STATE OF
LOUISIANA
CHILD OMBUDSMAN

2025
Annual Report

STATE OF
LOUISIANA
CHILD OMBUDSMAN

YOUR TRUSTED ADVISORS

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WHAT'S INSIDE

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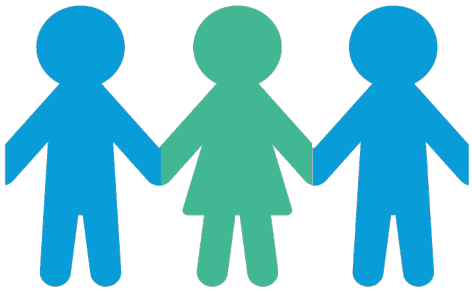


FROM THE OMBUDSMAN'S DESK

The Louisiana Legislature created the State Child Ombudsman within the office of the Louisiana Legislative Auditor (LLA) through Act 325 of 2023, with an effective date of July 1, 2023. The State Child Ombudsman was appointed effective October 1, 2023, and began planning and implementing the statutory duties outlined in La. R.S. 24:525. This first Annual Report of the Child Ombudsman Division is to satisfy the statutory requirement in Section 525 (12) and report data from calendar year 2025.

The duties of the Child Ombudsman Division of the LLA fall into two distinct categories: (1) Assist individuals who raise concerns about state services to children, including acting as a liaison for a child or family with the agency or provider, as well as making appropriate referrals; and (2) Evaluate and monitor public and private agencies, including periodic review of policies and procedures, with a view to protecting the rights, needs, welfare, and safety of children and make recommendations for systemic reform. There are other specific statutory duties outlined, as well.

In its first full year of operation, 2024, the Deputy Director of Child Ombudsman Services joined the staff. In 2025, staff capacity was expanded to include an Intake Coordinator and Assistant Child Ombudsman for Education Matters. Working with a contracted software designer, the Child Ombudsman Division designed and implemented a case management system for accurate case tracking and data collection. Written operational procedures were developed and tested. The Child Ombudsman webpage has been updated with an online complaint form, and a dedicated telephone complaint line was launched.

On the Web: *lla.la.gov/services/child-ombudsman*

EXECUTIVE SUMMARY

In 2025, the State Child Ombudsman Division, established within the Louisiana Legislative Auditor in 2023, continued building infrastructure, expanding capacity, and addressing concerns related to children served by state agencies. The Child Ombudsman Division's core mandate includes responding to individual complaints and identifying systemic issues affecting children's safety, rights, and wellbeing.

Operations and Capacity

The Division added an Intake Coordinator and an Assistant Ombudsman for Education Matters, launched a case management system, established operational procedures, and expanded access through an online complaint form and dedicated phone line.

Complaint Overview

The Ombudsman handled **371** complaints involving **575** children. Eighty percent of cases were closed, with two-thirds resolved through full review. Complainants included families, foster parents, youth, attorneys, service providers, educators, and other concerned individuals.

Most concerns involved the Department of Children and Family Services (83%), followed by the Department of Education (10%), Department of Health (3%), and Office of Juvenile Justice (<1%).

Key Themes and Systemic Issues

Department of Children and Family Services Concerns:

- ***Communication Failures:*** 230 reports involved unreturned calls, inadequate information, or misinformation.
- ***Relative Placement Barriers:*** Multiple cases showed failures in family notification, delays in home studies and ICPC processes, and departures from federal and state kinship placement requirements. Children often remained separated from relatives for months or years.
- ***Children Held in Psychiatric Hospitals After Discharge:*** Twenty-four complaints involved children—primarily foster youth—remaining hospitalized for extended periods after clinical clearance due to a lack of safe placements.
- ***Policy Noncompliance:*** Complaints revealed failures to follow required investigative procedures, breaches of confidentiality, improper denial of recording rights, untimely forensic interviews, and lengthy delays in case determinations.

Education Concerns:

Thirty-seven complaints involved special education services, discipline practices, IEP implementation, and Child Care Assistance Program (CCAP) errors. Many issues were resolved through coordination with schools and the Department of Education.

Child Fatalities:

- DCFS reported two foster child deaths in 2025.
- Following an August 2025 statutory change, the Ombudsman received 12 notifications of pending child death investigations but did not receive disposition outcomes.
- The Ombudsman issued 21 legislative notifications for fatalities confirmed by DCFS as resulting from abuse or neglect; most deaths involved children ages 0–3 and occurred across 16 parishes.

Outreach and Statutory Duties

The Division collaborated extensively with DCFS, OJJ, LDH, LEAs, CASA programs, legal advocates, grandparents' groups, behavioral health providers, and others. Staff served on commissions and committees, engaged in legislative advocacy, and advanced work on the first Biennial Conditions of Confinement Report.

Recommendations

The Child Ombudsman Division recommends:

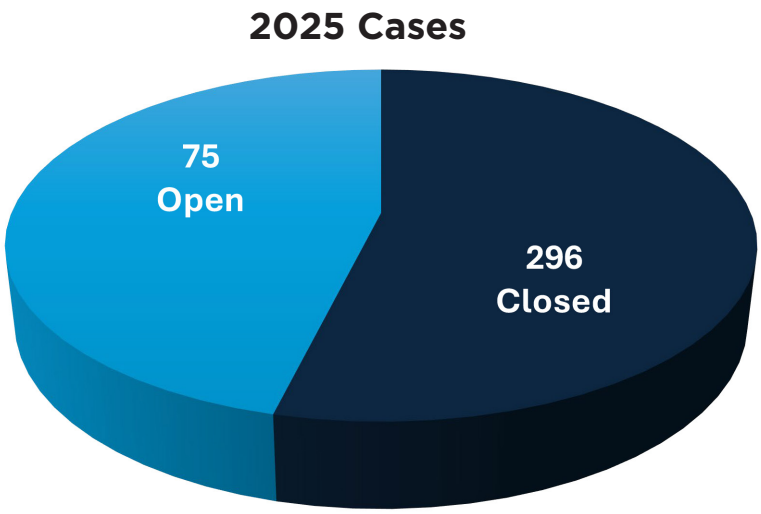
- Enhance DCFS data tracking on sibling separation, family notification, and time to kin placement.
- Review and revise hospital discharge placement practices.
- Strengthen compliance with placement, investigation, and confidentiality policies.

In 2026, priorities include expanding staff capacity, improving complaint response timelines, monitoring family notification requirements, enhancing oversight of detention conditions and congregate care, and deepening analysis of child fatalities.

2025 ACTIVITIES

In 2025, the Child Ombudsman Division received 371 complaints. Complaints were received from parents, foster parents, grandparents, other family members, attorneys, CASA volunteers, service providers including medical personnel and mental health providers, teachers, former foster youth, DCFS caseworkers, and concerned citizens.

Case Volume and Status



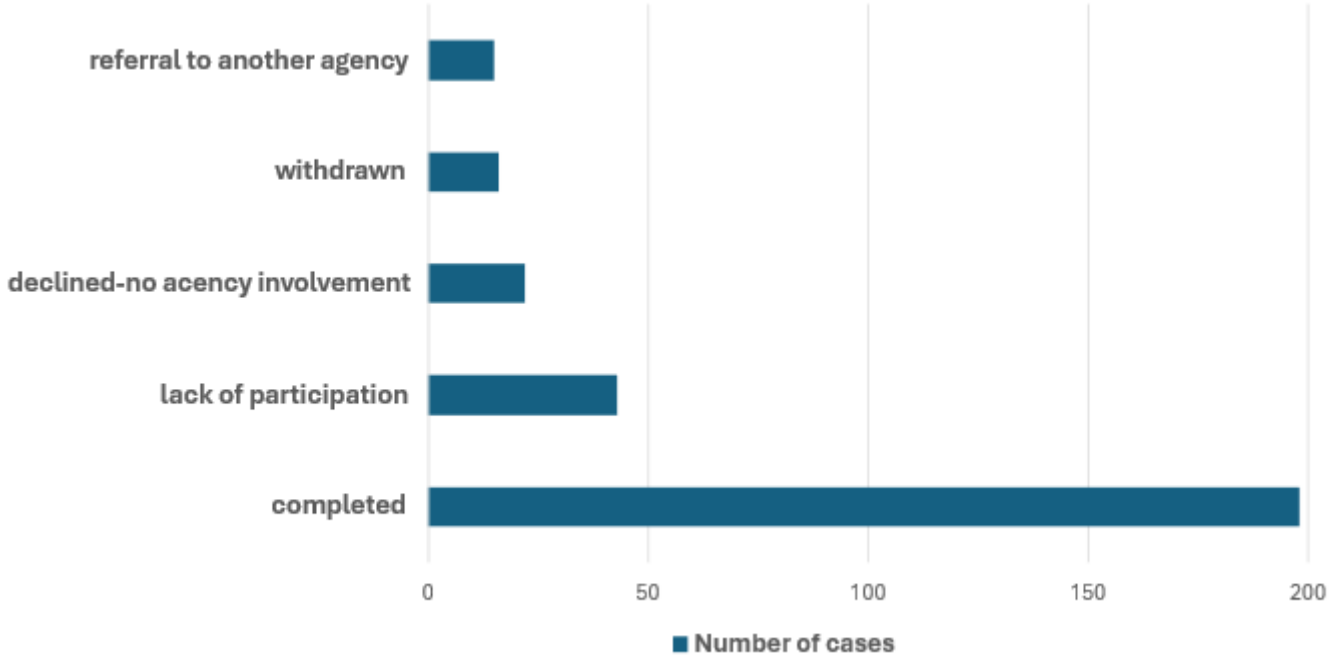
In 2025, the Office handled 371 total cases.

