assuming their responsibilities in early January 2025. It was also marked by the court-ordered formation of the Richland County Task Force, charged with urgently addressing crisis rates of placement instability in that county. Despite the leadership transition and these challenges, DSS maintained prior successes and advanced performance toward meeting the requirements of the FSA as discussed throughout this report.

A. Areas of Improvement

Since the start of implementation of the Settlement Agreement and continuing through this monitoring period, the Department demonstrated progress in some key areas:

- *Reduction in Foster Care Population:* The Department has emphasized efforts to prevent the separation of families, and as a result, the population of children in foster care continues to steadily decline. On March 31, 2025, 3,188 children were in foster care, a 27 percent decrease from the 4,371 children who were in the state's custody on March 31, 2020.
- *Increase in Placement of Children in Family-Based Settings:* Overall, far more children are in family-based placements, and very young children are no longer in congregate care settings. On October 18, 2024, the Court granted Maintenance of Effort Status for FSA provision IV.E.3., requiring that 98 percent of Class Members twelve years old and under be placed outside of congregate care, and for FSA provision IV.D.2, requiring DSS to prevent, with exceptions, the placement of any Class Member aged six or under in any non-family group placement.[13] The State has continued to meet or exceed these FSA targets since that time.
- *Increase in Placement of Children with Kin:* Recognizing the improved outcomes for children successfully placed with relatives, over the last five years, the Department has more than tripled the percentage of children placed with kin. Twenty-nine percent of children were placed with kin as of the last day of the monitoring period, compared to eight percent as of September 30, 2019. In April 2025, DSS hired a Kinship Care Program

[13] Court Order finding DSS has met the performance standards of the FSA with respect to sections IV.D.2, IV.E.3, and Appendix B and granting Maintenance of Effort Status in those areas and granting Termination and Exit with Respect to Sections IV.C.2. and IV.C.4(d), (e), and (f) of the FSA and terminating jurisdiction over those sections [Hereinafter "Order on Motion for Miscellaneous Relief"] (October 18, 2024, Dkt.329).

Manager who, among other responsibilities, will lead the development of policies and procedures that promote "kin-first" principles.[14] DSS is implementing strategies to offer payments to kinship caregivers, including supporting kin to become licensed. The number of licensed kin caregivers continues to steadily increase. Fifty-two percent of kin caregivers are now licensed or provisionally licensed, compared with 34 percent in September 2021. DSS is also supporting statutory amendments that will enable the Department to implement streamlined, kin-specific licensing/approval standards.[15] DSS reports that on September 15, 2025, it began piloting the kin specific approval standards. Under the pilot, kin who go through the approval process are assessed using the new standards, and those who are approved, whether provisionally or fully, receive the same board payment provided to licensed foster parents.

- *Improvement in Investigations of Allegations of Abuse or Neglect of Children in Foster Care:* The Department now more thoroughly investigates reports of allegations of abuse or neglect of children in its custody, and in this monitoring period has met three of four remaining FSA targets related to Out of Home Abuse and Neglect (OHAN).[16]
- *Improvement in Referrals for Developmental Assessments:* The State maintained its performance in meeting FSA targets for the timely referral of Class Members under 36 months of age for developmental assessments, for which Maintenance of Effort status was granted on October 18, 2024.[17]
- *Caseloads:* DSS showed improvement toward meeting FSA caseload requirements. Since the prior monitoring period, case managers with cases within required workload limits increased significantly for both foster care and adoptions case managers, though still fell short of the FSA target. One hundred percent of OHAN case managers continued to be within the required limit. Caseloads for foster care and OHAN team leaders continued to meet the FSA target. Caseloads for adoptions team leaders remained below the FSA target.
- *Richland County:* DSS launched multiple efforts within the context of the Richland County Task Force to address the problems with safety, placement, and care of children in the County. These emerging efforts include increasing the availability of mental health services including 24/7 rapid response interventions; promoting in-county placement by piloting a policy to hold placements open for a short-time (5 days) so they can be used by Richland County children and youth; shifting practice to better identify children's strengths

[14] Letter from J. Michael Montgomery with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 364).
[15] Letter from J. Michael Montgomery Providing Information Required by October 18, 2024, Order (EFC 330) prior to March 21, 2025 Status Conference (March 14, 2025, Dkt.354).
[16] In October 2024, the Court terminated jurisdiction over the following FSA OHAN provisions: (1) Intake – Decision Not to Investigate (FSA IV.C.2.); (2) Timely Completion of Investigation Within Forty-five (45) Days of Initiation (FSA IV.C.4(d)); (3) Timely Completion of Investigation Within Sixty (60) Days of Initiation (FSA IV.C.4(e)); and (4) Timely Completion of Investigation Within Ninety (90) Days of Initiation (FSA IV.C.4(f)). See Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt.329).
[17] Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt.329).

and needs to create individually tailored placements and services; and beginning to use Child and Family Team Meetings (CFTMs) to prevent unnecessary removals of children and youth to foster care and to support children and youth in foster care who are experiencing placement instability.[18,19] The work in Richland County is still in progress but has already demonstrated the Department's ability to collaborate in new ways with community stakeholders on behalf of the children and families it serves.

B. Areas of Challenge

While these areas of success are significant, challenges remain:

- *Lack of Adequate Support for Maintaining Family Connections:* Although performance improved across all FSA requirements related to family connections and nearly reached the target for sibling visitation, performance continued to be unacceptably below the FSA targets for the placement children with *all* their siblings (49% of the 80% target) and for parent-child visits (55% of the 85% target).
- *Unaddressed Health Care Needs of Children:* DSS continued its efforts to meet the health care needs of children in its care by improving its data and reporting capacity in addition to increased coordination with Department of Health and Human Services (DHHS), its Managed Care Organizations (MCO) partner, and health care providers. However, DSS's performance related to the health care FSA requirements remains unchanged from the previous monitoring period and continues to fall short of most health care outcomes included in the Health Care Improvement Plan and Health Care Addendum, approved by the Co-Monitors and the Court on August 23, 2018, and February 25, 2019, respectively.[20] More than five years after the Health Care Addendum was agreed upon, data show that many children are not receiving required periodic preventive visits, and there remains a need throughout the state for quality community-based mental health services for children and families. The State reports continued work on a modified Health Care Improvement Plan, but a final draft has not been shared with Co-Monitors for review and approval, and presentation to the Court. This effort has been delayed multiple times and has not been completed as of the date of this report.
- *Very High Rates of Placement Instability:* Children in DSS custody continue to experience high rates of placement instability and the problem remains acute in Richland County. The

[18] Child and Family Team Meetings (CFTMs) create opportunities to bring families, youth, formal and informal supports together to exchange information, discuss goals, identify strengths, assess progress, and create an action-driven plan that meets the family's individual and collective needs for safety, permanency, and well-being. For more information see: https://dss.sc.gov/about/prevention/family-engagement/.
[19] Letter from J. Michael Montgomery with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 364).
[20] To view the Health Care Improvement Plan, see: https://dss.sc.gov/media/nesgioju/8-23-2018-final-approved-dss-health-care-implementation-plan.pdf. The FSA Health Care Outcomes is available at: https://dss.sc.gov/media/c3ig211y/appendix-b-final-health-care-targets.pdf. The Health Care Addendum is available at: https://dss.sc.gov/media/0bdpenal/2-25-2019-approved-health-plan-addendum.pdf.

state continued to use DSS offices and emergency placements at unacceptably high rates. During Monitoring Period 17, 42 percent of children experienced at least one placement move; 216 children experienced a total of 1,064 overnight stays in a DSS office, hotel, motel, or other commercial non-foster care establishment; and 515 children spent a total of 6,802 nights in an emergency placement. Although there was a significant decrease in the use of emergency placements, the number of overnight stays in a DSS office increased in this six month monitoring period, and placement instability overall remains unacceptably high throughout the State.

- *The Richland County Improvement Plan was not approved by the Court Monitors as required.* In a letter dated May 20, 2025, the Co-Monitors informed the Court that they were withholding approval of the Plan due to deficits in periodic progress reporting on the State's efforts to expand behavioral health services through Medicaid and the provision of utilization data to assess progress.[21] The Department is moving forward to implement the Plan as is while awaiting the Court's review and decision.

To meet its challenges, DSS will need to continue to deepen its implementation of the Guiding Principles and Standards (GPS) Case Practice Model in its work with children, youth and families throughout the state by providing training, coaching and mentoring to workers and supervisors and through a range of Continuous Quality Improvement (CQI) activities that focus on direct practice.[22]

Additionally, much work remains to done with Medicaid and the behavioral health system to expand the availability of and access to services, both for children involved with child welfare as well as to support children and families so that children do not need to enter foster care due to mental health crises. South Carolina continues to need to considerably strengthen its support of and connection to community-based services for children and families.

DSS cannot successfully meet the challenges it faces on its own, and must get needed support from the Governor, the Medicaid agency, the Departments of Mental Health and Disabilities, the education system, law enforcement and the courts. It is important that DSS continue to grow its partnerships with private providers, these other state agencies, schools, foster families and especially children, youth and families. Some of this work is already in process through the Richland County Task Force, which has the potential to be a blueprint for action to address placement instability—and other challenges—throughout South Carolina.

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[21] Letter re: Co-Monitor Withholding of Approval for Supplemental Richland County DSS Child Welfare Improvement Plan (May 28, 2025, Dkt. 366).

[22] DSS's GPS Case Practice Model was designed in recognition of the need for a culture that "'engage[s], encourage[s], honor[s], and support[s] families."' To view the GPS Case Practice Model, see: https://dss.sc.gov/media/hnegmcwl/gps-practice-model-final-may-2023.pdf.

III. South Carolina's Foster Care System and the Children it Serves

A. Overview of the State Child Welfare System

South Carolina's Department of Social Services (DSS) is a cabinet-level agency, led by State Director Tony Catone who reports directly to Governor McMaster. DSS is responsible for the temporary custody and care of children who have been involuntarily separated from their parent(s) or guardian(s) due to a finding of abuse or neglect.[23] While in foster care, DSS is responsible for meeting children's needs, including ensuring: they are safe; have stable places to live with caring adults, preferably family members; their health care needs are monitored and addressed; and they are supported in maintaining connections with their communities and families – this includes DSS's obligation to engage with and support parents and guardians so children can return home safely and quickly (reunify). If "reunification" of a child with their parent(s) or guardian(s) is determined not to be possible, DSS must pursue another permanent, long-term plan, such as guardianship or adoption.

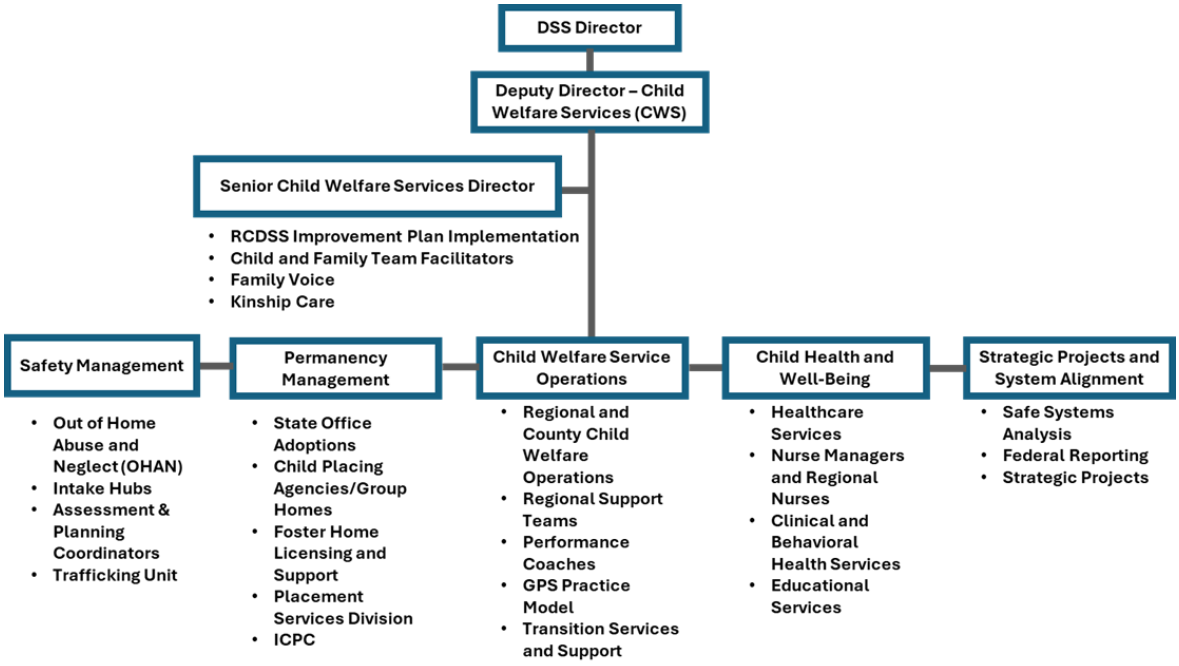
South Carolina's child welfare system is administered at the state level by DSS's Child Welfare Services Division, which is organized into five primary areas: Safety Management, Permanency Management, Child Welfare Service Operations, Child Health and Well-Being, and Strategic Projects and System Alignment (Figure 1). Services are delivered to children and families through county DSS offices. The State's 46 counties are organized into four regions – Lowcountry, Midlands, Pee Dee, and Upstate, and some DSS functions are delivered regionally, including adoptions, child health and well-being, and foster care placement.

[23] On January 2, 2025, Tony Catone was named Acting State Director of DSS following the resignation of former DSS Director Michael Leach. Mr. Catone was unanimously confirmed as the State Director by the South Carolina State Senate on May 8, 2025.

Figure 1. DSS Child Welfare Services Division Organizational Chart

March 3, 2025

Source: DSS



Richland County Child Welfare Improvement Task Force

Richland County is South Carolina's most populous county with the largest number of children in foster care.[24,25] On October 18, 2024, the Court prompted important action to address a placement instability crisis in Richland County by directing the creation of a task force to prepare and implement an improvement plan for Richland County DSS (RCDSS) to meet specific goals, including eliminating overnight stays of children in the RCDSS office and out-of-county emergency foster care placements; ending the routine presence of Class Members in the RCDSS office; and eliminating excessive late night work shifts for RCDSS staff, which includes consideration of dedicated staff for second and third shifts.[26] The Task Force includes members representing the South Carolina Department of Health and Human Services (SC DHHS); South Carolina Department of Juvenile Justice (SC DJJ); South Carolina Department of Mental Health (SC DMH); South Carolina Department of Children's Advocacy; Richland County Sherrif's Office; City of Columbia Police Department; Richland/Lexington School District Five and Richland School Districts One and Two;

[24] U.S. Census Bureau, U.S. Department of Commerce. (n.d.). Age and Sex. *American Community Survey, ACS 5-Year Estimates Subject Tables, Table S0101*. Retrieved August 7, 2025, from https://data.census.gov/table/ACSST5Y2023.S0101?q=child+population++&g=040XX00US45$0500000.

[25] CAPSS data provided by DSS

[26] Order directing the prompt creation of a task force to prepare and implement a plan to address issues relating to overnight stays in the Richland County DSS office (October 18, 2024, Dkt. 331).

Richland County Family Court Public Defender; Richland County Court Appointed Special Advocates; Palmetto Association for Children and Families; SCDSS State, Regional, and County leadership; Plaintiffs' Counsel; and co-monitoring staff.

The initial Richland County DSS Improvement Plan, submitted to the Court on December 23, 2024, included multiple efforts to address critical issues previously identified by the Co-Monitors.[27] After reviewing the plan, the Court found that "further refinements are necessary to meet the considerable challenges confronting DSS operations in Richland County," and ordered that a supplemental plan be submitted.[28] The Supplemental Plan was submitted to the Court on May 19, 2025, and includes key goals to address placement instability and related concerns raised by the Court in its October 2024 Order.[29] Each goal is supported by identified strategies, action steps, and target completion dates. The Co-Monitors declined to approve the Plan for reasons detailed in their letter to the Court dated May 20, 2025.[30] Although still pending formal consideration by the Court, the State is moving forward with Plan implementation with the involvement of the Task Force and its Workgroups.[31] The Richland County Improvement Plan, Task Force, and Workgroup activities are referenced frequently throughout this report as related to the FSA requirements and DSS's efforts to meet those requirements.

Fiscal Resources and Budget

South Carolina's child welfare system is financed through a blend of federal and state funding streams.[32] At the federal level, the Children's Bureau, part of the Administration for Children and Families, distributes funds to states for defined child welfare functions and services through mandatory spending programs. The largest of these programs, the Foster Care, Prevention, and Permanency Program, is authorized under Title IV-E of the Social Security Act and entitles states to federal reimbursement for part of the cost of providing foster care to children.[33] The program

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[27] Letter from J. Michael Montgomery with Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (December 23, 2024, Dkt. 339).
[28] Order Directing DSS Operations in Richland County (January 17, 2025, Dkt. 348).
[29] Letter from J. Michael Montgomery with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 364).
[30] Letter re: Co-Monitor Withholding of Approval for Supplemental Richland County DSS Child Welfare Improvement Plan (May 28, 2025, Dkt. 366).
[31] The Task Force is organized into 5 workgroups: (1) Capacity Building for Placement Array, (2) Enhancing Skills and Capacity of Staff and Caregivers to Meet the Needs of Children and Youth in Foster Care, (3) Community Action, (4) Kin First Implementation, and (5) Educational Needs for Children and Youth in Foster Care.
[32] Additionally, per state law, each county in South Carolina is required to provide office space and facility services – including janitorial, utility, and telephone services, and related supplies – for its county Department of Social Services (SC Code § 43-3-65 (2024)).
[33] The Title IV-E program was established by HR. 3434 Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272). Under Title IV-E, states may seek federal reimbursement for a portion of "foster care maintenance payments," defined as "payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, reasonable travel to the child's home for visitation, and reasonable travel for a child to remain in the school in which the child is enrolled at the time of placement" (42 USC § 675(4)).

operates as an "un-capped" source of matched funding, meaning states are entitled to receive reimbursement for a portion of every dollar spent on a defined service on behalf of an "eligible" child.[34] The child's eligibility depends on a number of factors, including the income level of the parents(s) from whose custody the child was removed.[35] To meet the Title IV-E income test, the income of the home of removal must be within eligibility guidelines, *as they were in effect on July 16, 1996*, for a former federal-state cash assistance program known as Aid to Families with Dependent Children (AFDC).[36] In South Carolina, this means the State can claim federal reimbursement if the child in foster care meets all other non-income eligibility requirements and the annual income of the home the child was removed from is not more than $6,288 for a family of three or $7,572 for a family of four.[37] Because Title IV-E eligibility is linked to 1996 income limits, generally fewer children are determined to be federally eligible each year, resulting in lower amounts of federal reimbursement to states. As of the writing of this report, 43 percent of children in foster care in South Carolina meet the Title IV-E eligibility requirements (referred to as the state's Title IV-E penetration rate).

Additionally, the federal Family First Prevention Services Act (FFPSA), passed in 2018, has financial implications for South Carolina's support of children in foster care.[38] Most relevant to *Michelle H.*, the FFPSA aligns with the FSA by creating financial disincentives for the placement of children in congregate care.[39] The FFPSA prevents federal reimbursement for most congregate placements

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[34] Federal reimbursement is made at a state's Federal Medical Assistance Percentage (FMAP) rate. South Carolina's FMAP rate for Federal Fiscal Year 2025 (October 1, 2024 – September 30, 2025) is 69.67%. See Kaiser Family Foundation. State Health Facts. Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier: https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

[35] Emilie Stoltzfus. (2019, April 19). *The Title IV-E Income Test Included in the "Lookback".* (Congressional Research Service Memorandum). https://www.cwla.org/wp-content/uploads/2019/09/CD_lookback_4_2019.pdf

[36] Ibid. Note, Aid to Families with Dependent Children (AFDC) was repealed by Congress in 1996 (P.L. 104-193) when it was replaced by the Temporary Assistance to Needy Families (TANF) block grant. However, eligibility for the Title-IV-E program remains linked to certain AFDC provisions. This linkage is often referred to as the "look back" because in determining income eligibility, states are required to *look back to* eligibility provisions from the prior AFDC law as they were in effect on July 16, 1996.

[37] Ibid.

[38] Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017)

[39] Ibid. Note, the FFPSA also incentivizes the provision of prevention services in the community to reduce the need for out-of-home placement by allowing states to use federal IV-E funding for evidence-based prevention services. In February 2022, the Children's Bureau approved South Carolina's 5-year Family First Prevention Services plan. DSS has not yet begun to make IV-E claims under the FFPSA for prevention services and is currently using 100% federal funding received through the Family First Transition Act grant. Transition Act funds must be used by September 30, 2025, and liquidated no later than December 30, 2025 (https://acf.gov/sites/default/files/documents/acyfcb_93556_families_first_transition_act_supplemental_terms_and_0.pdf). To view South Carolina's Family First Prevention Services plan, see: https://dss.sc.gov/media/jftfzltf/scdss-title-iv-e-prevention-planfinalclean_patcommunitypathwayclean.pdf

beyond 14 days unless the child is placed in a specified child-care institution.[40] The 14-day claiming limitation went into effect in October 2021.[41]

Medicaid is another essential source of federal revenue for state child welfare systems. Nearly all children in foster care are eligible for health insurance through Medicaid. States authorizing payment for Medicaid services included in their federally approved state plans and waiver programs receive federal matching funds for state expenditures at the state's Federal Medical Assistance Percentage (FMAP) rate. In South Carolina, this rate for Federal Fiscal Year 2025 (October 1, 2024 – September 30, 2025) is 69.67 percent.[42] This means that for each dollar South Carolina spends on a Medicaid-reimbursable service for a child or eligible family member, the federal government reimburses the State almost 70 cents. Because Medicaid reimbursement is applicable to nearly all children in foster care (as opposed Title IV-E reimbursement which applies to a fraction of foster children—e.g., 43% in South Carolina), states that have responsibly maximized the use of federal Medicaid matching dollars have been able to increase – sometimes vastly – funding available for the support of children in foster care. Additionally, Medicaid's coverage requirements are broad. Its Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions require that children be provided with all necessary medical treatment and services, and Medicaid can be used to cover non-direct medical care expenses such as transportation to medical appointments and necessary home modifications.

At the state level, funding obligations specific to the *Michelle H.* lawsuit are appropriated by South Carolina's General Assembly as part of the state budget process. For the State Fiscal Year (SFY) 2025-2026 which began July 1, 2025, DSS requested $31 million in additional recurring state general funds for child welfare services which, with federal and other fund estimates, would have generated a total of $40.8 million in additional state, federal, and other funds for DSS's budget priority "Enhancing the Future of South Carolina Children and Families.[43,44] The final approved SFY 2025-2026 Appropriations Act, passed in May 2025, allocated $12.7 million in new state recurring funds for this priority and authorized the use of $6.5 million in federal funds for continued child welfare reform efforts and promotion of compliance with the terms of the *Michelle H.* settlement.[45]

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[40] Federal reimbursement is available after 14-days for placement of a child in one of the following settings: qualified residential treatment programs (QRTPs); settings specializing in providing prenatal, post-partum, or parenting supports for youth; settings providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming sex trafficking victims; and supervised settings in which the child is living independently if the child has attained 18 years of age (Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017)).

[41] Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017).

[42] *Supra* note 34. Note, the FMAP rate is used as the reimbursement rate to states for both Title IV-E foster care maintenance payments and Medicaid services.

[43] South Carolina's State Fiscal Year runs from July 1st to June 30th.

[44] To view DSS's full SFY 2025-2026 Agency Budget Plan see: https://www.admin.sc.gov/sites/admin/files/Documents/Budget/FY26%20L040%20-%20Department%20of%20Social%20Services%20v2.pdf

[45] To view the full SFY 2025-2026 General Assembly Appropriation, see: https://www.scstatehouse.gov/sess126_2025-2026/appropriations2025/gab4025.php

In relation to DSS's budget request, the appropriated funds provided state general funds of $1.7 million for foster family home rate increases, which represents the full amount requested; $3.4 million state general funds of $3.9 million in requested state funding, which allows DSS to provide a monthly board payment for children who are placed in a licensed or approved kinship foster family home using licensing standards that differ from the standards used for non-kinship foster family homes; $3.7 million state general funds of $12 million in requested state funding for continued implementation of the salary plan ordered by the Court as part of DSS's Workload Implementation Plan; $1.1 million state general funds of $2 million in requested state funding to provide a time-limited child placing agency foster family supplement for SFY 2025-2026; $271,000 state general funds of $6.5 million in requested state funding to add 92 full-time equivalent positions (FTEs) for case management assistants, team leaders, team coordinators, CFTM staffing, foster family licensing and placement staffing, child health and wellbeing staffing, and child welfare support staffing. The $271,000 appropriated will provide four FTE positions. Additionally, $2.6 million state general funds of $5.3 million in requested state funding was allocated as a separate line item for the expansion of evidence-based prevention services.

For SFY 2025-2026, DHHS requested $79 million in new recurring state funding with $19 million specifically identified to expand rehabilitative and behavioral health care, an undetermined portion of which would be devoted to expanding the continuum of community-based and other behavioral health services available to children in the *Michelle H.* Class. DMH asked for an additional $4.8 million in funds for "Community Support", though it was unclear whether those resources would be devoted to expanding access to services for children in foster care and their families. The Co-Monitors requested information from DSS on the appropriations and allocations to services for children in the Class in these budgets, but it was not provided.

B. Population of Children in Foster Care

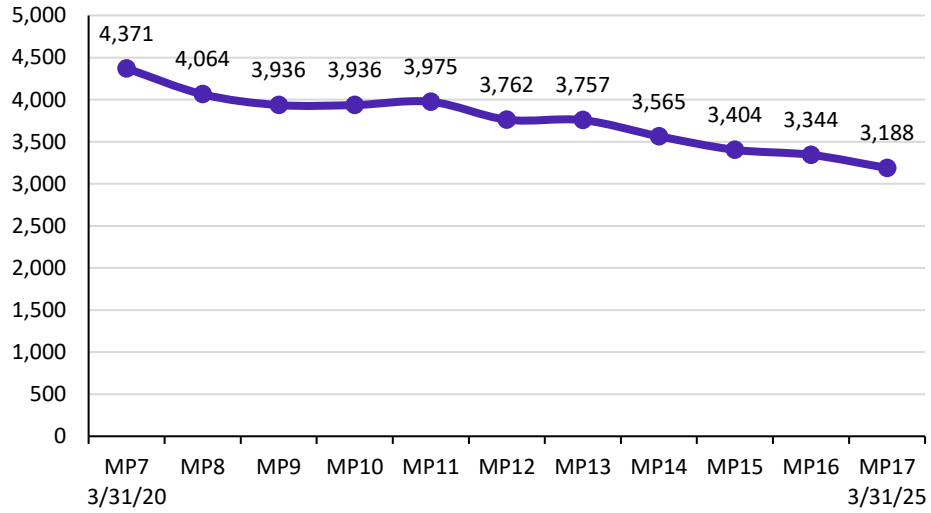
Number of Children in Foster Care

On the final day of the monitoring period, March 31, 2025, there were 3,188 children in the care of DSS statewide.[46] This continues the overall significant decline of children in foster care in South Carolina since the inception of the lawsuit, consistent with the state's policy priorities and national trends. In the past five years (10 monitoring periods), the number of children in foster care has decreased by 27 percent (Figure 2).

Figure 2. Number of Children in Foster Care

Children in care of DSS; MP7-17 (March 31, 2020 – March 31, 2025)

Source: DSS data dashboard, 7/10/25[47]



The map provided in Figure 3 shows the number of children in foster care on March 31, 2025, by county.

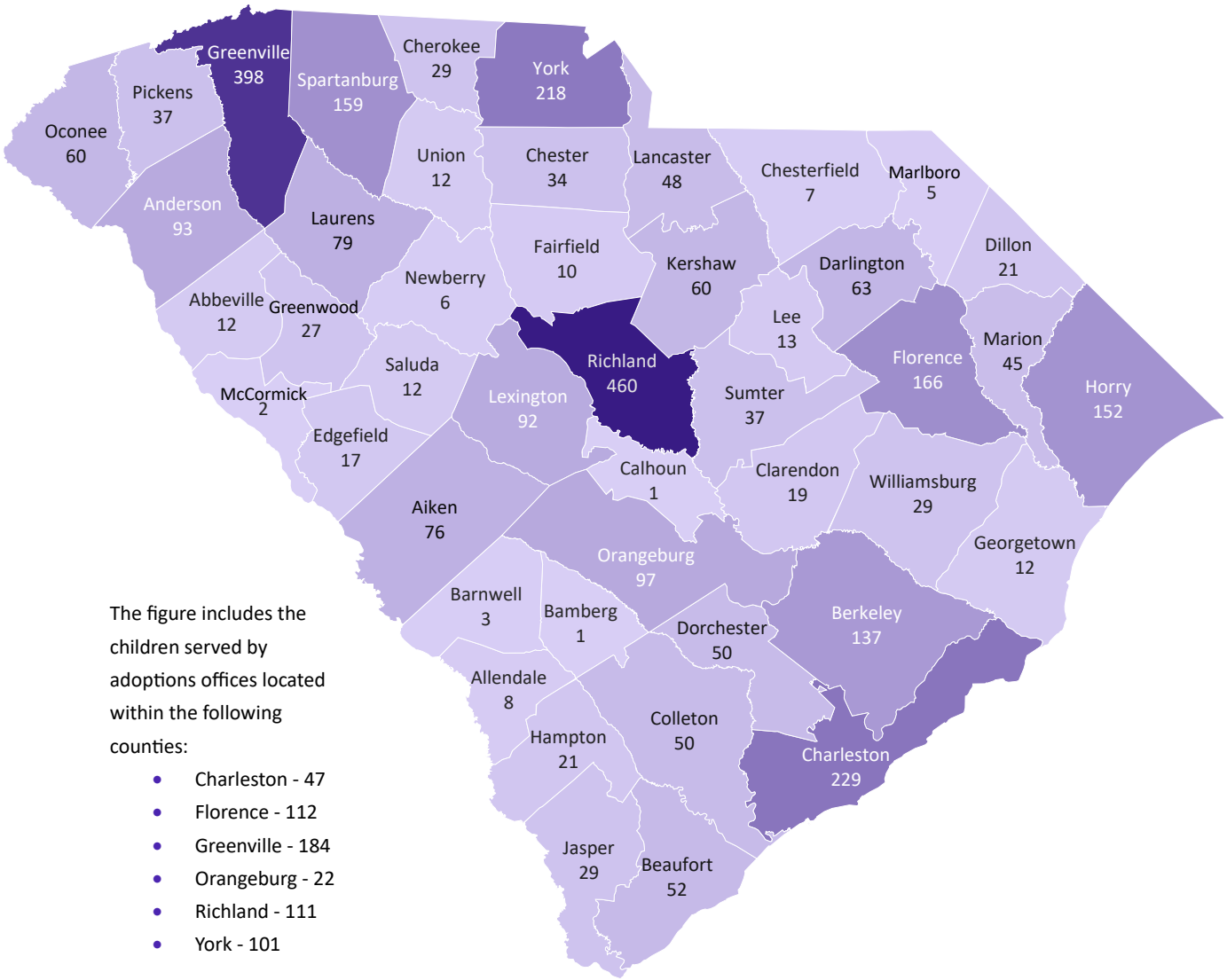
[46] This includes 19 children who resided in other institutional settings (e.g. Department of Juvenile Justice Facility, hospitalized for 30 days or more) on March 31, 2025, and may not match the data in *Section IV.A. Placements* of this report.

[47] Data from DSS's data dashboard include children in foster care who do not fall within the definition of Class Members under the FSA. To view DSS's data dashboard, see: https://dss.sc.gov/about/data-and-resources/foster-care-dashboard/

Figure 3. Number of Children in Foster Care, by County[48]

March 31, 2025

Source: CAPSS data provided by DSS



The figure includes the children served by adoptions offices located within the following counties:

- Charleston - 47
- Florence - 112
- Greenville - 184
- Orangeburg - 22
- Richland - 111
- York - 101

[48] To view this map with current data, see https://reports.dss.sc.gov/ReportServer/Pages/ReportViewer.aspx?/Foster+Care

Throughout this report, where relevant, data have been reported by the nine DSS County Offices with the largest number of children in foster care on March 31, 2025 (Figure 4). For each of these data points, complete data for all 46 South Carolina Counties can be found in Appendix D.

Figure 4. Counties with the Largest Foster Care Populations[49,50]

March 31, 2025

Source: CAPSS data provided by DSS; U.S. Census Bureau

Rank	County	Foster Care Population	County Child Population
1.	Richland	349	90,813
2.	Greenville	214	124,120
3.	Charleston	182	81,498
4.	Spartanburg	159	79,128
5.	Horry	152	63,618
6.	Berkeley	137	56,817
7.	York	117	68,920
8.	Anderson	93	47,118
9.	Lexington	92	69,460

[49] Adoption Services Offices have been omitted.

[50] U.S. Census Bureau, U.S. Department of Commerce. (n.d.). Age and Sex. *American Community Survey, ACS 5-Year Estimates Subject Tables, Table S0101*. Retrieved August 7, 2025, from https://data.census.gov/table/ACSST5Y2023.S0101?q=child+population++&g=040XX00US45$0500000.

