

February 24, 2026

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The Hon. J. Sandy Bartlett
Chair, House Judiciary Committee
100 Taylor House Office Building
Annapolis, MD 21401

Re: **HB 980 (2026) (Kanaiyah's Law) FWA: STRONGLY SUPPORT WITH AMENDMENTS**

Dear Chairperson Bartlett and Members of the Committee:

I strongly support HB 980 and urge the Committee to issue a favorable report with several amendments that would strengthen it and remove potential loopholes.

The tragic death of Kanaiyah Ward was preventable and predictable. When hundreds of foster children are forced to spend weeks or months in unlicensed—and thus illegal—placements, when these children are watched by unlicensed “one-on-one” aides under unacceptable risks that the Department of Human Services has known to exist, when the Department has steadfastly refused to study and assess the systemic deficiencies that have caused these conditions, the odds are that a tragedy will occur. And so, in Kanaiyah’s case, it did. I thank Delegate Griffith and the other sponsors of HB 980 for taking action to turn her tragedy into something positive: injecting accountability into a confidential system that desperately needs transparency and oversight. Maryland’s foster children and youth need your protection.

I strongly support all aspects of HB 980’s reforms: (1) a flat-out prohibition against placement of children in unlicensed settings; (2) provisions to protect children who exit foster care to guardianship from access by child predators; and (3) establishing an ombudsman’s office to monitor the provision of foster-care services to children and youth. To close potential loopholes in the current draft, I propose several modest amendments discussed below.

Kanaiyah’s death should provide all the justification needed to support the bill. But she was just one of hundreds of children who had to spend weeks or months in hotels, offices, or hospitals because DHS has failed to develop and maintain sufficient placements and services. This placement crisis has persisted since 2018. Despite many vows to end it, DHS and MDH simply have not done so. Time and time again, the Secretaries of the Departments of Health (“MDH”) and Human Services (“DHS”) have testified before various legislative histories and vowed to fix the problem soon. Year after year, the promised fixes don’t arrive or don’t work as promised. Two years ago, the DHS Secretary testified at a budget hearing that “I will fix it.” He didn’t.

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And then Kanaiyah died and DLS issued its scathing audit, and the whole state took note and alarm. After intense criticism, DHS announced no more hotels, no more offices. Just like that. And so, the problem supposedly was solved. But it wasn't, and it isn't. Children *still* reside in hospitals without medical reason because DHS and MDH still do not have placements for them or services that would allow them to return to their communities. When warm weather returns, Baltimore City DSS anticipates that it will again need to use one of its offices to house foster children. In sum: eight years of hundreds of children locked away in hospitals and offices because Maryland, one of the richest states in the country, doesn't have homes and services for them.

A. The Need for Reform.

DHS hired the premier child-welfare research institution in the United States, Chapin Hall of the University of Chicago School of Social Work, to conduct a needs assessment of foster-care placements and services—but it did not allow the Chapin Hall researchers to assess the supply of placements and services to determine what deficiencies exist. Chapin Hall therefore could not determine what specifically is needed. For example, the last psychiatric respite facility in Maryland closed in 2021. How many beds are needed now? How many facilities? We don't know, as Chapin Hall was not allowed to determine this. DHS insists that enough beds exist. Then why are children still languishing in unlicensed programs. One child has been in a hospital E.D. for over six months! This is her third hospital overstay.

Moreover, in its report issued last winter, Chapin Hall determined that 36%, over one-third, of the foster children who were staying in the Baltimore City DSS were new entrants—children just entering the system within the prior week, and another 12%, had been in care for less than half a year. *See* Larry Small, et al., Chapin Hall Final Report at 74 (2025) (“Chapin Hall Rep.”). Thus, nearly half of all the Baltimore City foster children housed in its office have been new entrants. Plainly, DHS should have emergency foster homes or shelters to house these children. Even if the children came into care with significant trauma and behavioral issues, programs like psychiatric respite would, seemingly, work here. Despite knowing the problem, DHS has failed to solve it.

It is time for the General Assembly to act.