- 75 cases (20%) remain open as of December 31, 2025
- 296 cases (80%) were closed as of December 31, 2025

Closure Types (296 Closed Cases)

- *Completed:* 198 (67%)
- *Incomplete Complaint:* 1 (<1%)
- *Declined – No Stated Agency Involved:* 22 (7%)
- *Referred to Appropriate Agency:* 15 (5%)
- *Complaint Withdrawn:* 16 (5%)
- *Lack of Complainant Participation:* 43 (15%)
- *Administrative/Blank:* 1 (<1%)

Closure Types Breakdown



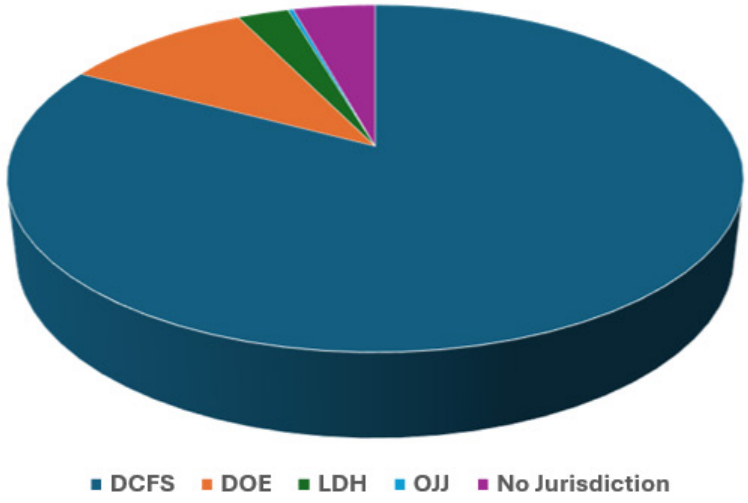
The majority of closed matters (67%) were completed through full review and resolution.

State Agencies Connected to Cases

Of the 371 cases handled in 2025, concerns involved the following agencies:

- *Department of Children and Family Services (DCFS):* 307 cases (83%)
- *Department of Education (DOE):* 37 cases (10%)
- *Department of Health:* 10 cases (3%)
- *Office of Juvenile Justice:* 1 case (<1%)
- *No State Agency Under Office Jurisdiction:* 16 cases (4%)

Agencies Connected to Complaints



The overwhelming majority of cases (83%) involved DCFS.

ISSUES REPORTED – DCFS

A total of 307 cases involved the Department of Children and Family Services (DCFS). Reported concerns included:

Most Frequently Reported Issues:

- *Lack of Communication by DCFS Case Worker:* 123
- *Insufficient Information Provided by DCFS Case Worker:* 60
- *Misinformation Provided by DCFS Case Worker:* 47
- *Relative Placement Concerns:* 31
- *Failure to Place Child After Discharge from Mental Health Facility:* 24
- *Sibling Separation:* 18
- *Policy Concerns:* 14

Additional Reported Issues:

- *Case Plan Deficiencies:* 6
- *Dilatory Referrals by Case Worker:* 4
- *ICPC Concerns:* 4
- *Lack of Services:* 4
- *Parent Representation:* 3
- *Child Representation:* 2
- *Child Treatment in Placement:* 3
- *Unprofessional Behavior of Worker:* 3
- *Notice Issues:* 1

Note: *Multiple issues can be reported per case.*

DCFS Case Descriptions

Communication Concerns:

Communication-related concerns (lack of communication, insufficient information, and misinformation) accounted for 230 reports, representing a substantial portion of DCFS-related complaints. Complaints ranged from a case worker's failure to return repeated phone calls to insufficient or inaccurate information provided to the complainant or contained in case records. In these cases, the Ombudsman's Office facilitated communication with the Department to address the complainant's concerns.

Relative Placement Concerns:

Children entering foster care experience significant trauma associated with removal from their homes. Placement decisions are among the most critical determinants of child well-being system outcomes. Research and law at both the federal and Louisiana levels strongly support prioritizing placement with biological relatives and fictive kin whenever safely possible. [42 U.S.C. § 671(a)(19), 673(d) and 675 and La. ChC. Art. 622, 683 and 702]

Children's Code Art 672.3 places an affirmative duty on DCFS to conduct a diligent search for adult relatives within **30 days** of the child's removal and to continually search for relatives. DCFS has an affirmative duty to notify the family of the child's circumstances and the options for placement with family. In the DCFS and court files reviewed, there were no required notifications documented.

Additionally, DCFS Policy 6-300, *Guidelines for Selecting a Care Setting*, clearly states: ***"Relatives and kin should always be considered as a care setting option for a child prior to placing a child in other types of family homes when the relative and kin have passed all criminal and agency clearance requirements..."***

In 2025, the Child Ombudsman's Division received **31** complaints regarding DCFS's decisions and actions regarding child placement with family. This section highlights examples of barriers faced by grandparents and other family members attempting to provide placement for the child with family.

Example 1 – Two young children and the maternal grandmother

Two young children, ages 4 and 18 months, were removed from their mother's care following a serious head injury of the 4-year-old. At the time of removal, the children's mother provided the name and contact information for the maternal grandmother. There is no indication that the department made any effort to contact the grandmother, who was residing in Virginia. When the grandmother learned that her grandchildren were in foster care, placed in separate foster homes, in Louisiana, she contacted the Department. After DCFS failed to initiate the ICPC (Interstate Compact on the Placement of Children) for over five months, the grandmother moved to Louisiana. Even once she was in the state, it took another 22 months, and the intervention of the Child Ombudsman's Division, for the children to be placed with their grandmother. The grandmother recently adopted these children.

Example 2 – A young child and maternal grandparents

A 2-year-old child was placed in state custody when his parents were unable to care for him. His maternal family members contacted DCFS regarding placement. He was first placed in a non-relative foster family and then moved to the maternal uncle's home. He remained in this relative placement for 19 months when the Department decided to change his placement. The relatives weren't told until they arrived at daycare to pick up the child. The child was then placed in a non-relative foster home for approximately 8 days before he was moved to yet another non-relative foster home. The maternal grandfather and grandmother had consistently offered their home for placement. Even though these grandparents had previously been awarded custody of the child's

two half-sisters, DCFS refused to consider their home as placement for the child. The DCFS case worker failed to give the grandparents the required forms to facilitate the placement, failed to follow Department policy regarding home studies, and required the grandparents to provide unnecessary and repetitive forms. After two years and four months, and intervention by the Child Ombudsman's Division, the child was placed with his grandparents. He has since been adopted and is thriving.

Example 3 – A newborn child and paternal grandparents

The child was born substance exposed and, according to law, DCFS was notified. When the CPI (Child Protection Investigator) arrived at the hospital, the mother was on a Zoom call with the father, who was in jail. The CPI was provided with the father's name and location. When the CPI later interviewed the father, he provided the name and contact information for his parents and his sister. However, the father's family was not contacted by DCFS. When the child was discharged from the hospital, the mother was unable to provide a safe home, and the father was still in jail awaiting trial. The child was placed in a non-relative foster home. When the paternal grandmother contacted DCFS, she was told that grandparents have no rights. The paternal family persisted and DCFS then decided that paternity testing would be required before there would be any visitation. DCFS Policy 6-410 clearly states, ***"If an individual accepts paternity his claim shall be accepted, unless the mother denies his paternity or multiple individuals claim paternity."*** *Even though Department policy is clear that in this case paternity testing should not be required, the case worker nevertheless refused to work with the father's family without paternity testing. The father, still in jail, cooperated with the testing, and his paternity was established. Department policy requires paternity testing within 30 days, but in this case the Department's testing took 23 months to complete. DCFS still refused to work with the paternal grandparents, claiming that the child had been with the foster family so long that it would be in the best interest of the child to be adopted, even though all delays were engineered by DCFS. The grandparents hired an attorney, filed an Intervention in the CINC case, and were ultimately awarded custody of the child after almost three years of opposition by DCFS.*

There have also been complaints filed by foster parents and CASA volunteers when a child who has been with a foster family for over a year is abruptly moved to a relative that the child has never met. This type of disruption causes significant trauma for a child. Recognizing this, the Legislature enacted ChC. Art. 672.3 in 2021, requiring diligent efforts to locate and work with the child's biological family as soon as the child is placed in DCFS custody. The Department is not following this law with fidelity. Additionally, Department Policy 6-305 requires a child-sensitive transition plan to minimize the trauma to the child. DCFS does not always follow its policy in transitioning children between placements.

Although federal and state law, as well as DCFS policy, prioritize relative placement, in 2025 data reflects less than 20% of children in foster care were placed with their family in certified foster homes, and approximately an additional 20% placed with relatives in non-certified family homes. Department data also indicates that relative family placement takes an inordinate amount of time to achieve. *Department Data regarding Family Placement is included in this report as Appendix C.*

Child Placement After Medical Discharge Concerns Identified Through Complaints:

The Child Ombudsman's Division received 24 complaints regarding children remaining in mental health hospitals after being clinically cleared for discharge. This reflects a systemic failure, including inadequate community-based behavioral health services, shortages of therapeutic foster placements, and delays in child welfare decision-making. These children no longer meet medical necessity criteria for inpatient care, yet remain hospitalized due to the absence of safe, appropriate discharge options, resulting in unnecessary institutionalization. This practice is costly, exposes children to potential harm from prolonged hospital stays, and restricts access to inpatient beds for other youth in acute psychiatric crisis. Moreover, it undermines federal and state legal principles favoring care in the least restrictive, most family-like setting. Addressing this issue is critical to ensuring timely access to appropriate care, protecting children's rights, and improving overall system outcomes.