Demographics of Children in Foster Care

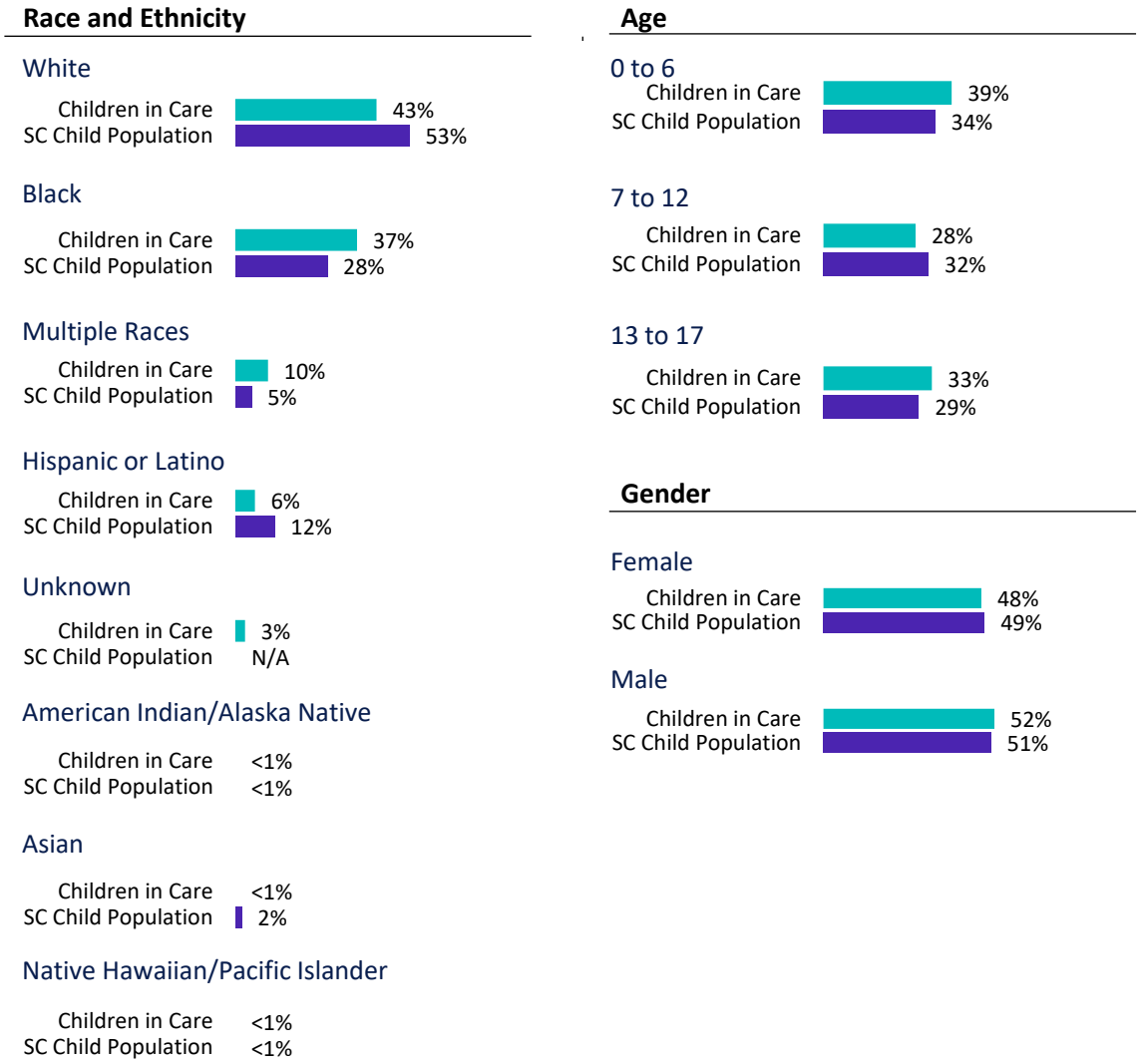
Of the children in foster care on March 31, 2025, 43 percent were identified as White, 37 percent as Black, and 10 percent as Multiracial (Figure 5).[51] White children composed 43 percent of children in foster care and 53 percent of the state population. Comparatively, Black children were overrepresented in care, composing just over 25 percent of the state population yet 37 percent of children in foster care in South Carolina. Children in foster care of Hispanic ethnicity (6%) were underrepresented when compared to their share of the state child population (12%).[52,53]
At the end of the monitoring period, almost 40 percent of children in foster care were aged six and under, slightly under 30 percent were aged seven through 12, and one-third were aged 13 through 17 (Figure 5). Both young children (six and under) and youth (13 through 17) were over-represented in foster care when compared to their share of the state population; children aged six and under make up 39 percent of the foster care population and 34 percent of the state population, while youth (13 through 17) represent 33 percent of the foster care population and 29 percent of the state population. Just under half (48%) of the children in foster care on March 31, 2025, were reported to be female.[54] These demographics have remained consistent for multiple monitoring periods.

[51] Data included herein were provided by DSS and have not been independently validated by the Co-Monitors.
[52] In accordance with federal guidelines, DSS does not record Hispanic ethnicity as a category in demographic data published on its public dashboard. However, DSS captures Hispanic ethnicity as a category in placement data.
[53] In this report, to allow for comparison to state-level data, children identified as being of Hispanic origin are counted as Hispanic and are not included in any other racial or ethnic categories.
[54] DSS collects data in CAPSS on children who identify as transgender, gender neutral, or non-binary, as well as information on children's pronouns. DSS constructs a quarterly report that goes to leadership and Child Welfare Operations so that the usage of the fields is monitored, and that leadership can continue to work with staff to increase reliable data entry.

Figure 5. Children in Foster Care, by Race and Ethnicity,[55,56] Age,[57] and Gender[58]

Compared to the child population of South Carolina; March 31, 2025

Sources: CAPSS data provided by DSS; U.S. Census Bureau, American Community Survey and Kids Count Data Center from the Annie E. Casey Foundation



[55] Child population by race and ethnicity | KIDS COUNT Data Center. (n.d.) https://datacenter.aecf.org/data/tables/103-child-population-by-race-and-ethnicity?loc=1&loct=1#detailed/2/42/false/2545/72,66,67,8367,69,70,71,12/423,424

[56] If a child is identified as being of Hispanic origin, they are only counted as Hispanic and are not included in any other racial or ethnic categories.

[57] "Kids Count Data Center from the Annie E. Casey Foundation." KIDS COUNT Data Center from the Annie E. Casey Foundation, July 2024, https://datacenter.aecf.org/.

[58] Ibid.

Entries into Foster Care

Throughout the monitoring period (October 1, 2024 to March 31, 2025) more children entered foster care (1,317) than exited (1,301) by a very small margin of 16 children (Figure 6). The margin was larger in the prior monitoring period (MP16) when 138 more children entered foster care than exited. Statewide, 1.2 children per 1,000 in the state child population entered foster care during the monitoring period. Comparing foster care entries among the nine counties in South Carolina with the largest foster care populations, Richland County had both the greatest number of children (163) enter foster care during MP17 and the highest rate of entry per 1,000 children (1.8) in the county child population (Figure 7).

Figure 6. Foster Care Entries and Exits

MP10 – 17 (April 2021 – March 2025)

Source: CAPSS data provided by DSS

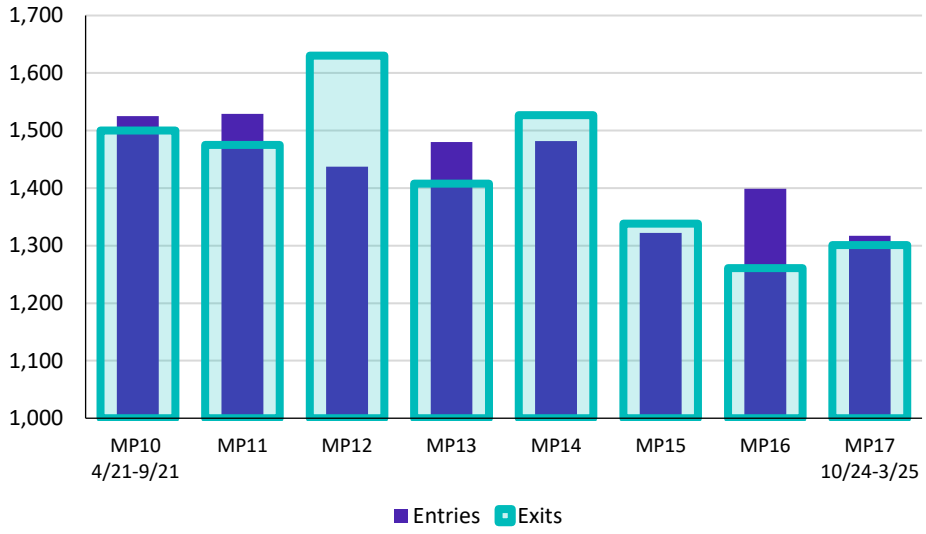
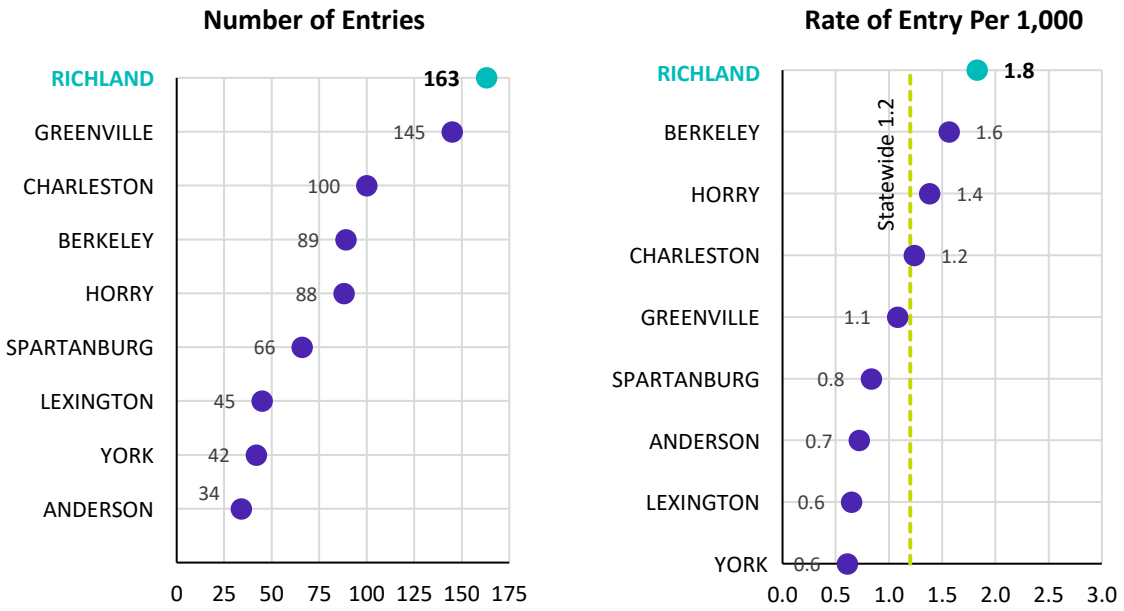


Figure 7. Foster Care Entries, by County

Entries and rates of entry per 1,000 children in county child population, MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS; U.S. Census Bureau, American Community Survey[59]



Most children who enter foster care in South Carolina enter due to law enforcement action placing them in "emergency protective custody" (EPC). State statute authorizes law enforcement officers to unilaterally remove children from their homes and place them in EPC in certain circumstances.[60,61] Statewide, 73 percent of all foster care entries between October 1, 2024 and

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[59] U.S. Census Bureau, U.S. Department of Commerce. (n.d.). Population Under 18 Years by Age. American Community Survey, ACS 5-Year Estimates Detailed Tables, Table B09001. Retrieved July 24, 2025, from https://data.census.gov/table/ACSDT5Y2023.B09001?t=Age+and+Sex:Children&g=040XX00US45,45$0500000.

[60] See SC Code § 63-7-620 (2024), authorizing law enforcement to use an EPC when, among other circumstances, (1) the officer has probable cause to believe that by reason of abuse or neglect the child is in substantial and imminent danger if not taken into emergency protective custody, and there is not time for a court order; (2) the child's parent(s) or guardian(s) has been arrested and as a result, the child's welfare is threatened due to loss of adult protection and supervision, and the parent(s) or guardian(s) does not consent to another person assuming physical custody of the child; or (3) a child has become lost accidentally and a search by law enforcement has not located the parent(s) or guardian(s).

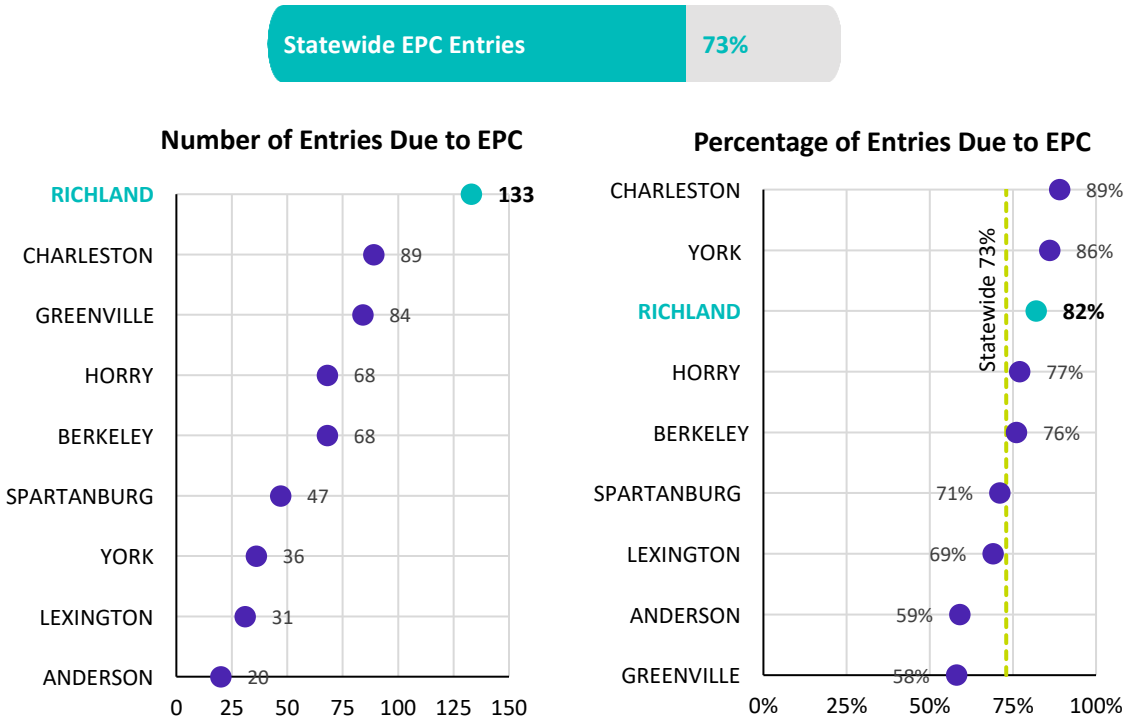
[61] Note, pursuant to SC Code § 63-7-740 (2024), family court judges are authorized to order ex parte that a child be taken into emergency protective custody without the consent of parents, guardians, or others, exercising temporary or permanent control over the child if: (1) the family court judge determines there is probable cause to believe that by reason of abuse or neglect there exists an imminent and substantial danger to the child's life, health, or physical safety; and (2) parents, guardians, or others exercising temporary or permanent control over the child are unavailable or do not consent to the child's removal from their custody.

March 31, 2025 were through EPC actions by law enforcement (Figure 8).[62] Comparing the nine counties with the largest foster care populations, Richland County had the greatest number of children (133) enter foster care due to an EPC by law enforcement. However, when compared to the percentage of EPC entries out of total foster care entries for each county, Richland County had the third highest rate of foster care entry due to an EPC (82%).[63]

Figure 8. Entries to Foster Care via an Emergency Protective Custody by Law Enforcement

Statewide and by counties with largest foster care populations, MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS



[62] Of the 1,317 who entered foster care between October 1, 2024 and March 31, 2025, 229 children (17%) entered foster care pursuant to an ex parte order for emergency protective custody issued by a family court judge. In total, 91% of children (1,192 of 1,317) entered foster care via either an EPC by law enforcement or an ex parte order for EPC issued by a family law judge.

[63] See Appendix D showing this data for all South Carolina Counties.

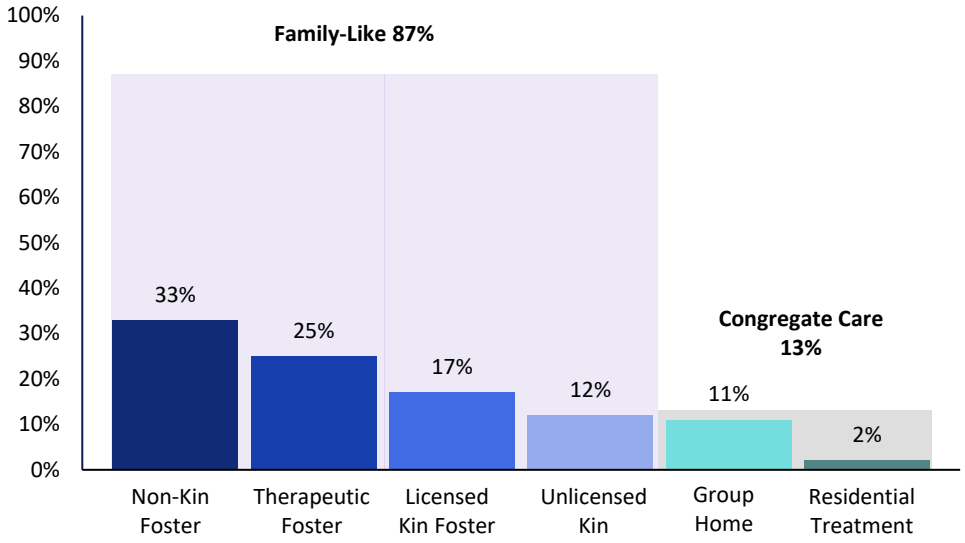
Placement Settings for Children in Foster Care

On March 31, 2025, 3,169 Class Members were in out-of-home foster care placements.[64] On the last day of the monitoring period, 87 percent of children (2,758) resided in family-like settings (Figure 9). Family-like settings include non-kin foster homes where 1,053 children (33%) resided, therapeutic foster homes where 781 children (25%) resided, licensed kin foster homes where 550 children (17%) resided, and court-ordered unlicensed kin homes where 374 children (12%) resided. Thirteen percent (411 children) resided in congregate care placements, including 363 children (11%) placed in group homes and 48 children (2%) placed in residential treatment facilities.

Figure 9. Placement Settings of Children in Care

March 31, 2025

Source: CAPSS data provided by DSS



Length of Stay and Exits from Foster Care

During the monitoring period (October 2024 – March 2025), 1,301 children exited foster care, with lengths of stays in care ranging from one to 4,595 days. The median length of stay among children exiting during MP17 was 235 days.

Focusing on children who experience foster care for shorter periods of time can help child welfare agencies better identify when the trauma of separating children from their families could have been avoided through improved cross-agency collaboration and the provision of in-home and community-based services. When successful, it prevents the lasting harm that children and

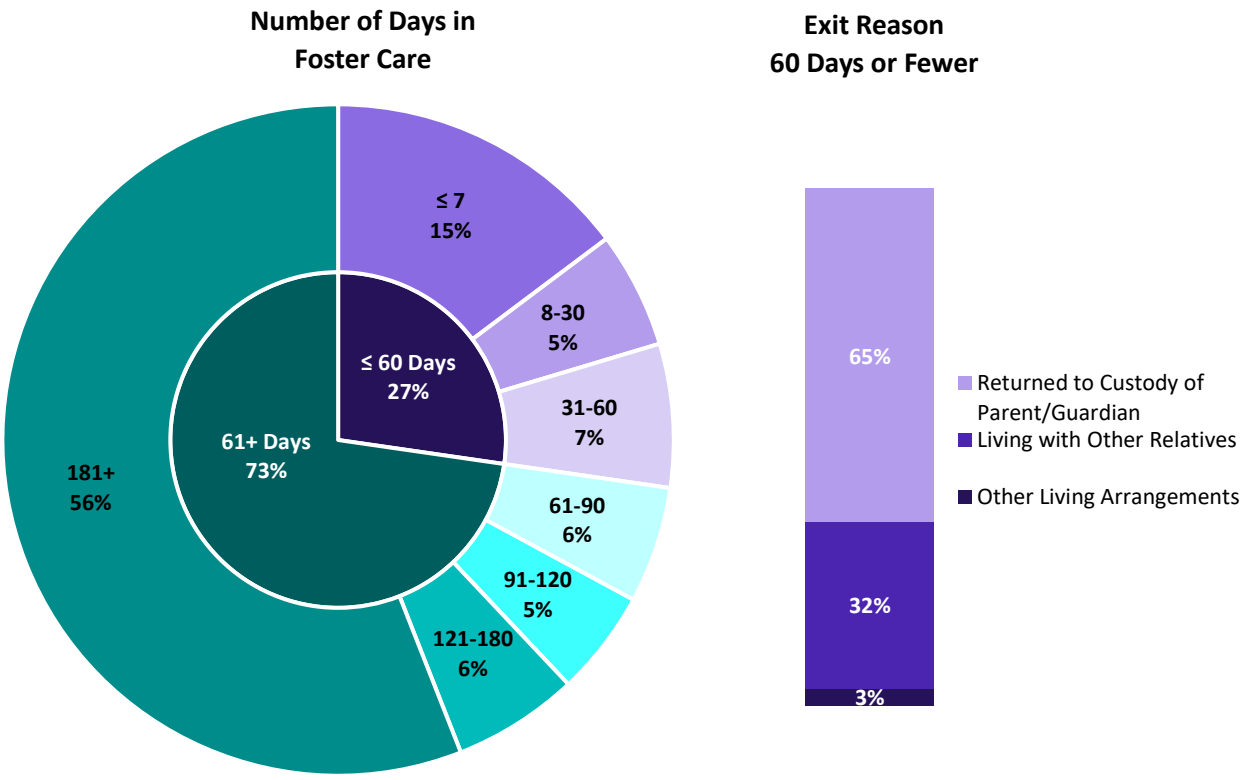
[64] This number excludes 19 children who resided in other institutional settings (e.g. Department of Juvenile Justice Facility, hospitalized for 30 days or more) on March 31, 2025.

families experience when separated by removals to foster care even for very short periods of time.[65] Accordingly, DSS's Office of Accountability, Data, and Research (ADR) analyzes the amount of time children spend in foster care, with an emphasis on children who remain in foster care for less than six months. The Co-Monitors focus the following analysis on children with "short stays" (60 days or fewer) and children with "very short stays" in foster care (7 days or fewer).

Among children who exited foster care between October 1, 2024 and March 31, 2025, 946 (73%) were in foster care for 60 days or more, while 355 (27%) experienced short stays of 60 days or fewer, including 192 children (15%) who exited foster care within seven days of entering (Figure 10). Among the 355 children with a stay of 60 days or fewer, 65 percent returned to the custody of their parent or guardian, 32 percent exited to live with other relatives, and three percent exited to other living arrangements.

Figure 10. Length of Stay in Foster Care and Exit Reason for Children with Stays of 60 Days or Less

Among children who exited foster care during MP17 (October 2024– March 2025)
Source: CAPSS data provided by DSS



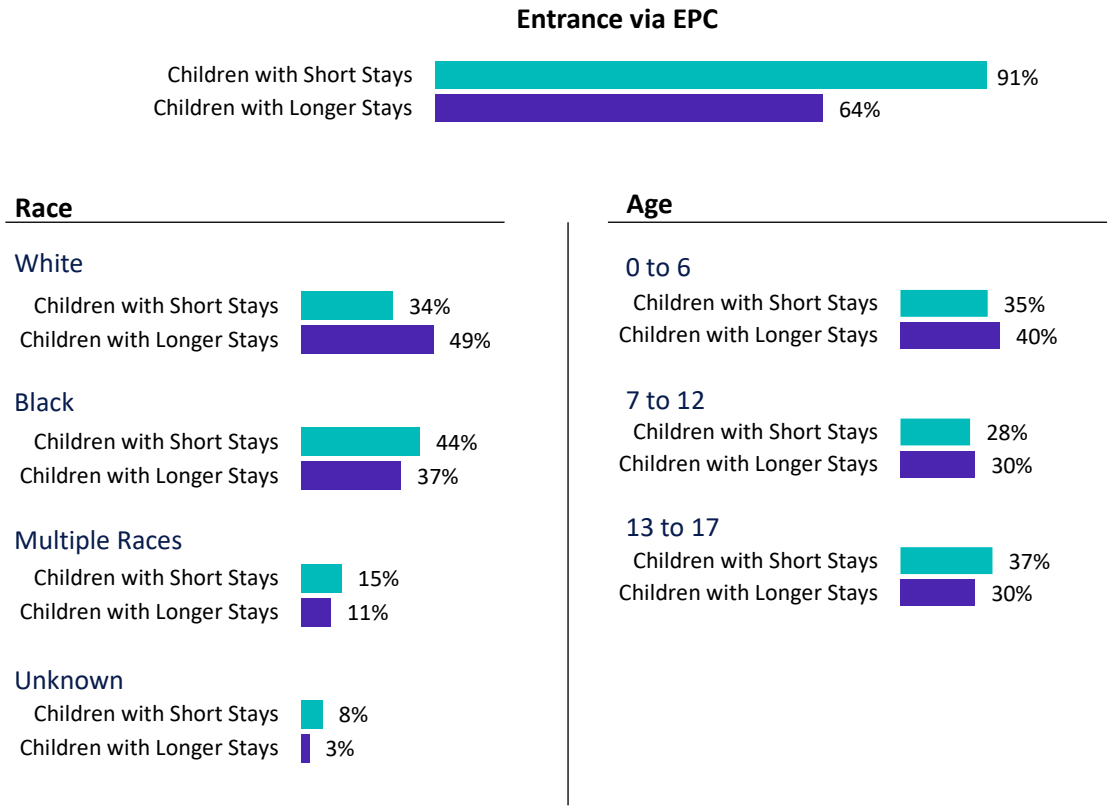
[65] See, e.g.: Sankaran, V., Church, C., & Mitchell, M. (2019). A Cure Worse than the Disease? The Impact of Removal on Children and their Families. University of Michigan Law School Scholarship Repository, 102(4). and Getz Z., Simmel C., Zhang L., Greenfield B. (2022). "Short-stayers" in child welfare: Characteristics and system experiences. Children and Youth Services Review, 138, 106531.

Comparing children who experienced short stays in foster care (60 days or fewer) to those who experienced longer stays (more than 60 days), children with short stays entered foster care through an EPC from law enforcement at a much higher rate (91%) than children with longer stays in foster care (64%) (Figure 11). Black children and children aged 13 through 17 made up higher proportions of children who experienced short stays in foster care compared to those who experienced longer stays in foster care.

Figure 11. Comparison of Children with Short Stays (60 Days or Less) and Longer Stays (61+ Days) in Foster Care

By entrance via EPC from law enforcement, race, and age among children who exited during MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS



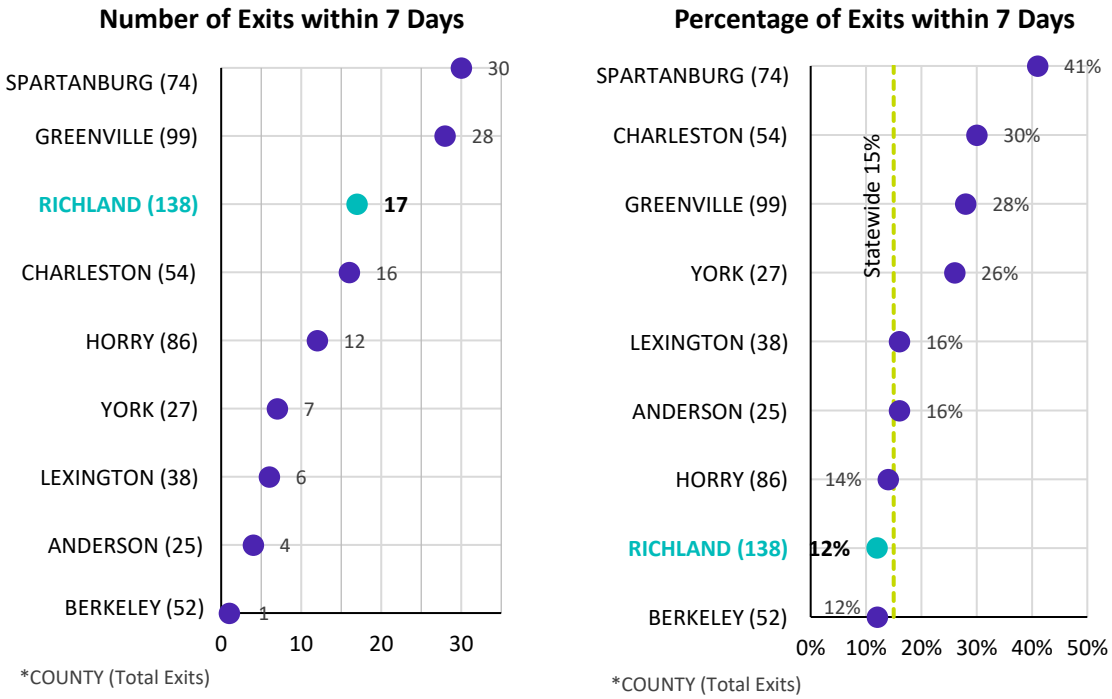
Statewide, 15 percent of children who exited foster care between October 1, 2024 and March 31, 2025 experienced very short stays (7 days or fewer) in foster care (Figure 10). Among South Carolina's nine counties with the largest foster care populations, Spartanburg County had the highest number of children (30) who experienced a very short stay in foster care (Figure 12). These 30 children made up 41 percent of all foster care exits (30 of 74) in Spartanburg County during the monitoring period. Of the nine counties, Richland County had the third highest number of children (17) who experienced foster care for seven days or fewer during the period. These 17 children made up 12 percent of all exits from foster care in Richland County during the monitoring period.

Among the nine counties, this is the lowest rate of very short stays (tied with Berkeley County) and is below the statewide rate of 15 percent.[66]

Figure 12. Exits from Care within 7 Days of Entry, by County

Among children who exited during MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS



[66] See Appendix D showing these data for all South Carolina Counties.

IV. Performance

A. Placements

When children are separated from their parent(s) and guardian(s) and placed into foster care, it is imperative that they are placed in settings where they are safe, stable, and supported. This means ensuring that children are in family-like environments, with kin and siblings, and within their communities. This policy and practice expectation requires that child welfare systems identify and support kin and family-based caregivers and provide flexible, accessible, individualized interventions to address children's safety, health, and well-being.

This expectation is recognized by FSA requirements related to placement stability, placement of children in family-like settings, placement of children with their siblings (discussed in this report in *Section IV.D.*, *Family Connections*), and placement of children in the least restrictive settings that can appropriately meet their therapeutic needs. The FSA also contains a requirement relating to the placement of children who are also involved with the juvenile justice system.

The availability of appropriate, stable placements for children throughout South Carolina has been a significant challenge for DSS for many years. That challenge has become acute in Richland County, and pursuant to a court order issued in October 2024, DSS is required to address high rates of placement instability in Richland County through the Richland County Child Welfare Improvement Plan and Task Force and the Capacity Building for Placement Array Workgroup co-facilitated by the Co-Monitors, a private provider leader, and DSS.[67,68] DSS, representatives from other state agencies, providers, community members, Plaintiffs, and the Co-Monitors continue to collaborate on strategies to address root causes of placement instability in Richland County with the hope that these strategies will serve as a blueprint for addressing placement instability throughout South Carolina.

[67] Order directing the prompt creation of a task force to prepare and implement a plan to address issues relating to overnight stays in the Richland County DSS office (October 18, 2024, Dkt. 331).
[68] Order Directing DSS Operations in Richland County (January 17, 2025, Dkt. 348).

1. Placement Instability

Placement Moves

FSA Requirement	*For all Class Members in foster care for eight (8) days or more during the 12-month period, Placement Instability shall be less than or equal to 3.37* (FSA IV.F.1.).
Performance Assessment	**FSA Requirement Not Met:** As previously reported in MP16, the annual 2023-2024 placement instability rate was **6.64**.

Section IV.F.1. of the FSA requires that the placement instability rate for all Class Members in foster care for eight days or more during the 12-month period, be less than or equal to 3.37. Placement instability is defined as the rate of placement moves per 1,000 days of foster care (FSA II.O). Placement moves are changes in foster care placements (FSA II.N.).[69] Performance on this provision is reported annually for the period between October 1st and September 30th. The 2023-2024 placement instability rate, included in the MP16 report, was 6.64, meaning Class Members were moved an average of 6.64 times per 1,000 days in care.[70]

In addition to the annual placement instability rate, DSS reports the number of placement moves children experience during each monitoring period. During Monitoring Period 17 (October 2024 – March 2025), 58 percent of children (2,603 of 4,509) did not experience a placement move. Forty-two percent of children (1,906 of 4,509) experienced at least one placement move, meaning they experienced at least two placements during the six-month period (Figure 13).

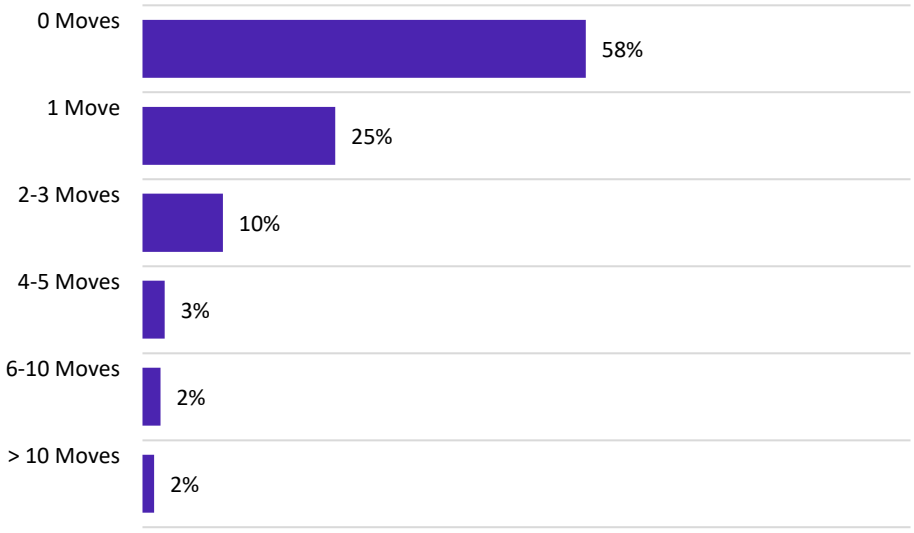
[69] A placement change is considered as a move if it was not temporary (the child did not return to the original placement), the move was not the original removal episode, and it did not occur after a Class Member's 18th birthday (FSA II.N-O.) Additionally, the re-designation of an emergency placement, that is not a congregate care placement, within 30 days as a long-term foster or therapeutic foster home is not considered a placement move (FSA. IV.E.4-5).