The available statistics on DHS performance reveal broad system-wide flaws. The Committee is already undoubtedly aware of the most recent DLS audit findings. But there is much, much more:

- Chapin Hall found “a clear need to expand the availability of specialized placements that can accommodate the complex behavioral and psychological needs of older youth, particularly those aged 14-17,” including increasing the capacity of existing

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- programs “as well as developing new programs specifically tailored to meet the needs of these high-risk populations.” (Chapin Hall Rep. 58).
- For children who were housed in hotels, Chapin Hall found that BCDSS recommended community placements, not high-end residential treatment. *See* Chapin Hall Rep. 64 (“Group Home (Non-Therapeutic) (58%), Treatment Foster Care (58%), Group Home (Therapeutic) (52%), regular Foster Care (42%), Independent Living (11%), and Mother Baby Program (16%). (Chapin Hall Rep. 64). It recommended RTCs for only 5% of the cases.
 - For children housed in the BCDSS office, Chapin Hall determined that 36% had entered OHP only 8 days or less, and almost all of them were housed in the office immediately upon entry into care—an indictment of the lack of emergency placement options. (Chapin Hall Rep. 74). Another 12% had been in care for more than 8 days but less than six months, *id.*, meaning that approximately *half* were new entrants.
 - Chapin Hall found that the precipitating events for overstays and use of unlicensed placements often was due to a placement shortage. *See* Chapin Hall Rep. 101 (“Likewise, many times, index events appeared to occur due to a lack of available placement resources, particularly for certain subgroups of children such as siblings or children with complex or specialized placement needs.”).
 - Chapin Hall further confirmed an alarming lack of clinical information about the children given to providers when requesting placements. (Chapin Hall Rep. 94-95). Providers often discharged children quickly after accepting them. *Id.* at 95-96. But poor casework also is a major culprit: “Sometimes index events occurred not because of provider-related factors but because of the case management practices of some caseworkers, e.g. the lack of targeted placement referrals or insufficient planning for expected periods of transitions such as a child aging out of their current placement.” *Id.* at 96. So, too, sometimes, “despite caseworkers’ best efforts or possible intentions, agency resources simply were too limited. For example, case reviewers reported that, “*The youth does not seem to have any behavioral challenges and appears to have been placed in a hotel due to lack of resources.*” ... In addition, capacity issues related to the unavailability of appropriate emergency or short-term housing options, were also implicated....” *Id.* at 97 (emphasis added).
 - Respite and crisis intervention are not sufficiently utilized to preserve and stabilize placements. *See* Chapin Hall Rep. 98 (“Placement disruptions sometimes also happened when stressed and depleted caregivers were not able to receive much needed respite, or other forms of support, from child welfare agencies. For example, a case

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reviewer noted that, “...*the caregiver was frustrated and needed a break. This disruption seemed avoidable if there could have been a formal or informal respite arrangement.*” (emphasis in original).

- Chapin Hall further found that “caseworker practices may, inadvertently, be contributing towards the occurrence or duration of index events for some children due to insufficient advance planning for known and expected periods of transition (e.g. aging out of the eligibility criteria for the group home). Initiating placement finding efforts in a timely manner, especially when it is known or apparent that a placement disruption is on the horizon and when time is already limited, is an important potential area for improvement to avert hospital overstays and hotel and office stays.” *Id.* at 100. There is little doubt that this is a major problem in Baltimore City. Generally, Chapin Hall concluded that “the need exists for Maryland to more quickly identify and stabilize youth who are in the grip of multiple crises and/or placement disruptions, and to match them with the appropriate level of care they need, ideally from their first placement. This is necessary not just for mitigating the likelihood of index events but also for avoiding the risk of further compounding the trauma already carried by foster children by asking them to shoulder the additional, yet *preventable*, burdens of extensive relational losses and grief each time placements are disrupted.” *Id.* (emphasis in original).
- Most critically and broadly, Chapin Hall confirmed what we have long said: a major structural problem exists in Maryland due to the fragmentation and siloed array of services with minimal coordination and meshed integration. *See id.* at 101 (“...[S]caling up the availability of certain placement settings are not sufficient on their own. An important factor to scale up as well would be caregiver resources. This thematic finding reflects the importance of greater coordination between child welfare agencies, mental health service providers, public health departments, and other allied partners, to develop a more effective system of care for meeting the complex placement and mental health needs of foster children in Maryland. Such a system of care can also help facilitate the pooling together of limited services and resources to better equip overwhelmed caregivers with more system level supports to prevent avoidable placement disruptions, such as the deployment of mobile crisis units or the provision of respite care.”).