Of the 24 complaints received in 2025, there were 16 foster children placed in a psychiatric hospital, and at discharge DCFS did not place the child in either a home setting or a "step down" facility timely. The length of time these foster children remained in the hospital after discharge was months in some cases. The other 8 complaints regarding children left in the hospital were children originally hospitalized by parents or guardians and then abandoned. When DCFS was notified that the child had been abandoned, it sometimes took months for the Department to seek a custody order to place the child in an appropriate placement.

The Child Ombudsman's Division has addressed this issue with the Association of Hospital Administrators, the Mental Health Advocacy Services, and the Department. However, this issue has not been resolved.

Policy Compliance Concerns Identified Through Complaints:

This section highlights examples of policy concerns identified through complaints received by the Child Ombudsman's Division during the reporting period. In these cases, a review of documentation and applicable DCFS policies determined that required procedures were not followed. These examples illustrate areas where policy compliance issues occurred and demonstrate the types of concerns raised to the Child Ombudsman's Division regarding investigative practices, confidentiality of records, and the rights of individuals involved in child welfare investigations. The cases summarized below are provided to illustrate recurring or notable policy adherence concerns identified during the review process.

Example 1 – Failure to Interview Mandatory Reporter

The Child Ombudsman's Division received a complaint that a party with relevant information had not been interviewed in a case involving allegations of child sexual abuse. A review of the case records indicated that DCFS Policy 4-507 requires the reporter to be contacted during the investigation. Further review determined that the mandatory reporter—the child's therapist who reported the child's disclosure of abuse—was not interviewed. This constituted a failure to follow DCFS Policy 4-507.

Example 2 – Improper Disclosure of Confidential Records

The Child Ombudsman's Division received a complaint from an adoptive parent stating that medical records pertaining to a different child were sent to her. The records received by the adoptive parent belonged to a child unknown to the family. A review of Department policy determined that this disclosure violated DCFS Policies 1-500 and 1-510, which govern confidentiality and the proper handling of protected information.

Example 3 – Denial of Right to Record Interview

The Child Ombudsman's Division received a complaint from an alleged perpetrator who reported being informed that they were not allowed to record their investigative interview. A review of DCFS Policy 4-510 indicates that individuals are permitted to record their investigative interviews. Denying this request constituted a violation of DCFS Policy 4-510.

Example 4 – Failure to Conduct Timely Forensic Interview and Improper Disclosure of Victim Information

The Child Ombudsman's Division received a complaint that a child who made allegations of sexual abuse had not been interviewed at a Child Advocacy Center (CAC). A review of the case file indicated that the DCFS investigator interviewed the child on multiple occasions prior to scheduling a CAC interview. A CAC interview was only scheduled following intervention by the Child Ombudsman's Division.

DCFS Policy 4-507(C)(2) requires that a forensic interview be conducted in cases involving allegations of sexual abuse, regardless of whether the child has disclosed the abuse to the investigator. The failure to timely schedule a CAC interview constituted a violation of policy.

Example 5 – Unauthorized Disclosure of Reporter Identity Due to System Error

The Child Ombudsman's Division received a complaint from a mandatory reporter alleging that identifying information they submitted through the online reporting portal was disclosed to the alleged caretaker perpetrator.

The Child Ombudsman's Division confirmed that the reporter's identifying information was improperly shared in violation of DCFS confidentiality policy. The department attributed the disclosure to a system error that resulted in reporter information being included in correspondence sent to alleged perpetrators.

In response, the Department reported that it contacted affected individuals, alleged perpetrators, and requested that the improperly-disclosed documents be destroyed. In at least one instance, the alleged perpetrator could not be reached. The Child Ombudsman's Division met with DCFS regarding this issue and received assurances that corrective measures had been implemented to prevent recurrence.

Example 6 – Improper Emergency Placement Without Required Checks

The Child Ombudsman's Division received a complaint regarding the emergency placement of a child with a neighbor without appropriate screening. The complaint also raised concerns that the child had special needs, and that insufficient information was obtained prior to placement.

A review determined that DCFS failed to follow Policy 4-807 and 1-1000, which require registry checks and appropriate assessment of emergency placement caregivers. This case was discussed with the department, which reported that the worker involved received additional training on policies governing emergency placements.

Example 7 – Timely Determination of Investigation Outcome

The Child Ombudsman's Division received a complaint from a parent who was alleged to have abused the child. As a result of the investigation, the civil custody order was amended by the presiding judge pending the outcome of the investigation. The parent was allowed only supervised visitation with the child. DCFS Policy 4-525 states, ***"The final finding (validity determination) shall be completed on an investigation within 30 days of the receipt of the report. The decision shall be made in a worker/supervisor conference."*** *In this case, the investigation was opened in November 2024 and was only closed as "Invalid" in February 2026 after repeated intervention throughout 2025 by the Child Ombudsman Division. The result is that the family was disrupted for more than a year and four months.*

ISSUES REPORTED – DOE

A total of **37** cases involved the Department of Education (DOE). Reported concerns included:

- *Special Education:* 4
- *Discipline:* 2
- *Policy Concerns:* 10
- *Education Plan Implementation:* 9
- *CCAP:* 2
- *Lack of Services:* 1
- *Athletics:* 1
- *Child Find Evaluations:* 1
- *Child safety:* 6
- *Other:* 6

Note: *Multiple issues can be reported per case.*

Special education and discipline-related matters represented the largest categories of education-related complaints. In addition to communicating with DOE, the Child Ombudsman Division interacted directly with the Local Education Agencies (LEA) and school administrations to resolve most issues.

DOE Case Descriptions

The majority of complaints filed with the Child Ombudsman's Division related to Special Education, including Child Find Evaluations, sufficiency of the Individual Education Program (IEP), Implementation of an IEP, and availability of services. Other issues raised concerns over school discipline, certification of teachers, and denial of Child Care Assistance.

Education Concerns:

Special education and discipline-related matters represented the largest categories of education-related complaints. While special education is a broad category, the complaints received typically address the provision of services for children with disabilities or parents who wish to have their child evaluated for special education and related services.

Example 1 – Special Education Delay in Services:

The Child Ombudsman's Division received a complaint from a parent whose child attends a Type 3 charter school and the provisions of services were delayed. The child was evaluated and found to be eligible for special education services under the Individual with Disabilities Educational Act (IDEA). IDEA policy requires that an Individual Education Program (IEP) must be developed within 30 days of eligibility; however, the IEP was not developed and implemented within this timeframe, causing a delay in the services and accommodations for the child. The Child Ombudsman's

Division reviewed IDEA policy with the parent and explained the relationship between Type 3 charters and the local education agency (LEA). The Child Ombudsman Division also connected the parents with staff within the school responsible for ensuring that services were implemented. The Child Ombudsman's Division contacted the LEA administrator to inform them of the delay of services, and the LEA was able to assist the family with scheduling the IEP meeting with the appropriate staff. However, the school was in violation of Sec. 300.323 (c) of IDEA.

Example 2 – Special Education Child Find

The Child Ombudsman's Division received a complaint from the parent of a child with a disability who attends a public school. The student was previously identified as having a specific learning disability (SLD) in another state, and the parents requested an independent educational evaluation (IEE) to assess additional areas of learning. The independent educational evaluation found that the student was no longer eligible for the specific learning disability classification. The parents held several meetings with members of the students' Individualized Education Program (IEP) team to determine what support the student needed. The parents alleged that the IEE results were inaccurate and filed a formal complaint with Dispute Resolution at the Louisiana Department of Education and alleged that the district violated the Individuals with Disabilities Education Act (IDEA) and Louisiana Bulletin 1508. The parents requested that the Office of the Child Ombudsman review the timeline of events, district, and state policies to determine if there were any misinterpretations of state and federal policies. The Child Ombudsman Division collaborated with the Local Education Agency (LEA) to discuss parent concerns and to develop possible resolutions that would meet the education and developmental needs of the child. This case is ongoing.

Example 3 – School Discipline

The Child Ombudsman Division received a complaint from a parent who was concerned about how her child was being disciplined in the school setting. The parent reported that she would receive multiple calls each week regarding the child's behavior and would be asked to pick up the child from school. The mother stated that some of the behaviors were a manifestation of the child's disability and did not feel that the school made efforts to understand the causes of the behaviors, nor did she feel they worked with the child to decrease behaviors. The Child Ombudsman Division was able to communicate with the principal of the school to discuss Positive Behavior Intervention and Supports (PBIS) and community resources for families with children with disabilities. PBIS is supported by both the Individuals with Disabilities Education Act (IDEA), and Act 1225, Juvenile Justice Reform Act (R.S. 17:252), which prioritizes the use of positive behavior interventions and school-based strategies that reduce or eliminate punitive disciplinary options. The principal agreed to work with the family to develop behavioral goals and strategies for both home and school. Due to the advocacy and mediation of the Child Ombudsman Division, it was established that the school was able to provide behavioral support and community resources to improve outcomes for the child.

Example 4 – Child Safety

The Child Ombudsman's Office received a complaint from a parent of a child with autism who is blind and non-verbal and attends public school. The parents raised concerns about the safety of children with disabilities in school settings when students are non-verbal or use augmentative or assistive communication. The concern was raised after the parents were notified by school administration of incidents where their child was assaulted by paraprofessionals. The parents were initially unsuccessful with obtaining video footage from the incidents but were told that the staff involved in the incident were either terminated, retired, or resigned. After obtaining video footage, the family filed a civil lawsuit against the school district. The Child Ombudsman Division consulted with the family to review state and federal policies regarding child safety in schools, mandatory reporting, and the use of cameras in special education classrooms. The parents requested to be informed of state initiatives regarding child welfare and safety. Louisiana's Act 479 of 2025 mandates that all public and charter schools install audio and video in self-contained classrooms and require districts to be in full compliance by February 1, 2026. The implementation of this Act will be an area of policy review for the Child Ombudsman Division.