[70] See Michelle H. v. McMaster and Catone Progress Report: South Carolina Department of Social Services (April 1, 2024 – September 30, 2024) at pg. 68.

Figure 13. Percentage of Children Experiencing Placement Moves, by Number of Moves

MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS



Data on placement moves were also analyzed by county. Although Richland County had the highest number of placement moves in total (714) during MP17, one-third of children (167) experienced at least one placement move – this is the lowest percentage among the nine counties with the largest foster care populations. (Figure 14-A and B). The average number of placement moves among children who experienced at least one placement move during MP17 was also calculated. Over the six month period, Richland County had the highest average number of placement moves at 4.3 per child. For Richland County overall, these data suggest that a comparatively small percentage of children are experiencing very high rates of placement instability.[71]

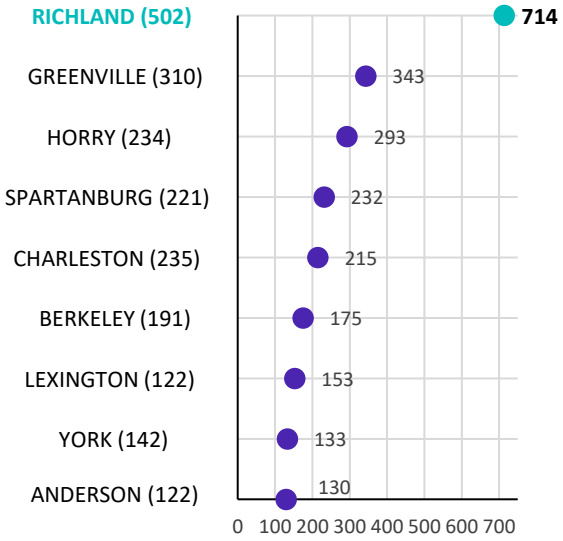
[71] See Appendix D showing these data for all South Carolina counties.

Figure 14. Placement Moves, by County

MP17 (October 2024– March 2025)

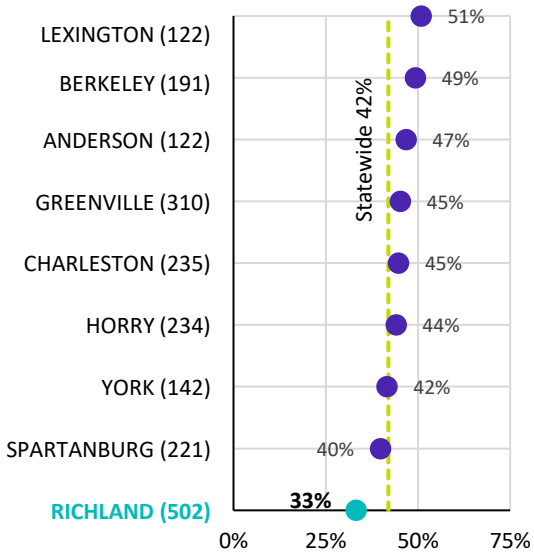
Source: CAPSS data provided by DSS

A. Total Number of Placement Moves



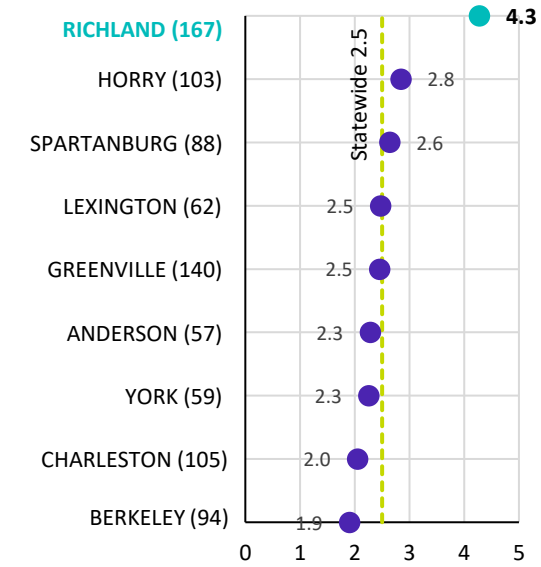
*COUNTY (Children in care at any point during MP17)

B. Percentage of Children with At Least One Placement Move



*COUNTY (Children in care at any point during MP17)

C. Average Number of Placement Moves Per Child Among Those Experiencing At least One Move



*COUNTY (Children with At Least One Placement Move)

Overnight Stays in DSS Offices and Hotels

FSA Requirement	[By November 28, 2015,] *DSS shall cease using DSS offices as an overnight placement for Class Members and shall cease placing or housing any Class Members in hotels, motels and other commercial non-foster care establishments. For any Class Members moved out of such DSS Offices or Hotels, DSS shall provide for their appropriate placement. In the extraordinary event that a child stays overnight in a DSS office, Defendants shall immediately notify the Co-Monitors, who shall provide a report to Parties as appropriate, including whether or not, in their view, the incident should be reported to the Court as a violation which would preclude Defendants' ability to achieve compliance on this provision* (FSA IV.D.3.).
Performance Assessment	**FSA Requirement Not Met: 216** (unduplicated) children spent a total of **1,064** nights in a DSS office, hotel, motel, or other commercial non-foster care placement.

The FSA requires DSS to cease using DSS offices as overnight placements for children. An "overnight stay" is defined as a minimum four-hour period in a DSS office, hotel, motel, or other commercial non-foster care establishment between the hours of 10:00 p.m. and 6:00 a.m.[72] Each night a child spends in a DSS office is counted as an overnight stay (e.g., if a child spends two consecutive nights in a DSS office, that is counted as two overnight stays.) DSS provides daily notification of any overnight stay to the Co-Monitors and tracks overnight stays weekly, monthly, and by monitoring period.

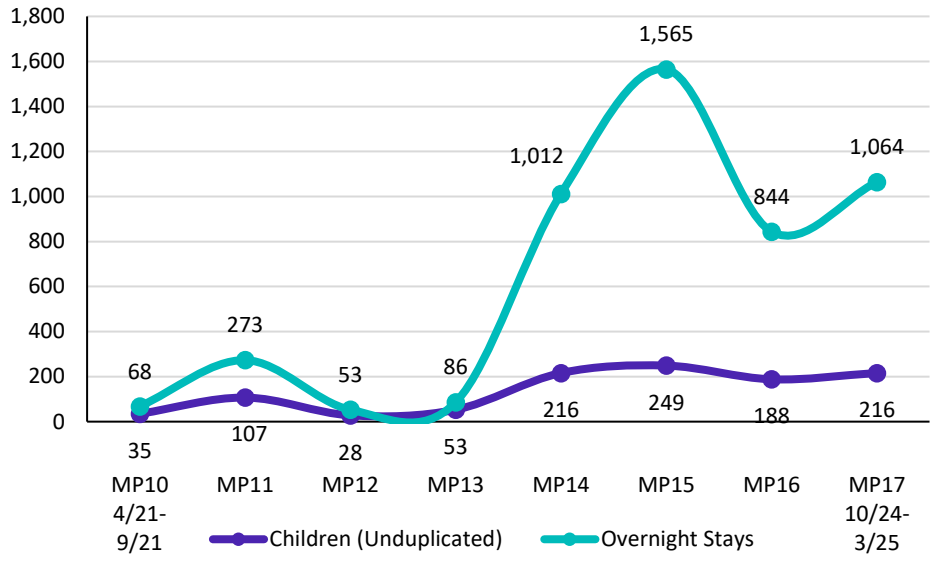
In Monitoring Period 17 (October 2024 – March 2025), 216 (unduplicated) children experienced a total of 1,064 overnight stays in a DSS office or hotel, motel, or other commercial non-foster care establishment (Figure 15). This is an increase in both the number of children and number of overnight stays since MP16 when 188 children experienced 844 overnight stays. The State did not meet the performance target on this FSA requirement.

[72] Note, this currently operative definition of "overnight stay" is included in the Short-Term Plan to Address Overnight Stays, which was approved by the Court on March 23, 2022. See Joint Motion for Approval of Overnight Stay Plan (March 4, 2022, Dkt. 236) at pg. 3 and Order Approving Overnight Stay Plan (March 23, 2022, Dkt. 238).

Figure 15. Overnight Stays

Number of unduplicated children who experienced an overnight stay and total number of overnight stays; MP10 – 17 (April 2021 – March 2025)

Source: CAPSS data provided by DSS

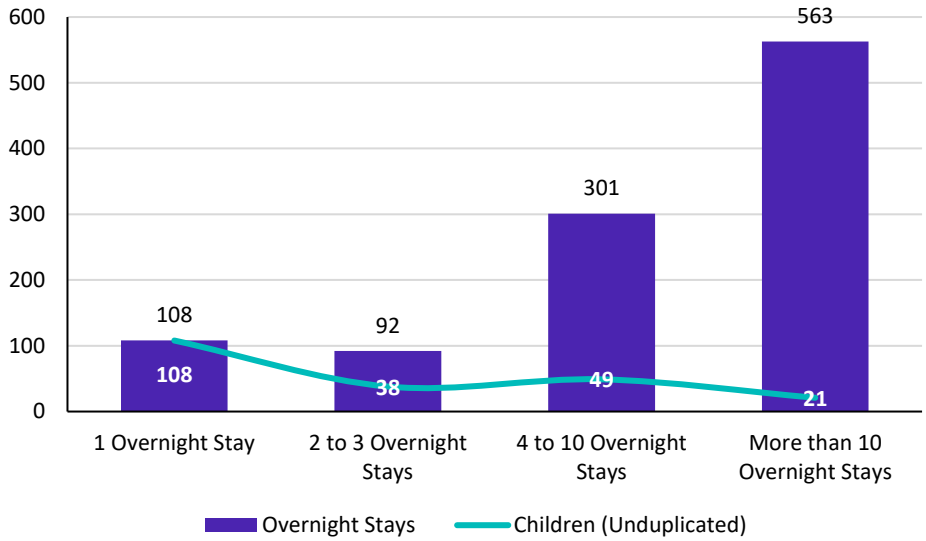


Overall, a small number of children accounted for most of the overnights stays. Among the 216 children who experienced an overnight stay during the monitoring period, 21 children (10%) experienced more than 10 overnight stays. These 21 children experienced a combined total of 563 overnight stays in a DSS office, which accounts for 53 percent (563 of 1,064) of all overnight stays during MP17. In other words, despite representing 10 percent of the children who experienced an overnight stay, these 21 children experienced 53 percent of the total number of overnight stays during the monitoring period (Figure 16).

Figure 16. Distribution of Overnight Stays Experienced, by Children

MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS

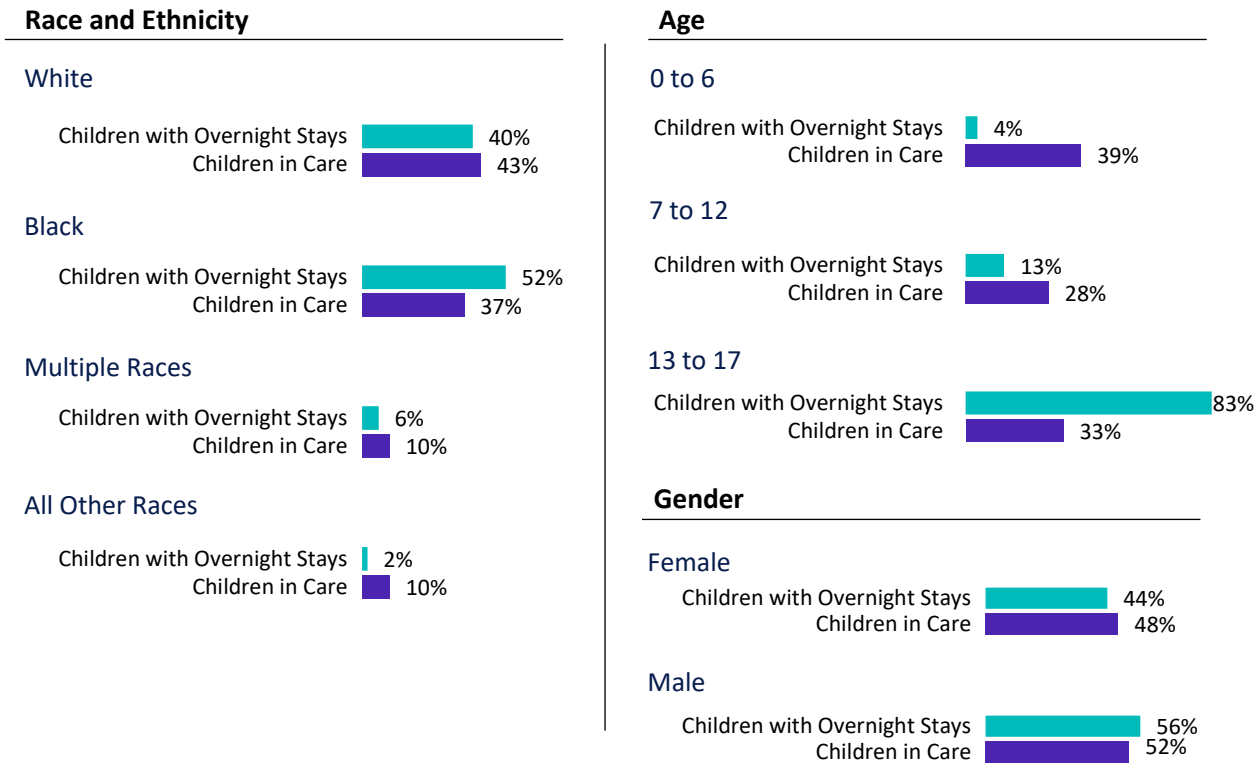


The majority of children who experienced an overnight stay during the monitoring period were aged 13 through 17 (83%) (Figure 17). Black children were over-represented among children who experienced an overnight stay (52%) when compared to their share of South Carolina's foster care population (37%), and males were slightly over-represented (56%) compared to their share of the foster care population (52%).

Figure 17. Children who Experienced Overnight Stays, by Race, Gender, and Age

MP17 (October 2024 – March 2025) compared to the state foster care population on March 31, 2025

Source: CAPSS data provided by DSS



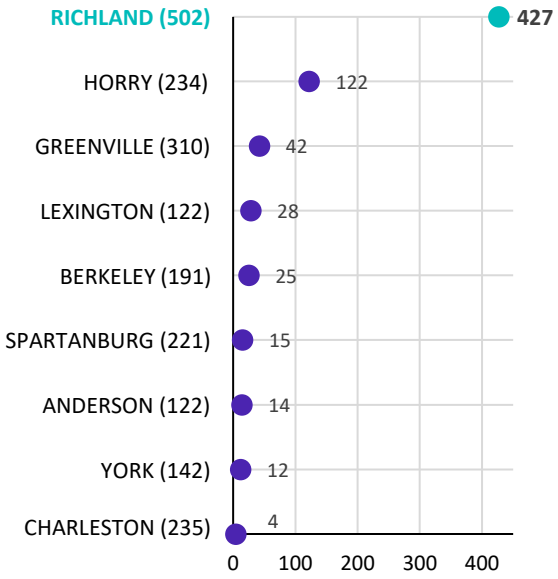
Data regarding overnight stays were also analyzed at the county level. Among South Carolina's nine counties with the largest foster care populations, Richland County had the highest total number of overnight stays (427) during the monitoring period (Figure 18-A) and the highest average number of overnight stays per child (11) (Figure 18-C). However, Richland County did not have the highest percentage of children who experienced an overnight stay (Figure 18-B). These data suggest that although Richland County's usage of DSS offices as overnight placements for children is high, it is not the only county where this is a problem.

Figure 18. Overnight Stays, by County

MP17 (October 2024 – March 2025)

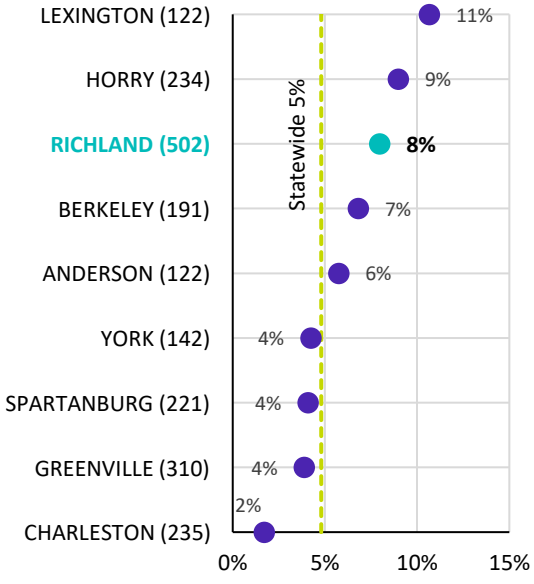
Source: CAPSS data provided by DSS

A. Total Number of Overnight Stays



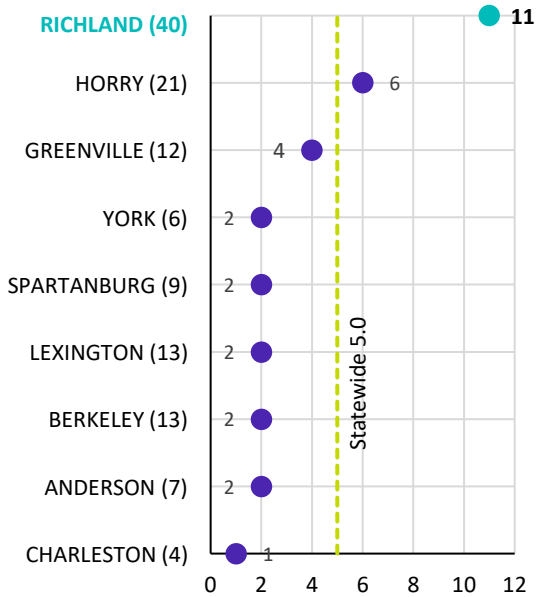
*COUNTY (children in care at any point during MP)

B. Percentage of Children with At Least One Overnight Stay



*COUNTY (children in care at any point during MP)

C. Average Number of Overnight Stays Per Child



*COUNTY (children with at least one overnight stay)

Emergency Placements

FSA Requirements	*Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days* (FSA IV.E.4.) [and] C*lass Members experiencing more than one Emergency or Temporary Placement within twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days* (FSA IV.E.5.).
Performance Assessment	**FSA Requirements Not Met: 10** children experienced an emergency placement lasting more than 30 days, and **137** children experienced subsequent emergency placements within 12 months lasting more than seven days.

The FSA places time limits on the use of emergency placements, including limiting initial emergency placements to 30 days or less and subsequent emergency placements, to seven days or less. DSS's policy defines an emergency placement as a short-term placement that is only utilized after all efforts have been made to identify a permanent long-term placement, and those efforts were unsuccessful.[73,74]

In Monitoring Period 17 (October 2024 – March 2025), 11 percent of children (515 of 4,509) who were in foster care at any point during the period experienced an emergency placement. In total, these 515 children experienced 1,457 emergency placements and spent 6,802 nights in those placements (Figure 19). This is a significant decrease from the prior monitoring period when 637 children experienced 1,957 emergency placements and spent a combined total of 10,322 nights in emergency placements. Of the 515 children who experienced an emergency placement in MP17, 10 had emergency placements lasting longer than 30 days.

Sixty-two percent of children (317 of 515) who experienced an emergency placement had already experienced at least one emergency placement within the prior 12 months, and 137 of those children had at least one subsequent emergency placement that lasted more than seven days. The State did not meet either FSA target related to emergency placements in MP17.

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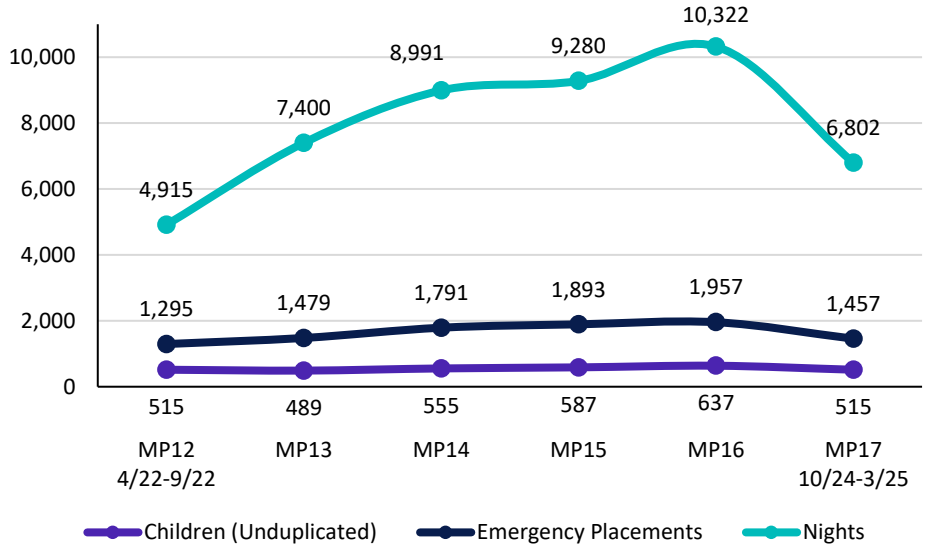
[73] Note, this currently operative definition of "emergency placement" differs from the definition provided in Section II.H. of the FSA, which is "an emergency shelter or other placement used as an emergency or temporary facility to house children as described by Human Services Policy and Procedure Manual § 817." The current definition is included in Section 510.2.4 of DSS's Child Welfare Policies and Procedures and is incorporated in DSS's filings with the Court related to the Richland County DSS Improvement Plan. See Letter from J. Michael Montgomery with Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (December 23,2024, Dkt.339) at pg. 4; see also Letter from J. Michael Montgomery (submitting Supplemental Richland County Improvement Plan) (May 19, 2025, Dkt.365) at pg. 7.

[74] For the purposes of this measure, emergency placements that are re-designated within 30 days as a long-term foster home or therapeutic foster home are excluded (FSA IV.E.4-5.).

Figure 19. Emergency Placements

Number of children who experienced an emergency placement, number of emergency placements, and total number of nights spent in emergency placement; MP12 – 17 (April 2022 – March 2025)

Source: CAPSS data provided by DSS

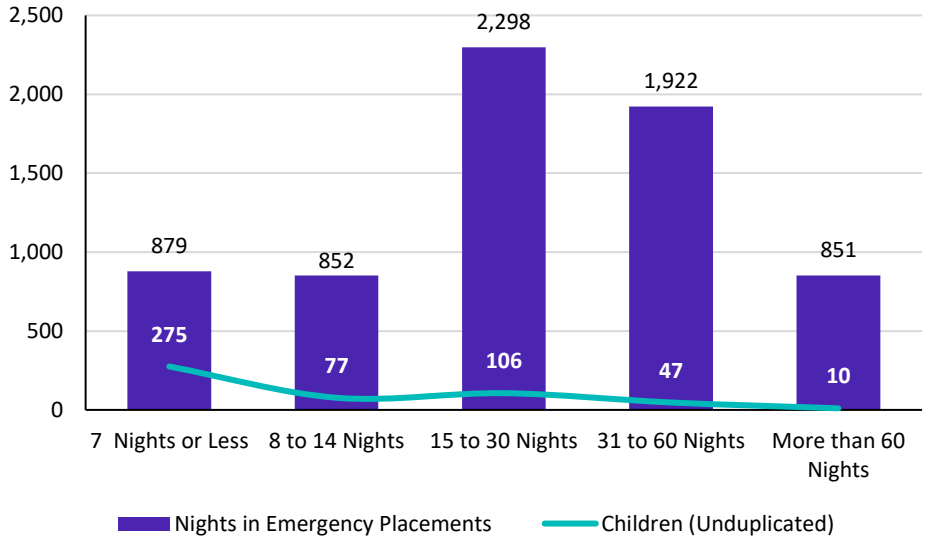


Children spent between one and 143 nights in emergency placements during MP17. Ten children experienced more than 60 nights in emergency placements, with a combined total of 851 nights. These 10 children made up two percent of those who experienced emergency placements but accounted for 13 percent of the total number of nights spent in emergency placements during the monitoring period (Figure 20).

Figure 20. Distribution of Nights Children Spent in Emergency Placements

MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS

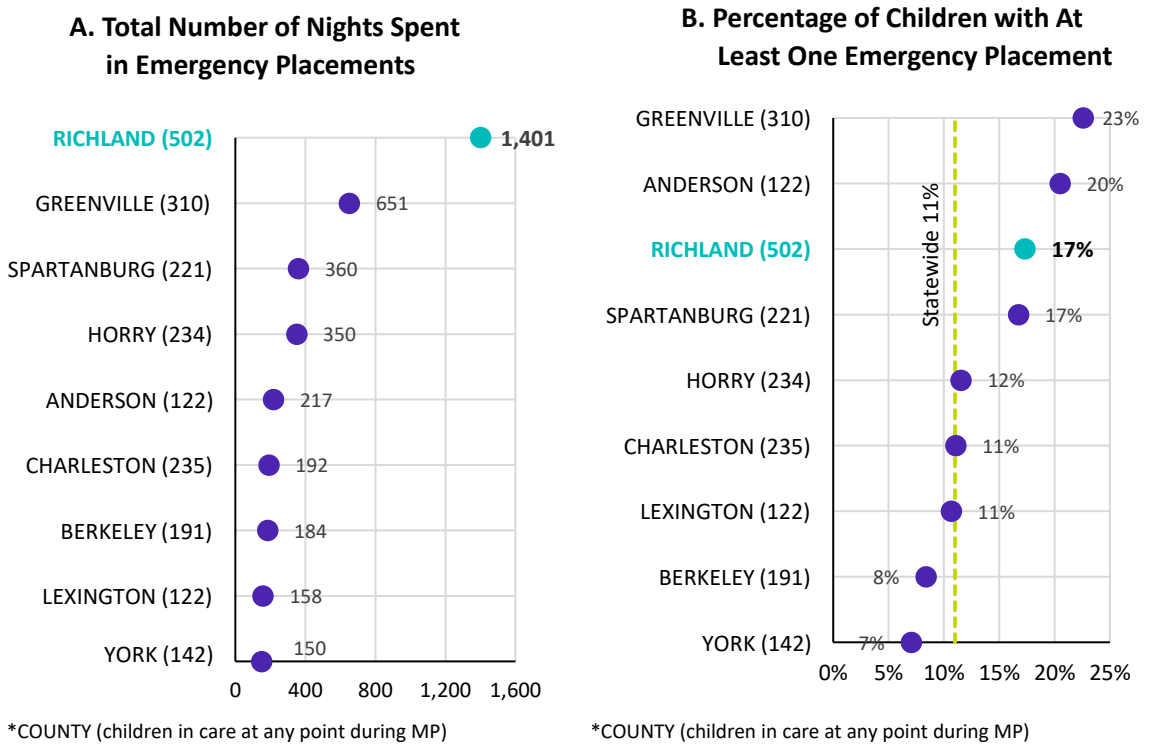


Data regarding the use of emergency placements were also analyzed at the county level. Among South Carolina's nine counties with the largest foster care populations, Richland County had the greatest total number of nights children spent in emergency placements (1,401) during the monitoring period (Figure 21-A) and the highest number of average nights per child (16) (Figure 21-C). However, Richland County did not have the highest percentage of children who experienced at least one emergency placement. Of the 502 children who were in the care of Richland County at any point during MP17, 87 (17%) experienced at least one emergency placement (Figure 21-B). These data suggest that although Richland County usage of emergency placements is high, the use of emergency placements also remains a problem in other counties.

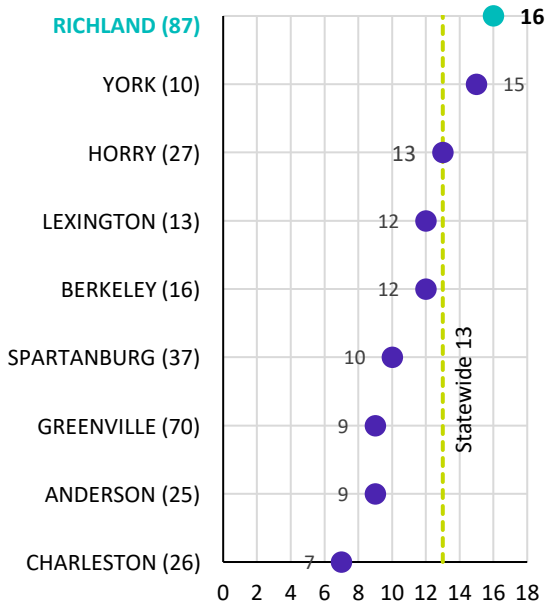
Figure 21. Emergency Placements, by County

MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS



C. Average Number of Nights Spent in an Emergency Placement, Per Child



*COUNTY (children with at least one emergency placement)

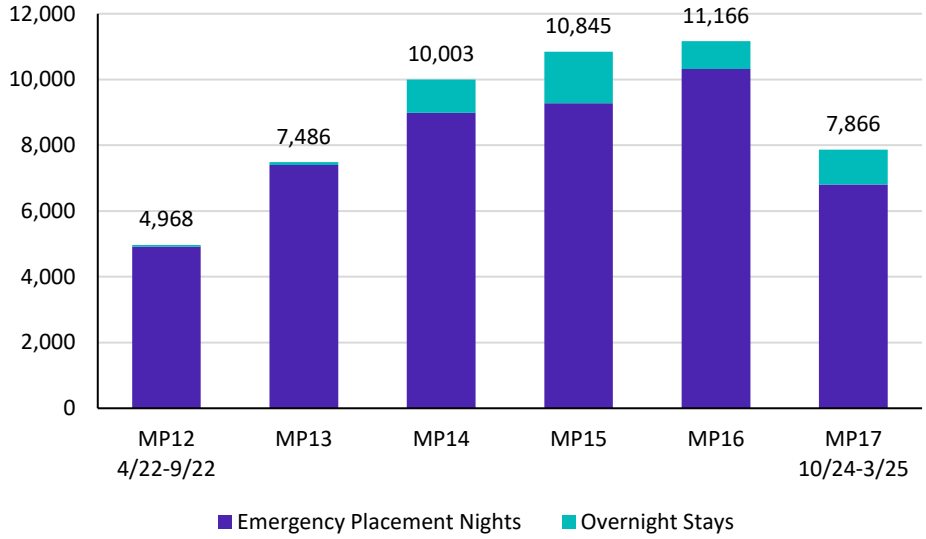
Short-Term Placements

In practice, children who experience unplanned, short-term placements are frequently moved between DSS offices and emergency placements while staff search for, and children await appropriate and stable placements. Overall, during the monitoring period, children spent a total of 7,866 nights in emergency placements and DSS offices. This is a 30 percent decrease from the prior monitoring period (MP16), when children spent 11,166 nights in these short-term placements (Figure 22).

Figure 22. Number of Nights Children Spent in Short-Term Placements

Combined overnight stays and nights in emergency placements; MP12 - 17 (April 2022 – March 2025)

Source: CAPSS data provided by DSS

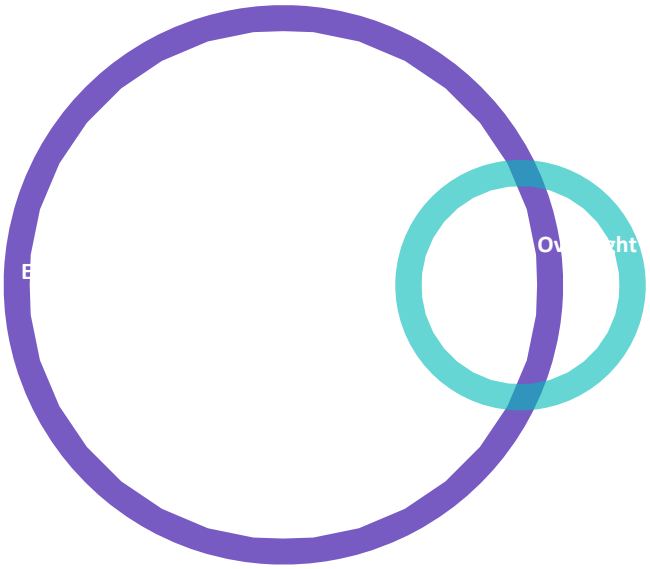


During the monitoring period, short-term placements were experienced by 582 (unduplicated) children, 149 (26%) of whom experienced both an emergency placement and an overnight stay (Figure 23). Those 149 children represent 69 percent of the total number of (unduplicated) children (149 of 216) who experienced an overnight office stay during MP17. DSS's ADR analyzed the "placement paths" of children who experienced overnight stays during MP17 and found that 66 of the 216 children (31%) who experienced an overnight stay were in an emergency placement immediately prior to the overnight stay and 158 (73%) were in an emergency placement immediately following the overnight stay.

Figure 23. Children who Experienced an Overnight Stay, an Emergency Placement, or Both

MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS



Discussion

High rates of placement instability are a pronounced challenge across South Carolina's child welfare system, including in Richland County. Statewide, 42 percent of children experienced at least one or more placement moves during Monitoring Period 17 (October 2024 – March 2025); 216 children experienced a total of 1,064 overnight stays in a DSS office, hotel, motel, or other commercial non-foster care establishment; and 515 children spent a total of 6,802 nights in an emergency placement. Although there was a significant decrease in the use of emergency placements since the prior six-month monitoring period, placement instability overall remains unacceptably high throughout the State.

The Co-Monitors collected and analyzed significant data on placement instability and the use of emergency placements and overnight stays. They also conducted a focus group with youth in foster care to get behind the numbers and look at the impact of the data.

> *My placement process wasn't exactly the best. They only found an open place for us; it didn't matter if it was a fit or not. We arrived around 12:00 a.m. and didn't get to go to bed until after 4:00 a.m. and had to get right back up and fit in immediately. It was hard.*

> *I was in emergency placement for three days and one day they drove me two hours away to a group home and took my phone away and I had to switch schools and couldn't even call to tell anyone if I was ok or not.*

Being moved away from my hometown made me more awkward. I started to eat alone in the library and that's not me. It was hard for me to connect with others.

