UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
CORPUS CHRISTI DIVISION

CIVIL ACTION NO. 2:11-CV-00084

January 20, 2023

M.D.; bnf STUKENBERG, *et al.*, Plaintiffs, v. GREG ABBOTT, *et al.*, Defendants.

Hon. Janis Graham Jack, Senior United States District Judge

FIFTH REPORT OF THE MONITORS: REMEDIAL ORDERS 1,2,3,5 to 11, 16, 18, 35, 36, A1 to A4, A6, AND B1 to B5

Deborah Fowler and Kevin Ryan, Monitors

Table of Contents

Introduction and Executive Summary

This is the Monitors' fifth comprehensive report (Fifth Report) to the United States District Court (Court) in *M.D. by Stukenberg v. Abbott* following the mandate issued by the United States Court of Appeals for the Fifth Circuit (Fifth Circuit) implementing the Court's remedial orders.[1] The Plaintiffs are a certified class of children in the Permanent Managing Conservatorship (PMC) of the Texas Department of Family and Protective Services (DFPS) who sought injunctive relief against the State of Texas. At the time Plaintiffs filed suit in 2011, DFPS was part of the Texas Health and Human Services Commission (HHSC).[2] Now DFPS is an independent State agency reporting directly to the Governor.[3]

Following a bench trial in 2014, the Court published a Memorandum Opinion and Verdict in December 2015 finding that Texas had failed to protect PMC children from an unreasonable risk of harm.[4] The Court issued a Final Order on January 15, 2018. Following a stay order, the Fifth Circuit adopted in part, reversed in part and modified in part the remedial orders. Upon remand, the Court issued a modified Order on November 20, 2018.[5] The Fifth Circuit again adopted in part and reversed in part the Court's Order and issued its Judgment as Mandate on July 31, 2019.[6] The Court's November 20, 2018 Order, as modified by the Fifth Circuit on July 8, 2019,[7] specifies numerous remedial orders that implement the Court's injunction as detailed below, charging the Monitors "to assess and report on Defendants' compliance with the terms of this Order."[8]

---

[1] *M.D. ex rel. Stukenberg v. Abbott*, 929 F.3d 272, 277 (5th Cir. 2019); J. (5th Cir. July 8, 2019), ECF No. 626.

[2] Effective February 2021, HHSC changed the name of its child care regulation unit, Residential Child Care Licensing (RCCL), to Residential Child Care Regulation (RCCR). This report uses RCCR to describe this division of HHSC even when referring to historic work done by the unit under its previous name.

[3] The 85th Texas Legislature passed House Bill 5, transforming DFPS into an independent State agency reporting directly to the Governor, H.B. 5 (TX 2017), 85th Leg., R.S.

[4] *M.D. ex rel. Stukenberg v. Abbott*, 152 F. Supp. 3d 684 (S.D. Tex. 2015).

[5] *M.D. ex rel. Stukenberg v. Abbott*, No. 2:11-cv-84, slip. op. (S.D. Tex. Nov. 20, 2018), ECF No. 606.

[6] *M.D. ex rel. Stukenberg,* 929 F.3d at 277; J. (5th Cir. 2019), ECF No. 626.

[7] *M.D. ex rel. Stukenberg*, 929 F.3d at 277.

[8] *M.D. ex rel. Stukenberg*, No. 2:11-cv-84, slip. op. at 16, ECF No. 606. ("The Monitors' duties shall include to independently verify data reports and statistics provided pursuant to this Order. The Monitors shall have the authority to conduct, or cause to be conducted, such case record reviews, qualitative reviews, and audits as the Monitors reasonably deem necessary. In order to avoid duplication, DFPS shall provide the Monitors with copies of all state-issued data reports regarding topics covered by this Order. Notwithstanding the existence of state data, data analysis or reports, the Monitors shall have the authority to prepare new reports on all terms of this Order to the extent the Monitors deem necessary. The Monitors shall periodically conduct case record and qualitative reviews to monitor and evaluate the Defendants' performance with respect to this Order. The Monitors shall also review all plans and documents to be developed and produced by Defendants pursuant to this Order and report on Defendants' compliance in implementing the terms of this Order. The Monitors shall take into account the timeliness, appropriateness, and quality of the Defendants' performance with respect to the terms of this Order. The Monitors shall provide a written report to the Court every six months. The Monitors' reports shall set forth whether the Defendants have met the requirements of this Order. In addition, the Monitors' reports shall set forth the steps taken by Defendants, and the reasonableness of those efforts; the quality of the work done by Defendants in carrying

On June 16, 2020, the Monitors filed the first comprehensive report (First Report) with the Court, concluding that "the Texas child welfare system continues to expose children in permanent managing conservatorship (PMC) to an unreasonable risk of serious harm." On July 2, 2020, Plaintiffs filed a Motion to Show Cause Why Defendants Should Not Be Held in Contempt for their failure to comply with Remedial Orders 2, 3, 5, 7, 10, 22, 24, 25, 26, 27, 28, 29, 30, 31, 37, and B5 (July 2, 2020 Show Cause Motion). The State filed written objections to the Monitors' First Report on July 6, 2020[9] and a Response in Opposition to the Motion to Show Cause on July 24, 2020. On September 3 and 4, 2020, the Court held a hearing on Plaintiffs' July 2, 2020 Show Cause Motion, and on December 18, 2020, found Defendants to be in contempt of Remedial Orders 2, 3, 5, 7, 10, 22, 25, 26, 27, 29, 31, 37, and B5, but not in contempt of Remedial Orders 24, 28, or 30.[10]

On May 4, 2021, the Monitors filed the second comprehensive report (Second Report) with the Court, concluding that the State made progress toward eliminating some of the "substantial threats to children's safety" that surfaced in the Monitors' First Report; but the Monitors also concluded the State's performance in some areas, including its oversight of the care of children by the Single Source Continuum Contractors (SSCC) and certain general residential operations (GRO), was contrary to the Court's remedial orders.[11]

Following discussions with the Court and parties in 2021, the Monitors developed a report schedule which focused the third report (Third Report) to the Court, filed on January 10, 2022, on Remedial Orders 1, 2, 3, 5 to 11, 16, 18 (as to DFPS), 35, 37, A1 to A4, A6, and B1 to B5 and the fourth report (Fourth Report) to the Court on the balance of the remedial orders was filed on June 2, 2022.

In preparing this Fifth Report, the Monitors and their staff (the monitoring team) undertook a broad set of activities to validate the State's performance, as detailed

---

out those steps; and the extent to which that work is producing the intended effects and/or the likelihood that the work will produce the intended effects.") *Id.* at 17.

[9] Defendants' Verified Objections to Monitors' Report, ECF No. 903.

[10] The Court held: "Defendants are ORDERED to file with the Court a sworn certification of their compliance with Remedial Orders 2, 3, 5, 7, 10, 25, 26, 27, 29, 31, 37, and B5 within thirty (30) days of the date of this Order. This sworn certification does not need to be verified by the Monitors prior to filing. Contemporaneously with this sworn certification, Defendants are ORDERED to submit to the Monitors for verification all supporting evidence relied on by Defendants to certify their sworn compliance with these Remedial Orders, including but not limited to documents, data, reports, conversations, studies, and extrapolations of any type. Defendants are further ORDERED to appear at a compliance hearing before this Court, beginning at 9:00 a.m. on Wednesday, May 5, 2021 and continuing thereafter until the compliance hearing concludes. The hearing will be held in-person in Courtroom 223 of the United States Courthouse at 1133 N. Shoreline Blvd., Corpus Christi, TX 78401. All of Defendants' supporting evidence of their compliance with Remedial Orders 2, 3, 5, 7, 10, 25, 26, 27, 29, 31, 37, and B5 is subject to verification by the Monitors prior to the May compliance hearing. No sanctions will issue at this time, but, failing the Monitors' verification of compliance, any sanctions as to Defendants' performance of Remedial Orders 2, 3, 5, 7, 10, 25, 26, 27, 29, 31, 37, or B5 will be revisited at the compliance hearing. To avoid additional future sanctions as to these findings of contempt, Defendants must comply with each of these Remedial Orders in the timeframe described. No retroactive sanctions will be imposed at the time of the compliance hearing."

[11] Deborah Fowler & Kevin Ryan, Second Report, ECF No. 1079.

throughout this report. The Monitors requested data and information from both DFPS and HHSC to validate the agencies' compliance with the Court's remedial orders, as detailed in various sections of this report. The Monitors also requested data and information from the SSCCs with which DFPS contracts to provide case management and placement services to foster children in DFPS regions that have transitioned to the Community Based Care (CBC) model.[12]

The monitoring team examined tens of thousands of documents and records, including data files; children's case records, both electronic and paper; investigations; critical incidents; child fatality reports; medical examiner reports; restraint log entries; videos of critical incidents; witness statements; interviews; policies; resource materials, such as handbooks, plans, guidelines and field guidance; child abuse, neglect or exploitation referrals to Statewide Intake (SWI or hotline), including E-Reports and recorded phone calls when appropriate; and an array of employee and caregiver human resources and training records and certifications.

Summary of the Monitors' Findings

The Court's Final Order enjoins the State "from placing children in the permanent managing conservatorship (PMC) in placements that create an unreasonable risk of serious harm. The Defendants SHALL implement the remedies herein to ensure that Texas' PMC foster children are free from an unreasonable risk of serious harm."[13]

The Monitors' investigation, analysis, interviews and site visits in preparation for this report identified areas in which the State made progress toward eliminating "substantial threats to children's safety" surfaced in prior reports and updates to the Court, including performance associated with Remedial Orders 2, 3 (Investigating), and 35.

- DFPS continued to improve its performance with respect to Remedial Order 3 (Investigating). With respect to investigations the Monitors reviewed in which DFPS's Residential Child Care Investigations (RCCI) did not substantiate any

[12] CBC was formerly known as Foster Care Redesign. There are currently four regions that have transitioned to the CBC model (excluding the failed transition in Region 8a): Region 1 (St. Francis, in the Texas Panhandle); Region 2 (2Ingage, in 30 counties in North Texas); Region 3b (OCOK, in seven counties around Fort Worth); and most recently, Region 8b (Belong, in 27 counties surrounding Bexar County). Region 8a, which previously was operating under the CBC model, has transitioned back to DFPS management. There are three stages to the transition to the CBC model: In Stage I, the SSCC "develops a network of services and provides placement services. The focus in Stage I is improving the overall well-being of children in foster care and keeping them closer to home and connected to their communities and families." DFPS, *Community-Based Care*, *available at* https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/default.asp. According to DFPS, "In Stage II, the SSCC provides case management, kinship, and reunification services. Stage II expands the continuum of services to include services for families and to increase permanency outcomes for children." *Id.* Two SSCCs – OCOK and 2INgage – moved to Stage II of the CBC model in 2020. Stage II includes shifting case management services from DFPS to the SSCC. Stage III involves performance assessment and financial incentives for achievement of permanency for children. *Id.*

[13] *M.D. ex rel. Stukenberg v. Abbott*, No. 2:11-cv-84, slip. op. at 2 (S.D. Tex. Nov. 20, 2018), ECF No. 606.

allegations of abuse, neglect or exploitation,[14] the Monitors' rate of disagreement and findings of deficiencies declined from 14% in the prior reporting period (the Third Report) to 4.9%.[15]

- In the Monitors' review of maltreatment investigations performed by Child Protective Investigations (CPI), which was new for this reporting period, the Monitors' rate of disagreement and findings of deficiencies was 5.6%.

- DFPS's performance with respect to Remedial Order 2 was again strong during the period reviewed. Similar to the findings in the Third Report, nearly all (99%) of the caseworkers who became eligible for primary case management during the period, after July 1, 2021 and before June 30, 2022, had caseloads that conformed to the graduated caseload standard.

- With respect to Remedial Order 35, the overall performance also improved and by June 30, 2022, at the end of the reporting period, 1,343 caseworkers (85%) had primary caseloads within or below the standard of 17 children per worker. Specifically, among DFPS caseworkers, of the 1,271 caseworkers carrying at least one PMC child on their caseloads on January 31, 2022, 913 workers (72%) had primary caseloads within or below the standard of 17 children per worker and by June 30, 2022, the number increased to 1,102 of 1,283 workers (86%). Similarly, by June 30, 2022, two of the three SSCCs, Our Community Our Kids (OCOK) and 2Ingage, exceeded the performance of DFPS with 97% (116 of 120) and 92% (80 of 87) of their caseworkers within or below the standard, respectively.

- The State's performance associated with caseloads for both RCCI investigations and regulatory investigations by HHSC with respect to Remedial Orders B1 to B4 was also strong. The Monitors' review found that almost all RCCI investigators and most HHSC inspector caseloads were within the guidelines during each month of the period from July 2021 through June 2022.

- With respect to Remedial Order 1, the Monitors confirmed that a strong majority of caseworkers hired between September 1, 2021 and March 31, 2022 and subject to full or partial Child Protective Services (CPS) Professional Development (CPD) pre-service training completed the program. Overall, the monitoring team validated the completion of CPD training by July 31, 2022 for 485 of 526 caseworkers (92.2%) hired between September 1, 2021 and March 31, 2022.

[14] In these investigations, RCCI issued a disposition of Ruled Out, Unable to Determine or Administrative Closure.

[15] *See* Deborah Fowler & Kevin Ryan, Third Report 5, ECF No. 1165. In the First Report, the rate was 28%. Deborah Fowler & Kevin Ryan, First Report 25, ECF No. 869. In the Second Report, the Monitors disagreed or found deficiencies in 18% of investigations they reviewed where RCCI did not substantiate any allegations. Deborah Fowler & Kevin Ryan, Second Report 73, ECF No. 1079.

The State's performance in some areas is contrary to the Court's remedial orders and some gaps in DFPS's oversight of the SSCCs persisted. Specifically:

- With respect to the Court's Injunction, DFPS continues to expose some PMC children to risk of serious harm in unregulated sites without sufficiently trained caregivers to monitor children who are under DFPS Supervision (also known as Children Without Placement or CWOP).

- With respect to Remedial Order 3, DFPS's performance declined as it relates to receiving reports of alleged abuse, neglect and exploitation. Callers to SWI reporting allegations waited an average of 5.2 minutes before their calls were handled or abandoned, an increase of more than half a minute from the data reported in the Third Report.

- With respect to Remedial Order 35, the caseloads of St. Francis's caseworkers lagged behind DFPS and the other two SSCCs through June 30, 2022. Only 45 out of 85 workers (53%) with at least one PMC child on their caseloads had primary caseloads within or below the standard on June 30, 2022.

- The Monitors' evaluation of the State's system for notifying caseworkers of allegations of abuse, neglect or exploitation for purposes of Remedial Order B5 demonstrated ongoing gaps. The monitoring team reviewed allegations and the State's documented safety actions to determine whether the State took sufficient action to ensure the immediate safety of children after receiving intakes with maltreatment allegations. The monitoring team found an automated notice of allegations to the caseworker in 100% of the 387 RCCI intakes included in the case record review; however, for intakes that SWI referred for investigation to CPI or Provider Investigations (PI),[16] the Monitors found no notifications to caseworkers. Moreover, the monitoring team found relevant documentation showing that DFPS took appropriate action to ensure a child's safety after notification of alleged child maltreatment in only 42% of all intakes reviewed.

Summary of Findings by Remedial Order

Screening, Intake and Investigation of Maltreatment in Care Allegations

[16] Provider Investigations (PI) is a division of HHSC and its investigative authority includes HHSC state operated facilities, including state-supported living centers, state hospitals and Home and Community Based Services (HCS) residences; the HCS residences include three and four person residences and host home settings. HHSC has authority to investigate abuse, neglect and exploitation of an individual receiving HCS Medicaid waiver services (under Sec. 1915 of the Social Security Act) in an HCS host home setting from a person who contracts with a health and human services agency or managed care organization to provide home and community-based services. CPI (DFPS) also investigates allegations in certain HCS residences in instances when PI's jurisdiction does not apply.

Remedial Order 3: *DFPS shall ensure that reported allegations of child abuse and neglect involving children in the PMC class are investigated; commenced and completed on time consistent with the Court's Order; and conducted taking into account at all times the child's safety needs. The Monitors shall periodically review the statewide system for appropriately receiving, screening, and investigating reports of abuse and neglect involving children in the PMC class to ensure the investigations of all reports are commenced and completed on time consistent with this Order and conducted taking into account at all times the child's safety needs.*

Receiving Allegations

- Between July 1, 2021 and June 30, 2022, SWI hotline staff received 735,938 calls. During the period analyzed, 22% (159,049) of calls were abandoned, similar to the rate of 20% observed in the previous report.[17]

- On average, callers waited for 5.2 minutes before their calls were handled or abandoned, an increase of more than half a minute from the data reported in the Third Report.[18] Forty-six percent (335,498) of callers waited on the queue for under one minute.

Screening Allegations

- The Monitors reviewed 770 referrals to SWI from July 1, 2021 to June 30, 2022, which SWI did not send to RCCI for an investigation of child abuse, neglect or exploitation but instead sent directly to HHSC (and that HHSC then assigned for a minimum standards investigation). Of these 770 reports, the Monitors concurred with SWI's determination in 93.4% (719) of reports.

Investigating Allegations

- Of the 1,604 RCCI investigations DFPS completed involving PMC children between May 1, 2021 and April 30, 2022, 93 investigations (5.8%) resulted in the substantiation of at least one allegation with a disposition of Reason to Believe; of the remaining 1,511 investigations (94.2%) where RCCI issued a disposition of Ruled Out, Unable to Determine or which resulted in Administrative Closure, the Monitors evaluated 776 investigations.

- The Monitors found that, of the 753 investigations reviewed where RCCI Ruled Out all of the allegations, RCCI did so appropriately in 716 (95%) cases; inappropriately in nine (1.2%) cases; and conducted investigations with such substantial

[17] *See* Deborah Fowler & Kevin Ryan, Third Report 32, ECF No. 1165.
[18] In the Third Report, the data demonstrated an average queue time of 4.6 minutes for calls placed from January 1, 2021 to June 30, 2021. *See* Deborah Fowler & Kevin Ryan, Third Report 30, ECF No. 1165.

deficiencies in 28 (3.7%) cases that the Monitors were prevented from reaching a conclusion.

- In addition to the 37 investigations that RCCI Ruled Out that were inappropriately resolved or had substantial deficiencies, the Monitors also identified one investigation, assigned a disposition of Unable to Determine, with such substantial deficiencies that the Monitors were prevented from reaching a conclusion.

- The Monitors found that of the 21 investigations with dispositions of Reason to Believe that RCCI later overturned during its Administrative Review and Appeals of Investigative Findings (ARIF) process during the period of review, RCCI did so appropriately in 17 investigations (81%) and inappropriately in four investigations (19%).

- In addition to the four investigations that RCCI inappropriately overturned during its ARIF process, the Monitors identified two other investigations that RCCI initially conducted with substantial deficiencies such that the Monitors agreed with RCCI's decision to overturn the disposition due to the investigative failure to gather a preponderance of evidence in support of the disposition.

- Of the 657 CPI investigations DFPS completed involving PMC children between September 1, 2021 and April 30, 2022, 78 (11.9%) investigations resulted in the substantiation of at least one allegation with a disposition of Reason to Believe; of the remaining 579 (88.1%) investigations where CPI issued a disposition of Ruled Out, Unable to Determine or which resulted in Administrative Closure, the Monitors evaluated 178 investigations.

- The Monitors found that, of the 151 investigations reviewed where CPI Ruled Out all of the allegations, CPI did so appropriately in 142 (94%) investigations; inappropriately in one; and conducted investigations with such substantial deficiencies in eight investigations that the Monitors were prevented from reaching a conclusion.

- In addition to the nine investigations that CPI Ruled Out that were inappropriately resolved or had substantial deficiencies, the Monitors also identified one investigation, assigned a disposition of Unable to Determine, with such substantial deficiencies that the Monitors were prevented from reaching a disposition conclusion, resulting in ten (5.6%) investigations that the Monitors' review identified as having been inappropriately resolved or conducted with substantial deficiencies.

Remedial Order 5: *Within 60 days and ongoing thereafter, DFPS shall, in accordance with existing DFPS policies and administrative rules, initiate Priority One child abuse and neglect investigations involving children in the PMC class within 24 hours of intake.*

(A Priority One is by current policy assigned to an intake in which the children appear to face a safety threat of abuse or neglect that could result in death or serious harm.)

- 79% (149) of Priority One RCCI investigations opened from July 1, 2021 to June 30, 2022 were initiated within 24 hours of intake; and

- 21% (39) of Priority One RCCI investigations opened from July 1, 2021 to June 30, 2022 were not initiated timely or did not have sufficient data to assess.

Remedial Order 6: *Within 60 days and ongoing thereafter, DFPS shall, in accordance with existing DFPS policies and administrative rules, initiate Priority Two child abuse and neglect investigations involving children in the PMC class within 72 hours of intake. (A Priority Two is assigned by current policy to any CPS intake in which the children appear to face a safety threat that could result in substantial harm.)*

- 83% (1,131) of Priority Two RCCI investigations opened from July 1, 2021 to June 30, 2022 were initiated within 72 hours of intake; and

- 17% (235) of Priority Two RCCI investigations opened from July 1, 2021 to June 30, 2022 were not initiated timely or did not have sufficient data to assess.

Remedial Order 7: *Within 60 days and ongoing thereafter, DFPS shall, in accordance with DFPS policies and administrative rules, complete required initial face-to-face contact with the alleged child victim(s) in Priority One child abuse and neglect investigations involving PMC children as soon as possible but no later than 24 hours after intake.*

- 79% (149) of Priority One RCCI investigations opened from July 1, 2021 to June 30, 2022 included initial face-to-face contact with all alleged victims within 24 hours of intake; and

- 21% (39) of Priority One RCCI investigations opened from July 1, 2021 to June 30, 2022 did not have timely face-to-face contact with all alleged victims or did not have sufficient data to assess.

Remedial Order 8: *Within 60 days and ongoing thereafter, DFPS shall, in accordance with DFPS policies and administrative rules, complete required initial face-to-face contact with the alleged child victim(s) in Priority Two child abuse and neglect investigations involving PMC children as soon as possible but no later than 72 hours after intake.*

- 83% (1,131) of Priority Two RCCI investigations opened from July 1, 2021 to June 30, 2022 included initial face-to-face contact with all alleged victims within 72 hours of intake; and

- 17% (235) of Priority Two RCCI investigations opened from July 1, 2021 to June 30, 2022 did not have timely face-to-face contact with all alleged victims or did not have sufficient data to assess.

Remedial Order 9: *Within 60 days and ongoing thereafter, DFPS must track and report all child abuse and neglect investigations that are not initiated on time with face-to-face contacts with children in the PMC class, factoring in and reporting to the Monitors quarterly on all authorized and approved extensions to the deadline required for initial face-to-face contacts for child abuse and neglect investigations.*

- Of 1,554 investigations opened by RCCI from July 1, 2021 to June 30, 2022 including both single and multi-alleged victim investigations, DFPS was able to track and report to the Monitors 92% of the time (1,431 investigations) whether face-to-face contact was made with each alleged child victim within an investigation and the date and time that contact occurred.

- Of the remaining 8% (123) of investigations, DFPS was not able to track and report to the Monitors whether face-to-face contact was made and the date and time that contact occurred.

Remedial Order 10: *Within 60 days, DFPS shall, in accordance with DFPS policies and administrative rules, complete Priority One and Priority Two child abuse and neglect investigations that involve children in the PMC class within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record. If an investigation has been extended more than once, all extensions for good cause must be documented in the investigative record.*

- Of the 1,554 Priority One and Priority Two investigations opened between July 1, 2021 and June 30, 2022, DFPS documented that 59% (922) were completed within 30 days of intake;

- Of the 1,554 Priority One and Priority Two investigations opened between July 1, 2021 and June 30, 2022, DFPS documented that 27% (420) of investigations were not completed timely; and

- Of the 1,554 Priority One and Priority Two investigations opened between July 1, 2021 and June 30, 2022, DFPS documented that 13% (197) of investigations had an approved extension and were completed within the extension timeframe.

- One percent (15) of the 1,554 Priority One and Priority Two investigations opened between July 1, 2021 and June 30, 2022 remained open with an active extension and, therefore, were not yet due at the time of analysis.

Remedial Order 11: *Within 60 days and ongoing thereafter, DFPS must track and report monthly all child abuse and neglect investigations involving children in the PMC class that are not completed on time according to this Order. Approved extensions to the*

standard closure timeframe, and the reason for the extension, must be documented and tracked.

- Of the 632 investigations that were opened by RCCI between July 1, 2021 and June 30, 2022 and were not completed within 30 days, DFPS data included extensions approved for 336 (53%) investigations with the dates the extensions were approved, the reasons for the extensions and the number of additional days approved by each of the extensions.

Remedial Order 16: *Effective immediately, the State of Texas shall ensure RCCL investigators, and any successor staff, complete and submit documentation in Priority One and Priority Two investigations on the same day the investigation is completed.*

- *(Remedial Order 16 applies to both DFPS and HHSC. The Monitors report on DFPS's performance in this Fifth Report and on HHSC's performance in the upcoming Sixth Report.)* With respect to DFPS, the agency advised the Monitors it uses the date the investigation was submitted to the supervisor as the investigation completion date. Therefore, according to DFPS, investigations are considered complete when the documentation is finally submitted to the supervisor in compliance with this Order.

Remedial Order 18: *Effective immediately, the State of Texas shall ensure RCCL investigators, and any successor staff, finalize and mail notification letters to the referent and provider(s) in Priority One and Priority Two investigations within five days of closing a child abuse and neglect investigation or completing a standards investigation.*

(Remedial Order 18 applies to both DFPS and HHSC. The Monitors' report on DFPS's performance in this Fifth Report and on HHSC's performance in the upcoming Sixth Report.) With respect to DFPS:

Notification to Referent:

- Of the 1,522 (out of 1,554) Priority One and Priority Two investigations opened by RCCI from July 1, 2021 to June 30, 2022 and documented as closed at the time of the Monitors' review, the notification letter to referents was mailed within five days of closure in 87% (1,329) of investigations.

- Of the remaining investigations, in 5% (69) of investigations, notification letters to the referents were not mailed timely; 3% (41) were mailed to the referent prior to supervisor approval; 2% (34) of investigations did not require notifications as the reporters were anonymous; and 3% (49) were unknown due to documentation deficiencies.

Notification to Provider:

- Of the 1,522 (out of 1,554) Priority One and Priority Two investigations opened by RCCI from July 1, 2021 to June 30, 2022 and documented as closed at the time of the Monitors' review, the notification letter to the provider was mailed within five days of closure in 83% (1,263) of investigations. Of the remaining cases, in 9% (140) of investigations, notification letters to the provider were not mailed timely; 3% (42) were mailed to the provider prior to supervisor approval; and 5% (77) were unknown due to documentation deficiencies.[19]

Remedial Order A6: *Within 30 days of the Court's Order, DFPS shall ensure that caseworkers provide children with the appropriate point of contact for reporting issues relating to abuse or neglect. In complying with this order, DFPS shall ensure that children in the General Class are apprised by their primary caseworkers of the appropriate point of contact for reporting issues, and appropriate methods of contact, to report abuse and neglect. This shall include a review of the Foster Care Bill of Rights and the number for the Texas Health and Human Services Ombudsman. Upon receipt of the information, the PMC child's caseworker will review the referral history of the home and assess if there are any concerns for the child's safety or well-being and document the same in the child's electronic case record.*

- Nearly half of children who responded to all of the relevant questions (37 of 75 or 49%) reported having heard of the hotline, including four children who initially indicated they had not heard of the hotline, but changed their answer after a description was given.

- Among children interviewed, 41 of 76 (54%) had heard of the Foster Care Bill of Rights (Bill of Rights); 17 responded "yes" to having heard of it only after a description was offered by the interviewer.

- Fewer than half of children interviewed (31 of 76 or 41%) had heard of the Foster Care Ombudsman (Ombudsman); 11 of them responded "yes" after a description was given by the interviewer.

- Overall, less than a quarter (17 of 75 or 23%) of children had heard of all three–the Bill of Rights, Ombudsman and the hotline. The percentage of children who had heard of the Ombudsman and hotline varied significantly by operation. Young children were less likely to have knowledge about the Ombudsman and hotline than older children.

Remedial Order B5: *Effective immediately, DFPS shall ensure that RCCL, or any successor entity, promptly communicates allegations of abuse to the child's primary caseworker. In complying with this order, DFPS shall ensure that it maintains a system to receive, screen, and assign for investigation, reports of maltreatment of children in the General Class, taking into account at all times the safety needs of children.*

[19] The documentation deficiencies included blank cells.

- The monitoring team conducted case record reviews for a randomly selected sample of 387 RCCI, 312 CPI and 99 PI abuse, neglect and exploitation intakes received by SWI during the months of January, March and June 2022. The monitoring team ascertained that the time from SWI's receipt of an intake to the time that a staffing contact assessing child safety occurred varied across all three intake types (RCCI, CPI, PI). Some staffing contacts did not include any information except the information about the alleged abuse, neglect or exploitation. When the monitoring team determined that additional action should have been taken due to the allegations to ensure child safety, the necessary actions most often included: training of operation staff or foster parents, increased supervision for the child, development of a safety plan for the child, and ensuring there would be no contact between the child and alleged perpetrator. Overall, the monitoring team found a staffing contact that documented appropriate action to ensure the child's safety in 42% (335 of 798) of all intakes reviewed.

Remedial Order 37: *Within 60 days, DFPS shall ensure that all abuse and neglect referrals regarding a foster home where any PMC child is placed, which are not referred for a child abuse and neglect investigation, are shared with the PMC child's caseworker and the caseworker's supervisor within 48 hours of DFPS receiving the referral. Upon receipt of the information, the PMC child's caseworker will review the referral history of the home and assess if there are any concerns for the child's safety or well-being and document the same in the child's electronic case record.*

- The Monitors' review of 22 intakes downgraded to Priority None (PN) involving PMC children between January 1, 2022 and June 30, 2022 revealed that none of the incidents occurred while any PMC child was placed in a verified foster home. The monitoring team also reviewed records associated with four Home History Reviews (HHRs) produced by the State between January 1, 2022 and June 30, 2022. The review raised concerns following two intakes that were downgraded. In the first, the Monitors found no evidence a required restaffing occurred. In the second, after a subsequent allegation was downgraded due to a previous investigation, DFPS's Complex Investigation Team reviewed the underlying investigation and determined that it was Ruled Out in error. A PMC child was still living in the foster home at the time that SWI received the intake that was later downgraded to PN. Though IMPACT records showed the caseworker and supervisor documented concerns during their HHR staffing based on the child's demeanor during the underlying investigation, the child remained in the home for weeks.

- The State conducted two case reads during the applicable period. Of the 13 reports made to SWI involving a PMC child placed in a foster home and later downgraded to PN, DFPS determined only one report required an HHR.

Organizational Capacity

Remedial Order 1: *Within 60 days, the Texas Department of Family Protective Services (DFPS) shall ensure statewide implementation of the CPS Professional*

Development (CPD) training model, which DFPS began to implement in November 2015.

- Overall, DFPS, OCOK, 2Ingage and St. Francis hired 632 caseworkers between September 1, 2021 and March 31, 2022 who were subject to full or partial CPD training prior to being assigned cases. Of those 632 caseworkers, 106 (16.8%) caseworkers left the agencies prior to or during CPD training and were excluded from the Monitors' analysis, which tracked a total of 526 caseworkers. Overall, the monitoring team validated the completion of CPD training by July 31, 2022 for 485 (92.2%) of 526 caseworkers.

- Of 448 DFPS caseworkers newly hired between September 1, 2021 and March 31, 2022, and subject to completion of full or partial CPD training, 422 (94%) caseworkers completed the full or partial training by July 31, 2022.

- OCOK hired 31 Permanency Specialists (caseworkers) between September 2021 and March 2022. Twenty-five of the 31 (81%) were subject to full or partial CPD training while six (19%) of the 31 were exempt from training. Two (8%) of the 25 caseworkers hired who were subject to training left OCOK prior to or during training. The Monitors confirmed that 22 of the remaining 23 staff completed CPD training by July 31, 2021.

- 2INgage hired 18 Permanency Case Managers (caseworkers) between September 2021 and March 2022. All 18 caseworkers were subject to full or partial CPD training. Seven (39%) of the 18 caseworkers subject to training left 2INgage prior to or during training, leaving 11 employees required to complete CPD training. The Monitors confirmed that nine (81.8%) of the 11 caseworkers completed CPD training by July 31, 2021.

- Of 46 caseworkers newly hired by St. Francis between November 1, 2021 and March 31, 2022, and subject to completion of full or partial CPD training, 32 (72.7%) caseworkers completed the full or partial training by July 31, 2022.

Remedial Order 2: *Within 60 days, DFPS shall ensure statewide implementation of graduated caseloads for newly hired CVS caseworkers, and all other newly hired staff with the responsibility for primary case management services to children in the PMC class, whether employed by a public or private entity.*

- For staff subject to graduated caseload standards between July 1, 2021 and June 30, 2022, caseloads conformed with the graduated caseload standards more than 99% of the time.

Remedial Order 35: *Effective immediately, DFPS shall track caseloads on a child-only basis, as ordered by the Court in December 2015. Effective immediately, DFPS shall report to the Monitors, on a quarterly basis, caseloads for all staff, including supervisors, who provide primary case management services to children in the PMC*

class, whether employed by a public or private entity, and whether full-time or part-time. Data reports shall show all staff who provide case management services to children in the PMC class and their caseloads. In addition, DFPS's reporting shall include the number and percent of staff with caseloads within, below and over the DFPS established guideline, by office, by county, by agency (if private) and statewide. Reports will include the identification number and location of individual staff and the number of PMC children and, if any, TMC children to whom they provide case management. Caseloads for staff, as defined above, who spend part-time in caseload carrying functions and part-time in other functions must be reported accordingly.

Remedial Order A2: *Within 120 days of the Court's Order, DFPS shall present the completed workload study to the Court. DFPS shall include as a feature of their workload study submission to the Court, how many cases, on average, caseworkers are able to safely carry, and the data and information upon which that determination is based, for the establishment of appropriate guidelines for caseload ranges.*

Remedial Order A3: *Within 150 days of the Court's Order, DFPS shall establish internal caseload standards based on the findings of the DFPS workload study, and subject to the Court's approval. The caseload standards that DFPS will establish shall ensure a flexible method of distributing caseloads that takes into account the following non-exhaustive criteria: the complexity of the cases; travel distances; language barriers; and the experience of the caseworker. In the policy established by DFPS, caseloads for staff shall be prorated for those who are less than full-time. Additionally, caseloads for staff who spend part-time in the work described by the caseload standard and part-time in other functions shall be prorated accordingly.*

Remedial Order A4: *Within 180 days of the Court's Order, DFPS shall ensure that the generally applicable, internal caseload standards that are established are utilized to serve as guidance for supervisors who are handling caseload distribution and that its hiring goals for all staff are informed by the generally applicable, internal caseload standards that are established. This order shall be applicable to all DFPS supervisors, as well as anyone employed by private entities who is charged by DFPS to provide case management services to children in the General Class. [The Court subsequently changed the effective date of this order to February 15, 2020.]*

- Upon agreement by the parties, the Court approved a workload standard of 14 to 17 children per Conservatorship (CVS) worker, pursuant to Remedial Order A3. To validate the State's performance, the Monitors reviewed and analyzed all relevant data provided by the State during the review period. The Monitors' analysis showed that as of June 30, 2022, 85% of all caseworkers (1,343 of 1,575), including those employed by OCOK, 2INgage and St. Francis had primary caseloads within or below the standard of 17 children per worker, which was the highest for the period from January 31, 2022 to June 30, 2022. Conformity with the standard was lowest on January 31, 2022 with 74% of all caseworkers (1,086 of 1,477) serving at least one PMC child within or below the standard.

- Supervisors carried only a small percentage of PMC cases; those who did rarely conformed with the workload standard. In the six months of caseload reports starting on January 31, 2022 and ending on June 30, 2022, conformity for supervisors managing at least one PMC child's case was lowest on March 30,2022, with 5% (1 of 21) of supervisors with one workload or less and highest on February 28, 2022, with 22% (7 of 32) of relevant supervisors with one workload or less. At the end of the period on June 30, 2022, conformity with the workload standard was 20% (5 of 25) of all supervisors carrying at least one PMC case.

- The Monitors found that conformity with the caseload standard varied among DFPS, OCOK, 2INgage and St. Francis. Of the 1,283 DFPS workers carrying at least one PMC case on June 30, 2022, 1,102 (86%) workers had primary caseloads within or below the standard of 17 children per worker. As of June 30, 2022, the three SSCCs that are undertaking case management, OCOK, 2INgage and St. Francis had 97%, 92% and 53% of their workers within or below the standard, respectively.

- Caseworkers reported significant CWOP shift work during interviews with the monitoring team, including workers whose caseloads did not conform to the caseload standards: 18 (17%) of the 106 workers interviewed who reported CWOP shift activity from January 2022 through June 2022 had caseloads that exceeded the caseload standard.

Remedial Orders B1: *Within 60 days of the Court's Order, DFPS, in consultation with and under the supervision of the Monitors, shall propose a workload study to: generate reliable data regarding current RCCL, or successor entity, investigation caseloads and to determine how much time RCCL investigators, or successor staff, need to adequately investigate allegations of child maltreatment, in order to inform the establishment of appropriate guidelines for caseload ranges; and to generate reliable data regarding current RCCL inspector, or successor staff, caseloads and to determine how much time RCCL inspectors, or successor staff, need to adequately and safely perform their prescribed duties, in order to inform the establishment of appropriate guidelines for caseload ranges. The proposal shall include, but will not be limited to: the sampling criteria, timeframes, protocols, survey questions, pool sample, interpretation models, and the questions asked during the study. DFPS shall file this proposal with the Court within 60 days of the Court's Order, and the Court shall convene a hearing to review the proposal.*

Remedial Order B2: *Within 120 days of the Court's Order, DFPS shall present the completed workload study to the Court. DFPS shall include as a feature of their workload study submission to the Court, how many cases, on average, RCCL inspectors and investigators, or any successor staff, are able to safely carry, and the data and information upon which that determination is based, for the establishment of appropriate guidelines for caseload ranges.*

Remedial Order B3: *Within 150 days of the Court's Order, DFPS, in consultation with the Monitors, shall establish internal guidelines for caseload ranges that RCCL investigators, or any successor staff, can safely manage based on the findings of the RCCL investigator workload study, including time spent in actual investigations. In the standard established by DFPS, caseloads for staff shall be prorated for those who are less than full-time. Additionally, caseloads for staff who spend part-time in the work described by the RCCL, or successor entity, standard and part-time in other functions shall be prorated accordingly.*

Remedial Order B4: *Within 180 days of this Order, DFPS shall ensure that the internal guidelines for caseload ranges and investigative timelines are based on the determination of the caseloads RCCL investigators, or any successor staff, can safely manage are utilized to serve as guidance for supervisors who are handling caseload distribution and that these guidelines inform DFPS hiring goals for all RCCL inspectors and investigators, or successor staff.*

- On December 16, 2019, the Court approved an agreed motion submitted by the parties establishing as caseload guidelines a standard of 14-17 investigations per RCCI investigator and 14-17 tasks per RCCR (HHSC) inspector.

- Almost all RCCI investigators' caseloads and most RCCR (HHSC) inspectors' caseloads were within the guidelines during each month of the period from July 2021 through June 2022. Of RCCR supervisors who carried a caseload, however, fifty percent or more were assigned 18 or more tasks and/or administrative reviews in seven of the 12 months analyzed for this report.

Demographics of Children in PMC Care

According to DFPS data, there were 10,124 children in PMC status as of June 30, 2022,[20] an increase of 445 children from the 9,679 children in PMC status on December 31, 2021 according to DFPS's corrected data.[21] DFPS cared for 13,208 PMC children between January 1, 2022 and June 30, 2022. During this period, 3,529 children entered PMC status and 3,084 children exited PMC status. Of the 10,124 children in PMC status on June 30, 2022, 3,327 (33%) children first entered PMC status after January 1, 2022.

[20] Analyses in this section for January 1, 2022 to June 30, 2022 are based on a comprehensive data file reflective of the reporting period. *See* DFPS, *RO.Inj_PMC_Children_List_010122_063022_log107017,* (Sept. 1, 2022) (on file with the Monitors). The Monitors became aware on July 6, 2022 that DFPS had previously misidentified the status of 339 children as Temporary Managing Conservatorship (TMC) instead of PMC. The Monitors were able to verify that the majority of those children (297 or 88%) were identified as PMC in the data received on September 1, 2022 and are included in this analysis. In addition, the Monitors removed 16 children who appeared twice in the data. These duplicate entries were often missing data or had other inconsistencies.

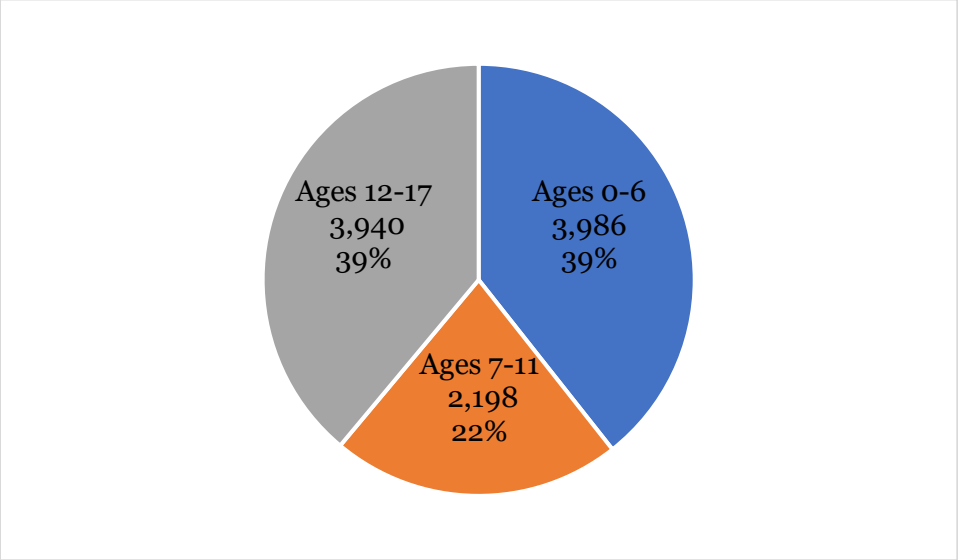
[21] In this reporting period, as noted above, DFPS provided to the Monitors a comprehensive data file reflective of the reporting period (January 1, 2022 to June 30, 2022) to address data lag issues that occurred in the monthly data reports. As a result, DFPS reported an additional 282 children were in PMC status but were not included in the data that DFPS submitted to the Monitors at the time of the Fourth Report. *See also* Deborah Fowler and Kevin Ryan, Fourth Report 18, ECF No. 1248.

Age, Gender and Race

As of June 30, 2022, 39% of children with PMC status were age zero to six years old (3,986); 22% were seven to 11 years old (2,198); and 39% were 12 to 17 years old (3,940).

Figure 1: Age of Children in PMC on June 30, 2022

n=10,124 children



Forty-eight percent of children in PMC status were reported as female and 52% were reported as male.

The race of non-Hispanic children in PMC status breaks down as follows: 27% (2,774) of children in PMC on June 30, 2022 were White; 23% (2,365) were Black/African American; <1% (38) were Asian; <1% (16) were Native American; and 6% (597) were categorized as "Other." Additionally, 43% (4,334) of children in PMC on June 30, 2022 were of Hispanic ethnicity. Non-Hispanic Black/African American children in PMC status appear to be disproportionately represented compared to the racial category totals for Texas's population of all children ages zero to 17 years in the 2020 census.

Table 1: Race for Children in PMC on June 30, 2022 and Estimates of Total Child Population in Texas by Race, August 12, 2021[22,23]

n=10,124 children

Race/Ethnicity	Children in PMC on June 30, 2022		Estimates of Total Population in Texas by Race	
	Frequency	Percent	Frequency	Percent
Non-Hispanic White	2,774	27.4%	11,584,597	40.2%
Non-Hispanic Black/African American	2,365	23.4%	3,444,712	12.0%
Non-Hispanic Other	597	5.9%	886,095	3.1%
Non-Hispanic Native American	16	<1%	27,857	<1%
Non-Hispanic Asian	38	<1%	1,561,518	5.4%
Hispanic (of any race)	4,334	42.8%	11,441,717	39.7%
Total	**10,124**	**100%**	**28,803,616**	**100%**

Note: Columns may not add to 100.0% due to rounding.

Living Arrangements and Length of Time in Care

Based upon information provided by DFPS, 80% (8,065) of children in PMC on June 30, 2022 lived in family settings, including 27% (2,780) living with relatives or fictive kin and 3% (334) living in adoptive homes; 15% (1,475) of children in PMC lived in congregate care; and 520 (5%) children lived in other types of living arrangements.[24] The remaining 64 (<1%) PMC youth were without an authorized placement (also known as CWOP) on June 30, 2022.

---

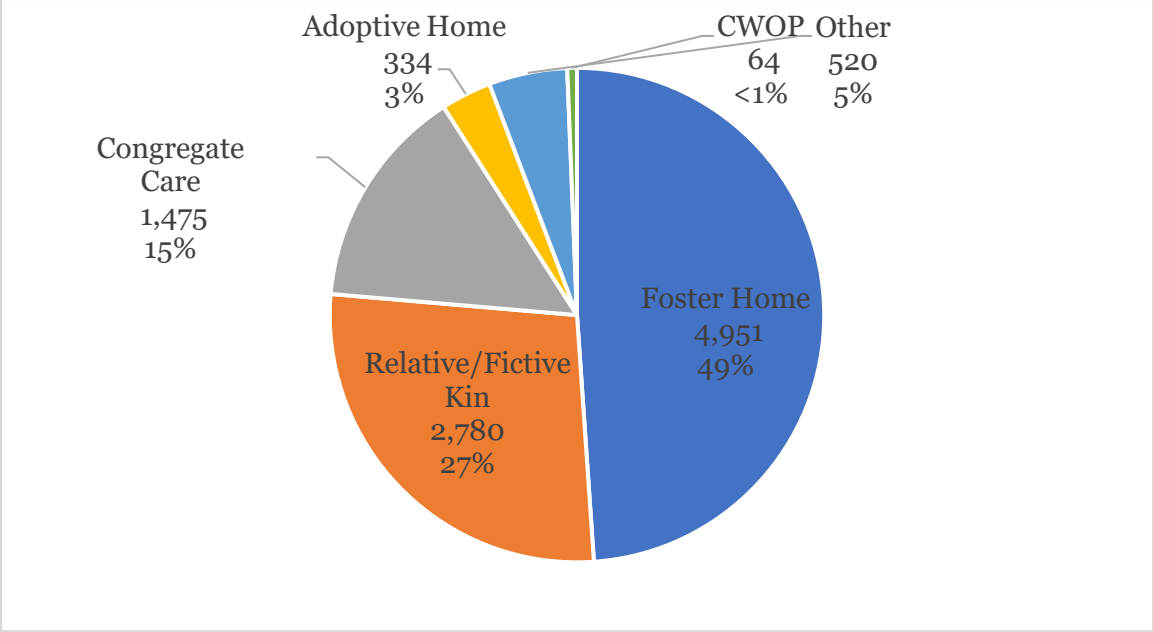
[22] *See* UNITED STATES CENSUS BUREAU, Table IDs P2 & P4, Product: 2020: DEC Redistricting Data (PL 94-171) (August 2021), available at https://data.census.gov/cedsci/table?q=Texas%20race%20by%20hispanic%20ethnicity&tid=DECENNIALPL2020.P2, and https://data.census.gov/cedsci/table?q=Texas%20race%20by%20hispanic%20ethnicity%20&tid=DECENNIALPL2020.P4. These totals were derived by subtracting Table P4 totals (population over 18) from Table P2 totals (total population). The categories used by the Census Bureau and Texas DFPS do not match exactly. The Census data were aggregated as follows: the Non-Hispanic Other category includes all children in the Non-Hispanic Other category with one race and all non-Hispanic children with more than one race; the Non-Hispanic Native American totals combine the American Indian Alaska Native category with the Native Hawaiian and Pacific Islander category.

[23] The format of the data provided by DFPS to the Monitors does not provide the ability to identify the racial categories for any child of Hispanic ethnicity.

[24] The 520 children in the "Other" living arrangement category in this figure include those identified by DFPS as: "Unauthorized Placement" (28%, 143), "HCS Group 1-4" (18%, 93), "Runaway" (17%, 88), "Incarcerated" (13%, 70), "Psychiatric Hospital" (6%, 30), "Own-home/Non-Custodial Care" (4%, 23), "Independent Living" (1%, 6), Data Entry Error (1%, 5), and eight other living arrangement types (12%, 62). DFPS identified 64 children without placement for this date from the ongoing e-mail notifications from DFPS to the Monitors about children without placements; the Monitors cross-referenced those children in the relevant June data report with living arrangements. Of the 64 children without placement, the Monitors confirmed 62 in the DFPS data for June 30, 2022.

Figure 2: Living Arrangements for Children in PMC on June 30, 2022

n=10,124 children



PMC children who were identified as either Black/African American or Hispanic were slightly more likely to live in family settings than those children identified as White. Of children identified as Hispanic, 82% lived in family settings; Black/African American children, 79%; and for White children, 76%.

Table 2 : Living Arrangement by Race, Children in PMC on June 30, 2022

n=10,124 children

	Living Arrangement					
Race/Ethnicity	**Foster Home**	**Adoptive Home**	**Congregate Care**	**Relative / Fictive Kin**	**Other**	**Total**
Non-Hispanic White	49% 1359	3% 97	19% 527	24% 655	5% 136	100% 2774
Non-Hispanic Black/African American	49% 1167	3% 76	14% 329	27% 633	7% 160	100% 2365
Non-Hispanic Other	56% 337	3% 19	12% 74	24% 145	4% 22	100% 597
Non-Hispanic Native American	50% 8	6% 1	19% 3	19% 3	6% 1	100% 16
Non-Hispanic Asian	47%	0%	21%	21%	11%	100%

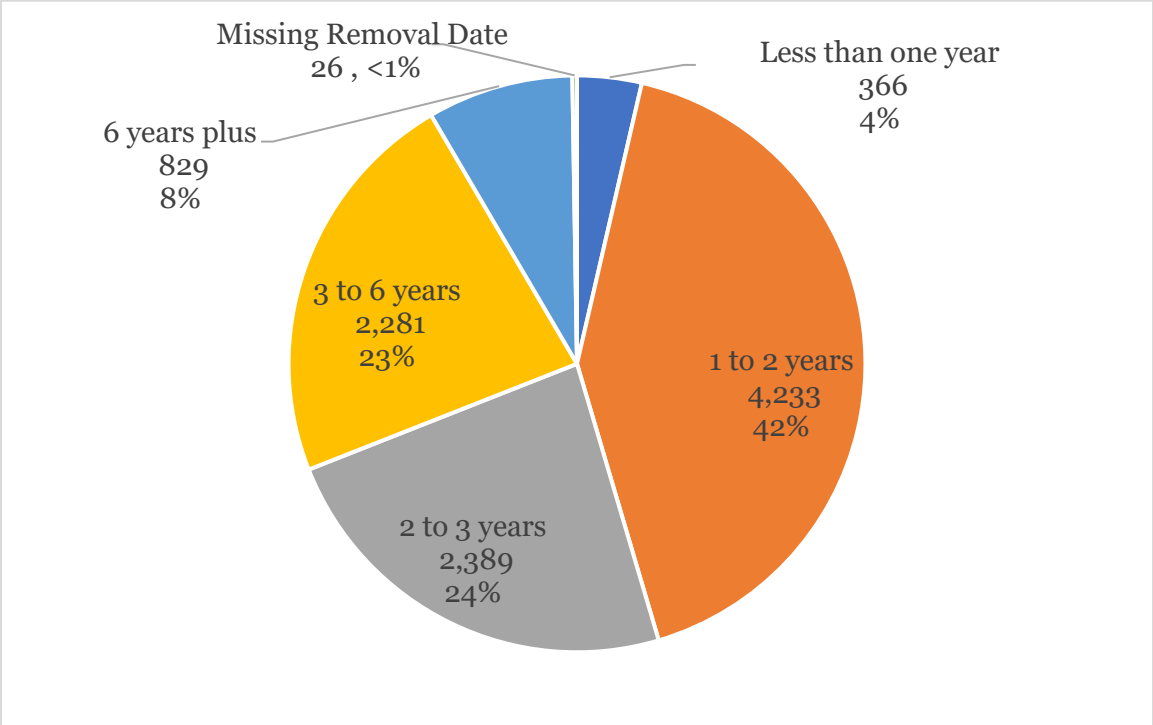
	18	0	8	8	4	38
Hispanic (of any race)	48% 2062	3% 141	12% 534	31% 1335	6% 261	100% 4333

Note: Columns may not add to 100% due to rounding.

Of the children in PMC status on June 30, 2022, 4% (366) were in care for less than one year, 42% (4,233) were in care for one to two years; 24% (2,389) were in care for two to three years; and 31% (3,110) were in care for more than three years. Additionally, for 26 children (<1%) the data did not include removal dates, thus the Monitors were unable to calculate their length of time in care.[25]

Figure 3: Length of Stay in Care of Children in PMC on June 30, 2022

n=10,124 children



Children exited from PMC status primarily through adoption; reunification with family; having custody transferred to relatives; or by aging out of care. Of the 3,084 children's exits from PMC status that DFPS reported between January 1, 2022 and June 30, 2022, the most frequent reason for exit was adoption, with more adoptions by non-relatives (1,101) than relatives (867). The breakdown of exit reasons is as follows: 64% (1,968) of children were adopted; 19% (589) of children had custody transferred to a relative; and

[25] Total does not add up to 100% due to rounding.

13% (414) of children who exited aged out of foster care. Finally, a small number of children were reunified with their families (3%, 82) or had other outcomes (1%, 31).

Table 3: Exits from PMC by Exit Outcome between January 1 and June 30, 2022

n=3,084 exits from foster care

Exit Outcome	Frequency	Percent
Adoption	1,968	64%
Custody to Relative	589	19%
Emancipation	414	13%
Reunification	82	3%
Other	31	1%
Total	**3,084**	**100%**

Out of State Placement

Of the 10,124 children in PMC status on June 30, 2022, 505 (5%) children were placed in living arrangements that were located out of state. Of the PMC children placed out of state, 374 (74%) lived in family settings, including 24% (120) living with relatives or fictive kin and 13% (68) living in adoptive homes; and 22% (110) of children in PMC lived in congregate care out of state, a 13% decrease from December 31, 2021.

Table 4: Out of State Living Arrangement Type for Children in PMC, December 31, 2021 and June 30, 2022

n=530 children and 505 children respectively

Living Arrangement Type	December 31, 2021	June 30, 2022	Percent Change
Congregate Care	126	110	-13%
Foster Home	172	186	8%
Relative/Fictive Kin	155	120	-23%
Adoptive Home	50	68	36%
Other	22	12	-45%
Own Home/Non-Custodial Care	2	3	50%
Data Entry Error	0	5	N/A
Independent Living	2	0	-100%
Incarcerated	1	1	0%
Total	**530**	**505**	**-5%**

Of the 505 children who were placed out of state, 175 (35%) were White and 111 (22%) were Black/African American.

Table 5: Children in PMC Placed Out of State by Race on June 30, 2022

n = 505 children

Race/Ethnicity	Frequency	Percent
Non-Hispanic White	175	35%
Non-Hispanic Black/African American	111	22%
Non-Hispanic Other	39	8%
Non-Hispanic Native American	1	<1%
Non-Hispanic Asian	1	<1%
Hispanic (of any race)	178	35%
Total	**505**	**100%**

Note: Columns may not add to 100% due to rounding

Level of Care

Of the 10,124 children in PMC status on June 30, 2022, 6,056 (60%) children were in a Basic level of care. Of the remaining 4,068 PMC children, 1,448 (14%) were in a Specialized level of care; 1,201 (12%) were in a Moderate level of care; and 441 (4%) were in an Intense level of care. The data included 901 (9%) PMC children with no authorized level of care recorded.[26]

Table 6: Authorized Level of Care for Children in PMC as of June 30, 2022

n=10,124 children

Authorized Level of Care	Frequency	Percent
Basic	6,056	60%
Specialized	1,448	14%
Moderate	1,201	12%
No Authorized Level of Care Recorded	901	9%
Intense	441	4%
(TFC) Treatment Foster Care	72	1%
Intense Plus	3	<1%
Psychiatric Transition	2	<1%
Total	**10,124**	**100%**

Geographic Location

For 38% (3,888) of the 10,124 children with PMC status on June 30, 2022, the county of removal was one of five Texas counties: Bexar, Harris, Dallas, Tarrant and Bell.

[26] The Monitors found that for most of those children lacking identification of an authorized level of care (773, or 86% of children with no authorized level of care recorded), the placement type in the data was identified as "kin only (non-licensed)."

Table 7: Top Five Counties of Removal for Children in PMC on June 30, 2022[27]

n=3,888 PMC children of 10,124 PMC children in care

County Name	Frequency	Percent
Bexar	1,273	13%
Harris	984	10%
Dallas	661	7%
Tarrant	645	6%
Bell	325	3%
Total	**3,888**	**38%**

Single Source Continuum Contractor Presence and Placement Oversight

As of June 30, 2022, 25% (2,519) of children in PMC status were from regions where SSCCs operated in the first two stages of implementation.[28]

Table 8: Children in PMC by Regions on June 30, 2022

n=10,124 children

Regions	PMC Children	Percent
SSCC Regions	2,519	25%
DFPS Regions	7,605	75%
All Regions	**10,124**	**100%**

As shown in the table below, Region 3b, where OCOK was responsible for placement, had the greatest number of PMC children from a region that has SSCC placement oversight.

Table 9: Children in PMC from Regions with Single Source Continuum Contractor Presence by Region on June 30, 2022[29]

n=2,519 children

SSCC Name	Legal Region	PMC Children	Percent
St. Francis Ministries	1	706	28%

[27] These are the counties with jurisdiction over the child's removal case. DFPS describes these counties as the "legal" counties in the corresponding IMPACT data. Total does not equal 38% due to rounding.
[28] DFPS reports to the Monitors both the Legal Region and the Placement Region of children; here, the Monitors are referring to Legal Region for ease of reference. However, the children may be placed in and therefore, currently living in another region.
[29] The 3b catchment area is comprised of Tarrant, Erath, Hood, Johnson, Palo Pinto, Parker, and Somervell counties in DFPS Region 3W. The 8b catchment area is comprised of all counties in DFPS Region 8 excluding Bexar County. *See* DFPS, *Quarterly Report on Community Based Care Implementation Status*, 4-5 (December 2021). Total does not equal 100% due to rounding.

2Ingage	2	537	21%
OCOK	3b	840	33%
Belong	8b	436	17%
Total		**2,519**	**100%**

Screening, Intake and Investigation of Maltreatment in Care Allegations

Remedial Order 3

Remedial Order 3: *DFPS shall ensure that reported allegations of child abuse and neglect involving children in the PMC class are investigated; commenced and completed on time consistent with the Court's Order; and conducted taking into account at all times the child's safety needs. The Monitors shall periodically review the statewide system for appropriately receiving, screening, and investigating reports of abuse and neglect involving children in the PMC class to ensure the investigations of all reports are commenced and completed on time consistent with this Order and conducted taking into account at all times the child's safety needs.*

To assess DFPS's performance with respect to Remedial Order 3, the Monitors gathered a wide range of data relating to the safety of PMC children for analysis and qualitative review. This section discusses the Monitors' assessment and review of the statewide system for appropriately receiving, screening and investigating reports of abuse, neglect and exploitation involving PMC children at several points, including referrals to SWI; the screening of those referrals to determine whether they should be investigated for child abuse, neglect or exploitation; and investigations of child maltreatment allegations.

Background

SWI is expected to assign for an RCCI investigation those reports that allege abuse, neglect or exploitation of children in licensed residential operations.[30] The RCCI investigator is required to assess the immediate safety of involved children,[31] to evaluate the risk to the children during the investigation,[32] and to initiate the investigation timely based on the assigned priority–24 hours for Priority One and 72 hours for Priority Two.[33] The RCCI investigator is required to conduct interviews of children and collateral witnesses,[34] to collect evidence,[35] and to complete the investigation within 30 days for both Priority One and Priority Two cases.[36] RCCI's possible findings include:

[30] DFPS, *Child Care Investigations Handbook* § 6100, *available at* https://www.dfps.state.tx.us/handbooks/CCI/default.asp (*Child Care Investigations*).
[31] *Child Care Investigations* § 6330.
[32] *Child Care Investigations* § 6220.
[33] *Child Care Investigations* § 6361.1-2.
[34] *Child Care Investigations* § 6420.
[35] *Child Care Investigations* § 6440.
[36] *Child Care Investigations* § 6110.

Reason to Believe (RTB) – A preponderance of evidence indicates that abuse, neglect, or exploitation occurred. If the disposition for any allegation is Reason to Believe, the overall case disposition is Reason to Believe.

Ruled Out (R/O) – A preponderance of evidence indicates that abuse, neglect, or exploitation did not occur. If the dispositions for all allegations are Ruled Out, the overall case disposition is Ruled Out.

Unable to Determine (UTD) – A determination could not be made because of an inability to gather enough facts. The investigator concludes that:

- there is not a preponderance of the evidence that abuse or neglect occurred; but
- it is not reasonable to conclude that abuse or neglect did not occur.