Child Care Assistance Program (CCAP) Concerns:

CCAP assists families with the cost of childcare needed for the parent to be employed, attend school, or complete training. This service is administered by the Louisiana Department of Education (LDOE). The Child Ombudsman's Division received a complaint from a parent whose CCAP renewal was denied, and her case had been closed in error. This error prevented the daycare from receiving payments, and her child was unable to attend daycare. The Child Ombudsman Division communicated with the Louisiana Department of Education - Early Childhood Office on behalf of the parent to share required documentation and to evaluate how the case closure impacted the parent and child. The LDOE was able to research the case and determined that the case was in fact closed in error. Although the case closure was overturned, the mother waited over a month for a resolution and was unsuccessful contacting her case worker during this process.

ISSUES REPORTED – LDH

During 2025, the Child Ombudsman's Office received 10 complaints raising concerns about hospital discharge (3); Medicaid and Waiver applications (2); accessibility of services for children, particularly ABA therapy (2); and complaints regarding SNAP applications (3) after The Louisiana Department of Health (LDH) assumed responsibility of the SNAP benefits program in October 2025. In each matter, the Child Ombudsman Division was able to connect the individual with appropriate Department personnel to resolve the concern.

ISSUES REPORTED – OJJ

During 2025, the Child Ombudsman's Division received only one complaint involving the Office of Juvenile Justice (OJJ). The concern was regarding the probation supervision of a 16-year-old child. The Child Ombudsman's Division was able to facilitate communication with the probation officer. The child successfully completed probation.

Additionally, the Child Ombudsman's Division operates the 24-hour PREA (Prison Rape Elimination Act) hotline for the juvenile secure facilities in Louisiana. In this reporting year, the Child Ombudsman's Division received 12 calls that required reporting to the facility and the OJJ PREA coordinator for intervention and further investigation.

CHILDREN IMPACTED

In 2025, complaints handled by the Child Ombudsman Division pertained to 575 children. This reflects that many complaints involve multiple children within a single family or case.

RECOMMENDATIONS

Based on issues identified through complaints and case reviews, the Child Ombudsman's Division recommends targeted efforts to strengthen data collection, improve placement practices, and enhance decision-making processes affecting children in care.

Enhanced Data Collection and Monitoring:

The Ombudsman's Division recommends that the Department of Children and Family Services (DCFS) expand data collection and tracking in key areas impacting child placement and family connections. This includes:

- The frequency and duration of sibling separation following removal;
- The timeliness of notification to relatives when a child enters care; and
- The amount of time between a child's entry into care and placement with a relative.

Improved data in these areas would support greater transparency, allow for better oversight, and inform policy and practice improvements aimed at preserving family connections.

Review of Hospital Discharge Placement Practices:

The Ombudsman's Division recommends that DCFS reevaluate its processes for handling child placements when children are medically discharged from psychiatric hospitals.

OUTREACH AND COLLABORATION

Staff of the Child Ombudsman's Division engaged in ongoing outreach and collaboration with a range of state agencies, local entities, and community stakeholders to address systemic issues and improve outcomes for children and families.

The Child Ombudsman Division participated in meetings with the Office of Juvenile Justice (OJJ), the Department of Children and Family Services (DCFS), Special Education (SPED) directors, and the Office of Behavioral Health. Staff also met with individual parish administrations to discuss local concerns and coordination of services.

In addition, the Child Ombudsman Division engaged with community-based stakeholders, including Grandparents Raising Grandchildren, Court Appointed Special Advocate (CASA) program directors, the statewide network of Family Resource Centers (prior to the Department cancelling the FRE contracts), Disability Rights Louisiana (formerly known as the Advocacy Center), the Louisiana Center for Children's Rights (LCCR), and Early Childhood Supports and Services providers, to better understand the needs of families and identify service gaps.

The Ombudsman's Division is also in the process of scheduling a meeting with the School Superintendents Association to further strengthen collaboration with education partners.

LLA team members always welcome the chance to talk to people outside the office, and in 2025 State Child Ombudsman Kathleen Richey – with Sandra Adams of Rotary Club of Baton Rouge – spoke to club members about the work her section does. *(LLA Photo)*

ADDITIONAL STATUTORY DUTIES

La. R.S. 24:525

Public Education and Legislative Advocacy – Section C (6)

The Child Ombudsman Division staff serve on several commissions, task forces, and committees designed to improve services for children and families, including:

- The Children's Cabinet Advisory Board and its work groups
- The Task Force on Child Sexual Abuse Investigation
- The State Child Death Review Panel [in accordance with Section C (9)]
- The Children's Code Committee of the Louisiana Law Institute
- The Children's Law Committee of the Louisiana Bar Association

In fulfilling the duty of Legislative Advocacy, the Child Ombudsman Division staff have worked with several Senators and Representatives to identify and craft needed legislative and policy revisions.

Community Outreach – Section C (10)

The Child Ombudsman Division staff have communicated and met with many individuals in the community, including parents, grandparents and family members, foster children, foster and adoptive parents, attorneys, CASA volunteers, agency staff, and service providers, including mental and behavioral health professionals, hospital administrators, residential care staff, and school personnel.

The Child Ombudsman Division has deferred implementation of a formal public awareness campaign due to current staff capacity and the potential for increased complaint volume. The office anticipates that a broad awareness initiative would likely result in a significant rise in calls and complaints requiring review and response.

Despite postponing a formal campaign, the office continues to engage in community outreach and stakeholder engagement activities. These efforts include providing education to community partners, service providers, and the public regarding the role, responsibilities, and functions of the Child Ombudsman Division. As a result of these engagements, the office regularly receives additional calls and inquiries raising concerns about child welfare, juvenile justice and education matters.

Biennial Conditions of Confinement Report – Section C (11)

The Child Ombudsman Division is preparing its first *Biennial Conditions of Confinement Report* in this reporting period. This report, which evaluates the conditions under which children are confined in secure detention facilities operated by a state agency, will be published on the Legislative Auditors' website and formally submitted to the legislature.

The *Biennial Conditions of Confinement Report* serves as a tool in identifying systemic issues affecting the treatment and rehabilitation of youth in confinement. The findings and recommendations provide a roadmap for future legislative action and facility reforms, emphasizing that a holistic approach is needed to improve both the physical environment and the treatment of children in state-run facilities. The Child Ombudsman Division will continue to monitor progress and advocate for the necessary reforms to ensure the rights and well-being of all children in the care of the state.

Report of Death of Children in State Custody – Section D (1)

The law requires that any state agency having responsibility for the custody or care of children provide monthly notice to the Child Ombudsman of the death of a child in its care or custody. In 2025, the Office of Juvenile Justice reported no (0) deaths of youth in care. The Department of Children and Family Services reported the death of two (2) foster children, although the circumstances of those deaths were not reported. In 2025, the Department of Health did not make any reports.

Child Fatality Notifications – Section C (13) and D (2)

Statutory Notification Requirement

The law requires DCFS to notify the Child Ombudsman of any child death that has been reported to the department for alleged abuse or neglect. The department was not statutorily required to report open investigations of child deaths until August 1, 2025. As a result, the Child Ombudsman's Division did not receive notice of pending investigations prior to that date unless and until a final determination was made.

Pursuant to statutory mandate, the Child Ombudsman is required to notify the Senator and Representative of the legislative district in which a child has died as a result of abuse or neglect within twenty-four (24) hours of being informed of the death. Notice is made once DCFS confirms that the child fatality was the result of abuse or neglect.

Pending Death Investigations (Post–August 1, 2025)

The department was not statutorily required to report investigations of child deaths resulting from abuse or neglect until August 1, 2025. Since that date, the Child Ombudsman Division has received notification of 12 pending death investigations that occurred in 2025. However, DCFS has not provided dispositions as to whether these deaths were the result of abuse or neglect.

Additionally, the Child Ombudsman Division has not been informed by the department of any investigations initiated prior to August 1, 2025, that remain outstanding.

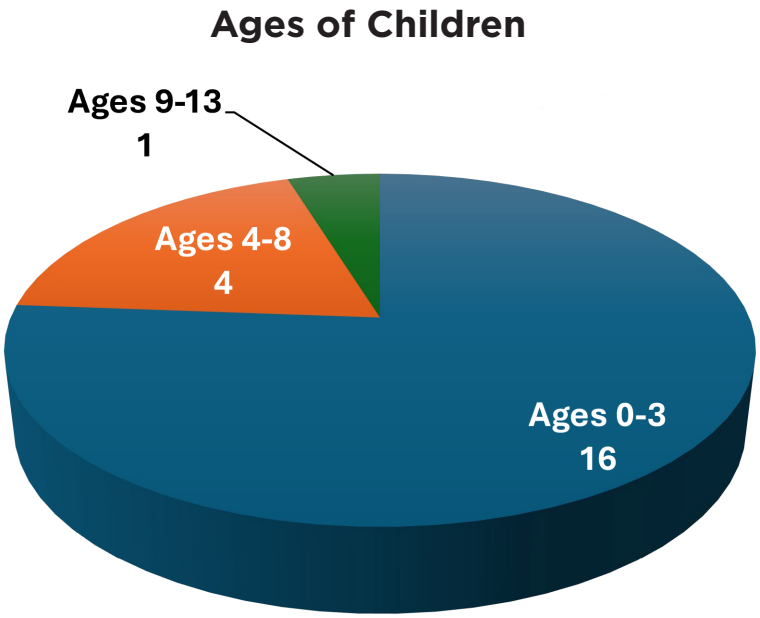
During the reporting period, calendar year 2025, the following investigations were pending with no determination of abuse or neglect provided by DCFS as of December 31, 2025:

Child's Age at Death	Parish of Child's Death	Investigation Notification Date to the Child Ombudsman
0-3	Caddo	9/3/2025
0-3	Calcasieu	12/19/2025
0-3	East Baton Rouge	9/25/2025
0-3	Lafayette	9/6/2025
0-3	Lafayette	8/14/2025
0-3	Lafayette	10/23/2025
9-13	LaSalle	10/25/2025
0-3	Lincoln	8/29/2025
9-13	Orleans	8/27/2025
0-3	Rapides	8/8/2025
0-3	Rapides	9/15/2025
4-8	Rapides	10/23/2025

Confirmed Fatalities Reported in 2025

In calendar year 2025, the Child Ombudsman's Division issued legislative notifications in accordance with the statute for **twenty-five (25)** child fatalities. Of these notifications **twenty-one (21)** were made upon receipt of confirmation from DCFS that the department had determined the deaths to be the result of abuse or neglect. **Four** of the notifications were made after Child Ombudsman staff was made aware of a child death by the media. *The dispositions received from DCFS are attached as Appendix A.*

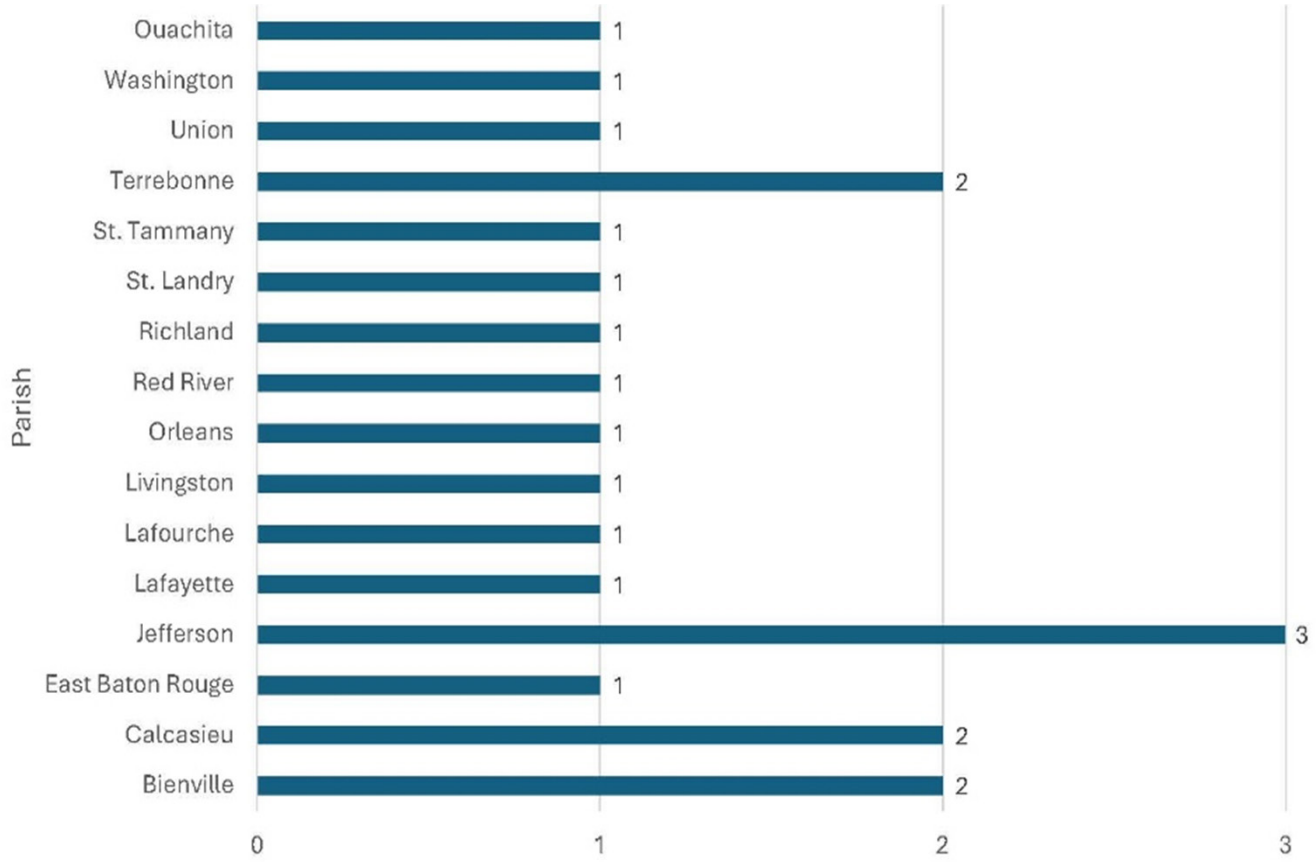
The ages of the children whose deaths were confirmed by DCFS to be the result of abuse and neglect ranged from **newborn to twelve (12) years old**. A significant majority of the fatalities — **sixteen (16) of the twenty-one (21) deaths (76%)** — occurred among the most vulnerable population: **children aged zero (0) to three (3) years**.



Of the twenty-one fatalities of which the Child Ombudsman Division was notified by DCFS, **twenty (20)** occurred in 2025, and **one (1)** occurred in 2024. The Child Ombudsman Division received notice in May 2025 that the death occurring on August 7, 2024, had been determined to be the result of abuse and neglect. Upon receipt of this determination from the department, the Child Ombudsman Division notified the appropriate parties within the relevant legislative district on the same day the notification was received.

The fatalities occurred across **sixteen (16)** different parishes statewide. In accordance with statutory requirements, the Child Ombudsman Division provided notice to the respective legislators representing those districts.

Fatalities



Child Fatality Data Provided by the DCFS

In response to a request from the Child Ombudsman Division, DCFS submitted the following child fatality data. The department indicated that 17 additional investigations were pending as of January 5, 2026, and are therefore not included in this table:

Number of Fatalities • Calendar Year 2025

		AGE AT INVESTIGATION OPEN DATE								
WORKER REGION	**WORKER OFFICE**	**0**	**1**	**2**	**3**	**6**	**7**	**8**	**12**	**Total**
ORLEANS REGION OCS	JEFFERSON	1		1			1			**3**
COVINGTON REGION OCS	TANGIPAHOA		1							**1**
	WASHINGTON	1								**1**
THIBODAUX REGION OCS	LAFOURCHE	1								**1**
	TERREBONNE					1			1	**2**
LAFAYETTE REGION OCS	LAFAYETTE		1							**1**
LAKE CHARLES REGION OCS	CALCASIEU	1						1		**2**
SHREVEPORT REGION OCS	CADDO		1							**1**
	WEBSTER		1		1					**2**
MONROE REGION OCS	LINCOLN	1	1							**2**
	MADISON	1								**1**
	OUACHITA	1								**1**
TOTAL		**7**	**5**	**1**	**1**	**1**	**1**	**1**	**1**	**18**

Note: *Although DCFS provided the Child Ombudsman Division with 20 individual notifications of fatalities, DCFS data lists only 18 fatalities.*

Proposed Amendments to Child Ombudsman Statute:

During the current legislative session, proposed amendments to Louisiana Revised Statute 24:525, which governs the authority and duties of the Child Ombudsman's Division, have been introduced to strengthen oversight and transparency in Senate Bill 237.

The proposed amendments would authorize the Child Ombudsman Division to obtain more comprehensive information from DCFS regarding the agency's involvement with a family prior to a child's death. Additionally, the amendments would provide the Child Ombudsman Division with real-time access to relevant department records necessary to evaluate agency actions preceding the fatality and to determine whether policy, procedural, or systemic recommendations are warranted.

2026 GOALS AND PROJECTS

In Calendar year 2026, the Child Ombudsman's Division plans to engage in the following projects:

Enhance the Capacity to Respond to Complaints and Inquiries

- Ensure the office has the resources and staffing needed to provide timely responses. Continue to recruit, hire, and onboard staff to address the growing number of complaints. Improve response times for complaints by 20% and ensure that 75% of complaints are resolved within 90 days.

Expand Public Awareness and Education on Child Welfare Issues

- Increase public awareness of the Ombudsman's role, encourage reporting of concerns, and educate the community about child protection laws and services.

Monitor Compliance with Family Notification Requirements

- Evaluate the effectiveness of notification to family upon a child entering foster care, including compliance with statutory notification requirements, response by family once notified, and timeliness of placing the foster child with family.

Improve Conditions of Confinement and Juvenile Detention

- Evaluate and advocate for better conditions for children in state detention facilities, with a focus on health, safety, and rehabilitation. Advocate for policy or facility changes based on the *Biennial Conditions of Confinement Report*.

Expand the Child Ombudsman Capacity to Review Child Placement Facilities

- One of the statutory duties of the Child Ombudsman Division is to review the facilities and procedures of any institution or residence where a child has been placed by any state agency or department [Section C (5)]. The statute further requires a review of the policies and procedures for the placement of special needs children [Section C (8)]. The Child Ombudsman Division plans to onboard an Assistant Ombudsman to evaluate and monitor congregate care settings, develop and implement an evaluation process, and work with state agencies to improve outcomes for this vulnerable population.

Evaluating Child Fatalities

- Systemically review child fatalities reported to the Department of Children and Family Services (DCFS) to identify patterns or trends and the need for targeted public awareness campaigns. Provide recommendations to DCFS, and other stakeholders regarding policy changes or systemic interventions that could help prevent future fatalities.

- Additionally, the Child Ombudsman Division has proposed legislation to increase access to records and information regarding child fatalities. This legislative proposal aims to improve transparency and enable more comprehensive analysis to prevent future child deaths.