They never gave me a choice. I was in five placements total from age 16-18 and I only got one good placement.

While efforts are necessarily focused on addressing placement instability in Richland County given the number of children involved and its impact on staff well-being and children's safety, it is not the only county where this problem exists. The data do not belie the fact that Richland County has an acute placement instability crisis; it does. Rather, the data underscore that high rates of placement instability are not limited to Richland County and are present throughout the State. It also highlights the critical importance of the success of the Richland County Task Force and Improvement Plan as a blueprint for addressing placement instability statewide.

The Supplemental Richland County DSS Improvement Plan ("Supplemental Plan") is "designed to support both youth in foster care from Richland County who are experiencing placement instability and the staff managing their cases."[75] The Plan includes strategies to increase placement resources and services in Richland County that are tailored to meet the individual needs of children; remove barriers to placement and promote placement stability; increase supports for kinship caregivers to help them meet the unique needs of children in their care; and prevent unnecessary removals to foster care through strengthened relationships with local law enforcement. Additionally, the Plan includes strategies to support the workforce such as creating and fully staffing second and third shifts, increasing retention efforts, and providing mentoring and other support focused on improving practice.

Many strategies in the Plan reflect a commitment to a fuller implementation of DSS's GPS Case Practice Model—a model of quality case practice that requires intensive engagement with children and families through teamwork, comprehensive assessments, and the crafting and resourcing of individualized case plans that address both immediate and ongoing needs.[76] This includes development and implementation of a "Whatever it Takes" approach to meeting the unique needs of children in foster care in Richland County through individualized placement and service planning within Child and Family Teams. Interim action steps such as the development of small capacity group homes for emergency placements must be implemented cautiously, so that these short-term placements do not become longer-term ones and that stop-gap approaches do not become long-term substitutes for appropriate family-based placement and care of children. The inclusion of strategies to prevent unnecessary removals of children to foster care via EPCs from law enforcement and family court judges is one important lever. DSS will struggle to address placement instability unless the strain these removals place on the system's placement array, staff, and provider community is significantly reduced. The other essential lever necessary to correct ongoing placement instability is the continued work needed to create an accessible system of

[75] See, Letter from J. Michael Montgomery with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 364) at pg. 4.
[76] To view the GPS Case Practice Model, see: https://dss.sc.gov/media/hnegmcwl/gps-practice-model-final-may-2023.pdf.

community mental and behavioral health services. If these efforts are to succeed, the investment in community-based services, especially those that leverage Medicaid dollars, will need to be robust and accelerated. Despite challenges, it is significant that these strategies have now been developed and refined in collaboration with private providers, representatives from other child-serving state agencies, members of the legal community, and with input from children and families, all of whom are critical to successful implementation.

2. Placement of Children in Family-Like Settings

FSA Requirement	*At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period* (FSA IV.E.2.).
Performance Assessment	**FSA Requirement Met**: **87%** of children resided in family-like placements.

The FSA requires that 86 percent of Class Members be placed outside of congregate care placements on the last day of the monitoring period. On March 31, 2025, 87 percent of Class Members (2,758 of 3,169) were placed in family-like settings and outside of congregate care.[77] The State met the final FSA target in MP17, as it has done each monitoring period since MP10. This provision may be eligible for Maintenance of Effort designation.

FSA Requirement	*At least 98% of the Class Members twelve (12) years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting Period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file* (FSA IV.E.3.).
Performance Assessment	**FSA Requirement Met**: **99%** of children aged 12 and under resided in family-like placements.

The FSA requires that at least 98 percent of Class Members aged 12 and under be placed outside of congregate care placements on the last day of the monitoring period, unless an exception approved by the Co-Monitors is documented in the Class Member's case file.[78] The Court granted

[77] Children residing in other institutional settings on the last day of the monitoring period are excluded from the universe. On the last day of MP17, 19 children resided in other institutional settings; 10 were in DJJ facilities and 9, including 3 children aged 12 or under, were in non-temporary (30-days or more) hospital settings. Children in emergency placements on the last day of the monitoring period are categorized as residing in family-like placements, and children experiencing an overnight stay in a DSS office, hotel, motel, or other commercial non-foster care establishment on the last day of the monitoring period are categorized as residing in congregate care.

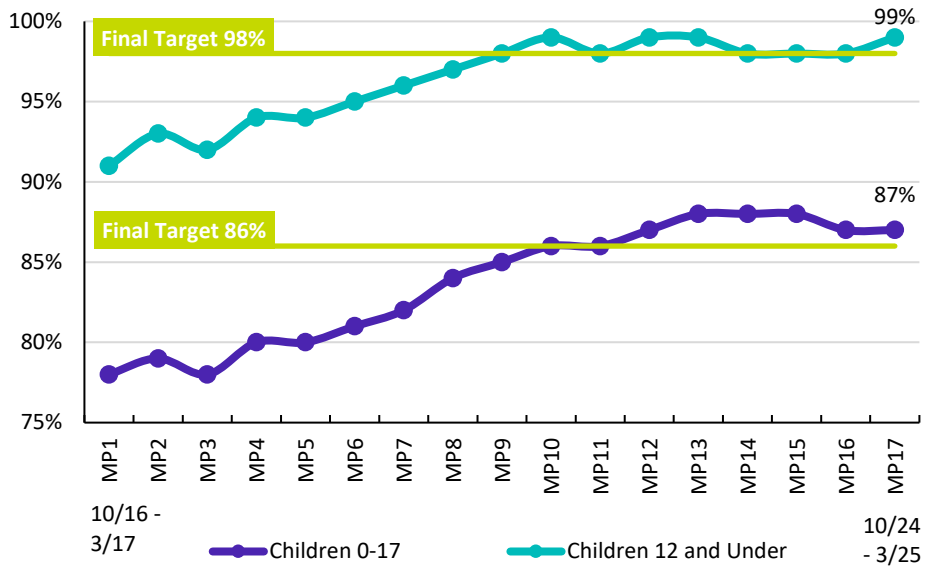
[78] The Co-Monitors have approved the following exceptions to the requirement that children aged 12 and under be placed outside of congregate care: (1) the child has clinical and medical needs that can only be met in a congregate care setting; (2) the child is the son or daughter of another child placed in a group care setting; (3) sibling group 4 or larger; and (4) the child has been removed and is in the legal custody of DSS and is placed with a parent who is not in DSS custody but who is temporarily in a residential group setting for treatment (DSS Placement Implementation Plan, pg. 55). Additionally, per DSS policy, placement of a child aged 12 and under in a congregate care placement pursuant to an approved exception requires prior approval of a Regional Director (DSS Policies and Procedures: Child Welfare Services, Policy 511 Group Care Utilization Management, effective February 28, 2025, pg. 2).

Maintenance of Effort status for this provision on October 18, 2024.[79] Subsequently, DSS met the final performance target in MP16 and continued to meet the target in MP17. On the last day of MP17, 99 percent of Class Members (2,093 of 2,120) aged 12 and under resided in a family-like setting and outside of a congregate care placement (Figure 24).[80]

Figure 24. Placement of Children in Family-Based Settings

MP1 – 17 (March 31, 2017 – March 31, 2025)

Source: CAPSS data provided by DSS



While the FSA does not include targets for the placement of children aged 13 to 17 outside of congregate care settings, it bears noting that children in this age range are far more likely than younger children to be placed in congregate settings and at consistently high rates. On March 31, 2025, 35 percent of children aged 13 to 17 (365 of 1,049) resided in a congregate care facility; this is nearly the same rate as the prior monitoring period (33%).

[79] Order on Motion for Miscellaneous Relief (October 18, 2025, Dkt.329).

[80] On the last day of MP17, 19 children were placed in congregate care pursuant to a valid exception, including 11 children aged 7-12 placed in psychiatric residential treatment facilities (PRTF) due to documented medical necessity and 8 children aged 6 and under who resided with their parent in a residential facility.

FSA Requirement	*[P]revent…, with exceptions approved by the Co-Monitors, the placement of any Class Member age six (6) and under in any non-family group placement (including but not limited to group homes, shelters or residential treatment centers)* (FSA IV.D.2.).
Performance Assessment	**FSA Requirement Met**: No child aged six or under was placed in a non-family group placement without a valid exception.

The FSA requires DSS to prevent, with approved exceptions, the placement of children aged six and under in non-family group placement.[81] The Court granted Maintenance of Effort status for this provision on October 18, 2024.[82] DSS met the final performance target in MP16 and continued to prevent the placement of children aged six and under in non-family settings in MP17. All 15 children aged six and under who resided in congregate care at any point during MP17 were placed in those settings pursuant to a valid exception.[83]

Placements with Kin

DSS has identified that placing children with kin and increasing financial and other supports provided to children and their kin caregivers to be an important strategy to improve children's stability and well-being and to reduce the use of congregate care placements. Kin placements have, for the most part, incrementally increased each monitoring period. On March 31, 2025, 29 percent of foster children were placed with kin (Figure 25). DSS has also prioritized licensing kinship placements because licensed homes are eligible for full foster care board payments while unlicensed kinship homes are not eligible for board payments. On March 31, 2025, 52 percent of children placed with kin were in licensed homes, and 48 percent were in unlicensed homes. Overall, the rate of kin licensure is increasing (Figure 26).

[81] *Supra* note 78.
[82] Order on Motion for Miscellaneous Relief (October 18, 2025, Dkt.329).
[83] All 15 children were residing with their parent in a congregate care facility.

Figure 25. Percentage of Children Placed with Kin

MP10 – 17 (April 2021 – March 2025)

Source: CAPSS data provided by DSS

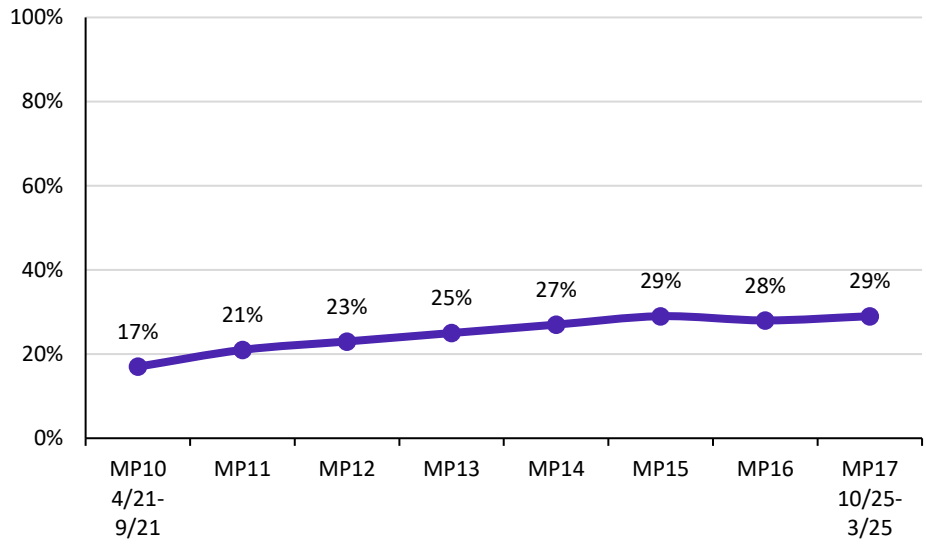
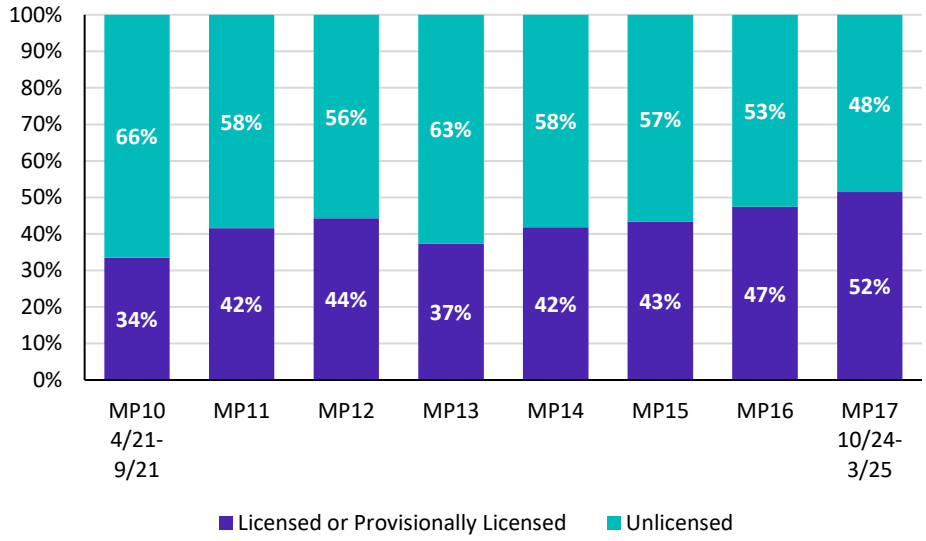


Figure 26. Kin Placements, by Licensure Status

MP10 – 17 (April 2021 – March 2025)

Source: CAPSS data provided by DSS



Discussion

DSS has met or exceeded targets for three of the FSA requirements related to the placement of foster children in family-like settings for this monitoring period (October 2024 – March 2025). On March 31, 2025, eighty-seven percent of children 17 and under (FSA IV.E.2.) and ninety-nine percent of children aged 12 and under (FSA IV.E.3.) resided in family-based placements, and no child aged six or younger resided in a non-family group placement without a valid exception (FSA IV.D.2.). The Court granted Maintenance of Effort status for the latter two provisions on October 18, 2024, and the State has continued to meet or exceed the FSA targets for these requirements since that time.

DSS has prioritized the development of its kinship foster care program in recent years, recognizing that kin foster care placements help reduce the trauma associated with removal, provide greater placement stability, and increase the likelihood of siblings being placed together; kin foster care placements lead to fewer instances of institutional abuse and repeat maltreatment, better mental and behavioral health, and greater educational stability. As part of the effort to move toward a kin-first culture, DSS reports that it is advancing statutory amendments that will enable it to streamline licensing and approval standards for kin caregivers. Kin caregivers who are licensed or approved are eligible to receive payments equal to those received by non-kin foster parents.

The statutory amendments are needed to take advantage of a September 2023 change in federal regulations allowing state child welfare agencies to utilize separate licensing and approval standards for kinship placements and receive Title IV-E federal reimbursement for foster care board payments on behalf of otherwise eligible children who are placed in those homes.[84] Before the rule change, state child welfare agencies could only claim Title IV-E reimbursement for foster care board payments if the agency applied the same licensing or approval standards to kin and non-relative foster homes. To begin using separate licensing and approval standards for kinship foster homes in South Carolina, the General Assembly must pass statutory amendments and approve the associated state regulations, which will then allow DSS to seek federal approval of the kin-specific licensing and approval standards. The necessary statutory amendments were introduced on March 4, 2025, in Senate Bill 415. Senate Bill 415 passed out of the Senate on April 2, 2025, and was introduced in the House on April 3, 2025. At the close of the legislative session in May, Senate Bill 415 had been referred to the House Judiciary Committee and will be taken up when the General Assembly reconvenes in 2026. The Kin Specific Licensing and Approval regulations were presented to the General Assembly in January 2025 and received approval on May 8, 2025.[85]

DSS reports that beginning September 15, 2025, it will be piloting the kin-specific approval

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[84] For information on separate licensing/approval standards for relative or kinship family foster homes, see: https://www.federalregister.gov/documents/2023/09/28/ 2023-21081/separate-licensing-or-approval-standards-for-relative-or-kinship-foster-family-homes

[85] See 415, 126th Gen. Assemb., 1st Reg. Sess. (S.C. 2025), https://www.scstatehouse.gov/sess126_2025-2026/bills/415.htm and S. 598, 126th Gen. Assemb., 1st Reg. Sess. (S.C. 2025), https://www.scstatehouse.gov/sess126_2025-2026/prever/598_20250423a.htm.

standards. Kin who are willing to go through the approval process will be assessed using the new standards. Those who are approved, whether provisionally or fully, will receive the same board payment provided to licensed foster parents. The pilot is focused on the Midlands Region. Phase one, beginning September 15, 2025, will include Aiken, Fairfield, Lexington, Saluda, and York counties. Phase two will begin in February 2026 and will include the remaining Midlands Region counties: Bamberg, Barnwell, Chester, Edgefield, Kershaw, Lancaster, and Richland as well as Midlands Adoptions.

As the State grapples with high rates of placement instability and seeks to eliminate overnight stays in DSS offices, it is important that it puts measures in place to guard against moving back towards overreliance on congregate care for children of all ages. As noted, the FSA does not include specific targets for the placement of children aged 13 to 17 outside of congregate care settings; and children in this age range are placed in congregate care at high rates and are also more likely to experience placement instability than younger children.[86] Establishing limits and escalating approval processes for the placement of children of any age in a congregate care setting, such as those included for the use of emergency group homes in the Supplemental Plan for Richland County, is essential to ensuring children are placed in the least-restrictive setting that meets their individual needs. In July 2024, DSS formed the Group Care Utilization Management Regional Implementation Teams to establish limits and approval processes for the placement of children in congregate care. To support this work, DSS created a new position responsible for tracking data, reporting to leadership on regional and county group care trends, and monitoring both the statewide use of group care and adherence to the Group Care Utilization Management policies. DSS filled this position, effective February 17, 2025.[87]

[86] Note, Section IV.I. of the FSA, related to Therapeutic Foster Care Placements and Services, also includes provisions related to the placement of children of all ages in non-family-based settings. Specifically, it requires that placement recommendations for children who have been identified as needing therapeutic placement and/or services be "driven by the least restrictive, most normalized care philosophy suitable to a child's individual needs and shall recommend placement of a child in the least restrictive family-like setting that preserves family and community connections" (FSA IV.I.2.). See *Section IV.A.4. Therapeutic Placements* of this report for further discussion.

[87] Letter from J. Michael Montgomery Providing Information Required by October 18, 2024, Order (EFC 330) prior to March 21, 2025 Status Conference (March 14, 2025, Dkt.354).

3. Juvenile Justice Placements

FSA Requirement	*When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the family court or Department of Juvenile Justice that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their plea or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member. DSS shall take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea. DSS shall provide for their appropriate placement* (FSA IV.H.1.).
Performance Assessment	**Not Reported**: Data are not available.

The FSA prevents DSS from recommending to the family court or Department of Juvenile Justice (DJJ) that a Class Member remain in juvenile justice detention or another juvenile justice placement without pending charges or beyond the term of the Class Member's plea or adjudicated sentence, because DSS does not have a foster care placement for the Class Member. The FSA further requires DSS to take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea and provide for the Class Member's appropriate placement.

Due to the lack of tracking data regarding these requirements, the Co-Monitors have historically had to rely on reports from community members and limited information from DSS about practice and performance related to this FSA requirement.[88] Because of the lack of data, the Co- Monitors are unable to assess DSS's performance on this FSA measure during MP17.

Discussion

As part of its Teaming for Teens work in Greenville, Anderson, and Spartanburg counties, DSS began implementing removal prevention CFTMs to reduce the number of unnecessary entries of children into foster care due to EPCs of teens by law enforcement and the DJJ court. DSS reported that as of July 31, 2025, 102 CFTMs involving 127 children in those counties had been completed, and 103 of those children did not enter foster care during the 30-day period following the CFTM. In Richland County, the use of removal prevention CFTMs began in the fourth quarter of 2024; 41 CFTMs involving 56 children who were involved with DJJ were completed, and as of July 31, 2025, 39 of those children had not entered foster care. Additionally, as part of the Community Action

[88] In November 2022, the Co-Monitors and DSS, with the South Carolina DJJ's permission and collaboration, published a report of findings from their joint comprehensive review of the experiences of children involved with both DSS and DJJ. To view the report, including key findings and recommendations, see: https://cssp.org/wp-content/uploads/2025/03/FINAL-Children-Concurrently-Involved-with-SC-DJJ-and-DSS-Joint-Review-Findings-002.pdf.

Workgroup of the Richland County Task Force, amendments to the Memorandum of Understanding between DSS and DJJ are in development. These efforts are aimed at strengthening collaboration between DSS and DJJ through proactive teaming at the earliest opportunity so that children and youth experiencing parent-child conflict or unmet mental and behavioral health needs may remain safely with their families.[89]

On February 18, 2025, the Co-Monitors re-engaged with members of the juvenile defense bar and held a Lunch & Learn about the *Michelle H*. settlement to better understand progress related to the FSA requirement. The Co-Monitors will work with DSS, in collaboration with members of the juvenile justice community, to develop a plan to allow for accurate assessment of performance on this FSA requirement.

[89] Letter from J. Michael Montgomery with Supplemental Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19, 2025, Dkt. 364).

4. Therapeutic Placements

The FSA requires that DSS timely and appropriately identify and meet Class Members' needs for therapeutic foster care placements and/or services. Although the FSA, through the Placement Improvement Plan, requires enforceable interim benchmarks with specific timelines to measure DSS's progress in meeting children's needs for therapeutic placements and/or services, the establishment of benchmarks was long delayed while DSS considered ways to align measurement with DSS's assessment and placement protocols and practices.

After considerable discussion, the Parties successfully negotiated a joint motion to modify FSA Section IV.I. Therapeutic Foster Care Placements and Services, which was approved by the Court on November 1, 2024.[90] The modified FSA requirements include provisions to ensure children identified as needing therapeutic placements and/or services are referred to and receive those placements and/or services on a timely basis and that they are provided with updated assessments at least annually, upon a placement disruption, or upon a material change in their needs. The modified FSA also requires that recommendations for therapeutic placements and/or services "be driven by the least restrictive, most normalized care philosophy suitable to the child's individual needs and shall recommend placement of a child in the least restrictive family-like setting that preserves family and community connections." Further, if a Class Member is placed in congregate care because a less restrictive, family-like setting to meet their individual needs is unavailable, the placement shall be considered inconsistent with the child's needs.

FSA Requirement	*At least 95% of Class Members that are both identified through an approved CANS (with fidelity to the CANS model) as needing therapeutic placement and/or services and recommended for specific therapeutic placement and/or services during a Child and Family Team Meeting (CFTM) (with fidelity to the CFTM model) will be referred for such recommended placement and/or services within 30 days of the date of the CFTM. The recommendation(s) may include but are not limited to diagnostic assessment; community support services; rehabilitative behavioral health services; therapeutic foster care; moderate, enhanced, or QRTP levels of group care; and placement in a psychiatric residential treatment facility. If a non-family-based placement is recommended, it shall identify why the youth's needs cannot be met in a family setting. The placement recommendation shall be driven by the least restrictive, most normalized care philosophy suitable to the child's individual needs and shall recommend placement of a child in the least restrictive family-like setting that preserves family and community connections. If a Class Member is placed in congregate care because a less restrictive, family-like setting to meet their individual needs is unavailable, then that placement shall be considered inconsistent with the child's needs under this Section* (FSA IV.I.2.).

[90] Court order (November 1, 2024, Dkt.333), approving Joint Motion to Amend the Final Settlement Agreement Section IV.I. (October 25, 2024, Dkt.332-1).

Performance Assessment	**Unable to Determine**: As of the writing of this report, work to establish baseline performance and interim benchmarks is in process.

FSA Requirement	*At least 95% of Class Members identified through an approved CANS and a Child and Family Team Meeting as needing therapeutic placement and/or services shall receive an updated assessment at least annually thereafter, upon a placement disruption or upon a material change in the Class Member's needs. The updated assessment will re-invoke the processes in I.2, consistent with DSS policies case planning and assessment*. (FSA IV.I.3.)
Performance Assessment	**Unable to Determine**: As of the writing of this report, work to establish baseline performance and interim benchmarks is in process.

FSA Requirement	*Children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family team and incorporated into DSS' case and service plan within sixty (60) days and (90) days following the date of the CFTM during which the recommendations were made*. (FSA IV.I.6.)
Performance Assessment	**Unable to Determine**: As of the writing of this report, work to establish the final objective outcome measure and its due date is in process.

The modified FSA provisions additionally require DSS, in collaboration with the Co-Monitors, to develop and implement a quality service review process to establish baseline data for measuring DSS practice regarding the assessment and provision of therapeutic placement and/or services to children in foster care. The baseline will be used to establish performance benchmarks and the final objective outcome measure, and due date, for FSA requirement IV.I.6. Since early 2025, DSS and the Co-Monitors have worked together to implement these new requirements and expect to complete this work by September 30, 2025. The Co-Monitors will report on the baseline and the methodology for the quality service review process within the next monitoring report. The reviews are expected to be implemented for the monitoring period beginning October 2025 (MP19).

Discussion

DSS's work, in collaboration with the Co-Monitors, to develop and implement a quality service review process to assess performance related to therapeutic placements and/or services, creates an opportunity for focused implementation of DSS's GPS Case Practice Model that includes assessing and meeting children's underlying needs in a systematic, comprehensive, and timely

manner that preserves family and community connections.[91] Through this work, it is hoped that DSS will be able to identify gaps in therapeutic placements and services, take steps in increasing access to such services, and ensure that children's therapeutic placement and/or service needs are identified and met in the least restrictive appropriate setting.

[91] DSS's GPS Case Practice Model was designed in recognition of the need for a culture that "engage[s], encourage[s], honor[s], and support[s] families." To view the GPS Case Practice Model, see: https://dss.sc.gov/media/hnegmcwl/gps-practice-model-final-may-2023.pdf.

B. Case Manager Caseloads and Contacts with Children

A sufficient, qualified, and trained workforce with manageable caseloads is foundational to a well-functioning child welfare system. Case managers must have the resources and support to allow them to conduct meaningful visits with children and families, assess safety and risk, and monitor progress towards individualized case goals, among many other important tasks. Child welfare agencies must ensure that the appropriate number and types of positions - including case managers, team leaders, and support staff - are allocated within each region and county office so that caseloads are manageable, and that when vacancies exist, they are quickly filled with as little disruption as possible to children, families and co-workers.

1. Caseloads

Workload Limits for OHAN, Adoptions, and Foster Care Case Managers

FSA Requirement	*At least 90% of Workers and Worker supervisors shall have a workload within the applicable Workload Limit* (FSA IV.A.2.(b)).[92]
Performance Assessment	**FSA Requirement Partially Met:** OHAN Case Managers **100%** | OHAN Team Leaders **100%** Foster Care Case Managers **81%** | Foster Care Team Leaders **92%** Adoptions Case Managers **73%** | Adoptions Team Leaders **83%**

The FSA requires that at least 90 percent of case managers and team leaders have a caseload within the standard. The Workforce Implementation Plan set the final targets for caseloads to be reached by DSS in March 2021.[93] Approved caseload standards differ by case manager type – specifically foster care, adoptions, and OHAN case managers (Figure 27).[94] The Co-Monitors

[92] The FSA utilizes the term "supervisor" to refer to DSS staff who oversee case-carrying staff. As part of its Guiding Principles and Standards (GPS) Case Practice Model development and work to define enhanced job expectations, DSS now utilizes the term "team leader" for this role, effective May 2023.
[93] To view the Workforce Implementation Plan, see: https://dss.sc.gov/media/i3qlwxka/dss-workload-implementation-plan.pdf
[94] DSS has many staff with "mixed" caseloads that include different types of cases involving both Class and Non-Class Members. On December 21, 2017, the Co-Monitors provisionally approved DSS's proposal to calculate caseloads for foster care case managers with mixed caseloads by adding the total number of children in foster care (Class Members) they serve to the total number of families (cases) of Non-Class Members also served. The following types of cases are currently counted by family (case): CPS investigations; family preservation; other child welfare services; and those involving a child subject to the Interstate Compact on the Placement of Children. This methodology is only applied to foster care case managers with mixed caseloads and is not applied to adoptions case managers.

selected a random day in each month this monitoring period to measure caseload compliance for each type of case manager and team leader.[95] Only performance for March 31, 2025, is reported.

Figure 27. Caseload Standards, by Worker Type

Source: Approved DSS Workforce Implementation Plan (February 2019)

Worker Type	Caseload Standard	Standard for New Case Managers[96]	More than 125% of Standard
Case Managers			
Foster Care Case Manager	1 case manager to 15 children (1:15)	No more than 8 children (1:8)	More than 18 children or Non-Class cases
Adoptions Case Manager[97]	1 case manager to 15 children (1:15)	No more than 8 children (1:8)	More than 18 Children
OHAN Case Manager	1 case manager per 8 investigations (1:8)	No more than 4 investigations (1:4)	More than 10 investigations
Team Leaders			
Foster Care Team Leader	1 team leader to 5 case managers (1:5)	N/A	More than 6 case managers
Adoptions Team Leader	1 team leader to 5 case managers (1:5)	N/A	More than 6 case managers
OHAN Team Leader	1 team leader to 6 case managers (1:6)[98]	N/A	More than 7 case managers

As of March 31, 2025, the percentage of case managers with caseloads within the required limits improved or was maintained from MP16 across all case manager types (Figure 28). Caseload compliance for foster care case managers improved significantly from 70 percent to 81 percent; adoptions case manager caseload compliance improved from 66 percent to 73 percent; and OHAN

[95] These random dates that caseloads were validated this monitoring period include October 18, 2024, November 7, 2024, December 16, 2024, January 9, 2025, February 21, 2025, and March 31, 2025.
[96] "New workers" refers to those workers who have been employed less than six months since completing Child Welfare Pre-Service Certification training.
[97] Prior to 2019, DSS's workforce was structured so that case management responsibilities remained with the foster care case manager until a placement agreement was signed, even when an adoptions case manager was also assigned. As a result, the approved caseload standard for adoptions case managers was 1:17. In 2019, DSS began transitioning case management responsibility to adoptions case managers once children became legally eligible for adoption. This was completed in January 2020; thus, adoptions case manager caseload performance is now assessed at a standard of 1:15.
[98] The Co-Monitors approved a higher caseload standard for OHAN team leaders in recognition of the fact that the OHAN case managers they supervise have lower caseload standards than other direct service case managers.

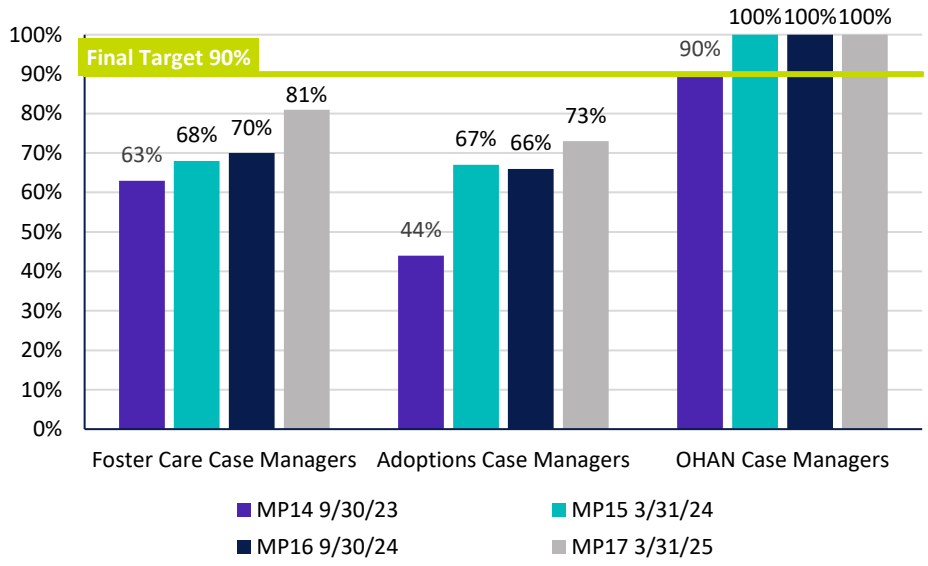
case managers maintained 100 percent compliance with caseload limits, exceeding the FSA target of 90 percent.

The percentage of caseload compliance for team leaders stayed relatively the same when compared to six months prior (Figure 29).[99] Both OHAN and foster care team leaders continue to meet the FSA requirement with 100 percent and 92 percent, respectively, in compliance with caseloads standards, while adoptions team leaders remain below the FSA target. The State has demonstrated progress on this commitment and has partially met the requirement.

Figure 28. Caseloads within Required Limits, by Case Manager Type

MP14 – 17 (September 2023 – March 2025)

Source: CAPSS data provided by DSS

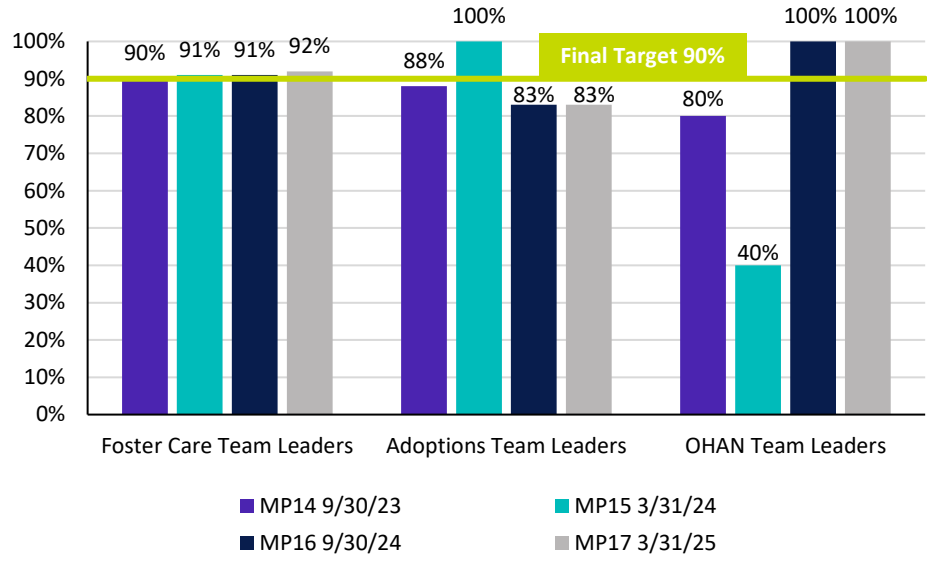


[99] DSS has identified situations in which it may be necessary for team leaders to be directly responsible for carrying cases for short periods of time. These include circumstances in which a case manager is promoted to team leader and may temporarily retain case management responsibilities for up to 45 days if a case is nearing closure, there are complexities regarding the case that need to be addressed, or an important legal event will occur within the timeframe. When cases are being transferred from one case manager, office, unit, or program area to another, the case may be temporarily assigned to the receiving team leader for up to 5 days until the team leader assigns the case to the receiving case manager. DSS has also identified that team leaders sometimes carry cases when a case manager leaves the agency and creates a vacancy that takes some time to fill or when case managers are on extended leave. While the team leader is directly managing, or "carrying" a case, they are responsible for all required case duties, including visits with the child; monitoring the child's safety, placement, well-being, case plan, and service delivery; ensuring the child is visiting with their siblings and/or parent(s); and other activities as necessary. For these circumstances, DSS requires Regional Director approval for team leaders to carry cases for more than 5 days and documentation of the case(s) the team leader will carry, the circumstances leading to the team leader carrying cases, and a specific plan and timeline be created to address the issue. This documentation must be shared with DSS's ADR unit. The Co-Monitors are provided with these data for review.