If the disposition for any allegation is Unable to Determine and there is no allegation assigned a disposition of Reason to Believe, the overall case disposition is Unable to Determine.

Administrative Closure (ADM) – The operation is not subject to regulation; or the allegations do not meet the definition of abuse, neglect, or exploitation. If the dispositions for all allegations are Administrative Closure, the overall disposition is Administrative Closure.[37]

RCCI is charged with investigating allegations of abuse, neglect or exploitation of children in operations licensed by RCCR (HHSC), which includes foster homes and GROs.[38]

CPI is responsible for investigating abuse, neglect or exploitation of children in unlicensed placements, such as kinship foster homes and children under DFPS Supervision in CWOP Settings. CPI's scope of authority also includes investigating reports of child abuse or neglect alleged to have occurred prior to the child's entrance into DFPS custody.[39,40]

Statewide Intake Performance

[37] *Child Care Investigations* § 6622.3
[38] *Child Care Investigations* § 1142.
[39] DFPS, *Child Protective Services Handbook* § 2120, *available at* https://www.dfps.state.tx.us/handbooks/CPS/default.asp.
[40] The language in Remedial Order 3 specifically refers to the General Class, rather than limiting its application to children in licensed settings. In an advisory filed with the Court on September 21, 2021, Governor Greg Abbott advised that with respect to the scope of the Court's injunctions, "[A] General Class member should receive the same protections under the Court's remedial orders regardless of the licensed or unlicensed nature of the facility where the member is housed, unless the remedial order at issue specifies that it applies only to the [Licensed Foster Care] subclass or licensed or unlicensed facilities." Governor Greg Abbott's Advisory Concerning the Court's September 14, 2021 Inquiries 3, ECF No. 1137.

Background

Calls to SWI are answered by an automated system that asks the caller a series of questions in order to determine the way the call is routed.[41] These questions include a caller's language preference; whether the caller is asking about the status of a case; and whether the caller wants to learn more about online reporting.[42] Depending upon the answers to these questions, the call is routed to one of 22 "call queues."[43] If an SWI staff member is not immediately available, the caller waits on the queue.[44] If a caller hangs up before an SWI staff member answers the call, the call is categorized as "abandoned."[45] If an SWI staff member speaks with the caller, the call is categorized as "handled." The automated system records the date and time that each call starts and ends; the call queue to which the call is routed; whether the call is handled or abandoned; the time the caller waits after being routed to a queue before speaking with an SWI staff member; and other information.[46]

During this reporting period, DFPS continued to produce data files containing monthly SWI call records of all hotline call made, pursuant to this Court's order; [47] the specific times of these calls to the hotline; and the wait time for each call, including, but not limited to, dropped and unanswered calls.[48]

Statewide Intake Call Center Performance Analysis

The Monitors analyzed SWI's Avaya call data related to the 735,938 calls made to SWI from July 1, 2021 to June 30, 2022.[49] The analysis examined the distribution of calls by month, weekday, hour and call queue, the prevalence of handled and abandoned calls, and the amount of time callers waited before the call was answered by a staff person.

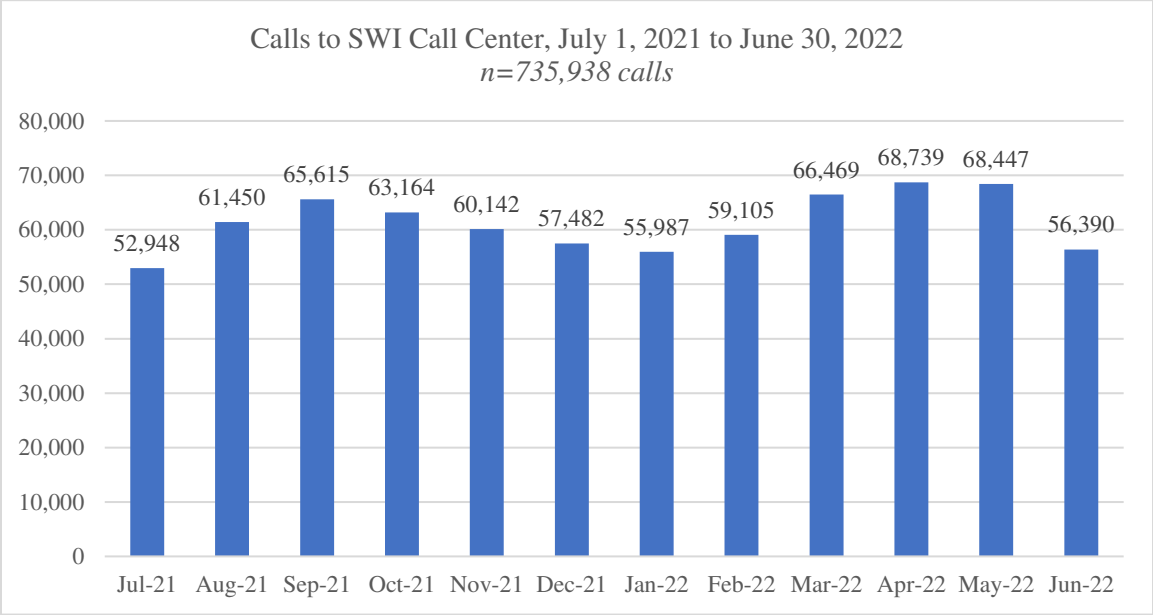
Volume of Calls to SWI

---

[41] *See* DFPS, *SWI Abuse Hotline Call Flow- AM 5-7-2019* (Mar. 30, 2020) (on file with the Monitors).
[42] *Id.*
[43] *Id.*
[44] *See* DFPS, *RO3 3-13-20 Response FINAL* (Mar. 30, 2020) (on file with the Monitors).
[45] *Id.*
[46] DFPS, *RO3 3-13-20 Response FINAL* (Mar. 30, 2020) (on file with the Monitors); DFPS, *SWI Abuse Hotline Call Flow- AM 5-7-2019* (Mar. 30, 2020) (on file with the Monitors).
[47] On February 21, 2020, the Court ordered DFPS to provide the Monitors by February 26, 2020, and continuing thereafter until further order of the Court, the records of all SWI calls made, the specific times of all calls made to SWI, and the wait time for each SWI call including, but not limited to, dropped and unanswered SWI calls. *M.D. ex rel. Stukenberg v. Abbott*, No. 2:11-CV-84, slip. op. at 2 (S.D. Tex. Feb. 20, 2020), ECF No. 811 (ordering that starting February 26, 2020 and continuing thereafter in 24-hour increments until further order of the Court, the Defendants are to provide the Monitors with records of all Statewide Intake hotline calls made and the wait time for each call including, but not limited to, dropped and unanswered calls, and including the specific times of these calls to the Statewide Intake hotline).
[48] The Monitors received SWI call data in workbooks with titles in the following format: "export_[month]-[day]-[year].csv". The Monitors received individual files for each day during the reporting period.
[49] Two hundred duplicate calls were removed from the dataset. Calls were determined to be duplicates if the Call ID, UC ID, and call queue were all identical.

On average, the SWI data recorded over 61,000 calls a month. Average call volume increased by an average of 2,000 calls per month compared to the average reported in the Monitors' previous report.[50] The calls listed in the data are from the public as well as calls and transfers within SWI. Call volume fell by 15% from September 2021 (65,615 calls) to January 2022 (55,987 calls), before it rose to its highest point in April 2022 (68,739 calls).

Figure 4: Number of SWI Calls by Month

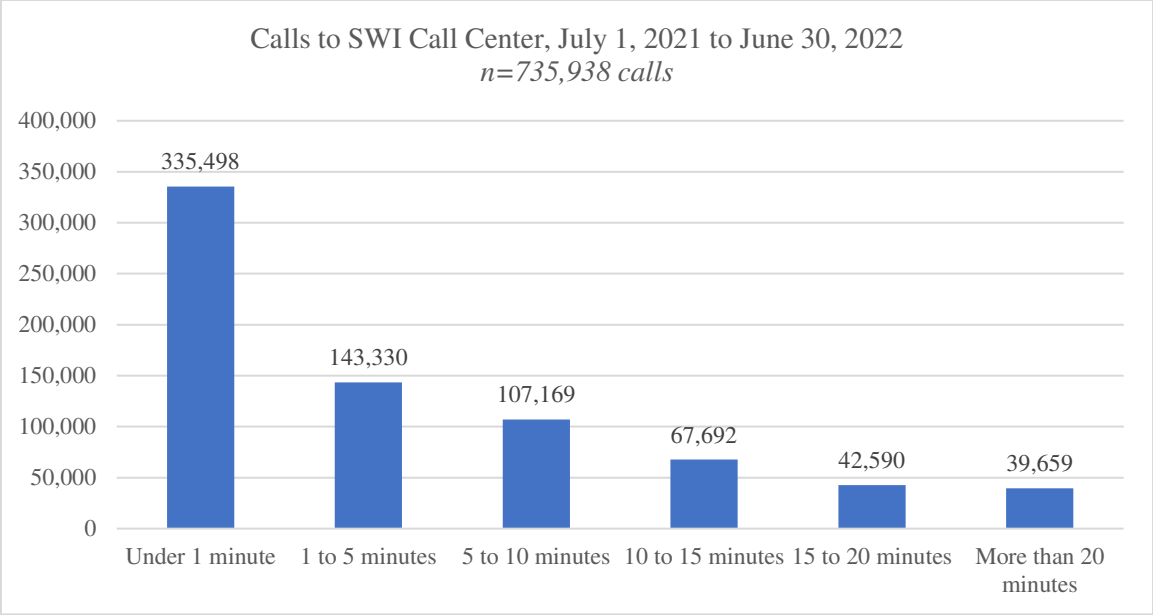


Queue Times

On average, callers waited for 5.2 minutes on the queue before their calls were handled or abandoned, 36 seconds longer than the wait time observed in the previous reporting period.[51] Forty-six percent (335,498) of callers waited on the queue for under one minute; 19% (143,330) waited for one to five minutes; 15% (107,169) waited five to ten minutes; 9% (67,692) waited ten to 15 minutes; 6% (42,590) waited 15 to 20 minutes; and 5% (39,659) waited more than 20 minutes.

Figure 5: Time Callers Waited before Calls were Handled or Abandoned

[50] The Third Report found an average of 59,000 calls per month from January 1, 2021 to June 30, 2021. *See* Deborah Fowler & Kevin Ryan, Third Report 29, ECF No. 1165.
[51] The Third Report found an average queue time of 4.6 minutes for calls placed between January 1, 2021 to June 30, 2021. *See* Deborah Fowler & Kevin Ryan, Third Report 30, ECF No. 1165.

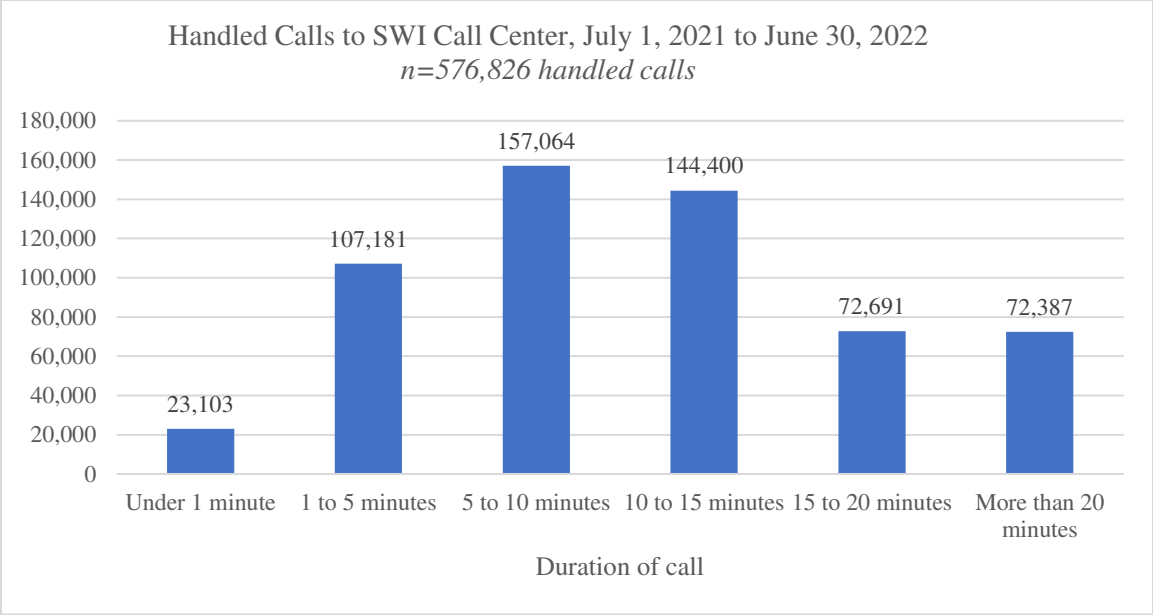


Handled Calls

Of 735,938 calls, 78% (576,826) were answered,[52] a decrease from 80% observed in the Third Report.[53] Handled calls had an average duration of 11.9 minutes. Four percent (23,103) of handled calls lasted under one minute; 19% (107,181) lasted one to five minutes; 27% (157,064) lasted five to ten minutes; 25% (144,400) lasted ten to 15 minutes; 13% (72,691) lasted 15 to 20 minutes; and 13% (72,387) lasted more than 20 minutes (percentages do not add to 100 due to rounding).[54]

Figure 6: Duration of Handled SWI Calls

[52] Handled calls were determined by the presence of a "Handled Flag." Sixty-three calls were not flagged as either handled or abandoned, an indicator of data quality issues.
[53] The Third Report found that 80% of calls were handled from January 1, 2021 to June 30, 2021. *See* Deborah Fowler & Kevin Ryan, Third Report 31, ECF No. 1165.
[54] Fewer than 1% (31) of handled calls had a duration of zero minutes, a potential indicator of data quality issues; calls that were answered should, by definition, have a duration. Calls with a duration of zero minutes were abandoned before the caller finished navigating the automated system.



There were 1,288 calls in the dataset with durations longer than two hours, which may be indicative of data system issues. Of these 1,288 calls, 693 (54%) lasted two to three hours; 301 (23%) lasted three to four hours; 186 (14%) lasted four to five hours; 64 (5%) lasted five to six hours; and 44 (3%) lasted more than six hours (percentages do not add to 100 due to rounding).

Abandoned Calls

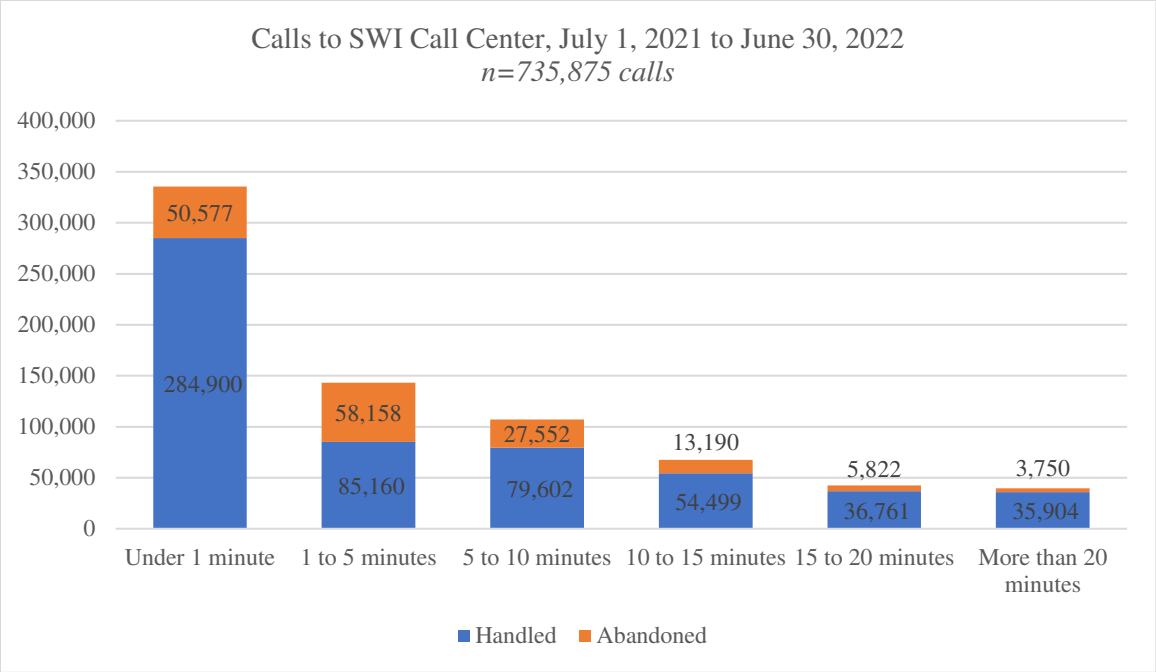
During the period analyzed, 22% (159,049)[55] of calls were abandoned, similar to the last reporting period at 20%.[56] A total of 68% (108,735) of abandoned calls occurred after callers waited for up to five minutes, including 18% (28,855) of all abandoned calls that occurred before the caller finished navigating the automated system.

Of the 335,498 calls waiting on the queue for up to one minute, 15% (50,577) were abandoned and 85% (284,900) were handled. The highest number of abandoned calls occurred among those 143,330 calls waiting on the queue for one to five minutes, when 41% (58,158) of those calls were abandoned.

The figure below shows the queue time of abandoned calls and handled calls.

Figure 7: Queue Time of Abandoned and Handled SWI Calls[57]

[55] Abandoned calls were determined by the presence of a "Queue Abandoned Flag." Sixty-three calls were not flagged as either handled or abandoned, an indicator of data quality issues.
[56] *See* Deborah Fowler & Kevin Ryan, Third Report 32, ECF No. 1165.
[57] The number of calls in the figure does not include the 63 calls that were not flagged in the data as either handled or abandoned.



Call Queues

Calls were routed to 22 different queues in the reporting period. Of the 735,938 calls, the abuse queue received the majority of incoming calls (65%, 481,472). The next most common queues were calls from law enforcement (11%, 82,844); calls from intake staff to their supervisors (11%, 80,254); calls to support staff (3%, 25,500); and other general calls in English including calls pertaining to state hospitals and state supported living centers (3%, 19,616). These five queues represent 94%[58] (689,686) of all calls.

Four percent (3,249) of the 82,844 calls to the law enforcement queue were abandoned. In contrast, 27% (128,313) of 481,472 calls to the abuse queue were abandoned. On the law enforcement queue, 75% (61,903) of calls were handled or abandoned in the first minute and 95% (78,523) in the first five minutes. In contrast, 30% (144,732) of calls to the abuse queue were handled or abandoned in the first minute and 52% (250,480) were handled or abandoned in the first five minutes.

The rate of abandoned calls to the abuse queue increased from 25% in the previous reporting period to 27% between July 1, 2021 to June 30, 2022. The rate of calls handled or abandoned in the first five minutes decreased from 58% in the previous reporting period to 52% for the current reporting period.[59]

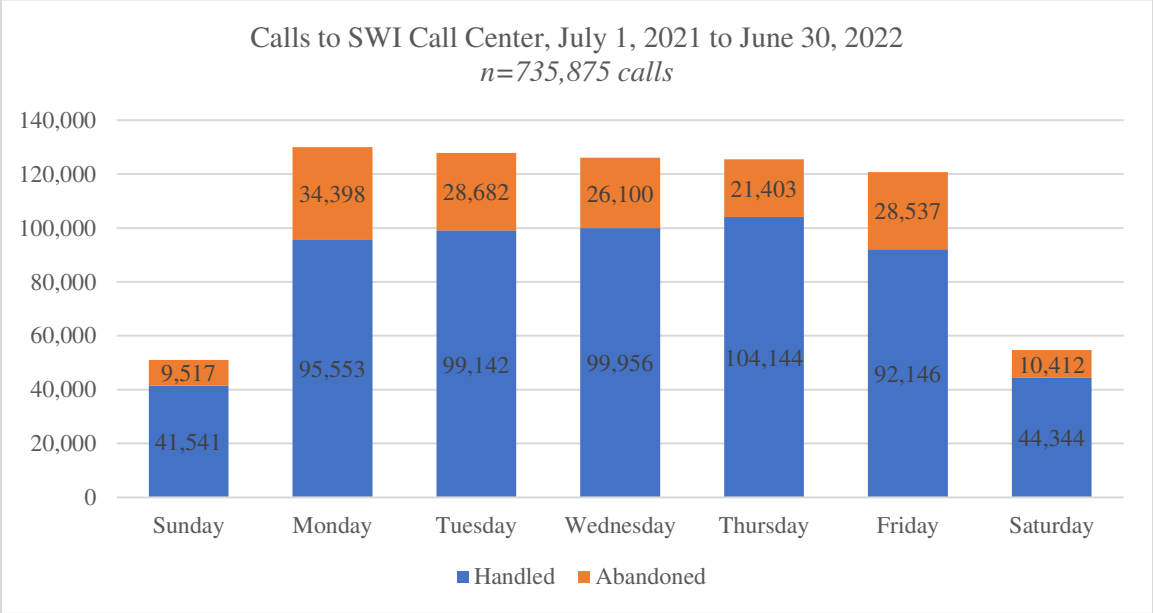
Calls by Day of the Week and Time of Call

SWI calls were higher in volume on weekdays than on weekends. The average weekday call volume (2,414 calls per day) was twice the average weekend call volume (1,018 calls

[58] This percentage is rounded to 94%.
[59] *See* Deborah Fowler & Kevin Ryan, Third Report 33, ECF No. 1165.

per day). On average, calls were abandoned at a slightly higher rate on weekdays (22%) as compared to weekends (19%). Average queue times were also two minutes longer on weekdays (5.4 minutes) as compared to weekends (3.5 minutes).

Figure 8: Number of SWI Calls Handled and Abandoned by Day of the Week[60]



Sixty-nine percent (507,199) of all calls were placed during typical work hours (9:00 a.m. through 6:00 p.m.), with a higher rate (72%) placed during work hours on weekdays as compared to weekends (52%). Calls were abandoned at a higher rate during the typical work week (Monday through Friday, 9:00 a.m. through 6:00 p.m.). On average, 25% of calls placed during the typical work week were abandoned, as compared to the overall average abandonment rate of 22%, a slight increase from the previous reporting period.[61]

DFPS Intake Screening and Maltreatment in Care Investigations

The Monitors used the monthly data files as provided by DFPS and HHSC on an ongoing basis for purposes of monitoring performance associated with Remedial Order 3. For purposes of data related to SWI, the State—DFPS and HHSC together or separately—remains unable to provide the Monitors with a unified list of all referrals to SWI involving PMC children as an apparent result of a bifurcated system for processing and storing data associated with referrals to SWI.[62]

Remedial Order 3: Screening and Intake Performance Validation

[60] The number of calls included is 735,875 because 63 of the total calls were not flagged in the data as either handled or abandoned.
[61] The Third Report found that 24% of calls were abandoned during the typical work week from January 1, 2021 to June 30, 2021. *See* Deborah Fowler & Kevin Ryan, Third Report 34, ECF No. 1165.
[62] *See* Deborah Fowler & Kevin Ryan, Second Report 61, ECF No. 1079.

Overview of Allegations in Referrals for Maltreatment in Care

The Monitors analyzed maltreatment in care allegations for PMC children using data about intakes pertaining to PMC children received by SWI from July 1, 2021 to June 30, 2022.[63] From July 1, 2021 to June 30, 2022, DFPS reported 1,683 intakes for PMC children in licensed placements (RCCI) that were coded as allegations of abuse, neglect or exploitation by SWI intake specialists. In that same period, DFPS reported 1,429 intakes for PMC children living in unlicensed placements (CPI) that were coded as allegations of abuse, neglect or exploitation by SWI intake specialists for investigation by CPI.

During its secondary screening between July 1, 2021 and June 30, 2022, DFPS downgraded 53 of the 1,683 RCCI intakes (3%) involving a PMC child to PN and determined that RCCI would not conduct an abuse or neglect investigation.[64] In addition, secondary screeners downgraded 198 of 1,683 intakes (12%) from Priority One investigations to Priority Two investigations. The overall rate of downgrades to PN was minimal, reflecting the DFPS policy change discussed in the Monitors' Second Report and implemented in November 2020.[65]

During the secondary screening for CPI intakes between July 1, 2021 and June 30, 2022, DFPS downgraded 20 of the 1,429 CPI intakes (1%) involving a PMC child to PN and determined that CPI would not conduct an abuse or neglect investigation. In addition, DFPS downgraded 155 of 1,429 total intakes (11%) from Priority One investigations to Priority Two investigations.

The 1,683 RCCI intakes reported by DFPS involved 2,110 children in licensed placements between July 1, 2021 and June 30, 2022 and contained 2,332 allegations of child abuse, neglect or exploitation, an average of 194 allegations per month.[66] This represents a decrease of average monthly allegations of 99 (33%) per month from the Monitors' Third Report.[67] Among those 2,332 allegations, Neglectful Supervision was the most common allegation type, constituting 55% of all allegations (1,286), affecting 893 children; Physical Abuse allegations constituted 25% of allegations (590), affecting 467 children; and Sexual Abuse allegations constituted 9% of all allegations (205), affecting 164

---

[63] The Monitors used the regular monthly data reports relevant to this time period submitted by DFPS and HHSC and those reports are on file with the Monitors and with DFPS and HHSC. The CPI data, as provided to the Monitors by DFPS, includes all allegations and allegations are included based upon the child's living arrangement at the time of intake; therefore, they are not necessarily related to the current caregiver or time period. Therefore, for example, it can include allegations of maltreatment alleged to have occurred in the child's birth home or with another guardian prior to the child's entry in care.

[64] *Child Care Investigations Handbook* § 6211.1. An allegation can be assigned PN only due to lack of RCCI jurisdiction over the allegation or when the allegation has already been investigated. *Id*.

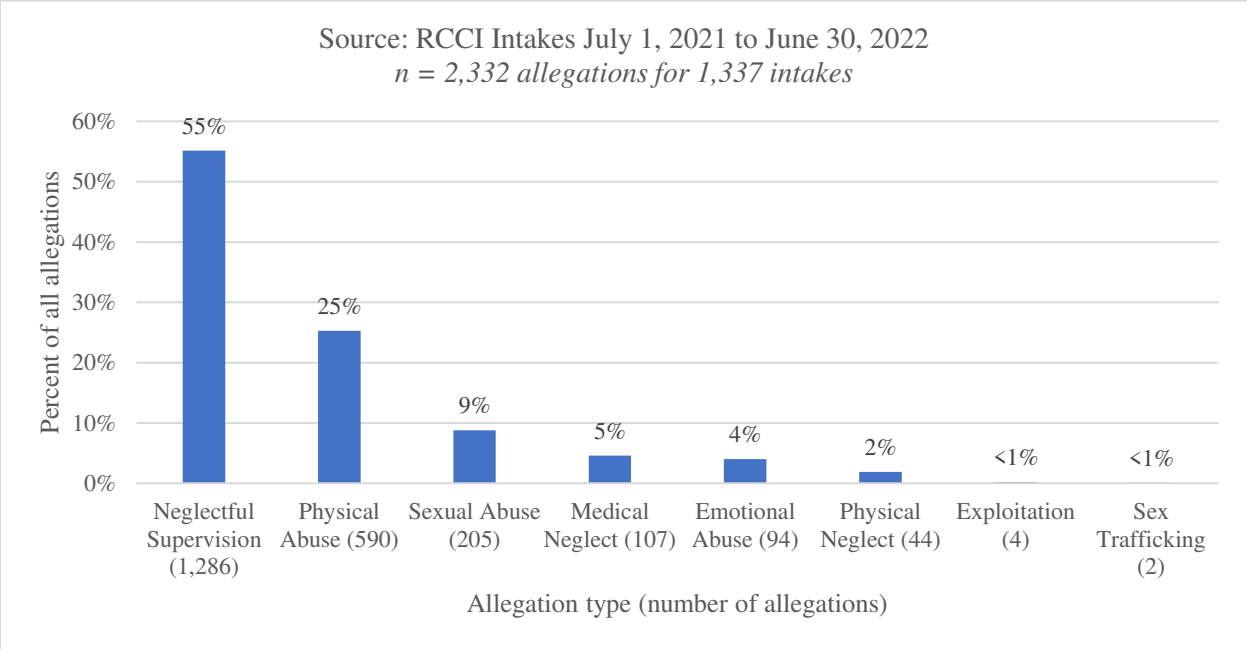
[65] Deborah Fowler & Kevin Ryan, Second Report 52-53, ECF No. 1079.

[66] Some intakes include more than one child and more than one allegation for each child. If a child was the subject of the same type of allegation in two separate intakes, that child is double counted in this analysis; the unique number of children is 1,337.

[67] Deborah Fowler & Kevin Ryan, Third Report 37, ECF No. 1165.

children.[68] The remaining 11% of allegation types included Medical Neglect, Emotional Abuse, Physical Neglect, Exploitation and Sex Trafficking. The data may underrepresent the prevalence of alleged sexual abuse victimization among PMC children due to the nature of Neglectful Supervision allegations. The Monitors have found during ongoing reviews of intakes and investigations that between one quarter and one third of allegations of Neglectful Supervision involve sexual contact among children in care.[69] DFPS's data does not identify the type of harm underlying Neglectful Supervision allegations.

Figure 9: Allegation Types for RCCI Intakes Involving PMC Children in Licensed Placements, July 1, 2021 to June 30, 2022



Note: Percentages do not add to 100% due to rounding.

In its monthly data reports to the Monitors, HHSC reported that 20,886 referrals were assigned to the agency by SWI between July 1, 2021 and June 30, 2022 to review and determine whether to conduct a minimum standards investigation (meaning they were not assigned to DFPS for an abuse, neglect or exploitation investigation). When the Monitors excluded the referrals related to facilities that did not house children in DFPS care, the total number of referrals was 15,925. Based upon ongoing monitoring and reporting, the monitoring team was able to determine that the rate of referrals assigned to HHSC involving PMC children was approximately 52% during this reporting period.[70]

[68] If a child was the subject of the same type of allegation in two separate intakes, that child would be double counted in this analysis.
[69] Deborah Fowler & Kevin Ryan, Third Report 37, ECF No, 1165; *see also*, Deborah Fowler and Kevin Ryan, Second Report 64-65, ECF No. 1079.
[70] This number is consistent with prior reporting but slightly higher. For example, in the Third Report, the Monitors found that 45.5% of referrals reviewed involved PMC children. *See* Deborah Fowler & Kevin Ryan, Third Report 40, ECF No. 1165. In the Second Report, the Monitors described that out of the 953

Therefore, from July 1, 2021 and June 30, 2022, it is estimated that out of the 15,925 relevant referrals SWI received and referred to HHSC, approximately 8,281 (52%) of these referrals would have involved PMC children.

SWI Original Screening Validation Results for Referrals Assigned to HHSC

To evaluate DFPS's performance associated with Remedial Order 3 and assess the appropriateness of screening of referrals of abuse, neglect or exploitation involving PMC children, the monitoring team conducted a qualitative review of referrals received by SWI. The Monitors' review focused on whether SWI appropriately screened the referrals when it determined that they did not contain any allegations of abuse, neglect or exploitation.[71]

As the HHSC referral data does not provide child identifiers, the Monitors' methodology and analysis continued to require a preliminary two-step process to discern which referrals involved children in PMC status. The monitoring team first undertook the effort of reviewing each individual report to identify which child or children were the subject of the report. Next, the monitoring team searched the IMPACT records of each child or children identified in each report to determine whether it involved a child in PMC status by checking for the child's legal status on the date of the intake report. Of the 1,482 referrals the Monitors reviewed, 770 involved PMC children. The other referrals involved children reported to be in Temporary Managing Conservatorship (TMC) status or children who were not in DFPS custody and therefore, were not included in the Monitors' full review.

In the Monitors' sample of 1,482 SWI referrals from July 1, 2021 to June 30, 2022 sent directly to HHSC and assigned by HHSC for a minimum standards investigation, the Monitors identified 770 reports that involved a child(ren) with PMC status.[72] Of these 770 reports, the Monitors assessed that SWI appropriately determined 93.4% (719 referrals) did not contain an allegation of abuse or neglect of a PMC child and were properly assigned to HHSC to determine whether to conduct a minimum standards investigation.

The Monitors found that SWI inappropriately referred 51 reports (6.6%) to HHSC instead of assigning them for an abuse, neglect or exploitation investigation. The Monitors concluded that these 51 reports contained allegations that warranted an investigation for

---

referrals selected for review, 441 (46%) involved children identified by DFPS as being in PMC status. *See* Deborah Fowler & Kevin Ryan, Second Report 68, ECF No. 1079.

[71] For this reporting period, for the reviews the Monitors conducted on referrals received by SWI for July 1, 2021 through December 31, 2021, the Monitors used the same methodology as reported in the Third Report. *See* Deborah Fowler & Kevin Ryan, Third Report 39, ECF No. 1165. For the reviews the Monitors conducted for referrals received by SWI in the second half of the reporting period for January 1, 2022 through June 30, 2022, the Monitors increased their sample and reviewed 50% of all referrals that SWI referred to HHSC and that were then assigned by HHSC for a minimum standards investigation, approximately doubling their monthly review sample for the second portion of the reporting period. For the full period, consistent with the Third Report, the Monitors excluded referrals that HHSC administratively closed due to the high rate of concurrence between the Monitors and the State regarding the disposition of that subset of referrals.

[72] The State reports that DFPS and HHSC are working together on an interface between the CLASS and IMPACT systems; as a result of the interface, the HHSC SWI data submissions will eventually identify the legal status of children subject to a referral but DFPS and HHSC do not have an anticipated date for completion of this legal status update feature at this time.

abuse, neglect or exploitation to ensure the safety and well-being of a child(ren) with PMC status. In the Third Report, the Monitors determined that 92% of referrals reviewed (223) did not contain an allegation of maltreatment of a PMC child and were properly assigned to HHSC and that 8% (20) had been inappropriately screened by SWI.[73]

Of the 51 reports elevated by the Monitors as containing allegations of abuse, neglect or exploitation, the Monitors found that Physical Abuse was the most common type of alleged maltreatment that SWI intake specialists did not refer for investigation; 29 (57%) of the 51 reports contained such allegations, frequently involving outcries by a child alleging that a foster parent hit them with a hand or an implement or allegations that a staff member at a congregate care facility improperly restrained or used force on a child. The Monitors' summaries of these 51 referrals are located in the Appendices.

Remedial Order 3: Maltreatment in Care Investigations

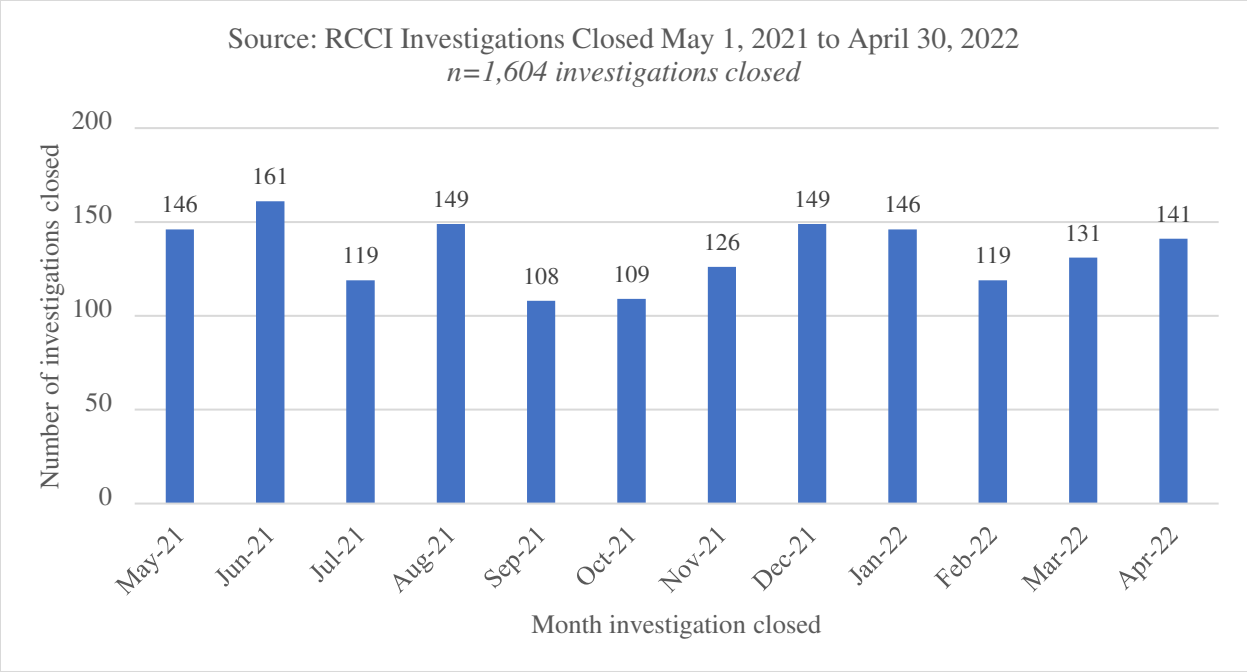
Overview of RCCI Maltreatment in Care Investigations Involving Children in Licensed Placements

RCCI opened 1,591 new investigations involving at least one PMC child between May 1, 2021 and April 30, 2022.[74] The number of investigations opened per month ranged from 104 to 172, with the highest number of investigations opened in March 2022 and the lowest number of investigations opened in July 2021.[75]

RCCI closed 1,604 investigations of maltreatment of a PMC child in licensed placements between May 1, 2021 and April 30, 2022. The number of investigations closed per month ranged from 108 to 161, with the highest number of investigations closed in June 2021 and the lowest number of investigations closed in September 2021.

Figure 10: Closed RCCI Investigations, May 1, 2021 to April 30, 2022

[73] *See* Deborah Fowler & Kevin Ryan, Third Report 40, ECF No. 1165. The Third Report review included only referrals with an intake priority of Minimum Standards One, Two, or Three upon referral to HHSC.
[74] The Monitors analyzed data about maltreatment in care investigations pertaining to PMC children in licensed facilities that were opened from May 1, 2021 to April 30, 2022 and that closed between May 1, 2021 and April 30, 2022 using monthly and biannual data reports submitted by DFPS during the relevant time period. DFPS, *RO3.2 RCI Investigations JUL 31 2019 -DEC 31 2021 105300 FCL 03* (Mar. 1, 2022) (on file with the Monitors); *RO3.2_RCI_Investigations_010122_063022d2022_09_01_log106898* (Sept. 1, 2022) (on file with the Monitors); *RO3.2_RCI_Investigations_2022_07d2022_09_01_log106834* (Sept. 1, 2022) (on file with the Monitors); *RO3.2_RCI_Investigations_2022_08d2022_10_03_log107126* (Oct. 3, 2022) (on file with the Monitors).
[75] Forty-six investigations that opened in this period were later Administratively Closed and those investigations were excluded from the investigations that the Monitors assessed for timeliness in relation to Remedial Orders 5 through 19.

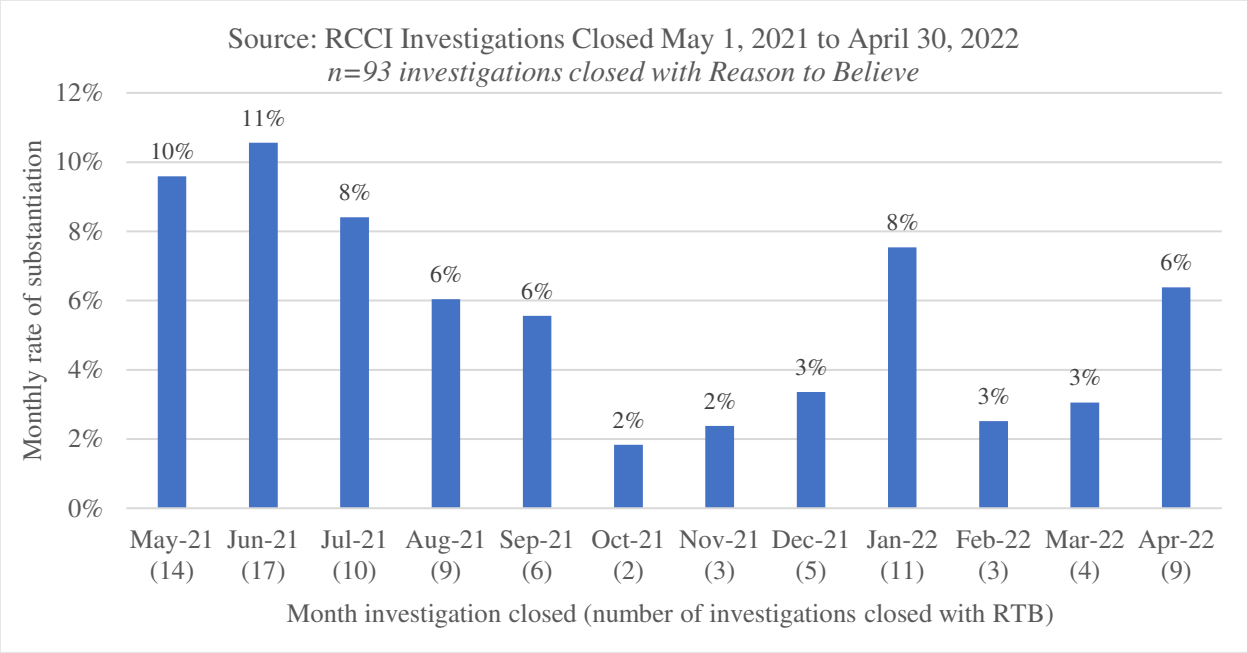


Of the 1,604 investigations closed during this period, 5.8% (93) of the investigations resulted in a disposition of Reason to Believe, thereby substantiating at least one allegation as abuse, neglect or exploitation in each of these 93 investigations.

The rate of substantiation represents a significant decrease from the Third Report, which found that 11% (102 of 911) of RCCI investigations closed between January 1, 2021 and April 30, 2021 resulted in a disposition of Reason to Believe.[76] Additionally in the current period, RCCI Ruled Out 1,459 (91%) investigations, Administratively Closed 46 (3%) investigations, and closed six (<1%) investigations as Unable to Determine. The Monitors previously reported in the Third Report that among the 911 investigations closed between January 1, 2021 and April 30, 2021, RCCI had Ruled Out 778 (85%) investigations, Administratively Closed 19 (2%) investigations, and closed eleven (1%) investigations as Unable to Determine.

Figure 11: Reason to Believe Findings in Closed RCCI Investigations Involving PMC Children in Licensed Placements, May 1, 2021 to April 30, 2022

[76] Deborah Fowler & Kevin Ryan, Third Report 41, ECF No. 1165.

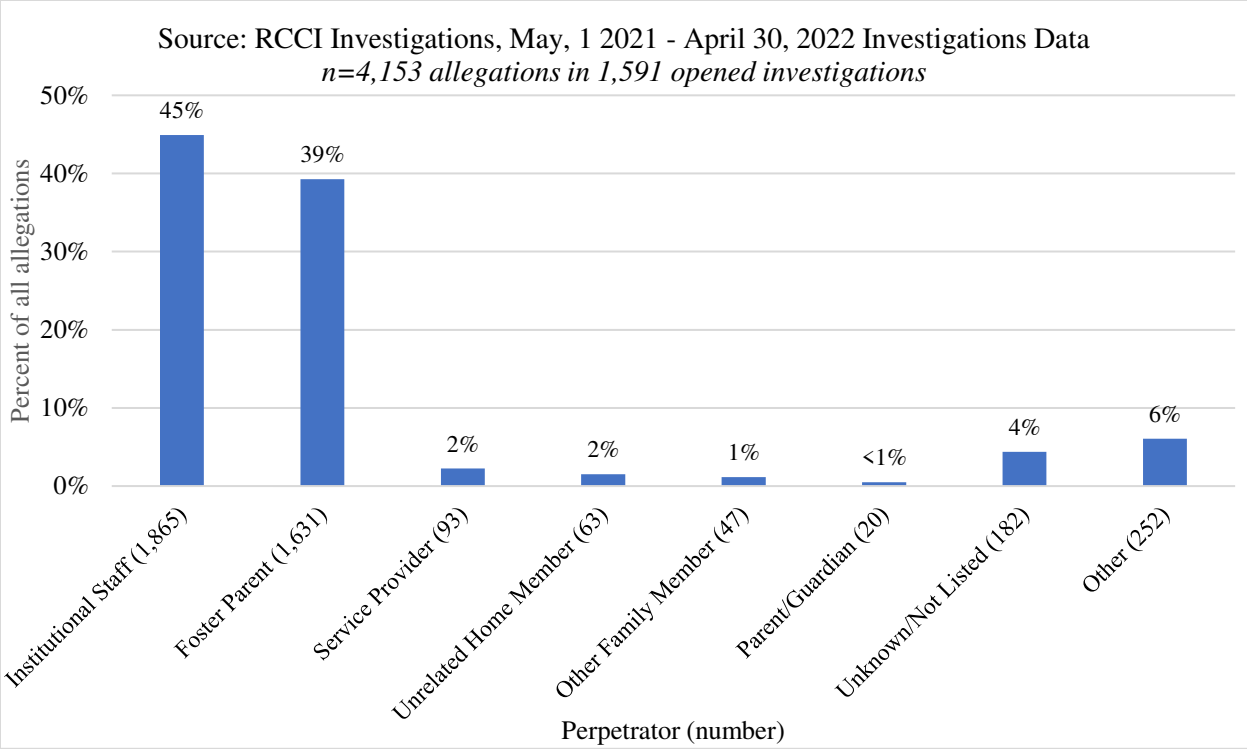


Institutional staff accounted for 1,865 (45%) of the 4,153 alleged perpetrators, which is striking because only 15% (1,475) of children in PMC on June 30, 2022 lived in congregate care settings.[77] Foster parents accounted for 1,631 (39%) of the alleged perpetrators; service providers accounted for 93 (2%); household members accounted for 63 (2%); parents and guardians accounted for 20 (<1%); other family members accounted for 47 (1%); and the alleged perpetrator was listed as unknown or not listed for 182 (4%) investigations. Of the alleged perpetrators, 252 (6%) were listed as other (175) or were identified as having some other relationship not already described above (77).[78]

Figure 12: Alleged Perpetrators in RCCI Allegations Involving PMC Children in Licensed Placements, May 1, 2021 to April 30, 2022

[77] The 1,591 RCCI investigations opened from May 1, 2021 to April 30, 2022 involved 4,153 allegations. In the data the Monitors received from DFPS, each allegation has a perpetrator category, but not a unique identifier for each perpetrator. As a result, it is possible that some perpetrators may be counted more than once in a single investigation or over time.

[78] Those perpetrators categorized as "other relationships not already described" include, for example, day care provider (25), babysitter (4), and parent's paramour (5).



Note: Percentages do not add to 100% due to rounding.

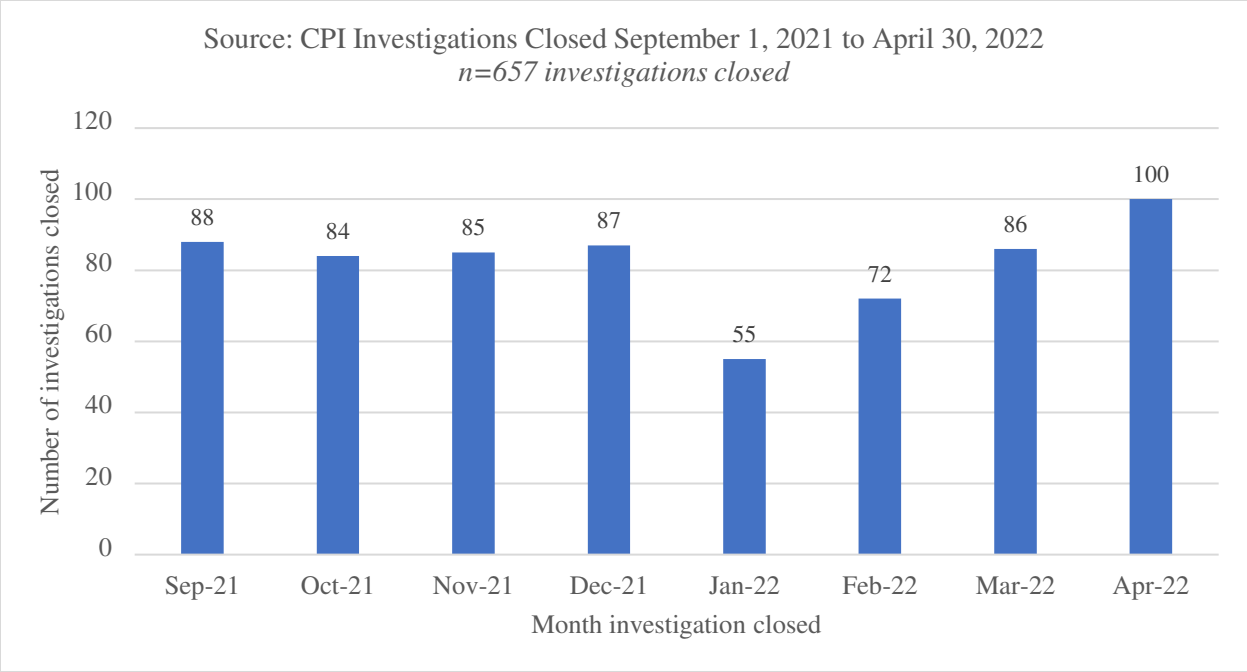
Overview of CPI Maltreatment in Care Investigations Involving Children in Unlicensed Settings

CPI opened 775 new investigations involving at least one PMC child between September 1, 2021 and April 30, 2022.[79] The number of investigations opened per month ranged from 78 to 120, with the highest number of investigations opened in March 2022 and the lowest number of investigations opened in February 2022. As reported below, the data included investigations as provided by DFPS to the Monitors and included those that commenced while the child was living in an unlicensed placement regardless of the identity of the alleged perpetrator.

CPI closed 657 investigations of maltreatment of a PMC child between September 1, 2021 and April 30, 2022. The number of investigations closed per month ranged from 55 to 100, with the highest number of investigations closed in April 2022 and the lowest number of investigations closed in January 2022.

Figure 13: Closed CPI Investigations Involving PMC Children, September 1, 2021 to April 30, 2022

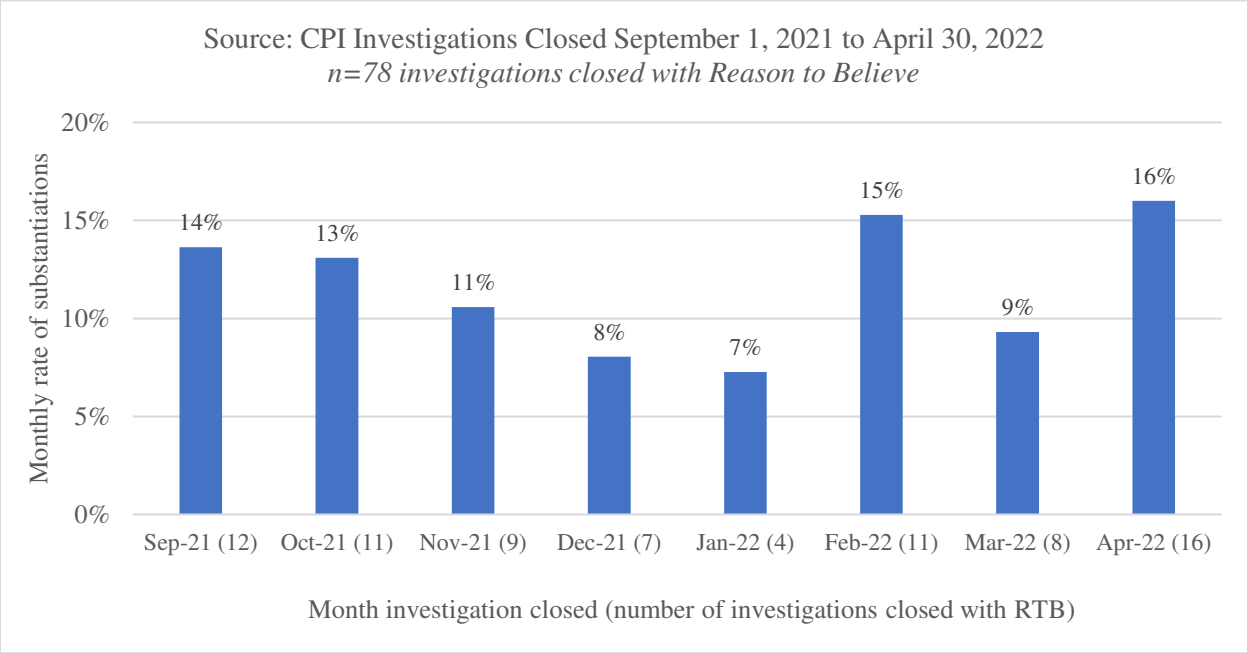
[79] The Monitors analyzed data about maltreatment in care investigations pertaining to PMC children in unlicensed facilities and included it for the first time in this reporting period. For this report, the Monitors analyzed data about the CPI investigations involving PMC children that were opened and closed from September 1, 2021 to April 30, 2022 using the relevant data reports submitted by DFPS during that period.



Of the 657 investigations CPI closed during this period, 12% (78) of the investigations resulted in a disposition of Reason to Believe, thereby substantiating at least one allegation as abuse, neglect or exploitation in each of the 78 investigations. Additionally, CPI Ruled Out 407 (62%) investigations, Administratively Closed 89 (14%) investigations, closed 77 (12%) investigations as Unable to Determine, and closed five (<1%) investigations as Unable to Complete.[80]

[80] According to DFPS, Unable to Complete is the dispositional result "usually because the family could not be located to begin the investigation or the family was contacted but later moved and could not be located to complete the investigation or the family refused to cooperate with the investigation." DFPS, *Child Protective Investigations, available at* https://www.dfps.state.tx.us/Investigations/. *See also*, DFPS, *Child Protective Services Handbook* § 2281.4, *available at* https://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_2200.asp#CPS_2281_4. Separately, one investigation was listed in the data as closed with no Overall Disposition listed.

Figure 14: Reason to Believe Findings in Closed CPI Investigations Involving PMC Children, September 1, 2021 to April 30, 2022



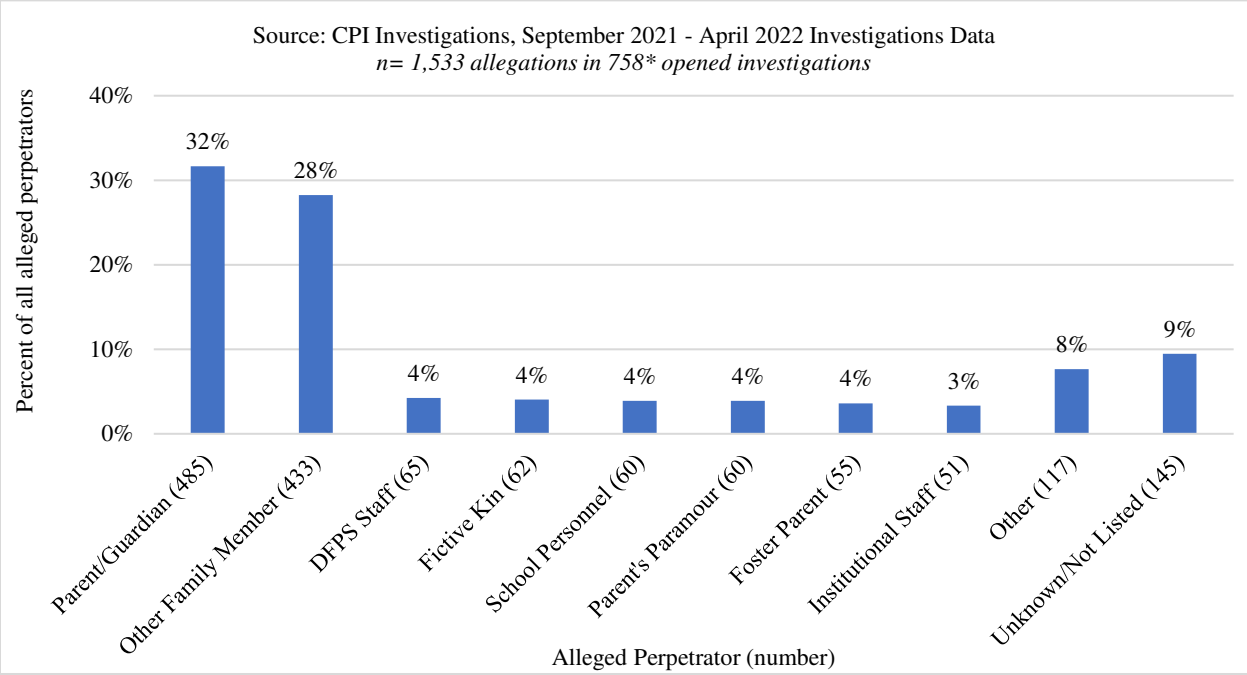
Parents and guardians accounted for 485 (32%) of the alleged perpetrators; other family members accounted for 433 (28%) of the alleged perpetrators; DFPS staff (65), fictive kin (62),[81] school personnel (60), parent's paramours (60), and foster parents (55) each accounted for 4% of the alleged perpetrators; institutional staff (51) accounted for 3% of the alleged perpetrators; and the alleged perpetrator was listed as unknown or not listed for 145 (9%) of the alleged perpetrators. Of the alleged perpetrators, 117 (8%) were listed as other (64), or as having some other relationship not already described (53).[82,83]

[81] Fictive kin is defined as "someone who is not related to a child under DFPS conservatorship, but who has, or who once had, a prior longstanding relationship with the child or the child's sibling group. Teachers, coaches, family friends, godparents, and long-time neighbors are examples of people who may be fictive kin." DFPS, Definition of Terms, *Child Protective Services Handbook*, *available at* https://www.dfps.state.tx.us/handbooks/CPS/Files/CPSDefinitions.asp.

[82] DFPS identifies alleged perpetrators based on their relationship to the oldest alleged victim in the investigation. Allegation information was unavailable in the data reports that DFPS submitted to the Monitors for 17 of 775 CPI investigations opened from September 2021 to April 2022. Those categorized as "some other relationship not already described" include, for example, unrelated household member (19), friend (6), and babysitter (4).

[83] The CPI investigations opened during September 2021 to April 2022 for which allegation data was available (758) involved 1,533 allegations. In the data reports that DFPS submitted to the Monitors, each allegation has a perpetrator category, but not a unique identifier for each perpetrator. As a result, it is possible that some perpetrators may be counted more than once in a single investigation or over time.

Figure 15: Alleged Perpetrators in CPI Allegations Involving PMC Children in Unlicensed Placements, September 1, 2021 to April 30, 2022



*Information on alleged perpetrators was unavailable in the data reports that DFPS submitted to the Monitors for 17 of the 775 CPI Investigations opened between September 1, 2021 and April 30, 2022.

Administrative Review of Substantiations

DFPS conducts administrative reviews pursuant to its ARIF process, which involves a reconsideration of the disposition by a DFPS division administrator or designee who was not involved in conducting the original investigation. The ARIF process occurs at the request of a designated perpetrator to determine whether DFPS's substantiated allegations are supported by a preponderance of evidence.[84]

From January 1, 2021 to December 31, 2021, DFPS conducted administrative reviews of 107 RCCI investigations involving PMC children that DFPS originally resolved with a disposition of Reason to Believe.[85,86] In 12 of these 107 (11%) investigations, DFPS

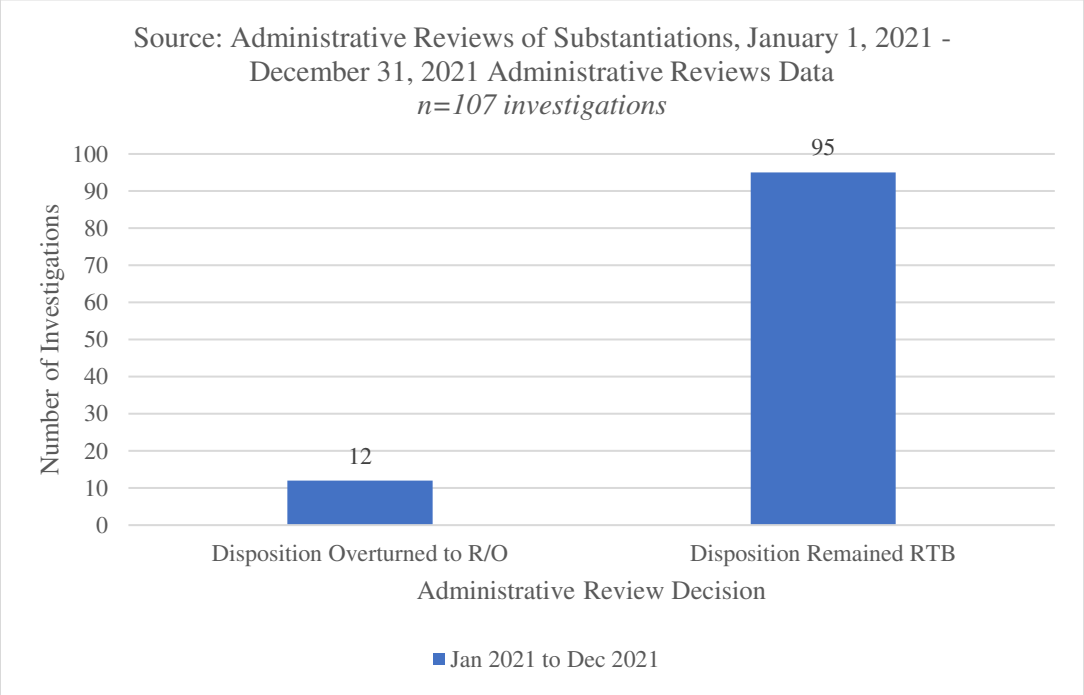
[84] 40 TEX. ADMIN. CODE §§707.815-831. The designated perpetrator must make the request within 15 calendar days of DFPS's notification to them of their right to an administrative review. During the administrative review, a division administrator or designee reviews the investigation file and any additional information provided by the designated perpetrator; a review conference is optional. After completion of these tasks, the administrator or designee sends a written decision to the designated perpetrator within 30 calendar days of conducting a conference or within 60 days of the request for an administrative review if a conference was not held. The written decision specifies the administrative review's finding to uphold, reverse or alter the abuse, neglect or exploitation finding. *Id.*

[85] In this reporting period, DFPS began to provide to the Monitors on a monthly basis data reports identifying investigations subject to its administrative review process, including the outcome of the review.