Overall, literally *hundreds* of foster children have stayed in these illegal placements since 2018. Many have had multiple such illegal placements, sometimes moving from hotels to hospitals or hospitals to hotels. The volume is shocking.

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- During the year that ended in September 2025, 93 children and youth had a total of 147 hotel stays that varied from seven to 178 days. (budget data reported in Feb. 23, 2026 *Baltimore Sun*). Five children were aged under five.
- On June 4, 2024, BCDSS illegally housed *11* foster children in hotels, nearly one percent of all BCDSS foster children. (*L.J. v. López*, Civ. A. No. SAG-84-4409 (D. Md.) (“*L.J.*”), Pls. Reply Mem at 18, ECF No. 698). As of June 6, 2024, these stays had lasted 252 days; 196 days; 152 days; 133 days; 98 days; 96 days; 70 days; and 68 days. *Id.* More children were in hospital overstays and the DSS office.

Moreover, as Kanaiyah’s death demonstrates all too vividly, grave safety and health risks exist.

- In the pending *T.G. v. DHS* federal class action regarding hospital overstays, unsafe practices concerning 1:1 aides were documented as having been reported to DHS, *e.g.*, a child who accessed fentanyl while purportedly supervised by a 1:1 aide in a hotel, and hospital reports that a child’s “sitter today is completely passed out” and that another aide was “spending time on social media and playing on the phone, rather than engaging with the child. *See T.G. v. MDHS*, Civ. A. No. 23-1433-MJM (D. Md.), Pls. Rev. Mem. in Supp. of Mot. to Reopen Class Cert. (Feb. 5, 2026), at 4, 24-25.
- Approximately one-third of Baltimore City DSS foster parents do not receive training required by law. (BCDSS Milestone Report, filed in *L.J.*, ECF 725-5 at 28).
- Baltimore City foster children are not having mental health needs met in 28% of the cases and are not having physical health needs met in 35% of the cases. (Md. SSA, most recent “CFSR” data).
- In FY 2025, only 68% of Baltimore City foster children had timely comprehensive health exams; only 51% had annual medical examinations; and only 46% had *annual* dental exams (and these are required twice yearly). (*L.J.* Defs. 73rd Rep. and Headline Indicators). Most worrisome, only 46% of Baltimore City children 48 months or younger had timely EPSDT exams during the most recent reporting period. (*L.J.* data compiled by Independent Verification Agent, to be reported in response to Defs. 73rd Six-Month Compliance Rep.)
- Virtually no Baltimore City foster children had health passports timely delivered to their caregivers, and, similarly, virtually none had health passports updated annually. (SSA Headline Indicators).

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- From Oct. 2023 through Oct. 2024, the rate of children aged 3-5 years old attending preschool, kindergarten, or first grade ranged from a high of 29% to a low of only 10%, with the average falling below 20%. (BCDSS Milestone Rep. 26).
- Instead of providing crisis intervention services, DHS is relying on hospitalization more than ever. For the year ending in September 2025, 717 foster children were admitted to medical hospitals and 511 to psychiatric hospitals, an increase respectively of 639% and almost 137% over the same period a year before. (Budget data reported in Feb. 23, 2026 *Baltimore Sun*). These data are shocking.

And the problems extend to basic casework: permanency planning and services to families:

- As of October 2024, only 27% of Baltimore City foster children were in care for less than one year, compared to 34% who had been in care for three years or more. (BCDSS Milestone Report, *L.J.*, ECF 725-5 at 18-19). The state standard is that 40% of foster children should return home within one year of entering foster care, yet, in FY 2025, just over 24% of foster children statewide returned home within one year. (*Balt. Sun* Feb. 23, 2026). Permanency was achieved in only 19% of BCDSS cases within one year, far below the state standard of 35%. (BCDSS Headline Indicators report).
- Over half (54%) of BCDSS children are not meeting permanency goals. Less than a quarter (23%) are meeting expected permanency outcomes. (most recent state CFSR).
- The most recent state CFSR review of Baltimore City DSS found that case planning was unsatisfactory in a *majority* of cases (56%).
- BCDSS provided appropriate services to parents and assessments of their needs in only 27% of its foster-care cases. (most recent state CFSR).
- According to recent budget data reported in the *Baltimore Sun*, “[t]he percentage of foster children who were reunited with their families, but ended up being removed again within 12 months, went from just over 9% in fiscal 2024 to 13% the following year. DHS said it tries to connect families to community services to address their needs and promote stability but there can be long waits and a limited number of providers.” (*Balt. Sun*, Feb. 23, 2026).
- 23% of children in BCDSS custody lacked stable living situations per last year’s CFSR (“In the majority of these cases, the review showed that placement providers were having difficulty managing the behaviors or developmental disabilities of the children

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in their care and services were not provided to them in order to support their ability to maintain the placement. As a result, placement disruptions occurred.”) (2024 CFSR).

- ***Safety concerns currently exist in 15% of BCDSS cases.*** (Current CFSR). The DLS audit raises clear concerns that safety standards are not followed in all cases for aides and group homes. In a recent six-month reporting period, maltreatment while in care occurred in 1.4% of the Baltimore City OHP cases, far below the *L.J.* and federal standard. (*L.J.* Independent Verification Agent report).
- Placement instability remains high, at approximately 50% higher than the State’s standard for acceptable number of moves per child per year. (BCDSS Headline Indicators). Statewide, in fiscal 2025, the rate was one move every 161 days, compared to the state’s goal of no more than one every 243 days. (*Balt. Sun*, Feb. 23, 2026).

It is time for the General Assembly to act.

B. HB 980’s Reforms Help Address These Grave Problems.

1. *Prohibiting Use of Illegal Unlicensed Settings as Ersatz Foster-Care Placements.* HB 980 flatly prohibits the use of offices, hotels, motels, and other unlicensed settings by DHS in lieu of licensed foster care. I applaud and strongly support this but note that hospital overstays, which also are not licensed to provide foster care are not specified in the statute. This omission should be fixed.

Also, the bill should clarify that the prohibition applies to any child housed in an unlicensed setting for four hours or longer. This is the definition that DHS accepted in the *L.J.* Modified Consent Decree. For consistency, it should be applied here. DHS’s use of 24 hours as the standard is unacceptable. This is important because, otherwise, foster children will spend the night in a DSS office, be removed by the worker and taken by the worker on errands or to school, and then returned to the office for another overnight stay, without that counting as an illegal placement. The bill should make clear that no overnight stay is permissible.

Finally, the bill uses the term “placed in”. It is unfortunate that we must worry about semantics, but the fact is that the Department does not consider an office or a hospital overstay to constitute a “placement.” I suggest that the term “placed” be replaced by “housed or maintained”.

2. *Requiring guardians to report criminal background checks showing risks to foster children in their care.* Given the DLS audit’s alarming finding about possible predators allowed in guardianship homes, this is a sensible and important reform. While compliance will be difficult to enforce, most guardians should comply, and greater safety thus should ensue.

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The bill does not, however, address the major safety issues concerning 1:1 aides, such as the aide who failed Kanaiyah. These aides are unregulated. No COMAR provisions exist. Individual DSS offices may have provisions in contracts regarding training and qualifications, and the Baltimore City provisions are reasonable, but no regulations govern how a local DDS must monitor the quality of aide services and address deficiencies. This is an important loophole that should be closed.

3. *Creating a statewide ombudsman for foster children with broad investigatory powers.* This might be the most important element of Kanaiyah’s Law. The child-welfare system is closed to the public and lacks accountability. Juvenile court CINA proceedings are confidential and, in any event, do not address systemic deficiencies and needs. Advocates for Children & Youth, the principal child advocacy organization in Maryland, closed in 2020 after three decades of important work, due to a loss of foundation funding. Other states and cities have publicly funded oversight of foster care services, often using an ombudsman model, such as New Jersey, Michigan, Rhode Island, California, Chicago, Massachusetts, etc. Maryland desperately needs this, and HB 980 commendably establishes an ombudsman office for Maryland foster children. My only concerns are that:

(1) Protections need to be required that shield the ombudsman from adverse influence and oversight by the Attorney General. The Attorney General defends DHS and MDH in related federal class actions (including the *L.J.* and *T.G.* cases cited above) and other matters. To protect against conflicts of interest, the bill should be amended to make clear that the ombudsman will operate with full independence and to prohibit the Office of the Attorney General from exercising oversight and any substantive control over the ombudsman’s work. The former Office of Independent Juvenile Justice Monitor provides a good model for this.