Figure 29. Team Leaders, by Type, with Assigned Workers within the Required Limits

MP14 – 17 (September 2023 – March 2025)

Source: CAPSS data provided by DSS



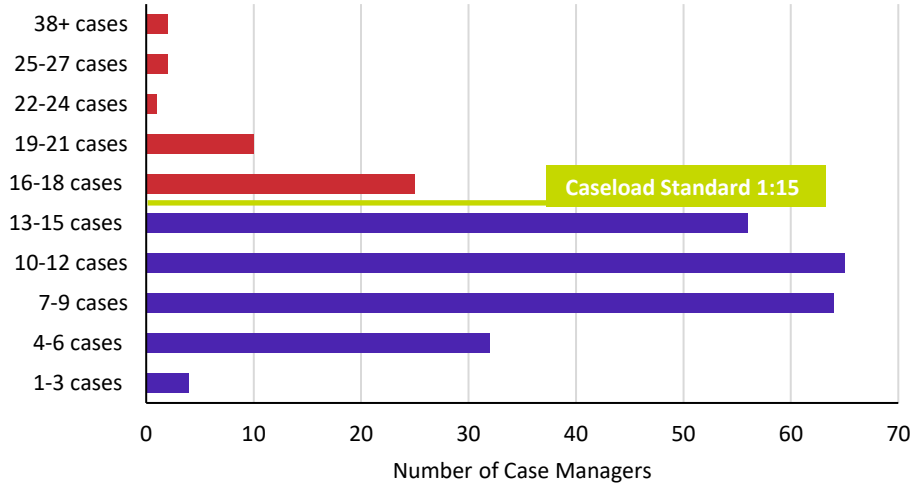
The Co-Monitors analyzed the caseloads of those foster care case managers whose caseloads were within and above the FSA standard. On the last day of the monitoring period (March 31, 2025), among the 261 foster care case managers who had completed Child Welfare Pre-Service Certification training more than six months prior, 221 (85%) had caseloads within the standard and 40 (15%) had caseloads above the standard, including two case managers who were responsible for 38 or more cases each – more than double the caseload standard (Figure 30).[100]

[100] DSS reported that the two staff were investigative case managers in Berkeley County. One case manager carried 38 cases including one foster care case involving a Class Member. The other case manager carried 41 cases, including five foster care cases involving Class Members.

Figure 30. Number of Cases Assigned to Foster Care Case Managers

March 31, 2025; N = 261

Source: CAPSS data provided by DSS



Caseload standards are graduated, in that new workers should not receive a full caseload until six months after completing pre-service training. Graduated caseload standards are an important staff retention strategy, allowing new staff the time to develop their skills and learn how to practice in accordance with the GPS Case Practice Model.[101] On March 31, 2025, there were 51 new foster care case managers for whom six months had not yet elapsed since the completion of their pre-service training; 63 percent of these new foster care case managers (32 of 51) had caseloads within the standard, and three new foster care case managers were responsible for 16 or more cases — double the graduated caseload standard (Figure 31).[102]

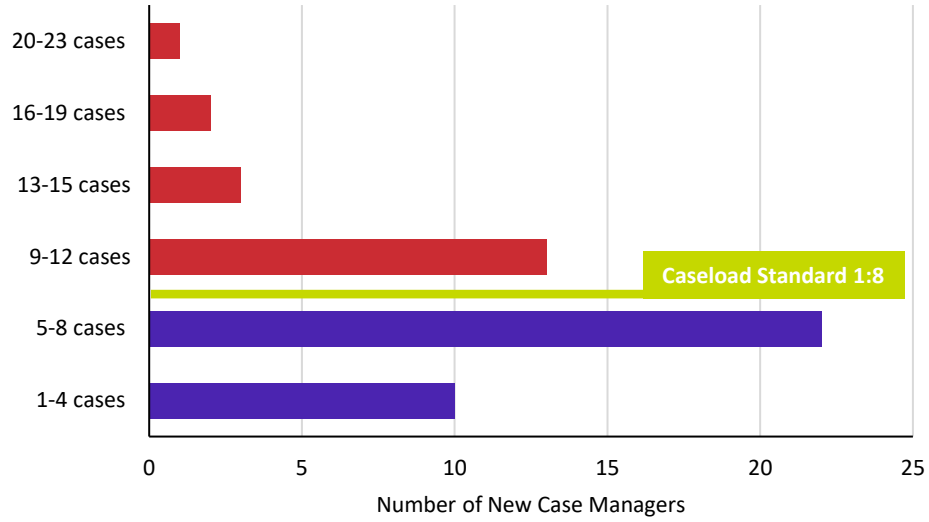
[101] To view the GPS case practice model, see: https://dss.sc.gov/media/hnegmcwl/gps-practice-model-final-may-2023.pdf.

[102] One foster care case manager worked in Berkeley County and carried 16 cases while the second foster care case manager worked in Charleston County and carried 19 cases.

Figure 31. Number of Cases Assigned to New Foster Care Case Managers

March 31, 2025; N = 51

Source: CAPSS data provided by DSS

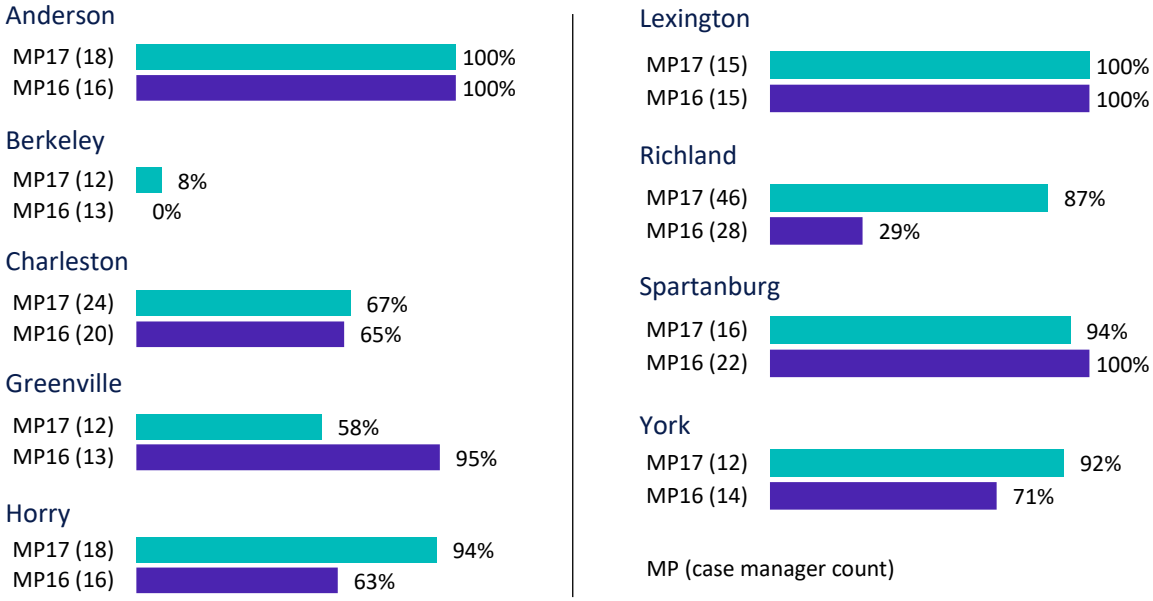


From MP16 to MP17, five of the nine counties with the largest foster care populations demonstrated improvement, and two maintained 100 percent performance in the percentage of foster care case managers with caseloads within the required standard. During this time, Richland County's caseload compliance improved from 29 percent to 87 percent (Figure 32).

Figure 32. Comparison of Caseload Compliance, by County

Percentage of case managers with caseloads within the standard; MP16 – 17 (September 30, 2024 and March 31, 2025)

Source: CAPSS data provided by DSS



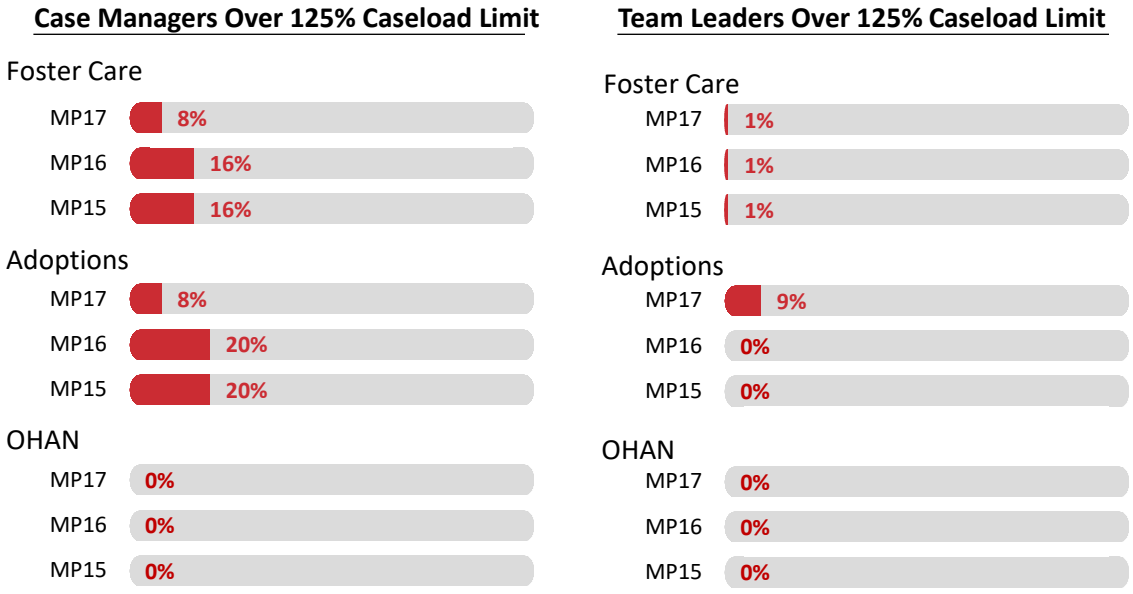
FSA Requirement	*No Worker or Worker's supervisor shall have more than 125% of the applicable Workload Limit* (FSA IV.A.2.(c)).
Performance Assessment	**FSA Requirement Not Met:** Number of case managers and team leaders over 125% of the standard - OHAN case managers **0 (of 30)|** OHAN team leaders **0 (of 7)** Foster care case managers **26 (of 312) |** Foster care team leaders **1 (of 130)** Adoptions case managers **8 (of 96) |** Adoptions team leaders **2 (of 23**)

The FSA requires that case managers and team leaders do not carry caseloads over 125 percent of the applicable caseload limit. On March 31, 2025, no OHAN case manager had a caseload over 125 percent of the applicable caseload limit; eight percent of both foster care case managers (26 of 312) and adoptions case managers (8 of 96) had caseloads over 125 percent of the applicable limit. Performance improved for both foster care and adoptions case managers from the prior two monitoring periods (Figure 33). On March 31, 2025, no OHAN team leader had a caseload over 125 percent of the applicable limit, while one percent of foster care team leaders (1 of 130) and nine percent of adoptions team leaders (2 of 23) had caseloads over 125 percent of the applicable limit. For adoptions team leaders, this represents a slight decrease in performance over the last two monitoring periods when no adoptions team leaders (0 out of 23) had a caseload over 125 percent of the limit (Figure 33).

Figure 33. Case Managers and Team Leaders with More than 125% of the Workload Limit

March 31, 2025

Source: CAPSS data provided by DSS



Discussion

DSS continued to have an overall improvement in the number of case managers and team leaders with caseloads within the required limits. In part, the continued downward trend in the number of children in foster care in South Carolina and the steady increase in the number of adoptions has contributed to this. In addition, the State has continued to invest in its workforce, with foster care and OHAN staff growing from 393 in March 2024 to 410 in September 2024 and 438 in March 2025.[103]

Most counties with significant improvement in caseload compliance experienced either no change or an increase in the number of case managers assigned to the county office. Richland County's foster care case manager workforce increased by 18 workers and the rate of case managers within the caseload standard doubled. The two counties that showed a decrease in performance since the prior monitoring period had six (Spartanburg) and three (Greenville) fewer case managers, respectively.

DSS has made significant progress since the inception of the lawsuit toward hiring and training workers and reducing worker turnover, aided by implementation of the court-ordered salary plan which has helped to raise worker compensation. Despite this significant progress, there remain challenges in creating and sustaining a skilled and stable workforce and in ensuring that all workers have caseloads that permit them to practice in accordance with DSS's GPS Case Practice Model. Case practice challenges include mentoring and training case managers to work as a team engaging children, families, and others who support them, and assessing the underlying needs of children and families so that interventions can be appropriately tailored to meet those needs.

To address these challenges, DSS reported in its March 14, 2025 Data Submission to the Court that it had invested in an array of activities aimed at supporting new and existing staff.[104] Efforts to recruit new staff included attending job fairs, conducting hiring blitzes, and working to finalize and implement the DSS Referral Bonus Program which identifies hard-to-fill positions as bonus-eligible. In addition, there were 41 interns within Child Welfare Services throughout the state for the Spring 2025 semester. Efforts aimed at staff retention included counseling services and trauma support; (compensated) peer support and mentoring to bolster growth and development of new staff; and the implementation of a telecommuting program that reported participation of 2,463 DSS employees. Further, DSS has allocated funding to increase recruitment and retention through tuition assistance and reimbursement programs.

Another strategy DSS has reported that promotes staff retention is the implementation of Regional Support Teams, aimed at balancing the workload of county case managers. These teams travel to counties experiencing spikes in turnover and/or high caseloads to provide support with making contacts with children, facilitating visitation, family search and engagement, and transportation. In March 2025, DSS reported 224 transportation requests from the Regional

[103] CAPSS data provided by DSS.
[104] Letter from J. Michael Montgomery Providing Information Required by October 18, 2024, Order (EFC 330) prior to March 21, 2025 Status Conference (March 14, 2025, Dkt.354).

Support Teams and of those, 149 (67%) were completed. Private contractors providing 24/7 service statewide received 1,095 requests in March 2025 and completed 1,044 (95%).

The ongoing placement instability crisis, in Richland County and across the state, has also increased the demands on case managers who must handle the stress and workload involved with children who do not have stable placements. Such demands include late-night hours requiring staff to respond to and transport children without placement, sometimes shuttling children to and from night-to-night emergency placements, which creates an additional burden on staff and places children in harm's way. To address the implications of these late-night work hours on staff wellness and address the goals as outlined in the Richland County Improvement Plan, DSS hired case management staff specifically dedicated to working eight-hour shifts that fall outside of normal business hours.[105] DSS continues to utilize volunteer "on call" case management staff to cover weekend shifts but reported it has increased the rate of pay when staff are on "standby."

[105] Letter from J. Michael Montgomery with Richland County DSS Improvement Plan, with Appendix A. Richland County Task Force Slide Deck (May 19,2025, Dkt.364).

2. Case Manager Contacts with Children

FSA Requirement	At least 90% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place (FSA IV.B.2.).
Performance Assessment	**FSA Requirement Not Reported:** Reporting on this provision was suspended in October 2021 and has not yet resumed.

FSA Requirement	At least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child (FSA IV.B.3.).
Performance Assessment	**FSA Requirement Not Reported:** Reporting on this provision was suspended in October 2021 and has not yet resumed.

In October 2021, after years of consistently low performance and poor documentation on contacts between case managers and children, and upon agreement of all the Parties, the Co-Monitors suspended case record reviews and reporting on these measures. The Parties agreed that reviews would be paused for at least four monitoring periods, or until DSS's internal data indicate there has been substantial increase in performance. Case reviews to assess if case manager contacts with children meet FSA requirements have not yet resumed, as DSS has not reported improvements to prior performance.[106] The Co-Monitors intend to resume the case reviews on this requirement during the next monitoring period and will work with DSS staff to carry this out.

[106] To view the Visitation Implementation Plan, see: https://dss.sc.gov/media/4evhcpky/3-28-2019-final-dss-visitation-implementation-plan.pdf.

C. Intakes and Investigations of Alleged Abuse and Neglect in Out-of-Home Care

Ensuring the safety and well-being of children in foster care is a primary obligation of any child welfare system. This obligation is recognized by FSA requirements for the timely and appropriate screening and investigation of allegations of abuse and/or neglect of children in foster care. In South Carolina, DSS's Intake Hub screens all reports of abuse and neglect and assigns allegations against a caregiver of a child in foster care to the Out-of-Home Abuse and Neglect (OHAN) unit for investigation.[107]

In October 2024, the Court found that DSS had made sufficient improvement to terminate its jurisdiction over four FSA provisions regarding allegations of institutional abuse and neglect; consequently, performance on those requirements is no longer monitored or reported.[108] Performance on the remaining four OHAN FSA requirements continues to be assessed through twice-yearly case record reviews.

1. Timely Initiation of Investigation and Timely Face to Face Contact with the Alleged Victim

FSA Requirements	*The investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations* (FSA IV.C.4.(a)) [and] *[t]he investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors* (FSA IV.C.4.(b)).
Performance Assessment	**FSA Requirements Met**: **95%** of OHAN investigations were initiated in 24 hours of DSS's receipt of the report and included a face-to-face contact with the alleged victim within 24 hours.

The FSA requires that at least 95 percent of referrals of abuse or neglect of children in DSS custody are initiated within 24 hours (FSA IV.C.4(a)) and that the investigation includes face-to-face contact with the alleged victim within 24 hours, with approved exceptions for good faith efforts, in at least

[107] SC Code § 63-7-1210 (2024); SC DSS Child Welfare Policies and Procedures Manual, Chapter 13: Out of Home Abuse and Neglect (OHAN) Investigations (effective September 18, 2024).
[108] See Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt.329), terminating jurisdiction over the following FSA OHAN provisions: (1) Intake – Decision Not to Investigate (FSA IV.C.2.); (2) Timely Completion of Investigation Within Forty-five (45) Days of Initiation (FSA IV.C.4(d)); (3) Timely Completion of Investigation Within Sixty (60) Days of Initiation (FSA IV.C.4(e)); and (4) Timely Completion of Investigation Within Ninety (90) Days of Initiation (FSA IV.C.4(f)).

95 percent of investigations (FSA IV.C.4(b)).[109,110] The Co-Monitors measure performance for both FSA requirements IV.C.4.(a) and (b) using the same methodology and timeframes, requiring face-to-face contact with the alleged child victim within 24 hours of receiving a report. The Co-Monitors and DSS staff review records of all investigations assigned to OHAN in the last month of the monitoring period (March 2025) to report on performance.

In March 2025, OHAN received 37 referrals involving Class Members. Case managers met with all alleged victim children within 24 hours in 34 investigations, and in one additional investigation, all applicable good faith efforts were made to contact each of the alleged victim children. Therefore, 35 of 37 investigations (95%) were initiated timely, including face-to-face contact with alleged victims (Figure 34). The State met the FSA requirements IV.C.4.(a) and (b) this monitoring period, and these measures may be eligible for Maintenance of Effort designation.

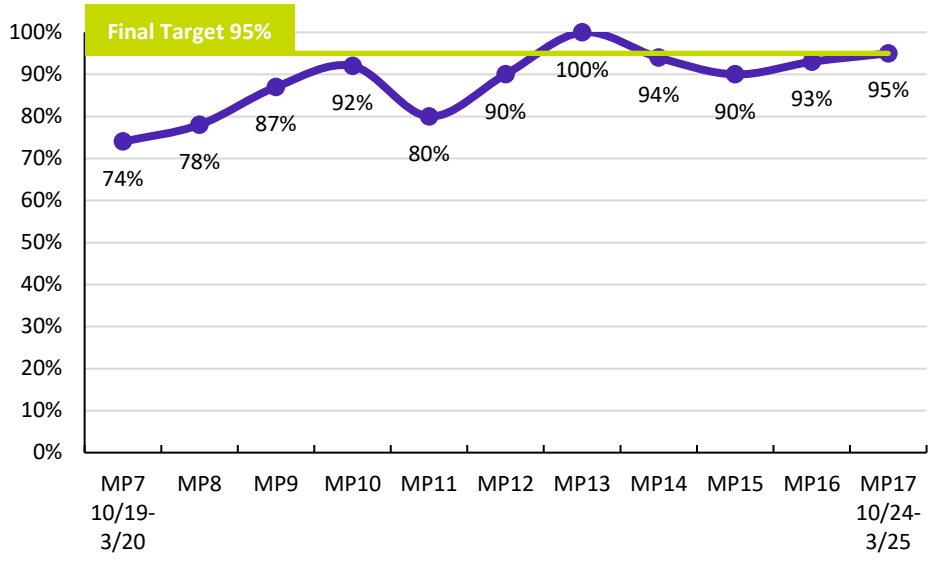
[109] On September 24, 2024, the Co-Monitors and the Parties agreed that for the purposes of the review, OHAN case managers would have a maximum of two additional hours from the time of the receipt of the report to initiate the investigation, including making face-to-face contact with the alleged victim child(ren) (i.e., OHAN case managers would have up to 26 hours from the receipt of a report to initiate the investigation). During MP17, 35 of 37 investigations were initiated within 26 hours of the receipt of the report; 31 of the 37 investigations were initiated within 24 hours of DSS's receipt of the report and an additional 4 of the 37 investigations were initiated within 26 hours, including one investigation where good faith efforts were made to initiate.

[110] The Co-Monitors approved the following efforts as "good faith efforts" for timely initiation which must be completed and documented, as applicable, to make contact with an alleged victim child(ren) within 24 hours: case manager attempted to see child(ren) at school or child care facility; case manager attempted to see child(ren) at doctor's visit or hospital; child(ren) moved to an out-of-state location in order to receive specialized treatment, case manager attempted to interview by virtual means; case manager attempted to see child(ren) at the police department; case manager attempted to attend forensic/Child Advocacy Center interview; case manager attempted to see child(ren) at therapist's office; case manager contacted the assigned foster care case manager(s) and/or team leader(s); case manager attempted to contact the parent/guardian of the victim child(ren) if the child(ren) has returned home; and case manager attempted to contact the child at all foster care placements where the child may temporarily be placed in the first 24 hours. Additionally, the following extraordinary circumstance exceptions to timely initiation were approved by the Co-Monitors: child was returned to biological family prior to report and family refuses contact; child is deceased; law enforcement prohibited contact with child(ren); facility restrictions due to child's medical requirements; natural disaster; and child missing despite efforts to locate (efforts should include all applicable good faith efforts).

Figure 34. OHAN Investigations with Timely Initiation and Face-to-Face Contact with Alleged Victims

MP7 - 17 (October 2019 – March 2025)

Source: Case record reviews completed by University of South Carolina Center for Child and Family Studies (up to September 2021), DSS, and co-monitor staff



2. Contact with Core Witnesses

FSA Requirement	*Contact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors* (FSA IV.C.4.(c)).
Performance Assessment	**FSA Requirement Not Met**: Contact was made with all necessary core witnesses in **86%** of investigations.

The FSA requires that DSS contact core witnesses in at least 90 percent of investigations of a referral of institutional abuse or neglect, with exceptions approved by the Co-Monitors (FSA IV.C.4(c)).[111] A core witness is defined as an individual who is pertinent to the investigation because they witnessed or have knowledge of the alleged actions and can shed light on the allegations and the actions of the alleged perpetrators.[112] Core witnesses may differ from investigation to investigation, but in all cases include alleged child victim(s); reporter(s); alleged perpetrator(s); law enforcement, when involved; the child's DSS case manager; and other adult(s) and/or child(ren) in the home. If the allegations involve an institutional setting, all other adults and children relevant to the investigation are also considered core witnesses. Performance on this FSA requirement is determined by a review of all OHAN investigations involving Class Members that were initiated in the last month of the monitoring period.

Of the 37 investigations initiated in March 2025 and reviewed by the Co-Monitors and DSS, 32 (86%) records contained documented contact with all necessary core witnesses during the investigation, a significant improvement from 75 percent during the prior MP16 review (Figure 35). Figure 36 shows the frequency of contact within all categories of core witness for investigations initiated in March 2025 (MP17) compared to the prior review of investigations in September 2024 (MP16). There was a marked improvement in the percentage of contact with law enforcement witnesses which rose from 73 percent in MP16 to 100 percent in MP17. Overall, however, the State came close but did not meet the FSA requirement for contacts with core witnesses in 90 percent of institutional abuse or neglect investigations during MP17.

[111] The following are exceptions approved by the Co-Monitors to the requirement that the case manager contact a core witness during an investigation: witness refused to cooperate; witness advised by counsel or law enforcement that interview could not occur (e.g., due to pending charges, lawsuit); witness is deceased; unable to locate or identify witness; and medical conditions prevented witness from cooperating. In all instances, the exception must be supported by documentation of the exception and best efforts to engage the witness.

[112] Out of Home Abuse and Neglect Implementation Plan, pg. 4; see https://dss.sc.gov/media/oagnwbjr/michelle-h-2017-approved-ohan-section-of-august-9-implementation-plan-su.pdf

Figure 35. OHAN Investigations with Contact with All Necessary Core Witnesses

MP7 - 17 (March 2020 – March 2025)

Source: Case record reviews completed by University of South Carolina Center for Child and Family Studies (up to September 2021), DSS, and co-monitor staff

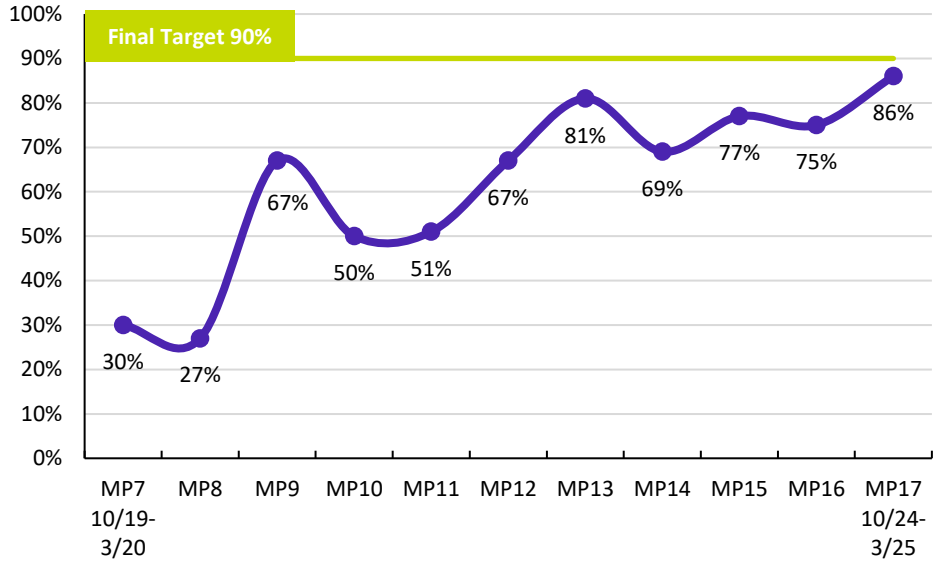
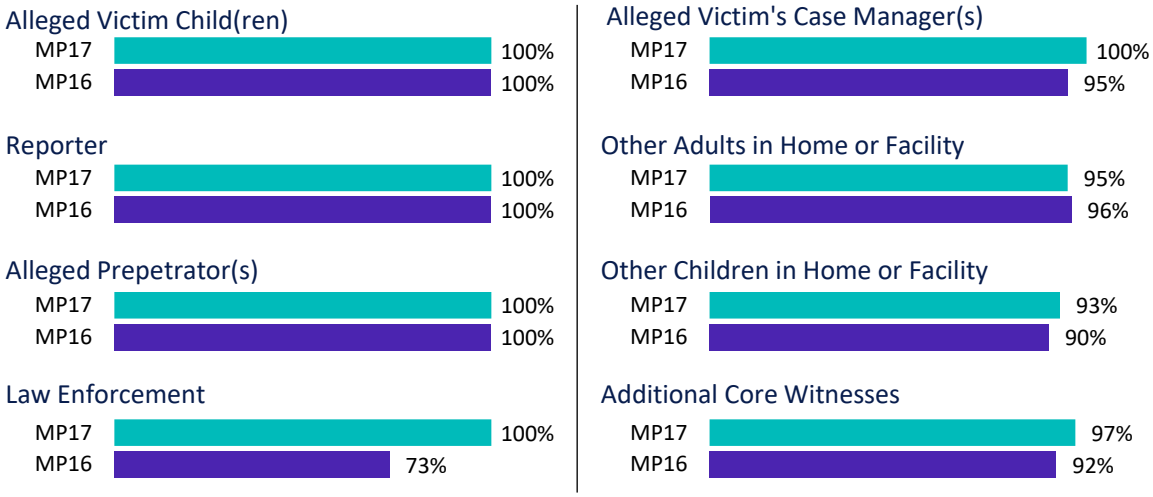


Figure 36. Frequency of OHAN Investigation Contacts by Witness Type[113]

MP16 (September 2024) compared to MP17 (March 2025)

Source: Case record reviews completed by DSS and co-monitor staff



[113] Good faith exceptions were applied as follows: reporter (2 of 31); alleged perpetrator(s) (2 of 37); law enforcement (2 of 15); other adults in the home or facility (1 of 33); other children in the home or facility (2) of 28); and additional core witnesses (4 of 32).

3. Investigation Decisions

FSA Requirement	*At least 95% of decisions to "unfound" investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected* (FSA IV.C.3.).
Performance Assessment	**FSA Requirement Met**: **97%** of decisions to "unfound" investigations of referrals for institutional abuse or neglect were determined to be appropriate.

The FSA requires that 95 percent of decisions to "unfound" allegations of institutional abuse and neglect be based on DSS ruling out abuse or neglect or determining that an investigation did not produce a preponderance of the evidence that a Class Member was abused or neglected (FSA IV.C.3.).[114]

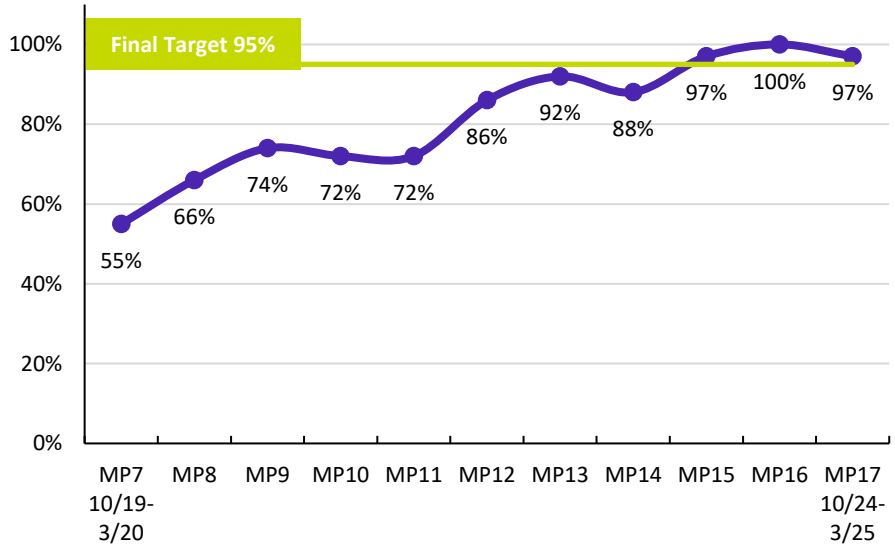
In 32 of the 37 OHAN investigations initiated in March 2025 and reviewed by the Co-Monitors and DSS, the final decision was to unfound allegations of abuse and neglect. Reviewers agreed that the decision to unfound was appropriate in 97 percent (31 of 32) of the investigations (Figure 37). This is the third consecutive monitoring period in which the State's performance has met and exceeded the final target of 95 percent, and this measure may be eligible for Maintenance of Effort designation.

[114] DSS policy provides that a decision to "indicate" or "unfound" allegations of abuse and neglect at the conclusion of an investigation be based upon the totality of information collected, with facts supported by a preponderance of the evidence. SC DSS Child Welfare Policies and Procedures Manual, Chapter 13: Out of Home Abuse and Neglect (OHAN) Investigations (effective September 18, 2024).

Figure 37. Appropriate Decisions to Unfound OHAN Investigations

MP7 - 17 (March 2020 – March 2025)

Source: Case Record Reviews completed by University of South Carolina Center for Child and Family Studies (up to September 2021), DSS, and co-monitor staff



Discussion

DSS continues to show consistent practice, efforts, and decision making in investigating allegations of institutional abuse and neglect of Class Members. Results from the review of OHAN investigations initiated in March 2025 show that DSS met FSA targets and may be eligible for Maintenance of Effort designation, for: (1) timely initiation of investigations (FSA IV.C.4.(a)), (2) timely face-to face contact with alleged child victims (FSA IV.C.4.(b)), and (3) appropriate decision-making regarding investigatory findings (FSA IV.C.3.). Though the State did not meet the FSA target for contact with core witnesses, performance improved from 75 to 86 percent over the prior period (FSA IV.C.4.(c)).

D. Family Connections

If children who enter foster care are to successfully reunify with their families, it is essential that they have meaningful contact with their parent(s), siblings, and relatives while they are apart. Regular, frequent, and dedicated time with family members should occur, ideally, in comfortable settings. As needed and appropriate, family visits may be unsupervised, supervised, or monitored by a case manager or other designated person, including a relative, foster parent, or clinician. Family visits keep connections vibrant, alleviate the trauma of separation, and provide opportunities for parents and children to stay engaged, learn, and heal.