Since its inception, the Child Ombudsman's Division of the Legislative Auditor's Office has prioritized responding to issues raised by Louisiana residents who are concerned about Louisiana's children. The Ombudsman's Division has diligently advocated with state agencies, service providers, and others to promote the rights and best interests of children. Working with complainants and state agencies, the Child Ombudsman's Division has identified systemic issues in the state's provision of services to children. Efforts to implement systemic reform are ongoing.

APPENDIX A

DCFS Summary Dispositions Provided for Legislative Notifications

Department of Children & Family Services
Building a Stronger Louisiana

627 North 4th Street
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(O) 225.342.0286
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www.dcfs.la.gov

Jeff Landry, Governor
Rebecca Harris, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender: 4-month-old female**
2. **Victim (if previously made public): K.B.**
3. **Date of fatality or near-fatality incident: 9/19/25**
4. **Parish of child's residence at the time of incident: Richland Parish**
5. **Cause/Manner of death: Non accidental trauma; Autopsy ruled homicide as cause of death**
6. **Circumstances surrounding the death or near-fatality incident: Richland Medical Center called to advise that they had an infant death. The hospital raised concern because an x-ray showed a new rib fracture as well as an older, healing rib fracture. The mother was interviewed and stated she didn't know of anything that could have caused her child to die and knew nothing about the fractured rib. On Sunday, 9/21, the medical examiner called to inform that this was a homicide. He informed that the child had several broken ribs, a completely transected femur, pus all in her leg and abdomen, and numerous healing bruises on her scalp. He stated that most of the injuries were at least 2-4 weeks old. The mother was arrested on 9/22/25. The agency received the report 9/25/25.**
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 8/5/2025 @ 2:15 pm

Department of Children & Family Services
Building a Stronger Louisiana
David N. Matlock, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 2 months old; Male
2. **Victim (if previously made public):** Not previously released.
3. **Date of fatality or near-fatality incident:** 4/11/2025 (Accepted for investigation – 5/29/25)
4. **Parish of child's residence at the time of incident:** Red River
5. **Cause of death:** Blunt trauma of the torso
6. **Circumstances surrounding the death or near-fatality incident:** The child victim was found unresponsive while at daycare on 4/11/2025. It was reported that the baby was unconscious and not breathing between feedings, they tried to administer CPR, and blood came out of the child's mouth. The coroner's report indicates the infant died of blunt force trauma/internal injuries. The investigation is on-going.
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 6/16/2025 @ 7:23am

Department of Children & Family Services
Building a Stronger Louisiana
David N. Matlock, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 1 month old; Male
2. **Victim (if previously made public):** Not previously released.
3. **Date of fatality or near-fatality incident:** 8/7/2024
4. **Parish of child's residence at the time of incident:** Ouachita
5. **Cause of death:** Asphyxia with methamphetamine intoxication
6. **Circumstances surrounding the death or near-fatality incident:** The mother laid the child down around 3-4pm in the pack and play. When the father went to pick up the baby about 6-7pm, the baby was deceased. The baby was cold and stiff. The parents' friend called 911. The Coroner of Ouachita Parish report states the cause of death is asphyxia with methamphetamine intoxication.
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 5/12/2025 @ 4:03pm

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Jeff Landry, Governor
Rebecca Harris, Secretary

SUMMARY DISPOSITION

1. **Victim's age and gender:** 10 month old; Male
2. **Victim (if previously made public):** Not previously released.
3. **Date of fatality or near-fatality incident:** Date of the accepted report 09/05/2025. Date of Death 08/27/2025. Date of medical confirmation 9/10/2025.
4. **Parish of child's residence at the time of the incident.** New Orleans
5. **Cause of death:** Preliminary Coroners Report indicates Blunt Force Trauma.
6. **Circumstances surrounding the death or near-fatality incident:** The child was found non-responsive at his home and transported to the hospital by Emergency Medical Services. The coroner stated that the cause of death was non-accidental blunt force trauma. Law Enforcement is investigating, but there have not been any arrests.
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 9/15/2025 @ 12:47 pm

Jeff Landry
GOVERNOR

Rebecca Harris
SECRETARY

State of Louisiana

Department of Children and Family Services

Summary Disposition

November 25, 2025

SUMMARY DISPOSITION

1. Victim's age & gender: The victim is a newborn female. DOB:11/21/25

2. Victim (if previously made public):

3. Date of fatality or near-fatality incident: 11/21/25

4. Parish of child's residence at the time of incident: Livingston Parish

5. Cause of death: The cause of death is pending. The manner of death has been ruled homicide.

6. Circumstances surrounding the death or near-fatality incident:

The infant was born at home to a 14-yr old child. The information the agency has at this time is that the 14-yr old did not know she was pregnant. Her mother was unaware of the pregnancy. The 14-yr old gave birth without the mother's knowledge in her room. Her mother discovered she was bleeding and took her to the hospital. Once at the hospital, the 14-yr. old told hospital personnel she gave birth to a baby at home. It was reported that a search of the home yielded the body of a deceased newborn with extensive neck injuries. It was also reported that the infant was alive when born.

The 14-yr old has been charged with 1st degree murder.

Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided: There is no agency history with this family.

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Department of Children & Family Services
Building a Stronger Louisiana
David N. Matlock, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 9 months old; Male

2. **Victim (if previously made public):** Not previously released.

3. **Date of fatality or near-fatality incident:** Near-Fatality Incident occurred 05/24/2024. Date of Fatality 02/05/2025. Date of Confirmation of Abuse: 04/09/2025

4. **Parish of child's residence at the time of incident:** Lafourche

5. **Cause of death:** Complications from a brain injury.

6. **Circumstances surrounding the death or near-fatality incident:** The child sustained a life-threatening injury in May of 2024 which resulted in his entering foster care, where he remained until he passed away on February 5, 2025. At the time of the incident, both parents were charged with attempted second-degree murder, as a result of the injuries sustained in the May 2024 incident. On February 5, 2025, the foster mother brought the child to the hospital due to a fever and seizures, ultimately showing no brain activity in the hospital. The child's cause of death was the result of the complications of traumatic brain injury with viral co-infections. Per the Assistant District Attorney, current charges for the mother are 2nd degree cruelty to a juvenile. The father is charged with domestic abuse battery with child endangerment.

7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** An investigation was initiated in May 2024 due to a life-threatening injury. As a result of this investigation, the family was referred to Foster Care.

Version Date and Time:

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Jeff Landry, Governor
Rebecca Harris, Secretary

SUMMARY DISPOSITION

1. **Victim's age and gender:** 18 month old; Male

2. **Victim (if previously made public):** Not previously released.

3. **Date of fatality or near-fatality incident:** Date of accepted report 9/16/2025. Date of Death 9/22/2025. Death of medical confirmation 10/2/2025.

4. **Parish of child's residence at the time of the incident:** Lafayette

5. **Cause of death:** According to medical professionals, the cause of death is Anoxic Brain Injury due to accidental drug ingestion.

6. **Circumstances surrounding the death or near-fatality incident:** Acadian Ambulance transported the child to hospital, due to him being unresponsive at his home. The child did not have a pulse, and was administered Narcan by Acadian Ambulance. The father admitted to drug use in the home. Medical professionals completed a drug screen on the child, and he was positive for Fentanyl. Medical professionals placed on life support. On September 22, 2025, the child was removed from life support, and succumbed to the exposure of substances.

7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 10/3/2025 @ 2:59 pm

Department of Children & Family Services
Building a Stronger Louisiana
David N. Matlock, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 4 months old; Male
2. **Victim (if previously made public):** Kamari Jones
3. **Date of fatality or near-fatality incident:** 6/27/2025
4. **Parish of child's residence at the time of incident:** Jefferson
5. **Cause of death:** Subdural Hemorrhage, Hypoxic-Ischemic Injury
6. **Circumstances surrounding the death or near-fatality incident:** The child was found unresponsive with extensive neurologic injury secondary to subdural hemorrhage and Hypoxic-ischemic injury (brain damage caused by a lack of oxygen (hypoxia) and reduced blood flow (ischemia) to the brain. Acute on chronic subdural and retinal hemorrhages concerning for NAT (non-accidental trauma). and retinal hemorrhages concerning for NAT (non-accidental trauma). The child's father was arrested, accused of second-degree cruelty to a juvenile.
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 7/10/2025 @ 3:45pm

Department of Children & Family Services
Building a Stronger Louisiana
David N. Matlock, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 7 years old; Male
2. **Victim (if previously made public):** Christian Rodriguez Padilla
3. **Date of fatality or near-fatality incident:** 4/19/2025
4. **Parish of child's residence at the time of incident:** Jefferson
5. **Cause of death:** Asphyxia due to suffocation and gastric aspiration; Willful neglect of child with spastic cerebral palsy
6. **Circumstances surrounding the death or near-fatality incident:** The child victim, who was medically complex and completely dependent on his caregivers for his basic needs, was left home alone on his bed in his bedroom at 4:00pm. When the mother and her live-in boyfriend returned at approximately 8:00pm, they found the child deceased. The parents are charged with 2nd degree murder and obstruction of justice.
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** The family was previously investigated by DCFS, but was not involved in a substantiated investigation.