[86] The Monitors analyzed data about investigations involving PMC children that were subject to DFPS administrative review from January 1, 2021 to April 30, 2022. DFPS,

overturned the final disposition and issued a new disposition of Ruled Out; in the remaining 95 (89%) investigations, DFPS upheld the disposition of Reason to Believe.[87]

Figure 16: Administrative Reviews of RCCI Investigations Involving PMC Children with a Disposition of Reason to Believe, January 1, 2021 to December 31, 2021



From January 1, 2022 to April 30, 2022, DFPS conducted administrative reviews of 66 RCCI investigations involving PMC children with a disposition of Reason to Believe.[88] In nine (14%) investigations, DFPS overturned the final disposition and issued a new disposition of Ruled Out; in the remaining 57 (86%) investigations, DFPS upheld the disposition of Reason to Believe.[89]

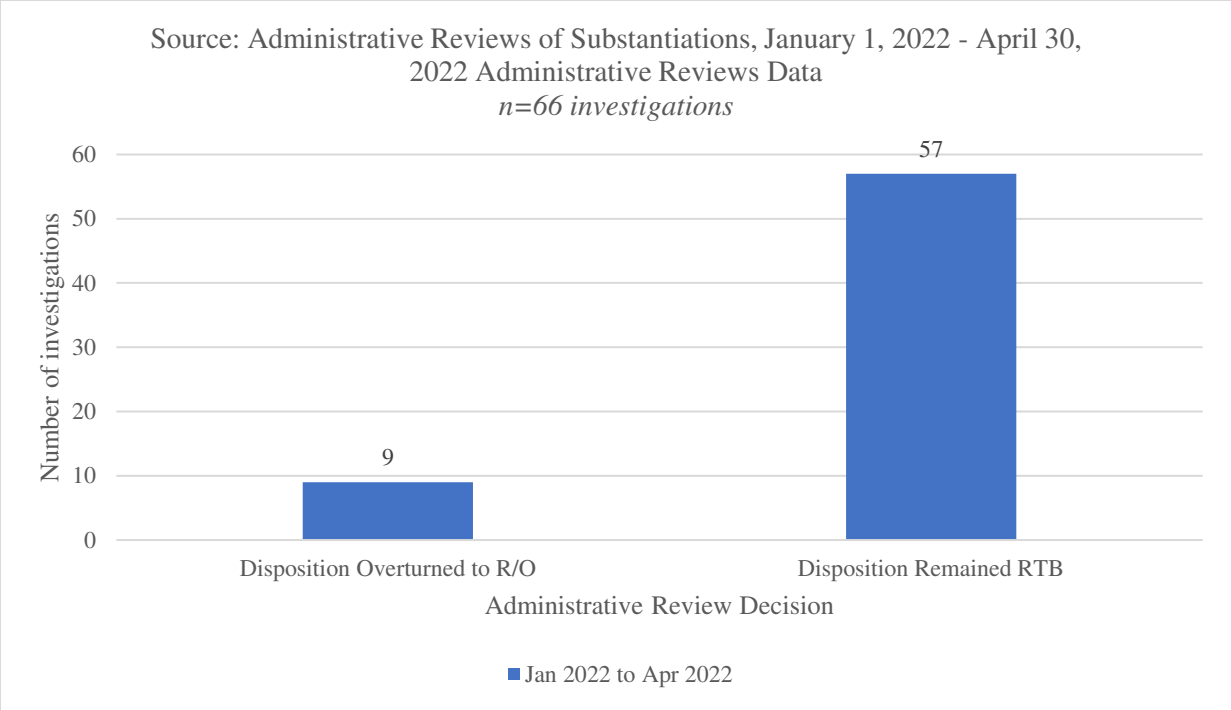
Figure 17: Administrative Reviews of RCCI Investigations Involving PMC Children with a Disposition of Reason to Believe, January 1, 2022 to April 30, 2022

RO3_ARIF_PMC_Children_2022_08d2022_10_03_log107103_rev (Oct. 13, 2022) (on file with the Monitors).

[87] In six of the 95 investigations, DFPS preserved the final disposition of Reason to Believe for the investigation but reversed the decision to substantiate one or more of the other allegations.

[88] The Monitors analyzed data about RCCI investigations involving PMC children that were subject to DFPS administrative review from January 1, 2021 to April 30, 2022. DFPS, *RO3_ARIF_PMC_Children_2022_08d2022_10_03_log107103_rev* (Oct. 13, 2022) (on file with the Monitors).

[89] In five investigations, DFPS preserved the final disposition of Reason to Believe for the investigation but reversed the decision to substantiate as to one or more of the other allegations.



Remedial Order 3 Investigation Validation Results

To validate DFPS's performance associated with Remedial Order 3 and the appropriateness of its RCCI and CPI investigations of alleged maltreatment of PMC children, the monitoring team conducted:

- Reviews of all 21 RCCI investigations subject to DFPS's administrative review process which resulted in the reversal of an investigative disposition from Reason to Believe to Ruled Out between January 1, 2021 and April 30, 2022;

- Reviews of a randomly selected sample of 776 (out of 1,604) RCCI investigations closed between May 1, 2021 and April 30, 2022;[90] and

- Reviews of a randomly selected sample of 178 (out of 657) CPI investigations closed between September 1, 2021 and April 30, 2022.[91]

[90] To evaluate dispositional results for the investigations included in the sample, the Monitors designed an instrument for the case record review. To support consistency in scoring, both inter-rater reliability and secondary reviews were tested and used. The sample was drawn from monthly reports provided to the Monitors by DFPS during the reporting period. During this time period, RCCI closed 1,604 investigations, of which the Monitors reviewed a random sample of 776 investigations using a 95% confidence level by quarter; the Monitors excluded from the population investigations where RCCI substantiated any or all allegations with a disposition of Reason to Believe.

[91] The sample of CPI investigations was drawn from monthly reports DFPS provided to the Monitors during the reporting period. During this time period from September 1, 2021 to April 30, 2022, CPI closed 657 investigations, of which the Monitors created a random sample of 413 investigations using a 95% confidence level; the Monitors excluded from the population investigations where CPI substantiated any or all allegations with a disposition of Reason to Believe. Within the sample of 413 investigations, the Monitors

RCCI Investigations

Investigations Subject to ARIF

Among the 21 investigations subject to ARIF in which DFPS changed its original disposition of Reason to Believe to Ruled Out, the Monitors found that RCCI's decision to overturn was appropriate in 17 investigations (81%) and inappropriate in four investigations (19%). In the four investigations inappropriately overturned, the Monitors found that the original investigative record contained a preponderance of evidence that an alleged perpetrator(s) abused or neglected a child(ren). In two other investigations among the 17 in which the Monitors agree with DFPS's reversal, the Monitors found that due to deficiently conducted investigations, the investigative record did not support a disposition of Reason to Believe. If these investigations had been appropriately conducted, the record may have supported a disposition of Reason to Believe. In sum, the Monitors' review found that RCCI inappropriately resolved (4) or conducted deficient investigations (2) in six investigations (28.6%) subject to RCCI's administrative review process. The Monitors' summaries of these six investigations are located in the Appendices.

Review of RCCI Investigations in Licensed Placements

RCCI Ruled Out all the allegations in 753 of the 776 investigations reviewed by the Monitors. The Monitors found that RCCI did so appropriately in 716 cases (95%); inappropriately in nine cases (1.2%);[92] and conducted investigations with such substantial deficiencies in 28 cases (3.7%) that the Monitors were prevented from reaching a conclusion. To appropriately reach a final disposition in these deficient investigations, additional information would have been required to determine whether children were abused or neglected.

In addition, of the 776 RCCI investigations analyzed by the monitoring team, 21 were Administratively Closed, and the Monitors agreed with RCCI's closure decision. Two of the investigations reviewed by the Monitors resulted in a disposition of Unable to Determine, and the Monitors found one of these investigations was conducted with such substantial deficiencies the Monitors were unable to reach a conclusion.

In sum, of the 753 investigations that RCCI assigned a disposition of Ruled Out to all allegations during the reporting period, the Monitors identified 28 investigations (3.7%) that had substantial deficiencies and nine (1.2%) that were inappropriately Ruled Out. An additional investigation with a disposition of Unable to Determine was conducted with

---

then identified and reviewed the investigations (178) involving allegations associated with maltreatment by a caregiver assigned by DFPS or associated with the time period the child was under DFPS Supervision without an authorized placement. The Monitors excluded those investigations in the sample where the allegations were associated with the child's home and caregiver prior to entry into DFPS care.

[92] Of the nine investigations the Monitors identified as inappropriately resolved, eight investigations should have been assigned a disposition of Reason to Believe for abuse or neglect and one investigation should have been assigned a disposition of Unable to Determine.

such substantial deficiencies that the Monitors were prevented from reaching a conclusion; therefore, the Monitors determined a total of 38 (5%) investigations had substantial deficiencies or were inappropriately resolved. In the Third Report, the Monitors determined 14% of sampled investigations had substantial deficiencies or were inappropriately resolved.[93] The results for this period involving a large sample of investigations reflect significant, continued improvement in the State's implementation of this component of Remedial Order 3.

RCCI Investigations with Improved Quality and Remaining Deficiencies

As discussed above, the State's performance in relation to investigating allegations of abuse, neglect or exploitation of PMC children in licensed placements has measurably improved over time. The Monitors' review of investigations included in the current reporting period showed that RCCI conducted more thorough investigations that often resulted in an appropriate disposition. Among the investigations the Monitors identified as deficient this period, certain common factors frequently contributed to deficiency. As discussed in the relevant Appendix, in investigations that involved multiple allegations of abuse or neglect among multiple children, DFPS at times did not consistently and adequately investigate each allegation contained in an investigation. Given the complex scope of allegations included in some of these investigations, DFPS supervisors and other experienced investigators should closely review these investigations during investigative staffings and prior to closure to ensure that all allegations of abuse or neglect of a child have been appropriately investigated. In addition, some investigations were deficient because of a failure to adequately interview, or interview at all, relevant individuals about the allegations.

CPI Investigations in Unlicensed Placements

Of the 178 CPI investigations the Monitors reviewed, CPI Ruled Out all the allegations in 151 (85%) of the investigations. The Monitors found that CPI did so appropriately in 142 investigations (94%); inappropriately resolved one investigation; and conducted investigations with such substantial deficiencies in eight investigations (5%) that the Monitors were prevented from reaching a conclusion. To appropriately reach a final disposition in these investigations, additional information would have been required to determine whether children were subject to maltreatment.

In addition, of the 178 CPI investigations analyzed by the monitoring team, ten were Administratively Closed and the Monitors agreed with CPI's closure decisions. Seventeen investigations reviewed by the Monitors resulted in a disposition of Unable to Determine and the Monitors found one of these investigations was conducted with such substantial deficiencies the Monitors were unable to reach a conclusion, resulting in ten investigations, (5.6% of the total reviewed), identified by the Monitors as having been

[93] *See* Deborah Fowler & Kevin Ryan, Third Report 43, ECF No. 1165. In the First and Second Reports, the Monitors determined 28.6% and 18% of sampled investigations to which RCCI assigned a disposition of Ruled Out to all allegations, respectively, had substantial deficiencies or were inappropriately resolved. *See* Deborah Fowler & Kevin Ryan, Second Report 73, ECF No. 1079; Deborah Fowler & Kevin Ryan, First Report 25, ECF No. 869.

inappropriately conducted or resolved between September 1, 2021 and April 30, 2022. The Monitors' summaries of the ten inappropriately resolved and deficient CPI investigations are located in the Appendices.

Of the ten investigations that were inappropriately resolved or conducted with substantial deficiencies, half of them were investigations into allegations of child maltreatment for children under DFPS Supervision in CWOP settings. The Monitors' review found that these investigations and their challenges amplified the safety concerns and additional risk of harm that children face when they are under DFPS Supervision in CWOP settings.

Summary of Performance for Receiving, Screening and Investigating Allegations of Maltreatment

Receiving Allegations

- Between July 1, 2021 and June 30, 2022, hotline staff received 735,938 calls. During the period analyzed, 22% (159,049) of calls were abandoned, similar to the rate of 20% observed in the previous report.[94]

- On average, callers waited for 5.2 minutes before their calls were handled or abandoned, an increase of more than half a minute from the data reported in the Third Report.[95] Forty-six percent (335,498) of callers waited on the queue for under one minute.

Screening Allegations

- The Monitors reviewed 770 referrals to SWI from July 1, 2021 to June 30, 2022, which SWI did not send to RCCI for an investigation of child abuse, neglect or exploitation but instead sent directly to HHSC (and that HHSC then assigned for a minimum standards investigation). Of these 770 reports, the Monitors concurred with SWI's determination in 93.4% (719) of reports.

Investigating Allegations

- Of the 1,604 RCCI investigations DFPS completed involving PMC children between May 1, 2021 and April 30, 2022, 93 investigations (5.8%) resulted in the substantiation of at least one allegation with a disposition of Reason to Believe; of the remaining 1,511 investigations (94.2%) where RCCI issued a disposition of Ruled Out, Unable to Determine or which resulted in Administrative Closure, the Monitors evaluated 776 investigations.

[94] *See* Deborah Fowler & Kevin Ryan, Third Report 32, ECF No. 1165.
[95] In the Third Report, the data demonstrated an average queue time of 4.6 minutes for calls placed from January 1, 2021 to June 30, 2021. *See* Deborah Fowler & Kevin Ryan, Third Report 30, ECF No. 1165.

- The Monitors found that, of the 753 investigations reviewed where RCCI Ruled Out all of the allegations, RCCI did so appropriately in 716 (95%) cases; inappropriately in nine (1.2%) cases; and conducted investigations with such substantial deficiencies in 28 (3.7%) cases that the Monitors were prevented from reaching a conclusion.

- In addition to the 37 investigations that RCCI Ruled Out that were inappropriately resolved or had substantial deficiencies, the Monitors also identified one investigation, assigned a disposition of Unable to Determine, with such substantial deficiencies that the Monitors were prevented from reaching a conclusion.

- The Monitors found that, of the 21 investigations with dispositions of Reason to Believe that RCCI later overturned during its Administrative Review and Appeals of Investigative Findings (ARIF) process during the period under review, RCCI did so appropriately in 17 investigations (81%) and inappropriately in four investigations (19%).

- In addition to the four investigations that RCCI inappropriately overturned during its ARIF process, the Monitors identified two other investigations that RCCI initially conducted with substantial deficiencies such that the Monitors agreed with RCCI's decision to overturn the disposition due to the investigative failure to gather a preponderance of evidence in support of the disposition.

- Of the 657 CPI investigations DFPS completed involving PMC children between September 1, 2021 and April 30, 2022, 78 (11.9%) investigations resulted in the substantiation of at least one allegation with a disposition of Reason to Believe; of the remaining 579 (88.1%) investigations where CPI issued a disposition of Ruled Out, Unable to Determine or which resulted in Administrative Closure, the Monitors evaluated 178 investigations.

- The Monitors found that, of the 151 investigations reviewed where CPI Ruled Out all of the allegations, CPI did so appropriately in 142 (94%) investigations; inappropriately in one; and conducted investigations with such substantial deficiencies in eight investigations that the Monitors were prevented from reaching a conclusion.

- In addition to the nine investigations that CPI Ruled Out that were inappropriately resolved or had substantial deficiencies, the Monitors also identified one investigation, assigned a disposition of Unable to Determine, with such substantial deficiencies that the Monitors were prevented from reaching a disposition conclusion, resulting in ten (5.6%) investigations that the Monitors' review identified as having been inappropriately resolved or conducted with substantial deficiencies.

Injunction

The Court therefore enjoins the Defendants from placing children in permanent management conservatorship (PMC) in placements that create an unreasonable risk of serious harm. The Defendants shall implement the remedies herein to ensure that Texas's PMC foster children are free from an unreasonable risk of serious harm.

Through the Monitors' validation of DFPS's performance related to Remedial Order 3, the Monitors continued to identify serious risks to the safety of children under DFPS Supervision in unlicensed CWOP settings. These investigations amplified the Monitors' concern regarding the presence of an unreasonable risk of serious harm to PMC children due to DFPS's use and reliance on this mode of care.

While reviewing these investigations of children who experienced a CWOP episode, the Monitors observed that the risk of serious harm exists in part because DFPS is relying on staff members who are not trained caregivers and are, therefore, unfamiliar with many of the standard protocols and guidelines that inform care for children with mental and behavioral health needs in congregate and foster home settings. The investigations provide examples of how the absence of trained caregivers and regulated settings creates safety risks for children.

In October 2022, the average number of PMC children in CWOP settings per night was 63, up from 52 in September 2022. DFPS has been unable to eliminate its use of this setting: From November 2021 to October 2022, the average number of children in CWOP settings per night has fluctuated between 72 and 52, rather than consistently decreasing. It was as high as 72 in November 2021 and 70, more recently in June 2002.

Supervisory Challenges Creating Unreasonable Risk of Harm

The examples below highlight some of the safety risks inherent in caring for children in these unregulated environments. These include difficulty monitoring medication, lack of protocol and use of new and inexperienced staff members as caregivers, competing job responsibilities for staff members assigned to supervise children, and other challenges. Many of these issues may not be unexpected given that DFPS has assigned individuals to manage children's complicated behavioral and mental health needs as untrained caregivers in short shifts for children with whom they are not familiar.

Medication Monitoring

In one DFPS investigation, a child's caseworker reported an allegation of Neglectful Supervision of a child under DFPS Supervision at a CWOP location at a hotel in Dallas. Through the investigation, the investigator determined that when the child arrived to the CWOP location with her belongings, including prescription and over-the-counter pain medications, after a visit with her family, the staff member greeted the child and took her photograph and temperature as required. The staff member did not attempt to locate or

secure the child's medications from her belongings before leaving the child alone in the bedroom to unpack. Shortly thereafter, the child ingested her pills.

To assess whether the staff member was negligent in her care of the child, the investigator did not identify whether DFPS provided the staff member with training regarding any policies or protocols that stipulated that upon a child's arrival to a CWOP location, staff members must identity and secure any medications in the child's possession. In a congregate care setting, this is a typical standard of care for caregivers to follow. As such, should this incident have occurred in a GRO, RCCI would likely have found a preponderance of evidence that the staff member Neglectfully Supervised the child.

Next, the staff member reported to the investigator that she was unaware that the child's belongings stored her prescription medications and that she did not have a notification from the child's caseworker that the child traveled with her medication. The child's CWOP binder, a collection of crucial information about the child that DFPS requires staff members to review at the beginning of their shifts, enumerated the numerous medications the child was prescribed. It was unclear whether the staff member appropriately reviewed, or had time to review, the child's lengthy binder prior to her shift to learn this important information about the child. The supervising staff member was coming to the shift from a full-time set of responsibilities as a caseworker for DFPS into a physical setting that was not designed to serve children with serious emotional and behavioral health needs, and without the requisite training and supervision to protect child safety.

The limited question explored in the DFPS investigation was whether the staff member perpetrated abuse or neglect but given the position in which the staff person was placed by DFPS, the more urgent question is whether the agency is adequately protecting children from a serious risk of harm when it continues to house children in CWOP settings like the one described in this investigation. Based upon the Monitors' review of DFPS investigations of CWOP settings over the past 18 months, the answer frequently is no.

Oversight of Trafficking Victims

In a second investigation, a DFPS staff member reported that a named staff member (Staff 1) allowed a child (age 17) to use her state-issued cell phone during a CWOP episode at a hotel. During the time the child had Staff 1's phone, she took nude photographs of herself. The child reportedly used a social media website to send the photograph(s) to an unknown individual. The child told Staff 1 that she needed to use Staff 1's cell phone to contact her parole officer and her advocate. Staff 1 was assigned to CWOP shifts from March 15 to 17, 2022; her shifts began at midnight and ended at 4:00 a.m. During these shifts, another staff member and child were also present in the hotel room.

The investigator determined that Staff 1 did not violate any policies when she allowed the child to use her state issued cell phone. The child was permitted to use Staff 1's cell phone to call or text an identified group of individuals, including the child's boyfriend, who Staff 1 presumed the child was texting. Although the staff member remained nearby while the child used the phone, the investigator found the child took at least three nude

photographs of herself using Staff 1's phone on March 17, 2022 in the early morning hours (1:00 a.m. approximately). The investigation found that given the position of the child on the hotel bed, Staff 1 "could not have seen the pictures being taken." The child sent the photographs to another individual by accessing Instagram on Staff 1's cell phone. (The child did not reveal to whom she sent the photographs and the investigation did not contain additional information regarding the recipient.)

The investigation raised the following child safety concerns: First, Staff 1 had another full-time set of responsibilities as a DFPS employee and did not have adequate guidance or training regarding how to supervise and care for a child who is a sex trafficking victim. The child had an extensive history of being trafficked but the child's binder did not include heightened supervision requirements for the child. Staff 1 reported "there were no time restrictions, [such as] watch out for this, sit next to her, only 8:00 a.m. to 5:00 p.m., nothing like that." Because the staff member did not have experience caring for a child victim of sex trafficking, she did not anticipate the safety risks that may arise from providing a child with her phone to use, even under close supervision. Monitoring this child's access to technology is informed by her history. The DFPS investigator asked Staff 1 what training she had received related to child sexual victimization/trafficking. Staff 1 reported that she took a training entitled "Be the One" in 2017 or 2018. She did not report any other trainings related to child sex trafficking and supervision.

Next, Staff 1 did not—and perhaps did not have time to—adequately review the child's Attachment A, which documents a child's sexual abuse history, including trafficking, or aggression history for caregivers in order to promote child safety from further sexual victimization. At the beginning of a CWOP shift, DFPS staff members are expected to review the child's binder, which includes the child's Attachment A. Staff 1 reported that she reviewed the child's Attachment A and was aware that the child had been determined by the State to be a confirmed victim of sex trafficking. However, Staff 1 reported that she did not closely review the child's Attachment A and was unaware of the severity of the child's trafficking history and that the confirmed trafficking had occurred only eight months prior to this supervision episode. The child's record documents four distinct, confirmed incidents of trafficking, beginning in 2020.[96]

[96] A stakeholder alerted the Monitors to another incident involving a PMC child that illustrates the difficulty caregivers experience in this setting appropriately supervising a child who needs therapeutic services in a licensed, needs-based placement. The child, a thirteen-year-old girl, was also a confirmed victim of sex trafficking: according to her IMPACT records, while she was on runaway status from a placement in late 2021, two men abducted her from a gas station, drugged, and sexually assaulted her. She had an extensive history of running away from her previous placements at RTCs and foster homes. The child's current service plan, dated September 20, 2022, was created while she was on runaway status from a different placement; it documented that "constant line of sight" supervision would be recommended for the child "once recovered." When the service plan was created, the child had been reported missing from a placement nine times since October 2021. The child was located on September 30, 2022. At that time, she was living with a woman who said she allowed the child to stay with her when a twenty-four-year-old man, who the child believed to be her "boyfriend," ended his relationship with her and moved out of the same apartment complex, leaving the child without a place to live. DFPS added the adult caregiver (neighbor) as an "unauthorized placement" in IMPACT when the child refused to leave the apartment.

On October 3, 2022, CPS removed the child from the unauthorized placement and placed her in a CWOP setting. When CPS removed the child, she threatened to run away if she was not returned to the

Lack of Clear Training and Protocol

The Monitors also observed that DFPS assigned untrained and contract staff members as caregivers in CWOP settings and did not provide them with consistent and clear instruction to inform how staff members were expected to care for children.

For example, one investigation involved an allegation of Neglectful Supervision by a DFPS staff member (Staff 1) charged with supervising two children (ages 16 and 17) at a CWOP location in a hotel. During a CWOP shift (4:00 p.m. to 8:00 p.m.), a DFPS staff member (Staff 2) and a contract worker (Staff 3) took the two children to a nearby park to play basketball. At the end of the shift at 8:00 p.m., Staff 2 and Staff 3 told the children it was time to return to the hotel; the children refused to return to the hotel and eventually left the park. Staff 2 stayed on duty after her shift ended when she could not locate the children and searched for them while working overtime, eventually locating them while driving in her car to look for them.

The investigation raised the following concerns: First, Staff 2 had only worked with DFPS for four months at the time of her CWOP shift. Because of family events, she had not completed her new hire training and was not yet eligible to be assigned as a primary caseworker for a child. Staff 2 worked her shift with a contract worker who volunteered to cover the shift when the assigned staff member was unable to work the shift. However, the record indicates that contract workers and protégé caseworkers are not permitted to work together, though it in fact happened in this instance.[97] Further, contract workers appear to have reduced responsibilities related to caring for the children during CWOP shifts. These two individuals did not have sufficient training or experience to care for children placed in CWOP.

---

unauthorized placement within ten days; IMPACT notes stated, "[s]he said she will run on day 11." The child ran away from the CWOP placement after three days but law enforcement located her immediately and brought her to the local juvenile detention facility. Four days later, she left detention and DFPS placed her in another CWOP setting. A week later, on October 17, 2022, the child ran away again from the CWOP location. According to IMPACT, that evening, at 12:23 a.m., the child reportedly went to her bedroom to go to sleep. When a DFPS staff member conducted a night check 25 minutes later, she observed that the child's window was open, and the child was no longer in her bedroom. DFPS contacted law enforcement to report the child as missing. Several hours later, law enforcement located the child. The child reported to law enforcement that a man sexually assaulted her in a motel room while she was on runaway status. According to a media article located by the Monitors, law enforcement charged the man with sexual assault of a minor.

It is not clear whether the caregivers at either CWOP location had been advised that the child's plan of service required line-of-sight supervision because DFPS did not open investigations following the runaway episodes from these settings. After law enforcement located her in mid-October, she was placed in a psychiatric hospital for more than two weeks. According to IMPACT, during her hospitalization, medical staff determined that she was approximately eight weeks pregnant; the child alleged that she was impregnated by her adult ex-boyfriend. At the time of the Monitors' most recent review of her record on January 12, 2023, the child was four months pregnant had been located after fleeing the foster home where she was placed following her discharge from the hospital. She was placed at a new foster home on January 5, 2023 and alleged that her previous foster home caregivers were emotionally and physically abusive; another child in the home also reported abuse in that home after the 13-year-old ran away.

[97] DFPS's refers to its newly hired conservatorship caseworkers as protégés.

Second, some staff members reported to the DFPS investigator a lack of consistency in the rules and protocols that they are expected to follow during CWOP shifts. As a result, they were reportedly unsure how to handle certain circumstances that may emerge during a shift. In this investigation, some staff members reported that they did not know whether they were required to stay with the children at the park after they refused to return to the hotel nor how to handle the children when they refused to leave the park.

- During her interview, "[Staff 2] repeatedly said that there was no consistency between the Program Directors when it came to following or not following the kids when they left without permission… Staff 2 said there is no consistency in dealing with these children."

- The investigator contacted an "Admin Tech" to gather "further information on CWOP procedures." The Admin Tech reported, "he worked a lot of CWOP and nothing is consistent." As a result, the investigator was unable to determine which policies may be pertinent for his assessment of whether staff members were negligent in their supervision of the children.

Yet another DFPS investigation involved an allegation of Neglectful Supervision by two DFPS staff members charged with supervising two children at another CWOP location. During the staff members' shift, the staff members allowed the two children to be in the bathroom at the same time and, during this time, the children allegedly engaged in inappropriate sexual contact.

According to the investigative record, an e-mail chain was developed between those DFPS staff members who worked in the county responsible for this CWOP location; the e-mail chain contained alerts and specific instructions about the children placed at the CWOP location. The DFPS investigator determined that one of those e-mail chains included documentation that the children involved in this investigation must be separated at all times, including in the bathroom. The investigator determined that because the two staff members involved in this investigation were from a different county, they were not included on the e-mail chain. Therefore, they had no information about this supervision requirement.

This investigation again raises serious concern that the two staff members responsible for the safety of two children were not informed about critical supervision requirements which resulted in the children engaging in alleged sexual contact while alone in the bathroom for approximately one minute.

Competing Job Responsibilities

In another investigation, a DFPS staff member reported allegations of Neglectful Supervision of a child under DFPS Supervision at a CWOP location, a house in Lufkin. According to the reporter, a named caseworker was charged with supervision of a child (age 16) who required close supervision due to her behavioral health needs. Due to the caseworker's alleged failure to appropriately supervise the child, the child left the CWOP

location alone for an unknown duration of time. Staff members later found and returned the child to the CWOP location.

The record surfaced the following concerns related to DFPS supervision of children. First, the DFPS investigator gathered and reviewed the child's plan of service. The plan detailed the child's significant behavioral and mental health needs and history and stated that the child "needs 24-hour supervision because of her behaviors." Second, according to the CWOP location's documented rules, staff members must maintain "Line of Sight" supervision of the children to whom they are assigned for supervision. At the time of the incident, the named caseworker was charged with the child's supervision.

During her interview with the DFPS investigator, the child reported that she left the CWOP location "through the door at the side of the house when no one was looking." The named caseworker reported to the investigator that when the child departed, she had been reviewing e-mails on her state issued cell phone regarding a child on her caseload who had run away 12 hours earlier. This caseworker was a fulltime DFPS caseworker and was focusing on those responsibilities. When she looked up from reviewing her e-mails, the child was no longer in the living room with her. The investigator found that staff members located the child approximately 15 minutes later near the CWOP location.

This investigation illustrated the untenable position that DFPS staff members often occupy when they work a CWOP shift: They are simultaneously responsible for the children who are on their assigned caseloads and the child(ren) they are charged to supervise at a CWOP location. As this investigation showed, this caseworker was unable to fulfill both responsibilities, which resulted in an unsupervised child leaving a CWOP location alone.

Timeliness of RCCI Investigations: Remedial Orders 5 through 11; 16; and 18 Performance Validation (DFPS)

Remedial Order 5: *Within 60 days and ongoing thereafter, DFPS shall, in accordance with existing DFPS policies and administrative rules, initiate Priority One child abuse and neglect investigations involving children in the PMC class within 24 hours of intake. (A Priority One is by current policy assigned to an intake in which the children appear to face a safety threat of abuse or neglect that could result in death or serious harm.)*

Remedial Order 6: *Within 60 days and ongoing thereafter, DFPS shall, in accordance with existing DFPS policies and administrative rules, initiate Priority Two child abuse and neglect investigations involving children in the PMC class within 72 hours of intake. (A Priority Two is assigned by current policy to any CPS intake in which the children appear to face a safety threat that could result in substantial harm.)*

Remedial Order 7: *Within 60 days and ongoing thereafter, DFPS shall, in accordance with DFPS policies and administrative rules, complete required initial face-to-face contact with the alleged child victim(s) in Priority One child abuse and neglect investigations involving PMC children as soon as possible but no later than 24 hours after intake.*

Remedial Order 8: *Within 60 days and ongoing thereafter, DFPS shall, in accordance with DFPS policies and administrative rules, complete required initial face-to-face contact with the alleged child victim(s) in Priority Two child abuse and neglect investigations involving PMC children as soon as possible but no later than 72 hours after intake.*

Remedial Order 9: *Within 60 days and ongoing thereafter, DFPS must track and report all child abuse and neglect investigations that are not initiated on time with face-to-face contacts with children in the PMC class, factoring in and reporting to the Monitors quarterly on all authorized and approved extensions to the deadline required for initial face-to-face contacts for child abuse and neglect investigations.*

Remedial Order 10: *Within 60 days, DFPS shall, in accordance with DFPS policies and administrative rules, complete Priority One and Priority Two child abuse and neglect investigations that involve children in the PMC class within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record. If an investigation has been extended more than once, all extensions for good cause must be documented in the investigative record.*

Remedial Order 11: *Within 60 days and ongoing thereafter, DFPS must track and report monthly all child abuse and neglect investigations involving children in the PMC class that are not completed on time according to this Order. Approved extensions to the standard closure timeframe, and the reason for the extension, must be documented and tracked. If an investigation has been extended more than once, all extensions for good cause must be documented in the investigative record.*

Remedial Order 16: *Effective immediately, the State of Texas shall ensure RCCL investigators, and any successor staff, complete and submit documentation in Priority One and Priority Two investigations on the same day the investigation is completed.*

Remedial Order 18: *Effective immediately, the State of Texas shall ensure RCCL investigators, and any successor staff, finalize and mail notification letters to the referent and provider(s) in Priority One and Priority Two investigations within five days of closing a child abuse and neglect investigation or completing a standards investigation.*

Remedial Orders 5 through 11; 16; and 18 Performance Validation (DFPS)

For validation of orders measuring the timeliness of various aspects of RCCI investigations, the monitoring team reviewed the data provided by DFPS to validate performance for all 1,554 investigations opened by RCCI from July 1, 2021 to June 30,

2022.[98,99] The monitoring team reviewed the 1,554 RCCI investigations for compliance with the Court's orders relating to timeliness using the methodologies described in prior reporting.[100]

Remedial Order 5: Initiation within 24 Hours in Priority One Investigations

Within 60 days and ongoing thereafter, DFPS shall, in accordance with existing DFPS policies and administrative rules, initiate Priority One child abuse and neglect investigations involving children in the PMC class within twenty-four hours of intake. (A Priority One is by current policy assigned to an intake in which the children appear to face a safety threat of abuse or neglect that could result in death or serious harm.)

The Monitors found that of 1,554 investigations opened by RCCI between July 1, 2021 and June 30, 2022, 188 (12%) were assigned Priority One, requiring that DFPS initiate the investigation within 24 hours of intake.[101] DFPS initiated 79% (149) of Priority One investigations within 24 hours of intake through face-to-face contact with all alleged victims. DFPS's rate of initiating Priority One investigations through face-to-face contact with each alleged victim within 24 hours in the Monitors' previous report was 81%.[102]

The remaining 39 investigations (21%) either did not include individual face-to-face contact with each alleged victim within 24 hours of intake (22) or did not have sufficient data to assess timeliness (17).

Figure 18: Initiation of Investigations within 24 Hours in Priority One Investigations

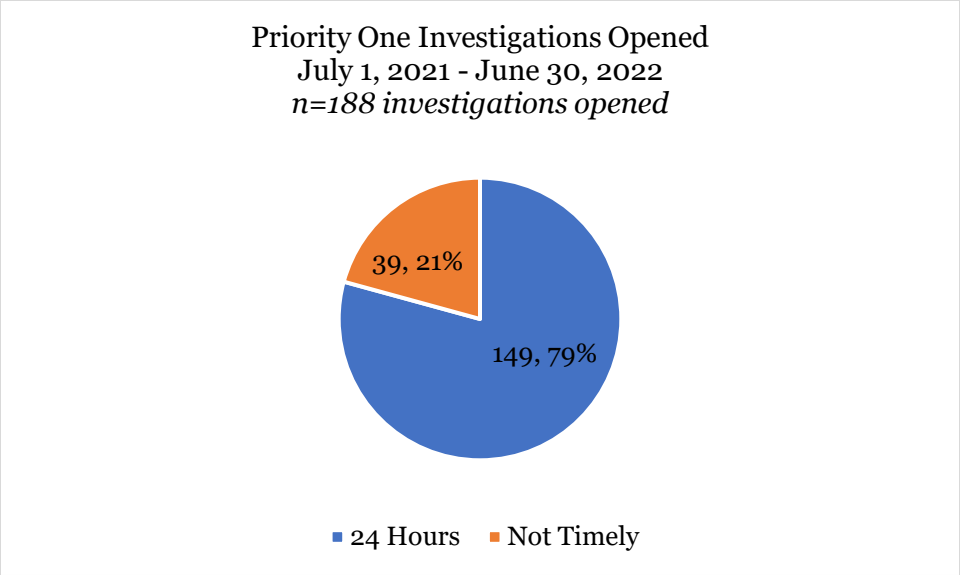
[98] To identify the investigations opened by DFPS and the corresponding data points, the Monitors used as source files monthly and bi-annual data files on open and closed investigations that DFPS submitted to the Monitors for the months corresponding with the investigations under review. In prior reporting periods, the Monitors performed case record reviews on every investigation reported in the data and were able to substantially validate the accuracy of the data reports; thus, the results in this report reflect the data as reported to the Monitors by DFPS. In this reporting period, the monitoring team independently performed case record reviews for all investigations opened from September 2021 through November 2021 in addition to random case record reviews on selected investigations opened during the remaining months in the reporting period to validate the data as reported by DFPS. Consistent with prior reporting periods, the Monitors were able to substantially validate the data.

[99] The DFPS data included 48 investigations that were administratively closed and were, therefore, excluded from the analysis.

[100] Deborah Fowler and Kevin Ryan, Third Report 52-53, ECF No. 1165.

[101] DFPS initiation occurs through face-to-face contact between the investigator and all alleged child victims. Deborah Fowler and Kevin Ryan, Third Report 52, ECF No. 1165.

[102] *See* Deborah Fowler and Kevin Ryan, Third Report 53, ECF No. 1165.

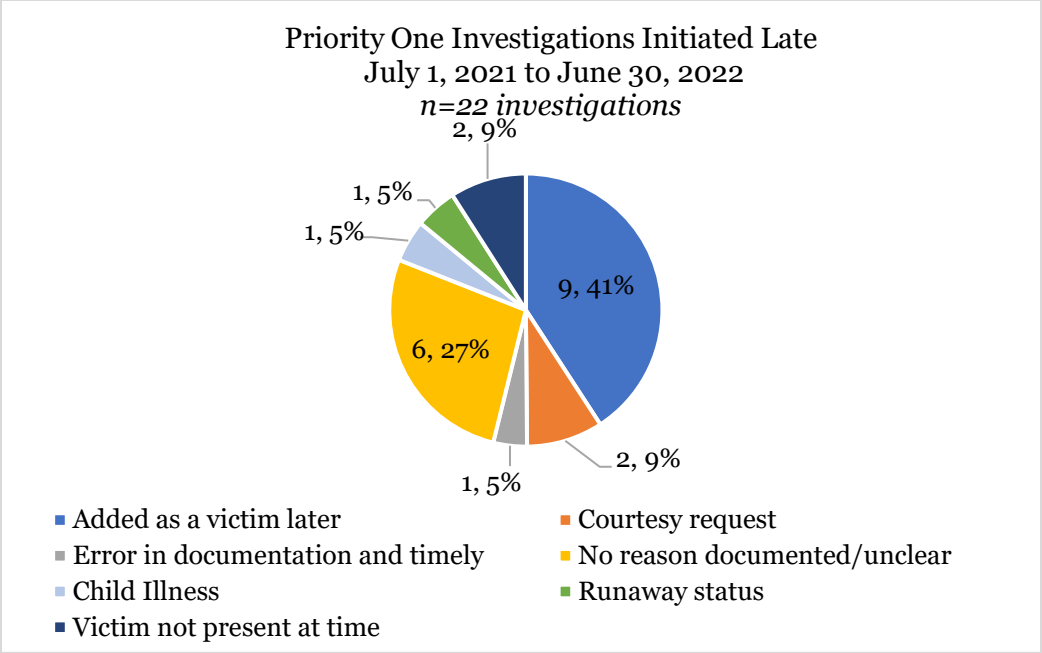


Of the 22 investigations where DFPS data provided evidence of untimely initiation, the late initiation was made in the following timeframes: up to one hour late (4), one to ten hours late (6), ten to 20 hours late (2), 20 to 24 hours late (2), and more than 24 hours late (8). In 17 instances, the data was insufficient to assess the timeframe.

The Monitors conducted case record reviews in those 22 instances where the DFPS data documented late initiation to identify documentation of the reasons for untimely face-to-face contact. In these 22 instances, the late contact was related to a child who was not initially listed as an alleged victim at intake but who was later added during the investigation (9); the child was located in another region, unit, or state and the investigator sent a courtesy request to an investigator in another location (2); the child was not present at the location where the investigator went to conduct the interview (2);[103] the contact was late due to child illness (1);[104] or the child was on runaway status (1). The record did not contain a reason or the reason for late contact was unclear in the remaining investigations (6); in most of those instances (5 of 6) where the record did not document a reason for late contact, the contact was late by one day or less. Finally, in one instance, it appears that the DFPS data documenting a late initiation may have contained an error as the Monitors' record review suggested that the initiation was timely.

Figure 19: Documented Reasons for Late Initiation in Priority One Investigations

[103] For example, in one instance, the child was not present at the facility at the time of the attempted face-to-face interview due to having been arrested prior to the investigator's arrival. The investigator rescheduled the interview once the child was released.
[104] In this instance, the child was ill at the time the investigator attempted to make face-to-face contact with the child, and the child's caseworker recommended that the investigator postpone the interview.



Note: Chart does not add up to 100% due to rounding.

Remedial Order 6: Initiation within 72 Hours in Priority Two Investigations

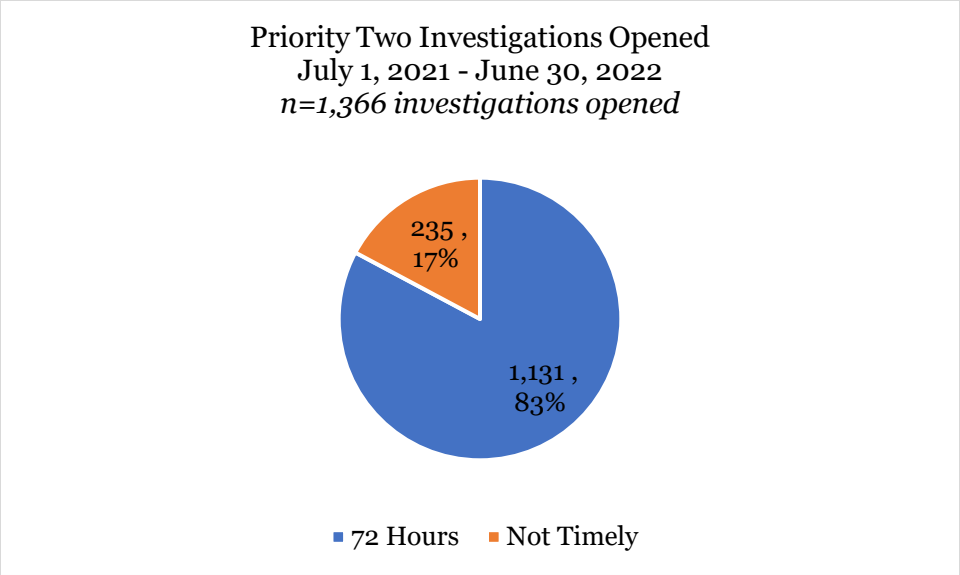
Within 60 days and ongoing thereafter, DFPS shall, in accordance with existing DFPS policies and administrative rules, initiate Priority Two child abuse and neglect investigations involving children in the PMC class within seventy-two hours of intake. (A Priority Two is assigned by current policy to any CPS intake in which the children appear to face a safety threat that could result in substantial harm.)

There were 1,366 Priority Two investigations requiring DFPS initiation within 72 hours of intake. DFPS initiated 83% (1,131) of Priority Two investigations within 72 hours of intake through face-to-face contact with all alleged victims. DFPS's rate of initiating Priority Two investigations through face-to-face contact with each alleged victim within 72 hours in the Monitors' previous report was 88%.[105]

The remaining 235 investigations (17%) either did not include individual face-to-face contact with each alleged victim within 72 hours (129) or did not have sufficient data to assess timeliness (106).

Figure 20: Initiation of Investigations within 72 Hours in Priority Two Investigations

[105] *See* Deborah Fowler and Kevin Ryan, Third Report 54, ECF No. 1165.

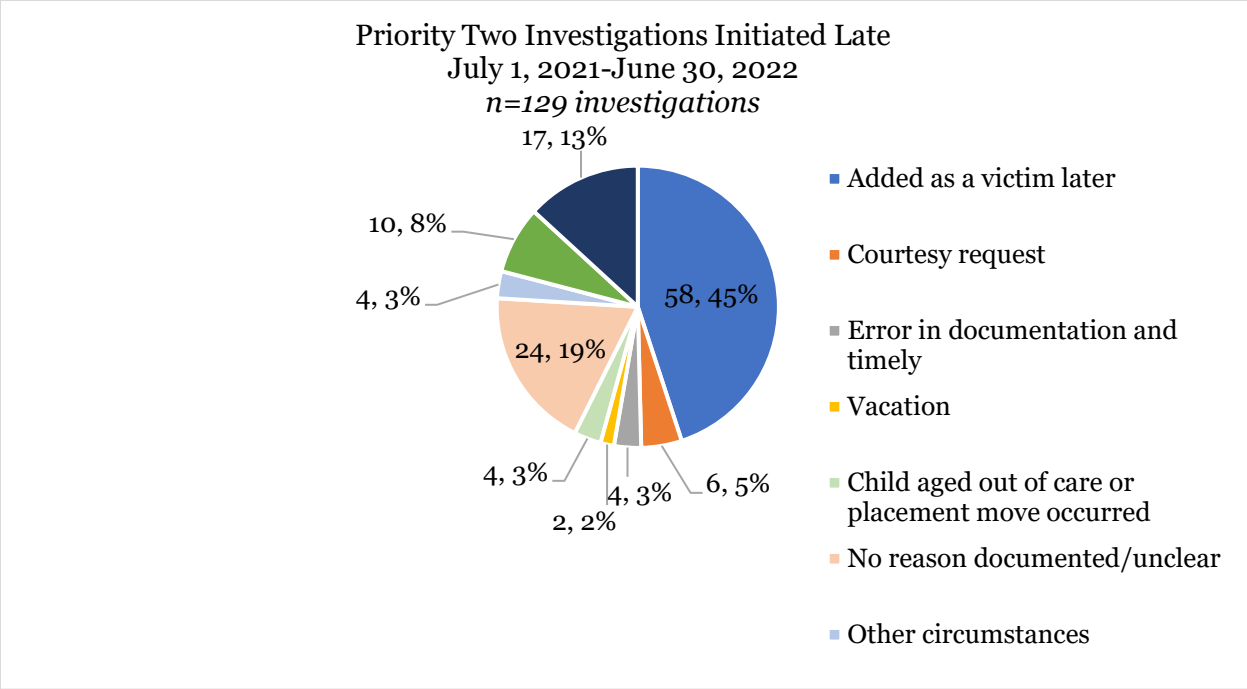


Of the 129 investigations where DFPS data provided evidence of untimely initiation, the late initiation was made in the following timeframes: up to 12 hours late (20), 12 to 24 hours late (4), 24 to 48 hours late (16), 48 to 72 hours late (12), 72 to 96 hours late (8), 96 to 120 hours late (7), and more than 120 hours late (62). In 106 instances, the data was insufficient to assess the timeframe.

The Monitors conducted case record reviews in those 129 instances where the DFPS data documented late initiation to identify the reasons for untimely face-to-face contact. In these instances, the late contact was related to a child who was not initially listed as an alleged victim at intake but who was later added during the investigation (58); the child was not present at the location where the investigator went to conduct the interview (17);[106] the child was on runaway status (10); the child was located in another region, unit, or state and the investigator sent a courtesy request to an investigator in another location (6); the investigator was delayed locating the child due to the child aging out of care or experiencing a recent placement move (4); the face-to-face contact was late due to other circumstances, such as child illness (4);[107] or the child was on a vacation (2). The record did not contain a reason or the reason for late contact was unclear in the remaining investigations (24); in most of those instances (15 of 24) where the record did not document a reason for late contact, the contact was late by one day or less. Finally, in four instances, it appears that the DFPS data documenting the late initiation may have contained an error as the Monitors' record review suggested that the initiation was timely.

[106] For example, in one instance, the child was not present at the facility due to attendance at an outing at the time of the investigator's attempted face-to-face contact, which caused a delay. In another investigation, the investigator attempted to make face-to-face contact with the child at her placement, but the child was on a home visit with her mother, which caused a delay.
[107] For example, in one investigation, the child was in quarantine due to being exposed to COVID-19, which caused a delay. In another instance, the investigator attempted to make face-to-face contact with the child, but his caregiver would not allow anyone from DFPS to interview him.

Figure 21: Documented Reasons for Late Initiation in Priority Two Investigations



Note: Chart does not add up to 100% due to rounding.

Remedial Order 7: Timeliness of initial face-to-face contact with the alleged victims in Priority One Investigations

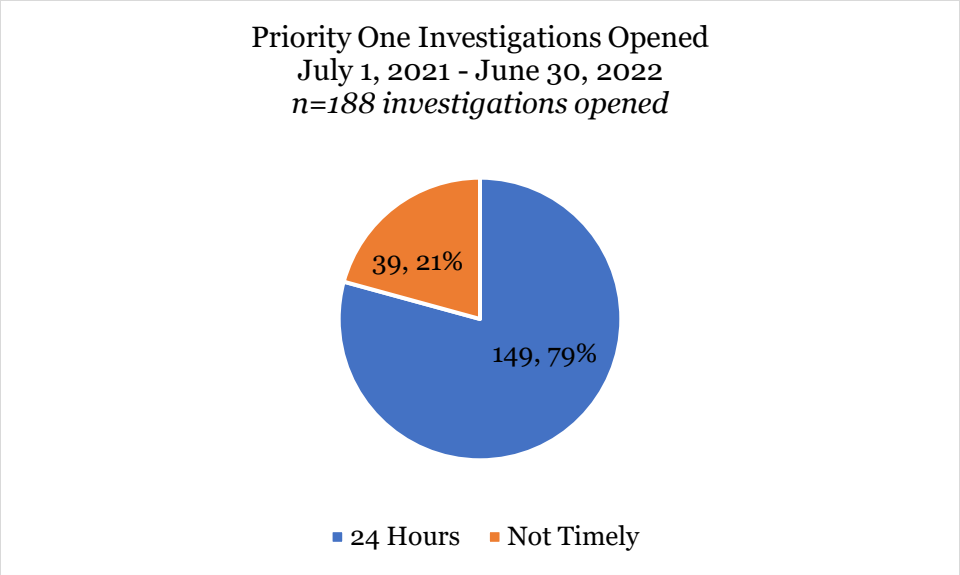
Within 60 days and ongoing thereafter, DFPS shall, in accordance with DFPS policies and administrative rules, complete required initial face-to-face contact with the alleged child victim(s) in Priority One child abuse and neglect investigations involving PMC children as soon as possible but no later than twenty-four hours after intake.

Of the 188 Priority One investigations opened by RCCI between July 1, 2021 and June 30, 2022, the Monitors found that 79% (149) of the investigations included initial face-to-face contact with each alleged child victim individually within 24 hours. DFPS's rate of completing initial face-to-face contact with each alleged victim in Priority One investigations within 24 hours in the Monitors' previous report was 81%.[108]

The remaining 39 investigations (21%) either did not include individual face-to-face contact with each alleged victim within 24 hours of intake (22) or did not have sufficient data to assess timeliness (17).

Figure 22: Face-to-Face Contact within 24 Hours with All Alleged Child Victims in Priority One Investigations

[108] *See* Deborah Fowler and Kevin Ryan, Third Report 55, ECF No. 1165.



Remedial Order 8: Initial Face-to-Face Contact with All Alleged Victims in Priority Two Investigations within 72 Hours

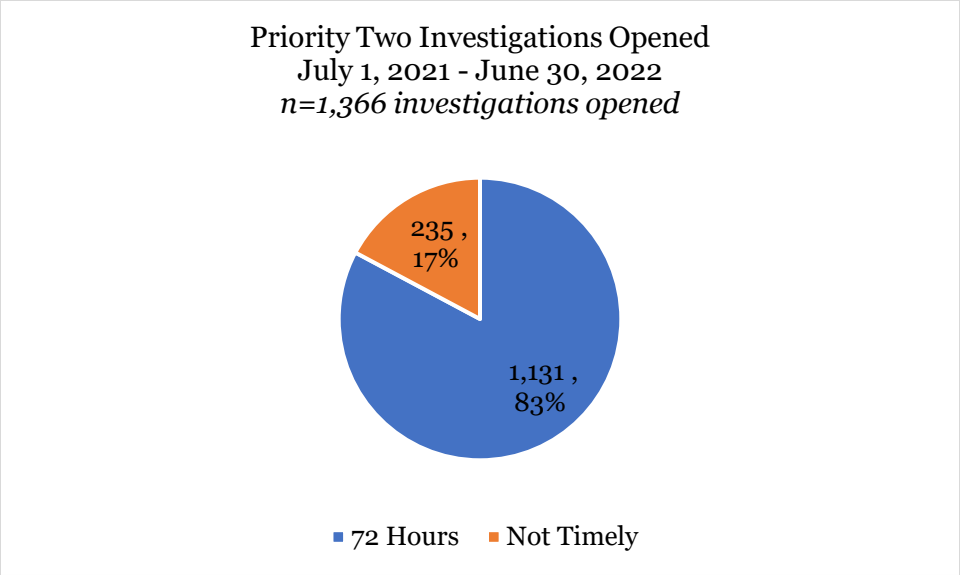
Within 60 days and ongoing thereafter, DFPS shall, in accordance with DFPS policies and administrative rules, complete required initial face-to-face contact with the alleged child victim(s) in Priority Two child abuse and neglect investigations involving PMC children as soon as possible but no later than seventy-two hours after intake.

Of the 1,366 investigations assigned Priority Two, the Monitors' review found that 83% (1,131) of investigations included initial face-to-face contact with each alleged child victim within 72 hours of intake. DFPS's rate of completing initial face-to-face contact with each alleged victim in Priority Two investigations within 72 hours in the Monitors' previous report was 88%.[109]

The remaining 235 investigations (17%) either did not include individual face-to-face contact with each alleged victim within 72 hours (129) or did not have sufficient data to assess timeliness (106).

Figure 23: Face-to-Face Contact within 72 Hours with All Alleged Child Victims in Priority Two Investigations

[109] *See* Deborah Fowler and Kevin Ryan, Third Report 56, ECF No. 1165.



Remedial Order 9: Tracking and Reporting Face-to-Face Contacts

Within 60 days and ongoing thereafter, DFPS must track and report all child abuse and neglect investigations that are not initiated on time with face-to-face contacts with children in the PMC class, factoring in and reporting to the Monitors quarterly on all authorized and approved extensions to the deadline required for initial face-to-face contacts for child abuse and neglect investigations.

Overall, in 92% (1,431) of all 1,554 investigations opened by RCCI from July 1, 2021 to June 30, 2022 (both single and multi-alleged victim investigations), DFPS was able to track and report in its submissions to the Monitors whether face-to-face contact was made with each alleged child victim within an investigation and the date and time that contact occurred for each child.[110] DFPS's rate of tracking and reporting whether face-to-face contact was made with each alleged child victim within an investigation and the date and time the contact occurred in the Monitors' previous report was 95%.[111]

In 96% (966) of the 1,005 investigations with one victim, DFPS was able to track and report in its data reports to the Monitors whether face-to-face contact was made with the alleged child victim within an investigation and the date and time the contact occurred. In investigations with one victim, DFPS's rate of tracking and reporting whether face-to-face contact was made with the alleged child victim and the date and time the contact occurred in the Monitors' previous report was 95%.[112]

In 85% (465) of the 549 investigations with more than one victim, DFPS was able to track and report in its submissions to the Monitors whether face-to-face contact was made with

[110] The Monitors did not consider data on initiation through face-to-face contact as valid if the recorded initiation date preceded the intake date, the initiation data fields were blank, or if the data did not contain unique time stamps for each alleged child victim.
[111] *See* Deborah Fowler and Kevin Ryan, Third Report 57, ECF No. 1165.
[112] *See* Deborah Fowler and Kevin Ryan, Third Report 57, ECF No. 1165.

each of the alleged child victims and the date and time the contacts occurred. In investigations with more than one victim, DFPS's rate of tracking and reporting whether face-to-face contact was made with each of the alleged child victims and the date and time the contact occurred in the Monitors' previous report was 93%.[113]

Remedial Order 10: Completion of Priority One and Priority Two Investigations within 30 Days

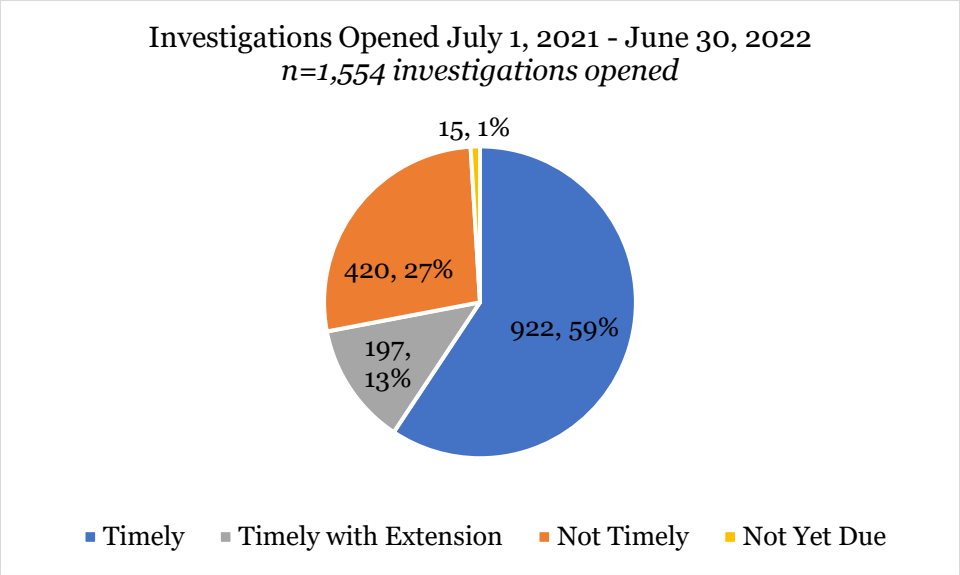
Within 60 days, DFPS shall, in accordance with DFPS policies and administrative rules, complete Priority One and Priority Two child abuse and neglect investigations that involve children in the PMC class within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record. If an investigation has been extended more than once, all extensions for good cause must be documented in the investigative record.

Of the 1,554 Priority One and Priority Two investigations opened between July 1, 2021 and June 30, 2022, DFPS documented that 27% (420) were not completed in a timely manner; of these, 19% (296) were not completed within 30 days of intake and 8% (124) had approved extensions but were not completed within the extension timeframe. Of the remaining investigations, 59% (922) were documented as completed within 30 days of intake and 13% (197) had approved extensions and were completed within the extension timeframe.[114] One percent (15) remained open with an active extension and, therefore, were not yet due at the time of analysis. DFPS's rate of completing Priority One and Two investigations within 30 days of intake in the Monitors' previous report was 63%.[115]

Of the 336 investigations with documented, approved extensions that were not completed within 30 days, as noted above, 197 of those investigations were completed within the approved timeframe allotted by the extension and 124 were not completed within the allotted extension timeframe.[116]

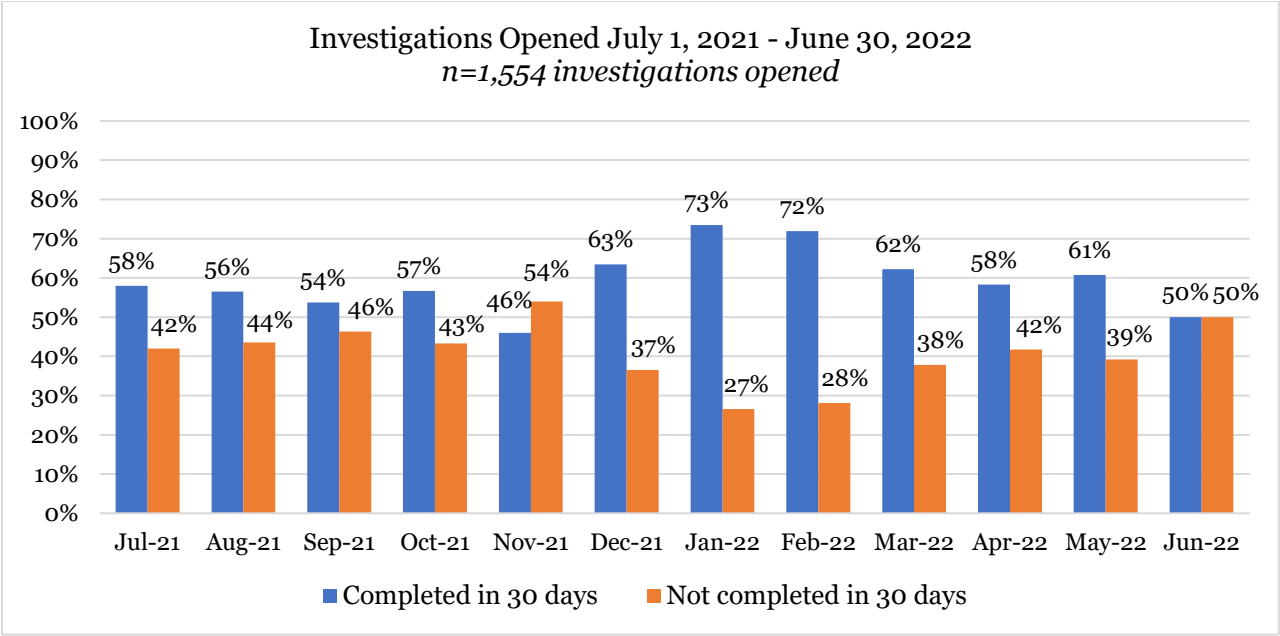
Figure 24: Completion of Priority One and Two Investigations within 30 Days

[113] *See* Deborah Fowler and Kevin Ryan, Third Report 58, ECF No. 1165.
[114] Three investigations had approved extensions but were still completed within 30 days.
[115] *See* Deborah Fowler and Kevin Ryan, Third Report 58, ECF No. 1165. An additional 9% had extensions. *Id.*
[116] Fifteen investigations that opened during this time period and had not yet closed as of August 31, 2022 had active extensions reported in the data from DFPS.