1. Children's Visits with Their Parents

FSA Requirement	*At least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought, unless (1) there is a court order prohibiting visitation or limiting visitation to less frequently than twice very month; or (2) based on exceptions approved by the Co-Monitors* (FSA IV.J.3.).
Performance Assessment	**FSA Requirement Not Met**: **55%** of children had the required number of visits with parents.

The FSA requires that at least 85 percent of Class Members with the goal of reunification have in-person visits twice each month with the parent(s) with whom reunification is sought.[115] DSS's Foster Care Visitation Policy states that within 30 days of a child entering foster care, a visitation

[115] The following are exceptions approved by the Co-Monitors to the parent-child visitation requirement: court order prohibits or limits parent visitation; parent is missing or child is on runaway during a calendar month with best efforts to locate; parent or child is incarcerated in or in a facility that does not allow visitation in the calendar month despite best efforts; parent refused to participate despite best efforts; parent did not show up to visit(s) despite attempts to successfully arrange and conduct the visit(s); parental rights were terminated in that month; parent visit is infeasible due to geographic distance, with efforts to provide alternative forms of contact (geographic distance will only be allowed as an exception upon individual review of the applicable case by the Co-Monitors); County Director approval with legal consultation for determination that a visit poses immediate safety concerns for the child (if an immediate safety incident or concern occurs prior to or during a visit, the case manager is to remove the child from the visit and notify the County Director afterward); and team leader approval for determination that visitation would be psychologically harmful for the child. A DSS team leader must confirm the determination that visitation would be psychologically harmful to the child based upon written documentation of clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and who is not an employee of DSS. The LPHA's name, professional title, signature, and date must be listed on the document to confirm the clinical decision. In all instances, the exception must be supported by documentation of the exception reason and best efforts to foster time between the parent and child.

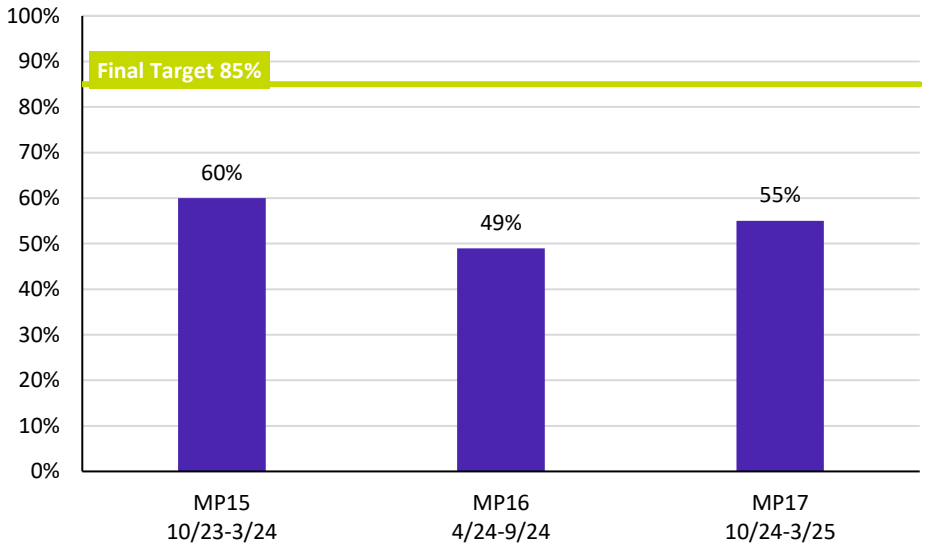
plan must be created collaboratively with the child and family team.[116,117] Unless required by court order, visitation should not be less than twice monthly, with other communication (e.g., text messages, phone calls, etc.) allowed and encouraged as appropriate.

Reviews of CAPSS documentation for the last month of the monitoring period are conducted to determine performance. As of March 31, 2025, there were 1,440 children who had been in foster care for at least 30 days with a permanency goal of "Reunification," "Extension for Reunification," or "Not Yet Established." A sample of 304 cases from this universe was reviewed.[118] Upon review, DSS and co-monitor staff determined that there were 41 cases for which an approved exception applied to both required monthly visits with the parent(s) with whom reunification was sought. Removing these 41 cases resulted in a representative sample of 263 cases; results from the case record review found that 55 percent (144) of these 263 cases met the standard of the child visiting twice with the parent(s) with whom reunification was sought. While performance on this FSA target has increased from 49 percent in MP16 to 55 percent in MP17, it continues to fall significantly below the FSA target of 85 percent (Figure 38). An intensified focus on improving the rates of visitation between children in foster care and their parents must be a priority as maintaining those connections is essential for reunification and healing.

Figure 38. Parent-Child Visits

Percentage of Class Members visiting with their parent(s) at least twice a month (March 2024 – March 2025)

Source: Case Record Reviews completed by DSS and co-monitor staff



[116] Child Welfare Services Manual, Chapter 5, Section 510.7.3 Family Visitation (effective February 22, 2022).
[117] To view the Visitation Implementation Plan, see: https://dss.sc.gov/media/4evhcpky/3-28-2019-final-dss-visitation-implementation-plan.pdf
[118] Based on a 95 percent confidence level and +/- 5% margin of error.

Discussion

In DSS's March 14, 2025 Data Submission to the Court, the agency reported working to increase contacts between children in foster care and their parents through several strategies, including the use of Regional Support Teams to provide as-needed assistance to counties with facilitating family visitation and transportation. During the period between May 2023 and February 2025, almost 30 percent of all transport requests were for family/sibling visits.[119] Additionally, DSS contracted with private providers to provide 24-hour, seven days per week emergency transportation support, of which almost 39 percent of requests from August 2024 through January 2025 were for parent visitation.[120]

DSS reported that The Child Welfare Operations Team, with support from ADR, examined the barriers to visitation beyond transportation through quarterly visitation meetings with frontline staff. In addition to these meetings, DSS recently began addressing low performance at the county level by implementing improvement plans in counties that have fallen below 60% on the monthly visitation reports. DSS reports it will be able to see the impact of this effort in the coming months. Given the low performance and the lack of significant progress over several monitoring periods, the Co-Monitors believe that DSS must continue to examine closely the reasons for this low performance and continue the work to develop improvement plans with poorly performing counties.

[119] Letter from J. Michael Montgomery Providing Information Required by October 18, 2024, Order (EFC 330) prior to March 21, 2025 Status Conference (March 14, 2025, Dkt.354).
[120] Ibid.

2. Sibling Connections

Placement of Children with Their Siblings

FSA Requirements	*At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with at least one of their siblings* (FSA IV.G.2.) [and] [a]*t least 80% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with* all *their siblings* (FSA IV.G.3.).
Performance Assessment	**FSA Requirements Not Met**: **76%** of children who entered foster within 30 days of their siblings were placed with at least one of their siblings and **49%** were placed with all of their siblings.

When Class Members enter care with or within 30 days of their siblings, the FSA requires that at least 85 percent be placed with *at least one* of their siblings (FSA IV.G.2.) and that at least 80 percent be placed with *all* of their siblings (FSA IV.G.3.).[121,122] Performance is measured based on whether a child is placed with their sibling(s) 45-days after entering foster care. Between October 2024 and March 2025, 76 percent (472 of 621) of children who entered foster care with or within 30 days of their siblings were placed with *at least one* of their siblings (Figure 39), and 49 percent (303 of 621) of children were placed with *all* of their siblings (Figure 40). Although performance improved since the last monitoring period, the State did not meet either FSA requirement in MP17.

[121] The term "siblings" is defined as "[c]hildren in foster care who have one or more parents in common either biologically, through adoption, or through marriage of their parents, and with whom the child lived before their foster care placement" (Placement Implementation Plan,) pg. 58; https://dss.sc.gov/media/cgnjurvv/dss-placement-implementation-plan.pdf.

[122] The FSA allows for the following exceptions to the placement of children with their siblings: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors (FSA IV.G.2 & 3.). No exceptions were applied during MP17; therefore, actual performance may be higher than reported. DSS will develop a process for review and approval of exceptions in a future monitoring period.

Figure 39. Placement of Children Entering Foster Care with at Least One Sibling

MP10 – 17 (April 2021 – March 2025)

Source: CAPSS data provided by DSS

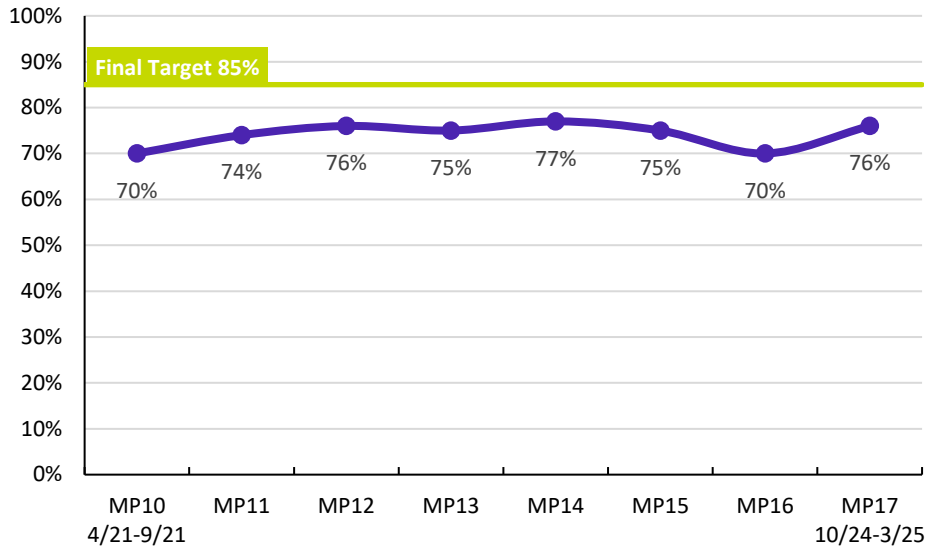
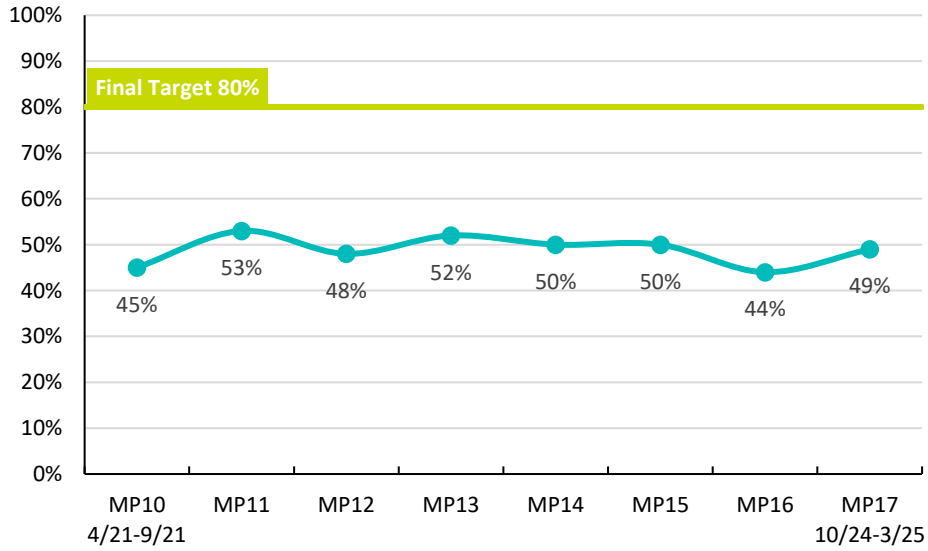


Figure 40. Placement of Children Entering Foster Care with All Siblings

MP10 – 17 (April 2021 – March 2025)

Source: CAPSS data provided by DSS



Children's Visits with Their Siblings

FSA Requirement	*At least 85% of the total minimum number of monthly sibling visits for all sibling not living together shall be completed, with exceptions when (1) there is a court order prohibiting visitation or limiting visitation to less frequently than once every month; (2) visits are not in the best interests of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) with exceptions approved by the Co-Monitors* (FSA IV.J.2.).
Performance Assessment	**FSA Requirement Not Met**: **84%** of children had the required number of visits.

The FSA requires that at least 85 percent of monthly sibling visits for all siblings occur. Assessing performance on this target is done through a combination of results from a SafeMeasures® visitation report and a case review of CAPSS documentation.[123] SafeMeasures® reliably reports sibling visits that occur but does not account for whether there was an approved exception for a sibling visit when a visit does not occur. DSS and co-monitor staff review, from a statistical sample, each case in which a visit did not occur to determine whether an exception for a visit applies.[124,125]

[123] For more information on SafeMeasures®, see: https://evidentchange.org.

[124] The following are exceptions approved by the Co-Monitors to the sibling visitation requirement: court order prohibits or limits sibling visitation; child or sibling is on runaway during a calendar month with best efforts to locate; child or sibling is incarcerated or in a facility that does not allow visitation despite efforts; child or sibling refuses to participate in the visit, where age appropriate; sibling visit is infeasible due to geographic distance with efforts to provide alternative forms of contact (geographic distance will only be allowed as an exception upon individual review of the applicable case by the Co-Monitors); County Director approval with legal consultation for determination that a visit poses immediate safety concerns for the child or sibling (if an immediate safety incident or concern occurs prior to or during a visit, the case manager is to remove the child from the visit and notify the County Director afterward); and team leader approval for determination that visitation would be psychologically harmful for the child. A DSS team leader must confirm the determination that visitation would be psychologically harmful to the child based upon written documentation of a clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and who is not an employee of DSS. The LPHA's name, professional title, signature, and date must be listed on the document to confirm the clinical decision. In all instances listed above, the exception must be supported by documentation of the exception reason and best efforts to foster time with sibling(s).

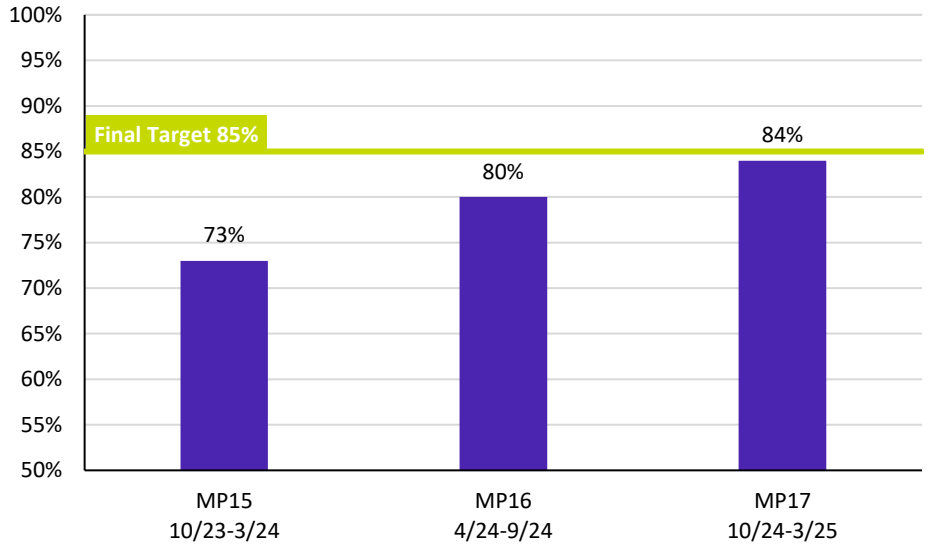
[125] For the purposes of the review, "siblings" are defined as Class Members who entered foster care within 30 days of each other and resided apart the entire month. Class Members who resided out of state during the month are excluded from the analysis.

DSS generated a universe of 1,951 sibling pairs of children meeting the definition of sibling and pulled a statistically valid sample of 320 sibling pairs.[126,127,128] The SafeMeasures® report indicated that 240 of 320 sibling pairs visited each other in March 2025, and 80 did not. Results from the record review of those 80 sibling pairs without a required visit concluded that three sibling pairs met criteria for an approved exception to a visit during the month, lowering the overall sample total from 320 to 317.[129] Findings further determined that 26 of the 80 sibling pairs were incorrectly identified as not having had a visit in March 2025 when one did occur. This resulted in a final performance of 84 percent of sibling pairs (266 of 317) who had the required visits with their siblings in March 2025. While the State has not yet met the FSA target of 85 percent, performance has improved and is very close to meeting the FSA requirement (Figure 41).

Figure 41. Sibling Visits

Percentage of Class Member sibling pairs visiting at least once a month (March 2024 - March 2025)

Source: Case record reviews completed by DSS and co-monitor staff



[126] Based on a 95 percent confidence level +/- 5% margin of error.
[127] A child is counted for every sibling for whom they should have visitation; therefore, a child may be included multiple times in a month.
[128] In the process of the review, two child pairs were identified to be duplicates and were eliminated from the original sample of 322, bringing the final sample size to 320. Data are from a CAPSS record review conducted by Co-Monitor and DSS staff of a statistically valid sample designed to produce results at a 95% confidence level with a +/- 5% margin of error.
[129] All three exceptions identified during March 2025 were due to documented instances of one or both children refusing to participate.

Discussion

Being separated from family is a life-altering event for a child. The placement of children with their siblings is of the highest priority, and when that is not possible, it is imperative that DSS ensure consistent visits between siblings. DSS has made significant progress towards these ends and improved its performance in placing siblings together over the prior monitoring period but still falls short of reaching the FSA targets, especially in its placement of all siblings together. For those children who are not placed together, the State's performance in ensuring sibling visits are occurring as required has improved, and in March 2025, was one percent below the final target of 85 percent.

The Co-Monitors conducted a focus group with youth in foster care to gauge the importance of sibling connections and heard familiar themes.

> *How can I maintain a relationship with my siblings if we are all spread out in different regions?*
>
> *We were originally placed together. However, once he got kicked out, I didn't see him until I was able to get a car and drive myself.*

E. Health Care

Child welfare systems must provide children in foster care with the support and services they need to be healthy. This requires the ability to quickly identify children's health needs, to provide high quality preventative and acute care, and to maintain a system for both tracking care delivery and communicating key health care information. The responsibility of delivering health care to children in foster care is a legal responsibility of the State in accordance with federal Medicaid mandates for Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) for all children who are eligible for Medicaid, which includes children in foster care. Guidance issued on September 26, 2024, by the Centers for Medicare and Medicaid (CMS) affirms this obligation to children to provide treatment to meet their physical, developmental, mental, and behavioral health needs; it supports states as they work to strengthen their implementation of EPSDT requirements and ensure health outcomes for children enrolled in Medicaid.[130]

The FSA requires the development of a Health Care Improvement Plan with enforceable dates and targets for phased implementation of initial and periodic screening services, documentation, and health care services for Class Members in the areas of physical health, immunizations and laboratory tests, mental health, developmental and behavioral health, vision and hearing, and dental health. The Plan shall address:

> (a) developing the capacity to track screening and treatment services for individual children and aggregate tracking data, including but not limited to screens that are due and past due;
>
> (b) assessing the accessibility of health care screening and treatment services throughout the state, including the capacity of the existing health care providers to meet the screening and treatment needs of Class Members; and
>
> (c) identifying baselines and interim percentage targets for performance improvement in coordinating screens and treatment service (FSA IV.K.1.(a-c)).

The Health Care Improvement Plan, FSA Health Care Outcomes, and the Health Care Addendum, approved by the Co-Monitors and the Court on August 23, 2018, December 21, 2018 and February 25, 2019, respectively, established commitments to outcomes and a framework for care coordination involving distinct, interrelated roles for the DSS Office of Health and Well-Being, DSS case managers, SC DHHS and its private managed care organization (MCO) care coordinators, and foster caregivers and families.[131] The Plan, Outcomes, and Addendum were approved and ordered

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[130] To view the Centers for Medicare & Medicaid's new guidance in the form of a State Health Official letter entitled Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements, see: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf

[131] To view the Health Care Improvement Plan, see: https://dss.sc.gov/media/nesgioju/8-23-2018-final-approved-dss-health-care-implementation-plan.pdf. The FSA Health Care Outcomes is available at: https://dss.sc.gov/media/c3ig211y/appendix-b-final-health-care-targets.pdf. The Health Care Addendum is available at: https://dss.sc.gov/media/0bdpenal/2-25-2019-approved-health-plan-addendum.pdf.

by the Court with the understanding that additional details would be determined during implementation and that the efficacy and adequacy of the model and methodology for measuring outcomes would be assessed on an ongoing basis to determine what changes or additions are needed.

More than five years later, DSS does not yet have the capacity to produce aggregate health care data related to initial medical screens, mental health assessments (following a screening which identified a need for such an assessment), and follow-up care.[132,133,134] Thus, the Co-Monitors are unable to assess performance in those areas. As noted in previous monitoring reports, the Co-Monitors and DSS have been engaged in discussions about reassessing the approved methodologies for measuring health care outcomes related to periodic preventive care given the shared goal of efficiently and effectively producing timely performance data that can be used for public and court accountability purposes, and for day-to-day management and quality improvement. Performance on periodic preventive visits is not assessed, but available DSS data related to these outcomes are provided.

Initial Medical Screens

FSA Requirement	*At least 90% of Class Members will receive an initial medical screen prior to initial placement or within 48 hours of entering care. (*FSA IV.K.5; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirement Not Reported:** Data are not available.

Performance on this FSA requirement is not reported because DSS does not yet have the capacity to produce aggregate health care data related to initial medical screens.

[132] DSS ADR is currently working with CAPSS IT to extract data collected from the completion of the Family Advocacy and Support Tool (FAST) medical module to potentially utilize for this purpose.
[133] DSS has provided data on the total number of children who receive mental health assessments, but those assessments are not necessarily tied to an identified need for a mental health assessment from a comprehensive medical assessment. DSS is not yet able to report data on the number of children receiving mental health assessments after the need for such an assessment has been identified. As a result, the Co-Monitors have not reported these data.
[134] DSS has proposed collecting additional qualitative information using a case review process to measure follow-up care, based on the instrument used for the federal Child and Family Services Review and is discussing potential approaches and review methodology with the Co-Monitors.

Comprehensive Medical Assessment

FSA Requirement	*At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care;* [and] *at least 95% will receive a comprehensive medical assessment within 60 days of entering care (*FSA IV.K.5; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirements Not Met**: **48%** of children received a comprehensive medical assessment within 30 days of entering care, and **67%** received a comprehensive medical assessment within 60 days of entering care.

In DSS's Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, DSS committed that children will receive a comprehensive medical assessment within 30 and 60 days of entering care.[135] DSS committed to achieving these targets by March 2021. Health care data reporting timelines are adjusted each monitoring period to accommodate delays in access to Medicaid administrative data. To provide the most up-to-date information, data on initial comprehensive medical visits are reported for all children who entered care between September 2024 and February 2025. Data included were extracted by DSS and SC DHHS from Medicaid administrative claims data and have not been validated by the Co-Monitors.

Of the 831 children who entered foster care between September 2024 and February 2025 and were in foster care for at least 30 days, 48 percent (399 of 831) received a comprehensive medical assessment within 30 days of entering care (Figure 42). Of those children who entered foster care during the months cited and who were in foster care for at least 60 days, 67 percent (414 of 618) received a comprehensive medical assessment within 60 days (Figure 43). Performance remains substantially below the final targets of 85 percent of children receiving an initial exam within 30 days and 95 percent of children receiving an initial exam within 60 days.

[135] To view the Health Care Outcomes, see: https://dss.sc.gov/media/c3ig211y/appendix-b-final-health-care-targets.pdf.

Figure 42. Comprehensive Medical Assessments within 30 Days

Percentage of Class Members who received a comprehensive medical assessment within 30 days of entering foster care; MP10 - 17 (April 2021 - February 2025)

Source: Medicaid claims data provided by DSS

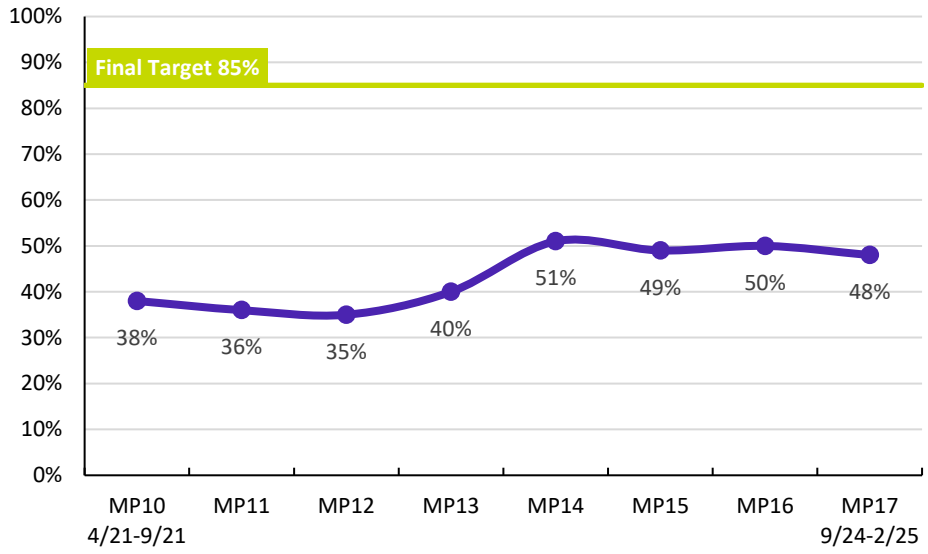
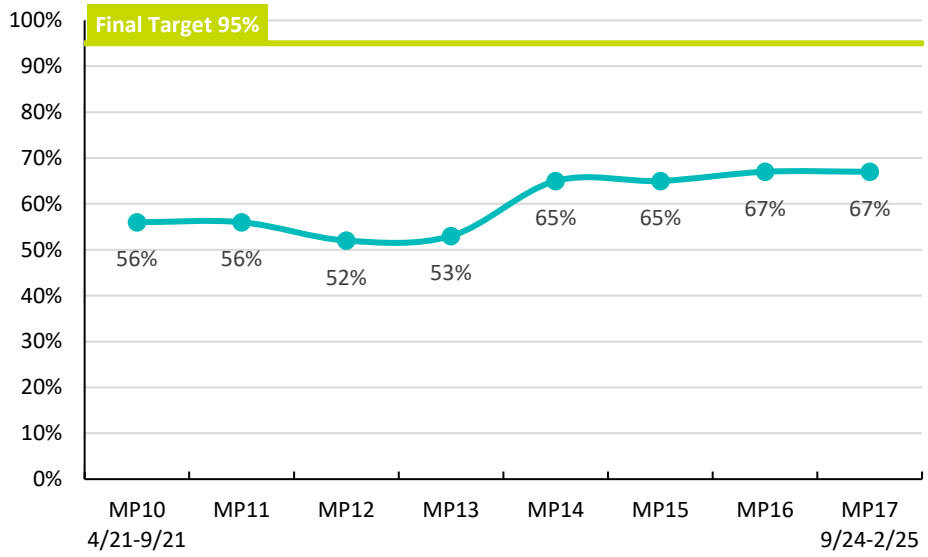


Figure 43. Comprehensive Medical Assessments within 60 Days

Percentage of Class Members who received a comprehensive medical assessment within 60 days of entering foster care; MP10 - 17 (April 2021 - February 2025)

Source: Medicaid claims data provided by DSS



Developmental Assessment

FSA Requirement	*At least 90% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 30 days of entering care;* [and] *at least 95% shall be referred within 45 days* (FSA IV.K.5; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirement Met**: **94%** of children under 36 months of age were referred to developmental assessments within 30 days of entering care, and **97%** were referred within 45 days of entering care.

In DSS's Health Care Outcomes, DSS committed to providing referrals for developmental assessment for children under 36 months of age within 30 days and 45 days of entering care.[136] DSS committed to achieving these targets by March 2021. DSS provides data from CAPSS on developmental assessment referrals for all children under 36 months of age who entered care during the monitoring period (October 2024 and March 2025). These data convey whether a child was referred for a developmental assessment and do not capture whether and when an assessment occurred.

According to DSS data, 94 percent (261 of 277) of children under 36 months of age who entered care in MP17 and who were in care for least 30 days were referred to BabyNet — the state entity responsible for developmental assessments — within 30 days of their entry into foster care (Figure 44); 97 percent (258 of 265) of children who were in foster care for at least 45 days were referred to BabyNet within 45 days. Performance continues to meet the final targets for this measure (Figure 45). On October 18, 2024, based on DSS achieving and demonstrating performance, the Court granted Maintenance of Efforts status for this measure.[137]

[136] To view the Health Care Outcomes, see: https://dss.sc.gov/media/c3ig211y/appendix-b-final-health-care-targets.pdf.

[137] Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt.329).

Figure 44. Developmental Assessments within 30 Days

Percentage of Class Members under 36 months of age who were referred for a developmental assessment within 30 days of entering care; MP10 - 17 (April 2021 - March 2025)

Source: CAPSS data provided by DSS

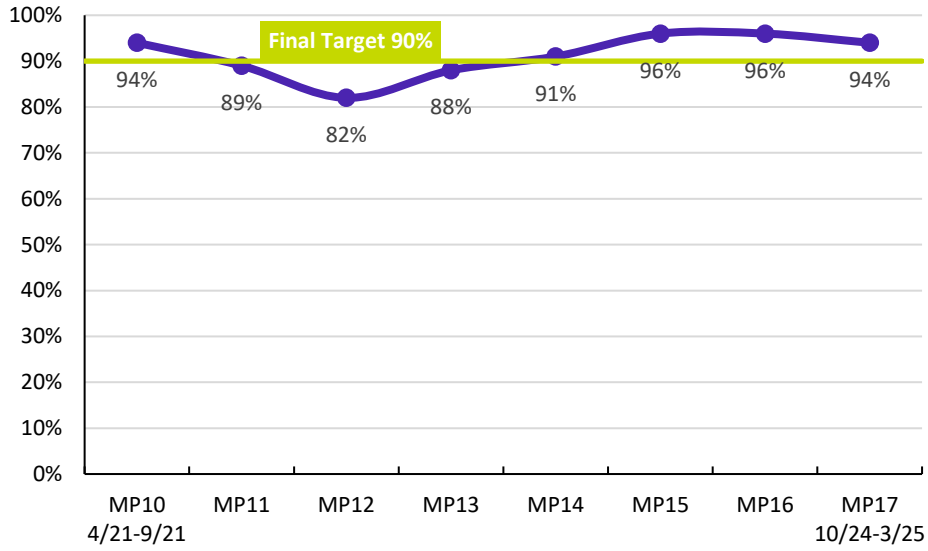
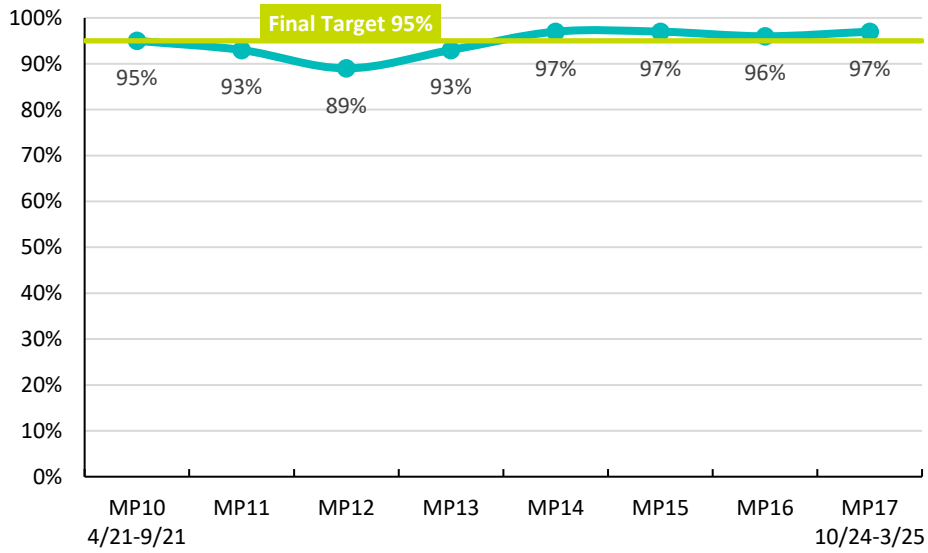


Figure 45. Developmental Assessments within 45 Days

Percentage of Class Members under 36 months of age who were referred for a developmental assessment within 45 days of entering care; MP10 -17 (April 2021 - March 2025)

Source: CAPSS data provided by DSS



Dental Examination

FSA Requirements	*At least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care;* [and] *at least 90% will receive a dental examination within 90 days of entering care* (FSA IV.K.5; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirement Partially Met**: **61%** of children aged two and above received a dental examination within 60 days of entering care, and **76%** of children aged two and above received a dental examination within 90 days of entering care.

In DSS's Health Care Outcomes, DSS committed that children ages two and above receive a dental exam within 60 and 90 days of entering care.[138] DSS committed to achieving these targets by March 2021. Health care data reporting timelines are adjusted each monitoring period to accommodate delays in access to Medicaid administrative data. To provide the most up-to-date information, data on initial dental visits are reported for all children who entered care between September 2024 and February 2025. Data included were extracted by DSS and DHHS from Medicaid administrative claims data and have not been validated by the Co-Monitors.

DSS reported that 61 percent (205 of 403) of children aged two and older who entered foster care between September 2024 and February 2025 and who were in foster care for at least 60 days had a dental exam within 60 days (Figure 46), and 76 percent (225 of 297) of children aged two and older who remained in care for at least 90 days had a dental exam within 90 days (Figure 47). Performance meets the target for dental examination within 60 days of entering foster care but does not meet the target of 90 percent of children receiving a dental examination within 90 days of entering foster care.

[138] To view the Health Care Outcomes, see: https://dss.sc.gov/media/c3ig211y/appendix-b-final-health-care-targets.pdf.