(2) No budget is established. The ombudsman’s scope of work is large. Without sufficient funds, it will be impossible for the ombudsman to perform effectively.

(3) The mission should make clear that the ombudsman shall address systemic deficiencies in the child welfare and foster-care systems, so that there will be strong analyses and reports of data similar to what is reported above. As currently drafted, the duties focus more on individual case investigations than system-wide oversight and accountability.

C. Specific Amendments.

1. On page 6, after line 22, add new line: “4. A HOSPITAL WHERE A FOSTER CHILD HAS BEEN DETERMINED BY HOSPITAL STAFF TO BE MEDICALLY READY FOR DISCHARGE AND IN NEED OF A FOSTER-CARE PLACEMENT.”

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2. On page 7, after line 5, add new paragraph: “(IV) ‘HOUSED OR MAINTAINED’ MEANS ANY STAY IN AN UNLICENSED SETTING LASTING FOUR HOURS OR LONGER.”

2. On page 7, line 30, replace “PLACED” with “HOUSED OR MAINTAINED”.

3. On page 7, after line 31, add new paragraph: “(3) THE DEPARTMENT SHALL ADOPT REGULATIONS REQUIRING ALL LOCAL DEPARTMENTS TO MONITOR THE PERFORMANCE OF AIDES UNDER CONTRACT WITH THE LOCAL DEPARTMENT IN PROVIDING SUPERVISION AND ENSURING SAFETY OF FOSTER CHILDREN IN THEIR CARE.”

5. On page 13, after line 20, add new paragraph: “(E) THE ATTORNEY GENERAL SHALL DEVELOP AND IMPLEMENT PROCEDURES THAT PRESERVE THE INDEPENDENCE OF THE OMBUDSMAN AND ENSURE THAT THE OMBUDSMAN IS NOT SUBJECT TO THE OVERSIGHT OR CONTROL OF THE ATTORNEY GENERAL OR THE OFFICE OF THE ATTORNEY GENERAL.”

6. On page 16, line 1, replace “CHILD ADVOCATE” with “OMBUDSMAN” and “ITS” with “THEIR”.

D. Conclusion and Personal Background.

Kanaiyah’s Law is the most important foster-care reform bill that I have seen in Maryland in my professional career. It would ban practices that should never occur in a good system. It would close major safety loopholes that endanger foster children. And it would inject oversight and accountability into a closed, secretive system that largely functions without public access and knowledge. This is the least we can do for the thousands of abused, neglected, and abandoned foster children in state custody—*our* custody.

I say this as someone who has worked on foster-care and child-welfare reform since 1979, at both federal and the state levels, including 4½ years representing hundreds of Baltimore City foster children while working at Maryland Legal Aid. Since 1988, I have served as lead counsel in the federal *L.J.* case monitoring implementation of a consent decree and then a comprehensive modified consent decree for Baltimore City foster children. Even though a court order issued in 1988 prohibits the use of hotels and the modified consent decree issued in 2009 flatly prohibits housing foster children in any unlicensed facility, the defendants have repeatedly violated these requirements, causing multiple petitions for enforcement and/or contempt. Three years ago, I joined Disability Rights Maryland in bringing the federal *T.G.* class action to end hospital

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overstays (outside of Baltimore City). Separate from this litigation, I have testified many times before the General Assembly on various child-welfare and foster-care legislation.

Again, this is the best, most important legislation that has been introduced in the General Assembly in all of my decades of work on this issue. I applaud and thank the Delegates for their work in putting it together. I cannot think of a better way to mourn Kanaiyah's death and to celebrate her life than to issue a favorable report to HB 980 (with the proposed amendments) and to pass it as soon as possible.

Thank you for your consideration.

Respectfully submitted,

/s/ Mitchell Y. Mirviss