The percentage of investigations completed within 30 days increased from 58% in July 2021 to 73% in January 2022, before falling over the next three months. By the end of the review period, in June 2022, the rate had dropped to 50%, not including those investigations with extensions.

Figure 25: Completion of Priority One and Two Investigations within 30 Days over Time



Remedial Order 11: DFPS Track and Report Requirement

Within 60 days and ongoing thereafter, DFPS must track and report monthly all child abuse and neglect investigations involving children in the PMC class that are not completed on time according to this Order. Approved extensions to the standard closure

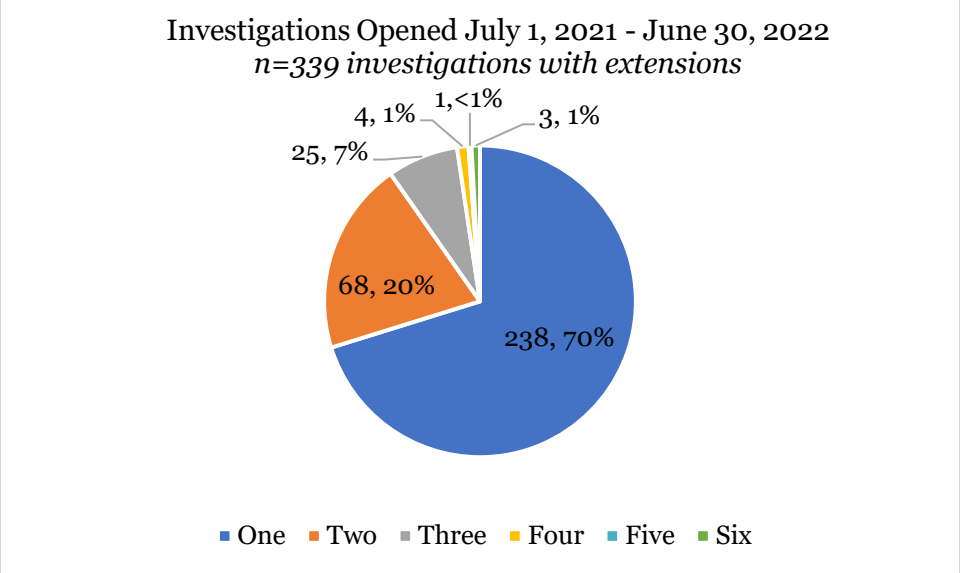
timeframe, and the reason for the extension, must be documented and tracked. If an investigation has been extended more than once, all extensions for good cause must be documented in the investigative record.

The Monitors reviewed data and information provided by DFPS in association with Remedial Order 11, which requires DFPS to track and report all investigations that are not completed on time. Approved extensions to the standard closure timeframe, and the reason for the extension, must be documented and tracked. If an investigation has been extended more than once, all extensions for good cause must be documented in the investigative record.

Of the 632 investigations that were opened by RCCI between July 1, 2021 and June 30, 2022 and were not completed within 30 days, DFPS data included extensions approved for 336 (53%) investigations with the dates the extensions were approved, the reasons for the extensions, and the number of additional days approved by each of the extensions.[117] (There were 339 investigations with extensions; however, three of those investigations were still completed within 30 days).

Of these 339 investigations that contained at least one extension, the extensions were approved for either seven, 14, 21, or 30 days each. Of those with extensions, 70% (238) included one extension, 20% (68) included two, 7% (25) included three extensions, 1% (4) included four extensions, <1% (1) included five extensions, and 1% (3) included six extensions. All extensions included documented approval dates; 25 were missing documented reasons for the extension.

Figure 26: Number of Extensions in Priority One and Two Investigations



[117] These data matched to the investigations' corresponding intake start date and original due date and therefore, the Monitors were able to determine the due dates associated with the extensions to assess timeliness of completion within the extension period.

The total number of extension days approved for an investigation ranged from seven to 180 days. Seventeen percent (58) of investigations with extensions were extended for seven-14 days; 55% (185) were extended for 15-30 days; 4% (15) were extended 31-50 days; and 24% (81) were extended for more than 50 days.

Remedial Order 16: Timeliness of Completion and Submission of Documentation in Priority One and Priority Two Investigations

Effective immediately, the State of Texas shall ensure RCCL investigators, and any successor staff, complete and submit documentation in Priority One and Priority Two investigations on the same day the investigation is completed. (Remedial Order 16 applies to both DFPS and HHSC. The Monitors report on DFPS's performance in this Fifth Report and on HHSC's performance in the upcoming Sixth Report.)

DFPS advised the Monitors that the agency uses the date the investigation was submitted to the supervisor as the investigation completion date. Therefore, according to DFPS, investigations are considered completed when the documentation is finally submitted to the supervisor in compliance with this Order.[118]

Remedial Order 18: Timeliness of Notification Letters to Referent and Provider

Effective immediately, the State of Texas shall ensure RCCL investigators, and any successor staff, finalize and mail notification letters to the referent and provider(s) in Priority One and Priority Two investigations within five days of closing a child abuse and neglect investigation or completing a standards investigation. (Remedial Order 18 applies to both DFPS and HHSC. The Monitors report on DFPS's performance in this Fifth Report and on HHSC's performance in the upcoming Sixth Report.)

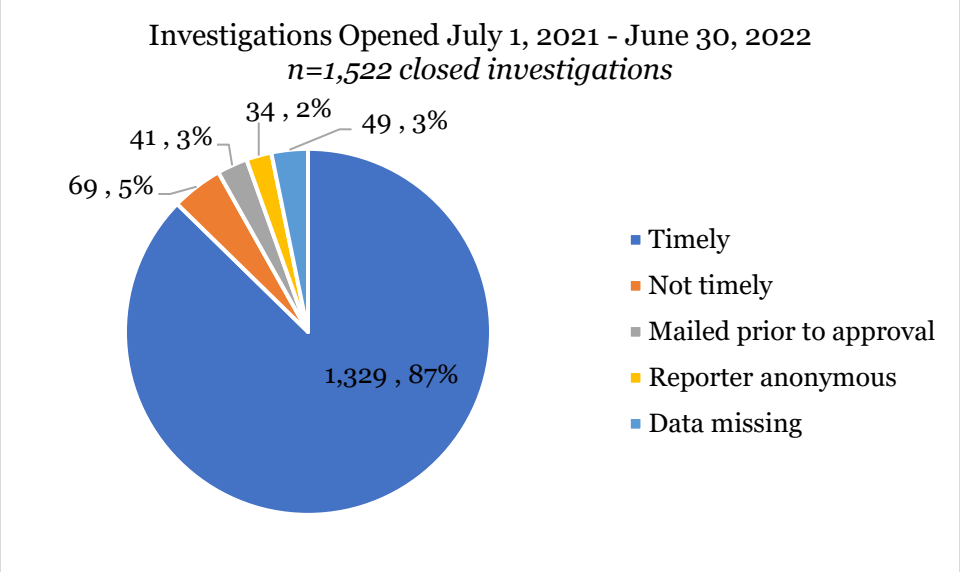
For the referent letter, of the 1,522 (out of 1,554) Priority One and Priority Two investigations opened by RCCI from July 1, 2021 to June 30, 2022 and documented as closed at the time of the Monitors' review, the notification letter to referents was mailed within five days of closure in 87% (1,329) of investigations.[119] Of the remaining cases, in 5% (69) of investigations, notification letters to the referents were not mailed timely; 3%

[118] DFPS advised the Monitors, "When an investigator submits for closure an investigation in IMPACT, the supervisor may determine that the case needs additional work or documentation to ensure a quality investigation has occurred. If so, the supervisor will return the investigation and once the additional tasks have been completed, the caseworker will submit it again. Because the IMPACT date is captured in an automated way and the CLASS date is manually entered, the IMPACT date will provide a more accurate date and may ease verification and as the agency moves forward in its efforts to improve the quality of its investigations, it believes it's important to capture the final submission rather than initial submission date. Finally, the final date submitted for approval in IMPACT will also be used as the one date to determine compliance with Remedial Order 16 to 'submit and complete documentation in Priority One and Priority Two investigations on the same day the investigation is completed.' The date complete in CLASS will no longer be used to calculate compliance with any remedial order." E-mail from Heather Bugg, former Dir. of Project Management, DFPS, to Kevin Ryan and Deborah Fowler, Monitors (Jan. 4, 2021) (on file with the Monitors).

[119] Closure data was not yet available for 32 investigations that remained open. As noted above, 15 investigations had active extensions and 17 were overdue because either their extensions expired (15) or they had no extensions (2).

(41) were mailed to the referent prior to supervisor approval; 2% (34) of investigations had an anonymous reporter; and 3% (49) were unknown due to documentation deficiencies.[120] In the Monitors' previous report, the State's rate of mailing notification letters to referents within five days of investigation closure in Priority One and Two investigations was 74%.[121]

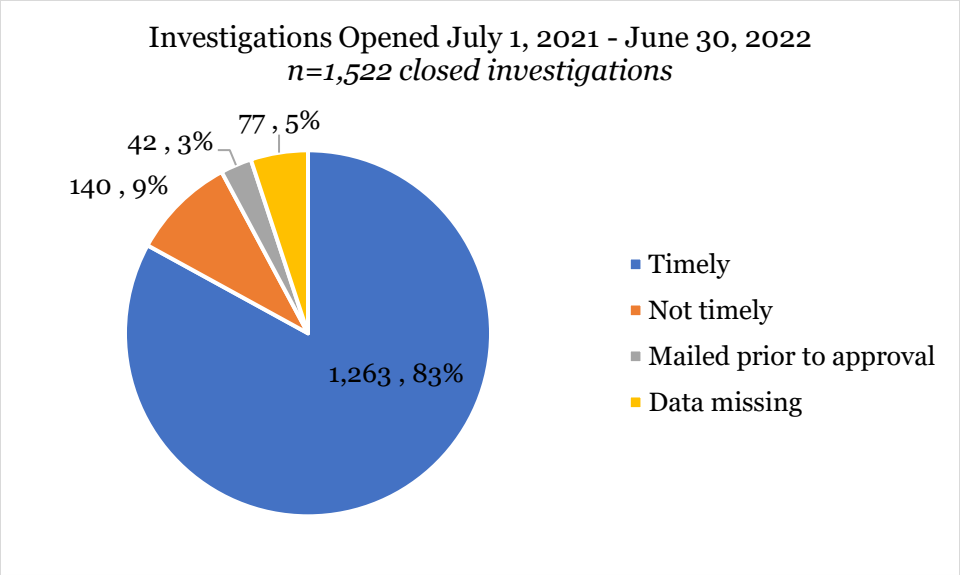
Figure 27: Notification Letter Sent to Referent within Five Days of Investigation Closure in Closed Priority One and Two Investigations



For the provider letter, of the 1,522 (out of 1,554) Priority One and Priority Two investigations opened by RCCI from July 1, 2021 to June 30, 2022 and documented as closed at the time of the Monitors' review, the notification letter to the provider was mailed within five days of closure in 83% (1,263) of investigations. Of the remaining cases, in 9% (140) of investigations, notification letters to the provider were not mailed timely; 3% (42) were mailed to the provider prior to supervisor approval; and 5% (77) were unknown due to documentation deficiencies.[122] The State's rate of mailing notification letters to providers within five days of investigation closure in Priority One and Two investigations in the Monitors' previous report was 51%.[123]

Figure 28: Notification Letter Sent to Provider within Five Days of Investigation Closure in Closed Priority One and Two Investigations

[120] The documentation deficiencies included blank cells.
[121] *See* Deborah Fowler and Kevin Ryan, Third Report 62, ECF No. 1165.
[122] The documentation deficiencies included blank cells.
[123] *See* Deborah Fowler and Kevin Ryan, Third Report 62, ECF No. 1165.



Of the 1,522 (out of 1,554) investigations opened by RCCI from July 1, 2021 to June 30, 2022 and documented as closed at the time of the Monitors' review, 73% (1,114) included evidence that notification to both the referent and provider occurred within five days of closure of the investigation as required by Remedial Order 18. DFPS's rate of mailing notification letters to the referents and providers within five days of investigation closure in the Monitors' previous report was 41%.[124]

Summary

Remedial Order 5:

- 79% (149) of Priority One RCCI investigations opened from July 1, 2021 to June 30, 2022 were initiated within 24 hours of intake; and

- 21% (39) of Priority One RCCI investigations opened from July 1, 2021 to June 30, 2022 were not initiated timely or did not have sufficient data to assess.

Remedial Order 6:

- 83% (1,131) of Priority Two RCCI investigations opened from July 1, 2021 to June 30, 2022 were initiated within 72 hours of intake; and

- 17% (235) of Priority Two RCCI investigations opened from July 1, 2021 to June 30, 2022 were not initiated timely or did not have sufficient data to assess.

Remedial Order 7:

- 79% (149) of Priority One RCCI investigations opened from July 1, 2021 to June 30, 2022 included initial face-to-face contact with all alleged victims within 24 hours of intake; and

[124] *See* Deborah Fowler & Kevin Ryan, Third Report 63, ECF No. 1165.

- 21% (39) of Priority One RCCI investigations opened from July 1, 2021 to June 30, 2022 did not have timely face-to-face contact with all alleged victims or did not have sufficient data to assess.

Remedial Order 8:

- 83% (1,131) of Priority Two RCCI investigations opened from July 1, 2021 to June 30, 2022 included initial face-to-face contact with all alleged victims within 72 hours of intake; and

- 17% (235) of Priority Two RCCI investigations opened from July 1, 2021 to June 30, 2022 did not have timely face-to-face contact with all alleged victims or did not have sufficient data to assess.

Remedial Order 9:

- Of 1,554 investigations opened by RCCI from July 1, 2021 to June 30, 2022 including both single and multi-alleged victim investigations, DFPS was able to track and report to the Monitors 92% of the time (1,431 investigations) whether face-to-face contact was made with each alleged victim within an investigation and the date and time that contact occurred.

- In the remaining 8% (121) of investigations, DFPS was not able to track and report whether face-to-face contact was made with each alleged victim.

Remedial Order 10:

- Of the 1,554 Priority One and Priority Two investigations opened between July 1, 2021 and June 30, 2022, DFPS documented that 59% (922) were documented as completed within 30 days of intake;

- Of the 1,554 Priority One and Priority Two investigations opened between July 1, 2021 and June 30, 2022, DFPS documented that 27% (420) of investigations were not completed timely; and

- Of the 1,554 Priority One and Priority Two investigations opened between July 1, 2021 and June 30, 2022, DFPS documented that 13% (197) of investigations had an approved extension and were completed within the extension timeframe.

- One percent (15) of the 1,554 Priority One and Priority Two investigations opened between July 1, 2021 and June 30, 2022 remained open with an active extension and, therefore, were not yet due at the time of analysis.

Remedial Order 11:

- Of the 632 investigations that were opened by RCCI between July 1, 2021 and June 30, 2022 and were not completed within 30 days, DFPS data included extensions approved for 336 (53%) investigations with the dates the extensions were approved, the reasons for the extensions, and the number of additional days approved by each of the extensions.

Remedial Order 16:

- Investigation completion is measured by DFPS on the date the investigation is submitted for supervisor approval. Therefore, all investigations are completed on the same day as submission.

Remedial Order 18 (Notification to Referent):

Notification to Referent by DFPS:

- Of the 1,522 (out of 1,554) Priority One and Priority Two investigations opened by RCCI from July 1, 2021 to June 30, 2022 and documented as closed at the time of the Monitors' review, the notification letter to referents was mailed within five days of closure in 87% (1,329) of investigations.

- Of the remaining cases, in 5% (69) of investigations, notification letters to the referents were not mailed timely; 3% (41) were mailed to the referent prior to supervisor approval; 2% (34) of investigations did not require notifications as the reporters were anonymous; and 3% (49) were unknown due to documentation deficiencies.

Notification to Provider by DFPS:

- Of the 1,522 (out of 1,554) Priority One and Priority Two investigations opened by RCCI from July 1, 2021 to June 30, 2022 and documented as closed at the time of the Monitors' review, the notification letter to the provider was mailed within five days of closure in 83% (1,263) of investigations. Of the remaining cases, in 9% (140) of investigations, notification letters to the provider were not mailed timely; 3% (42) were mailed to the provider prior to supervisor approval; and 5% (77) were unknown due to documentation deficiencies.[125]

Remedial Order A6: Reporting Allegations

Remedial Order A6: *Within 30 days of the Court's Order, DFPS shall ensure that caseworkers provide children with the appropriate point of contact for reporting issues relating to abuse or neglect. In complying with this order, DFPS shall ensure that children in the General Class are apprised by their primary caseworkers of the appropriate point of contact for reporting issues, and appropriate methods of contact, to report abuse and neglect. This shall include a review of the Foster Care Bill of Rights and the number for the Texas Health and Human Services Ombudsman. Upon receipt of this information, the PMC child's caseworker will review the referral history of the home and assess if there are any concerns for the child's safety or well-being and document the same in the child's electronic case record.*

Background

[125] The documentation deficiencies included blank cells.

The Monitors rely on information gathered during site visits to validate the State's compliance with Remedial Order A6. Since July 31, 2019, the monitoring team has visited more than 70 GROs, CWOP Settings, and operations subject to Heightened Monitoring[126] despite having to curtail visits during the height of the pandemic. While the percentage of youth interviewed who reported knowing about the SWI hotline improved between the Monitors' First and Third reports (from 60% to 75%),[127] many (45%) did not know how to call the hotline, and most children either did not know how to reach the Ombudsman (71%) or did not understand the Ombudsman's role (69%).[128] Even for children who reported understanding how to call the hotline or Ombudsman, some children indicated they were not guaranteed access to a phone as reported in the Monitors' First and Third reports.

For the Third Report, the Monitors analyzed data provided by the State that revealed, for the six-month period reviewed, 20 calls made by foster children to the Ombudsman were subsequently forwarded by Ombudsman staff to SWI, suggesting that although these children did not identify the hotline to be the appropriate resource for the problem they were reporting, they were able to utilize the Ombudsman as a resource.

Performance Validation

The monitoring team conducted site visits at eight GROs between January 1, 2022, and August 31, 2022. The monitoring team visited Camp Worth, DePelchin Children's Center (DePelchin), Gold Star Academy, Guiding Light RTC, Helping Hand Home for Children (Helping Hand Home), Roy Maas Youth Alternatives–Girlsville Junction (GRO) and Meadowlands (RTC) (reported in combination as Roy Maas), Silver Lining, and Whispering Hills Achievement Center RTC. The table below shows the total number of children and staff interviewed and records reviewed across all eight visits.[129]

Table 10: Total Number of Children and Staff Interviewed

Type of Data Collected at Site Visits	Number of Interviews/ Files Reviewed
Child Interviews	78[130]
Direct Caregiver Interviews	58

[126] Visits to operations under Heightened Monitoring were short and focused on the providers' experience with Heightened Monitoring. Interviews with children were not conducted during these shortened visits.
[127] Deborah Fowler & Kevin Ryan, First Report 123, ECF No. 869; Deborah Fowler & Kevin Ryan, Third Report 68, ECF No. 1165
[128] Deborah Fowler & Kevin Ryan, Third Report 68, ECF No. 1165.
[129] Participation in interviews was voluntary. Respondents were allowed to refuse any question or terminate the interview prior to completing. Sixty-eight of the 78 PMC children interviewed completed the entire interview. The denominator (N) for children interviewed in the charts and analysis reflects the number of children responding to a given question and can vary across questions.
[130] As noted above, not all 78 children answered every question during interviews with the monitoring team, which accounts for variations in the denominators discussed in this section.

Case Manager Interviews	8
Program Administrator Interviews	14
Total Interviews	**158**
Child File Reviews	112
Direct Caregiver File Reviews	156
Total File Reviews	**268**

Foster Care Bill of Rights

During its reviews of children's files on site, the monitoring team determined that 87% of PMC children's files (97 of 112) contained a Bill of Rights signed by the child. Eight additional child files (7%) included a Bill of Rights, but the document was not signed by the child. Seven of 112 child files (6%) did not include a Bill of Rights. This result varied slightly across operations; in three of eight operations visited, all the PMC children's files contained a signed Bill of Rights.

Figure 29: Child File Contained Signed Bill of Rights

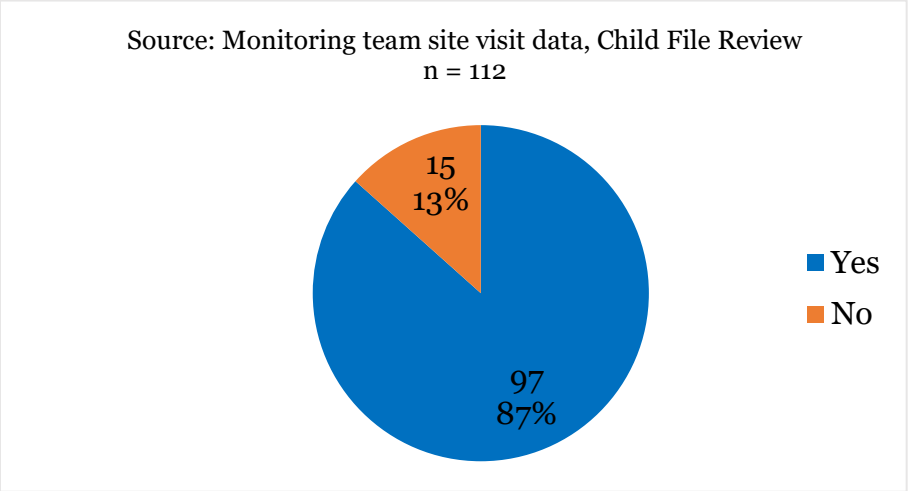
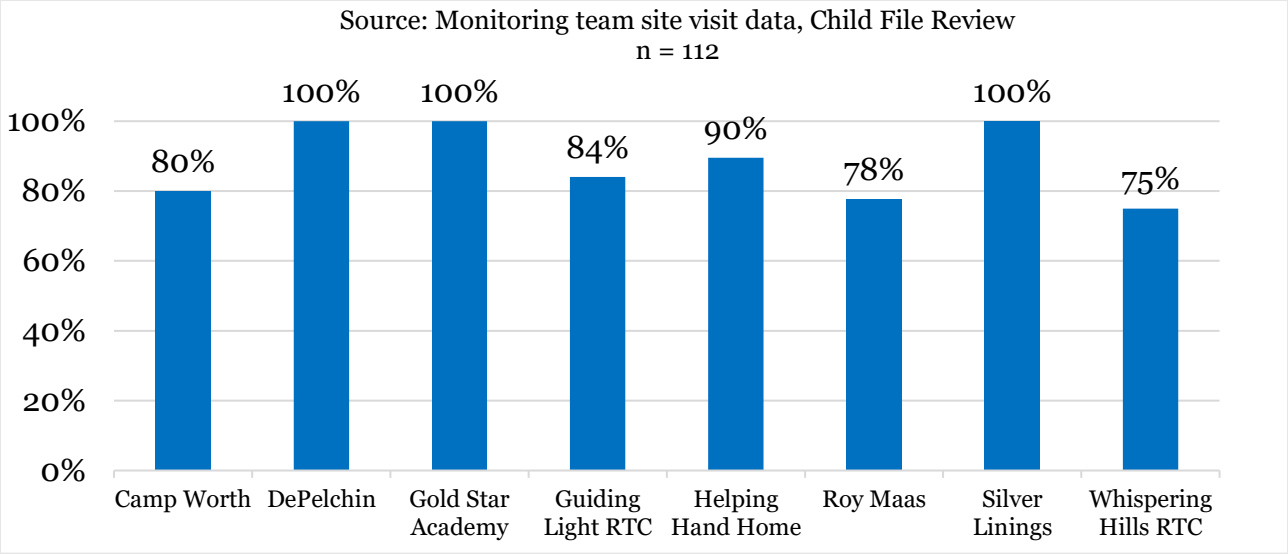


Figure 30: Percentage of Child Files by Operation Containing a Signed Bill of Rights

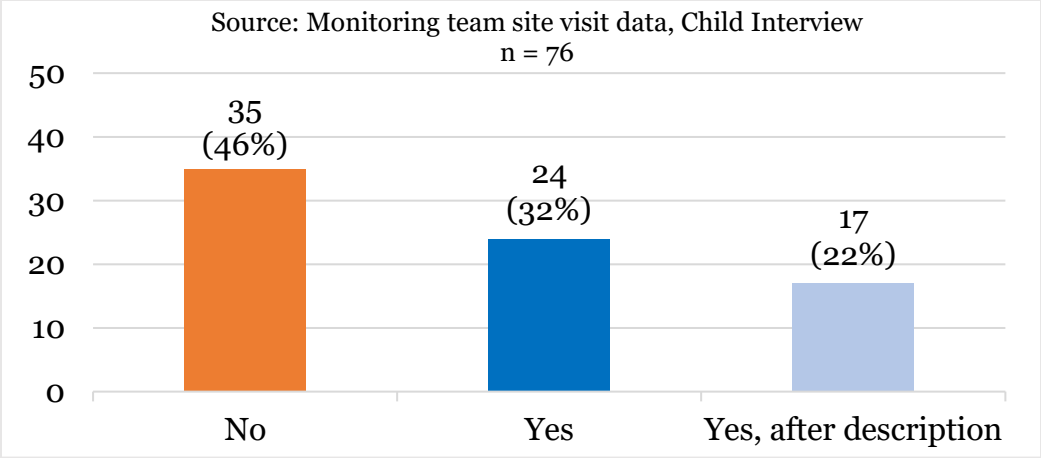


Of the eight case managers interviewed across five sites (Camp Worth, Guiding Light, Helping Hand Home, Roy Maas, and Whispering Hills), only half (4 of 8 or 50%) responded that they "always" (3 or 38%) or "sometimes" (1 of 8 or 12%) reviewed the Bill of Rights with children at intake/admission.[131]

Among children interviewed, 41 of 76 (54%) had heard of the Bill of Rights; 17 responded "yes" to having heard of it only after a description was offered by the interviewer. Thirty-five of 76 children interviewed (46%) had not heard of the Bill of Rights even after a description was given. The age of the child correlated with whether they were familiar with the Bill of Rights–69% of nine and ten-year-olds (11 of 16) had not heard of the Bill of Rights compared to 15% of 15 to 17-year-olds (2 of 13). Twenty-three of the 35 children (66%) who had not heard of the Bill of Rights were 12 years old or younger.

Figure 31: Percentage of Children Responding They Had Knowledge of the Bill of Rights

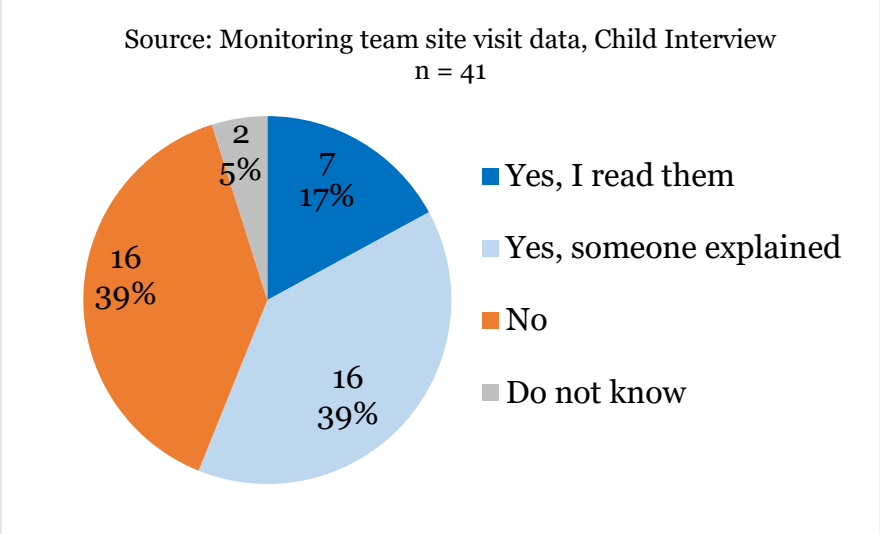
[131] The results of these interviews may explain why children's files contain a signed Bill of Rights, but few children reported having heard of the document. In addition, many of the children interviewed by the monitoring team reported having to sign so many documents at intake that the children did not always absorb the information relayed in documents signed during intake.



Of all children interviewed, 41 of the 76 (54%) reported having heard of the Bill of Rights. However, of the 41 children who reported having heard of the Bill of Rights, only 17% (7 of 41) had read the document, and 39% (16 of 41) said someone had explained the Bill of Rights to them.

Younger children were less likely to report having read the Bill of Rights or having the document explained to them: 45% (9 of 20) of children 12 years old or younger had never read nor had the Bill of Rights explained to them compared to 37% (7 of 19) of children over the age of 12.

Figure 32: Children Reporting Having Read or Someone Else Explained the Bill of Rights

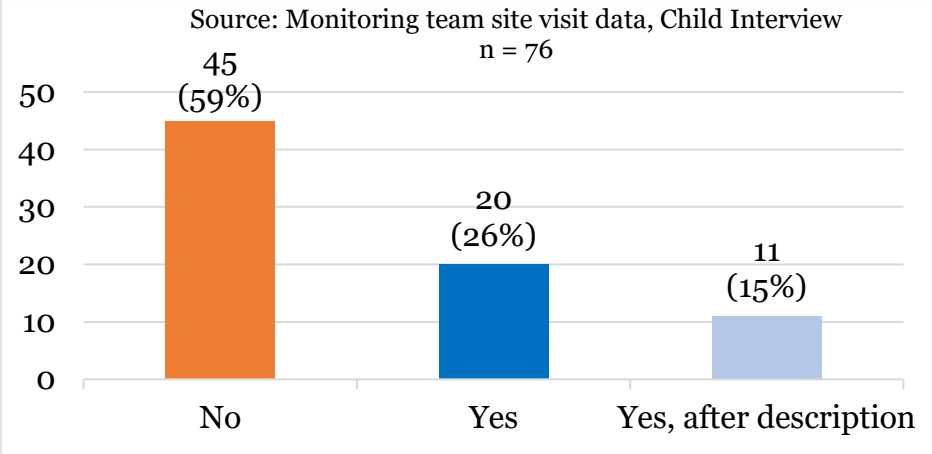


Foster Care Ombudsman

Fewer than half of children interviewed (31 of 76 or 41%) had heard of the Ombudsman; 11 of them responded "yes" after a description was given by the interviewer. Forty-five of 76 (59%) children had not heard of the Ombudsman even after a description was given.

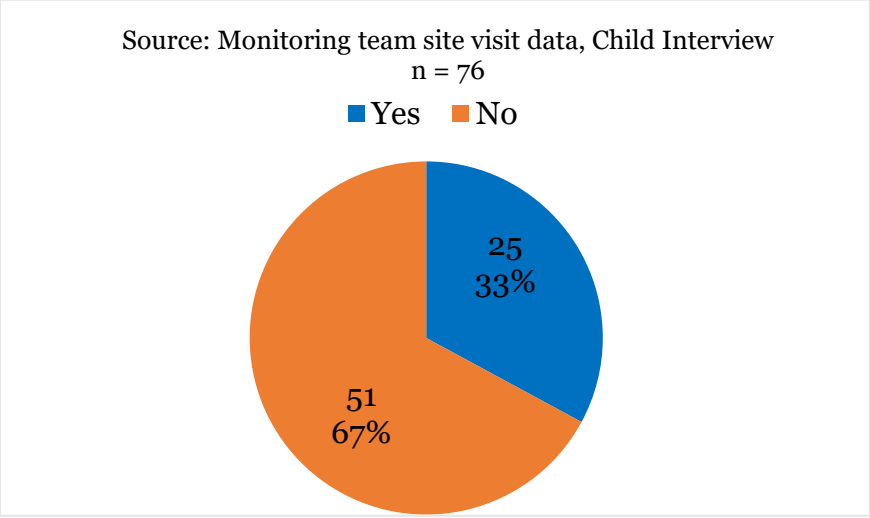
Three-quarters of nine and ten-year-old children (12 of 16 or 75%) had not heard of the Ombudsman compared to less than one-third of 15 to 17-year-olds (4 of 13 or 31%).

Figure 33: Children Reporting Knowledge of the Ombudsman



The 31 children who responded that they had heard of the Ombudsman were also asked if they knew how to contact the Ombudsman if they ever needed to do so. Of children who had heard of the office, 25 (81%) of 31 responded that they knew how to contact it. In total, 25 (33%) of 76 children interviewed knew how to contact the Ombudsman.

Figure 34: Children Reporting Knowledge of How to Reach the Ombudsman if Necessary



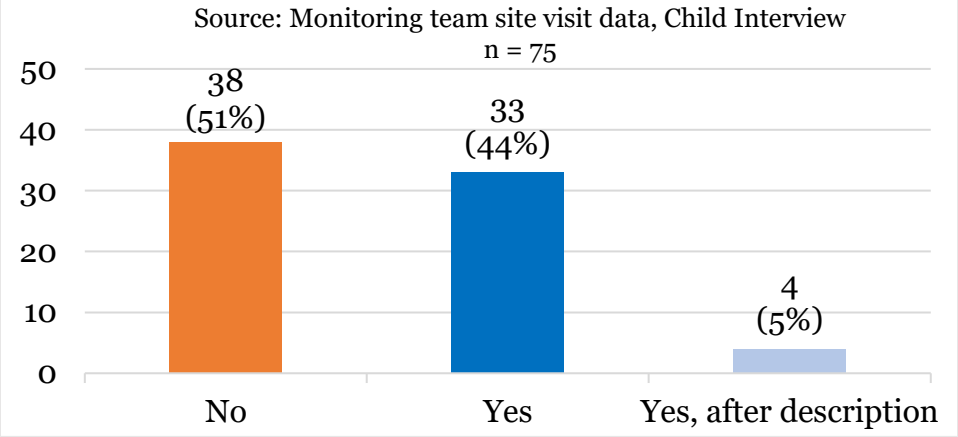
SWI Hotline

Nearly half of children interviewed (37 of 75 or 49%) reported having heard of the hotline, including four children who initially indicated they had not heard of the hotline, but

changed their answer after a description was given. Thirty-eight of 75 children interviewed (51%) had not heard of the hotline even after a description was given.

Knowledge of the hotline varied greatly by age category. Nearly all 15 to 17-year-olds had heard of the hotline–ten of 13 (77%) had heard of it and another two (15%) reported having heard of it after a description was given; but 80% (12 of 15) of nine and ten-year-olds had not heard of the hotline even after a description was given.

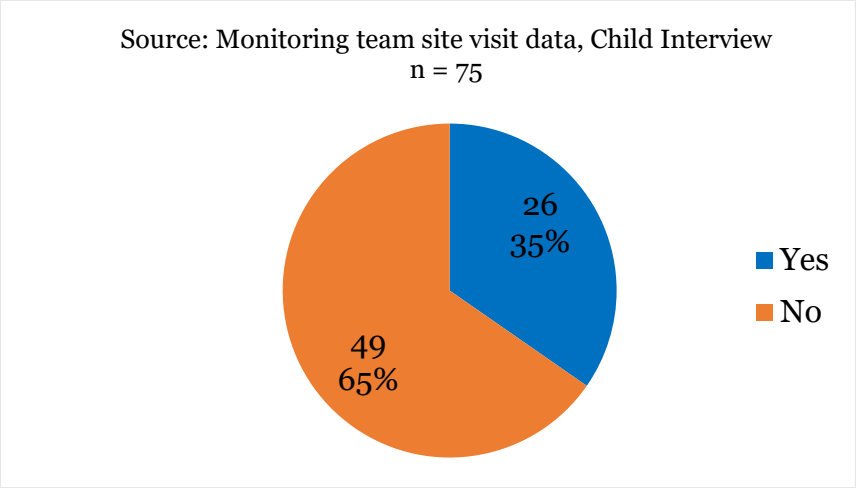
Figure 35: Children Reporting Knowledge of the Hotline



The 37 children who responded that they had heard of the hotline were also asked if they knew how to call the hotline. Of the children who had heard of the hotline, 26 of 37 (70%) knew how to call the hotline.

In total, only 26 (35%) of 75 children interviewed knew how to call the hotline. However, 11 (85%) of 13 children ages 15 to 17 knew how to call the hotline while only two (12%) of 17 children ages nine and ten knew how to call the hotline.

Figure 36: Children Reporting Knowledge of How to Call the Hotline if Necessary to Report Abuse, Neglect and Exploitation



Children who reported having heard of the hotline were also asked if they had ever wanted to call the hotline while in their current placement and if so, whether they were able to call. Of the 74 children who responded to the question, eight children said that they wanted to call the hotline at some point during the placement, but only two reported having called the hotline.

Figure 37: Children Reporting a Need to Call the Hotline

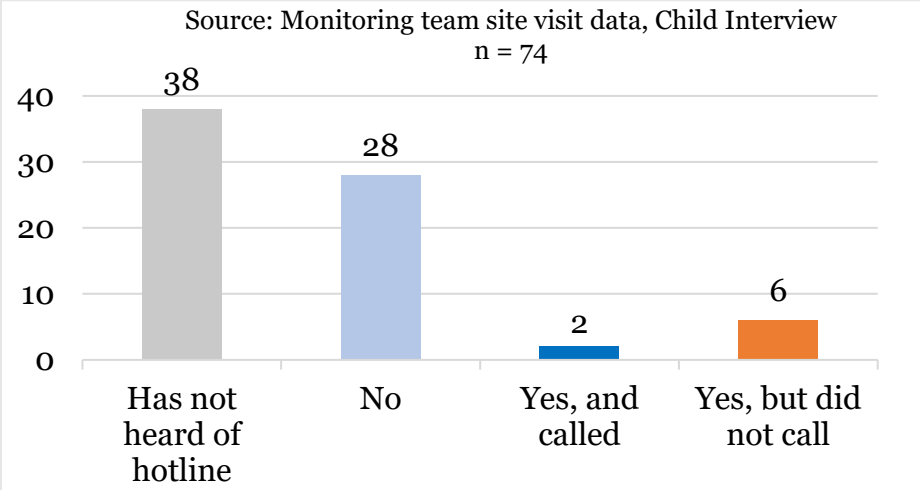
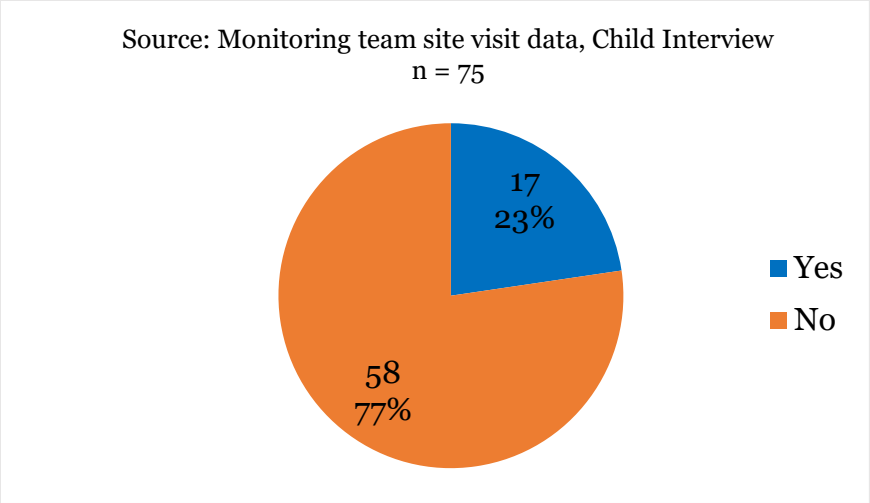


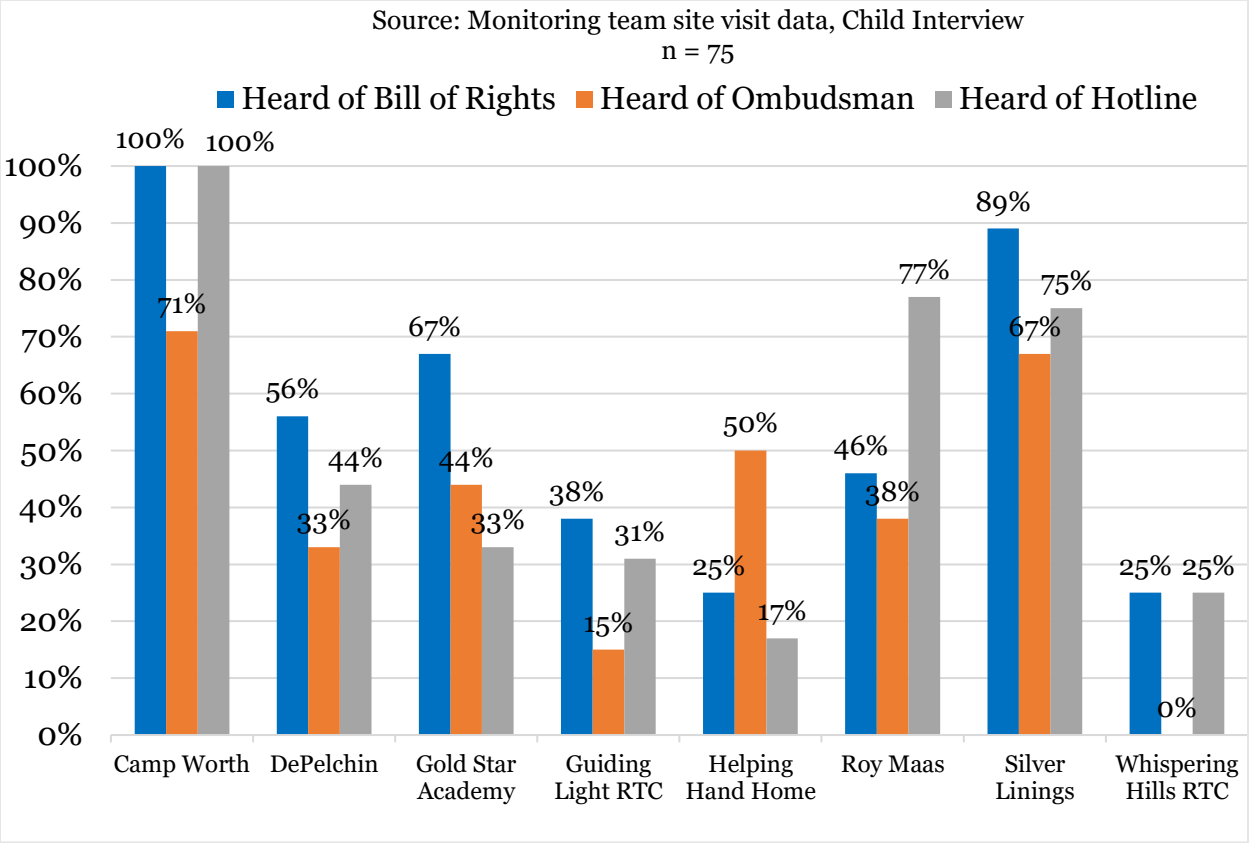
Figure 38: Children Reporting Knowledge of the Bill of Rights, Ombudsman, and Hotline



Children's responses to all these questions varied by facility visited. This variation may reflect differences between the age of children housed in the operations, particularly for Camp Worth, which houses older youth, but also raises questions about differences in practice between placements, as well as serious concerns regarding the ability of children in some facilities to reach out for help if they encounter safety risks.

Figure 39: Percentage of Children by Operation with Knowledge of the Bill of Rights, Ombudsman, and Hotline[132]

[132] Includes yes after description.



Posting of Hotline and Ombudsman Numbers

Nearly all direct caregiver staff interviewed (57 of 58 or 98%) reported that both the hotline phone number and Ombudsman phone number are posted in the unit on site. The remaining caregiver reported that only the Ombudsman number is posted.

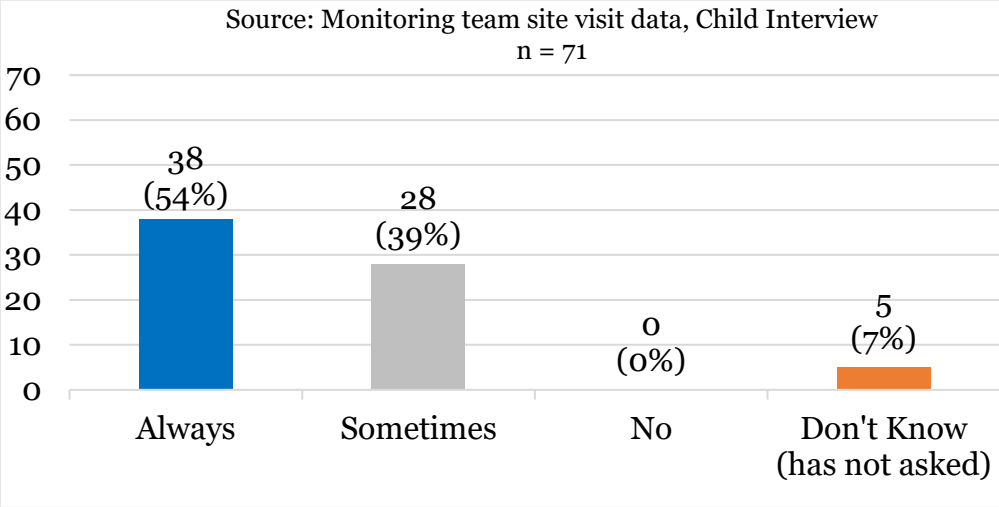
The monitoring team found that in three of the eight operations visited, the Ombudsman and hotline numbers were not consistently posted in every living unit. For example, in one operation, Camp Worth, the Ombudsman number was not posted in one unit and the hotline was posted in Spanish but not in English in another of the units. In another operation, Silver Lining, the hotline number was not posted in one of the houses, but the Ombudsman number was posted in both houses. In a third operation, Whispering Hills, the hotline was not posted at all.

Phone Process

Children were asked about phone access and their ability to make calls, as well as the process for making phone calls. Almost all the children (66 of 71 or 93%) interviewed reported having access to a phone; five had never asked to use the phone. Just over half (38 of 71 or 54%) reported always being able to use a phone and 39% (28 of 71) reported sometimes, but not always, being able to use a phone.

While children reported a high degree of access to a phone, they frequently reported that others could overhear their phone conversations. Seventy-one children responded to the question whether they had access to a phone. Of those children, 38 (54%) reported they always had access, 28 (39%) said they sometimes had access and five (7%) were uncertain.

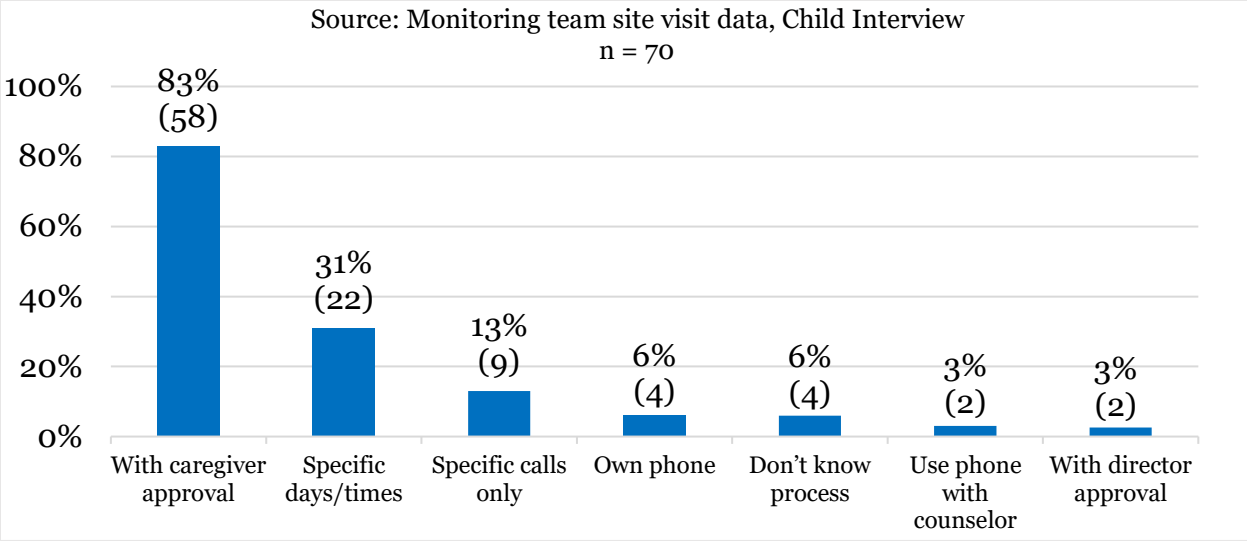
Figure 40: Children Reporting Ability to Use a Phone



Seventy children answered a question about the process for using a phone. Only ten of those 70 children (14%) reported being able to use the phone without other children or staff overhearing their conversation. Nearly half (34 of 70 or 49%) reported that other children or staff could always hear their conversation while 30% (21 of 70) said other children or staff could sometimes hear their conversations. This was consistent across the eight operations the monitoring team visited. Most of these 70 children (58 or 83%) across locations described having to gain caregiver approval before using a phone. Nearly one-third of children (22 of 70 or 31%) reported specific days or times of the day when phone use was allowed.

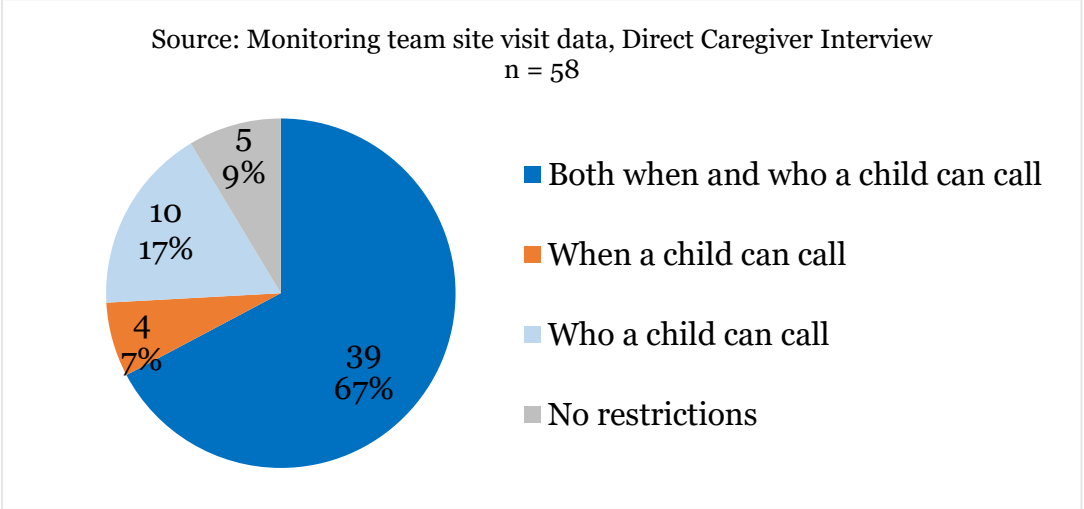
Figure 41: Children's Reported Process for Using a Phone[133]

[133] Multiple responses were allowed. Eight children did not answer.



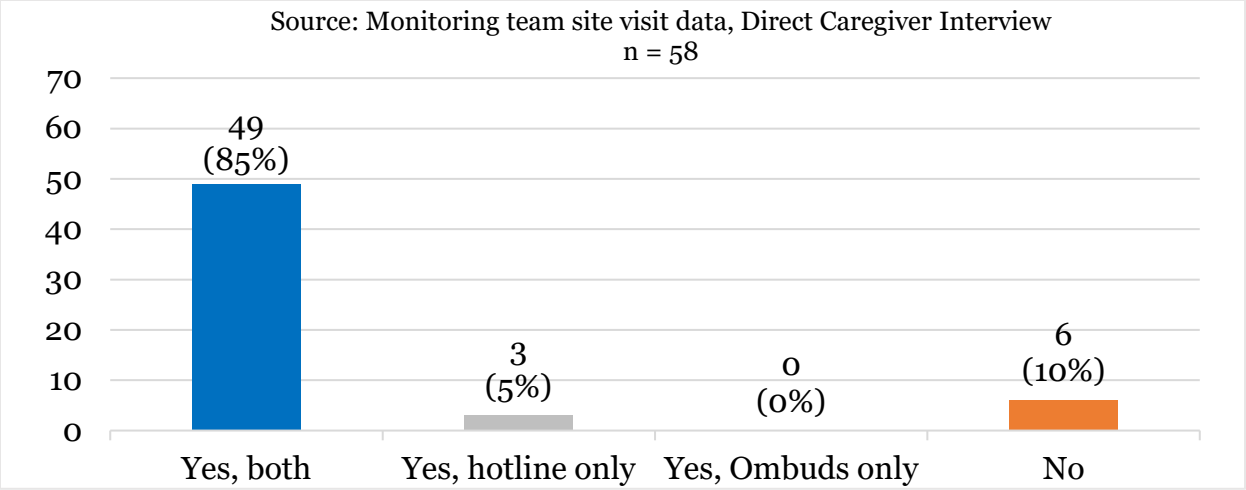
Most caregivers also reported at least some restrictions on phone use. Two-thirds (39 of 58 or 67%) of direct care staff members interviewed reported restrictions on both when a child may make a call and who a child may call. Nearly three-quarters (43 of 58 or 74%) of staff members reported there were restrictions on when a child can make a call. Only five (9%) of 58 caregivers reported no call restrictions of any kind.

Figure 42: Caregiver Reported Restrictions on Phone Use



While most caregivers reported restrictions on phone use, 90% (52 of 58) said children could call the hotline whenever they wanted and 85% (49 of 58) said children could call the Ombudsman whenever they wanted to call. Staff members at three operations (Gold Star Academy, Silver Lining, and Whispering Hills RTC) said children could not call the hotline or Ombudsman whenever they wanted to call.

Figure 43: Caregivers Reporting Ability of Children to Call the Hotline/Ombudsman



Child Grievances and General Safety

More than 85% of program administrators (12 of 14 or 86%) and case managers (7 of 8 or 88%) reported having a formal process to handle children's grievances, but just under 60% (34 of 58 or 59%) of direct care staff reported a formal process. Twenty-nine percent (17 of 58) of direct care staff reported not having a formal process and 12% (7 of 58) did not know whether there was a formal process for children's grievances.

One-third (23 of 69 or 33%) of children responding said they had wanted to report a grievance since coming to their current placement while two-thirds (46 of 69 or 67%) said they had not wanted to report a grievance. Of the 23 children who said they had wanted to report a grievance, 18 (78%) said they were able to report it and five (22%) said they were not able to report it.

Figure 44: Children Reporting Wanting to Report a Grievance Since Being in Current Placement

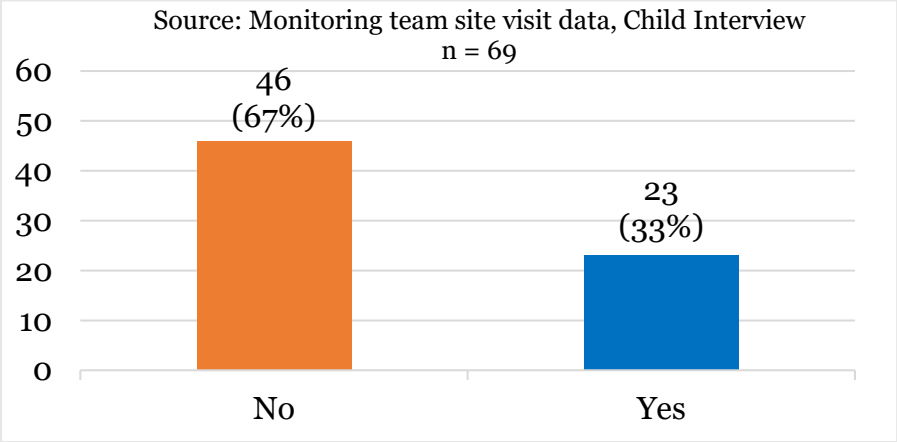
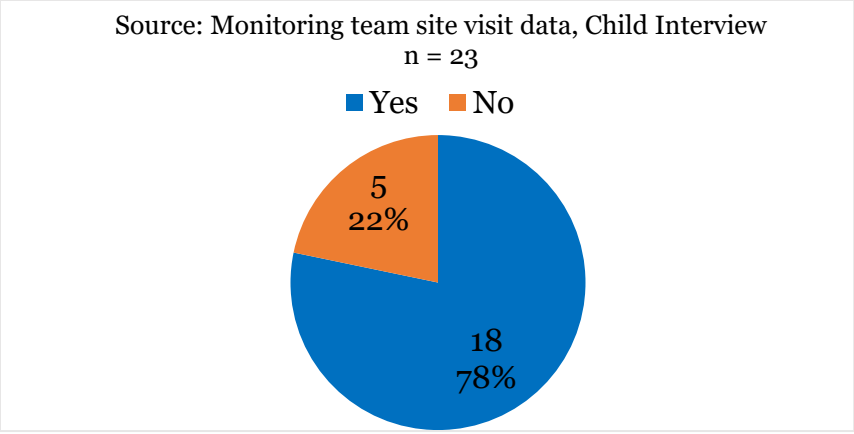


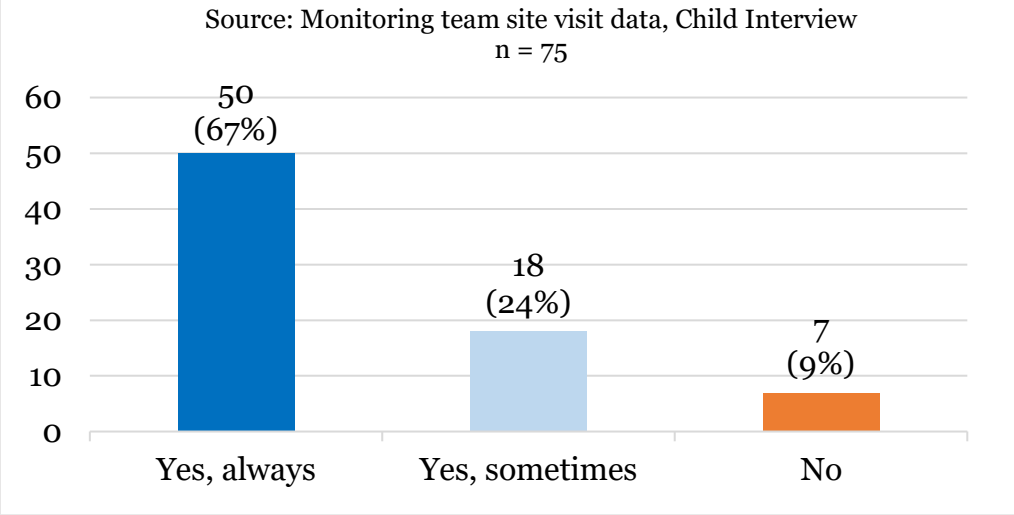
Figure 45: Children Reporting Ability to Report a Grievance



When asked generally about feelings of safety, two-thirds (50 of 75 or 67%) of children said they "always" felt safe in their current placement and one-quarter (18 of 75 or 24%) said they "sometimes" felt safe. Seven children said they did not feel safe in the placement. Of the seven children who reported not feeling safe, all reported they were only "sometimes" able to use the phone. Of the eight operations visited, all children interviewed reported that they "always" felt safe in only one: Roy Maas.

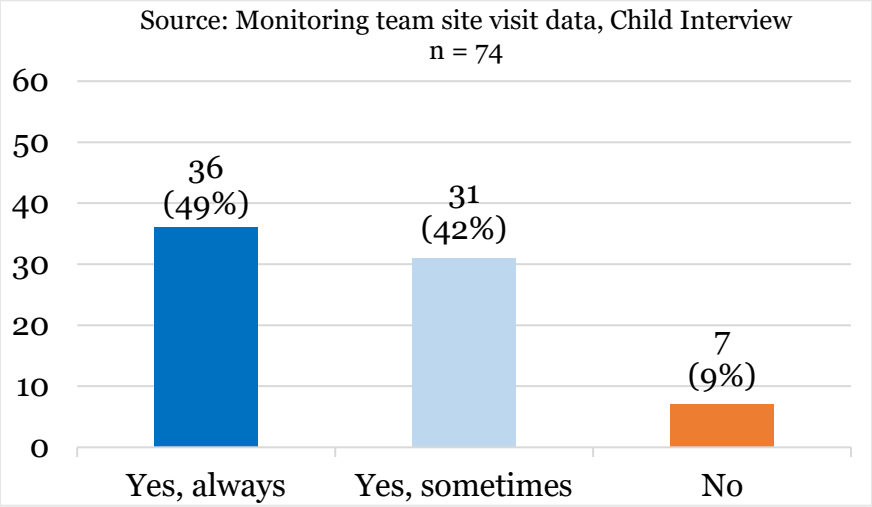
Of 71 children who responded to a question asking whether they had been bullied in the past or were currently bullied, 21 (30%) reported currently being bullied and another eight (11%) children reported having been bullied in the past.