Figure 46. Initial Dental Examinations 60 Days

Percentage of Class Members aged two and older who received a dental examination within 60 days of entering care; MP10 - 17 (April 2021 – February 2025)

Source: Medicaid claims data provided by DSS

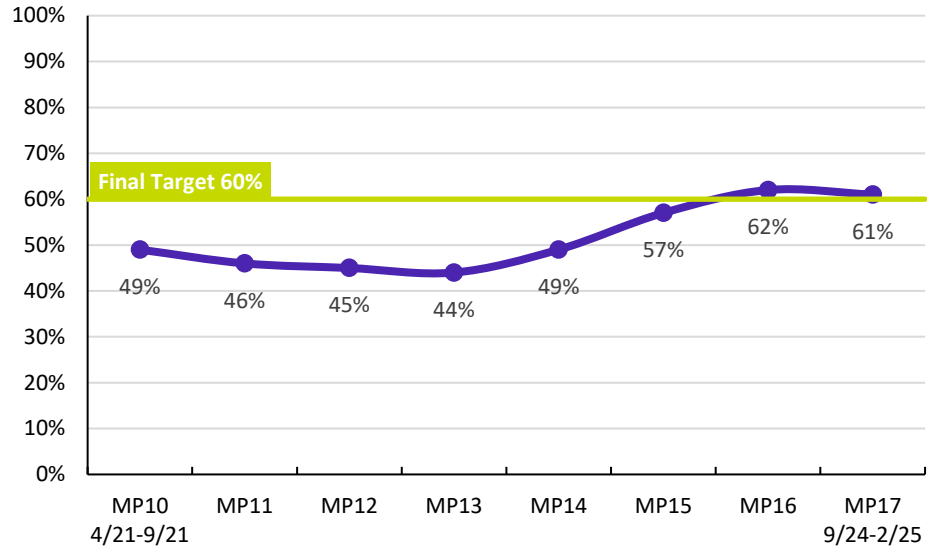
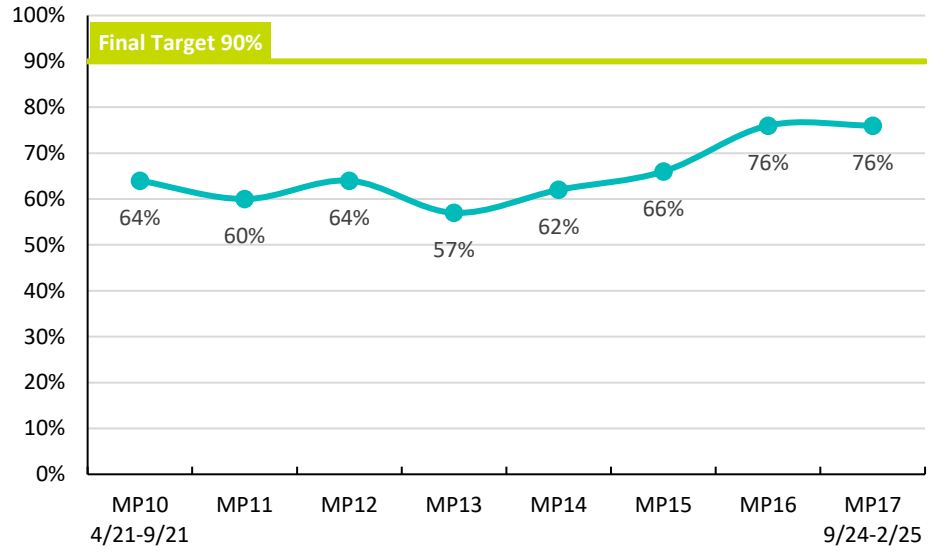


Figure 47. Initial Dental Examinations 90 Days

Percentage of Class Members aged two and older who received a dental examination within 90 days of entering care; MP10 - 17 (April 2021 – February 2025) [139]

Source: Medicaid claims data provided by DSS



[139] Please note, Figure 46 of the Michelle H. v. McMaster and Catone Progress Report: South Carolina Department of Social Services (April 1, 2024 – September 30, 2024) erroneously reported the MP16 performance data for Class Members ages two and older who received an initial dental examination within 90 days as 63%. Performance on this measure for MP16 was 76% and has been corrected in Figure 38.

Comprehensive Mental Health Assessment

FSA Requirement	*At least 85% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 30 days of the comprehensive medical assessment* [and] *at least 95% will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment* (FSA IV.K.5; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirement Not Reported:** Data are not available.

This FSA requirement is not reported because DSS does not yet have the capacity to produce aggregate health care data related to comprehensive mental health assessments.

Periodic Preventive Care

FSA Requirement	• *At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly.* • *At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics periodicity guidelines; and at least 98% will receive a periodic preventative visit semi-annually.* • *At least 90% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit semi-annually; and at least 98% will receive a periodic preventative visit annually* (FSA IV.K.5).
Performance Assessment	**FSA Requirement Not Reported:** Data are not available.

DSS committed in its Health Care Outcomes that children within its care receive periodic preventative medical visits in accordance with current American Academy of Pediatrics (AAP) periodicity guidelines.[140] DSS committed to achieving these targets by March 2021.

DSS and the Co-Monitors determined that the approved methodology did not produce

[140] To view the AAP Recommendations for Preventative Pediatric Health Care, see: https://publications.aap.org/pediatrics/article/155/5/e2025071066/200933/2025-Recommendations-for-Preventive-Pediatric .

information that DSS leadership, staff, and the field were able to use to improve health care delivery and outcomes for children in its care. As a result, performance for these FSA requirements is not reported. The Co-Monitors and DSS have been engaged in discussions about changing the approved methodology for measuring periodic preventive care given the shared goal of efficiently and effectively producing timely performance data that can be used for public and court accountability purposes, and for day-to-day management and quality improvement. Completing this work is a high priority for both DSS and the Co-Monitors.

While performance is not reported for these FSA requirements, related data provided by DSS that are used for day-to-day management and quality improvement are provided. These data are validated by DSS regional nurses who review CAPSS for encounters entered by case managers and after-visit summaries completed by doctors. Data are also cross-checked with administrative data from DHHS and its MCO partner.

DSS reported that of all children 17 years and younger who were in foster care for at least 30 days, 64 percent (1,879 of 2,932) were up to date on their well-child visits as of March 2025 (Figure 48). Of the remaining children, 35 percent (1,023) were past due for their well-child visits, and 30 children (1%) did not have a well-child visit on record. These data are also reported to the Co-Monitors by the age of the children (Figure 49). As determined by DSS, 25 percent of children under six months of age were up to date on their well-child visits as of March 2025. This represents a significant improvement in performance from September 2024, when 13 percent of children were determined to be up to date.

Figure 48. Well-Child Visits

Percentage of Class Members 17 years and younger who were up to date on their well-child visits; MP10 - 17 (April 2021 - March 2025)

Source: CAPSS, DHHS, and Select Health data provided by DSS

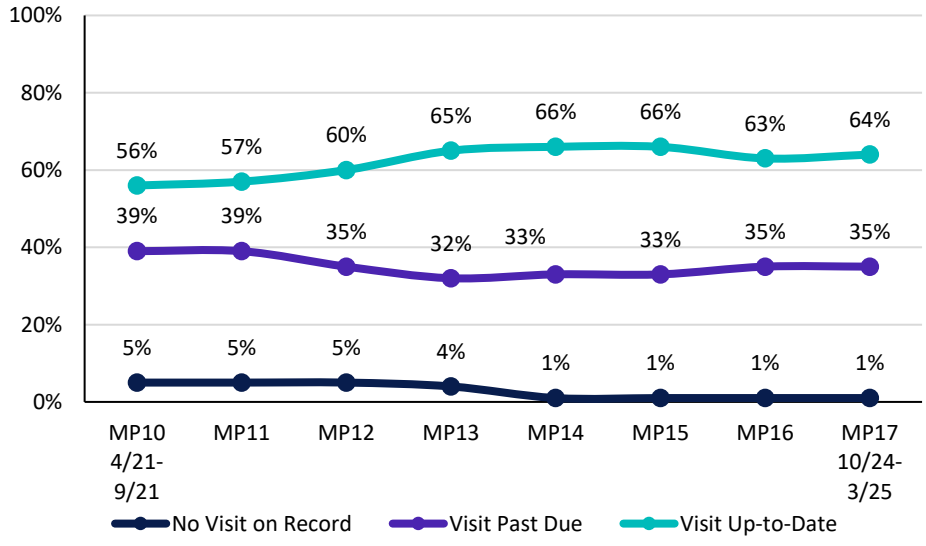
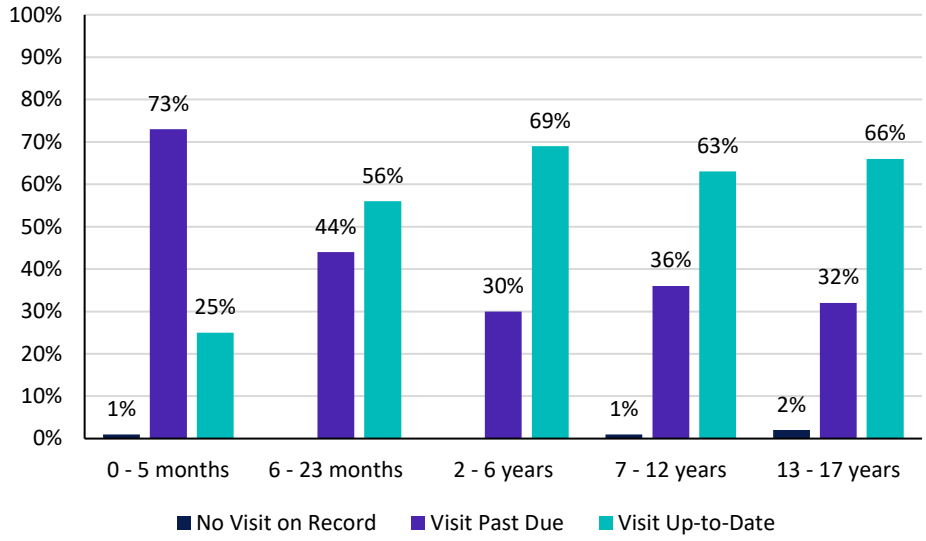


Figure 49. Well-Child Visits, by Age

Percentage of Class Members who were up to date on their well-child visits by age; March 31, 2025

Source: CAPSS, DHHS, and Select Health data provided by DSS



Periodic Preventive Dental Care

FSA Requirement	*At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually* [and] *at least 90% will receive a dental examination annually* (FSA IV.K.5; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirement Not Reported:** Data are not available.

DSS committed in its Health Care Outcomes that children within its care will receive periodic dental examinations. DSS committed to achieving these targets by March 2021.

DSS and the Co-Monitors determined that the approved methodology did not produce information that DSS leadership, staff and the field were able to use to improve health care delivery and outcomes for children in its care. As a result, performance for these FSA requirements is not reported. The Co-Monitors and DSS have been engaged in discussions about changing the approved methodology for measuring periodic preventive care given the shared goal of efficiently and effectively producing timely performance data that can be used for public and court accountability purposes, and for day-to-day management and quality improvement. DSS's proposed new methodology is expected to be included in the modifications to the health care plan. While performance is not reported for these FSA requirements, data regarding semi-annual dental examinations used by DSS for day-to-day management and quality improvement are

provided. These data are validated by DSS regional nurses who review CAPSS for encounters entered by case managers and for after-visit summaries completed by doctors. Data are also cross-checked with administrative data from DHHS and its MCO partner.

DSS reported that of children aged two through 17 who were in care for at least 30 days, 69 percent (1,783 of 2,566) were up to date on their semi-annual dental examination as of March 2025 (Figure 50). Of the remaining children, 27 percent (695 of 2,566) were past due for their dental exam, and three percent (88 of 2,566) had no dental examination on record. These data are also reported to the Co-Monitors by age (Figure 51). As determined by DSS, performance slightly increased for children aged two through six, with 69 percent up to date on their dental exams as compared to 67 percent during the last monitoring period. Performance slightly increased from 70 percent in September 2024 for children aged seven through 12 who were up to date to 72 percent in March 2025; performance slightly increased to 68 percent in MP17 from 64 percent in MP16 of children aged 13 through 17 who were up to date.

Figure 50. Periodic Dental Examinations

Percentage of Class Members aged two to 17 years who were up to date on their dental examinations; MP10 – 17 (April 2021 -March 2025)

Source: CAPSS, DHHS, and Select Health data provided by DSS

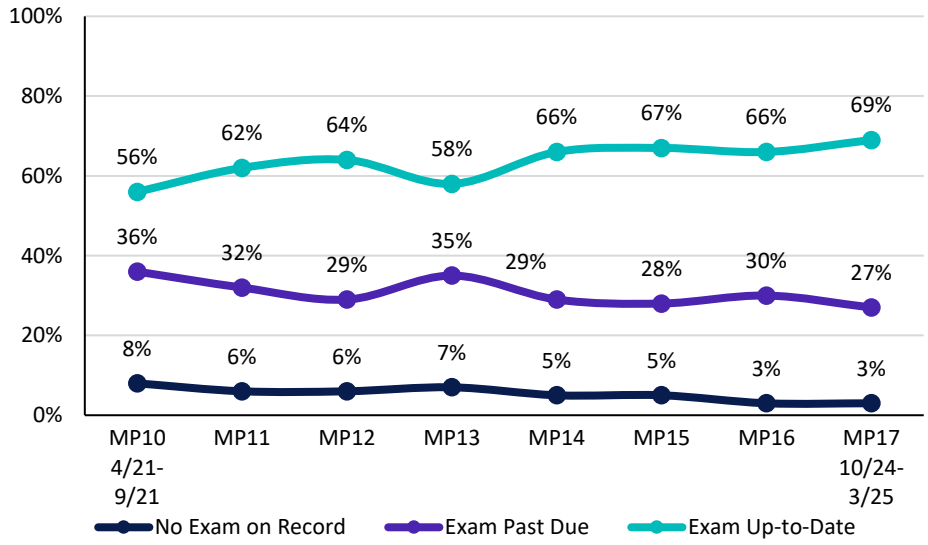
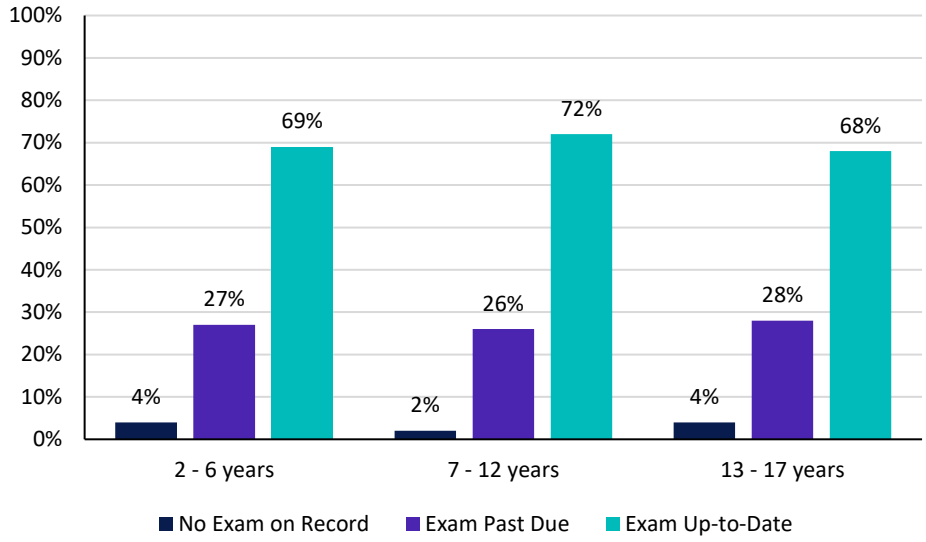


Figure 51. Periodic Dental Examinations, by Age

Percentage of Class Members aged two to 17 years who were up to date on their dental examinations; March 31, 2025

Source: CAPSS, DHHS, and Select Health data provided by DSS



Follow-up Care

FSA Requirements	*At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs.* (FSA IV.K.5; FSA Health Care Outcomes).
Performance Assessment	**FSA Requirement Not Reported:** The Parties have not yet agreed upon a methodology for measurement.

This FSA requirement is not reported because there is not yet an approved methodology for measuring this outcome. The Co-Monitors and DSS are engaged in conversations regarding potential approaches to methodology.

Discussion

During Monitoring Period 17, DSS continued its efforts towards making needed modifications to the Health Care Improvement Plan and related Addendum for improved performance. The revised plan will include DSS's strategies for meeting the underlying health and well-being needs of children in foster care, timeframes for implementation, performance targets and processes for quality monitoring, and performance measurements. DSS also strengthened its collaboration with

DHHS and its MCO partner to put systems in place for ongoing data sharing, analysis, and care coordination.

The revised plan is long-overdue and will require the Co-Monitor and court approval once completed. Although progress toward meeting children's health care needs has continued, in the Co-Monitor's view, progress has been too slow. Revisions to the Health Care Plan have yet to be finalized and shared with the Co-Monitors for review and approval.

DSS continued to develop its capacity to readily access and analyze health care data for children in its care. However, despite multiple actions, DSS is still unable to produce robust data to track its performance on FSA requirements related to initial medical screens, mental health assessments (following a screening which identified a need for such an assessment), preventative periodic care, and whether it provided appropriate care to meet children's identified needs (follow-up care). While DSS met the FSA requirement for initial dental visits within 60 days of entry into care, performance for comprehensive medical assessments upon entering foster care has yet to significantly improve.

In an effort to promote the provision of effective and coordinated medical and mental health services for children in its care, DSS revived the Foster Care Health Advisory Committee (FCHAC). The FCHAC's goal is to address barriers to quality and timely health care service delivery for children in foster care and includes representatives from DSS, SC DHHS, its MCO partner, and medical providers within the community. Additionally, DSS and its MCO partner held weekly Foster Care Rounds meetings to discuss children with complex medical and/or behavioral health needs and worked together to address identified placement and service barriers.

The Richland County Taskforce Capacity Building for Placement Array workgroup has also begun taking actions to improve health care delivery to children in foster care within Richland County, including through efforts to implement practices and models which replicate some of the strengths of the Medical University of South Carolina's USC Foster Care Clinic in Charleston. This work is at early stages but holds promise.

Over five years after the Health Care Addendum was agreed upon (six years into the implementation of the Health Care Improvement Plan), there remains confusion about care coordination roles and responsibilities among the MCO and DSS. In January 2025, changes were made to the MCO contract that more clearly defined the roles and responsibilities of the MCO and outlined a tiered health care coordination and case management approach requiring the provision of support that matches the assessed level of need for each child. A key change is the provision of intensive case management for children in foster care who have four co-occurring conditions pursuant to the eligibility requirements listed in the contract. Children in foster care who are eligible for intensive case management are expected to receive face-to-face visits by MCO staff and a "Person-Centered Care Plan that includes: identification of strengths, preferences, needs, and desired outcomes; identification of supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes regardless of whether those services and supports are currently available; specific providers that can provide the identified supports and services; transition planning section for children and youth

transitioning from an institutional setting to a community setting." As of September 5, 2025, 596 children in foster care have been enrolled to receive intensive case management. This contractual change is a critical first step toward clarifying care coordination roles and responsibilities and improving health care outcomes for children in DSS's care. On August 1, 2025, DHHS implemented a pilot program where all children in foster care in Richland County receive intensive case management from the MCO partner. As of September 5, 2025, 344 children in Richland County are enrolled to receive these services.

Given the need to improve health care outcomes and access to quality health and well-being services for children in foster care, it is essential that DSS work with its partners to actively pursue ways to expand behavioral health services through Medicaid. Work remains to be accomplished in key strategies, such as assessing and ensuring network adequacy. It continues to be critical that DSS work with its state agency partners like DHHS, DMH, and DDSN and community partners to develop mechanisms for data sharing, in addition to expanding robust, accessible, community-based services and supports across the state that meet the underlying health and well-being needs of children and families.

V. Appendix/Sources

A. Table of Monitoring Periods

Monitoring Periods		
MP17	October 1, 2024	March 31, 2025
MP16	April 1, 2024	September 30, 2024
MP15	October 1, 2023	March 31, 2024
MP14	April 1, 2023	September 30, 2023
MP13	October 1, 2022	March 31, 2023
MP12	April 1, 2022	September 30, 2022
MP11	October 1, 2021	March 31, 2022
MP10	April 1, 2021	September 30, 2021
MP9	October 1, 2020	March 31, 2021
MP8	April 1, 2020	September 30, 2020
MP7	October 1, 2019	March 31, 2020
MP6	April 1, 2019	September 30, 2019
MP5	October 1, 2018	March 31, 2019
MP4	April 1, 2018	September 30, 2018
MP3	October 1, 2017	March 31, 2018
MP2	April 1, 2017	September 30, 2017
MP1	October 1, 2016	March 31, 2017

B. Monitoring Activities

The Co-Monitors are responsible for independent validation of data and documentation to compile and issue public reports on the State's performance with respect to the terms of the FSA. In carrying out this responsibility, the Co-Monitors and their staff have worked closely with DSS leadership and staff. The Co-Monitors use multiple methodologies to conduct their work, including verification and analysis of information available through CAPSS; review of individual electronic case records of Class Members; review and validation of data aggregated by DSS; interviews and conversations with DSS leaders and staff; and conversations with external partners, including providers, advocates, and community organizations. The Co-Monitors worked with DSS to establish review protocols to gather performance data and assess current practice for some measures. The Co-Monitors conducted an in-person site visit to the Richland County DSS office and a Day Center in Richland County where they met with DSS and provider leadership and staff. The Co-Monitors participated in the Richland County Task Force and with each of five workgroups. The Co-Monitors also participated in a virtual focus group facilitated by Youth Empowering Advocates, (YEA! Network) for young people aged 14-17 who are in foster care. Additionally, the Co-Monitors also met with a range of involved parties throughout the monitoring period.

Other specific data collection and/or validation activities conducted by the Co- Monitors for the current period include the following:

• Review of monthly caseload reports for foster care, adoptions, and out-of-home abuse and neglect (OHAN) case managers and team leaders (FSA IV.A.2.(b)&(c));

• Review of all OHAN investigation records in CAPSS involving Class Members as an alleged victim and accepted in March 2025, to assess for timely initiation, contact with core witnesses, timely completion, and appropriateness of unfounded decisions (FSA IV.C.3.&4.);

• Review of case files of Class Members aged six and under who were placed in a congregate setting between October 1, 2024 to March 31, 2025 (FSA IV.D.2.);

• Review of a statistically valid sample of case records in CAPSS for Class Members in foster care for 30 days or more on March 31, 2025, and living apart from a sibling also in foster care, to assess whether a sibling visit occurred in March 2025 (FSA IV.J.2.);

• Review of a statistically valid sample of case records in CAPSS for Class Members with a permanency goal of reunification, or with a permanency goal which had not yet been established in family court, and in foster care for 30 days or more on March 31, 2025, to assess whether the child visited with the parent(s) with whom reunification was sought during March 2025 (FSA IV.J.3.);

- Site visits to Richland County DSS office on January 28, 2025 and Day Center on January 29, 2025 to meet with leadership and staff.
- Participation in a virtual focus group on February 12, 2025, with young people aged 14-17 who are in foster care. The virtual focus group was facilitated by the YEA! Network.

- Participation in the Richland County Task Force kickoff meeting on January 28, 2025.
- Co-facilitation of one of the five Richland County Task Force workgroups: Capacity Building for Placement Array and participation in each of the four other workgroups.

C. Glossary of Acronyms

AAP: American Academy of Pediatrics

ADR: Office of Accountability, Data, and Research

AFDC: Aid to Families with Dependent Children

CAPSS: Child and Adult Protective Services System

CFTM: Child and Family Team Meeting

CMS: Center for Medicare and Medicaid Services

DDSN: Department of Disability and Special Needs

DHHS: Department of Health and Human Services

DMH: Department of Mental Health

DJJ: Department of Juvenile Justice

DSS: Department of Social Services

EPC: Emergency Protective Custody

EPSDT: Early and Periodic, Screening, Diagnostic and Treatment

FAST: Family Advocacy and Support Tool

FCHAC: Foster Care Health Advisory Committee

FFPSA: Family First Prevention Services Act

FMAP: Federal Medical Assistance Percentage

FFY: Federal Fiscal Year

FSA: Final Settlement Agreement

FFE: Full-Time Equivalent

GPS: Guiding Principles and Standards Case Practice Model

HRSN: Health-Related Social Need

LPHA: Licensed Practitioner of the Healing Arts

MCO: Managed Care Organization

MST: Multi-Systemic Therapy

OHAN: Out-of-Home Abuse and Neglect Unit

PRTF: Psychiatric Residential Treatment Facilities

QA&CQI: Quality Assurance & Continued Quality Improvement

QRTP: Qualified Residential Treatment Program

RC/RCDSS: Richland County/ Richland County DSS

SACWIS: State Automated Child Welfare Information System

SFY: State Fiscal Year

TANF: Temporary Assistance for Needy Families

U of SC CCFS: University of South Carolina's Center for Child and Family Studies

D. County-Level Data

Entries to Foster Care and Entries via EPC from Law Enforcement (EPC-LE), by County

MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS; U.S. Census Bureau, American Community Survey

OFFICE OF CASE MANAGEMENT	COUNTY CHILD POPULATION	ENTRIES	ENTRIES PER 1,000	EPC-LE ENTRY	PERCENT EPC-LE ENTRY
ABBEVILLE	4,780	4	0.84	3	75%
ADOPTIONS	--	4	--	0	--
AIKEN	37,064	28	0.76	20	71%
ALLENDALE	1,447	1	0.69	1	100%
ANDERSON	47,118	34	0.72	20	59%
BARNWELL	4,866	5	1.03	1	20%
BEAUFORT	34,196	21	0.61	8	38%
BERKELEY	56,817	89	1.57	68	76%
CHARLESTON	81,498	100	1.23	89	89%
CHEROKEE	12,927	13	1.01	4	31%
CHESTER	7,212	12	1.66	8	67%
CHESTERFIELD	9,663	6	0.62	6	100%
CLARENDON	5,756	1	0.17	0	0%
COLLETON	8,763	15	1.71	9	60%
DARLINGTON	14,052	36	2.56	35	97%
DILLON	7,124	8	1.12	8	100%
DORCHESTER	39,749	17	0.43	11	65%
EDGEFIELD	4,573	9	1.97	7	78%
FAIRFIELD	3,819	7	1.83	7	100%
FLORENCE	32,439	30	0.92	17	57%
GEORGETOWN	11,099	12	1.08	1	8%
GREENVILLE	124,120	145	1.17	84	58%
GREENWOOD	15,627	15	0.96	10	67%
HAMPTON	3,833	7	1.83	2	29%
HORRY	63,618	88	1.38	68	77%
JASPER	5,838	10	1.71	7	70%
KERSHAW	15,557	18	1.16	7	39%
LANCASTER	21,807	30	1.38	23	77%
LAURENS	14,947	37	2.48	29	78%
LEE	3,079	1	0.32	1	100%
LEXINGTON	69,460	45	0.65	31	69%
MARION	6,494	40	6.16	40	100%
MCCORMICK	1,014	3	2.96	3	100%
NEWBERRY	8,274	5	0.60	5	100%

OCONEE	15,402	35	2.27	34	97%
ORANGEBURG	18,054	47	2.60	43	91%
PICKENS	24,850	17	0.68	15	88%
RICHLAND	90,813	163	1.79	133	82%
SALUDA	4,146	9	2.17	7	78%
SPARTANBURG	79,128	66	0.83	47	71%
SUMTER	25,055	18	0.72	8	44%
UNION	5,686	5	0.88	4	80%
WILLIAMSBURG	6,004	19	3.16	3	16%
YORK	68,920	42	0.61	36	86%
STATE TOTAL	**1,116,688**	**1,317**	**1.2**	**963**	**73%**

*U.S. Census Bureau, U.S. Department of Commerce. (n.d.). Population Under 18 Years by Age. American Community Survey, ACS 5-Year Estimates Detailed Tables, Table B09001. Retrieved July 24, 2025, from https://data.census.gov/table/ACSDT5Y2023.B09001?t=Age+and+Sex:Children&g=040XX00US45,45$0500000.

Short Length of Stays (LOS) in Foster Care, by County

MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS

OFFICE OF CASE MANAGEMENT	EXITS	LOS ≤ 60 DAYS	PERCENTAGE LOS ≤ 60 DAYS	LOS ≤ 7 DAYS	PERCENTAGE LOS ≤ 7 DAYS
ABBEVILLE	3	0	0%	0	0%
AIKEN	35	4	11%	3	9%
ALLENDALE	1	0	0%	0	0%
ANDERSON	25	7	28%	4	16%
BARNWELL	8	1	13%	1	13%
BEAUFORT	12	3	25%	1	8%
BERKELEY	52	15	29%	6	12%
CHARLESTON	54	27	50%	16	30%
CHEROKEE	5	2	40%	1	20%
CHESTER	17	1	6%	0	0%
CHESTERFIELD	6	3	50%	0	0%
CLARENDON	10	0	0%	0	0%
COLLETON	14	2	14%	0	0%
DARLINGTON	18	6	33%	1	6%
DILLON	24	5	21%	2	8%
DORCHESTER	13	9	69%	5	38%
EDGEFIELD	3	2	67%	2	67%
FAIRFIELD	6	1	17%	0	0%
FLORENCE	25	9	36%	6	24%
GEORGETOWN	11	1	9%	1	9%

GREENVILLE	99	48	48%	28	28%
GREENWOOD	13	9	69%	7	54%
HAMPTON	2	2	100%	0	0%
HORRY	86	31	36%	12	14%
JASPER	5	4	80%	0	0%
KERSHAW	27	4	15%	0	0%
LANCASTER	23	6	26%	2	9%
LAURENS	17	3	18%	2	12%
LEE	9	0	0%	0	0%
LEXINGTON	38	12	32%	6	16%
LOWCOUNTRY ADOPTIONS	39	0	0%	0	0%
MARION	27	14	52%	10	37%
MCCORMICK	5	0	0%	0	0%
MIDLANDS ADOPTIONS	88	0	0%	0	0%
NEWBERRY	12	2	17%	2	17%
OCONEE	16	6	38%	6	38%
ORANGEBURG	43	14	33%	8	19%
PEE DEE ADOPTIONS	61	0	0%	0	0%
PICKENS	12	5	42%	2	17%
RICHLAND	138	42	30%	17	12%
SPARTANBURG	74	35	47%	30	41%
SUMTER	10	2	20%	2	20%
UNION	5	4	80%	2	40%
UPSTATE ADOPTIONS	83	0	0%	0	0%
YORK	27	14	52%	7	26%
STATE TOTAL	**1,301**	**355**	**27.3%**	**192**	**15%**

Placement Moves, by County

MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS

OFFICE OF CASE MANAGEMENT	CHILDREN IN CARE AT ANY POINT DURING MP17	NUMBER OF CHILDREN WITH PLACEMENT MOVE	PERCENTAGE OF CHILDREN WITH PLACEMENT MOVE	TOTAL NUMBER OF PLACEMENTS	TOTAL NUMBER OF PLACEMENT MOVES	AVERAGE NUMBER OF MOVES PER CHILD
ABBEVILLE	16	10	62.5%	34	18	1.8
AIKEN	115	47	40.9%	274	159	3.4
ALLENDALE	9	2	22.2%	24	15	7.5
ANDERSON	122	57	46.7%	252	130	2.3
BAMBERG	1	0	0.0%	1	0	0.0
BARNWELL	12	6	50.0%	25	13	2.2

BEAUFORT	68	26	38.2%	120	52	2.0
BERKELEY	191	94	49.2%	366	175	1.9
CALHOUN	1	0	0.0%	1	0	0.0
CHARLESTON	235	105	44.7%	450	215	2.0
CHEROKEE	35	14	40.0%	81	46	3.3
CHESTER	50	24	48.0%	100	50	2.1
CHESTERFIELD	13	6	46.2%	21	8	1.3
CLARENDON	28	9	32.1%	39	11	1.2
COLLETON	65	19	29.2%	96	31	1.6
DARLINGTON	81	42	51.9%	220	139	3.3
DILLON	45	18	40.0%	72	27	1.5
DORCHESTER	64	30	46.9%	139	75	2.5
EDGEFIELD	19	9	47.4%	48	29	3.2
FAIRFIELD	16	9	56.3%	28	12	1.3
FLORENCE	80	35	43.8%	138	58	1.7
GEORGETOWN	27	18	66.7%	86	59	3.3
GREENVILLE	310	140	45.2%	653	343	2.5
GREENWOOD	42	17	40.5%	128	86	5.1
HAMPTON	24	7	29.2%	31	7	1.0
HORRY	234	103	44.0%	527	293	2.8
JASPER	35	12	34.3%	60	25	2.1
KERSHAW	85	39	45.9%	216	131	3.4
LANCASTER	71	30	42.3%	128	57	1.9
LAURENS	101	46	45.5%	192	91	2.0
LEE	22	6	27.3%	69	47	7.8
LEXINGTON	122	62	50.8%	275	153	2.5
LOWCOUNTRY ADOPTIONS	86	60	69.8%	156	70	1.2
MARION	71	41	57.7%	186	115	2.8
MARLBORO	5	2	40.0%	21	16	8.0
MCCORMICK	7	0	0.0%	7	0	0.0
MIDLANDS ADOPTIONS	324	109	33.6%	547	223	2.0
NEWBERRY	19	8	42.1%	48	29	3.6
OCONEE	72	44	61.1%	152	80	1.8
ORANGEBURG	116	50	43.1%	219	103	2.1
PEE DEE ADOPTIONS	176	61	34.7%	290	114	1.9
PICKENS	53	22	41.5%	108	55	2.5
RICHLAND	502	167	33.3%	1216	714	4.3
SALUDA	12	3	25.0%	17	5	1.7
SPARTANBURG	221	88	39.8%	453	232	2.6
SUMTER	48	21	43.8%	153	105	5.0
UNION	17	7	41.2%	24	7	1.0
UPSTATE ADOPTIONS	270	114	42.2%	503	233	2.0
WILLIAMSBURG	29	8	27.6%	51	22	2.8