Version Date and Time: 6/6/2025 @ 7:23am

Department of Children & Family Services
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David N. Matlock, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 2 years; Female
2. **Victim (if previously made public):** Amy Bohne
3. **Date of fatality or near-fatality incident:** 1/18/2025
4. **Parish of child's residence at the time of incident:** Jefferson
5. **Cause of death:** Gunshot wound
6. **Circumstances surrounding the death or near-fatality incident:** The father shot and killed the child victim and the mother. The father also shot and wounded the victim's 9-year-old and 13-year-old siblings.
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 1/27/2025 @8:21am

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SUMMARY DISPOSITION

1. **Victim's age & gender**: 3 month old; Male
2. **Victim (if previously made public):** Not previously released.
3. **Date of fatality or near-fatality incident:** Date of the accepted report 05/16/2025. Date of Death 5/18/2025. Date of medical confirmation 8/26/2025.
4. **Parish of child's residence at the time of the incident:** East Baton Rouge
5. **Cause of death:** Traumatic Brain Injury
6. **Circumstances surrounding the death or near-fatality incident:** While under the care of his father, the child began exhibiting concerning symptoms and was transported to the hospital by EMS. Additional imaging and testing were conducted, and an absence of brain activity was confirmed. According to the media, on August 22, 2025, the father was taken into custody and formally charged with first-degree murder.
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 8/27/2025 @ 2:59 pm

Department of Children & Family Services
Building a Stronger Louisiana
David N. Matlock, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 8 year old; Male

2. **Victim (if previously made public):** Not previously released.

3. **Date of fatality or near-fatality incident:** 7/6/2025

4. **Parish of child's residence at the time of incident:** Calcasieu

5. **Cause of death:** Traumatic brain injury secondary to suspected non-accidental trauma.

6. **Circumstances surrounding the death or near-fatality incident:** The child sustained a life-threatening injury in January of 2020. The father and his girlfriend were charged, in January of 2020. As a result of the abuse, the child sustained a traumatic brain injury, bruises, and a fracture. Because of the abuse, the child was a quadriplegic, had developmental delays, a G-tube, and seizure disorder. The child died from medical complications resulting from injuries sustained in 2020.

7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** There was a previous investigation involving the mother in which the father was given custody of the child. The child previously entered foster care in 2020 due to the abuse that led to his death.

Version Date and Time: 7/11/2025 @ 1:47pm

Department of Children & Family Services
Building a Stronger Louisiana
David N. Matlock, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 4 months; Male
2. **Victim (if previously made public):** Not previously released
3. **Date of fatality or near-fatality incident:** 1/23/2025
4. **Parish of child's residence at the time of incident:** Calcasieu
5. **Cause of death:** Traumatic Brain Injury
6. **Circumstances surrounding the death or near-fatality incident:** Child was under his mother's care, along with an unrelated individual. The pair used methamphetamines and marijuana while caring for the child. The mother left the child with the unrelated individual and upon her return found the child screaming and then unresponsive.
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 2/21/2025 @ 3:46pm

Department of Children & Family Services
Building a Stronger Louisiana
David N. Matlock, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 3 years old; Male
2. **Victim (if previously made public):** Rayshawn Lard
3. **Date of fatality or near-fatality incident:** 2/13/2025
4. **Parish of child's residence at the time of incident:** Bienville
5. **Cause of death:** Non-accidental trauma
6. **Circumstances surrounding the death or near-fatality incident:** According to medical observations, the child was noted to have both old and recent bruising. Marks were visible on his hands, wrist, feet, face, thigh, abdomen, and back. Additionally, a laceration was noted on his ear, and swelling was present at the back of his head.
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** Rayshawn previously entered foster care in 2022 due to reasons not related to the abuse or neglect that led to his death. Louisiana DCFS is currently investigating this family due to allegations of child abuse/neglect.

Version Date and Time: 3/14/2025 @ 11:00am

Department of Children & Family Services
Building a Stronger Louisiana
David N. Matlock, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 1 year old; Female
2. **Victim (if previously made public):** Not previously released.
3. **Date of fatality or near-fatality incident:** 1/15/2025
4. **Parish of child's residence at the time of incident:** Bienville
5. **Cause of death:** Blunt force trauma
6. **Circumstances surrounding the death or near-fatality incident:** The father was driving intoxicated with 5 children in the car, all unrestrained. The mother and father engaged in a domestic dispute, ultimately leading to the car crashing and flipping over. The 1-year-old child victim was deceased at the scene of the crash. The father was arrested and charged with vehicular homicide and six counts of attempted 2nd degree murder.
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 5/23/2025 @ 10:24am

Department of Children & Family Services
Building a Stronger Louisiana
David N. Matlock, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 8 months old; Male
2. **Victim (if previously made public):** Sterling Rogers
3. **Date of fatality or near-fatality incident:** 3/17/2025
4. **Parish of child's residence at the time of incident:** Washington
5. **Cause of death:** Prolonged Physical Abuse
6. **Circumstances surrounding the death or near-fatality incident:** The child had multiple fractures in various stages of healing. The mother was arrested for first-degree murder.
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 3/20/2025 @ 3:40 pm

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Rebecca Harris, Secretary

SUMMARY DISPOSITION

1. **Victim's age and gender: 2 month old female**
2. **Victim (if previously made public):**
3. **Date of fatality or near-fatality incident: 10/25/2025**
4. **Parish of child's residence at the time of the incident: St. Landry**
5. **Cause of death: Preliminary autopsy indicates cause of death is due to spinal damage and other injuries.**
6. **Circumstances surrounding the death or near-fatality incident: Child was found unresponsive by her parents. There were no outward observable injuries to the child at time of death, so no concern was noted for abuse/neglect until an autopsy was performed and revealed significant injuries.**
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided: The mother was a victim in an investigation on 12/1/2017 with allegations of dependency with a disposition of unsubstantiated. Collaterals indicate the mother entered foster care in Alabama and records have been requested.**

Version Date and Time:

Department of Children & Family Services
Building a Stronger Louisiana
David N. Matlock, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 0 (newborn); Male
2. **Victim (if previously made public):** Not previously released.
3. **Date of fatality or near-fatality incident:** 2/12/2025
4. **Parish of child's residence at the time of incident:** Union
5. **Cause of death:** On 5/29/25, Forensic Pathologist determined the cause of death to be Acute Respiratory Failure due to Near Drowning in Toilet Bowl, with multiple congenital malformations being a contributing factor.
6. **Circumstances surrounding the death or near-fatality incident:** The mother reported being unaware that she was pregnant. She gave birth to the child at home in the bathroom. When EMS arrived, they observed the infant lodged in the toilet. The infant's umbilical cord was completely white, indicating he had been under water between 20 to 40 minutes.
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 6/20/2025 @ 7:25am

Department of Children & Family Services
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Jeff Landry, Governor
Rebecca Harris, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender:** 6-year-old; male and 12-year-old; male
2. **Victim (if previously made public):** Not previously released.
3. **Date of fatality or near-fatality incident:** 6/5/25
4. **Parish of child's residence at the time of incident:** Terrebonne
5. **Cause of death:** 6-year-old male: Polytrauma with significant devastating traumatic brain injury; 12-year-old male: Aortic Transection; Motor Vehicle Accident
6. **Circumstances surrounding the death or near-fatality incident:** The mother was driving with her 3 children unrestrained in the vehicle while under the influence. Standard toxicology samples collected revealed that the mother's Blood Alcohol Concentration was over the legal limit at the time of the crash. The children's deaths were medically determined to be a direct result of the accident. The mother was arrested and charged with LA RS 14:32.1 – Vehicular Homicide (two counts), LA RS 14:39.2 – First Degree Vehicular Negligent Injuring (one count), LA RS 32:295 – No Child Restraints (three counts), LA RS 32:295.1 – No Seat Belt (one count), and LA RS 32:104 – Failure to Yield While Turning Left (one count).
7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** N/A

Version Date and Time: 8/5/2025 @ 2:15 pm

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Rebecca Harris, Secretary

SUMMARY DISPOSITION

1. **Victim's age & gender: 4 years old; female**

2. **Victim (if previously made public): Janna Haynes**

3. **Date of fatality or near-fatality incident: 10/23/25**

4. **Parish of child's residence at the time of incident: St. Tammany**

5. **Cause of death: Preliminary cause of death is Acute Respiratory Failure secondary to blunt force trauma to the head. The official coroner's report is pending.**

6. **Circumstances surrounding the death or near-fatality incident: Janna Haynes (age 4) was transported to St. Tammany Parish Hospital Emergency Room by EMS with her mother and Law Enforcement. It was reported that her 21-year-old brother slammed the child's face into the ground. The child sustained significant facial trauma. The child was life-flighted to Manning Family Children's Hospital in New Orleans. Once she arrived, she was diagnosed with rib fractures, facial fractures, subdural hematomas and intracranial injuries. The child succumbed to her injuries at 7:28 AM on October 23, 2025. The 21 year old brother was arrested on October 23, 2025 and booked into the St. Tammany Parish Jail and charged with First Degree Murder and Resisting an Officer By Refusing to Identify.**

7. **Prior abuse or neglect investigations that are pertinent to fatality/near fatality, including findings and services provided:** None

Version Date and Time: 8/5/2025 @ 2:15 pm

APPENDIX B

Reports and Investigations Data provided by DCFS

Reports/Investigations of Abuse or Neglect CY 2025

*Please note that this is a count of reports. There may be more than 1 potential victim in each report.
Reports are calls/contacts Louisiana received of potential abuse or neglect.
Investigations are a count of those calls that met the criteria to conduct an investigation.