Figure 46: Children Reporting Feeling Safe in Current Placement



Just fewer than half (36 of 74 or 49%) of children responded that they always felt comfortable talking to staff members if they needed something, while 42% (31 of 74) said they "sometimes" felt comfortable talking to staff members. Seven children (9%) reported they did not feel comfortable talking to staff members.

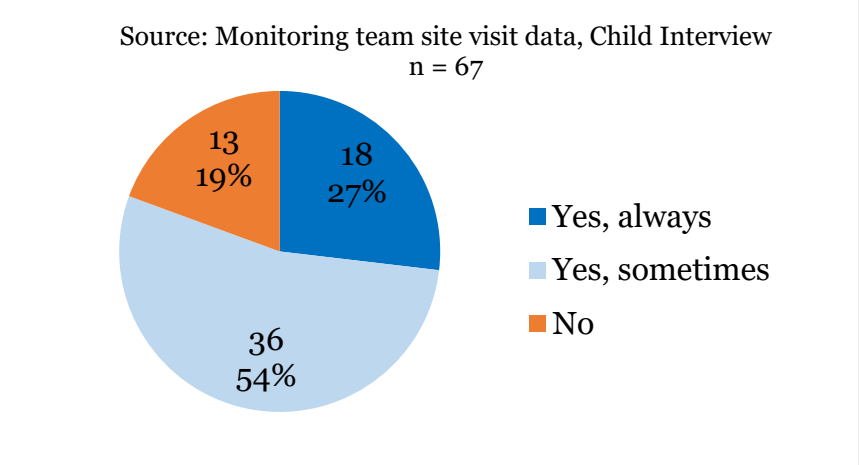
Figure 47: Children Reporting Feeling Comfortable Talking to Staff about Needs



Of the 74 children who responded to both questions about whether they felt safe and whether they were always comfortable talking to staff members, 20 (27%) reported that they did not always feel safe and were not always comfortable talking to staff members. Eight (40%) of these 20 children were placed at Guiding Light RTC, the remaining twelve children were placed at Camp Worth (4), Silver Lining (3), DePelchin Children's Center (2), Gold Star Academy (2), and Helping Hand Home for Children (1).

A child's caseworker is required to report allegations of abuse, neglect and exploitation to the hotline if the child makes an outcry of maltreatment. However, only 27% (18 of 67) of children said that when they called or texted their caseworker, their caseworker "always" answered or responded later. More than half (36 of 67 or 54%) said their caseworker "sometimes" answered or responded and 19% (13 of 67) said their caseworker did not answer or respond when they called or texted.

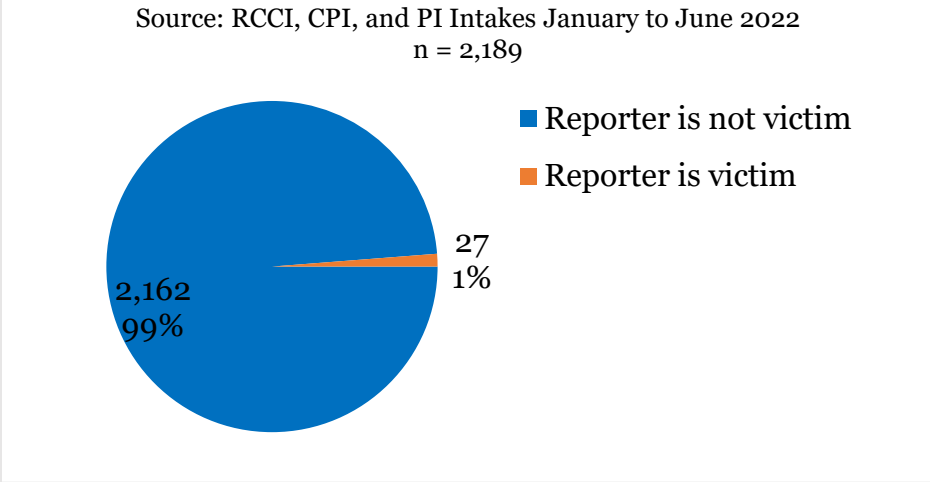
Figure 48: Children Reporting Whether Their Caseworker Answers or Responds to Phone Calls or Texts



Analysis of Abuse, Neglect and Exploitation Hotline Reporting, January to June 2022

The monthly hotline data submitted to the Monitors includes information detailing whether the alleged child victim was the reporter of the alleged abuse, neglect or exploitation. Between January 1, 2022 and June 30, 2022 there were 2,189 intakes to the hotline referred for investigation to RCCI, CPI, or PI for which the alleged victim was a PMC child[134] and the intake included information related to whether the reporter was the alleged victim or someone else.[135] A total of 27 of the 2,189 intakes (1%) were reported by the alleged victim.

Figure 49: RCCI, CPI, and PI Intakes, January to June 2022

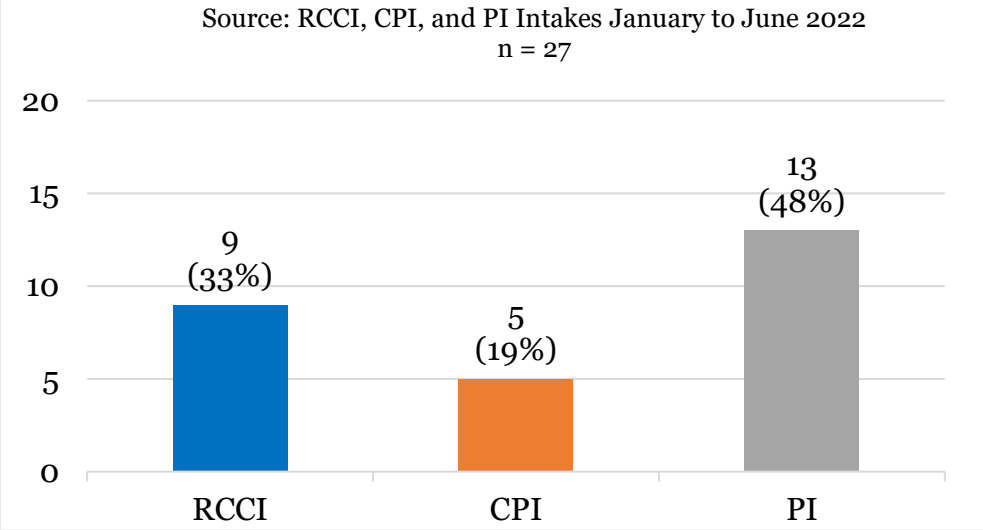


[134] According to data provided by the State, a total of 13,208 children had an active PMC status between January and June 2022.

[135] As discussed in the section for Remedial Order 3, RCCI's jurisdiction includes allegations in licensed residential settings, such as a GRO, RTC, or foster home. CPI's jurisdiction includes kinship or unlicensed placements. PI's jurisdiction includes state supported living centers, psychiatric or state hospitals, and private HCS homes. Intakes that did not include information allowing for a determination regarding the reporter were not included in the analysis.

Although intakes referred to PI were the smallest in number (172 of 2,189 or 8% of intakes), nearly half (13 or 48%) of the 27 intakes where the alleged victim was the reporter came from an intake referred to PI.[136] Overall, 13 (8%) of 172 of PI intakes were reported by the alleged victim compared to nine (0.8%) of 1,164 RCCI intakes and five (0.6%) of 853 CPI intakes.

Figure 50: Intakes by Investigation Type where Reporter is Alleged Victim



The Monitors reviewed the cases reported to the hotline by PMC children. Two of the investigations illustrate the importance of foster children understanding how to contact the hotline. One of them involved an 11-year-old child who was in a fictive kin placement at the time of the intake. The child reported that his foster father yelled at him, threatened to hit him, and pushed him, causing him to fall backward and hit his back on the stairs. The child reported that he was afraid of his foster father. During his interview, the child said that when his foster father pushed him down, he told him that "it was going to get worse for him," and that he called the hotline because he did not want that to happen. His foster father had reportedly broken his cell phone, but his foster mother allowed him to use her phone to call the hotline. The child was removed from the home, and CPI (DFPS) substantiated the allegations with a disposition of a Reason to Believe for Physical Abuse of the child by his foster father.

In another interview, a 17-year-old child who was in a court-ordered kinship placement with his aunt reported being pressured to use cocaine by his aunt and said he did not feel safe in the home.[137] The child called the hotline from a convenience store after running

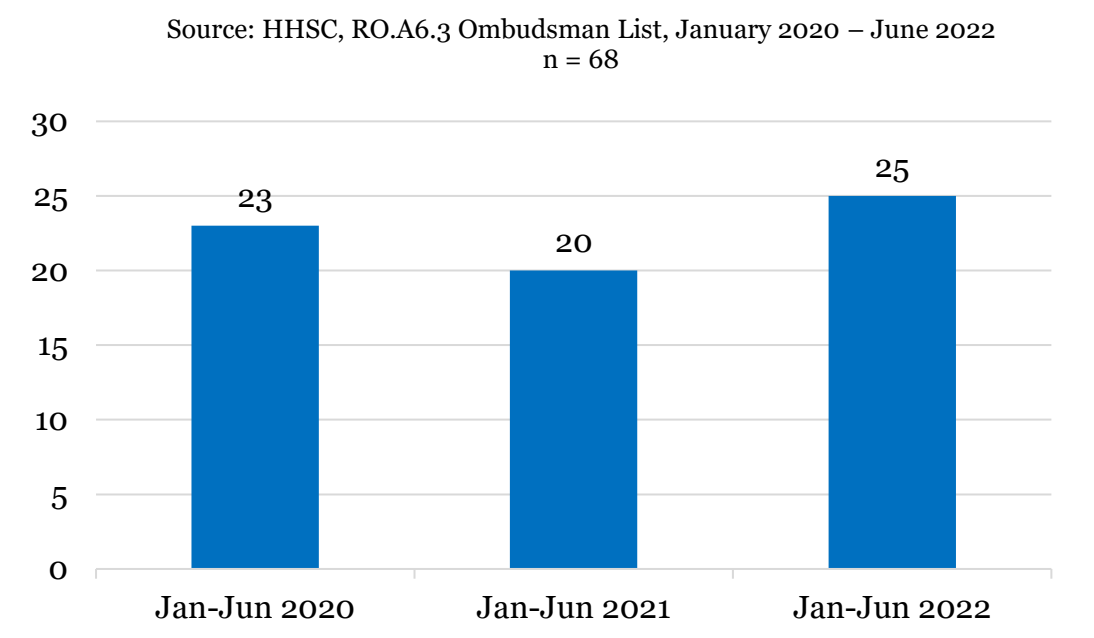
[136] Of these 13 intakes, five were reported by one child, and six were reported by another child. DFPS Ruled Out all of the allegations in the investigations following the 11 reports. The Monitors reviewed the investigations and do not disagree with the findings. Both children were placed in State Supported Living Centers when the reports were made.

[137] During the court hearing that resulted in the child's placement, CPS expressed concern about the home, citing the aunt's history of substantiations for Physical Neglect of her own children due to unsanitary

away. The child was removed from the home. DFPS-CPI investigated and made an Unable to Determine finding for Physical Abuse. The same home has been the subject of two subsequent reports to SWI related to two other children living in the home.

The Monitors also receive monthly data on complaints, in the form of phone calls, made by children to the Ombudsman that are reported to SWI by the Ombudsman. Between January and June 2022, the Ombudsman staff made 25 hotline reports resulting from a child's complaint to the Ombudsman. Five of the 25 SWI reports, or 20%, were made by children in CWOP settings. The substance of the children's complaints included concerns related to inappropriate behavior, abuse or neglect by staff, Medical Neglect, and feeling unsafe. These numbers have remained relatively consistent over the course of the Monitors' reporting.

Figure 51: Youth Complaints to Foster Care Ombudsman Resulting in Notification to Statewide Intake



Summary

conditions in the home, including "feces on the wall, floor, and carpet." However, by the time of the hearing, the child had been cycling between CWOP settings and juvenile detention. According to a note in IMPACT, the Judge ordered the placement based on the child's wishes, age, and "to get him out of CWOP." When the caseworker brought the child to the placement, the aunt reported the household members were "in the middle of chores." The caseworker observed that the floor of the apartment "was very dirty with trash…and dog feces," noticed dirt on the walls in the living area "from about waist down," a bathroom sink with water standing in it (the child's aunt said they were having "sewage issues" and the landlord was supposed to come to fix it that day), and about "30 or more roaches" on the top of a door in the kitchen. In one of the back bedrooms, the caseworker observed several dogs in kennels and dog feces on the floor; according to the caseworker, there were six to eight large dogs, two small lap dogs, and seven to eight puppies living in the home.

- Nearly half of children who responded to all of the relevant questions (37 of 75 or 49%) reported having heard of the hotline, including four children who initially indicated they had not heard of the hotline, but changed their answer after a description was given.

- Among children interviewed, 41 of 76 (54%) had heard of the Bill of Rights; 17 responded "yes" to having heard of it only after a description was offered by the interviewer.

- Fewer than half of children interviewed (31 of 76 or 41%) had heard of the Ombudsman; 11 of them responded "yes" after a description was given by the interviewer for a total of 45 of 76 (59%) children.

- Overall, less than a quarter (17 of 75 or 23%) of children had heard of all three–the Bill of Rights, Ombudsman, and the hotline. The percentage of children who had heard of the Ombudsman and hotline varied significantly by operation. Young children were less likely to have knowledge about the Ombudsman and hotline than older children.

Remedial Order B5: Communicating Allegations to Caseworkers

Remedial Order B5: *Effective immediately, DFPS shall ensure that RCCL or any successor entity promptly communicates allegations of abuse to the child's primary caseworker. In complying with this order, DFPS shall ensure that it maintains a system to receive, screen, and assign for investigations, reports of maltreatment of children in the General Class, taking into account at all times the safety needs of children.*

Background

In its Contempt Order of December 18, 2020, The Court included specific instructions to the Monitors related to their validation of the State's compliance with Remedial Order B5:

> [T]he Court instructs the Monitors to assess Defendants' evidence and determine whether Defendants are "promptly communicat[ing] allegations of abuse to the child's primary caseworker." To implement the remedy to ensure that PMC children are free from an unreasonable risk of serious harm, compliance with Remedial Order B5 requires more than prompt communication to the caseworker of the existence of an allegation. It requires that caseworkers receive prompt communication of "allegations of abuse." Therefore, the Court instructs the Monitors that in their assessment of Defendants' compliance with this Remedial Order, they must assess whether Defendants "promptly communicate [ ]" the substance of the "allegations of abuse" to "the child's primary caseworker."
>
> Furthermore, Remedial Order B5 requires that Defendants "maintain [ ] a system to receive, screen, and assign for investigation, reports of

> maltreatment of children in the General Class, taking into account at all times the safety needs of children." The Monitors are therefore instructed to continue to assess not just whether Defendants are maintaining a system for receiving, screening, and assigning for investigation allegations of child maltreatment, but also that it "takes into account at all times the safety needs of children."[138]

After entry, DFPS changed its policies to conform compliance to the requirements articulated in the Court's Order. However, as discussed in the Monitors' Third Report, the State struggled to implement the new policies, which require that caseworkers be notified of the substance of any allegations of abuse, neglect or exploitation for a child on their caseload in an "I&R Notification" in IMPACT.[139] The caseworker is required to document an "I&R Notification Staffing" contact (staffing contact) in IMPACT within one business day of receiving the notification.[140] DFPS requires the staffing contact to include: a copy of the notification, notes of the discussion between the caseworker, their supervisor, and program director, consideration of the child's safety needs, and any follow-up action identified during the staffing related to the child's safety.[141] If follow-up is required, the caseworker must document its execution and the results in a subsequent IMPACT contact.[142] In the Third Report, the Monitors reported on case record reviews, which showed that I&R Notification Staffings were absent in 38% (248 of 654) of the RCCI intakes included in the sample. Results were worse for the samples of CPI and PI intakes, where I&R Staffings were absent in 71% (263 of 373) of CPI intakes and 60% (70 of 117) of the PI intakes.

For this report, the monitoring team conducted case record reviews for a randomly selected sample of 387 RCCI, 312 CPI, and 99 PI intakes alleging child maltreatment received during the months of January, March, and June 2022. If the randomly selected sample included an intake for a child that DFPS linked to other intakes, all the linked intakes were included in the analysis.

Performance Validation

Review of Automated Notification for RCCI Intakes

The monitoring team's case record review included evaluation of the timing of the automated notification sent to caseworkers when a report of alleged maltreatment was made to SWI. The monitoring team found an automated notice to the caseworker in 100% of the 387 RCCI intakes included in the case record review. Most notifications (63% or 244 of 387) occurred on the same day as the intake; the remainder (37% or 143 of 387) occurred on the day after the intake. The average time from intake to system-generated notice to the caseworker was 0.37 days.

---

[138] Order 327, ECF No. 1017.
[139] Deborah Fowler & Kevin Ryan, Third Report 71, ECF No. 1165.
[140] *Id.*
[141] *Id.*
[142] *Id.* at 71-72.

The monitoring team did not find an automated notification to caseworkers in IMPACT for any of the CPI or PI intakes included in the case record review.

The monitoring team also compared the date of the automated notification included in the monthly RCCI intake data produced by the State with the information the monitoring team found in IMPACT. All the 387 RCCI intakes in the sample matched the notification date included in the monthly data.

The Monitors also evaluated the time between DFPS's receipt of the RCCI intake and the automated notification to the caseworker using the monthly SWI data produced by the State.[143] For RCCI intakes, the average time between intake and the system-generated notification to the caseworker was 11 hours and 17 minutes.

Review of IMPACT Case Contacts for RCCI, CPI, and PI intakes for I&R Notification Staffing

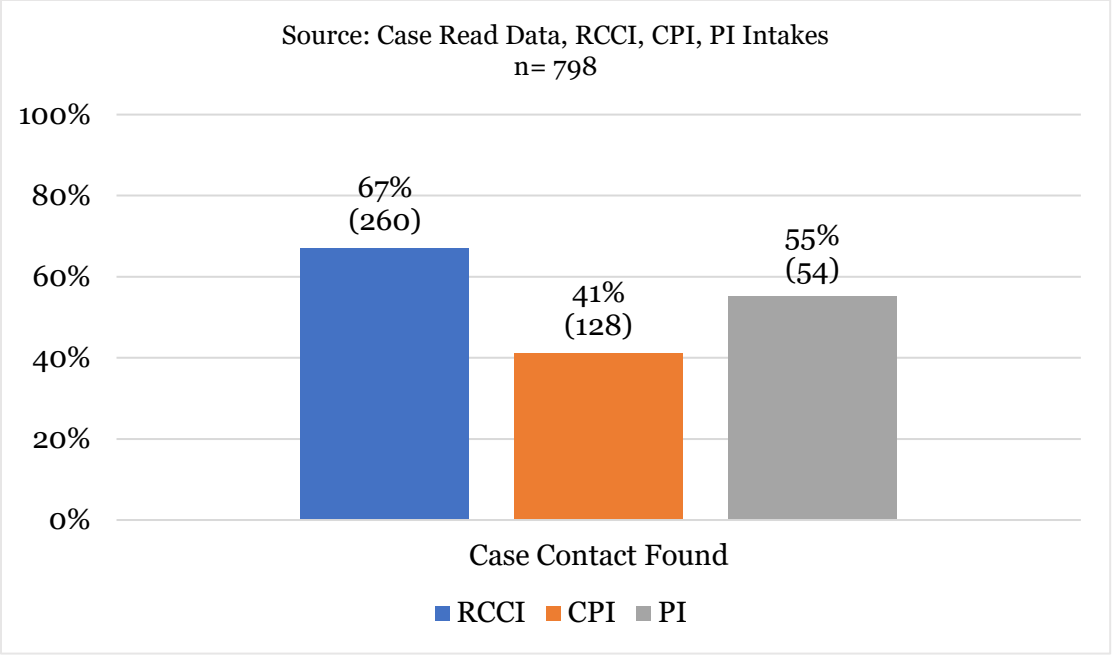
After receiving notification of an intake alleging child maltreatment, a caseworker is required to review the intake, discuss the intake with their supervisor and/or program director, and contact the RCCI or CPI investigator for additional information. The caseworker is expected to create a staffing contact in the child's IMPACT record and to document the following in the contact: a copy of the I&R Notification (which includes the allegations) and notes related to the staffing with the caseworker's supervisor and/or program director, including consideration of the child's safety needs and any actions taken or plans for future action needed to ensure the child's safety.

During the case record review, the monitoring team identified a staffing contact for most RCCI and PI intakes but did not find a staffing contact for most of the CPI intakes.[144] Of the 387 RCCI intakes, the monitoring team found a staffing contact for 67% (260 of 387). Of the 99 PI intakes, the monitoring team found a staffing contact for 55% (54 of 99) and for 41% (128 of 312) of the CPI intakes.

Figure 52: Percentage of Intakes with a Case Contact Found by Intake Type

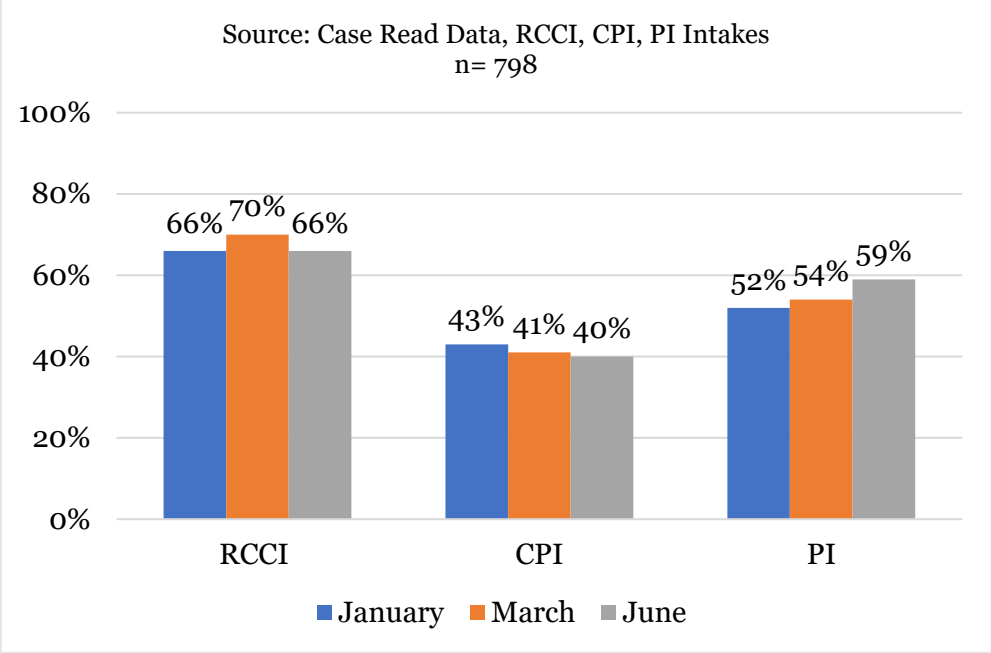
[143] This data included information related to the automated I&R Notification, and the timing of the I&R Notification Staffing for RCCI.

[144] Of the contacts found across all intake types, 84% (371 of 442) were documented using an I&R A/N Notification Staffing contact and 71 (16%) were documented using another type of contact. Monthly data produced by the State related to RCCI intakes include a data field titled, "Date of 1st A/N Notification Staffing Contact." During the case record review for RCCI intakes, when the monitoring team found an I&R Notification Staffing contact rather than another type of contact, the Monitors compared the date included in the data field for the monthly data with the date found in the IMPACT contact. In the 234 RCCI intakes where the contact found in IMPACT during the review was an I&R A/N Notification Staffing, the contact date in IMPACT matched in 91% (214 of 234). Of the remaining 20 intakes, the date did not match for 12 of the contacts, and eight of the 234 contacts found in IMPACT were not included in the monthly data produced by the State. Of the 153 RCCI intakes included in the case record review for which a contact documenting the I&R Notification Staffing was not found by the monitoring team, the monthly data included an I&R Notification Staffing date for 37% (57 of 153).



The percentage of case contacts found during the case read varied slightly by month.

Figure 53: Percentage of Intakes with a Case Contact Found by Type and Month



The time from intake to the staffing contact varied; however, across all three intake types (RCCI, CPI, PI), staffing contacts most frequently occurred the same day as the intake.

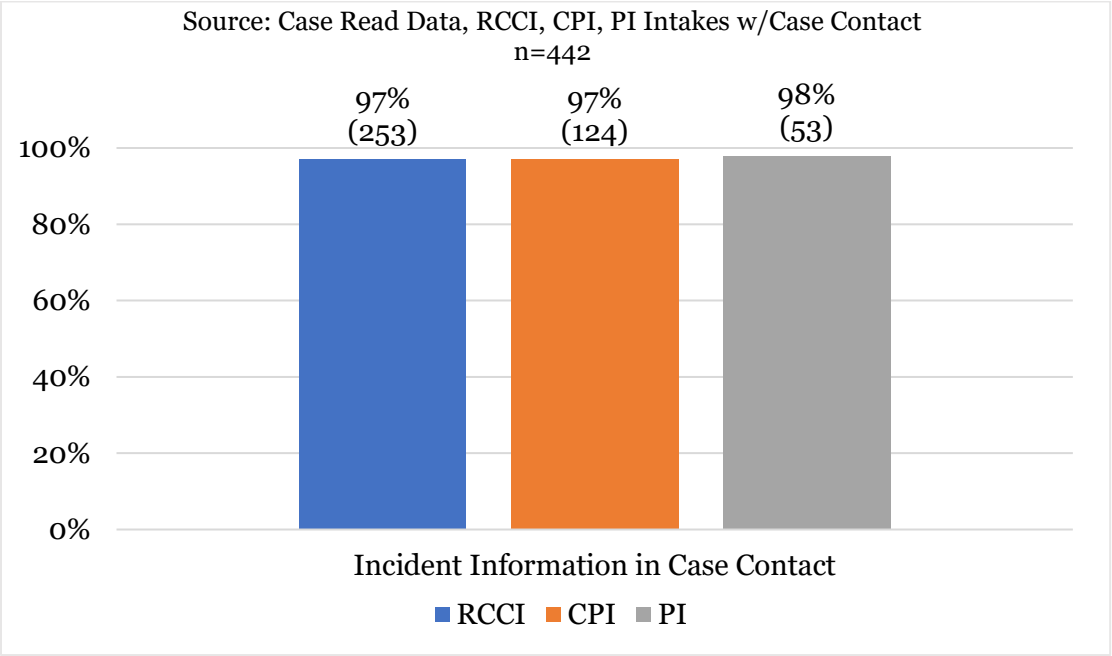
The average time between intake and the staffing contact was under two days across all three intake types.[145]

Table 11: Intakes with a Case Contact Found and Timing from Intake to Contact by Intake Type

	RCCI Intakes (n=387)		CPI Intakes (n=312)		PI Intakes (n=99)	
Intake to Case Contact – Up to Two Days Prior	1	LT 1%	3	2%	1	2%
Intake to Case Contact-Same Day	101	39%	58	45%	26	48%
Intake to Case Contact-Next Day	80	31%	24	19%	16	30%
Intake to Case Contact-2+ Days	78	30%	43	34%	11	20%
Total Case Contact Found (#/%)	**260**		**128**		**54**	
Average Days–Intake to Case Contact	**1.61 Days**		**1.97 Days**		**1.28 Days**	

The monitoring team found that nearly all the staffing contacts across all intake types (RCCI, CPI, and PI) included information about the alleged abuse, neglect or exploitation.

Figure 54: Case Contacts with Incident Information



[145] The State produces monthly SWI data to the Monitors that also includes a field for the date and time the I&R Notification Staffing occurred. However, the Monitors' case record reviews have identified instances in which the caseworker documented the date of the staffing within the contact narrative, and this date was different from the date found in the contact detail. In addition, the monitoring team found instances in which the contact detail date entered by the caseworkers was weeks, and even months, before the system timestamp for the creation of the staffing contact. For this reason, the contact detail date in the SWI data cannot be used to validate the date that an I&R Staffing was held.

Some staffing contacts did not include any information except the information about the alleged abuse, neglect or exploitation: 34% (44 of 128) of staffing contacts related to CPI intakes did not contain any additional information, compared to 32% (17 of 54) of staffing contacts related to PI intakes, and 14% (36 of 260) of staffing contacts related to RCCI intakes.

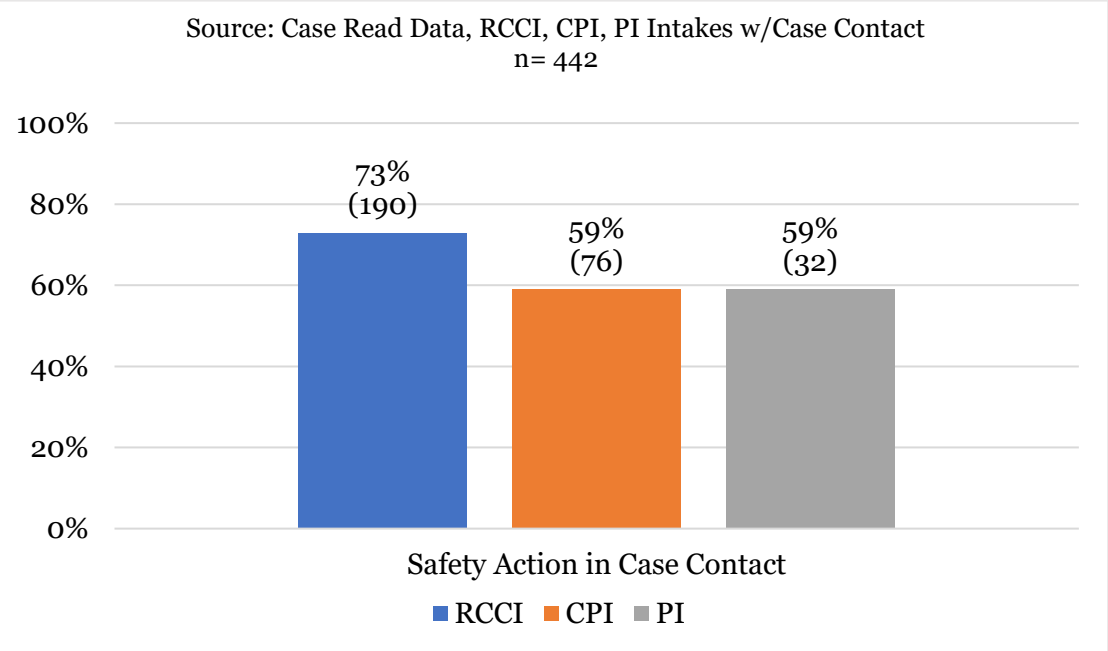
Most of the contacts found across all intake types included notes describing a staffing between the caseworker, supervisor and/or program director.

Table 12: Case Contacts with a Staffing Documented by Intake Type and Month

	RCCI Case Contacts (n=260)		**CPI Case Contacts** (n=128)		**PI Case Contacts** (n=54)	
Total Case Contacts with Staffing Documented	**209 (80%)**		**74 (58%)**		**30 (56%)**	
Staffing Documented-January	57	74%	18	47%	7	41%
Staffing Documented-March	86	88%	26	53%	16	76%
Staffing Documented-June	66	78%	30	73%	7	44%

When the monitoring team found a staffing contact, the contact documented that the caseworker planned to take some action to ensure the child's safety in more than half of the CPI and PI intakes and in almost three quarters of the RCCI intakes.

Figure 55: Case Contacts with Safety Action Documented



The staffing contact related to some intakes indicated that the caseworker planned to take more than one action to ensure the child's safety:

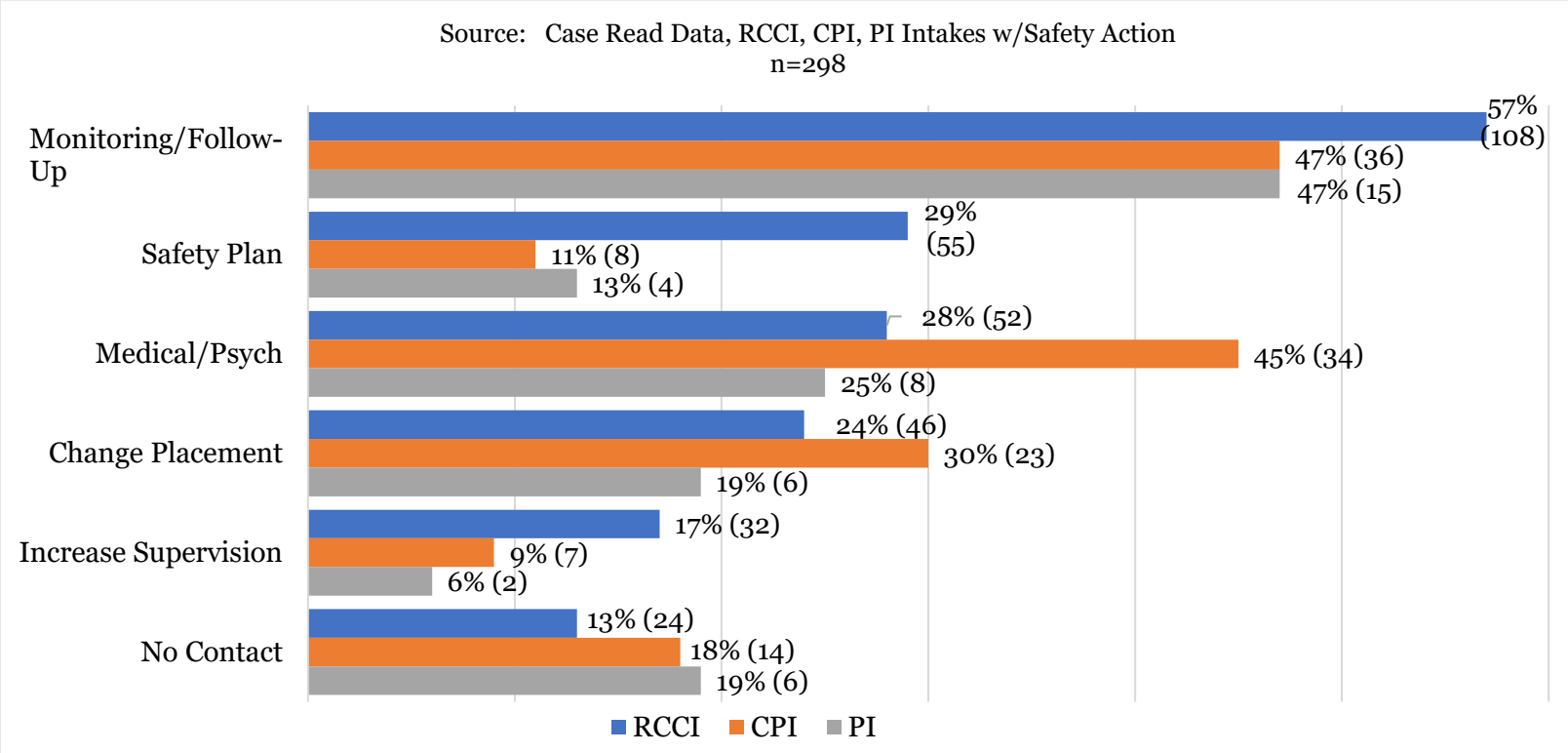
- Forty-six percent (87 of 190) of staffing contacts related to an RCCI intake that documented a safety action planned or taken included one safety action; 30% (56 of 190) included two; and 24% (47 of 190) included three or more.

- Forty-three percent (33 of 76) of staffing contacts related to a CPI intake that documented a safety action planned or taken included one safety action; 43% (33 of 76) included two; and 14% (10 of 76) included three or more.

- Sixty-nine percent (22 of 32) of staffing contacts related to a PI intake that documented a safety action planned or taken included one safety action; 22% (7 of 32) included two; and 9% (3 of 32) included three or more.

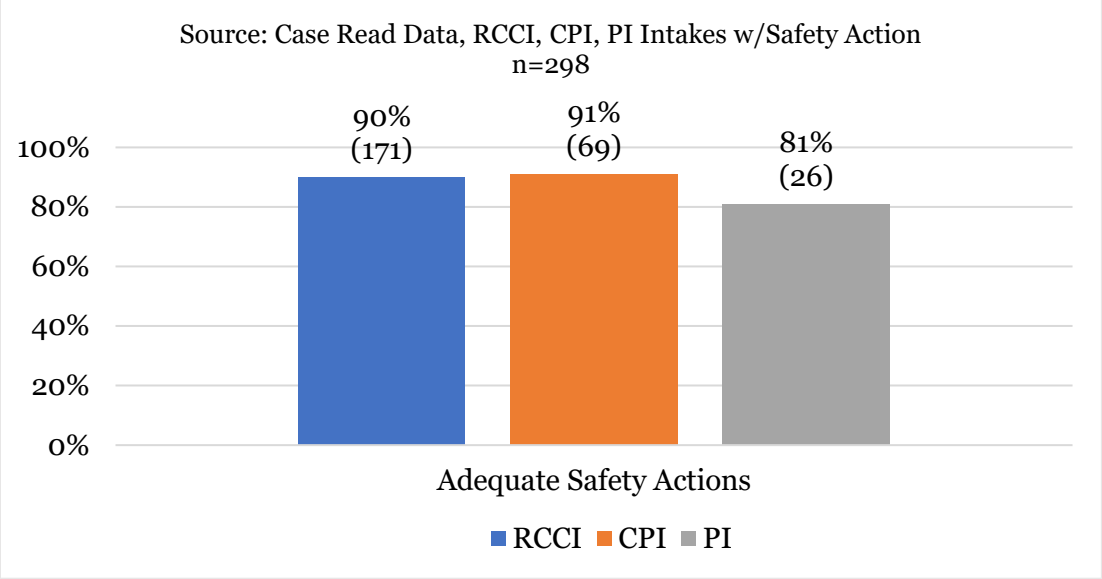
The most common safety action documented during the case record review across all intake types was continued monitoring and follow-up. The type of monitoring and follow-up found in staffing contact notes included: monitoring the outcome of the investigation, visiting the operation or foster home, and talking with children, staff, foster parents, law enforcement, the investigator on the case and others with information about the incident or the child.

Figure 56: Safety Actions Documented in RCCI, CPI, and PI Case Contacts



The monitoring team reviewed the allegations and documented safety actions included in the staffing contacts to determine whether sufficient action was taken to ensure the child's immediate safety. In most cases, the monitoring team determined that the documented safety action was sufficient.

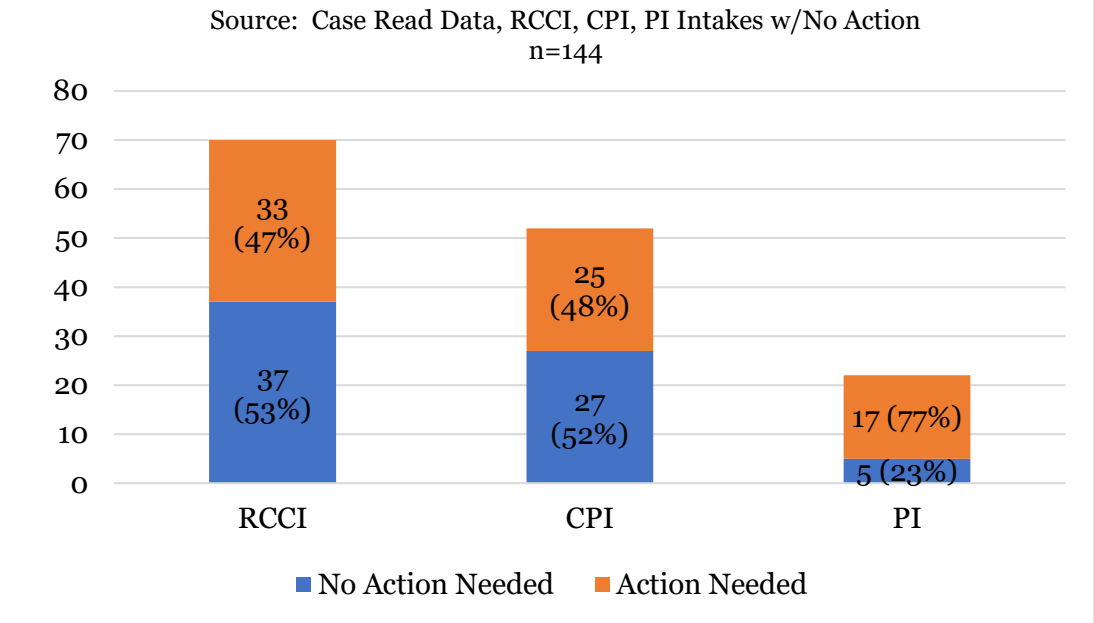
Figure 57: Percentage of Documented Safety Actions that Adequately Ensured the Immediate Safety of the Child



When the monitoring team determined that additional action should have been taken, the actions that were most often needed included: training of operation staff or foster parents, increased supervision for the child, development of a safety plan for the child, and ensuring there would be no contact between the child and alleged perpetrator.

Of the 442 intakes for which the monitoring team found a corresponding staffing contact, 144 (33%) did not include any notes documenting that the caseworker planned to take some action to ensure the child's safety. Of these 144 intakes, the monitoring team determined some action should have been taken to ensure child safety in almost half of cases involving an RCCI or CPI intake and in over three-quarters of PI intakes.

Figure 58: Case Contact with No Safety Action Documented and Whether Action Was Needed



The staffing contacts that the monitoring team identified during the case read that did not document any action taken to ensure the child's safety included:

- A staffing contact for a March 12, 2022 intake involving a 16-year-old non-verbal PMC child with a developmental disability that documented allegations that the child was picked up by the local police after wandering away from his Home and Community-Based Services (HCS) group home. The contact indicated the child was found in a traffic median at the intersection of two busy highways during rush hour. The local police who reported the incident to SWI said that this was not the first time the police department had been in contact with the child; the law enforcement official who made the report to SWI said the child ran away from the home frequently and that police had picked him up multiple times.[146] The staffing contact did not document any action taken to determine whether a safety plan or some other step was needed to ensure the child's safety, despite the serious concerns presented by the report to SWI. As of October 28, 2022, the PI investigation does not appear to have been completed.

- A staffing contact for a January 19, 2022 intake involving a 16-year-old PMC child who is autistic and has a history of suicidal ideation and other mental health needs

[146] The child was first placed in the HCS group home in 2018. This child's most recent service plan indicates that he is diagnosed with autism spectrum disorder, speech impairment, moderate cognitive impairment, and attention-deficit/hyperactivity disorder (ADHD). It notes that the local My Health My Resources (MHMR) accepted him into services for ABA Therapy but that he was terminated in 2020 after missing two consecutive sessions. He was placed back onto the top of the waiting list "with the understanding that [the child] will attend sessions on a regular schedule." The service plan further notes that the MHMR "reached out in September 2021 to schedule an appointment but due to lack of communication [the child] was again taken off of the list to receive services." This note, in conjunction with the notes indicating the child frequently wanders from the HCS group home, raised serious concerns about whether the home can meet his needs. Yet, according to IMPACT, the child remains in the placement.

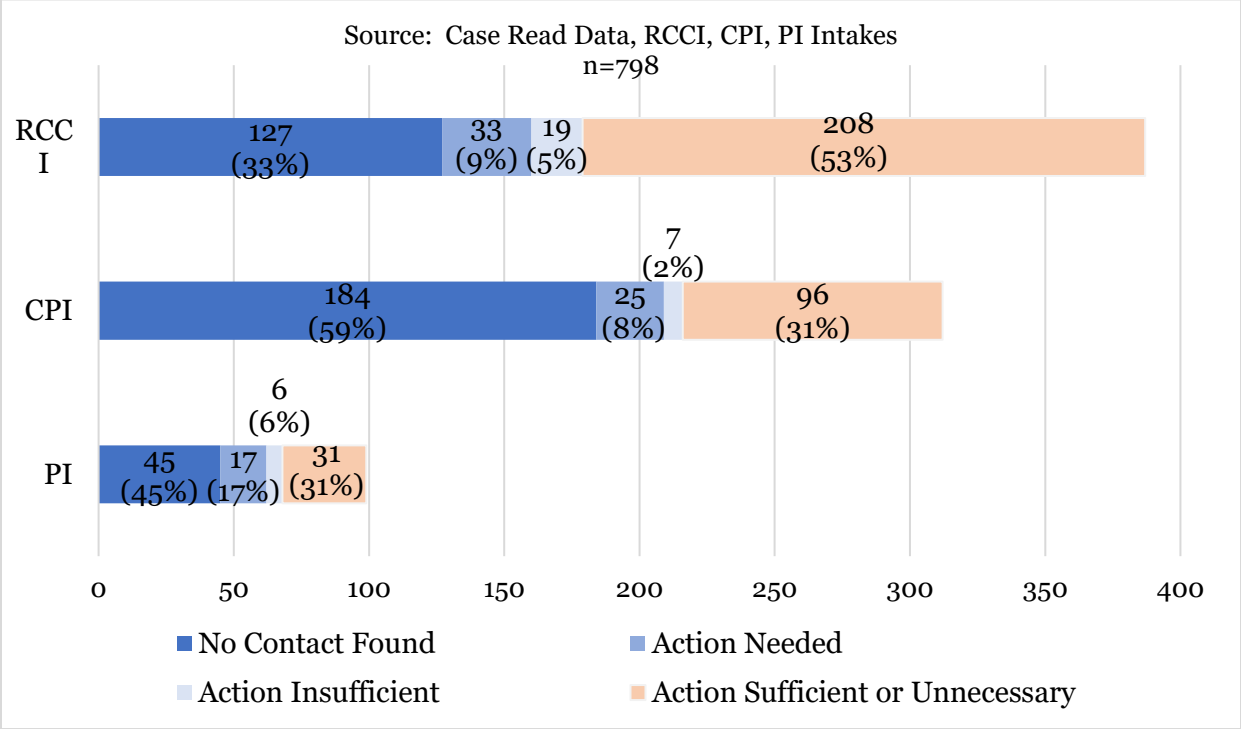
that documented allegations that the child was not given his medication because the facility, a Residential Treatment Center (RTC), "ran out of [the child's] meds and didn't realize it," and "forgot to fill [the child's] prescriptions." The staffing contact indicated the child required an emergency psychiatric hospitalization. The SSCC caseworker did not document any steps taken to ensure that the facility would be an appropriate setting for the child to return to, despite the serious allegations. A face-to-face visit between the child and a caseworker occurred six days after the staffing contact was entered into IMPACT; the caseworker who made the visit does not appear to have asked the child about the missed medication. The RCCI investigation was not completed until April 25, 2022, and while it did not result in a substantiated finding of Medical Neglect, the investigator found that the child had missed a dose of the medication prescribed for "Mood, anger, and aggression" prior to his hospitalization and that there were "inconsistencies contained in the medication documentation." The child remained in this placement until he was discharged approximately eight months later.

- A staffing contact for a March 29, 2022 intake involving a 13-year-old PMC child who told the caregiver in his HCS group home that, in a previous placement, he had acted out sexually with a younger child in the placement. The day before the intake, a caseworker made a face-to-face visit to the child's placement. The notes for the visit indicate that the child "still has behavior issues that need to be addressed. [The child] continues to get on the computer without permission and access web sites that are not appropriate." Despite the child's outcry and the notes made during the face-to-face visit the day before, there is nothing in the staffing contact indicating that the caseworker took steps to determine whether other children were placed in the home and to ensure that supervision in the home was appropriate.

- Four staffing contacts for a March 28, 2022 intake involving an 11-year-old child placed in an RTC who allegedly took two psychotropic medications that were not prescribed to him, rather than his own prescriptions. All four of the staffing contacts appear to be related to the same intake, though the contact notes indicate that subsequent blank I&R Notifications were received after the first. The second staffing contact indicates that the program director instructed the caseworker to follow up with the RCCI investigator and "stated if the placement becomes concerning after the follow up with the investigator, [they] may have to meet again and talk about moving the child." The caseworker said that she would be "sure to follow up" but the caseworker did not enter any subsequent contact notes indicating she had done so. The RCCI investigation did not result in a substantiated finding of Medical Neglect, but the operation received a citation for a minimum standards violation because "a staff gave a child another child's prescribed medication by mistake."

Overall, the monitoring team found an IMPACT staffing contact that documented appropriate action to ensure the child's safety in only 42% (335 of 798) of all intakes reviewed.

Figure 59: Whether Action Was Documented Ensuring Child Safety



Summary

The monitoring team conducted case record reviews for a randomly selected sample of RCCI, CPI, and PI abuse, neglect and exploitation intakes received during the months of January, March, and June 2022. The monitoring team ascertained that the time from SWI's receipt of an intake to the staffing contact varied across all three intake types (RCCI, CPI, PI). Some staffing contacts did not include any information except the information about the alleged abuse, neglect or exploitation. When the monitoring team determined that additional action should have been taken, the actions most often necessary included: training of operation staff or foster parents, increased supervision for the child, development of a safety plan for the child, and ensuring there would be no contact between the child and alleged perpetrator. Overall, the monitoring team found an IMPACT staffing contact that documented appropriate action to ensure the child's safety in 42% of all intakes reviewed.

Remedial Order 37

Remedial Order 37: *Within 60 days, DFPS shall ensure that all abuse and neglect referrals regarding a foster home where any PMC child is placed, which are not referred for a child abuse and neglect investigation, are shared with the PMC child's caseworker*

and the caseworker's supervisor within 48 hours of DFPS receiving the referral. Upon receipt of the information, the PMC child's caseworker will review the referral history of the home and assess if there are any concerns for the child's safety or well-being and document the same in the child's electronic case record.

Background

As discussed in the Monitors' Second and Third Reports, the State's restrictions around the practice of downgrading abuse, neglect and exploitation intakes for children in licensed placements dramatically reduced the number of downgraded intakes. DFPS's current protocol only permits these intakes to be downgraded to PN when the allegations were previously investigated or fall outside RCCI's jurisdiction to investigate. The Monitors' Third Report found that, for the five-month period reviewed, only three downgraded intakes required a Home History Review (HHR) and staffing, pursuant to Remedial Order 37, down from 129 that required an HHR and staffing for the seven-month period reviewed for the Monitors' Second Report.[147] Since the Monitors filed the Third Report, the only change to policy related to HHRs clarified the process for creating an HHR for downgraded intakes involving an out-of-state foster home.[148]

Performance Validation

Based on data provided by the State, the Monitors identified 22 hotline intakes downgraded to PN between January 1, 2022 and June 30, 2022 that related to a PMC child placed in a foster home.[149] The monitoring team reviewed case records associated with the intakes and determined that none of the incidents occurred while the PMC child was placed in a foster home.

The monitoring team reviewed four HHRs completed and provided by the State between January 1, 2022 and June 30, 2022.[150] The monitoring team's review of these HHRs and the case records associated with the four downgraded intake reports found concerns in two of the four:

---

[147] Deborah Fowler & Kevin Ryan, Third Report 85, ECF No. 1165.
[148] DFPS, *Child Protective Services Handbook*, Redlined §4221.1 (Feb. 1, 2022) (on file with the Monitors).
[149] Between January 1, 2022 and June 30, 2022, the State reported 1,169 RCCI intakes to SWI involving a PMC child; 30 were subsequently downgraded to PN. The PN closure reason provided for these cases included "incident jurisdiction of other DFPS program," (19 or 63%), "incident addressed in previous case," (5 or 17%), and "incident responsibility of other agency/out-of-state," (6 or 20%).

SWI intake data includes a data field entitled "Private CPA or CPS acting as CPA," defined as "an indicator for whether the entity that the subject of the intake is a private Child Placing Agency (CPA) or Child Protective Services acting as a CPA (RCCI)." Of the 30 intakes downgraded to PN, 22 cases were identified as involving a PMC child in a foster home and had "CPS as CPA" or "Private CPA" indicated for the data field. None of these children were living in foster homes at the time of the incidents.
[150] All four HHRs identified a TMC child as the alleged victim named in the intake. However, DFPS documented a total of five other foster children living in the four homes under review, three of whom were identified in the HHRs as PMC children. The Monitors verified the legal status of each of the nine children identified in the reports and found that, at the time of the intake under review, two children misidentified in the HHRs as TMC were PMC children.

- On April 24, 2022, SWI received a report that a child said she had been sexually abused in a previous foster home. DFPS determined that the allegations had been investigated and Ruled Out in 2021. However, at the time of the intake, a PMC child was living in the foster home. While the child's IMPACT event list did not include a system-generated notification of the intake, the child's records indicated an HHR staffing between the caseworker and supervisor occurred on April 26, 2022. The contact contained the completed HHR and did not identify any safety concerns but identified several follow-up steps for the caseworker which included: obtaining the Home Study for the foster home from the CPA to identify males living in the home and asking the child to identify who frequented the home and who had access to her. After obtaining this information, the caseworker was supposed to restaff the case. No subsequent staffing contact was documented in the child's electronic record to evidence whether the caseworker took the steps assigned to her.

- On June 8, 2022, SWI received a report that a child placed in an emergency shelter told his CASA advocate that one of the other children living in the shelter had sexually assaulted his brother in a previous placement. The reporter said that the child expressed concern about being placed with the child who allegedly assaulted his brother. The sexual assault allegation was reported to SWI on April 1, 2022, and DFPS investigated and Ruled Out Neglectful Supervision. The June 8, 2022 intake was downgraded based on this prior investigation.

  At the time of the June 8, 2022 intake, an 11-year-old PMC child was living in the foster home where the sexual assault allegedly occurred. The monitoring team's review of the PMC child's IMPACT records found the event list contained a system-generated notification of the intake dated June 9, 2022, and documentation showing that an HHR staffing occurred on June 10, 2022. The IMPACT contact narrative for the staffing includes the completed HHR and reflects a staffing between the child's caseworker and supervisor. The caseworker and supervisor did not find that any immediate interventions were necessary. However, they expressed concerns that the 11-year-old would not speak to anyone during the investigation, and that when the child was interviewed by the long-time caseworker, the child "was not very verbal." The child's caseworker was to follow up with the child's therapist to determine whether the therapist had any concerns about the placement. The child was removed from this foster home at the end of June 2022.

  On July 19, 2022, the DFPS Complex Investigations Team reopened the original Neglectful Supervision investigation received on April 1, 2022, after the Conservatorship Quality Assurance Team determined that an incorrect disposition was assigned to the case. The disposition was changed to Reason to Believe after DFPS determined that the foster parents were "blatantly negligent in their supervision which led to the sexual abuse of children in their care."

  The monitoring team's review of CLASS records showed that this foster home had been verified since October 8, 2001 by three different CPAs. From 2021 until the

date of the home's closure, the State had opened 28 investigations of the home: ten for abuse, neglect or exploitation and 18 for minimum standards violations. Four of the investigations resulted in citations for minimum standards violations related to supervision. The foster home was closed on August 11, 2022.

The State's Case Reads

The State conducted two case reads that overlapped with the period reviewed by the Monitors for this report: the first covered the second quarter of the Fiscal Year 2022, or December 1, 2021 through February 28, 2022.[151] Of the 13 reports of abuse, neglect or exploitation made to SWI that involved a PMC child placed in a foster home and later downgraded to PN, only one required an HHR. Of the remaining 12:

- Six involved an incident that did not occur in a licensed foster home;
- Three were called back into SWI for an investigation;
- One was for a foster home that was no longer open;
- One was for a home where no children were placed; and
- One already had an investigation open on the foster home.

In the case requiring an HHR, the State found that the HHR was completed 30 minutes outside of the 48-hour time frame required by DFPS policy. An accurate summary of the HHR was found in the narrative, as was the summary of the staffing with the supervisor, and details or actions taken by the caseworker or supervisor.

The State's second case read covered March 1, 2022 through May 31, 2022, or the third quarter of Fiscal Year 2022.[152] Of the 19 reports made to SWI involving a PMC child placed in a foster home that were downgraded to PN, none required an HHR. Of the 19 reports:

- Eighteen involved an incident that did not occur in a licensed foster home; and
- One was determined to have occurred years ago.

Summary

The Monitors' review of 22 intakes downgraded to PN involving PMC children between January 1, 2022 and June 30, 2022 revealed that none of the incidents occurred while any PMC child was placed in a verified foster home. The monitoring team also reviewed records associated with four HHRs produced by the State between January 1, 2022 and June 30, 2022. The review raised concerns in two of them. In one, the Monitors found no evidence a required restaffing occurred. In another, after a subsequent allegation was downgraded to PN due to a previous investigation, DFPS's Complex Investigation Team reviewed the underlying investigation that preceded the downgrade and determined that it was Ruled Out in error. A PMC child was still living in the foster home at the time the

[151] DFPS, *Home History Case Review Results*, December 2021-February 2022 Review/Quarter 2-Fscal Year 2022 (undated) (on file with the Monitors).
[152] DFPS, *Home History Case Review Results*, March 2022-May 2022 Review/Quarter 3-Fiscal Year 2022 (undated) (on file with the Monitors).

intake was downgraded to PN and, thus, not investigated. Though IMPACT records showed the caseworker and supervisor documented concerns during their HHR staffing based on the child's demeanor during the investigation that preceded the downgraded intake, the child remained in the home for weeks.

The State conducted two case reads during the applicable period. Of the 13 reports made to SWI involving a PMC child placed in a foster home, later downgraded to PN status, DFPS determined only one report required an HHR.

Organizational Capacity

Remedial Order 1: CPS Professional Development

Remedial Order 1: *Within 60 days, the Texas Department of Family Protective Services (DFPS) shall ensure statewide implementation of the CPS Professional Development (CPD) training model, which DFPS began to implement in November 2015.*

Background

As discussed in the Monitors' first three reports, the training model ordered in RO 1 is required both for DFPS caseworker training, as well as for SSCCs that enter Stage II of the CBC model, at which time DFPS transitions responsibility for casework services to the SSCCs. The Monitors' prior reports analyzed the training programs adopted by the first two SSCCs (OCOK and 2Ingage) to transition to Stage II. The Third Report confirmed that the abbreviated training that 2Ingage initially adopted was inconsistent with the CPD training model but noted that the SSCC transitioned to the full CPD training in March 2021. This analysis is the first for both the revised 2Ingage training program for the St. Francis training program, as St. Francis transitioned to Stage II after the Third Report was filed.[153]

Performance Validation

Caseworkers Hired and Trained by DFPS

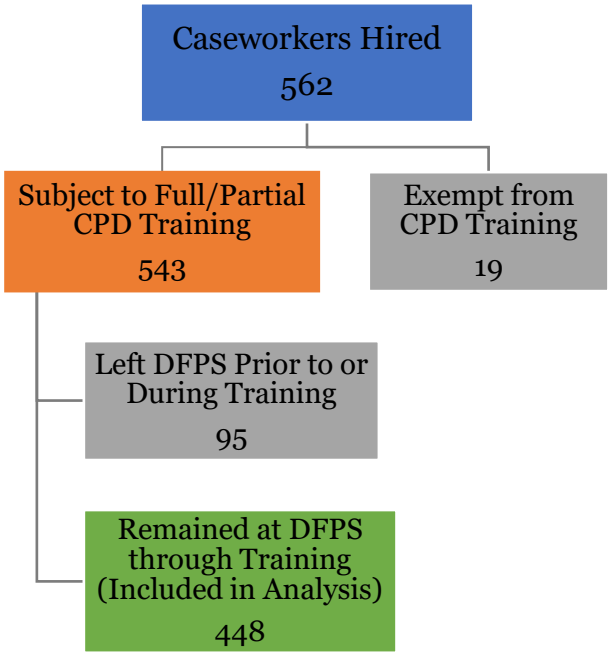
DFPS hired 562 caseworkers between September 1, 2021, and March 31, 2022.[154] Of those caseworkers hired, 543 (97%) were subject to full or partial CPD training prior to being

[153] The fourth SSCC, Belong, transitioned to Stage II in October 2022. The Monitors will assess their performance in future reporting.

[154] Data limitations discussed in the Monitors' previous reports still apply. *See* Deborah Fowler & Kevin Ryan, Third Report 92, ECF No. 1165. The analysis included in this report covers a cohort of all CVS caseworkers hired (including transfers and rehires) by either DFPS or an SSCC between September 2021 and March 2022. This cohort was tracked through July 31, 2022 to give adequate time for caseworkers hired in March to complete CPD training. The case assignable date is the date used as a proxy for training completion because DFPS and the SSCCs have not been able to provide actual training completion dates (OCOK provides a cohort completion date; but it is estimated, not actual).

assigned cases, while 19 (3%) staff, including 11 transfers and eight rehires, were exempt from training. Ninety-five (18%) of 543 caseworkers hired who were subject to CPD training left the agency prior to or during CPD training and were excluded from the Monitors' analysis, which tracked a total of 448 caseworkers.