YORK	142	59	41.5%	275	133	2.3
STATE TOTAL	**4,509**	**1,906**	**42.3%**	**9,320**	**4,811**	**2.5**

Overnight Stays, by County

MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS

OFFICE OF CASE MANAGEMENT	CHILDREN IN CARE AT ANY POINT DURING MP17	PERCENTAGE OF CHILDREN WHO EXPEIRENCED AN OVERNIGHT STAY	NUMBER OF CHILDREN WITH OVERNIGHT STAY	TOTAL NUMBER OF OVERNIGHT STAYS	AVERAGE NUMBER OF OVERNIGHT STAYS PER CHILD
ABBEVILLE	16	0%	0	0	0
AIKEN	115	6%	7	59	8
ALLENDALE	9	11%	1	2	2
ANDERSON	122	6%	7	14	2
BAMBERG	1	0%	0	0	0
BARNWELL	12	0%	0	0	0
BEAUFORT	68	4%	3	4	1
BERKELEY	191	7%	13	25	2
CALHOUN	1	0%	0	0	0
CHARLESTON	235	2%	4	4	1
CHEROKEE	35	6%	2	5	3
CHESTER	50	8%	4	13	3
CHESTERFIELD	13	0%	0	0	0
CLARENDON	28	0%	0	0	0
COLLETON	65	3%	2	2	1
DARLINGTON	81	14%	11	17	2
DILLON	45	0%	0	0	0
DORCHESTER	64	2%	1	1	1
EDGEFIELD	19	11%	2	4	2
FAIRFIELD	16	13%	2	2	1
FLORENCE	80	6%	5	11	2
GEORGETOWN	27	7%	2	7	4
GREENVILLE	310	4%	12	42	4
GREENWOOD	42	10%	4	13	3
HAMPTON	24	0%	0	0	0
HORRY	234	9%	21	122	6
JASPER	35	3%	1	1	1
KERSHAW	85	9%	8	45	6
LANCASTER	71	3%	2	7	4
LAURENS	101	3%	3	21	7

LEE	22	0%	0	0	0
LEXINGTON	122	11%	13	28	2
LOWCOUNTRY ADOPTIONS	86	0%	0	0	0
MARION	71	13%	9	22	2
MARLBORO	5	20%	1	5	5
MCCORMICK	7	0%	0	0	0
MIDLANDS ADOPTIONS	324	2%	8	68	9
NEWBERRY	19	5%	1	2	2
OCONEE	72	1%	1	1	1
ORANGEBURG	116	1%	1	1	1
PEEDEE ADOPTIONS	176	2%	3	13	4
PICKENS	53	6%	3	13	4
RICHLAND	502	8%	40	427	11
SALUDA	12	0%	0	0	0
SPARTANBURG	221	4%	9	15	2
SUMTER	48	2%	1	20	20
UNION	17	0%	0	0	0
UPSTATE ADOPTIONS	270	1%	3	16	5
WILLIAMSBURG	29	0%	0	0	0
YORK	142	4%	6	12	2
STATE TOTAL	**4,509**	**5%**	**216**	**1,064**	**5**

Emergency Placements, by County

MP17 (October 2024 – March 2025)

Source: CAPSS data provided by DSS

OFFICE OF CASE MANAGEMENT	CHILDREN IN CARE AT ANY POINT DURING MP17	PERCENTAGE OF CHILDREN WHO EXPERIENCED AN EMERGENCY PLACEMENT	CHILDREN WHO STARTED EMERGENCY PLACEMENT IN MP17	TOTAL NUMBER OF NIGHTS SPENT IN EMERGENCY PLACEMENTS	AVERAGE NUMBER OF NIGHTS IN EMERGENCY PLACEMENT PER CHILD
ABBEVILLE	16	13%	2	41	21
LOWCOUNTRY ADOPTIONS	86	1%	1	28	28
MIDLANDS ADOPTIONS	324	5%	16	208	13
PEE DEE ADOPTIONS	176	3%	6	85	14
UPSTATE ADOPTIONS	270	5%	13	300	23
AIKEN	115	11%	13	264	20
ALLENDALE	9	11%	1	73	73
ANDERSON	122	20%	25	217	9
BAMBERG	1	0%	0	0	0
BARNWELL	12	8%	1	6	6

BEAUFORT	68	9%	6	80	13
BERKELEY	191	8%	16	184	12
CALHOUN	1	0%	0	0	0
CHARLESTON	235	11%	26	192	7
CHEROKEE	35	17%	6	95	16
CHESTER	50	10%	5	47	9
CHESTERFIELD	13	0%	0	0	0
CLARENDON	28	0%	0	0	0
COLLETON	65	8%	5	82	16
DARLINGTON	81	19%	15	207	14
DILLON	45	0%	0	0	0
DORCHESTER	64	13%	8	72	9
EDGEFIELD	19	16%	3	61	20
FAIRFIELD	16	19%	3	3	1
FLORENCE	80	5%	4	54	14
GEORGETOWN	27	11%	3	104	35
GREENVILLE	310	23%	70	651	9
GREENWOOD	42	21%	9	329	37
HAMPTON	24	0%	0	0	0
HORRY	234	12%	27	350	13
JASPER	35	6%	2	8	4
KERSHAW	85	9%	8	153	19
LANCASTER	71	6%	4	50	13
LAURENS	101	16%	16	142	9
LEE	22	14%	3	39	13
LEXINGTON	122	11%	13	158	12
MARION	71	11%	8	162	20
MARLBORO	5	20%	1	1	1
MCCORMICK	7	0%	0	0	0
NEWBERRY	19	16%	3	80	27
OCONEE	72	21%	15	74	5
ORANGEBURG	116	9%	11	96	9
PICKENS	53	17%	9	87	10
RICHLAND	502	17%	87	1401	16
SALUDA	12	0%	0	0	0
SPARTANBURG	221	17%	37	360	10
SUMTER	48	8%	4	95	24
UNION	17	0%	0	0	0
WILLIAMSBURG	29	3%	1	13	13
YORK	142	7%	10	150	15
STATEWIDE	**4,509**	**11%**	**516**	**6,802**	**13**

E. Summary Performance on Settlement Agreement Requirements

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
Workload Limits for Foster Care:[1] 1a. At least 90% of caseworkers shall have a workload within the applicable Workload Limit. 1b. No caseworker shall have more than 125% of the applicable Workload Limit. (FSA IV.A.2.(b)&(c))	OHAN case managers: None within required limit (September 2017) 100% had more than 125% of the limit (September 2017)	OHAN case managers: 100% within the required limit Monthly range within the required limit: 71 – 100% 0% had more than 125% of the limit Monthly range with caseloads more than 125% of the limit: 0 – 4%	OHAN case managers: 100% within the required limit Monthly range within the required limit: 97 – 100% 0% had more than 125% of the limit Monthly range with caseloads more than 125% of the limit: 0%	OHAN case managers:[2] 100% within the required limit Monthly range within the required limit: 96 – 100% 0% had more than 125% of the limit Monthly range with caseloads more than 125% of the limit: 0%

[1] The FSA utilizes the term "caseworker" to refer to DSS case-carrying staff and "supervisor" to refer to DSS staff who oversee case-carrying staff. As part of its GPS Case Practice Model development and outlining enhanced job expectations, DSS now utilizes the terms "case manager" and "team leader," respectively. Where appropriate and for consistency with practice, this report utilizes the terms case manager and team leader.

[2] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of case manager and team leader. These random dates are as follows: October 18, 2024; November 7, 2024; December 16, 2024; January 9, 2025; February 21, 2025; and March 31, 2025. Only performance for March 31, 2025, is included in this report.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
Approved Workload Limits:[3,4] • *OHAN worker* - 8 investigations • *Foster care worker* – 15 children • *Adoptions worker* – 15 children[5] • *New caseworker* – ½ of the applicable standard for first six months after completion of Child Welfare Certification training	Foster care case managers: 28% within the required limit (September 2017) 59% had more than 125% of the limit (September 2017) Adoptions case managers: 23% within the required limit (September 2017) 62% had more than 125% of the limit (September 2017)	Foster care case managers: 68% within the required limit Monthly range within the required limit: 60 – 68% 16% had more than 125% of the limit Monthly range with caseloads more than 125% of the limit: 16 – 26%	Foster care case managers: 70% within the required limit Monthly range within the required limit: 69 – 75% 16% had more than 125% of the limit Monthly range with caseloads more than 125% of the limit: 13 – 16%	Foster care case managers: 81% within the required limit Monthly range within the required limit: 74 – 81% 8% had more than 125% of the limit Monthly range with caseloads more than 125% of the limit: 8 – 13%

[3] These limits were approved by the Co-Monitors on December 6, 2016, after completion of the Workload Study.

[4] Caseload limits and methodologies to calculate performance for case managers with mixed caseloads, both Class and Non-Class Members, were approved in December 2017. Non-Class Members include children receiving family preservation services while remaining in the home with their parent or caregiver, Adult Protective Services cases, families involved in CPS assessments, and children placed by ICPC. Performance for foster care case managers with mixed caseloads is calculated by adding the total number of foster care children (Class Members) the case manager serves to the total number of families (cases) of Non-Class Members the case manager also serves; the total number should not exceed 15 children and cases.

[5] Prior to 2019, DSS's workforce was structured so that case management responsibilities remained with the foster care case manager, even when an adoptions case manager was assigned, until a placement agreement was signed. As a result, the approved caseload standard for adoptions workers was 1:17. In 2019, DSS began transitioning case management responsibility to adoptions workers once children became legally eligible for adoption. This transition was complete in January 2020; thus, adoptions case manager caseload performance is assessed at a standard of 1:15, the same standard applied to foster care case managers.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
		Adoptions case managers: 67% within the required limit Monthly range within the required limit: 37 – 67% 22% had more than 125% of the limit Monthly range with caseloads more than 125% of the limit: 21 – 35%	Adoptions case managers: 66% within the required limit Monthly range within the required limit: 62 - 67% 17% had more than 125% of the limit Monthly range with caseloads more than 125% of the limit: 17 - 22%	Adoptions case managers: 73% within the required limit Monthly range within the required limit: 62 - 75% 8% had more than 125% of the limit Monthly range with caseloads more than 125% of the limit: 8 - 17%
Workload Limits for Foster Care: 2a. At least 90% of team leaders shall have a workload within the applicable Workload Limit. 2b. No team leader shall have more than 125% of the applicable Workload Limit. (FSA IV.A.2.(b)&(c))	OHAN team leaders: 100% within the required limit (March 2018) None were more than 125% of the limit (March 2018)	OHAN team leaders: 40% within the required limit each month this period Monthly range within the required limit: 40 – 100% 0% had more than 125% of the limit each month this period	OHAN team leaders: 100% within the required limit each month this period Monthly range within the required limit: 100% 0% had more than 125% of the limit each month this period	OHAN team leaders: 100% within the required limit each month this period Monthly range within the required limit: 100% 0% had more than 125% of the limit each month this period

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
Approved Team Leader Limits: • *OHAN team leaders* – 6 case managers • *Foster care* and *Adoptions* team leaders – 5 case managers	Foster care team leaders: 42% within the required limit (March 2018) 36% had more than 125% of the limit (March 2018) Adoptions team leaders 38% within the required limit (March 2018) 19% had more than 125% of the limit (March 2018)	Foster care team leaders: 91% within the required limit Monthly range within the required limit: 91 – 92% 1% had more than 125% of the limit Monthly range supervising more than 125% of the limit: 1– 4% Adoptions team leaders: 100% within the required limit Monthly range within the required limit: 93 – 100% 0% had more than 125% of the limit each month this	Foster care team leaders: 91% within the required limit Monthly range within the required limit: 91 – 95% 0% had more than 125% of the limit Monthly range supervising more than 125% of the limit: 0% Adoptions team leaders: 83% within the required limit Monthly range within the required limit: 83 – 100% 0% had more than 125% of the limit each month this	Foster care team leaders: 92% within the required limit Monthly range within the required limit: 89 – 93% 1% had more than 125% of the limit Monthly range supervising more than 125% of the limit: 0-3% Adoptions team leaders: 83% within the required limit Monthly range within the required limit: 83 – 88% 9% had more than 125% of the limit each month this

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
		period Monthly range supervising more than 125% of the limit: 0%	period Monthly range supervising more than 125% of the limit: 0%	period Monthly range supervising more than 125% of the limit: 0 - 9%
Visits Between Case Managers and Children: 3. At least 90% of the total minimum number of face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place. (FSA IV.B.2.)	24% of cases reviewed had all agreed-upon elements of a visit. (September 2019)	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been substantial increase in performance.	See prior performance comment. This review has not yet resumed.	See prior performance comment. This review has not yet resumed.
Visits Between Case Managers and Children: 4. At least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken	22% of documented face-to-face contacts with children had all agreed upon elements of a visit and took place in the child's residence. (September 2019)	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has	See prior performance comment. This review has not yet resumed.	See prior performance comment. This review has not yet resumed.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
place in the residence of the child. (FSA IV.B.3.)	92% of face-to-face contacts took place in the child's residence. (September 2019)	been substantial increase in performance.		
Investigations - Intake: 5. At least 95% of decisions not to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be made in accordance with South Carolina law and DSS policy. (FSA IV.C.2.)	44% of screening decisions to not investigate were determined to be appropriate. (March 2017)	98% of screening decisions not to investigate were determined to be appropriate.	100% of screening decisions not to investigate were determined to be appropriate.	Upon order of the Court, jurisdiction over this provision was terminated.[6]
Investigations - Case Decisions: 6. At least 95% of decisions to	47% of applicable investigation decisions to unfound were determined	97% (29) of 30 applicable investigation decisions to unfound were determined	100% (34) of 34 of applicable investigation decisions to unfound were	97% (31) of 32 of applicable investigation decisions to unfound were determined

[6] See Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt.329), terminating jurisdiction over the following FSA OHAN provisions: (1) Intake – Decision Not to Investigate (FSA IV.C.2.); (2) Timely Completion of Investigation Within Forty-five (45) Days of Initiation (FSA IV.C.4(d)); (3) Timely Completion of Investigation Within Sixty (60) Days of Initiation (FSA IV.C.4(e)); and (4) Timely Completion of Investigation Within Ninety (90) Days of Initiation (FSA IV.C.4(f)).

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
"unfound" investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected. (FSA IV.C.3.)	to be appropriate. (March 2017)	to be appropriate.	determined to be appropriate.	to be appropriate.
Investigations - Timely Initiation: 7. The investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations. (FSA IV.C.4.(a))	78% of applicable investigations were timely initiated. (March 2017)	90% (27) of 30 applicable investigations were timely initiated.	93% (37) of 40 applicable investigations were timely initiated.	95% (35) of 37 applicable investigations were timely initiated.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
Investigations – Face-to-Face Contact with Alleged Child Victim: 8. The investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four (24) hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors.[7] (FSA IV.C.4.(b))	78% of applicable investigations included face-to-face contact with the alleged victim within twenty-four (24) hours. (March 2017)	90% (27) of 30 applicable investigations included face-to-face contact with the alleged victim within twenty-four (24) hours.	93% (37) of 40 applicable investigations included face-to-face contact with the alleged victim within twenty-four (24) hours.	95% (35) of 37 applicable investigations included face-to-face contact with the alleged victim within twenty-four (24) hours.
Investigations - Contact with Core Witnesses: 9. Contact with core witnesses must be made in at least 90% of	27% of applicable investigations included contact with all necessary core witnesses. (March 2017)	77% (23) of 30 applicable investigations included contact with all necessary core witnesses.	75% (30) of 40 applicable investigations included contact with all necessary core witnesses.	86% (32) of 37 applicable investigations included contact with all necessary core witnesses.

[7] On September 24, 2024, the Co-Monitors and Parties agreed that for the purposes of the review, OHAN case managers would have a maximum of two additional hours from the time of the receipt of the report to initiate the investigation, including making face-to-face contact with the alleged victim child(ren) (i.e., OHAN case managers would have up to 26 hours from the receipt of a report to initiate the investigation). During MP17, 35 of 37 investigations were initiated within 26 hours of the receipt of the report; 31 of the 37 investigations were initiated within 24 hours of DSS's receipt of the report and an additional 4 of the 37 investigations were initiated within 26 hours, including one investigation where good faith efforts were made to initiate.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors. (FSA IV.C.4.(c))				
Investigations - Timely Completion: 10.a. At least 60% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within forty-five (45) days of initiation of an investigation, unless the DSS Director or DSS Director's designee authorizes an extension of no more than fifteen (15) days upon a showing of good cause.[8] (FSA IV.C.4.(d))	95% of applicable investigations reviewed were appropriately closed within 45 days. (March 2017)	100% of investigations reviewed were appropriately closed within 45 days.	90% of investigations reviewed were appropriately closed within 45 days.	Upon order of the Court, jurisdiction over this provision was terminated.[9]

[8] For the purposes of this provision, an investigation is not completed if DSS determines the report is unfounded because the deadline to complete the investigation has passed.

[9] See Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt.329), terminating jurisdiction over the following FSA OHAN provisions: (1) Intake – Decision Not to Investigate (FSA IV.C.2.); (2) Timely Completion of Investigation Within Forty-five (45) Days of Initiation (FSA IV.C.4(d)); (3) Timely Completion of Investigation Within Sixty (60) Days of Initiation (FSA IV.C.4(e)); and (4) Timely Completion of Investigation Within Ninety (90) Days of Initiation (FSA IV.C.4(f)).

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
Final target by March 2021: 95% closure in 45 days				
Investigations - Timely Completion: 10.b. At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of good cause.[10]	96% of investigations reviewed were closed within 60 days. (March 2017)	100% of investigations reviewed were closed within 60 days.	100% of investigations reviewed were closed within 60 days.	Upon order of the Court, jurisdiction over this provision was terminated.[11]

[10] See Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt.329), terminating jurisdiction over the following FSA OHAN provisions: (1) Intake – Decision Not to Investigate (FSA IV.C.2.); (2) Timely Completion of Investigation Within Forty-five (45) Days of Initiation (FSA IV.C.4(d)); (3) Timely Completion of Investigation Within Sixty (60) Days of Initiation (FSA IV.C.4(e)); and (4) Timely Completion of Investigation Within Ninety (90) Days of Initiation (FSA IV.C.4(f)).
[11] Ibid.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
(FSA IV.C.4.(e)) ***Final target by March 2021: 95% closure in 60 days***				
Investigations - Timely Completion: 10.c. At least 95% of all investigations of a Referral of Institutional Abuse or Neglect not completed within sixty (60) days shall be completed within ninety (90) days.[12] (FSA IV.C.4.(f))	93% of investigations reviewed were closed within 90 days. (September 2017)	100% of investigations reviewed were closed within 90 days.	100% of investigations reviewed were closed within 90 days.	Upon order of the Court, jurisdiction over this provision was terminated.[13]
Family Placements for Children Ages Six and Under:	Baseline data for this measure are not available.	The circumstances of all children met an agreed	The circumstances of all children placed in a	The circumstances of all children placed in a

[12] See Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt.329), terminating jurisdiction over the following FSA OHAN provisions: (1) Intake – Decision Not to Investigate (FSA IV.C.2.); (2) Timely Completion of Investigation Within Forty-five (45) Days of Initiation (FSA IV.C.4(d)); (3) Timely Completion of Investigation Within Sixty (60) Days of Initiation (FSA IV.C.4(e)); and (4) Timely Completion of Investigation Within Ninety (90) Days of Initiation (FSA IV.C.4(f)).
[13] Ibid.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
11. No child age six and under shall be placed in a congregate care setting except with approved exceptions. (FSA IV.D.2.)		upon exception. A total of 9 Class Members aged six and under were placed in congregate care.	congregate setting met an agreed upon exception. A total of 11 Class Members aged six and under were placed in congregate care.	congregate setting met an agreed upon exception. A total of 15 Class Members aged six and under were placed in congregate care.
Phasing-Out Use of DSS Offices and Hotels: 12. No child shall be placed or housed in a DSS office, hotel, motel, or other commercial non-foster care establishment. (FSA IV.D.3.) (Referred to as an "overnight stay" which is defined as a minimum four-hour period in a DSS office, hotel, motel, or other commercial non-foster care	Baseline data for this measure are not available.	DSS reports there were 1,565 overnight stays (for 249 unique children)	DSS reports there were 844 overnight stays (for 188 unique children)	DSS reports there were 1,064 overnight stays in a (for 216 unique children)

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
establishment between the hours of 10:00 p.m. and 6:00 a.m.[14]				
Congregate Care Placements: 13. At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period. (FSA IV.E.2.)	78% of children in foster care were placed outside of a congregate care setting. (March 2018)	88% of children in foster care were placed outside of a congregate care setting.	87% of children in foster care were placed outside of a congregate care setting.	87% of children in foster care were placed outside of a congregate care setting.[15]
Congregate Care Placements - Children Ages 12 and Under:	92% of children aged 12 and under in foster care were	98% of children aged 12 and under in foster care were	98% of children aged 12 and under in foster care were	99% of children aged 12 and under in foster care were

[14] Note, this currently operative definition of "overnight stay" is included in the Short-Term Plan to Address Overnight Stays, which was approved by the Court on March 23, 2022. See Joint Motion for Approval of Overnight Stay Plan (March 4, 2022, Dkt. 236) at pg. 3 and Order Approving Overnight Stay Plan (March 23, 2022, Dkt. 238).

[15] Nineteen children resided in other institutional settings and were removed from the universe. Specifically, DSS reports that 10 children were incarcerated in correctional or juvenile detention facilities, 9 children were hospitalized.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
14. At least 98% of the Class Members 12 years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file. (FSA IV.E.3.)	placed outside of a congregate care setting. (March 2018)	placed outside of a congregate care setting.	placed outside of a congregate care setting.	placed outside of a congregate care setting. [16]
Emergency or Temporary Placements for More than 30 Days: 15. Class Members shall not remain in any Emergency or Temporary Placement for more	Baseline data for this measure are not available.	25 children remained in an initial Emergency or Temporary Placement for more than thirty (30) days.	22 children remained in an initial Emergency or Temporary Placement for more than thirty (30) days.	10 children remained in an initial Emergency or Temporary Placement for more than thirty (30) days.

[16] This includes eight children under the age of six who resided with their parent in a residential facility.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
than thirty (30) days. (FSA IV.E.4.) ***Dates to reach final target and interim benchmarks to be added once approved.***				
Emergency or Temporary Placements for More than Seven Days: 16. Class Members experiencing more than one Emergency or Temporary Placement within twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days. (FSA IV.E.5.) ***Dates to reach final target and***	Baseline data for this measure are not available.	Of the 323 children who experienced more than one Emergency or Temporary Placement in a 12-month period, 170 (53%) children experienced at least one subsequent Emergency or Temporary Placement for more than seven (7) days.	Of the 391 children who experienced more than one Emergency or Temporary Placement in a 12-month period, 216 (55%) children experienced at least one subsequent Emergency or Temporary Placement for more than seven (7) days.	Of the 317 children who experienced more than one Emergency or Temporary Placement in a 12-month period, 137 (43%) children experienced at least one subsequent Emergency or Temporary Placement for more than seven (7) days.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
interim benchmarks to be added once approved.				
Placement Instability: 17. For all Class Members in foster care for eight (8) days or more during the 12-month period, Placement Instability shall be less than or equal to 3.37. (FSA IV.F.1.)	3.55 moves per 1,000 days. (October 1, 2016, to September 30, 2017).	Data for this measure are produced on an annual basis.	6.64 moves per 1,000 days. (October 1, 2023, to September 30, 2024).	Data for this measure are produced on an annual basis.
Sibling Placements: 18. At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with at least one of their siblings	63% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry. (March 2018)	75% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.	70% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.	76% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.[17]

[17] Exceptions have been approved, though not applied, during this monitoring period; therefore, actual performance may be higher than reported.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
unless an exception applies (FSA IV.G.2.)				
<u>*Sibling Placements:*</u> 19. At least 80% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with all their siblings, unless an exception applies. (FSA IV.G.3.)	38% of children entering foster care with siblings were placed with all their sibling on the 45th day after entry. (March 2018)	50% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	44% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	49% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry. [18]
<u>*Youth Exiting the Juvenile Justice System:*</u>	Baseline data for this measure are not available.	See Section VIII. *Placements*.	See Section VIII. *Placements*.	See Section VIII. *Placements*.[19]

[18] Exceptions have been approved, though not applied, during this monitoring period; therefore, actual performance may be higher than reported.
[19] As discussed in Section VIII. Placements, the complexities of tracking performance in this area have meant that the Co-Monitors have historically had to rely significantly on reports by DSS and stakeholders to assess performance.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
20. When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the family court or DJJ that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their plea or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member. DSS shall take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea. DSS shall provide for their appropriate placement. (FSA IV.H.1.)				

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
Therapeutic Placements and/or Services - Referral for placement and/or services 21. At least 95% of Class Members that are both identified through an approved CANS (with fidelity to the CANS model) as needing therapeutic placement and/or services and recommended for specific therapeutic placement and/or services during a Child and Family Team Meeting (CFTM) (with fidelity to the days of the need being identified. (FSA IV.I.2.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period. Parties agreed to a modification of the FSA provision that will require new monitoring methodology to be co-developed with Plaintiffs.	Data are not available for this period. Parties successfully negotiated a joint motion to modify FSA Section IV.I. which was approved by the Court on November 1, 2024.[20]

[20] Court order (November 1, 2024, Dkt.333), approving Joint Motion to Amend the Final Settlement Agreement Section IV.I. (October 25, 2024, Dkt.332-1).

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
<u>*Therapeutic Placement and/or services – Reassessment*</u> 22. At least 95% of Class Members identified through an approved CANS and a Child and Family Team Meeting as needing therapeutic placement and/or services shall receive an updated assessment at least annually thereafter, upon a placement disruption or upon a material change in the Class Member's needs. (FSA IV.I.3.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period. Parties agreed to a modification of the FSA provision that will require new monitoring methodology to be co-developed with Plaintiffs.	Data are not available for this period. Parties successfully negotiated a joint motion to modify FSA Section IV.I. which was approved by the Court on November 1, 2024.[21]
<u>*Therapeutic Placement and/or*</u>	Baseline data for this	Data are not available for	Data are not available for	Data are not available for

[21] Court order (November 1, 2024, Dkt.333), approving Joint Motion to Amend the Final Settlement Agreement Section IV.I. (October 25, 2024, Dkt.332-1).

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
Services – Receipt of placement and services: 23.a. Within 60 Days: Children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family Team and incorporated into DSS' case and service plan within sixty (60) days following the date of the CFTM during which the recommendations were made. (FSA IV.I.6.) ***Final target, interim benchmarks and date to be reached will be***	measure are not available.	this period.	this period. Parties agreed to a modification of the FSA provision that will require new monitoring methodology to be co-developed with Plaintiffs.	this period. Parties successfully negotiated a joint motion to modify FSA Section IV.I. which was approved by the Court on November 1, 2024.[22]

[22] Court order (November 1, 2024, Dkt.333), approving Joint Motion to Amend the Final Settlement Agreement Section IV.I. (October 25, 2024, Dkt.332-1).

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
added once approved				
23.b. Within 90 Days: Children assessed through the CANS and determined to need therapeutic placement and/or services during a CFTM shall be placed in the recommended setting and receive the recommended therapeutic services as set forth by the Child and Family Team and incorporated into DSS' case and service plan within sixty (90) days following the date of the CFTM during which the recommendations were made. (FSA IV.I.6.) ***Final target, interim benchmarks and date to be reached will be***	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period. Parties agreed to a modification of the FSA provision that will require new monitoring methodology to be co-developed with Plaintiffs.	Parties successfully negotiated a joint motion to modify FSA Section IV.I. which was approved by the Court on November 1, 2024.[23]

[23] Court order (November 1, 2024, Dkt.333), approving Joint Motion to Amend the Final Settlement Agreement Section IV.I. (October 25, 2024, Dkt.332-1).

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
added once approved				
Family Visitation - Siblings 24. At least 85% of the total minimum number of monthly sibling visits for all siblings not living together shall be completed, unless an exception applies. (FSA IV.J.2.)	66% of all required visits between siblings occurred for those who were not placed together (March 2018).	73% of siblings in foster care and living apart visited each other (including exceptions).	80% of siblings in foster care and living apart visited each other (including exceptions).	84% of siblings in foster care and living apart visited each other (including exceptions).[24]
Family Visitation - Parents: 25. At least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought, unless an exception applies.	12% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought. (March 2018)	60% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought (including exceptions.	49% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought (including exceptions.	55% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought (including exceptions.[25]

[24] Data are from a CAPSS record review conducted by Co-Monitor and DSS staff of a statistically valid sample designed to produce results at a 95% confidence level with a +/- 5% margin of error.
[25] Data are from a CAPSS record review conducted by Co-Monitor and DSS staff of a statistically valid sample designed to produce results at a 95% confidence level with a +/- 5% margin of error.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
(FSA IV.J.3.)				
Health Care - Immediate Treatment Needs: 26. Within forty-five (45) days of the identification period, DSS shall schedule the necessary treatment for at least 90% of the identified Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue. (FSA IV.K.4.(b))	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[26]

[26] FSA IV.K.4.(b)). required that by August 31, 2016, DSS "identify Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue." Though initially intended to apply to children in DSS custody at the time of entry into the agreement in October 2016, DSS lacked a mechanism for measuring performance with respect to this requirement. On October 28, 2019, DSS and Plaintiffs entered into the Joint Agreement on the Immediate Treatment Needs of Class Members (Dkt. 162), which set out a timeline for specific action steps DSS would take to comply with and ultimately measure performance with respect to, a new set of standards that would replace the initial FSA IV.K.4(b) requirements.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
Health Care - Initial Medical Screens 27. At least 90% of Class Members will receive an initial medical screen prior to initial placement or within 48 hours of entering care. ***Dates to reach final target and interim benchmarks to be added once approved.***[27]	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.
Health Care - Initial Comprehensive Assessments 28. At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care.	36% of children received a comprehensive medical assessment within 30 days. (March 2019)	49% of children received a comprehensive medical assessment within 30 days.	50% of children received a comprehensive medical assessment within 30 days.	48% of children received a comprehensive medical assessment within 30 days.

[27] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS was to present approvable interim benchmarks for Initial Medical Screens and Initial Mental Health Assessments to the Co-Monitors by May 31, 2020. Given the delay in production of baseline data, benchmarks have not yet been proposed.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
Health Care - Initial Comprehensive Assessments 29. At least 95% of Class Members will receive a comprehensive medical assessment within 60 days of entering care.	52% of children received a comprehensive medical assessment within 60 days. (March 2019)	65% of children received a comprehensive medical assessment within 60 days.	67% of children received a comprehensive medical assessment within 60 days.	67% of children received a comprehensive medical assessment within 60 days.
Health Care - Initial Mental Health Assessments 30. At least 85% of Class Members aged three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 30 days of the comprehensive medical assessment. ***Dates to reach final target and***	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
interim benchmarks to be added once approved.				
Health Care - Initial Mental Health Assessments 31. At least 95% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment. ***Dates to reach final target and interim benchmarks to be added once approved.***	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.
Health Care –Referral to Developmental Assessments	19% of children under 36 months of age were referred within 30 days. (July-	96% of children under 36 months of age were referred within 30 days.	96% of children under 36 months of age were referred within 30 days.	94% of children under 36 months of age were

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
32. At least 90% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 30 days of entering care.	December 2017)			referred within 30 days.[28]
Health Care –Referral to Developmental Assessments 33. At least 95% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 45 days of entering care.	20% of children under 36 months of age were referred within 45 days. (July to December 2017)	97% of children under 36 months of age were referred within 45 days.	96% of children under 36 months of age were referred within 45 days.	97% of children under 36 months of age were referred within 45 days.[29]
Health Care – Initial Dental Examinations 34. At least 60% of Class Members	35% of children aged one and above received a dental exam within 60 days. (March 2018)	57% of children ages two and above received a dental exam within 60 days.	62% of children aged two and above received a dental exam within 60 days.	61% of children aged two and above received a dental exam within 60 days.

[28] See Order on Motion for Miscellaneous Relief (October 18, 2024, Dkt.329), granting Maintenance of Effort status for this provision.
[29] Ibid.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
aged two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care.				
Health Care – Initial Dental Examinations 35. At least 90% of Class Members aged two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 90 days of entering care.	48% of applicable children aged one and above received a dental exam within 90 days. (March 2018)	66% of applicable children aged two and above received a dental exam within 90 days.	63% of applicable children aged two and above received a dental exam within 90 days.	76% of applicable children ages two and above received a dental exam within 90 days.
Health Care – Periodic Preventative Care (Well visits)	49% (40) of 82 children under the age of six months received a periodic	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
36. At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly.	preventative visit monthly. (March 2019) 30% (42) of 137 children under the age of six months who entered care between October 1, 2018, and March 31, 2019, received a periodic preventative visit monthly.			
Health Care - Periodic Preventative Care (Well visits) 37. At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics (AAP) periodicity guidelines.	38% of children between the ages of six and 36 months received periodic preventative visits in accordance with the periodicity schedule. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
Health Care – Periodic Preventative Care (Well visits) 38. At least 98% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit semi-annually.	62% of children between the ages of six and 36 months received a periodic preventative visit semi-annually. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*
Health Care – Periodic Preventative Care (Well visits) 39. At least 90% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit semi-annually.	12% of children aged three years and older received a periodic preventative visit semi-annually. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*
Health Care – Periodic Preventative Care (Well visits)	58% of children aged three years and older received an annual preventative visit.	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
40. At least 98% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit annually.	(March 2019)			
Health Care – Periodic Dental Care 41. At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually.	54% of children ages two years or older received a dental exam semi-annually. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*
Health Care – Periodic Dental Care 42. At least 90% of Class Members ages two and older in care for six months or longer will receive a dental examination annually.	81% of children ages two years or older received an annual dental examination. (March 2019)	See Section IX. *Health Care*	See Section IX. *Health Care*	See Section IX. *Health Care*
Health Care - Follow-Up Care 43. At least 90% of Class Members	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.

Summary of Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2023– March 2024 Performance**	**April – September 2024 Performance**	**October 2024 – March 2025 Performance**
will receive timely accessible and appropriate follow-up care and treatment to meet their health needs. ***Dates to reach final target and interim benchmarks to be added once approved.***[30]				

[30] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS was to present approvable interim benchmarks to the Co-Monitors by November 30, 2019.

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