COMMONWEALTH of VIRGINIA

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MEMORANDUM

To: All DBHDS Licensed Children's Residential Providers

From: Jae Benz, Director, Office of Licensing
Taneika Goldman, Director, Office of Human Rights

Cc: Heather Norton, Deputy, DBHDS Commissioner, Community Services, DBHDS
Dev Nair, Assistant Commissioner, Division of Provider Management, DBHDS
Kristin Zagar, Chief Deputy Commissioner, VDSS
Samantha Brooks, Special Projects Manager & High Acuity Team Supervisor, VDSS
Em Parente, Division of Family Services Assistant Director, VDSS
Scott Reiner, Executive Director, Office of Children's Services
Tammy J. Whitlock, Deputy Director of Complex Care and Services, DMAS
Lisa Jobe-Shields, Behavioral Health Division Director, DMAS

Date: July 24, 2026

Re: Elopement Prevention, Supervision, Incident Response, and Reporting Expectations

Purpose

The Office of Licensing has observed an increase in reported elopement incidents across licensed children's residential providers. This memorandum is issued to all licensed children's residential providers to reinforce regulatory expectations related to elopement prevention, supervision, incident response, and reporting, and to identify proactive steps all providers should currently have implemented.

The Department recognizes that providers across the Commonwealth serve individuals – including children, adolescents and adults-with a wide range of developmental, intellectual, behavioral, emotional, and clinical needs. Increasing complexity and acuity across these populations brings elevated elopement risk and managing that risk is genuinely challenging work. This memorandum is not issued in response to any single provider or incident; it reflects a pattern observed across the system. Our shared objective is to ensure that supervision practices, individualized planning, and incident response strategies keep pace with the needs of all individuals served.

Higher acuity is not a mitigating factor when supervision fails; rather, it reinforces the need for supervision plans that are individualized, current, and actively implemented. Providers are expected to

ensure staffing, training, and supervision practices are appropriate for the actual needs and acuity of the individuals in their care, not with the population they were originally designed to serve.

Regulatory Expectations

Providers are reminded of the following requirements under the *Regulations for Children's Residential Facilities* (12 VAC 35-46-10 *et seq*.):

- **Emergency preparedness.** Elopement risk must be addressed in the provider's emergency preparedness and response plan, which is required to address missing persons among the potential emergencies that would disrupt the normal course of service delivery (12VAC35-46-1110.A.2.).
- **Supervision.** At least one trained child care worker must be on duty and actively supervising residents at all times when one or more residents are present. Staffing ratios must meet the minimum of one staff to eight residents during waking hours unless the Department has approved or required a different ratio based on the needs of the population served (12VAC35-46-870). *A provider may have no less than 1 staff person responsible for direct support and observation of 8 children. The needs of the population served will determine how actively supervising will be defined. If the population has* ***higher behavioral, safety, or elopement risks****, "active supervision" might require constant line-of-sight monitoring, frequent check-ins, or staying within immediate proximity. It may even require a higher staff ratio.* Supervision policies must include contingency plans for emergencies, off-campus activities, and resident preferences, and must be based on the needs of the population served.
- **Structured program of care.** "Structured program of care" means a comprehensive planned daily routine including appropriate supervision that meets the needs of each resident both individually and as a group. Providers must maintain a structured program of care that meets each resident's physical and emotional needs, provides protection, guidance, and supervision, and meets the objectives of any required individualized service plan. It also includes a structured daily routine and requires use of a daily communication log for sharing significant information among staff (12VAC35-46-800.A-C). Consistent routines and shift-to-shift communication are among the most effective elopement prevention tools available.
- **Serious incident reporting.** Any overnight absence without permission; any runaway; and any other unexplained absence from the facility are serious incidents. They must be reported within 24 hours to the placing agency and to the parent or legal guardian, as appropriate, and noted in the resident's record, with all elements required by 12VAC35-46-1070.A-D and documented. The Department must also be notified within 24 hours as required. For residents placed through the Interstate Compact on the Placement of Children, copies of serious incident reports must be sent to the Compact administrator (12VAC35-46-680.B). Reporting requirements do not absolve the provider of its responsibility to initiate an immediate search, notify law enforcement when appropriate, and take all necessary actions to locate the resident.
- **Staff training.** Staff responsible for supervising children must receive required orientation and training within the timeframes established by 12VAC35-46-310, with required annual retraining. Training must be comprehensive and based on the needs of the population served so that staff have the competencies to perform their jobs.

Expected Provider Actions

The Office of Licensing and the Office of Human Rights expect each provider to take the following steps promptly:

- Review and update elopement risk assessments for each individual, as appropriate and ensure individualized supervision expectations reflect current risk, not the risk level identified at admission.
- Verify that staffing plans and actual staffing levels align with the acuity of individuals currently in care.
- Confirm that all staff, including relief staff, know the facility's missing-person response procedures, including immediate search protocols, law enforcement notification, and required notifications to placing agencies, parents or legal guardians, and the Department.
- Conduct a debrief after every elopement or attempted elopement to identify contributing factors and incorporate findings and trend analysis into the provider's quality improvement process.
- Review environmental and programmatic factors that contribute to elopement risk, including transitions between activities, off-campus outings, shift changes, and overnight supervision.
- Communicate proactively with placing agencies and guardians when an individual's elopement risk changes, so that placement appropriateness can be reassessed jointly.
- Report to the Department whenever an individual's absence cannot be explained by their supervision needs; when an individual under the age of 18 elopes from a program without permission, when there is any suspicion of neglect, or someone files a complaint alleging neglect. The report should be entered in CHRIS as an Abuse Report under Neglect-Elopement/AWOL and an investigation must be conducted in accordance with 12VAC35-115-175.
- Review physical security measures, including perimeter controls, door alarms, camera coverage, and other environmental safeguards appropriate to the population served.

Technical Assistance

Providers are encouraged to seek technical assistance proactively, before concerns escalate into regulatory issues. The Office of Licensing and the Office of Human Rights are available to provide regulatory technical assistance related to supervision planning, elopement prevention, and incident reporting. Providers with questions, or who wish to request assistance in reviewing their supervision policies or emergency preparedness plans, should contact their assigned licensing specialist. Providers should expect licensing specialists and human rights advocates to review supervision practices, individualized supervision plans, staffing implementation, emergency preparedness, and incident response during routine inspections and complaint investigations. Regulatory citations or other enforcement actions may be imposed when inadequate supervision, inconsistent with individuals' assessed needs, is identified.

Thank you for your continued commitment to the safety and well-being of the individuals in your care.