Figure 60: DFPS Caseworkers Hired September 2021 – March 2022 and Included in CPD Training Completion Analysis



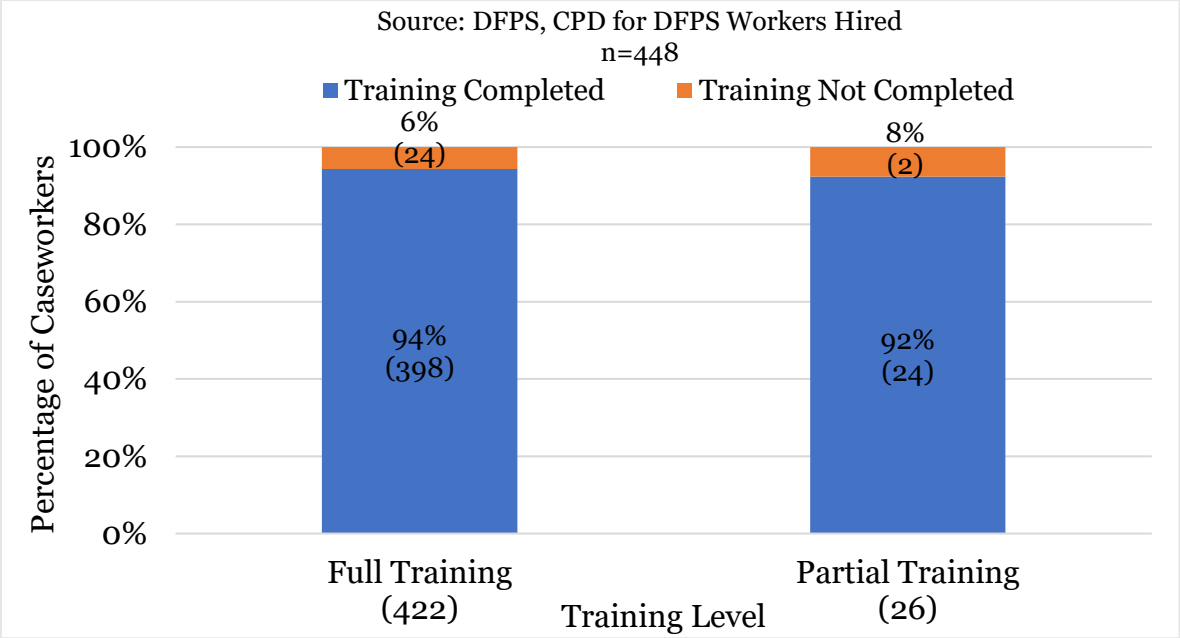
Four hundred forty-eight DFPS caseworkers were subject to the completion of full or partial CPD training, including 422 requiring full training (339 newly hired staff and 83 transferred and rehired staff) and 26 (6%) transferred and rehired caseworkers who were subject to partial CPD training. Of the 448 caseworkers subject to completion of full or partial CPD training, 422 (94%) caseworkers completed the training by July 31, 2022.

According to DFPS, CPD training takes an average of 13 weeks (91 days) to complete. Of the caseworkers subject to training, 398 of 422 (94%) had completed full CPD training and 24 of 26 (92%) had completed partial CPD training by July 31, 2022. The time to complete full CPD training ranged from 66 to 291 days,[155] with an average of 99 days.

Seven of the 398 caseworkers who completed full CPD training did so more than seven and up to 25 days earlier than expected given the DFPS timeline of 91 days to completion. DFPS did not provide an explanation for the early completion.

[155] One caseworker, a stipend student, was reported to have completed training (case assignable) prior to their cohort's training start date. Stipend students complete training prior to being hired as caseworkers. For caseworkers subject to partial CPD training, the average time taken to complete was 78 days.

Figure 61: DFPS Caseworker CPD Training Completion by Training Level



The State did not provide data and information to validate completion of CPD training for 26 caseworkers (15 new hires and 11 transfers or rehires). Of these 26 caseworkers, four were identified as caseworkers with full caseloads before July 31, 2022.[156]

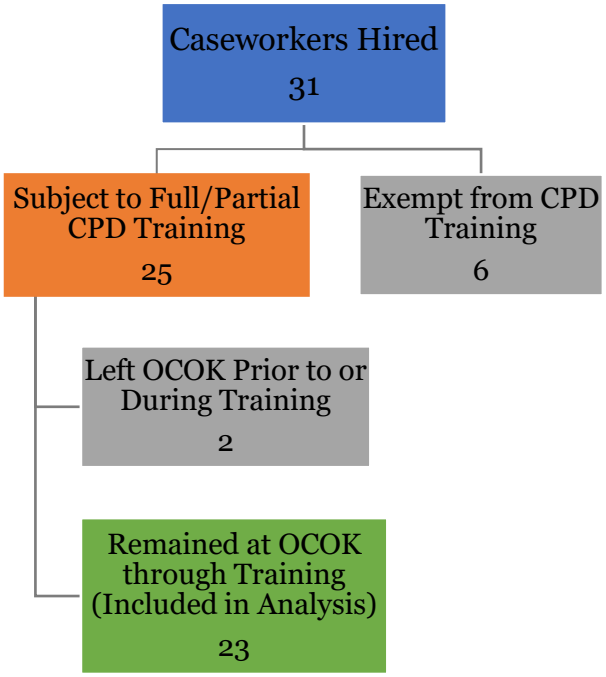
Caseworkers Hired and Trained by OCOK

OCOK CPD training begins with a one-week agency orientation, followed by two to six weeks of field work while the staff person awaits the start of the next OCOK Permanency Academy training. The OCOK Permanency Academy training lasts eight weeks, consisting of 50% field work and 50% classroom time. The training alternates two weeks of classroom training with two weeks of training in the field. Time in training depends on the specialist's hire type and experience. In total, the expected time to complete OCOK CPD training is ten to 14 weeks (70 to 98 days). Once training is complete, the caseworker becomes case assignable and may begin working with children as a child's primary caseworker.

OCOK hired 31 caseworkers between September 2021 and March 2022. Twenty-five of the 31 (81%) were subject to full or partial CPD training while six of the 31 (19%) were exempt from training. Two (8%) of the 25 caseworkers hired who were subject to training left OCOK prior to or during training. The Monitors tracked a total of 23 OCOK employees for CPD training completion.

[156] The Monitors validate completion of CPD training through regular monthly data reports that DFPS provides to the Monitors with case assignable data and data on employee separations.. Once the information is provided by DFPS to the Monitors, DFPS does not update the data. Errors or omissions in the data impact the Monitor's ability to validate caseworker completion of CPD training.

Figure 62: OCOK Caseworkers Hired September 2021 – March 2022 and Included in CPD Training Completion Analysis

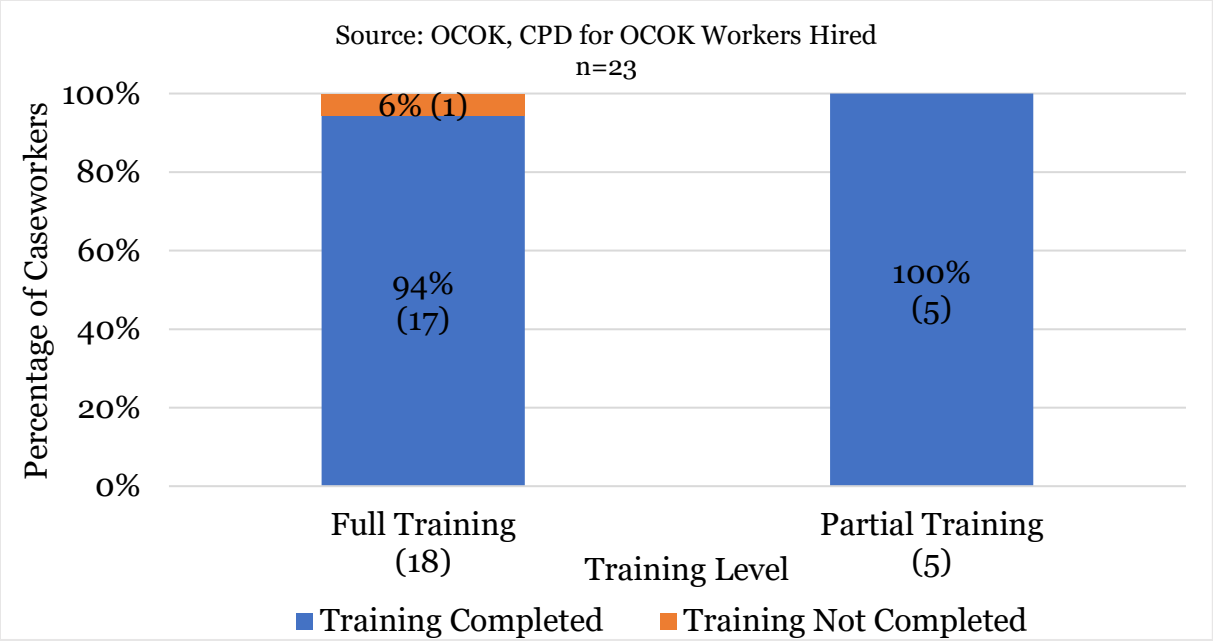


Eighteen (78%) of 23 caseworkers were subject to full CPD training, while five (6%) were subject to partial CPD training.[157]

Of caseworkers subject to training, 17 of 18 (94%) completed full CPD training and all of the remaining five workers completed partial CPD training by July 31, 2022. For those subject to full training, the average time to complete training was 128 days, with a range in training time of 105 to 158 days.[158] All caseworkers required to complete full training completed training more than seven days after the expected completion date.

Figure 63: OCOK Caseworker CPD Training Completion by Training Level

[157] All caseworkers in the OCOK data were categorized as new hires. The Monitors could not validate whether those workers subject to partial training were staff with prior experience as a caseworker.
[158] The average time to complete training was 97 days for the five caseworkers who completed partial training.



The monitoring team could not validate completion of CPD training for one caseworker who was not identified in the full caseload data before July 31, 2022 and had an estimated case assignable date of June 20, 2022.

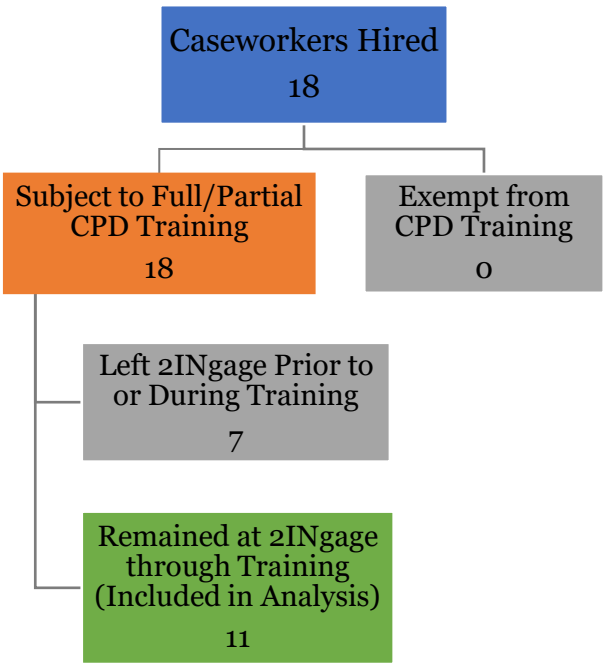
Caseworkers Hired and Trained by 2Ingage

2Ingage policy requires all staff hired to perform the function of caseworker to complete the 2Ingage Academy training prior to being assigned to serve as the primary caseworker for children. In the Second Report, the Monitors reviewed the initial 2Ingage caseworker training and determined that it was designed as a six-week course, which is inconsistent with the CPD training model. 2Ingage reported receiving approval from DFPS to limit caseworker training to six weeks. However, after the Monitors raised concerns regarding the shorter period for SSCC training, particularly for 2Ingage, DFPS notified 2Ingage that it was required to revise its curriculum and lengthen its training period to 13 weeks.

In early 2021, 2Ingage lengthened the training curriculum to 13 weeks (91 days), the average length of time that DFPS reports it takes to complete CPD training. Staff hired after March 1, 2021 were required to complete the extended training program. The timing of the Third Report did not allow for an analysis of the revised training curriculum; the analysis confirmed that the initial training program fell short of the CPD model.

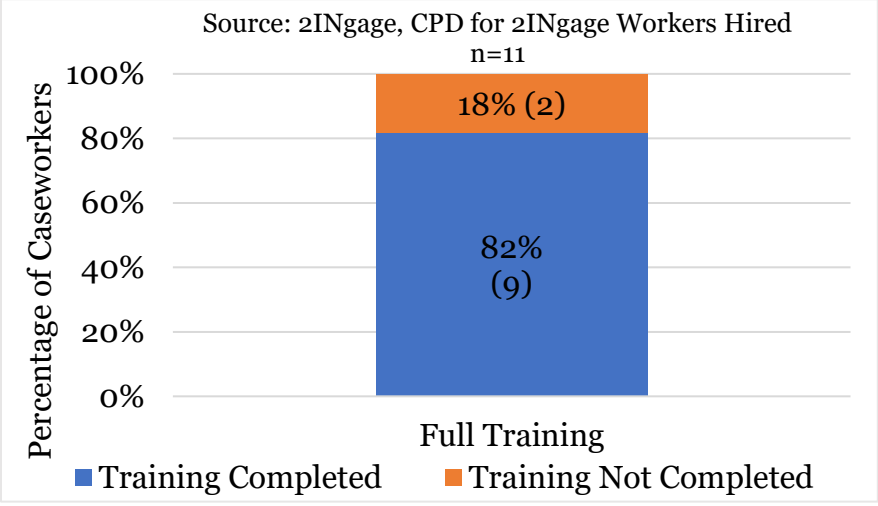
2Ingage hired 18 caseworkers between September 2021 and March 2022. All 18 caseworkers were subject to full or partial CPD training. Seven (39%) of the 18 caseworkers subject to training left 2Ingage prior to or during training, leaving 11 employees who the Monitors tracked for CPD training completion.

Figure 64: 2Ingage Caseworkers Hired September 2021 – March 2022 and Included in CPD Training Completion Analysis



Two of the 11 caseworkers subject to training had previous DFPS experience, but both required full training. Nine (82%) of 11 caseworkers completed full CPD training as of July 31, 2022. The average time to complete full training was 101 days, with a range in training time from 88 to 122 days. Only one caseworker completed the training more than seven days after the expected completion date.

Figure 65: 2Ingage Caseworker CPD Training Completion



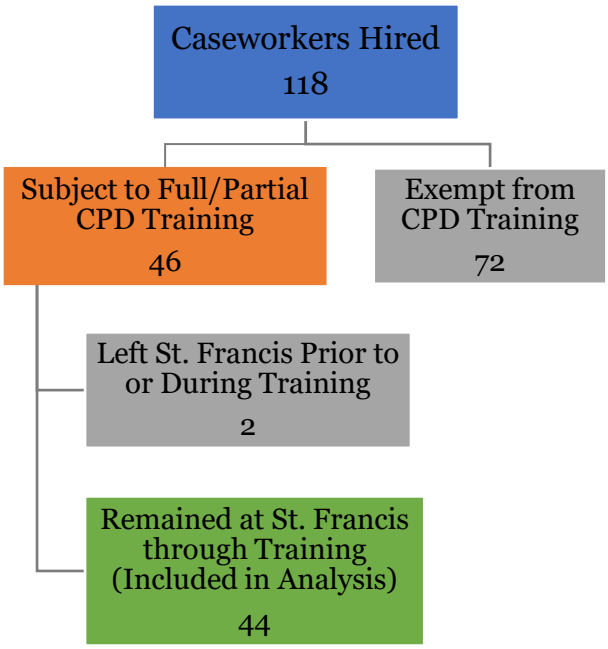
Of the two caseworkers (both new hires) for whom the monitoring team could not validate completion of CPD training, one was identified as a caseworker in the full caseload data before July 31, 2022.[159]

Caseworkers Hired and Trained by St. Francis

The CPD curriculum for caseworkers hired by St. Francis follows the same outline and trainings as the DFPS Individualized Training Plan (ITP) which is a combination of field and classroom experiences. New hires are required to complete two weeks of St. Francis-specific orientation training online prior to beginning CPD training. The St. Francis CPD training is 13 weeks (91 days) long, which does not include the time required for orientation. St. Francis transitioned to Stage II and employed case assignable caseworkers beginning in March 2022. St. Francis hired DFPS transfer staff (resource transfers), internally transferred staff, and new staff as caseworkers as early as November 2021.

Between November 2021 and March 2022, St. Francis hired 118 caseworkers, of which 93 (79%) were resource transfers from DFPS, 19 (16%) were internal transfers, and six (5%) were new hires. Forty-six of the 118 caseworkers (39%) were subject to full or partial CPD training.[160] Two of the 46 caseworkers subject to training left the agency prior to or during training. A total of 44 employees were tracked for CPD training completion.

Figure 66: St. Francis Caseworkers Hired November 2021 – March 2022 and Included in CPD Training Completion Analysis

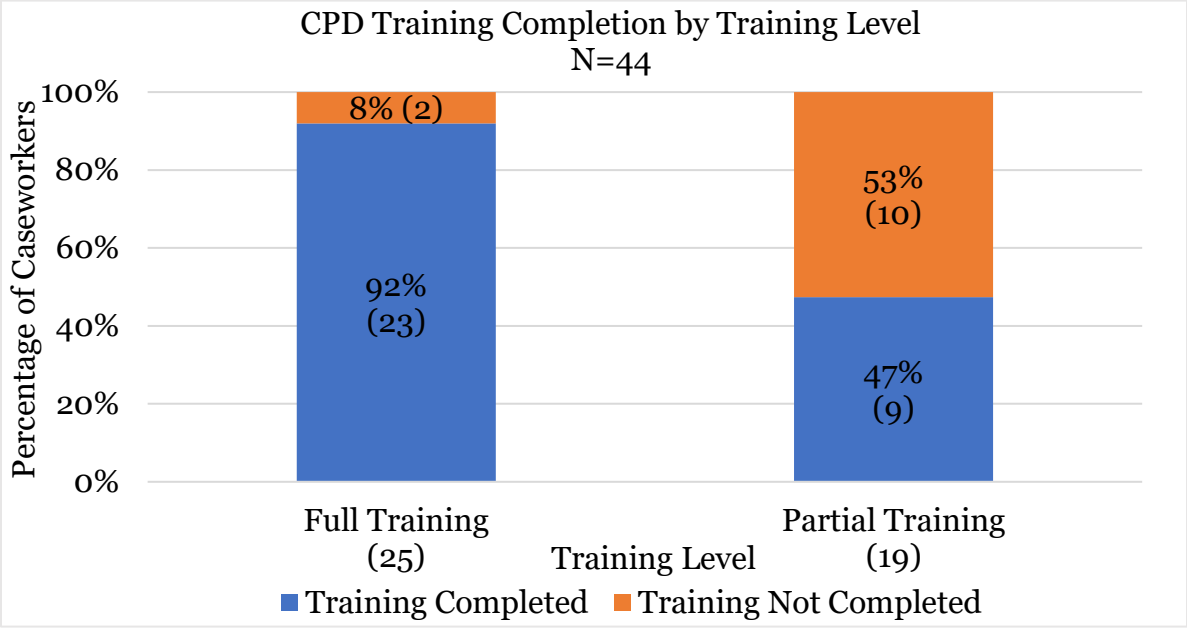


[159] The other caseworker was not identified in the full caseload data.
[160] Twenty-one of 46 caseworkers hired were resource transfers from DFPS, of which all but one was subject to partial training (one was subject to full CPD training at the request of a supervisor).

Twenty-five of 44 caseworkers (57%) were subject to full CPD training, while 19 (43%) caseworkers were subject to partial CPD training.[161]

Of caseworkers subject to training, 23 (92%) of 25 completed full CPD training and nine (47%) of 19 completed partial CPD training by July 31, 2022. For those subject to full training, the average time to complete training was 98 days, with a range in training time of 85 to 129 days.[162] All caseworkers required to complete full training completed training within a week before or after the expected completion date.

Figure 67: St. Francis Caseworker CPD Training Completion by Training Level



Of the 12 caseworkers for whom the monitoring team could not validate completion of CPD training, they identified nine (75%) as caseworkers in the caseload data submitted by DFPS before July 31, 2022.

Summary

DFPS hired 562 caseworkers between September 1, 2021 and March 31, 2022. Of these newly hired caseworkers, 448 were subject to the completion of full or partial CPD training, including 422 requiring full training (94%) and 26 (6%) caseworkers subject to partial CPD training. Of the 448 caseworkers subject to full or partial CPD training, 422 (94%) caseworkers completed training by July 31, 2022.

The monitoring team could not validate completion of CPD training for 26 (6.1%) caseworkers (15 new hires and 11 transfers or rehires).

[161] All 19 caseworkers subject to partial training were resource transfers from DFPS. Eighteen of the 25 employees subject to full training were internal transfers, one was a resource transfer, and six were new hires.
[162] Of the nine caseworkers who completed partial training, the average time to complete training was 44 days.

OCOK hired 31 caseworkers between September 2021 and March 2022. Twenty-five of the 31 (81%) were subject to full or partial CPD training while six of the 31 (19%) were exempt from training. Two (8%) of the 25 caseworkers hired who were subject to training left OCOK prior to or during training. The Monitors confirmed that 22 of the remaining 23 staff completed CPD training.

In early 2021, 2Ingage lengthened its training curriculum to 13 weeks (91 days), the average length of time that DFPS reported it took to complete CPD training. Staff hired after March 1, 2021 were required to complete the extended training program.

2Ingage hired 18 caseworkers between September 2021 and March 2022. All 18 caseworkers were subject to full or partial CPD training. Seven (39%) of the 18 caseworkers subject to training left 2Ingage prior to or during training, leaving 11 employees required to complete CPD training. The Monitors confirmed nine of 11 did so.

Between November 2021 and March 2022, St. Francis hired 118 caseworkers, of whom 93 (79%) transferred from DFPS, 19 (16%) transferred within St. Francis and six (5%) were newly hired. Forty-six (39%) of the 118 caseworkers were subject to full or partial CPD training. Two of the 46 caseworkers subject to training left the agency prior to or during training. In total, 44 employees were required to complete CPD training; the Monitors confirmed that 32 (72%) of the 44 completed training.

Remedial Orders 35, A1, A2, A3, and A4: Caseworker Caseloads

Remedial Order 35: *Effective immediately, DFPS shall track caseloads on a child-only basis, as ordered by the Court in December 2015. Effective immediately, DFPS shall report to the Monitors, on a quarterly basis, caseloads for all staff, including supervisors, who provide primary case management services to children in the PMC class, whether employed by a public or private entity, and whether full-time or part-time. Data reports shall show all staff who provide case management services to children in the PMC class and their caseloads. In addition, DFPS' reporting shall include the number and percent of staff with caseloads within, below and over the DFPS established guideline, by office, by county, by agency (if private) and statewide. Reports will include the identification number and location of individual staff and the number of PMC children and, if any, TMC children to whom they provide case management. Caseloads for staff, as defined above, who spend part-time in caseload carrying functions and part-time in other functions must be reported accordingly.*

Remedial Order A1: *Within 60 days of the Court's Order, DFPS, in consultation with and supervision of the Monitors, shall propose a workload study to generate reliable data regarding current caseloads and to determine how many children caseworkers are able to safely carry, for the establishment of appropriate guidelines for caseload ranges. The proposal shall include, but will not be limited to: the sampling criteria, timeframes, protocols, survey questions, pool sample, interpretation models, and the questions asked during the study. DFPS shall file this proposal with the Court within 60 days of the Court's Order, and the Court shall convene a hearing to review the proposal.*

Remedial Order A2: *Within 120 days of the Court's Order, DFPS shall present the completed workload study submission to the Court, how many cases, on average, caseworkers are able to safely carry, and the data and information upon which the determination is based, for the establishment of appropriate guidelines for caseload ranges.*

Remedial Order A3: *Within 150 days of the Court's Order, DFPS shall establish internal caseload standards based on the findings of the DFPS workload study, and subject to the Court's approval. The caseload standards that DFPS will establish shall ensure a flexible method of distributing caseloads that takes into account the following non-exhaustive criteria: the complexity of the cases; travel distances; language barriers; and the experience of the caseworker. In the policy established by DFPS, caseloads for staff shall be prorated for those who are less than full-time. Additionally, caseloads for staff who spend part-time in the work described by the caseload standard and part-time in other functions shall be pro-rated accordingly.*

Remedial Order A4: *Within 180 days of the Court's Order, DFPS shall ensure that the generally applicable, internal caseload standards that are established are utilized to serve as guidance for supervisors who are handling caseload distribution and that its hiring goals for all staff are informed by the generally applicable, internal caseload standards that are established. This order shall be applicable to all DFPS supervisors, as well as anyone employed by private entities who is charged by DFPS to provide case management services to children in the General class. [The Court modified the effective date of this Remedial Order to February 15, 2020.*[163]*]*

Background

On December 16, 2019, the Court approved an agreed motion submitted by the parties that, in lieu of conducting workload studies pursuant to Remedial Orders A1, A2, B1 and B2, DFPS and HHSC would use as caseload guidelines:

- 14-17 children per conservatorship caseworker, for the purpose of satisfying State obligations within Remedial Orders A2, A3 and A4;
- 14-17 investigations per RCCI investigator, for the purpose of satisfying State obligations within Remedial Orders B2, B3 and B4; and
- 14-17 tasks per RCCR (HHSC) inspector, for the purpose of satisfying State obligations within Remedial Orders B2, B3 and B4.

To assess the State's compliance with Remedial Order 35, the Monitors requested, and the State has provided point-in-time caseload data monthly to the Monitors. To validate the accuracy of the State's caseload data submissions, the Monitors randomly selected

[163] Order Regarding Workload Studies in the November 20, 2018 Order 1-2, *M.D. ex rel. Stukenberg v. Abbott, No. 2:11-CV-84*, slip. op. (S.D. Tex. Dec. 17, 2019), ECF No. 772.

and interviewed 178 caseworkers from 65 counties as described below. In advance of the monitoring team's interviews with caseworkers, DFPS provided caseload information from the State's INSIGHT reporting tool for each identified worker for a date selected by the Monitors;[164] for the SSCCs, DFPS provided the alternative workload reports that the respective SSCCs currently use as they do not use INSIGHT. On March 2, 2022, the SSCC responsible for Region 1, St. Francis, advanced into Stage II of the CBC model, undertaking casework responsibility; therefore, the Monitors included their performance for the relevant portion of this reporting period.[165]

Remedial Orders 35 and A4: Caseworker Caseloads Performance Validation Results

Remedial Order 35: *Effective immediately, DFPS shall track caseloads on a child-only basis, as ordered by the Court in December 2015. Effective immediately, DFPS shall report to the Monitors, on a quarterly basis, caseloads for all staff, including supervisors, who provide primary case management services to children in the PMC class, whether employed by a public or private entity, and whether full-time or part-time. Data reports shall show all staff who provide case management services to children in the PMC class and their caseloads. In addition, DFPS' reporting shall include the number and percent of staff with caseloads within, below and over the DFPS established guideline, by office, by county, by agency (if private) and statewide. Reports will include the identification number and location of individual staff and the number of PMC children and, if any, TMC children to whom they provide case management. Caseloads for staff, as defined above, who spend part-time in caseload carrying functions and part-time in other functions must be reported accordingly.*

Remedial Order A4: *Within 180 days of the Court's Order, DFPS shall ensure that the generally applicable, internal caseload standards that are established are utilized to serve as guidance for supervisors who are handling caseload distribution and that its hiring goals for all staff are informed by the generally applicable, internal caseload standards that are established. This order shall be applicable to all DFPS supervisors, as well as anyone employed by private entities who is charged by DFPS to provide case management services to children in the General class. (The Court modified the effective date of this Remedial Order to February 15, 2020.)*

The Monitors cross-checked the monthly data files provided by the State for DFPS, OCOK, 2Ingage, and St. Francis caseworkers and found the number of children assigned to each

[164] DFPS describes INSIGHT as a tool to "manage critical case tasks and deadlines." DFPS, *IMPACT Modernization*, available at https://www.dfps.state.tx.us/Doing_Business/IMPACT_Modernization/default.asp.

[165] The Monitors excluded the first St. Francis point-in-time caseloads report for March 31, 2022 due to data quality concerns with the data provided to the Monitors by DFPS. When the Monitors notified DFPS of the inaccuracies in the data, DFPS reported that it is unable to extract and report the caseloads of St. Francis workers for Region 1 properly for March 2022 data due to limitations of IMPACT. For example, workers who were employed by DFPS on March 1, 2022 appeared on the caseload report as DFPS employees even if they worked for St. Francis as of March 31, 2022. Therefore, many workers' caseloads were not properly attributed under St. Francis.

worker in the listing table added to the number of children in the caseload table. To analyze caseloads, the Monitors used the total number of children assigned to CPS CVS Specialists (I-V) at DFPS, Permanency Specialists at OCOK and St. Francis, and Permanency Case Managers at 2Ingage.[166,167,168] The monitoring team also independently replicated caseload validation by interviewing 178 caseworkers, selected by the Monitors, about their caseloads and by conducting a comparison of the 178 workers' workload reports (INSIGHT or alternative reports used by SSCCs) with the State's caseload data report for the corresponding month.

On June 30, 2022, there were 1,575 caseworkers who managed at least one PMC child's case; the total includes caseworkers employed by DFPS (1,283), OCOK (120), 2Ingage (87), and St. Francis (85).[169] In the six months of caseload reports that the State submitted, representing caseloads from January 1, 2022 to June 30, 2022, the data revealed the highest number of caseworkers managing at least one PMC child's case on May 31, 2022 (1,576) and the lowest number on January 31, 2022 (1,477). From January 1, 2022 to June 30, 2022, the number of caseworkers managing at least one PMC case increased by 98 (7%).

Remedial Order A4 became effective on February 15, 2020, requiring DFPS to ensure that the caseload standard of 14 to 17 children is "utilized to serve as guidance for supervisors who are handling caseload distribution" and is used to inform "hiring goals for all staff." In six months of caseload reports starting on January 1, 2022 and ending on June 30,

---

[166] CVS Specialists I, II, III, IV, and V account for over 95% of all the staff listed by DFPS carrying at least one PMC child's case in each of the caseload reports the Monitors received from DFPS for the period January 2022 to June 2022. Supervisors account for most of the remaining case-carrying staff. For this report, the Monitors eliminated from the analysis staff with other titles because they account for a relatively small number of staff who carry a small number of PMC children, unless otherwise noted. On June 30, 2022, for example, of the 1,321 DFPS staff carrying at least one PMC case, 1,283 (97%) are CVS Specialists I-V and 21 (3%) are supervisors. Program specialists (7), master CVS specialists (7), and staff with other titles (4) account for the remaining 18 staff.

[167] The Monitors did not weight secondary assignments in their assessment of conformity with the caseload guidelines for this report and they continue to collect information in interviews with caseworkers and assess the appropriate methodology.

[168] Furthermore, since the State advised the Monitors that "the supervisor to staff ratio for CVS is 1:7," via E-mail from Tara Olah, former Director of Implementation and Strategy, DFPS, to Kevin Ryan and Deborah Fowler, on March 24, 2020, in order to assess conformance with standards for supervisors who carried cases, the Monitors calculated supervisors' workloads. The Monitors assigned a weight of 14.29% for each supervised caseworker (100% - a full workload - divided by seven) and 5.88% (100% - a full caseload - divided by the agreed-upon standard of 17 cases) for each PMC/TMC child's case that the supervisor managed directly. To assess a supervisor who supervises six caseworkers and is the primary case manager for one child, the supervisor dedicates 85.74% of their time to supervision (six workers x 14.29%) and 5.88% of their time to primary case management for one child, yielding 91.62% of a workload, which is below the supervisor's 100% availability and within the standard. If the supervisor supervises six caseworkers and serves as the primary case manager for four children, an additional 23.52% weight (5.88% x four) is added to their workload of six supervision assignments (85.74% + 23.52%) yielding 109.26% of a caseload, which is greater than 100% of their availability. *See* Deborah Fowler & Kevin Ryan, First Report 173, ECF No. 869.

[169] DFPS, RO2.1 CVS caseloads January 2022 3-1-2022 log105088 (Mar. 1, 2022); RO2.1 CVS caseloads February 2022 4-1-2022 log105441 (Apr. 1, 2022); RO2.1 CVS Caseloads March 2022 5-2-2022 log105887 (May 2, 2022); RO2.1_CVS_Caseloads_2022_04d2022_06_01_log106162 (June 1, 2022); RO2.1_CVS_Caseloads_2022_05d2022_07_01_log106397 (July 1, 2022); RO2.1_CVS_Caseloads_2022_06d2022_08_01_log106687 (Aug. 1, 2022) (on file with the Monitors).

2022, an average of 80% of all caseworkers managing at least one PMC child's case were assigned to serve 17 or fewer children and an average of 20% of these caseworkers served 18 or more children. The highest rate of conformance with the guidelines among the six caseload reports occurred on June 30, 2022 (85%) and the lowest rate occurred on January 31, 2022 (74%). In the Monitors' prior Update to the Court Regarding RO 35 Caseload Performance (Update to the Court), the average rate of caseworkers managing at least one PMC child's case assigned to serve 17 or fewer children was 62%.[170]

As shown in the table below, on June 30, 2022, of the 1,575 caseworkers who managed at least one PMC child's case, 1,343 (85%) caseworkers had 17 or fewer children on their caseloads. One hundred thirty-seven (9%) carried 18 to 20 children on their caseloads. Seventy-eight (5%) carried 21 to 25 children on their caseloads. The remaining 17 workers (1%) carried more than 25 children on their caseloads, with one of those 17 workers carrying more than 30 children on their caseload. Ninety-five (6%) caseworkers carried 21 children or more on their caseloads on June 30, 2022.

Table 13: All Caseworkers Managing at Least One PMC Child, January 2022 to June 2022

Month	Caseworkers Serving at least one PMC Child	17 Children or Fewer		18 Children or More	
	No.	No.	%	No.	%
January 2022	1,477	1,086	74%	391	26%
February 2022	1,519	1,156	76%	363	24%
March 2022	1,499	1,197	80%	302	20%
April 2022	1,546	1,270	82%	276	18%
May 2022	1,576	1,298	82%	278	18%
June 2022	1,575	1,343	85%	232	15%
Average	**1,532**	**1,225**	**80%**	**307**	**20%**

On June 30, 2022, 25 supervisors managed at least one PMC child's case. The 25 supervisors reflect a decrease of 42% from the 43 supervisors managing at least one case on January 31, 2022. In the six months of caseload reports starting on January 31, 2022 to June 30, 2022, an average of 17% of supervisors managing at least one PMC child's case had one workload or less and an average of 83% had more than one full workload.

Table 14: All Supervisors Managing at Least One PMC Child and Total Workload, January 2022 to June 2022

Month	Supervisors Serving at least one PMC Child	One Workload or Less	More Than One Workload

[170] *See* Deborah Fowler & Kevin Ryan, Update to the Court Regarding RO 35 Caseload Performance 4, ECF No., 1244 (June 1, 2022).

	No.	No.	%	No.	%
January 2022	43	9	21%	34	79%
February 2022	32	7	22%	25	78%
March 2022	30	5	17%	25	83%
April 2022	21	1	5%	20	95%
May 2022	17	2	12%	15	88%
June 2022	25	5	20%	20	80%
Average	**28**	**5**	**17%**	**23**	**83%**

Note: The average number of supervisors in each column is rounded to the nearest integer. The average percentage sums the number of supervisors each month.

As of June 30, 2022, 1,283 (81%) of the 1,575 caseworkers managing at least one PMC child's case were employed by DFPS. The 1,283 caseworkers are an increase of 1% from the 1,271 DFPS caseworkers managing at least one PMC child on January 31, 2022. In the six months of caseload reports starting on January 31, 2022 and ending on June 30, 2022, an average of 79% of DFPS caseworkers managing at least one PMC child's case were assigned to serve 17 or fewer children and an average of 21% of these caseworkers served 18 or more children. DFPS's highest rate of conforming to the guidelines among DFPS-only caseworkers in the six caseload reports occurred on June 30, 2022 (86%) and the lowest rate occurred on January 31, 2022 (72%). In the Monitors' prior Update to the Court, the average rate of DFPS caseworkers managing at least one PMC child's case assigned to serve 17 or fewer children was 61%.[171]

As shown in the table below, on June 30, 2022, of the 1,283 DFPS caseworkers who managed at least one PMC child's case, 1,102 (86%) caseworkers had 17 or fewer children on their caseload. Ninety-nine (8%) carried 18 to 20 children on their caseloads. Sixty-six (5%) carried 21 to 25 children on their caseloads. Sixteen DFPS caseworkers (1%) carried more than 25 children on their caseloads, including one of those 16 caseworkers who carried more than 30 children on their caseload.

Table 15: DFPS Caseworkers Managing at Least One PMC Child, January 2022 to June 2022

Month	DFPS Caseworkers Serving at least one PMC Child	17 Children or Fewer		18 Children or More	
	No.	No.	%	No.	%
January 2022	1,271	913	72%	358	28%
February 2022	1,305	965	74%	340	26%
March 2022	1,291	1,009	78%	282	22%
April 2022	1,250	1,030	82%	220	18%

[171] *See* Deborah Fowler & Kevin Ryan, Update to the Court Regarding RO 35 Caseload Performance 6, ECF No. 1244 (June 1, 2022).

May 2022	1,284	1,072	83%	212	17%
June 2022	1,283	1,102	86%	181	14%
Average	**1,281**	**1,015**	**79%**	**266**	**21%**

On June 30, 2022, 21 DFPS supervisors managed at least one PMC child's case. The 21 supervisors are a decrease of 45% from the 38 DFPS supervisors managing at least one PMC child's case on January 31, 2022. In the six months of caseload reports starting on January 31, 2022 and ending on June 30, 2022, an average of 8% of DFPS supervisors managing at least one PMC child's case in an end of the month report had one workload or less and an average of 92% had more than one workload. The highest rate of conforming to the guidelines among the six caseload reports occurred on February 28, 2022 (15%) and the lowest rate, 0%, occurred on April 30, 2022 and May 31, 2022.

Table 16: DFPS Supervisors Managing at Least One PMC Child and Total Workload, January 2022 to June 2022

Month	**DFPS Supervisors Serving at least one PMC Child**	**One Workload or Less**		**More Than One Workload**	
	No.	**No.**	**%**	**No.**	**%**
January 2022	38	5	13%	33	87%
February 2022	27	4	15%	23	85%
March 2022	24	1	4%	23	96%
April 2022	14	0	0%	14	100%
May 2022	14	0	0%	14	100%
June 2022	21	1	5%	20	95%
Average	**23**	**2**	**8%**	**21**	**92%**

Note: The average number of supervisors in each column is rounded to the nearest integer. The average percentage sums the number of supervisors each month.

As of June 30, 2022, 120 (8%) of the 1,575 caseworkers who managed at least one PMC child's case were employed by OCOK. The 120 OCOK caseworkers are an increase of 3% (4) from the 116 OCOK caseworkers managing at least one PMC child on January 31, 2022. In the six months of caseload reports starting on January 31, 2022 and ending on June 30, 2022, an average of 94% of OCOK caseworkers managing at least one PMC child's case were assigned to serve 17 or fewer children and an average of 6% of these caseworkers served 18 or more children. OCOK's highest rate of conforming to the guidelines among the six caseload reports occurred on April 30, 2022 (98%) and the lowest rate occurred on January 31, 2022 (84%). In the Monitors' prior Update to the Court, the average rate of OCOK caseworkers managing at least one PMC child's case who had 17 or fewer children on their caseloads was 70%.[172]

[172] *See* Deborah Fowler & Kevin Ryan, Update to the Court Regarding RO 35 Caseload Performance 7, ECF No. 1244 (June 1, 2022).

As shown in the table below, on June 30, 2022, of the 120 OCOK caseworkers who managed at least one PMC child's case, 116 (97%) caseworkers had 17 or fewer children on their caseloads. Four caseworkers (3%) carried 18 to 20 children on their caseloads. No OCOK worker carried more than 20 children on their caseloads.[173]

Table 17: OCOK Caseworkers Managing at Least One PMC Child, January 2022 to June 2022

Month	OCOK Caseworkers Serving at least one PMC Child	17 Children or Fewer		18 Children or More	
	No.	No.	%	No.	%
January 2022	116	97	84%	19	16%
February 2022	125	117	94%	8	6%
March 2022	121	113	93%	8	7%
April 2022	123	121	98%	2	2%
May 2022	122	117	96%	5	4%
June 2022	120	116	97%	4	3%
Average	**121**	**114**	**94%**	**8**	**6%**

On June 30, 2022, no OCOK supervisor managed a PMC child's case. This is the same as January 31, 2022, when no supervisors managed any PMC children's cases.

Table 18: OCOK Supervisors Managing at Least One PMC Child and Total Workload, January 2022 to June 2022

Month	OCOK Supervisors Serving at least one PMC Child	One Workload or Less		More Than One Workload	
	No.	No.	%	No.	%
January 2022	0	0	--	0	--
February 2022	1	0	0%	1	100%
March 2022	2	0	0%	2	100%
April 2022	1	0	0%	1	100%
May 2022	1	0	0%	1	100%
June 2022	0	0	--	0	--
Average	**1**	**0**	**0%**	**1**	**100 %**

Note: The average number of supervisors in each column is rounded to the nearest integer.

As of June 30, 2022, 87 (6%) of the 1,575 caseworkers managing at least one PMC child's case were employed by 2Ingage. The 87 2Ingage caseworkers managing at least one PMC

[173] By September 2022, OCOK's performance had decreased and of the 102 caseworkers who managed at least one PMC child's case, 61 (62%) had 17 or fewer children.

child are a decrease of 3% from the 90 caseworkers managing at least one PMC child on January 31, 2022. In the six months of caseload reports for 2Ingage starting on January 31, 2022 and ending on June 30, 2022, an average of 86% of 2Ingage caseworkers managing at least one PMC child's case were assigned to serve 17 or fewer children and an average of 14% of these caseworkers served 18 or more children. 2Ingage's highest rate of conforming to the guidelines among the six caseload reports occurred on June 30, 2022 (92%) and the lowest rate, 83%, occurred on both February 28, 2022 and April 30, 2022. In the Monitors' prior Update to the Court, the average rate of 2Ingage caseworkers managing at least one PMC child's case who had 17 or fewer children on their caseloads was 73%.[174]

As shown in the table below, on June 30, 2022, of the 87 2Ingage caseworkers who managed at least one PMC child's case, 80 (92%) caseworkers had 17 or fewer children on their caseloads. Six caseworkers (7%) carried 18 to 20 children on their caseloads. One worker (1%) carried 21 to 25 children on their caseloads. No 2Ingage workers carried more than 25 children on their caseloads.

Table 19: 2Ingage Caseworkers Managing at Least One PMC Child, January 2022 to June 2022

Month	2Ingage Caseworkers Serving at least one PMC Child	17 Children or Fewer		18 Children or More	
	No.	No.	%	No.	%
January 2022	90	76	84%	14	16%
February 2022	89	74	83%	15	17%
March 2022	87	75	86%	12	14%
April 2022	87	72	83%	15	17%
May 2022	86	76	88%	10	12%
June 2022	87	80	92%	7	8%
Average	**88**	**76**	**86%**	**12**	**14%**

On June 30, 2022, four 2Ingage supervisors managed at least one PMC child's case. The four supervisors are a decrease of 20% from the five supervisors managing at least one case on January 31, 2022. In the six months of caseload reports starting on January 31, 2022 and ending on June 30, 2022, an average of 90% of 2Ingage supervisors managing at least one PMC child's case had one workload or less and an average of 10% had more than one workload. The highest rate of conforming to the guidelines among the six caseload reports occurred in the March 31, 2022, April 30, 2022, May 31, 2022, and June 30, 2022 monthly reports (100%) and the lowest rate, 75%, occurred in the February 28, 2022 monthly report.

[174] *See* Deborah Fowler & Kevin Ryan, Update to the Court Regarding RO 35 Caseload Performance 8, ECF No.1244 (June 1, 2022).

Table 20: 2Ingage Supervisors Managing at Least One PMC Child and Total Workload, January 2022 to June 2022

Month	2Ingage Supervisors Serving at least one PMC Child	One Workload or Less		More Than One Workload	
	No.	No.	%	No.	%
January 2022	5	4	80%	1	20%
February 2022	4	3	75%	1	25%
March 2022	4	4	100%	0	0%
April 2022	1	1	100%	0	0%
May 2022	2	2	100%	0	0%
June 2022	4	4	100%	0	0%
Average	**3**	**3**	**90%**	**0**	**10%**

Note: The average number of supervisors in each column is rounded to the nearest integer. The average percentage sums the number of supervisors each month.

As of June 30, 2022, 85 (5%) of the 1,575 caseworkers managing at least one PMC child's case were employed by St. Francis. The 85 St. Francis caseworkers managing at least one PMC child are a decrease of 1% from the 86 caseworkers managing at least one PMC child on April 30, 2022. In the three months of caseload reports for St. Francis starting on April 30, 2022 and ending on June 30, 2022, an average of 49% of St. Francis caseworkers managing at least one PMC child's case were assigned to serve 17 or fewer children and an average of 51% of these caseworkers served 18 or more children. St. Francis's highest rate of conforming to the guidelines among the three caseload reports occurred on April 30, 2022 (55%) and the lowest rate occurred on May 31, 2022 (39%).[175]

As shown in the table below, on June 30, 2022, of the 85 St. Francis caseworkers who managed at least one PMC child's case, 45 (53%) caseworkers had 17 or fewer children on their caseload. Twenty-eight (33%) carried 18 to 20 children on their caseloads. Eleven workers (13%) carried 21 to 25 children on their caseloads. One St. Francis worker carried more than 25 children on their caseload.[176]

Table 21: St. Francis Caseworkers Managing at Least One PMC Child, April 2022 to June 2022[177]

[175] The Monitors met by videoconference with DFPS and St. Francis leadership on September 19, 2022. The Monitors reviewed the Court's remedial orders with St. Francis's leaders, who expressed a commitment to comply with the orders and forecasted substantial improvement in the organization's caseload performance by November 30, 2022.
[176] By September 2022, St. Francis's performance had improved and of the 82 caseworkers who managed at least one PMC child's case, 56 (68%) had 17 or fewer children.
[177] As noted above, St. Francis commenced case management services on March 2, 2022 and, due to data quality concerns regarding the data the State submitted, the Monitors included St. Francis's performance starting with April 2022.

Month	St. Francis Caseworkers Serving at least one PMC Child	17 Children or Fewer		18 Children or More	
	No.	No.	%	No.	%
April 2022	86	47	55%	39	45%
May 2022	84	33	39%	51	61%
June 2022	85	45	53%	40	47%
Average	**85**	**42**	**49%**	**43**	**51%**

On June 30, 2022, no St. Francis supervisor managed a PMC child's case. This is a 100% decrease from the five supervisors who managed at least one PMC child's case on April 30, 2022.

Table 22: St. Francis Supervisors Managing at Least One PMC Child and Total Workload, April 2022 to June 2022

Month	St. Francis supervisors with PMC	One Workload or Less		More Than One Workload	
	No.	No.	%	No.	%
April 2022	5	0	0%	5	100%
May 2022	0	0	--	0	--
June 2022	0	0	--	0	--
Average	**2**	**0**	**0%**	**2**	**100%**

Note: The average number of supervisors in each column is rounded to the nearest integer.

To validate the accuracy of the State's monthly caseload data submissions from its IMPACT system, which the Monitors received on a 30-day lag, the monitoring team examined the symmetry of the data within those reports with caseload data from the DFPS INSIGHT database and the SSCCs' data reports. The monitoring team remotely interviewed by videoconference 120 DFPS and 58 SSCC caseworkers[178] and their supervisors from 65 counties between February 3, 2022 and July 7, 2022 from a sample selected by the Monitors.[179,180] In preparation for these interviews, at the Monitors' request, DFPS provided caseload reports from DFPS's INSIGHT system for the final day of the month preceding the interview; the date of those reports corresponds with the data reports that DFPS submits to the Monitors to measure the State's conformance with

[178] The DFPS caseworkers in the sample had job titles of CPS CVS Specialist I, II, III, or IV. The OCOK and St. Francis caseworkers had a title of Permanency Specialist and the 2Ingage caseworkers had a title of Permanency Case Manager.
[179] One worker was interviewed at two points during the monitoring period. Data for each interview is reflected separately.
[180] Interview data includes 13 St. Francis caseworkers interviewed in April 2022 about their caseloads and activity in March 2022. Although the monitoring team noted quality concerns about the data reports for St. Francis in March 2022, DFPS provided sufficient data to validate the information received during the interview process for the workers the Monitors interviewed.

Remedial Order 35. For the interviews with the SSCC workers, DFPS provided the alternative workload reports utilized by the respective SSCCs. The monitoring team then reviewed the records with the caseworker, discussing each listed child, by name, and other work assignments, if any, to verify whether the caseworker's workload matched the DFPS and SSCC records.

The monitoring team compared the monthly caseload data from IMPACT submitted by DFPS with the results of the caseworker interviews to confirm the accuracy of the State's IMPACT caseload data. During cross-data validation of the workload and INSIGHT reports for 176 of the 178 workers interviewed with the monthly caseload data, the monitoring team found that 93% of primary case assignments were a perfect match and 98% were within one case in the caseloads reviewed.[181] The individual caseloads of the sample of interviewed caseworkers ranged from two to 30 children. The monitoring team found that 147 (84%) of the 176 workers were within the generally applicable caseload standards and 29 (16%) exceeded the caseload standards. Forty-one (28%) of the 147 workers meeting the standards were subject to Advancing Practice graduated caseloads.

Caseloads and Supervision of Children Without Placement

The Monitors' interviews with caseworkers to validate the data DFPS submitted about caseloads provided additional insight into other major job responsibilities, over and above the duties associated with caseload management. Most notably, workers described being assigned CWOP shifts (both required and voluntary) to supervise children who are experiencing a lack of placement. During the interviews conducted with 120 DFPS and 58 SSCC caseworkers between February 3, 2022 to July 7, 2022, 60% (106) of the 178 caseworkers reported responsibility for CWOP shifts between January 2022 and June 2022.[182]

CWOP responsibility was reported by 96 (80%) of 120 DFPS workers and 11 (19%) of 58 SSCC workers. The highest levels of involvement were reported by 27 (90%) of 30 DFPS workers for April 2022, and 26 (87%) of 30 for February 2022. The lowest DFPS CWOP involvement reported was 19 (63%) of 30 workers in June 2022. SSCCs, by contrast, reported involvement of one (3%) of 29 workers in March 2022, and ten (34%) of 29 workers in May 2022. SSCC CWOP work activity was high for OCOK, with ten (59%) of 17 workers reporting CWOP activity, compared with one (7%) of 14 2Ingage workers reporting CWOP activity. No St. Francis worker reported CWOP activity.

Seventeen percent (18) of the 106 workers interviewed who reported CWOP activity between January 2022 and June 2022 had caseloads that exceeded the caseload standard. Of those workers whose caseloads exceeded the caseload standard, eight (8%) carried 18-20 children on their caseloads, ten (9%) carried 21-25 children on their caseloads, and all were DFPS workers. Of the 87 (82%) caseworkers reporting CWOP activity who carried

[181] Two of the 178 workers are excluded as each had no PMC assignment as of the last date of the month under review, and thus were not included in the monthly IMPACT caseload data report for that month.
[182] As noted above, one worker was interviewed at two points during the monitoring period. Data for each interview is reflected separately.

caseloads meeting the standards, 29 were subject to graduated caseloads at the time they were interviewed because they were new to their positions.[183]

Workers continued to describe CWOP activity as a mix of required and voluntary shifts that varied in length, typically from four to eight hours and including activity during normal business hours, which was referred to as "Day Watch." Twenty-eight (29%) of 96 DFPS workers reported spending more than 35 hours in a month working CWOP shifts, while 45 (47%) reported spending between 12 and 35 hours working CWOP shifts. Twenty-two (23%) DFPS workers reported spending fewer than 12 hours a month working CWOP shifts. By contrast, ten (91%) of 11 SSCC workers with CWOP activity reported spending no more than nine hours a month working CWOP shifts.

DFPS now uses a CVS Tracker tool that provides a daily point-in-time count of unique children who are included as primary case assignments on each caseworker's caseload, as well as the aggregate average number of children on a caseload.[184] There is also a similar version of the tool for SSCC caseloads. Despite adjustments to content and functionality since its launch, the CVS and SSCC Trackers do not provide sufficient information to serve as stand-alone tools for assessing compliance with the Court's remedial orders on caseloads at this time.[185]

---

[183] Caseload data excludes one of the 106 workers, also subject to Advancing Practice, who did not have a PMC assignment as of the last date of the month under review, and thus was not included in the caseload data report submitted by DFPS to the Monitors for that month.

[184] The data reflects the caseloads as of midnight on the prior day. The fields provided are: Region, Unit, County, Personal Identification Number, Worker Name, Job Title, Graduated Caseload (GCL) status, and Child Count. A color-coded bar indicates compliance with caseload standards. Newer features include: a column chart of caseload sizes (≤5, 6-9, 10-12, 13-15, 16-18, 19-21, 22-29, 30+) to allow a view of workers by each category; keep/exclude options and drill-down capability across data fields; and the ability to view or download data. A separate version of the tool, the SSCC Caseload Tracker, contains fewer data fields and less functionality than the CVS Tracker described above. Specifically, the SSCC Tracker does not include Agency, Job Title, or GCL status fields. It also does not have the keep/exclude options and data view or download capabilities found in the CVS Tracker.

[185] For example, the Tracker categories in a column chart that allow for assessing compliance with the caseload guidelines do not align with the graduated caseload categories. Moreover, the descriptions in the tools state that the data do not align with other caseload reports. Neither tracker provides: the number of PMC children on a workload; the identities of children; the identity of the caseworker's supervisor; inclusion of supervisors carrying SUB/ADO cases; nor exceptions to graduated caseload standards. The structure of data based on worker and unit location versus child location obscures data for certain counties, especially in the version of the tool that is used for the SSCCs. Finally, the inability to view data over time and to view entire caseloads, including other primary and secondary assignments, also limits the usefulness of the tools in managing workloads and verifying compliance with the Court's orders. The Monitors reviewed CVS and SSCC Caseload Tracker data from January to June 2022 for 178 caseworkers interviewed between February and July 2022. The monitoring team conducted the review between four and seven days per month, for a total of 33 days during the monitoring period. One hundred seventy-three (97%) of the 178 interviewed workers appeared in either the CVS or SSCC Caseload Tracker at least one day during the data month under review. One hundred seventy-one (96%) of the workers appeared in their respective Caseload Tracker on the last day of the month. The Monitors compared the number of primary case assignments in the Caseload Trackers on the last day of the data month with the number of unique children contained on the INSIGHT and Workload reports used during caseworker interviews, as well as with the caseload data reports from IMPACT received on a 30-day lag to reflect caseloads as of the same date.

Caseload Conformity and Workforce

Over the six monthly caseload reports submitted from January 31, 2022 to June 30, 2022, conformity with the caseload guidelines increased by 11%, from 74% to 85%. To learn more about these improvements, the Monitors conducted a separate analysis of the total number of caseworkers and children assigned to DFPS, OCOK, 2Ingage, and St. Francis.

The number of caseworkers assigned at least one child (of any legal status) increased slightly during the period from January 31, 2022 to June 30, 2022. There were 2,018 caseworkers assigned at least one child on June 30, 2022, an increase of 37 caseworkers (2%) from the 1,981 workers assigned at least one child on January 31, 2022.

The total number of children assigned to any worker managing at least one PMC child, in contrast, decreased over this same period.[186] The total number of children of any legal status assigned to any workers managing at least one PMC child decreased by 1,277 (6%) children from 22,023 on January 31, 2022 to 20,745 on June 30, 2022. This decrease occurred because of a large decline in TMC children assigned to workers with at least one PMC case. During this period, the number of PMC children assigned to workers managing at least one PMC child *increased* by 472 (5%), from 9,508 children on January 31, 2022 to 9,980 children on June 30, 2022. The number of TMC children decreased by 1,476 (14%) from 10,256 on January 31, 2022 to 8,780 on June 30, 2022. Overall, a smaller number of children were assigned to more caseworkers on June 30, 2022 compared to January 31, 2022, corresponding with improvements in conformity to caseload guidelines.

Summary

- The parties agreed to, and the Court approved, a workload standard of 14 to 17 children per Conservatorship (CVS) worker, pursuant to Remedial Order A3. To validate the State's performance, the Monitors reviewed and analyzed all relevant data provided by the State during the review period. The Monitors' analysis showed that as of June 30, 2022, 85% of all caseworkers (1,343 of 1,575), including those employed by OCOK, 2INgage, and St. Francis had primary caseloads within or below the standard of 17 children per worker. From January 31, 2022 to June 30, 2022, conformity with the standard was 80% of all serving at least one PMC child.

Among all workers interviewed during the period, the Caseload Tracker case counts on the last day of the data month matched INSIGHT and Workload reports for 158 (89%) of the 178 workers. The Caseload Tracker case counts on the last day of the relevant month matched the caseload data reports from IMPACT for 160 (90%) of the 178 workers. Given the absence of child identifiers in Caseload Trackers, however, it was not possible to verify that the numbers in the Caseload Trackers represented the same children as those identified in the INSIGHT, Workload, and data reports from IMPACT.

[186] Any worker in this paragraph includes any staff member, including those staff members without caseworker titles.

- Supervisors carried only a small percentage of PMC cases; those who did rarely conformed with the workload standard. In the six months of caseload reports starting on January 31, 2022 and ending on June 30, 2022, conformity for supervisors managing at least one PMC child's case was lowest on March 30,2022, with 5% (1 of 21) of supervisors with one workload or less and highest on February 28, 2022, with 22% (7 of 32) of relevant supervisors with one workload or less. From January 31, 2022 to June 30, 2022, conformity with the standard decreased from 21% to 20% of all supervisors carrying at least one PMC case.

- The Monitors found that conformity with the caseload standard varied among DFPS, OCOK, 2INgage and St. Francis. Of the 1,283 DFPS workers carrying at least one PMC case on June 30, 2022, 1,102 (86%) workers had primary caseloads within or below the standard of 17 children per worker. As of June 30, 2022, the three SSCCs that are undertaking case management, OCOK, 2INgage, and St. Francis had 97%, 92%, and 53% of their workers within or below the standard, respectively.

- Caseworkers reported significant CWOP shift work during interviews with the monitoring team, including workers whose caseloads did not conform to the caseload standards: 18 (17%) of the 106 workers interviewed who reported CWOP shift activity from January 2022 through June 2022 had caseloads that exceeded the caseload standard.

Remedial Orders B1-B4: RCCI and RCCR Investigator Caseloads

Remedial Orders B1: *Within 60 days of the Court's Order, DFPS, in consultation with and under the supervision of the Monitors, shall propose a workload study to: generate reliable data regarding current RCCL, or successor entity, investigation caseloads and to determine how much time RCCL investigators, or successor staff, need to adequately investigate allegations of child maltreatment, in order to inform the establishment of appropriate guidelines for caseload ranges; and to generate reliable data regarding current RCCL inspector, or successor staff, caseloads and to determine how much time RCCL inspectors, or successor staff, need to adequately and safely perform their prescribed duties, in order to inform the establishment of appropriate guidelines for caseload ranges. The proposal shall include but will not be limited to: the sampling criteria, timeframes, protocols, survey questions, pool sample, interpretation models, and the questions asked during the study. DFPS shall file this proposal with the Court within 60 days of the Court's Order, and the Court shall convene a hearing to review the proposal.*

Remedial Order B2: *Within 120 days of the Court's Order, DFPS shall present the completed workload study to the Court. DFPS shall include as a feature of their workload study submission to the Court, how many cases, on average, RCCL inspectors and investigators, or any successor staff, are able to safely carry, and the data and*

information upon which that determination is based, for the establishment of appropriate guidelines for caseload ranges.

Remedial Order B3: *Within 150 days of the Court's Order, DFPS, in consultation with the Monitors, shall establish internal guidelines for caseload ranges that RCCL investigators, or any successor staff, can safely manage based on the findings of the RCCL investigator workload study, including time spent in actual investigations. In the standard established by DFPS, caseloads for staff shall be prorated for those who are less than full-time. Additionally, caseloads for staff who spend part-time in the work described by the RCCL, or successor entity, standard and part-time in other functions shall be prorated accordingly.*

Remedial Order B4: *Within 180 days of this Order, DFPS shall ensure that the internal guidelines for caseload ranges and investigative timelines are based on the determination of the caseloads RCCL investigators, or any successor staff, can safely manage are utilized to serve as guidance for supervisors who are handling caseload distribution and that these guidelines inform DFPS hiring goals for all RCCL inspectors and investigators or successor staff.*

Background

As discussed in the Monitors' prior reports, on December 16, 2019, the Court entered an agreed order requiring, in part, DFPS and HHSC to use standardized, statewide caseload guidelines of 14 to 17 investigations per RCCI investigator, and 14 to 17 tasks per RCCR (HHSC) inspector. On February 18, 2020, the State sent the Monitors the guidance developed for HHSC and DFPS staff related to the caseload guidelines.[187]

In the Third Report, the Monitors found that a majority of RCCI investigator caseloads were at or below the guidelines for the six-month period included in the analysis.[188] Most RCCR inspectors' caseloads were also within the guidelines in four of the six months analyzed for the Third Report.[189] However, in February 2021, only 47% of RCCR inspectors' caseloads were within the guidelines, and in March of 2021, half (50%) of inspectors' caseloads were within the guidelines.[190]

For this report, the Monitors analyzed caseloads for RCCI and RCCR for the 12-month period of July 2021 through June 2022, using point-in-time caseload data submitted by the State and validated through investigator and inspector interviews.