WORKER REGION	WORKER OFFICE	REPORTS	INVESTIGATIONS
CW Region 1 Greater New Orleans	CW JEFFERSON - EAST BANK / ST. BERNARD	23	5
	CW JEFFERSON - WEST BANK / PLAQUEMINES	5,889	1,942
	CW ORLEANS	5,183	2,177
CW Region 2 Baton Rouge	CW EAST BATON ROUGE	5,409	2,371
	CW EAST FELICIANA / WEST FELICIANA	249	119
	CW IBERVILLE / WEST BATON ROUGE	627	262
	CW POINTE COUPEE	244	108
CW Region 3 Covington	CW LIVINGSTON	1,941	834
	CW ST. TAMMANY	2,877	1,062
	CW TANGIPAHOA / ST. HELENA	1,864	852
	CW WASHINGTON	745	315
CW Region 4 Thibodaux	CW ASCENSION	1,239	504
	CW ASSUMPTION	157	81
	CW LAFOURCHE	979	443
	CW ST. JOHN / ST. CHARLES / ST. JAMES	1,067	461
	CW TERREBONNE	1,144	468
CW Region 5 Lafayette	CW ACADIA	753	265
	CW EVANGELINE	404	188
	CW IBERIA	800	359
	CW LAFAYETTE	2,612	1,094
	CW ST. LANDRY	1,021	442
	CW ST. MARTIN	450	188
	CW ST. MARY	509	217
	CW VERMILION	633	258
CW Region 6 Lake Charles	CW ALLEN	263	133
	CW BEAUREGARD	375	176
	CW CALCASIEU / CAMERON	2,641	1,211
	CW JEFFERSON DAVIS	366	162
CW Region 7 Alexandria	CW AVOYELLES	575	260
	CW CATAHOULA / LASALLE	262	109
	CW CONCORDIA	219	105
	CW GRANT	239	111
	CW RAPIDES	2,003	971
	CW VERNON	568	292
	CW WINN	134	66
CW Region 8 Shreveport	CW BOSSIER	1,593	690
	CW CADDO	2,765	1,237
	CW DESOTO	325	138
	CW NATCHITOCHES / RED RIVER	430	206
	CW SABINE	292	138
	CW WEBSTER / BIENVILLE / CLAIBORNE / JACKSON	919	419
CW Region 9 Monroe	CW EAST CARROLL	42	19
	CW FRANKLIN	190	81
	CW LINCOLN	412	183
	CW MADISON / TENSAS	132	64
	CW MOREHOUSE	304	156
	CW OUACHITA / CALDWELL	2,470	1,153
	CW RICHLAND	194	102
	CW UNION	209	99
	CW WEST CARROLL	117	51
	State Total	**54,858**	**23,347**

** Data extracted 1/5/2026.*

"Intakes Report - CASA" and "Investigations Received - CASA" ACESS 2.0 report

APPENDIX C

Family Placement Data Provided by DCFS

FC Relative vs Non Relative Placements CY 2025

Date	Total FC	Certifed Relative Placements	% of FC Placed with Certified Relative	Certified Non Relatives	% of FC Placed with Certified Non Relative	Non Certified Fictive Kin	% of FC Placed with Non Certified Fictive Kin	Non Certifed Relative	% of FC Placed with Non Certifed Relative	Non Home Setting	% of FC in a Non Home Setting
3/31/2025	4,269	813	19.04%	1,640	38.42%	140	3.28%	836	19.58%	840	19.68%
6/30/2025	4,309	817	18.96%	1,662	38.57%	151	3.50%	808	18.75%	871	20.21%
9/30/2025	4,311	826	19.16%	1,712	39.71%	149	3.46%	759	17.61%	865	20.06%
12/31/2025	4,337	837	19.30%	1,739	40.10%	148	3.41%	750	17.29%	863	19.90%

Placement Type and Days in placement for FC in Care 3/31/2025

	Days in placement				
Placement Type	**01-07 Days**	**08-30 Days**	**31-90 Days**	**Over 90 Days**	**Total**
Certifed Relative Placements	15	75	183	540	**813**
Certified Non Relatives	58	165	402	1,015	**1,640**
Non Certified Fictive Kin	7	17	48	68	**140**
Non Certified Relative	82	120	249	385	**836**
Non Home Setting	54	152	252	382	**840**
Total	**216**	**529**	**1,134**	**2,390**	**4,269**

Placement Type and Days in placement for FC in Care 6/30/2025

	Days in placement				
Placement Type	**01-07 Days**	**08-30 Days**	**31-90 Days**	**Over 90 Days**	**Total**
Certifed Relative Placements	31	106	170	510	**817**
Certified Non Relatives	96	156	346	1,064	**1,662**
Non Certified Fictive Kin	15	30	55	51	**151**
Non Certified Relative	45	122	248	393	**808**
Non Home Setting	56	138	214	463	**871**
Total	**243**	**552**	**1,033**	**2,481**	**4,309**

Placement Type and Days in placement for FC in Care 9/30/2025

	Days in placement				
Placement Type	**01-07 Days**	**08-30 Days**	**31-90 Days**	**Over 90 Days**	**Total**
Certifed Relative Placements	30	113	200	483	**826**
Certified Non Relatives	84	208	414	1,006	**1,712**
Non Certified Fictive Kin	5	25	64	55	**149**
Non Certified Relative	49	137	218	355	**759**
Non Home Setting	77	178	204	406	**865**
Total	**245**	**661**	**1,100**	**2,305**	**4,311**

Placement Type and Days in placement for FC in Care 12/31/2025

	Days in placement				
Placement Type	**01-07 Days**	**08-30 Days**	**31-90 Days**	**Over 90 Days**	**Total**
Certifed Relative Placements	1	56	190	590	**837**
Certified Non Relatives	24	132	421	1,162	**1,739**
Non Certified Fictive Kin	2	24	54	68	**148**
Non Certified Relative	5	131	220	394	**750**
Non Home Setting	16	141	273	433	**863**
Total	**48**	**484**	**1,158**	**2,647**	**4,337**

APPENDIX D

Key Terms and Definitions

1. **Parent representation -** Complaint concerning attorney's representation of the parent.

2. **Child representation -** Complaint concerning attorney's representation of the child.

3. **Lack of Services -** Agency has failed to provide services in accordance with child's needs, or school is unable to provide services recommended in child's evaluation.

4. **Case Plan Deficiency -** The case plan does not adequately address the issues that led to the child's removal. The case plan includes unnecessary or unrelated requirements that prolong the parent's ability to complete it without addressing their actual needs.

5. **Misinformation provided by DCFS case worker -** Worker provides information that is misleading or untrue, impacting the case or services. Examples:

    a. *Case worker tells grandparents they will be able to get foster parent stipends for the children placed with them prior to becoming certified foster parents.*

    b. *Case worker states something that is untrue in the verified complaint.*

6. **Insufficient Information provided by DCFS case worker -** Worker fails to give sufficient information for a party to obtain a service they need or accomplish requirements of their case plan. Examples:

    a. *Worker tells parents they need to attend parenting classes but fails to give them information on how to do so.*

    b. *Agency fails to provide timely notice regarding case updates, supervised visits, family team meetings, or other critical matters affecting the child or involved parties.*

    c. *Agency fails to notify a caregiver of a finding.*

7. **Notice -** Failure of an agency to properly notify a party about an issue, a policy, or a right.

8. **Dilatory referrals by DCFS case worker -** Case worker does not provide referrals in a timely manner, delaying parties' ability to obtain services or complete case plan requirements.

9. **Child Find/Evaluations -** Concerns regarding parent requests for an evaluation or district recommendations for evaluations to determine eligibility for services under the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act. Parents or guardians may express concern or opposition to the findings, conclusions, or eligibility determinations made during the evaluation process. Parents and guardians may also express concerns when a district does not deem an evaluation necessary.

10. **Education Plan Implementation -** Concerns regarding the implementation and adequacy of educational services in situations in which a child is not receiving required services or accommodations, progress toward Individual Education Program (IEP) goals is insufficient or not communicated, or parents disagree with the current placement or seek changes, including the addition of new services to better meet the child's needs.

11. **CCAP -** The Child Care Assistance Program (CCAP) is a program that assists eligible families with paying for childcare while they are working, participating in training, or attending school. Concerns arise when a family's case is closed in error or the childcare facility is not receiving payments in a timely manner, which may prevent a child from attending daycare.

12. **Discipline -** Concern that a student is being disciplined in a manner believed to be inappropriate or excessive. The concern may involve repeated punitive actions, lack of communication about disciplinary measures, or consequences that appear inconsistent with school policy. The reporting party requests a review to ensure the students' rights are being respected and that disciplinary practices are fair, reasonable, and in accordance with established guidelines.

13. **Special Education -** Concerns regarding district programs that support students with disabilities. Concerns may include teacher training, certification status, and inaccurate student records.

14. **Athletics -** Situations in which a student is restricted, excluded, or unable to fully participate in school-based sports or physical activities due to eligibility decisions, lack of appropriate accommodations, medical or disability-related needs, or disputes regarding access and inclusion.

15. **Child Safety -** Child safety concerns refer to situations in which a student's physical or emotional well-being may be at risk within the school environment, including incidents of injury, elopement from campus, alleged bullying, inappropriate use of physical restraint or discipline, or any event resulting in harm such as bruises, cuts, or other injuries.

16. **Lack of communication by DCFS case worker -** Worker does not return telephone calls or respond to any other forms of communication.

17. **Lack of communication by OJJ case worker -** Worker does not return telephone calls or respond to any other forms of communication.

18. **Lack of communication by LDH case worker -** Worker does not return telephone calls or respond to any other forms of communication.

19. **Policy Concern -** Complainant or LCO staff identifies a specific policy relevant to the case that is potentially not being followed.

20. **Sibling Separation -** Failure to place siblings in DCFS custody together.

21. **Relative Placement -** Failure to place child in DCFS custody with available relative, including fictive kin.

22. **Unprofessional Behavior of Worker -** Worker engaged in behavior that was unprofessional.

23. **Failure to place child after discharge from mental health facility -** Failure to request that a child be taken into DCFS custody after being abandoned at a hospital or failure to secure an appropriate placement for a child in DCFS custody upon discharge from a mental health facility.

24. **Child Treatment in Placement -** Concerns about how a child is being cared for while living in a placement managed or overseen by a state agency.

25. **ICPC -** Delays, miscommunication, or failures in coordination between Louisiana and other states regarding ICPC procedures.

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