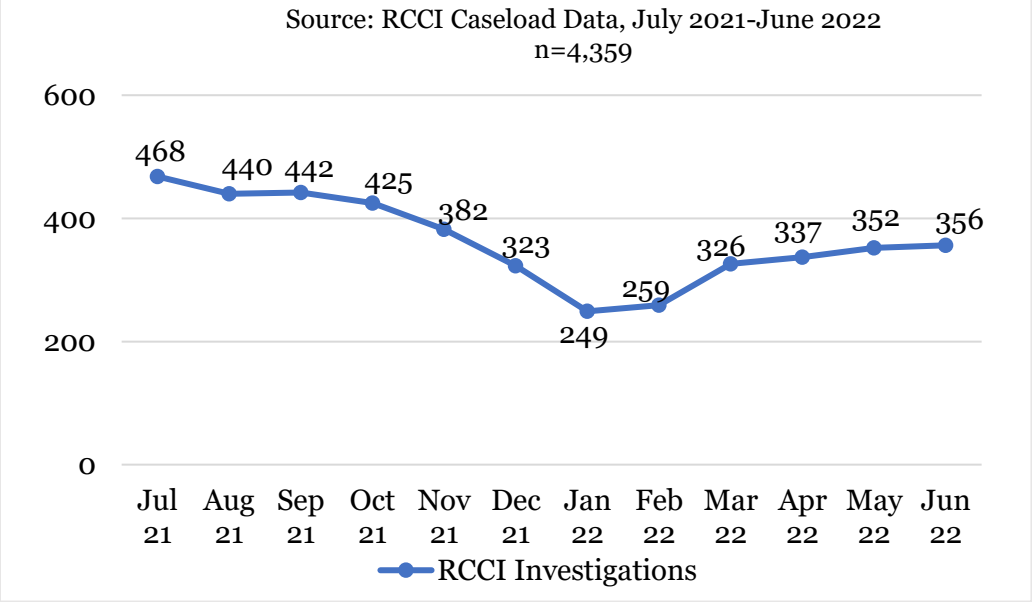
Performance Validation

RCCI Caseloads

[187] Deborah Fowler & Kevin Ryan, First Report 182-84, ECF No. 869.
[188] Deborah Fowler & Kevin Ryan, Third Report 114, ECF No. 1165.
[189] *Id.* at 120.
[190] *Id.*

The Monitors analyzed monthly caseload data for RCCI investigators, supervisors, and non-investigator RCCI staff working on RCCI investigations.[191] The total number of open RCCI investigations continued to decline through the end of 2021 and into January 2022, in keeping with the trend reported in the Monitors' Third Report,[192] but increased slightly each month from February 2022 through June 2022. However, even with the slight increase during those months, the number of investigations assigned to a caseload declined 24% between July 2021 and June 2022.

Figure 68: Number of RCCI Investigations by Month, July 2021 to June 2022



The number of RCCI investigators assigned to at least one investigation increased 30% between July 2021 and June 2022, from 64 to 83.[193] The majority of RCCI investigator caseloads were consistent with or below the guidelines between July 2021 and June 2022; all investigators' caseloads were within or below the guidelines in eight of the months studied.

Table 23: RCCI Investigators with Caseloads at or Below the Guidelines,[194] July 2021 to June 2022

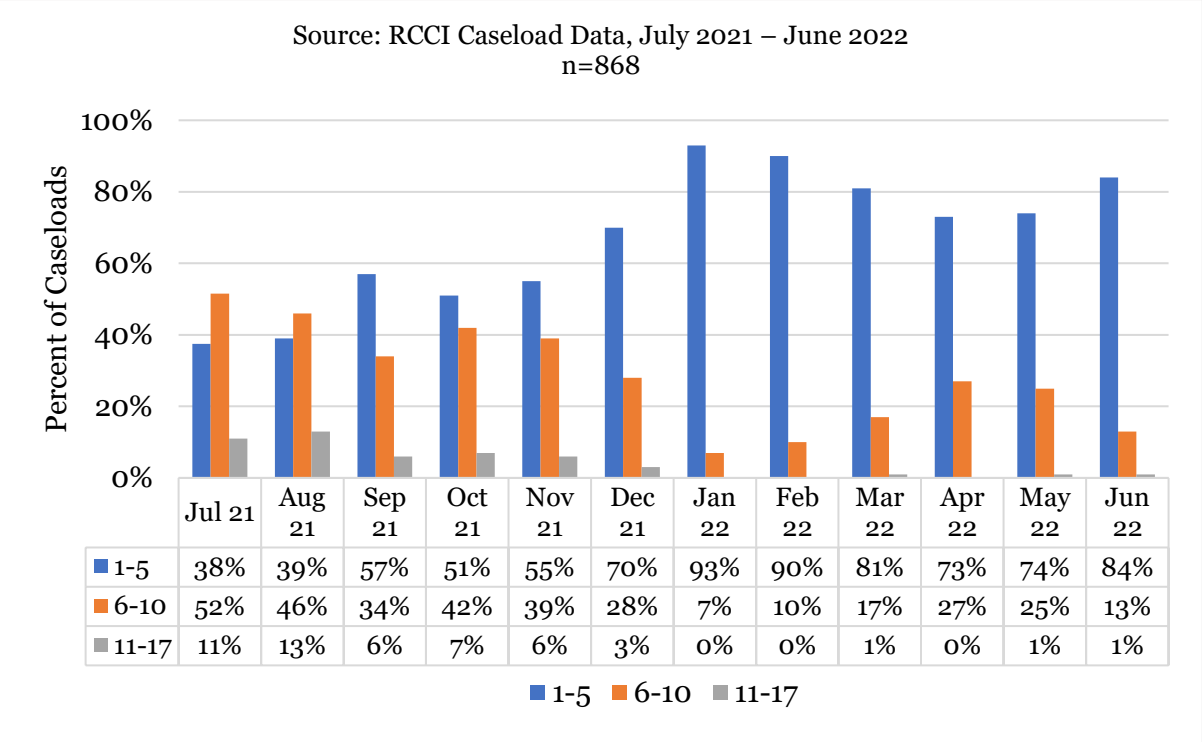
Month/Year	Investigators with at least one Investigation	17 or Fewer Investigations

[191] Each month, DFPS produces point-in-time caseload data for RCCI investigators, supervisors, and non-investigator staff assigned an investigation as of the last day of the month.
[192] *Id.* at 113-14.
[193] This reflects the number of investigators who were assigned at least one investigation as of the last day of the month.
[194] Includes only investigations assigned to investigators as of the last day of the month. Does not include investigations assigned to supervisors or non-investigators.

	No.	No.	%
July 2021	64	64	100%
August 2021	61	60	98%
September 2021	76	74	97%
October 2021	71	71	100%
November 2021	66	66	100%
December 2021	69	69	100%
January 2022	69	69	100%
February 2022	78	78	100%
March 2022	77	76	99%
April 2022	77	77	100%
May 2022	77	77	100%
June 2022	83	82	99%

More than half of RCCI investigators had five or fewer cases on their caseload in ten of the 12 months analyzed.

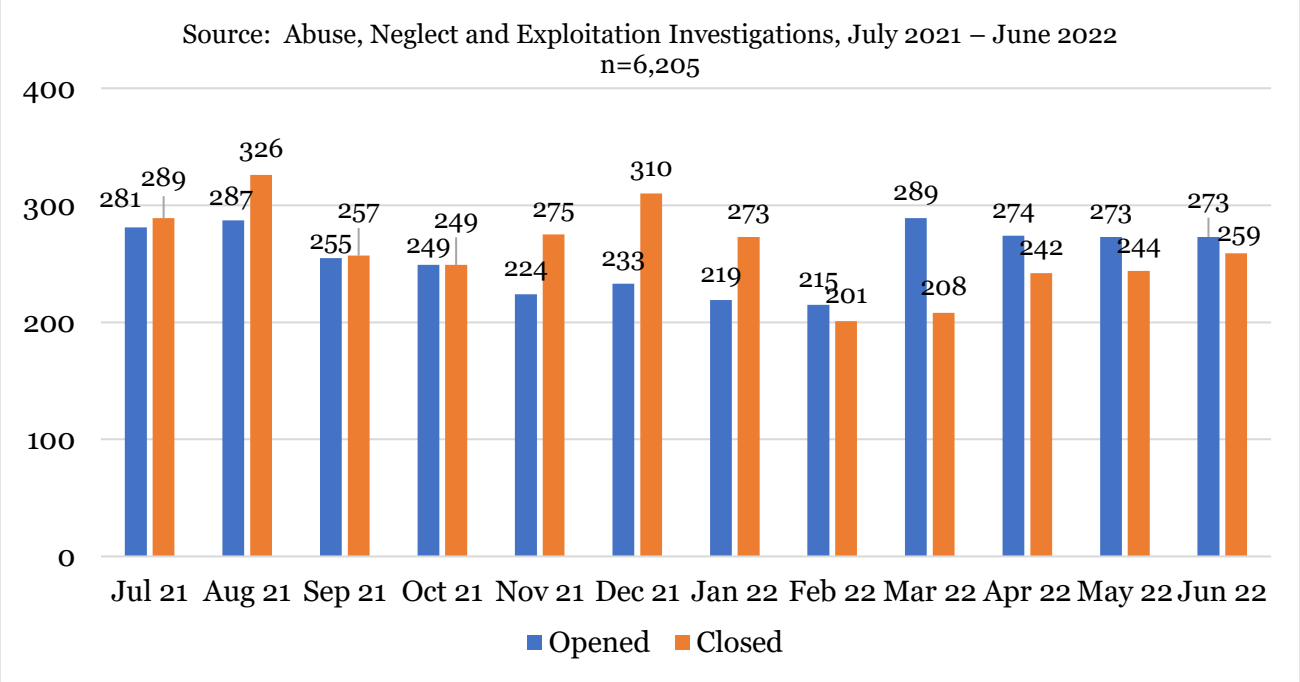
Figure 69: RCCI Investigator Caseloads by Number of Investigations, July 2021 to June 2022



	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
1-5	38%	39%	57%	51%	55%	70%	93%	90%	81%	73%	74%	84%
6-10	52%	46%	34%	42%	39%	28%	7%	10%	17%	27%	25%	13%
11-17	11%	13%	6%	7%	6%	3%	0%	0%	1%	0%	1%	1%

Between July 2021 and January 2022, the number of investigations closed outpaced the number of new investigations opened. This trend did not hold for the remaining months included in the analysis (February 2022 through June 2022), despite the increase in the number of investigators assigned a caseload.

Figure 70: Abuse, Neglect and Exploitation Investigations Opened and Closed by Month, July 2021 to June 2022



Supervisors of RCCI investigators were responsible for supervising up to six investigators, providing support on as many as 83 investigations a month during the period analyzed. RCCI supervisors assisted with cases as needed and approved completed cases. Each supervisor supervised four-to-six RCCI investigators and assisted with 14-to-32 investigations each month.

Table 24: Number of RCCI Supervisors[195], Average Investigators Supervised, Average RCCI Investigations Overseen, July 2021 to June 2022

Month/Year	Number of RCCI Supervisors	Average RCCI Investigators per Supervisor	Average RCCI Investigations Overseen
July 2021	14	5	31
August 2021	13	4	28
September 2021	12	6	32

[195] Includes only those RCCI supervisors supervising an RCCI investigator with one or more investigations on their caseload as of the last day of the month.

October 2021	13	5	30
November 2021	16	4	21
December 2021	18	4	17
January 2022	18	4	14
February 2022	16	5	15
March 2022	15	5	20
April 2022	17	5	20
May 2022	15	5	21
June 2022	16	5	21

As discussed in the Monitors' previous reports, RCCI supervisors sometimes act as the primary investigator in an investigation in addition to supervising staff.[196] Between July 2021 and June 2022, the number of supervisors working as the primary investigator in an investigation each month ranged from zero to four, and the total number of investigations assigned to supervisors each month ranged from zero to seven.

The monitoring team interviewed investigators to validate the data provided by the State related to caseloads.[197] While there were some inconsistencies between the investigators' responses to questions related to the number of cases on their caseloads and the data provided, and between the caseload reports provided for the interviews and the data, the differences were never greater than two cases and would not have affected caseloads for those investigators for purposes of the guidelines.

RCCR (HHSC) Caseloads

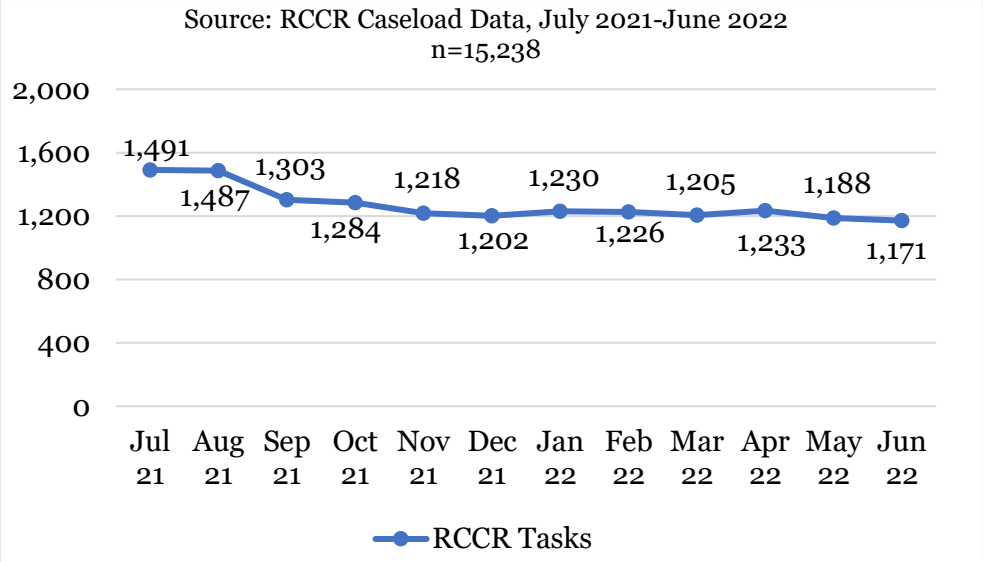
RCCR caseloads consist of "tasks," including investigations referred from RCCI, minimum standard investigations, assigned operations, and sampling inspections in agency foster homes. According to the point-in-time caseload data provided by HHSC,

[196] Deborah Fowler & Kevin Ryan, Third Report 115, ECF No. 1165.

[197] The monitoring team conducted interviews with RCCI investigators and supervisors via videoconference on February 1, 2022, February 2, 2022, March 31, 2022, and August 1, 2022. A total of 44 RCCI staff were interviewed: 35 investigators and nine supervisors. The monitoring team randomly selected investigators and supervisors for interview from a list provided by DFPS of all staff working as RCCI investigators and supervisors. Staff previously interviewed, staff not yet case assignable, and staff who had been case assignable for 60 days or less were not eligible for interview. Staff were randomly selected from those eligible for interview. Prior to the interviews, the monitoring team requested caseload reports for RCCI staff selected for interview. DFPS provided a total of 48 investigator caseload reports. The caseload reports provided by DFPS included RCCI investigations assigned to the selected investigators the day of, or the day before (for investigators interviewed February 2, 2022), the interview. The Monitors compared data from the caseload reports to monthly RCCI caseload data received from DFPS to verify the accuracy of the State's monthly caseload data. RCCI investigators were asked about the number of investigations on their caseload reports as of the last day of the preceding month and as of the day of the interview. The monitoring team also compared State caseload reports to caseload information reported by investigators.

the total number of RCCR tasks assigned to RCCR caseloads[198] decreased 21% (from 1,491 to 1,171) between July 2021 and June 2022.[199]

Figure 71: Number of RCCR Tasks, July 2021 to June 2022



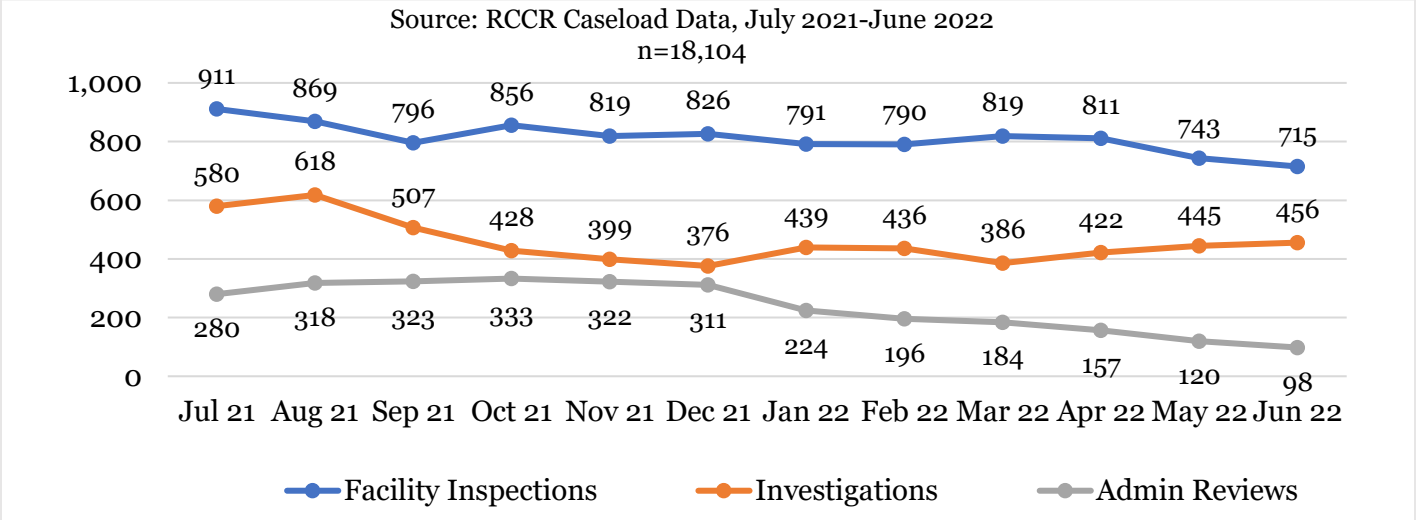
The decline in the number of tasks assigned to RCCR caseloads may be related to the decline in RCCI investigations opened (discussed above),[200] as well as increases in the number of RCCR Heightened Monitoring inspectors who were assigned tasks that were not associated with Heightened Monitoring.[201]

A comparison between the types of tasks assigned to caseloads shows that facility inspections (which include both regular inspections of assigned operations and sampling inspections of foster homes) consistently accounted for most tasks, ranging from 68% to

[198] The number of tasks does not include administrative reviews assigned to the caseload of RCCR supervisors or RCCR inspectors. RCCR inspectors are assigned administrative reviews after completion by the supervisor to ensure compliance and/or to close the investigation.
[199] Each month, HHSC produces point-in-time caseload data for RCCR inspectors and supervisors as of the first day of the month.
[200] Generally, once RCCI has completed an investigation of allegations of abuse, neglect or exploitation, the case is transferred to RCCR to investigate potential minimum standards violations. A decline in the number of RCCI investigations may therefore have resulted in fewer RCCR investigations.
[201] When HHSC developed policies and procedures associated with Heightened Monitoring, it created new positions for staff dedicated to operations under Heightened Monitoring. Heightened Monitoring inspectors have between five and eight Heightened Monitoring operations on their caseload. In March 2021, RCCR began assigning up to five Priority 5 investigations (which require only a desk review) to Heightened Monitoring inspectors. However, the number and type of non-Heightened Monitoring tasks assigned to these inspectors changed in February 2022. According to data produced to the Monitors by the State, the number of Heightened Monitoring inspectors assigned tasks increased from six in February 2022 to 21 in March 2022. Similarly, the number of non-Heightened Monitoring tasks assigned to Heightened Monitoring inspectors increased from 25 in February 2022 to 69 in March 2022. Recent changes associated with streamlining Heightened Monitoring may also affect the way tasks are assigned to Heightened Monitoring inspectors.

58% of tasks per month. Both facility and investigation tasks declined during the period, as did administrative reviews.[202]

Figure 72: Number of Facility Inspections, Investigations, and Administrative Reviews, July 2021 to June 2022



The majority of RCCR inspectors' caseloads were within the guidelines throughout the review period;[203] the proportion of inspectors with caseloads within the guidelines increased as the total number of assigned tasks decreased.

Table 25: RCCR Inspectors with Caseloads at or Below Guidelines,[204] July 2021 to June 2022

Month/Year	Inspectors with at Least One Task	17 or Fewer Tasks	
	No.	No.	%
July 2021	95	75	79%
August 2021	89	60	67%
September 2021	88	72	82%

[202] Administrative reviews are conducted by RCCR supervisors. An RCCR inspector receives an administrative review in order to ensure compliance and/or to close the investigation in CLASS after a determination has been made by the supervisor conducting the review. As of July 1, 2022 (which is outside the period reviewed for this report), the responsibility for conducting administrative reviews was shifted from RCCR to a different division within HHSC.

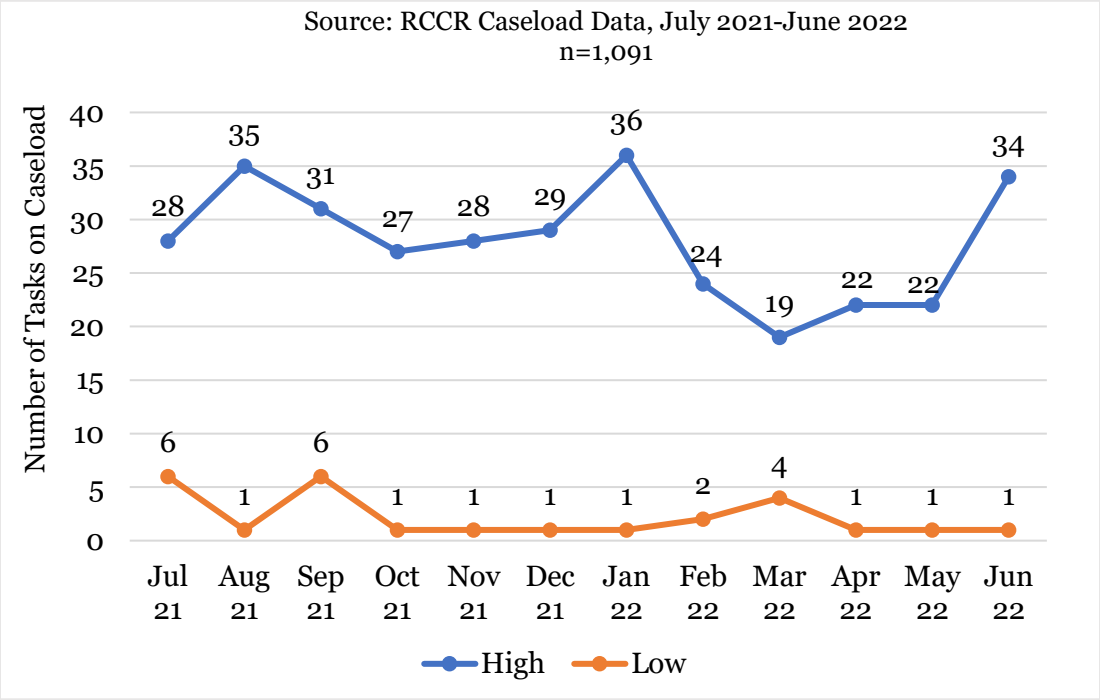
[203] RCCR inspector caseload calculations do not include administrative reviews assigned to an inspector as of the first day of the month.

[204] This calculation does not include administrative reviews assigned to inspectors to ensure compliance or to close the investigation nor does it include RCCR Heightened Monitoring inspectors or their assigned tasks.

October 2021	88	71	81%
November 2021	92	83	90%
December 2021	90	82	91%
January 2022	89	76	85%
February 2022	90	77	86%
March 2022	92	87	95%
April 2022	95	91	96%
May 2022	93	87	94%
June 2022	91	84	92%

However, for RCCR inspectors whose caseloads exceeded the guidelines, caseload highs were more than twice the guidelines in three of the months reviewed.

Figure 73: RCCR Inspector Caseload High and Low by Month, July 2021 to June 2022



RCCR supervisors managed an average of four inspectors and oversaw an average of 45 inspector tasks each month during the review period.[205]

Table 26: Number of RCCR Supervisors, Average Inspectors Supervised, Average Tasks Overseen, July 2021 to June 2022

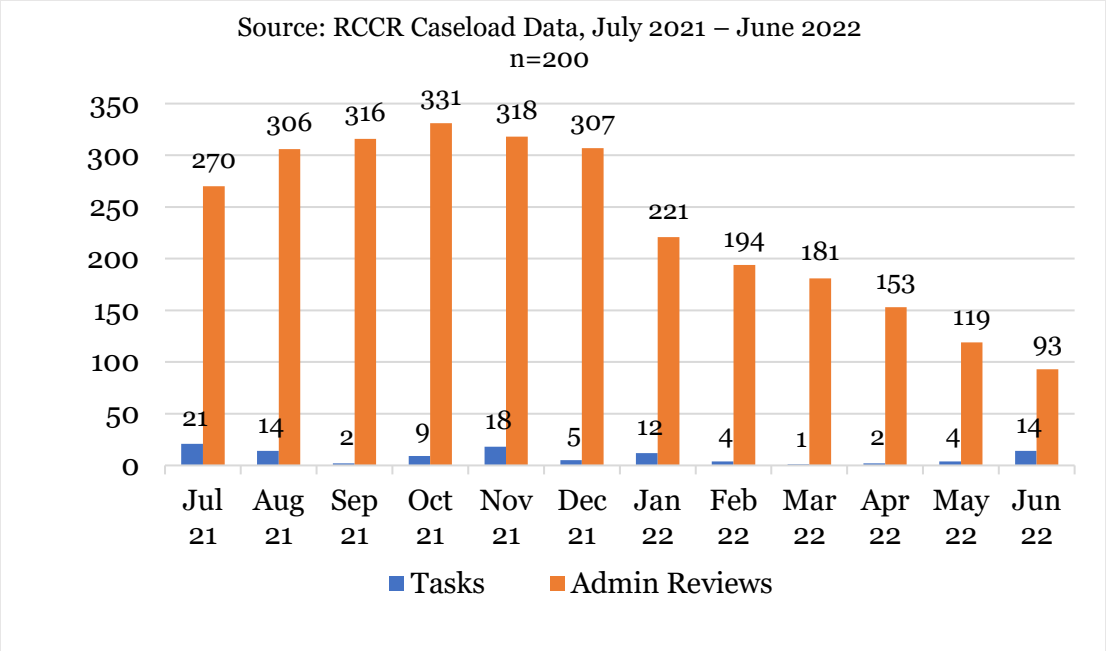
[205] The average number of inspectors supervised includes only those with one or more assigned tasks as of the first of the month.

Month/Year	Number of RCCR Supervisors	Average RCCR Inspectors per Supervisor	Average RCCR Tasks Overseen
July 2021	25	4	53
August 2021	29	4	45
September 2021	28	4	42
October 2021	26	4	44
November 2021	25	4	45
December 2021	26	4	43
January 2022	22	5	51
February 2022	23	5	49
March 2022	27	5	43
April 2022	28	5	43
May 2022	28	5	40
June 2022	27	4	40

Administrative reviews kept some supervisors' caseloads high throughout the review period.

Figure 74: Tasks[206] and Administrative Reviews Assigned to RCCR Supervisors, July 2021 to June 2022

[206] Tasks assigned to RCCR supervisors included investigations, inspections of assigned operations, and sampling inspections in agency foster homes.

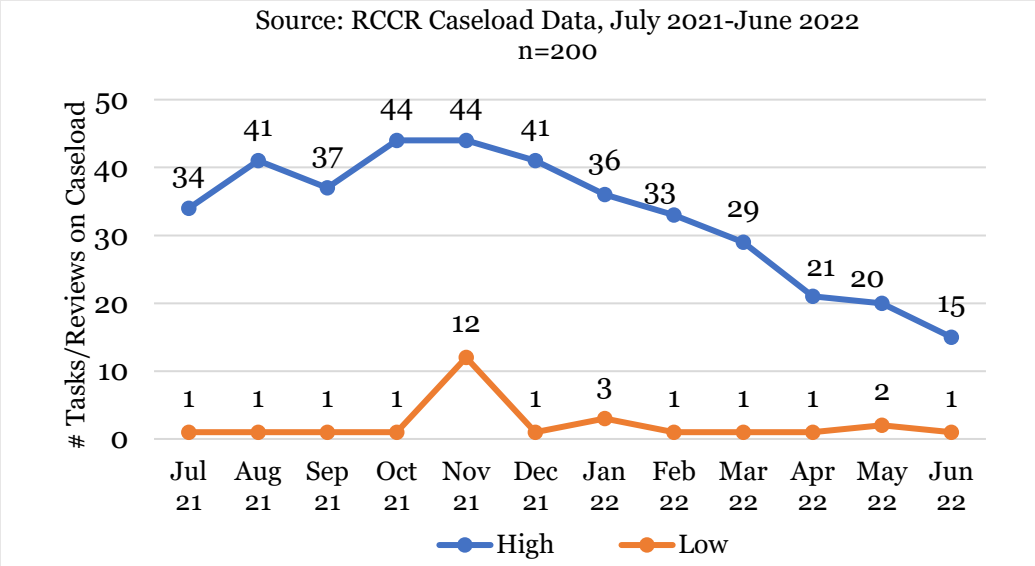


On average, 59% of RCCR supervisors were assigned one or more tasks and/or administrative reviews per month, in addition to supervising subordinates.[207] For supervisors with a caseload, between July 2021 and January 2022, the majority were assigned 18 or more tasks and/or reviews. In September, October, and November 2021, more than 40% (18 of 41) of supervisors with a caseload were assigned 26 or more tasks and/or reviews, with supervisor caseload highs in October 2021 and November 2021 reaching 44 tasks and/or reviews. In February 2022, supervisor caseloads began to decline; from February 2022 through June 2022, most supervisors who carried a caseload had 17 or fewer tasks and/or reviews on their caseloads.

Figure 75: RCCR Supervisor Caseload High and Low by Month,[208] July 2021 to June 2022

[207] Supervisors may be solely responsible for supervising inspectors or responsible for supervising inspectors as well as being assigned tasks and/or administrative reviews. As of July 1, 2022, the responsibility for conducting administrative reviews was shifted from RCCR to a different division within HHSC.

[208] Includes only supervisors assigned one or more task or administrative review in the month.



The monitoring team also interviewed RCCR inspectors and supervisors to validate the caseload data provided by the State.[209] All of the February 2022 caseload reports provided to the monitoring team prior to the interviews matched the monthly caseload data for those inspectors. The caseload reports provided to the monitoring team prior to the interviews conducted on April 1, 2022 and August 2, 2022 were pulled from the same data set that the State produces for the Monitors monthly. For this reason, the caseload data for these months could not be validated through the interview process.[210]

---

[209] The monitoring team conducted RCCR inspector and supervisor interviews via videoconference on February 3, 2022, February 4, 2022, April 1, 2022, and August 2, 2022. A total of 46 RCCR staff were interviewed: 32 inspectors and 14 supervisors. The monitoring team randomly selected inspectors and supervisors from a list provided by HHSC of all staff working as RCCR inspectors and supervisors as of January, March, and June 2022. Staff previously interviewed, staff not yet case assignable or who had been case assignable 60 days or less, and Heightened Monitoring inspectors and supervisors were not eligible for interview.

Prior to the interviews, the monitoring team requested caseload reports for the RCCR inspectors selected for interviews. HHSC provided a total of 42 caseload reports for the selected inspectors showing tasks assigned to the inspectors one or two days (for those interviewed February 4, 2022) prior to the interview.

[210] In an e-mail from HHSC, the monitoring team was informed that the caseload reports for the inspectors who were scheduled to be interviewed in April 2022 were available on Tableau, and that the reports could be pulled by HHSC or by the monitoring team by accessing the monthly caseload data in Tableau and filtering for everyone to be interviewed. E-mail from Katy Gallagher, Counsel, HHSC, to Linda Brooke, Monitoring Team (Apr. 4, 2022) (on file with the Monitors). In this e-mail and in a subsequent call with HHSC staff on June 27, 2022, the monitoring team was informed that the caseload reports pulled prior to inspectors' interviews were generated from the same data source as caseload data provided monthly. HHSC continued to provide caseload reports to the monitoring team to assist with the interview process, though the caseload reports could not be used to validate the monthly data produced by the State. On October 25, 2022, the monitoring team had a second call with HHSC staff to discuss the methodology used to pull caseload reports and the purpose of the requested reports to verify monthly caseload data provided to the Monitors. HHSC indicated that CLASS did not allow for caseload reports to be generated and printed for individual inspectors in the same way that IMPACT allows caseload reports to be generated and printed for DFPS caseworkers and investigators. HHSC suggested that the Monitors could instead use a laptop to

During interviews, inspectors reported differences between the number of tasks assigned and the number of tasks shown on caseload reports provided to the monitoring team prior to the interviews. Inspectors were asked for the number of tasks on their caseloads as of the first of the month. The number of operations and investigations on the caseload reports provided by HHSC did not match the reported number and type of task reported by inspectors for 17 of 32 (53%) inspectors interviewed.[211] However, of the inspectors who reported a difference in the number of tasks, only one inspector reported having a caseload over the guidelines; though the data produced by HHSC showed this inspector had 12 assigned tasks, the inspector reported having 19 tasks on their caseload.

Most inspectors also reported conducting team inspections and receiving secondary assignments that did not appear on their caseload reports: 97% (31 of 32) of inspectors interviewed said they had participated in a team inspection of an operation for which they were not the primary inspector. In addition, 59% of inspectors interviewed (19 of 32) reported being assigned as a "designee," or secondary, for an investigation.[212] Most of these inspectors (16) said that these investigations were not included on caseload reports.

Eighty-four percent of the RCCR inspectors interviewed reported job duties in addition to the tasks included in caseload reports.

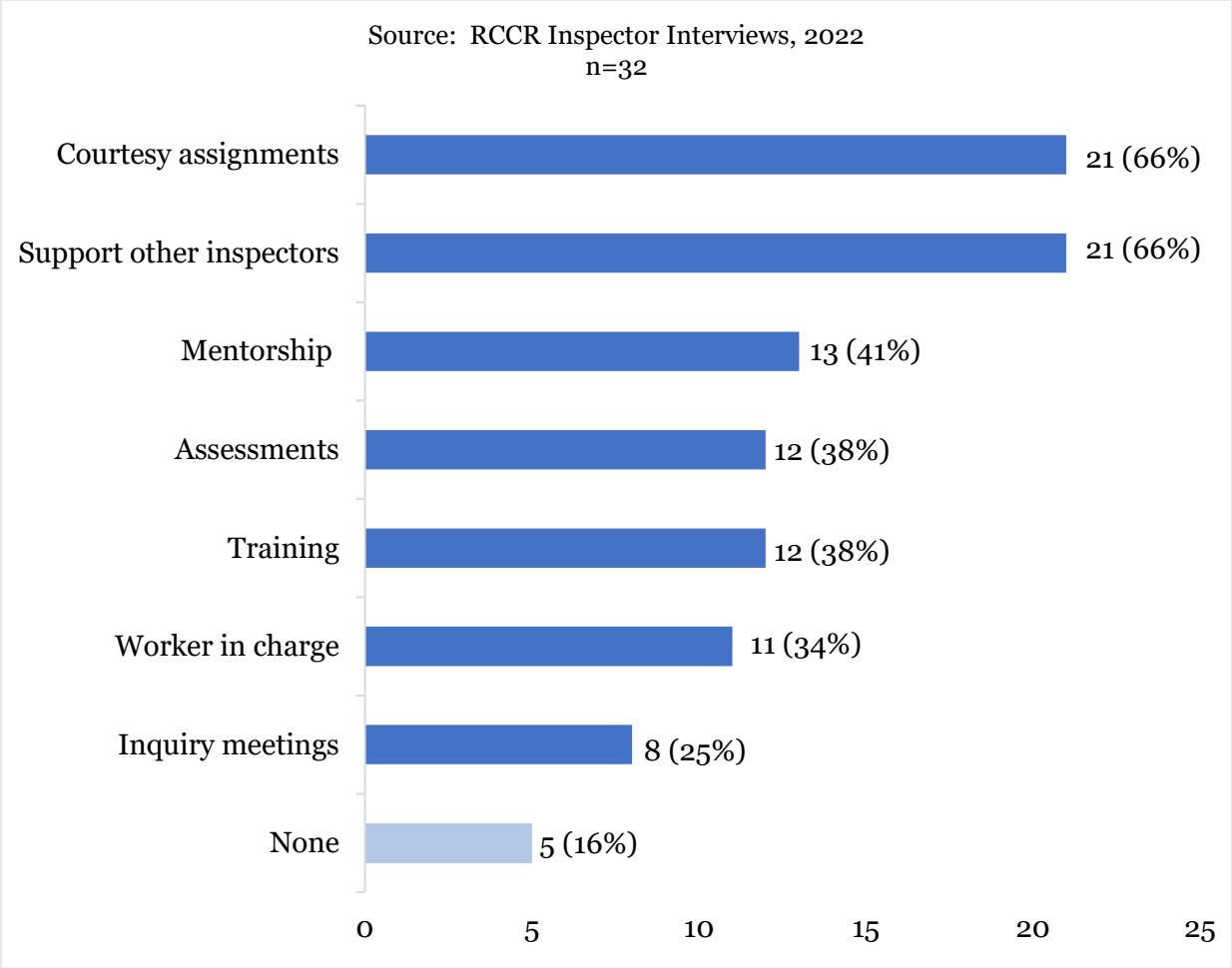
Figure 76: Other Job Responsibilities Reported by RCCR Inspectors[213]

access and view an inspector's caseloads on CLASS during the inspector's interview, then compare the information in CLASS to the monthly data. The Monitors agreed to use this method going forward.

[211] The number of tasks assigned to inspectors may change daily. Differences in the caseload reports compared to the number of tasks reported by inspectors may be the result of changes in the inspectors' assignments not yet reflected in their caseload report.

[212] According to the Residential Child Care Regulation Handbook, a "CLASS designee" is assigned a specific task in a caseload belonging to another employee for a specified period. The Handbook also notes, "Designees may be assigned tasks not routinely associated with their job position (for example, serving as an acting supervisor while the actual supervisor is on leave)." HHSC-RCCR, *Child Care Regulation Handbook*, Definitions of Terms (May 2021), *available at* https://www.hhs.texas.gov/handbooks/child-care-regulation-handbook/definitions-terms.

[213] Each inspector interviewed was asked what other job responsibilities they were assigned, in addition to RCCR tasks. An inspector could have responded multiple times, one response for each job responsibility they had in addition to tasks.



Summary

Almost all RCCI investigator and most RCCR (HHSC) inspector caseloads were within the guidelines during each month of the period from July 2021 through June 2022. Of RCCR supervisors who carried a caseload, however, most were assigned 18 or more tasks in seven of the 12 months analyzed for this report.

Remedial Order 2: Graduated Caseloads

Within 60 days, DFPS shall ensure statewide implementation of graduated caseloads for newly hired CVS caseworkers, and all other newly hired staff with the responsibility for primary case management services to children in the PMC class, whether employed by a public or private entity.

Background

Pursuant to the generally applicable, internal caseload standards, effective February 15, 2020, in the first month following a protégé worker's eligibility for primary case

assignment, per DFPS's policy, the protégé's caseload may not exceed six children.[214] In the second month of eligibility, the protégé's caseload may not exceed 12 children.[215] In the third month of eligibility, the protégé is eligible to be assigned a full caseload.[216]

DFPS provides monthly data reports to the Monitors for its caseworkers, along with dates associated with primary case assignment eligibility. In its monthly reports, DFPS includes compliance data reporting on caseloads for the 15th and 45th days after caseworkers' eligibility for primary case assignment.[217] DFPS provides the same information for caseworkers employed by the SSCCs responsible for case management in their respective regions.

Remedial Order 2 Graduated Caseloads Results and Performance Validation

The Monitors evaluated the State's performance associated with Remedial Order 2 through analysis of the data provided by DFPS about its own caseworkers and the caseworkers employed by OCOK, 2Ingage, and St. Francis, the three SSCCs responsible for case management during this period consistent with prior reporting periods.[218, 219] To further validate the accuracy of the State's caseload data, the monitoring team also interviewed 42 randomly selected caseworkers during this reporting period who were subject to graduated caseloads and validated the data in the caseload reports.

For this report, the monitoring team examined the caseloads of caseworkers who became eligible for case assignment between July 1, 2021 to June 30, 2022. As in prior reporting, the Monitors verified the caseloads at three points in time.[220] The monitoring team identified 866 instances where caseworkers stayed in their positions for at least 15 days after they became eligible for case assignment between July 1, 2021 and June 30, 2022.

---

[214] DFPS, *Generally Applicable Caseload Standards – Guidelines for Conservatorship (CVS)*, at 8 (July 2020).
[215] *Id.*
[216] *Id.*
[217] DFPS reported in March 2020 that it was unlikely it could report on the daily compliance data for graduated caseloads in the near term as requested. *See* E-mail from Tara Olah to Kevin Ryan and Deborah Fowler (Mar. 24, 2020) (attaching DFPS response to Feb. 21, 2020 Data and Information Request).
[218] As previously identified and consistent with prior reporting, the Monitors used the relevant monthly data reports for the corresponding time period, along with a comprehensive file submitted by DFPS at the close of the reporting period, all on file with the Monitors and DFPS.
[219] As reported previously, DFPS informed the Monitors that the department did not have the capacity to report the total number of days during the month that new caseworkers' caseloads are not compliant with the graduated caseload standard. *See* Deborah Fowler & Kevin Ryan, First Report 163-164, ECF No. 869; E-mail from Andrew Stephens, Ass't Att'y Gen., Office of Att'y Gen. of Tex. to Kevin Ryan and Deborah Fowler (Oct. 18, 2019) (on file with the Monitors) (attaching DFPS Information and Data Request Proposal in response to the Monitors' Sept. 30, 2019 Data and Information request).
[220] The Monitors used the same methodology as reported in the Third Report. *See* Deborah Fowler & Kevin Ryan, Third Report 17, ECF No. 1165. The Monitors verified whether staff subject to graduated caseloads conformed to the graduated caseload standard at three points in time: the 15th day after eligibility, the 45th day after eligibility, and on the calendar date at the end of the month after the 15th day of eligibility. To assess performance associated with the graduated caseload standards, the monitoring team calculated the percentage of workers who carried a number of children on their caseloads that was at or below the allotted caseload limit by the total number of staff subject to graduated caseloads at each point in time.

Of these 866 instances, 738 were staff who worked for DFPS, 60 were staff who worked for OCOK, 39 were staff who worked for 2INgage and 29 were staff who worked for St. Francis. Most of the caseworkers subject to graduated caseloads who worked for DFPS had the job title CPS CVS Specialist I (649 of 738 or 88%). The other workers at DFPS subject to graduated caseloads had the job titles CPS CVS Specialist II (24 of 738 or 3%), III (26 of 738 or 4%), IV (37 of 738 or 5%) or CPS Program Specialist (2 of 738 or 0.002%). The caseworkers subject to graduated caseloads at 2INgage all had the title of Permanency Case Manager. The caseworkers subject to graduated caseloads at OCOK and St. Francis all had the title of Permanency Specialist.

As shown in the table below, on the 15th day after becoming case assignable, more than 99% (863 workers) of the 866 workers conformed to the graduated caseload standard of six or fewer case assignments. On the last day of the month following the 15th day, 99% (760 workers) of 768 workers who matched the monthly data were in conformance with the graduated caseload standard.[221] On the 45th day after becoming case assignable, more than 99% (794 workers) of the 797 workers still receiving case assignments and who had reached their 45th day after becoming case assignable conformed to the graduated caseload standard.

Table 27: Caseworkers Conforming to the Graduated Caseload Standards at Three Points in Time

Month Case Assignable	New Caseworkers that reached 15th day	15th Day	Last Day of Month Following 15th Day	45th Day	Average conformity Rate
July 2021	52	98%	94%	100%	97%
August 2021	48	100%	100%	98%	99%
September 2021	50	100%	98%	100%	99%
October 2021	87	99%	100%	100%	100%
November 2021	104	100%	100%	99%	100%
December 2021	74	100%	99%	99%	99%
January 2022	125	100%	99%	100%	100%
February 2022	45	100%	100%	100%	100%

[221] The standard the Monitors used on the last day of the month after the 15th day of case assignability was either six assignments or 12 assignments, depending on when the worker became eligible to accept cases. Thirty-six workers were not matched to the end of the month caseload data and had no termination date. Of these 36, 14 were St. Francis workers with case assignability dates in early March 2022 and did not match because the Monitors determined that the March 31, 2022 St. Francis caseload data were insufficient due to data quality concerns. All St. Francis workers who were subject to graduated caseloads and who had a last day of the month on April 30,2022 or later matched the last day of the month. Some workers subject to graduated caseloads are not assigned any cases on the last day of the month and thus do not appear in the monthly caseload reports received by the Monitors. Of the 17 DFPS workers who did not match on the last day of the month, for example, 15 had not been assigned any children on their 15th day after becoming case assignable. In other situations, workers subject to graduated caseloads were sent for retraining in a different casework specialty and no longer appear in the graduated caseload reports.

March 2022	102	100%	99%	100%	100%
April 2022	63	100%	100%	100%	100%
May 2022	50	98%	98%	100%	99%
June 2022	66	100%	100%	100%	100%
Total	**866**	**100%**	**99%**	**100%**	**99%**

On average over the three points in time, more than 99% of new caseworkers' caseloads were in conformance with the graduated caseload standard. The high correlation of rates of conformance on the last day of the month to the rates of conformance on the 15th and 45th days is important, as the end of month data were verified by the Monitors through interviews with caseworkers.

In general, almost all workers who became case assignable on or after July 1, 2021 received assignments that conformed to the graduated caseload standards. Assignments at the SSCCs (OCOK, 2Ingage, and St. Francis) were rarely above the applicable standards in the first and second months of case assignability.

The monitoring team interviewed 42 caseworkers assigned to 22 counties across the state who were subject to the graduated caseloads policy under Advancing Practice. Between May 4, 2022 and June 7, 2022, the monitoring team interviewed via videoconference a randomly selected sample of 30 caseworkers from DFPS and 12 caseworkers from the three SSCCs (OCOK, 2INgage, and St. Francis) responsible for case management during this reporting period. All were hired between November 8, 2021 and March 2, 2022 and became subject to graduated caseloads between March 17, 2022 and May 27, 2022. Twenty-two of the caseworkers in the sample had the job title CPS CVS Specialist I, two had the title CPS CVS Specialist II, three had the title CPS CVS Specialist III, and one was a CPS CVS Specialist IV. The SSCC workers included one Permanency Case Manager and 11 Permanency Specialists.

The monitoring team reviewed, with the workers interviewed in May 2022, their case assignment detail reports dated May 1, 2022 generated from the DFPS INSIGHT system. With the SSCC workers interviewed in June 2022, the monitoring team reviewed their case assignment workload reports dated June 1, 2022 and supplied by DFPS. The individual caseloads of 41 of the 42 caseworkers interviewed ranged from two to 11 children.[222] Twenty-four of the caseworkers were in the first month of eligibility for case assignment and 17 of the workers were in the second month of case assignability. One (2%) of the 41 caseworkers had a caseload that exceeded the caseload guidance during the first month of case assignability. The monitoring team compared the results of the interviews of these caseworkers with the corresponding monthly caseload data submitted by DFPS to confirm the accuracy of the graduated caseload data collected during caseworker interviews. During the Monitors' cross-data validation of the INSIGHT and workload reports of these 41 workers with the DFPS monthly caseload data, the

[222] One caseworker had no PMC assignment on the last day of the month under review; therefore, the worker was not included in the monthly caseload data reported by DFPS.

monitoring team found that 100% of the caseloads were a perfect match to those reported directly by caseworkers interviewed who were subject to graduated caseloads.[223]

Summary of Performance Validation

For staff subject to graduated caseload standards between July 1, 2021 and June 30, 2022:

- On average, staff's caseloads conformed with the graduated caseload standards more than 99% of the time. This represents the average rate of conformance of the 866 workers assessed on their 15th day following case assignability; the 768 workers assessed on the last day of the month following the 15th day of case assignability; and the 797 workers assessed on their 45th day following case assignability.

- On the 15th day, more than 99% of workers conformed to the graduated caseload standard of six children.

- On the last day of the month following the 15th day of case assignability, 99% of workers conformed to the graduated caseload standard.

- On the 45th day, more than 99% of workers conformed to the graduated caseload standard of 12 children.

- The State's compliance with Remedial Order 2 exceeded 97% in each of the 12 months during the period.

- Rates of conformity did not vary significantly between DFPS and the SSCCs with case management responsibilities.

Child Fatalities

After learning through the Monitors of the death of a child in the PMC General Class, the Court ordered on February 21, 2020:

Within 24 hours of this order's time and date, Defendants are ordered to report to the Monitors the death of any PMC child occurring from July 31, 2019 forward until further order of this Court. Defendants are further ordered to provide to the Monitors all records that the Monitors deem necessary and relevant including, but not limited to, reports, interviews, witness statements, and investigations from any and all said deaths that have occurred from July 31, 2019 forward until further order of this Court.

Defendants have continued to provide notification to the Monitors of PMC child fatalities. As discussed in the First and Second Monitors' Reports and the April 2022 Update to the

[223] *Id.*

Court Regarding Child Fatalities, DFPS notified the Monitors that 33 children in the PMC General Class died between July 31, 2019 and December 31, 2021. These fatalities included seven children whom DFPS determined were abused or neglected by their caregivers in connection with their deaths or their care prior to their deaths.

Since the April 2022 Update to the Court, DFPS reported that 14 additional PMC children died between January 1, 2022 and December 1, 2022, bringing the number of PMC children who have died since July 31, 2019 to 47. Of the 14 children who died during this report period, DFPS or HHSC determined that 11 of these children's deaths did not involve abuse or neglect or determined that an investigation was not necessary. These 11 fatalities involved nine children with severe medical conditions and two teenagers who died from gun violence. As of November 15, 2022, DFPS's investigations into the remaining three children's deaths remained opened. The Monitors will review and discuss these children's deaths in the next report to the Court.

Child Fatalities Involving Children in the PMC Class

Child Fatalities, No Abuse or Neglect Determined

S.P., Born January 29, 2010; Died January 2, 2022

S.P., an 11-year-old boy, passed away from significant medical complications. S.P. had the following diagnoses: cerebral palsy, chronic lung disease and congenital muscular dystrophy. S.P. was non-verbal, unable to walk and required the assistance of oxygen 24 hours a day. From 2016 until his death, S.P. resided in a therapeutic foster home that served Primary Medical Needs (PMN) children. According to RCCI's investigation into S.P.'s death, in the early hours of January 2, 2022, S.P.'s oxygen saturation and heart rate began to fall. S.P.'s in-home nurse called 911 while S.P.'s foster father and another in-home nurse performed lifesaving measures on the child until Emergency Medical Services (EMS) arrived at the home. The First Aid Responders' efforts to resuscitate S.P. were unsuccessful, and the child was pronounced dead 45 minutes later. In response to his death, S.P.'s primary care physician reported that S.P.'s congenital muscular dystrophy and weakness in his lungs were "just too much and it [S.P.'s respiratory system] gave out." The physician reported that she did not have concerns about the care the foster parents or nursing staff provided to S.P. in the foster home. During their interviews with the investigator, S.P.'s in-home nurses stated that the foster parents were "very caring" and S.P. received appropriate care in the foster home. RCCI's investigation into S.P.'s death found no concerns for maltreatment. Due to S.P.'s medical condition, the county medical examiner did not perform an autopsy.

I.B., Born November 27, 2016; Died January 13, 2022

I.B., a five-year-old girl, passed away from significant medical complications. I.B. had the following diagnoses: spastic quadriplegic cerebral palsy, chronic obstructive pulmonary disease, static encephalopathy (permanent lack of brain function), epilepsy, developmental delays, catatonic, severe scoliosis, failure to thrive and oropharyngeal

dysphasia. I.B. was nonverbal and legally blind; she used a gastrostomy button and a wheelchair. At the time of her death, I.B. resided in a therapeutic foster home and received 24-hour nursing care in the home. Due to I.B.'s medical condition, I.B. was in hospice care and subject to an active Do Not Resuscitate (DNR) order. According to RCCI's investigation into I.B.'s death, on January 12, 2022, I.B. stopped eating, started retaining more body fluid and experienced fluctuating oxygen levels and heart rate. A hospice nurse advised the foster father that I.B. would soon pass away. Nurses provided I.B. with acetaminophen and, later, morphine to ease her pain. In the early hours of January 13, 2022, a hospice nurse pronounced I.B. as deceased. In its investigation into I.B.'s death, the RCCI investigator interviewed several of I.B.'s hospice nurses, her CPS caseworker, and her case manager; these individuals reported no concerns regarding the quality of care I.B. received in the foster home. Three of the child's nurses, as well as her caseworker, reported that due to I.B.'s medical condition, her doctors did not expect her to live much longer than she did. RCCI's investigation into I.B.'s death found no concerns for maltreatment. Due to I.B.'s medical condition and DNR order, the director of the funeral home confirmed that the county medical examiner did not perform an autopsy.

E.B., Born July 13, 2017; Died January 18, 2022

E.B., a four-year-old boy, passed away from significant medical complications. E.B. had the following diagnoses: congenital heart disability, cerebral palsy, tracheomalacia, esophageal atresia (EA) repair, laryngomalacia, tracheoesophageal fistula, hypoxemia, dysphagia, hypertonia/hypotonia, epilepsy, sleep apnea, dystonia, encephalopathy, temperature irregularity, seizures, and neuro storming. He used a tracheostomy tube and a ventilator. At the time of his death, E.B. resided in a therapeutic foster home where he received 24-hour nursing care. Starting in August 2020, E.B. was subject to an active DNR order and, in December 2021, E.B. was placed in hospice care. According to the investigative record, the week prior to his death, E.B. stopped absorbing formula and urinating, his heart rate slowed, and his circulation worsened. On the day of his death, E.B.'s heart temporarily stopped twice, and the investigative record stated that his nurses knew the child would pass soon. E.B.'s nurses administered morphine to ensure E.B. was not in pain and, later that evening, at 6:45 p.m., E.B. passed away in his foster home. In its investigation into E.B.'s death, RCCI Ruled out Medical Neglect of E.B. by his foster parents. A Forensic Assessment Center Network (FACN) physician assessed E.B.'s death and found no concerns for abuse or neglect by E.B.'s foster parents. E.B.'s neurologist stated that E.B.'s "respiratory system could not keep up with the size of his body" and that his primary cause of death was respiratory failure. E.B.'s nurses reported that E.B.'s health significantly declined during the final six months of his life and that, as a result, his death was expected. In the investigative record, the investigator documented that, "due to the nature of [E.B.'s] passing while in hospice care, no autopsy was performed."

C.B., Born July 22, 2007; Died March 6, 2022

C.B., a 14-year-old girl, passed away at a hospital from complex medical complications. C.B. had the following diagnoses: STAT 1 gain of function (GOF) disease, hypothyroidism, reactive airway disease, chronic mucocutaneous candidiasis, recurrent oral aphthae, congenital malformation syndrome, dysphagia, failure to thrive, and skin eruption. At the

time of her death, C.B. was under the care of a hospital where she had resided for the prior two months. According to C.B.'s record, C.B.'s cause of death was "adult respiratory distress from bone marrow transplant related to STAT 1 GOF [gain of function disease]." From December 2018 until her death, C.B.'s placement was in a specialized foster home, operated under the auspices of an HCS provider. According to the Texas Administrative Code, HHSC investigates the death of a child in an HCS placement when the child's death is suspected to be the result of abuse or neglect;[224] HHSC did not pursue an investigation into C.B.'s death because the agency did not suspect abuse or neglect.[225]

R.P., Born June 10, 2010; Died March 12, 2022

R.P., an 11-year-old boy, passed away from significant medical complications. R.P. had the following diagnoses: acute encephalitis with encephalopathy, epilepsy, seizures, contractures, focal dystonia, neuromuscular scoliosis, and dysphagia. He used a gastrostomy tube, oxygen, and a tracheostomy tube. R.P. was non-verbal and unable to walk. At the time of his death, R.P. was subject to an active DNR order. For the four years prior to his death, R.P. resided in a therapeutic foster home that cared for PMN children. According to the investigative record, on January 24, 2022, R.P.'s foster mother, a registered nurse, identified that R.P.'s pulse rate was elevated and contacted EMS for the child to be transported to a hospital. While hospitalized, R.P.'s condition continued to deteriorate. On the day R.P. passed, R.P.'s birth family, foster family, CPS and hospital teams chose to remove R.P.'s lifesaving equipment and R.P. passed naturally. R.P.'s death certificate stated that the cause of death was "acute on chronic respiratory failure" due to chronic lung disease, chronic respiratory failure, and septic shock. RCCI's investigation into R.P.'s death found no concern for maltreatment by R.P.'s foster parents. When interviewed, R.P.'s virologist reported that R.P.'s passing was "the natural progression of his medical condition;" the physician expressed no concern for the care R.P. received in his foster home. R.P.'s death certificate documented that an autopsy was not requested due to R.P.'s active DNR order.

A.W., Born July 6, 2006; Died March 24, 2022

A.W., a 15-year-old boy, died from gun violence while on runaway status from a one-night Child Without Placement (CWOP) episode at a DFPS office. At the time of his death, A.W., who had a history of running away, had been on runaway status for approximately one week, beginning on March 16, 2022. On this day, A.W.'s caseworker arrived to the CWOP location in the morning and brought A.W. to a friend's home to play basketball for the afternoon.[226] The caseworker did not possess or gather contact information about the friend. The caseworker knew the apartment building's address, but not the apartment number. During the day, A.W.'s caseworker reported that he was in contact with A.W., including that at 6:00 p.m., he called A.W. and A.W. informed him that he and his friend

[224] 40 TEX. ADMIN. CODE §9.175.
[225] When the Monitors inquired to HHSC and DFPS about the decision not to investigate and the policy underlying the decision, HHSC noted the above portion of the administrative code. E-mail from Katy Gallagher to Megan Annitto, Monitoring Team (Aug. 9, 2022).
[226] At this time, DFPS was considering A.W.'s friend's family as a placement option for A.W. DFPS had not yet undertaken a review of the friend's family, such as completing criminal and CPS background checks.

would like to go to a movie, which the caseworker allowed. The caseworker spoke to A.W. one more time that evening at 8:45 p.m. while A.W. was at the movies. Following this call, the caseworker made numerous attempts to contact A.W.; however, these attempts were unsuccessful.

According to A.W.'s case record, the caseworker did not promptly report A.W. as missing to law enforcement and DFPS; the caseworker made these reports the following morning on March 17, 2022, after the caseworker's supervisor instructed him to do so. The caseworker's supervisor also documented that the caseworker did not request her approval for A.W.'s visit with his friend.

While on runaway status for the week prior to his death, DFPS was unaware of A.W.'s whereabouts. On the night of March 23, 2022, A.W. was reportedly sleeping at a different friend's home when the friend fatally shot A.W. and another individual in the home. A.W. was pronounced as deceased on March 24, 2022 at 3:26 a.m. CPI did not pursue an investigation into A.W.'s death, citing that A.W.'s death "was not in the jurisdiction of CPI. [A.W]. … had been on runaway status since March 16, 2022. [A.W.] was murdered, while on runaway status, by a 'friend,' not some [sic] who was responsible for his care… this person did not fit the definition of an alleged perpetrator."

While in DFPS care, A.W. experienced the following placements:

Start Date	End Date	Placement
03/16/2022	03/24/2022	Runaway
03/15/2022	03/16/2022	DFPS Supervision (CWOP Setting): 503 Priest Dr. Office in Killeen
03/07/2022	03/15/2022	Runaway
12/10/2021	03/07/2022	St Peter - St Emergency Shelter
05/22/2020	12/10/2021	Kinship Home

D.S., Born September 30, 2005; Died March 29, 2022

D.S., a 16-year-old boy, passed away at a hospital from complex medical complications. D.S. had the following diagnoses: spastic diplegic cerebral palsy, epilepsy, microcephaly, seizure disorder, remote nephrolithiasis, developmental delay, gastroesophageal reflux disease (GERD), asthma, intellectual disability, sleep apnea, scoliosis, bilateral hip dislocation, and osteopenia (brittle bone disease). D.S. used a gastrostomy tube, oxygen, and a tracheostomy tube. At the time of his death, D.S. resided in a therapeutic foster home that served PMN children. In the foster home, D.S. received 24-hour nursing care. According to the investigative record, on March 27, 2022, two days prior to his death, D.S.'s in-home nurse observed that D.S.'s oxygen levels had dropped. When the nurse was unable to increase D.S.'s oxygen levels, the foster father called 911 and D.S. was

subsequently admitted to a hospital. On March 29, 2022, while hospitalized, D.S.'s health continued to decline and, despite medical personnel's sustained life saving measures, D.S. passed away that morning at 10:47 a.m. D.S.'s death certificate lists his causes of death as: pneumonia due to viral illness; respiratory failure secondary to pneumonia; and hypoxia leading to cardiac arrest. In its investigation of D.S.'s death, RCCI Ruled Out allegations of maltreatment by the foster parents. Interviews with D.S.'s in-home nurses raised no concerns about the level of care the medically fragile child received in the foster home. Due to D.S.'s medical condition, the county medical examiner did not perform an autopsy.

T.A., Born December 9, 2020; Died April 1, 2022

T.A., a one-year-old boy, passed away from significant medical complications. T.A. had the following diagnoses: congenital heart disease, congenital eventration of right crus of diaphragm, facial dysmorphism with multiple malformations, fetal drug exposure, cleft palate and stickler's syndrome. He used a gastrostomy tube, oxygen, and a tracheostomy tube. At the time of his death, T.A. resided in a foster home that cared for PMN children; T.A. received 24-hour nursing care in the home. According to the investigative record, on April 1, 2022, T.A.'s registered nurse identified that T.A. had dislodged his tracheostomy tube. The nurse immediately re-inserted the tube; however, T.A.'s oxygen levels began to drop. When the nurse was unable to increase T.A.'s oxygen levels, the foster mother contacted 911. The First Aid Responders' efforts to resuscitate T.A. were unsuccessful, and the child was pronounced dead shortly thereafter at a hospital. T.A.'s death certificate listed the following causes of death: decannulation, tracheostomy and ventilator dependence, chronic respiratory failure and idiopathic. The death certificate also documented that the significant condition that contributed to T.A.'s death was: "medically complex child with repaired congenital heart defect." RCCI's investigation into T.A.'s death found no concerns for maltreatment. Due to T.A.'s medical condition, the county medical examiner did not perform an autopsy.

T.S., Born July 25, 2004; Died June 13, 2022

T.S., a 17-year-old boy, was fatally shot by another individual during an altercation. At the time of his death, T.S. was on runaway status from a CWOP episode at a hotel for approximately seven weeks and his whereabouts were unknown to DFPS. On the day T.S. left the CWOP location, T.S.'s caseworker, a supervisor, CASA advocate, and a judge held a virtual meeting to discuss T.S.'s placement options; according to T.S.'s record, T.S. was unwilling to attend the virtual meeting. During the meeting, the judge ordered T.S. to a placement secured by T.S.'s caseworker. Following the meeting, T.S.'s caseworker informed T.S. of the judge's order, which T.S. promptly refused. Shortly thereafter, T.S. packed his belongings and left the CWOP location. T.S.'s caseworker timely reported to law enforcement that T.S. had run away.

While on runaway status, DFPS records indicate the agency made efforts to locate T.S. and, through intermittent contact with T.S., determined that T.S. was unwilling to provide his location or return to DFPS care. CPI did not pursue an investigation into T.S.'s death.

While in DFPS care, T.S. experienced the following placements:

Start Date	End Date	Placement
04/21/2022	06/13/2022	Runaway
04/03/2022	04/21/2022	DFPS Supervision (CWOP Setting): La Quinta Inn
03/31/2022	04/03/2022	Grandma - Unauthorized Placement
03/27/2022	03/31/2022	DFPS Supervision (CWOP Setting): La Quinta Inn
03/26/2022	03/27/2022	Runaway
02/07/2022	03/26/2022	DFPS Supervision (CWOP Setting)
02/02/2022	02/07/2022	Foster home
01/26/2022	02/02/2022	DFPS Supervision (CWOP Setting): Baymont Hotel
12/08/2021	01/26/2022	Runaway
07/16/2021	12/08/2021	Foster Home
07/03/2021	07/16/2021	West Oaks Hosp Psychiatric Hospital
05/12/2021	07/03/2021	The Lighthouse Residential Treat
08/14/2020	05/12/2021	Placement with adult brother
12/05/2019	08/14/2020	Athletes For C Residential Treat
07/29/2019	12/05/2019	City Of Hope M Basic Child Care
07/15/2019	07/29/2019	Grandma - Unauthorized Placement
03/05/2018	07/15/2019	Athletes For C Residential Treat
01/24/2018	03/05/2018	Millwood Psychiatric Hospital

K.A., Born May 18, 2021; Died July 5, 2022

K.A., a one-year-old boy, passed away from significant medical complications. K.A. had the following diagnoses: congenital hydrocephalus, cranial abnormalities, hydranencephaly, optic atrophy of both eyes, and seizures. K.A. used a gastrostomy tube and required the assistance of oxygen. As a newborn, K.A. entered DFPS custody and lived in the same therapeutic foster home for the duration of his life. K.A. received 24-hour nursing care in the foster home. At the time of his death, K.A. was subject to an active DNR order. On the day of K.A.'s death, K.A.'s foster father and nurse observed that K.A.'s heart rate and oxygen levels began to drop. When they were unable to increase K.A.'s levels, the foster mother contacted 911 and EMS transported the child to a hospital.

Despite medical personnel's efforts to stabilize K.A. at the hospital, a doctor pronounced K.A. as deceased at 6:31 p.m. on July 5, 2022. According to the child's autopsy report, K.A.'s cause of death was congenital abnormalities. The report documented that the child had experienced "multiple hospitalizations for chronic respiratory failure and respiratory acidosis." In its investigation into K.A.'s death, the RCCI investigator interviewed K.A.'s nurses, speech, physical and occupational therapists, and CASA advocate; these individuals reported no concerns regarding the quality of care K.A. received in the foster home. RCCI's investigation into K.A.'s death found no concerns for maltreatment.

D.G., Born June 10, 2007; Died September 9, 2022

D.G., a 15-year-old girl, appears to have passed away from significant medical complications. D.G. had the following diagnoses: cerebral palsy quadriplegic, gastrostomy malfunction, and global developmental delays. D.G. used a gastrostomy tube; she was non-verbal and blind. From February 2022 and until her death, D.G. was placed in an HCS foster home. On the morning of her death, D.G.'s caregiver reported that D.G.'s heart rate and oxygen levels began dropping. The caregiver contacted 911 and began administering life saving measures to D.G. After the ambulance arrived, the First Aid Responders resumed efforts to resuscitate D.G.; however, these efforts were unsuccessful, and the child was pronounced dead 30 minutes later in the foster home. According to the Texas Administrative Code, HHSC investigates the death of a child in an HCS placement when the child's death is suspected to be the result of abuse or neglect;[227] HHSC did not pursue an investigation into D.G.'s death because the agency did not suspect abuse or neglect.

PMC Child Fatality Investigations Pending

R.F., Born April 9, 2019; Died August 21, 2022

R.F., a three-year-old girl, passed away from an unknown cause(s). On August 20, 2022, the day prior to her death, R.F. and her foster family attended another child's birthday party. After the family returned home from the birthday party, R.F. complained to her foster parents that her stomach hurt; her foster parents took the child's temperature and found that she had a mild fever (101°F). R.F.'s foster mother administered Children's Tylenol to reduce the child's fever. Later that evening, R.F.'s foster parents put her to bed and she was reportedly feeling well. The next morning, on August 21, 2022, the foster father went into the child's bedroom and found R.F. unconscious and cold to the touch. As of November 28, 2022, the county medical examiner's office had not finalized R.F.'s autopsy results and RCCI's investigation into R.F.'s death remained open.

K.A, Born December 8, 2020; Died August 27, 2022

[227] 40 TEX. ADMIN. CODE §9.175.

K.A., a one-year-old boy, passed away from an unknown cause(s). Since entering DFPS's care at six-months old, K.A. had resided in a court ordered kinship foster home with his twin brother. For approximately one week prior to the child's death, the child had experienced a fever. On August 27, 2022, in the mid-morning, the foster mother reportedly checked on K.A. and found him unconscious. She contacted 911; when the First Aid Responders arrived at the home, they determined K.A. was deceased. As of November 28, 2022, the county medical examiner's office had not finalized K.A.'s autopsy results and RCCI's investigation into K.A.'s death remained open.

F.C., Born January 27, 2016; Died September 22, 2022

F.C., a six-year-old girl, appears to have passed away from significant medical complications. F.C. had the following diagnoses: autosomal recessive kidney disorder; cerebral palsy; and epilepsy and brain damage. F.C. required the assistance of dialysis daily. Starting in 2017, F.C. resided in a therapeutic foster home that served PMN children. In the foster home, F.C. received 24-hour nursing care. On September 4, 2022, F.C. was admitted to a hospital due to a drop in her blood pressure. In the hospital, F.C. was placed on life support as her health continued to decline. On September 22, 2022, F.C. passed away at the hospital. As of November 28, 2022, RCCI's investigation into F.C.'s death remained open. Based upon preliminary information in the investigation record, there does not appear to be concern for maltreatment in relation to F.C.'s death.

List of Tables

List of Figures

Appendix 1 Intake Screening Results Case Summaries

The following are 51 referrals (of 770 that the Monitors reviewed) that were received by Statewide Intake (SWI) and that the Monitors concluded should have been referred to DFPS for an abuse, neglect or exploitation investigation.

Intakes Received in July 2021

1. Case ID: 2762615

Intake ID: 74963301

Sample File: July 2021

Summary of Intake Allegations: A DFPS caseworker reported that a child (age 12) disclosed that during a restraint, a staff member at Abundance of Joy Home Shelter, a GRO, placed her knee on the child's chest. Reportedly, the staff member's placement of her knee on the child caused the child pain and left a scratch on the child's chest.

Monitors' Review: The allegation that a staff member performed an improper restraint on a child which allegedly caused the child pain and injury and meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 – injury or serious mistreatment of a child.

Minimum Standards Investigation Findings: "During the course of the investigation, documentation was reviewed and interviews conducted to support the following: 748.2605(a)(4) regarding Personal Restraints Prohibited-Restraints that interfere with the child's ability to communicate or vocalize distress. Victim child refused the interview. There were no witnesses to report in question. Not enough evidence was found to support a violation for this standard. This standard was evaluated and determined compliant. 748.2461(a)(1) regarding Short Personal Restraint-Caregiver must minimize risk of physical discomfort, harm, or pain to child. Three of four children did not confirm a restraint took place. One of three staff previously restrained the child. Victim child refused the interview. There was not enough evidence was found [sic] to support a violation for this standard. This standard was evaluated and determined compliant. 748.2455(a)(1) regarding Emergency Behavior Intervention-Before using EBI, the caregiver must attempt less restrictive interventions that prove to be ineffective. Two of four child witnesses stated

that staff did not attempt less restrictive interventions before placing [the child] in a hold. Two of three staff witnesses stated that staff attempted to use a less restrictive method. There is not enough evidence was found [sic] to support a violation for this standard. This standard was evaluated and determined compliant. 748.685(a)(4) regarding Caregiver responsibility - providing the level of supervision necessary to ensure each child's safety and well-being. 3 of 4 children stated they were properly supervised. Victim child refused to be interviewed. 3 of 3 staff stated supervision was appropriate. There was not enough evidence [sic] did not support children not being properly supervised. This standard was evaluated and determined compliant. 748.1101(b)(4)(A)(vii) regarding Children's rights- Free from demeaning behavior to embarrass/control/harm/intimidate/isolate the child. None of the children interviewed stated they were intimidated by staff. Victim child refused to interview. There were no witnesses to the incident. Not enough evidence was not found [sic] to support this standard. This standard was evaluated and determined compliant. 748.2551(c)(2) regarding EBI Implementation-Caregiver must use the minimal amount of reasonable and necessary physical force. Three of 4 children did not report force used. [The child] refused to be interviewed. There is not enough evidence found during the investigation to support a deficiency. This standard was evaluated and determined compliant by the operation. 748.2851(b) regarding EBI Follow-Up-Caregivers involved in EBI must conduct a post discussion with child. There were no witnesses to any of the restraints. Victim child refused to be interviewed. Facility provided documentation for the behavior of victim child. Staff reported having post discussion with a child after a restraint in the past. This standard was evaluated and determined compliant by the operation. This investigation was without citations or deficiencies. No Technical Assistance was provided. Any pictures and/or documentation will be placed in the file. Recommended Action: Routine Monitoring."

2. Case ID: 2768317

Intake ID: 75018118

Sample File: July 2021

Summary of Intake Allegations: A therapist at the Child Crisis Center of El Paso, a GRO, reported that two female children (Child A, age 11 and Child B, age 13) disclosed that another child who was male (Child C, age 11) engaged in inappropriate sexual behavior toward them. Child A and Child B reported that while returning from an outing earlier that day in the GRO's van, Child C kissed Child B on the lips, rubbed the thighs of Child A and Child B under their shorts, and refused to stop when they told him to do so. The reporter stated staff members were present in the van at the time of the alleged incident. Reportedly, Child A hit and scratched Child C when she attempted to make him stop the inappropriate touching. Child A and Child B also reported that, upon return at the GRO, Child C tried to hit Child B on her buttocks. Child B disclosed that after returning to the GRO, Child C approached her and her younger brother (who was visiting the facility) and claimed that he and Child B had "done it," and that he had fathered her younger brother. The reporter also stated that Child C claimed that Child A and Child B initiated the contact in the van and that he thought they were playing.

Monitors' Review: The allegation that a child engaged in inappropriate sexual contact with two other children meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 - minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the information gathered through the course of this investigation, there is preponderance of evidence that [the children] were inappropriately supervised while being transported in the van. The interview with [the children] corroborated that [Child C] and [Child B] kissed while in the van pretending to play a game as seen on Tik Tok. [Child C] denied touching [Child A and Child B] on the legs and stated that [Child B] was the one that touched his legs. The interview with [Child A and Child B] corroborated that both girls made an outcry of being touched on the legs by [Child C]. [Child A] admitted to slapping [Child C] on the face for touching them on the legs. The interview with [Child C] corroborated that he was slapped by [Child A] for kissing [Child B] but [Child B] kissed him first. The interview with the therapist corroborated that he interviewed [the children] shortly right after the incident. The agency will be cited for; HRC42.04412(a) – interference with an investigation – The therapist interviewed the children in care shortly after the icindent [sic]. 748.685(a)(3) – Caregiver responsibility – being aware of and accountable for each child's on-going activity. – [two children] kissed in the back of the van while being transported back to the shelter. Recommended Action: Routine monitoring."

3. Case ID: 2760870

Intake ID: 74944403

Sample File: July 2021

Summary of Intake Allegations: A therapist at the DePelchin Children's Center, a GRO, reported that a staff member improperly restrained a child (age 11). The child disclosed that a staff member restrained him by twisting his arm behind his back and putting him on the floor. The reporter stated the restraint allegedly did not cause the child pain. The child also disclosed that the staff member previously threatened him with discharge from the facility; the child reportedly felt this staff member targeted him**.**

Monitors' Review: The allegation that a staff member improperly restrained a child by twisting his arm and putting him on the floor meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

"Physical injury that results in substantial harm to the child" means any bodily harm, including but not limited to scratches; scrapes; cuts, welts, red marks; skin bruising; lacerations, pinch marks; sprains; dislocated, fractured, or broken bones; concussions; burns; and damage to internal organs. When determining whether the harm is substantial, we may consider factors including but not limited to the location of the harm; the child's age, physical condition, psychological functioning, and level of maturity; any special needs the child may have; and other relevant factors. 40 TAC § 707.789 (b)(3).

Summary of RCCR Minimum Standard Investigative Findings: Priority 3 - Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the preponderance of information, it was found that the operation was deficient as it concerns EBI as an improper restraint was performed on a child in care. Additionally, the operation failed to notify licensing of construction taking place at the operation, causing the children in care to sleep in the gym. The operation was cited for this action as it is against the standards regarding reporting to licensing within 24 hours when part or all of an operation renders danger. The children in care and also the operation staff were able to produce aligning stories on what was taking place at the operation during interviews. Recommended Action: Routine monitoring."

Intakes Received in August 2021

4. Case ID: 2774553

Intake ID: 75070577

Sample File: August 2021

Summary of Intake Allegations: A DFPS heightened monitoring inspector reported that a child (age 7) disclosed that her foster parent, who was scheduled to adopt the child in two weeks, spanked the child with a spatula as a form of punishment. The reporter stated that the child was unable to provide a timeframe for the allegation and that the child was unclear about whether the alleged inappropriate discipline resulted in bruises.

Monitors' Review: The allegation that a foster parent used a spatula to hit a child meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 - Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the information gathered throughout the course of this investigation there is not a preponderance of evidence that supports the allegations that a child in care is being inappropriately disciplined. The children in care both stated that they have been spanked with a spatuala [sic] but neither one of them could inform me when they were last spanked. According to [the foster parent] she admitted to spanking the children prior to becoming licensed. She stated that she and her previous agency came up with alternative ways to discipline. The families [sic] caseworker informed me that [the foster parent] was stuggling [sic] with how to discipline when she first got into fostering and they informed her that [a] popping can no longer be used. She states that she has had no concerns regarding inappropriate discipline since it was addressed. [The adoption caseworker] also stated that same thing. Therefore, the home will not be cited due to the timeline of the events and not being able to determine if the popping happened while she was a licensed foster parent. However, TA will be given. Recommended Action: Routine monitoring."

As of September 1, 2022, the foster home was closed.

5. Case ID: 2773382

Intake ID: 75062205

Sample File: August 2021

Summary of Intake Allegations: A DFPS contract monitor reported that a child (age 6) disclosed in an interview that her foster parents spanked her with "the trouble spoon" as a form of discipline. The child stated that the foster parents had different rules regarding the use of the "trouble spoon." The foster father reportedly instructed the child to not "wiggle, don't scream and lay down" and the foster mother required the child to "lay down and [she would] smack 3 times."

Monitors' Review: The allegation that foster parents hit a child with a wooden spoon meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standards Investigative Findings: Assigned Priority 3 - Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the preponderance of evidence in this case, [the foster parents] have been spanking [Child A] and [Child B] (ages 6 and 5). Both girls told me about the wooden spoon (AKA the "trouble spoon") that they get spanked with if they lie to their parents. This could be for stealing candy from their older sister, [Child C], lying about peeing the bed, etc. The biological daughter, [Child C], also verified this story. Both [foster parents] admitted to spanking the girls with the wooden spoon as a last resort. A safety plan was put into place by [the CPA] when this first came out, and the administrator was very disappointed to hear it was true. The CPA is being cited for Corporal Punishment. Exited with [CPA Administrator]. Recommended Action: Routine monitoring."

As of September 1, 2022, the foster home was closed.

Intakes Received in September 2021

6. Case ID: 2795213

Intake ID: 75216720

Sample File: September 2021

Summary of Intake Allegations: A DFPS caseworker reported that a staff member at Gold Star Academy, a GRO, grabbed a child (age 11) by the arm and threw the child to the floor approximately three weeks prior to the report. Allegedly, the staff member then falsely told other staff members that that the child tripped. Reportedly, the staff member believed that the child called him a derogatory name. The child reported that after the incident, he had a red mark on his upper right arm and that his arm hurt. The reporter stated that there were no marks on the child at the time of the report and stated that the child was diagnosed with attention deficit hyperactivity disorder (ADHD), emotional disorders, and intellectual delays. The reporter also stated that there were previous incidents at the facility that involved other GRO staff members threatening children, performing inappropriate restraints, and hitting children. The reporter did not provide additional information about these allegations.

Monitors' Review: The allegation that a staff member threw this child to the floor resulting in pain and a red mark on his arm meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 - minor violations of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the preponderance of evidence and the information gathered through out [sic] this investigation, there were zero deficiencies found in relation to the allegation of inappropriate discipline. After speaking with [the child], multiple other residence and multiple staff member, there was no evidence found that staff member had harmed [the child] or any other residence. Outside of [the child], there was no other staff members or residence [sic] who witnessed the alleged incident. Due to lack of evidence, no deficiencies were found. Recommended Action: Routine monitoring."

7. Case ID: 2791053

Intake ID: 75185818

Sample File: September 2021

Summary of Intake Allegations: A DFPS caseworker reported that a child (Child A, age 16) allegedly smoked and vaped marijuana at Kids Safe Harbor Treatment Center LLC, an RTC. The reporter also stated that Child A reported that he had sex with another child (Child B, age 15) while at the RTC. Child A stated that Child B did not force him to have sex, however, Child A did not want to have sex with Child B. Lastly, Child A alleged that someone threw or dumped water on other children at the RTC while he and possibly some other children smoked and vaped marijuana.

Monitors' Review: The allegation that a child vaped and smoked marijuana and engaged in inappropriate and unwanted sexual contact with another child at an RTC meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 - minor violations of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the preponderance of Evidence there is not sufficient evidence to find that the operation violated any minimum standards based on the allegations. This was determined by 8 out of 9 residents interviewed during the investigation. Additionally, this was determined that there was not a preponderance of evidence based on staff interviews with 8 out of 8 staff members as well. The operation staff consistently deal with children who are classified on various levels of assessment. The children in care do not always make the best decisions my investigation found and react negatively at times to staff. Staff do the best to continue to de-escalate behaviors that are considered inappropriate by standards. The allegation that it is alleged that children in care are being humiliated was found to be complaint [sic]. It is also alleged that children in care are not being supervised properly was found to be compliant. The standard tasked §748.507(1) – Employee general responsibilities – found that the operation is in compliant [sic] based on interview with 8 out of 9 children in care [and] the staff are doing their

job. Additionally, during 8 out of 8 interviews with staff it was determined that the operation staff and management do in fact utilize prudent judgment as it relates to the children in care and do not find any violations of this standard. Standard §748.685(a)(4) Caregiver responsibility found that during the interview with 8 out of 8 staff members the operation does provide the necessary level of supervision to maintain compliance. Additionally, it was determined that with 9 out of 9 children in care the residents shared during interviews that staff either annoyed them or did not allowed [sic] them to do various aspects of what they considered freedom. This reinforced that supervision was provided as it relates to the residents stating that they were annoyed and wanted to leave. The operation is in compliance. The standard § 748.1101(b)(4)(A) Children's rights found that the operation is in compliance and did not violate this standard. The victim shared multiple areas of concern and was not consistent in his experience at the RTC. During the various interviews there were no residents who shared any concerns about concerns of [the child] being exposed to any harsh, cruel or humiliating treatment or punishment. The investigation found that [the child] has had a lot of trauma throughout his life experience. There are no concerns with the operation. Routine Monitoring suggested. Recommended Action: Routine monitoring."

8. Case ID: 2798511

Intake ID: 75243412

Sample File: September 2021

Summary of Intake Allegations: A staff member at an afterschool program reported that a foster parent allegedly denied food to four children in her care (Child A, age 5; Child B, age 7; Child C, age 8; and Child D, age 9). The children reportedly disclosed that they were "deathly afraid" of their foster mother. The reporter observed that the children ate a lot of food during snack time at the program. The children disclosed to the reporter that they only ate at school and they also could not drink liquids at the foster home. She also stated that she overheard one of the children say that they do not get to eat at home. Recently, Child D told the reporter, while crying, that she broke her water bottle and that the foster mother was "going to get me." In another instance, Child A told the reporter that she lost her hair bows and stated that the foster mother was "going to get me." The reporter did not know how the foster mother punished or disciplined the children. The reporter stated she had not observed children so "panicked" about a foster parent in her years of experience.

Monitors' Review: The allegation that a foster parent withheld food and drink from four children, ranging in age from five to nine years old and that the children were "deathly afraid" of her meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 - Injury or serious mistreatment of a child.

Minimum Standards Investigation Findings: "Based on the information gathered during this investigation, allegations of foster parents [names omitted] not providing children in care with adequate food could not be validated. Children including [Child A, Child B, Child C and Child D] stated that they attend the YMCA after school program and eat a snack/dinner during this program at around 4:30pm. They get picked up by foster mom around 6:30pm. The children stated that they don't eat dinner when they get home and sometimes, they get a snack which is usually a fruit. All the children however stated that they felt like they get enough food to eat at the home. [Child E is] the only child to not attend the YMCA, states that she eats dinner every day at the home. [Child E] stated the other children in the home don't eat dinner but they get one snack which is fruit. [The foster parents] both stated that the children eat dinner at the YMCA after school program. They stated that they pick up the children from the program at around 6:30 and give them a snack when they get home. The foster parents stated the next time the children eat is breakfast at school the next morning. Breakfast is served at [the school] from 7:05-7:30am. Due to the children receiving a snack at the home around 6:30pm and having breakfast at the school around 7am, this does not exceed 14 hours therefore the operation will not be cited for standard 749.3061(c). Technical assistance was provided: Young children need to be fed often. Appetite and interest in food varies from one meal or snack to the next. To ensure that the child's daily nutritional needs are met, it is recommended even if the child does not ask, a snack be offered a few hours after one meal ends. It is also recommended incorporating a bedtime snack into the child's nightly routine as an easy way to ensure that they've had enough to eat, help them settle down for bed, and can help to fill in any nutritional needs that they might have missed during the day. Allegations of the children not being provided adequate water could not be validated. [Child D] stated that they can get water, [Child B] and [Child C] stated that sometimes they can get water and sometimes they can't, [Child A] was the only child to state she can never get water when she asks. Child E stated that foster mom will only allow the younger children to drink whatever water they have left in their water bottles from school but cannot get more water because they wet the bed. [The foster parents] stated that each of the children have their own water bottles and can get water whenever they want. Water bottles for each child in the home was observed during the inspection at the home on 9/27/2021. The operation will not be cited for standard 749.3063(c). Allegations of children being inappropriately disciplined by having to pull weeds and write sentences could not be validated. [The foster father] stated that they have never made the kids write sentences as a punishment, but the school made Child E do that. [The foster father] stated that the children help out in the yard, but it is not as a punishment and they like doing it. [The foster mother] stated that she has never made the children write repetitive sentences but may have made them write an apology letter to school personnel or write down their feelings. [The foster mother] stated that this will take maybe 5 minutes. [The foster mother] stated the children helped her in the yard but not as a punishment and they enjoyed helping. All the younger children stated that they must write when in trouble but were unable to tell me exactly what they write or how long it takes. [Child E] stated that she is not made to write when in trouble but has observed the younger children doing this. [Child E] was unable to tell me what they must write but that it takes 5-10 minutes. [Child E] confirmed that they do help in the hard [sic] but that the younger kids enjoy doing it and it is not for a punishment. [Child E] also stated that the foster parents grab the younger children in the home by the arm. All the younger children denied being grabbed by the foster parents. The foster parents denied grabbing any of the foster kids. The operation will not be cited for standard 749.1953(a) Recommended Action: Routine monitoring."

As of September 1, 2022, the foster home was open and serving three children.

Intakes Received in October 2021

9. Case ID: 2808427

Intake ID: 75354529

Sample File: October 2021

Summary of Intake Allegations: A case manager at Boysville, Inc., a GRO, reported that a child (Child A, age 15) reportedly slept in the same bed as another child (Child B, age 12). While in the bed together, Child A allegedly touched and "humped" Child B. Another child (Child C, age 13) disclosed the incident to a therapist stating that on the previous Friday, the two cottages at the GRO were combined due to a lack of female staffing. As a result, a staff member asked Child A to sleep on a couch, however, Child A refused and went to Child B's room to sleep on the floor. Child C stated that Child A got into bed with Child B and they "humped."

Monitors' Review: The allegation that two children shared a bed and engaged in inappropriate sexual contact meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 – Serious supervision problems.

Minimum Standards Investigation Findings: "Based on the information gathered through face to face interviews, documentation and phone interviews a concern with minimum standards was found as both victims statements confirmed child was sleeping on the floor and at some point shared a bed with another child in care. Staff stated [Child A] was refusing to sleep on the couch and wanted to sleep on the floor of the other residents [sic] room. Staff stated they had been short-staffed and she had two cottages overnight and never saw the girls in bed together. There will be no citations regarding supervision as staff stated although they were short staffed Staff conducted bed checks every 30 minutes to ensure supervision. Both victims denied the allegations of touching and dry humping. [Child C] stated she was told by [Child B] that [Child A] had touched her breast over her clothing. Other residents interviewed denied seeing the girls in the same bed but did see her sleep on the floor of the room. CPS caseworkers had no concerns with the placement. Service plans reviewed and incident report and no concerns or high-risk behaviors identified. Recommended Action: Routine monitoring."

10. Case ID: 2804705

Intake ID: 75309361

Sample File: October 2021

Summary of Intake Allegations: A staff member at Roy Maas Youth Alternative - Girlsville Junction, an RTC, reported he placed a child (age 11) in a restraint and during the restraint, the child was cut on his chin. The reporter stated that he restrained the child because the child exhibited self-harming and aggressive behaviors. Prior to the alleged incident, the child was reportedly banging his shoulder and arm against the wall and door, and head butting the wall. When the reporter intervened, the child started making homicidal statements to the reporter and began head butting the reporter. The reporter told the child that if he did not stop, the reporter would need to restrain him. The child continued to try to head butt the reporter, so the reporter put the child into a restraint. Once in the restraint, the child allegedly kicked off of the wall and caused both the reporter and the child to fall. The child reportedly hit his chin from the fall. Following the restraint, staff members brought the child to urgent care where he received two stitches. The child also expressed suicidal ideations and was evaluated at urgent care; medical staff determined that the child was not a threat to himself or others.

Monitors' Review: The allegation that a staff member injured a child during a restraint meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 - minor violations of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the preponderance of evidence the standard for a qualified caregiver may administer EBI except a short personal restraint is found in compliance. The standard for EBI implementation must be an appropriate response to the behavior demonstrated and de-escalation must have failed is found in compliance. The standard for the caregiver providing EBI must minimize the risk of physical discomfort, harm, or pain to the child is found in compliance. The standard for the caregiver must use the minimal amount of reasonable and necessary physical force is found in compliance. The standard for the child being released from a personal restraint as soon as the child is not a danger to himself or other is found in compliance. The standard for the caregivers involved in EBI must conduct a post discussion with a child is found in compliance. The standard for the child's service plan must document their high-risk behaviors and plan to minimize risk to self or other is found in compliance. The standard for a child in care must receive medical care as needed for injury, illness, and pain is found in compliance. An intake was self-reported on 10/02/2021 with concerns that a youth was injured during an EBI restraint to prevent self-harming behaviors. The incident started with youth self-harming by hitting his arm on the wall of the common area in Junction cabin. This was verified by video footage, three staff present for the incident, [child] himself, and one other youth present in

the same room. Video and those interviewed verified that when [the child] was hitting his arm on the wall that staff responded verbally to de-escalate [the child]. [The child] continued to hit his arm on the wall and to prevent [the child] from re-injuring his arm that was in a sling staff intervened by restraining [the child]. Due to the intensity of the self-harm as well as the efforts of the staff to de-escalate [the child] verbally EBI was an appropriate response to his behavior. The standard for EBI implementation must be an appropriate response to the behavior demonstrated, and de-escalation must have failed is in compliance. During the two restraints performed on [the child] by [Staff 1] and [Staff 2], efforts were made to adjust and loosen their restraint of [the child]. Although through video footage and interviews done with [Staff 1], [Staff 2], [child], and [Staff 3]– [child] headbutted [Staff 1] and kicked off the wall near them which landed both [child] and [Staff 1] onto the ground during the restraint resulting in [child]'s chin hitting the ground and [Staff 1]'s elbow hitting the ground. The evidence supports that the staff minimized the risk of physical discomfort, harm, or pain to the child while performing the EBI restraints – this standard is found in compliance. Video footage, and interviews of three staff involved as well as the youth restrained supports that the minimal amount of force was used in response to the self-harming [the child] was performing. The standard that the caregiver must use the minimal amount of reasonable and necessary physical force is found in compliance. During the restraint with [Staff 1] [the child] headbutted [Staff 1], once [the child] was able to stop and calm down [Staff 1] released him. This was verified through video footage. During the restraint with [Staff 2] [the child] was able to stop jerking his body and attempting to hit [Staff 2], once this occurred, he was released from the restraint. The standard for the child being released from a personal restraint as soon as the child is not a danger to himself or other is found in compliance. Verified through interviews conducted with staff and youth, as well as documentation for the EBI restraints and debrief. [The child] was debriefed by [Staff 3], [Staff 2] and [Staff 1]; [the child] did participate in the conversation and was understanding of what occurred, he had no concerns. The standard for the caregivers involved in EBI must conduct a post discussion with a child is found in compliance. EBI certificates and training reports were reviewed for [Staff 1], [Staff 3], and [Staff 2]. All three staff were in compliance with the appropriate training and were able to perform EBI restraints at the time of the incident. The standard for a qualified caregiver may administer EBI is found in compliance. [Child]'s service plan was reviewed it is documented that he is at risk for self-harm and suicidal behavior. When engaging in these behaviors he will be assessed by a clinician and placed on upgraded supervision as needed. Both of these behaviors are being addressed in therapy. The standard for the child's service plan must document their high-risk behaviors and plan to minimize risk to self or other is found in compliance. Due to the injury to [the child]'s chin during the restraint with [Staff 1] he was given first aid by staff on campus as well as taken to the ER where he received three stitches. This was verified through interviews with staff, youth, and medical documents were reviewed. [The child] was taken the same day of the incident to the ER. The standard for a child in care must receive medical care as needed for injury, illness, and pain is found in compliance. Recommended Action: Routine monitoring."

Intakes Received in November 2021

11. Case ID: 2819120

Intake ID: 75520492

Sample File: November 2021

Summary of Intake Allegations: A law enforcement officer reported that he found a child (age 16) in a school's stadium bleachers at 7:30 p.m. and the child was crying hysterically. The child told the reporter that he was scared and did not want to return to his foster home. He stated that his foster parents do not let him go to the bathroom and that the bathrooms are locked, that the foster parents do not feed him enough food, and that on the weekends, the child must stay in the living room area and cannot go outside. The child stated that he felt like a prisoner in the foster home. The reporter stated he was familiar with the foster mother due to other children who previously resided in the foster home. The reporter stated those children also complained about being hungry and that the refrigerator was locked.

Monitors' Review: The allegation that a foster mother did not adequately feed a child in her care and that the child was not permitted to use the bathroom meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 – Minor violation of the law or minimum standards that involve low risk to children.

*Minimum Standards Investigation Findings: "*Based on the preponderance of evidence gathered throughout the investigation there will be citations issued. Allegations concerning possible violation of child rights based on information provided by a child in care. Child stated that doors in the home were locked and he was denied access to his bedroom. He also stated being underfed and not allowed outside to play. Based on information gathered during interviews there will be 3 deficiencies issued. The first regarding a child's belongings being free of unreasonable search. Caregiver admitted to searching children's belongings. The second deficiency regarding feeding children, caregiver must provide food of adequate variety, quality, and in sufficient quantity to supply nutrients for growth and development. Child stated being underfed and fed only sandwiches and cereal on most occasions. Finally, the third deficiency is regarding prudent judgement. Caregiver failed to use prudent judgment when denying children access to their bedroom in order t [sic] conduct search. Recommended Action: Routine monitoring."

Through the Monitors' review of this intake report, the Monitors identified the following additional information about the foster home. The foster home opened on June 15, 2007 and closed on July 1, 2022. While open, the foster home operated under four different CPAs.

CPA	Dates Operated
Beacon of Hope	06/15/2007 - 02/14/2013
Hope for Tomorrow	02/15/2013 - 09/24/2014
Circle of Living Hope	10/29/2014 - 02/17/2022
Hands for Healing	2/18/2022 - 07/1/2022

After the above minimum standards investigation, Circle of Living Hope, the foster home's CPA, closed the foster home. Circle of Living Hope noted that the foster home's closure was "involuntary" and the home was closed "without deficiencies." One day after closure with Circle of Living Hope, a different CPA, Hands of Healing, opened the foster home. The child involved in the above intake report continued to be placed in this foster home during this transition and exited the foster home approximately three months later on May 30, 2022.

While open, the foster home was subject to nine abuse, neglect or exploitation investigations, of which the most recent closed in 2014. Of the nine investigations, RCCI entered a disposition of Ruled Out for eight investigations and a disposition of Unable to Determine for the remaining one investigation. Two investigations resulted in citations. The foster home was additionally subject to ten minimum standards investigations, including the one related to the referral in this review. Four of these investigations resulted in citations. The following concerns were raised across some of the abuse or neglect and minimum standards investigations: the foster parents' alleged use of corporal punishment and restraints; alleged use of food as a punishment or reward; and alleged failure to provide adequate food choice to children.

12. Case ID: 2821092

Intake ID: 75553512

Sample File: November 2021

Summary of Intake Allegations: A DFPS caseworker reported that a child (age 17) stated that two staff members at Journey to Dream Kyle's Place, a GRO, came into his room and pulled his mattress off the bed while he was sleeping on it. The child reported that he hit his head on the floor as a result. The child further disclosed that staff members gave his mattress to another resident; however, shortly before the DFPS caseworker arrived, they gave him another mattress. The reporter observed dirty sheets on the floor. The child's case manager at the GRO told the reporter that staff members were going to wash the sheets. The child also disclosed that he did not receive

lunch the previous day because staff members did not wake him, and that he had not eaten the day of the report.

Monitors' Review: The allegation that two staff members pulled a child's mattress off his bed while he was sleeping, causing him to hit his head on the floor meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the information gathered during this investigation, allegations of staff taking a child's personal belongings as a punishment could not be validated. [The child] stated that [Staff 1] took all of his shoes except for 4 pairs as a form of punishment. [A]nother child at the operation, stated that the staff did take [the child's] shoes but he did still have other shoes to wear. [Three staff members] stated that they do have a rule that if there are items left on floor, they will collect those items and place them in storage. Staff members stated that the children are asked several times to clean up these items before they are collected. The staff all stated that [the child] still had several pairs of shoes left after and some were collected due to not being cleaned up as required. During the inspection at the operation on 12/2/2021, [the child's] shoes were observed, and a photo was taken. There were several pairs of shoes observed in [his] bedroom therefore the operation will not be cited for standard 748.1101(b)(3)(I). Allegations of [the child] not being provided adequate food and personal food could not be validated. [The child] stated that he gets enough food to eat at the operation however spoke about one day that he was not able to get some of his personal food for a snack. [Another child] agreed that he gets enough food to eat at the operation and gets personal snacks. Staff members ... all stated that the children can get their personal snacks during specific snack times. [Two staff members] both stated that when it is not snack time, there is always a fruit bowl out which the children can get at any time. The fruit bowl filled with apples and oranges was observed during the inspection at the operation on 12/2/2021. The operation will not be cited for standard 748.1693(a)(1). Allegations of staff inappropriately discipling [the child] for not waking up by pulling his mattress to floor with him still on it could be validated. [Staff 1] denied flipping [the child] off the mattress and stated that she and intern ... held the mattress and shook it back and forth to wake him. Intern ... stated that she and [Staff 1] each grabbed an end of the mattress and slid it from the bed frame down to floor while [the child] was still on it to get him to wake up. [The child] stated that [Staff 1] and another staff flipped home [sic] out of bed and he fell to the floor. Another child... witnessed the incident and stated that the staff pulled the mattress from under [the child] and he fell. Due to the staff physically moving [the child's] mattress to the floor while he was still on it in order to wake him up, the operation will be cited for standard 748.2307(1). Technical Assistance was provided: Caregivers are more likely to avoid inappropriate discipline practices if they are well-informed about effective methods for managing children's behaviors. It is important that caregivers are adequately trained on constructive guidance and discipline of

children. It is recommended that the operation re-train staff on positive techniques to accomplish the goal of managing a child's defiant behaviors. Recommended Action: Routine monitoring."

13. Case ID: 2819723

Intake ID: 75525886

Sample File: November 2021

Summary of Intake Allegations: A doctor reported that a child (age 13), who had a genetic condition that puts her at high risk for cancer and who required significant medical treatment, was not receiving necessary medical care in her foster home. The reporter stated that the child was not seen by her doctor for approximately four months prior to the date of the report. The doctor reported that the child's foster mother canceled the child's follow-up visit regarding genetic testing results twice, and she also declined to receive the results from the genetic counselor via phone. The reporter stated that the child needed referrals to multiple specialists and that the child's medical care was delayed. According to the doctor, the child was at increased risk for developing blood cancer and for having abnormal blood clotting, heart problems, thyroid problems, kidney problems, eye problems, and hearing loss.

Monitors' Review: The allegation that a foster mother did not secure appropriate medical care for a child in her care with a predisposition for high-risk medical conditions meets the threshold for a Medical Neglect investigation based upon:

Failure to seek, to obtain, or to follow through with medical care for a child, by an employee, volunteer, or other individual working under the auspices of a facility or program that causes or may cause substantial emotional harm or substantial physical injury to a child. 40 TAC §707.801(b)(1)(E).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the preponderance of evidence, [Foster Parent] was not neglecting to obtain medical treatment for [the child] in this case. [Foster Parent] had received two phone calls since the last appointment with her foster child, and she understood that they were to be discussing the results of genetic testing. She was driving with [the child] and her sister the first time - shopping for Christmas, and the second time, they were going to Palestine for a family outing. She told the receptionist that they would need to reschedule the talk, and the second time she forgot that they were calling her and didn't want to talk with the girls in the car. She was given no indication that there was cause for alarm or a sense of urgency. That's when the intake was called in. When I met with [foster parent], and I told her of the illnesses that could possibly be connected to [the child], she began to cry. The girls have been in her home for a couple years, and she was planning to adopt [the child]. After I left [the foster parent] called me within an hour with a new appointment for [the child's] genetic testing. Since then, there have been three appointments for [the child]. [The foster parent] is clearly very committed and ready to do whatever the child needs. After reviewing the appointments that were made in the last year and

talking with all the [county] and CPS workers, there is no doubt in my mind that this was not a case of medical negligence. There will be no Minimum Standard Violations."

14. Case ID: 2820684

Intake ID: 75557152

Sample File: November 2021

Summary of Intake Allegations: A staff member at St. Jude's Ranch for Children, a GRO, reported that a child (Child A, age 14) disclosed to staff members that another child (Child B, age 17) self-harmed by cutting herself at the GRO and that the cuts were covered by the child's clothes. According to the reporter, following Child A's request that staff members examine Child B's legs, staff members observed that Child B had "quite a lot of cuts on her legs." A staff member then contacted the Mobile Crisis Outreach Team (MCOT); MCOT assessed Child B and found that the child required admittance to an inpatient psychiatric hospital. A sheriff transported the child to the hospital. At the time of the incident, the child was reportedly on an increased level of supervision, which required staff members to check on her every 15 minutes. According to the reporter, the child's diagnoses included an unspecified mental health disorder, of which her symptoms involved self-harming by cutting.

Monitors' Review: The allegation that a child, with a history of self-harm, cut her legs to self-harm while subject to an increased supervision level meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3: Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the information gathered through face to face interviews, documentation and phone interviews there was no concern with minimum standards found. Victim [Child B] did state she had cut herself with a pencil sharpener another resident had stole [sic] from store. Victim [Child A] refused to be interviewed. Staff stated [Child A] had told her that [Child B] had been cutting herself and she called MCOT for her to evaluated [sic]. Victim did not require any medical treatment for the cuts. CVS Caseworker was aware and had no issues with the facility. Service plan and serious incident report reviewed and no concerns. Recommended Action: Routine monitoring."

Intakes Received in December 2021

15. Case ID: 2827988

Intake ID: 75739568

Sample File: December 2021

Summary of Intake Allegations: A DFPS caseworker reported that a foster parent spanked three children in her care (Child A, age 5, Child B, age 6, and Child C, age 3) with a paddle. Child A made the outcry to the reporter during a visit with the child in the home. The reporter asked the child what happens when she gets into trouble and Child A responded, "she [the foster parent] whoops us with a paddle or sends us to our room." The reporter stated that she did not observe any injuries to Child A nor the other children. The child did not specify to the reporter where the foster mother hit her on her body. The reporter also asked the foster parent what occurs when the children get in trouble, and the foster parent stated that she separates the children and sends them to their rooms. The foster parent did not report hitting or paddling the children.

Monitors' Review: The allegation that a foster parent spanked three children in her care with a paddle meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority P3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Explanation of Disposition: "After conducting interviews and analyzing the information obtained, the standard that was tasked was evaluated and determined to be in compliance, however another standard was tasked and determined to be deficient. According to standard 749.1003(b)(4)(A)(ii) Children's rights-Adhere to the child's rights to be free from being subjected to corporal punishment, this standard was marked compliant based on the interviews conducted. The foster parent and the victim that allegedly stated the allegation stated that the child was speaking of a prior incident that happened when the child was living with their bio mom. The reporter stated she (the reporter), at the time of the allegation, couldn't determine whether or not the child was speaking of the foster parents or the bio parents during the reporter's interview. According to standard HRC42.04412(a) Interference with an investigation, this standard was marked deficient based on the observation/inspection conducted in the home. Upon arrival at the home, one of the foster parents stated to the rccr staff that the rccr staff wouldn't be able to speak to the children with the use of profanity, based on a prior experience with another caseworker. After entering the home with the other foster parent, the foster mom was informed interviews would need to be conducted with the children privately. After a walk-thru /inspection of the home was conducted the foster parent was informed the interviews needed to be conducted with the children preferably privately in the child's bedroom for privacy. The foster

parent then sat down with both of the girls and told the girls that rccr staff wanted to speak with them, and then stated to the girls that rccr staff wanted to talk to them regarding what happened at their bio mom's home. The foster mom then stated to the girls that they didn't have to speak to rccr staff. One of the girls then stated she didn't want to speak to rccr staff. The foster parent informed me to speak to the child in the kitchen area, and the foster parent was informed the interview would need to be private. After the foster parent was informed two times that the interviews would need to be conducted privately, the foster parent still didn't let rccr speak to the children privately. The foster parent first told rccr staff that the interviews would need to be conducted in the kitchen area, then the foster parent wouldn't leave the kitchen area in order for their [sic] to be privacy during the interview. The interviews were later conducted at the children [sic] school. The interview conducted with the home fad worker stated the foster parent has came [sic] to the door of the child's room during interviews in the past, as well. After analyzing the report, the allegation regarding the children being subjected to corporal punishment couldn't be substantiated due to the children and the foster parent stating the corporal discipline happened prior to the children coming into the home. Recommended Action: No action."

As of September 1, 2022, the foster home was closed.

16. Case ID: 2827487

Intake ID: 75726711

Sample File: December 2021

Summary of Intake Allegations: The father of two children in care (Child A, age 3 and Child B, age 7) reported that the children's foster parent scared Child A by telling her that when she reportedly misbehaved or did not listen, the police would "take her," that she would not come back, and that the police "will do something to her." The reporter stated that every time he and his wife, Child A's mother, visited the children, Child A "freak[ed] out" and seemed traumatized when she heard a siren. When they asked Child B why Child A acted that way, Child B disclosed that the foster mother made statements that scared Child A. The reporter also stated that every time he attempted to hug Child A, Child A seemed afraid. The reporter stated he and his wife observed a man staying with the foster mother and reported it to CPS. The reporter stated that he believed the foster mother was manipulative.

Monitors' Review: The allegation that a foster parent scared a child in her care by telling her that the police would take her away and "do something to her" if she misbehaved and that this action reportedly caused emotional injury to the child meets the threshold for an Emotional Abuse investigation based upon:

Mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.787(a)(1).

In its discussion of the substantive due process rights of PMC children, the Fifth Circuit stated, "egregious intrusions on a child's emotional well-being—such as, for example, persistent threats of bodily harm or aggressive verbal bullying—are constitutionally cognizable."[1]

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority P3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Explanation of Disposition: Based on the preponderance [of evidence] gathered there will be no citations for supervision nor other standards. All persons spoken to did not disclose someone else living in the home that was not suppose [sic] to be living in the home. Foster children did not disclose any corporal pusnihsment [sic] or feeling unsafe in the home. Foster children's [sic] did not disclose someone touching their privet [sic] parts. Foster children did not disclose someone using the police as a threat. One foster child disclosed a foster parent in another home use [sic] the cops so the child can go to sleep, but this comment was not done in a mean hurtful way. The injuries' [sic] sustained in the hand of the victim occurred outside of the home and it has been previously investigated. There were no other concerns noted in this investigation. Recommended Action: Routine monitoring."

As of September 1, 2022, this foster home was closed.

17. Case ID: 2825058

Intake ID: 75666612

Sample File: December 2021

Summary of Intake Allegations: A DFPS caseworker reported allegations that a foster parent spanked two children in her care (Child A, age 6 and Child B, age 4) with a belt as punishment. Child A stated that the foster mother hit him with a belt. The reporter stated that the child pointed to his bottom when she asked where the foster mother hit him and he stated that "[the belt] hit his shoulders too." Child B did not state where on her body the foster parent hit her with the belt, but she shook her head "yes" when the reporter asked her whether it hurt when the foster parent hit her. Child B told the reporter that she did not have any marks on her body as a result. The reporter did not observe any marks or bruises on the children.

Monitors' Review: The allegation that a foster parent hit two children in her care with a belt meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

[1] *M.D. by Stukenberg v. Abbott*, 907 F.3d 237, 251 (2018).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Explanation of Disposition: Based upon the information gathered during the course of this investigation, there is enough evidence to conclude that children in care were inappropriately disciplined. All 4 foster children interviewed stated that the foster mother spanks them whenever they get in trouble and/or break a rule. One of the four foster children stated that they were told by the foster mother to say they do not get spankings if anyone asks them about it. One of the four teachers interviewed stated that one of the foster children told her about the spankings last week but wasn't sure if she was supposed to report it since there were no physical signs. Both foster parents interviewed denied the allegations and stated that they only use time outs as a form of discipline. Due to the statements made by the four children and one of the teachers, a safety plan was requested and received by the operation. Recommended Action: Routine monitoring."

18. Case ID: 2823223

Intake ID: 75617890

Sample File: December 2021

Summary of Intake Allegations: A staff member at Arrow Child and Family Ministries of Texas, a Child Placing Agency, reported that a foster mother encountered her foster children (Child A, age 14 and Child B, age 12), who are siblings, touching each other's genitals with a colored pencil. The foster mother stated that the children reported that they had touched each other before, sometimes with an object and sometimes without an object. The foster mother stated that when she observed the behavior, the children were clothed; she did not know the frequency of the behavior and she did not know whether the children ever engaged in inappropriate behavior unclothed. The foster mother stated that the children reported that they engaged in the same inappropriate behavior "a lot" when the children were placed in a respite foster home and that it also occurred when they lived "at home." The children reported to the foster mother that sometimes Child A asked Child B if he could touch her genital area and Child B at times answered yes and other times, she told him no. The reporter believed that the children had been placed in this foster home for approximately two years. The reporter stated that the foster mother requested permission from the CPA to install a video monitor and reportedly bought door chimes to alert her when the children's doors opened.

Monitors' Review: The allegation that two foster siblings engaged in inappropriate sexual contact in a foster home meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority P3 – Minor violation of the law or minimum standards that involve low risk to children.

*Minimum Standards Investigation Findings: "*Explanation of Disposition: No new allegations were added. The investigation was upgraded to abuse and neglect. The investigation number is 2823337. Permission granted to close by RCCR supervisor.[2] Recommended Action: Routine monitoring."

As of September 1, 2022, this foster home was closed.

19. Case ID: 2830123

Intake ID: 75773472

Sample File: December 2021

Summary of Intake Allegations: A DFPS caseworker reported that a staff member at L'Amor Village RTC wrapped his arm around a child's (Child A, age 16) neck and threw him to the ground. Reportedly, Child A and another child (Child B, age unknown) were engaged in a verbal altercation and when Child A gestured that he was going to hit Child B, the staff member intervened and wrapped his arm around Child A's neck and threw him to the ground. The reporter stated that there were no other known witnesses to the allegations (other than those involved), and that she did not know where the incident occurred or whether there were any cameras at the facility. Child A told the reporter that that he did not have any marks or bruises; the reporter stated the child was upset when he recounted the incident.

Monitors' Review: The allegation that a staff member wrapped his arm around a child's neck and threw him to the ground meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority P3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Explanation of Disposition: Based on a preponderance of information, there is evidence to conclude that there are concerns with inappropriate discipline. The two children involved in the incident, [Child A] and [Child B], were interviewed and corroborated that [Staff 1] grabbed [Child A] by the neck and threw him onto the couch. Both boys stated that they were not fighting, which is what [Staff 1] was attempting to

[2] SWI received another intake report from the foster mother regarding these allegations and it was misrouted to DFPS CPI. DFPS CPI referred that report to DFPS RCCI for an investigation and at that time, HHSC closed its minimum standards investigation due to the RCCI investigation into the same allegations.

prevent, they were just having an argument. It was stated by [Staff 1] and the 2 children involved that there were no other staff or children inside the facility during the incident. [Staff 1] stated he did get in between the 2 boys to keep them from fighting and he and [Child A] fell over the side of the couch together. There are cameras at the facility but the timeframe in which the incident occurred was too far back to view. None of the other children interviewed expressed concern with being physically disciplined at the facility by [Staff 1] or any other staff. TA was provided for documenting the incident because the report was reviewed at the facility but not provided upon asking for the report via email. Violations cited: 1. 748.2307(1): Two children in care expressed that a staff grabbed a child in care around the neck and threw him onto the couch to stop them from potentially fighting. TA: The purpose of this rule is to prevent harm to children due to the use of behavior management techniques that inflict physical or emotional pain or discomfort. These prohibited methods of punishment are considered physically, psychologically and/or emotionally abusive. Discipline is most effective when it is consistent, recognizes and reinforces desired behaviors, and offers natural consequences (for example, when a child breaks a toy, the toy no longer works) and logical consequences (for example, not being able to play in the sandbox for a period of time as a consequence for throwing sand) for negative behaviors. 748.311: TA: The purpose of this rule is to clarify the information that is required when documenting a serious incident. The required information may assist in analyzing the incident to determine steps that are needed to prevent similar incidents in the future. Recommended Action: Routine monitoring."

20. Case ID: 2830229

Intake ID: 75776874

Sample File: December 2021

Summary of Intake Allegations: A staff member at The Retreat Home for Children, a GRO, reported that while on an outing, a child (Child A, age 16) was involved in an argument and threw a cup that hit another child (Child B, age 16) in the eye. Child B's right eye was allegedly cut, swollen and bruised from the incident. The reporter stated that two staff members were present at the time of the incident and attempted to separate the children. Following the incident, a staff member contacted the GRO Treatment Director who advised staff members to give Child B an ice pack and over-the-counter medication to treat her eye. The Treatment Director told staff members that if an issue arose [with Child B's eye], a staff member should secure the child medical attention in the morning. The following morning, Child B had "complications" with her eye and a staff member took her to an urgent care facility. The reporter stated that she received an antibiotic ointment for a cut "on her eye."

Monitors' Review: The allegation that the GRO treatment director advised staff members to delay seeking medical attention for a child after she injured her eye meets the threshold for a Medical Neglect investigation based upon:

Failure to seek, to obtain, or to follow through with medical care for a child, by an employee, volunteer, or other individual working under the auspices of a facility or program that causes or

may cause substantial emotional harm or substantial physical injury to a child. 40 TAC §707.801(b)(1)(E).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority P3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the information received through interviews and documentation reviewed, it was determined that there was a preponderance of evidence to support the allegations. While there was [sic] no concerns regarding supervision and medical care being received, there was evidence to show that the operation did not report the incident timely. All children and staff confirmed that staff supervise properly and are in ratio, as well as giving kids medical treatment as needed. The child was injured on 12/21/21, seen by a medical professional on 12/22/21 but Licensing was not notified until 12/28/21, which will result in a citation. Recommended Action: Routine monitoring."

21. Case ID: 2830218

Intake ID: 75776321

Sample File: December 2021

Summary of Intake Allegations: A staff member (Staff 1) at Hill Country Youth Ranch, a GRO, reported that another staff member (Staff 2) performed a restraint that allegedly injured a child (age 13). At the time of the incident, the child was attempting to run away from the facility and Staff 2 placed the child in a "safe containment" to prevent the runaway. During the restraint, the reporter stated that the child hit her chin on the ground, which caused a bruise and bump. The child also stated that one of her back teeth was chipped. Following the incident, staff members took the child to the Emergency Room for medical attention. The reporter did not believe that the child required stitches. Medical personnel also assessed the child's tooth and recommended that the child receive a dental evaluation to determine whether her back tooth was chipped.

Monitors' Review: The allegation that a staff member injured a child during a restraint meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority P3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the preponderance of information obtained through interviews, and records, the operation is not in compliance with the standards evaluated as part of this investigation. This report is in regards to a child-in-care, [the child] getting injured while running away from staff and being restrained. The staff member that performed the restraint,

[Staff 1], was interviewed and the Serious Incident Report regarding the restraint was reviewed. [The child] declined to be interviewed for this investigation on two separate occasions. Regarding the restraint, the [Staff 1] [sic] stated that [the child] was running away from him down a hill while it was dark and foggy outside. [Staff 1] stated that he ran after [the child] and in her attempt to get away from him she fell and hit her face on the ground resulting in the injuries. [Staff 1] helped [the child] up and held onto her wrist, a personal restraint, and escorted her back up the hill towards the cabin. [Staff 1] stated that [the child] became aggressive while they were walking up the hill and she had to be restrained further. [Staff 1] felt that the restraint was justified because [the child] could have been hurt while running because it was dark and foggy on the steep hill. Program Director, [name removed] was interviewed and he himself also questioned whether the restraint was justified based on the circumstances and was not sure if the situation was a life threatening emergency. The area where the runaway and restraint took place was observed. The hill that [Staff 1] described [the child] running down consisted of only a gentle slope with light brush/vegetation and no dangerous drop offs or other life-threatening hazards. Standard 748.2455(a)(2) will be found deficient due to a restraint being used on a child when the situation was not an emergency or life threatening. [Staff 1] did not have sufficient justification to restrain [the child] as she was only running from him and was not acting aggressively until she was restrained by having her wrist grabbed. The hill that [the child] was running down did not present itself as life threatening. Regarding [the child's] restraint, there are no indications that it was performed incorrectly. Standard 748.2453 will be found compliant as a qualified caregiver performed the restraint. Standard 748.2851(b) will be found compliant as it was documented in the Serious Incident Report that a post EBI discussion was completed with [the child] the following day. Standard 748.2553(2)(C) will be found compliant as it was determined that [the child] was released from the restraint as soon as she was not a danger to herself or others. Standard 748.2551(c)(2) will be found compliant as there is no evidence to suggest that excessive force was used during the restraint. During this investigation four girls residing in [the S] Cabin were interviewed regarding their care at the operation. Of the four girls interviewed, three of them made similar complaints about their house parent, [name removed], yelling at them. They individually stated that [the house parent] will yell at them because she is grumpy, not in a good mood, having a bad day or frustrated with them. Additionally, one child stated that [the house parent] yelled at her and called her a brat. Standard 748.2307(8) will be found deficient as yelling and ridiculing a child is a prohibited form of punishment. Recommended Action: Routine monitoring."

Intakes Received in January 2022

22. Case ID: 2838236

Intake ID: 75847668

Sample File: January 2022

Summary of Intake Allegations: An OCOK caseworker reported that a foster mother hit a child in her care with a belt. The child (Child A, age 5) disclosed to the reporter that her foster mother

gave her "whoopings" with a belt. The reporter did not observe any bruises or marks on the child's body. Child A's brother (Child B, age 8) told the reporter that the foster mother hit Child A with her hand; he did not observe the foster mother hit Child A with a belt. Child B stated that the foster mother hit Child A when she "act[ed] out" or was "not listening." The reporter stated that she did not discuss these allegations with the foster mother.

Monitors' Review: The allegation that a foster parent hit a child in her care with a belt meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority P2 – Injury or serious mistreatment of a child.

Minimum Standards Investigation Findings: "Explanation of Disposition: Two children in care stated that one child in care was spanked with a belt. One child in care stated the child that was hit told the spanking occurred and [sic] hear sibling crying in the foster parent [sic] room. Both foster parents denied using physical discipline on children in care. One caregiver admitted to putting a belt on the table as a form of discipline and stated when this is done the children in care listen. One caregiver admitted to put [sic] a belt on the table as a form of discipline to the children in care. Minimum standard evaluated was 749.1953(a) and was found to be deficient. Recommended Action: Routine monitoring."

As of September 1, 2022, this foster home was closed.

23. Case ID: 2834931

Intake ID: 75831838

Sample File: January 2022

Summary of Intake Allegations: A child's parent reported that a staff member at Turning Point Children's Social Service, a GRO, "slammed" the child on the floor because he did not get up from a table "fast enough." Reportedly, the child (age 9) experienced headaches following the incident. The reporter also alleged that older children (ages unknown) at the GRO fought with the child, took his belongings away from him and threatened to beat him up. The reporter stated that the child allegedly told staff members about the older children's behavior toward him; however, the staff members failed to take seriously Child A's complaints due to his alleged behavior.

Monitors' Review: The allegation that a staff member slammed a child on the floor and the child experienced headaches following the incident meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Note: Four days after the above intake report was received by SWI, a DFPS caseworker reported a similar allegation of Physical Abuse of the child to SWI. SWI assigned the latter intake for a Physical Abuse investigation, as referenced in the minimum standards investigation below.

Next, the allegation that staff members failed to appropriately respond to potentially harmful behavior between children, including fighting and making threats, meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the information gathered throughout the course of this investigation there is not a preponderance of evidence that supports the allegations [sic] alleged the children in care are inappropriately supervised by the caregivers. After speaking with the conservatorship caseworker, interviewing school staff, reviewing incident reports of [the child's] behavior, interviewing children at the operation, and staff/case manager at operation. The allegations of the child, being physically assaulted by a staff was previously investigated by A/N #48975823. The case was Ruled Out and closed. I attempted to conduct a comprehensive interview with the child, but he was uncooperative. The intake did not have [sic] alleged perpetrator and listed the victim as Unknown 1. [The child's] father was the reporter who identified his child in questioned [sic] of the allegations. I found no concerns with 748.685(a)(4) Caregiver responsibility – providing the level of supervision necessary to ensure each child's safety and well-being. I spoke with the child's case manager, who reported the child had given away his belonging and all children are aware to not give away their property. [The caseworker] stated the child was being discharged from the operation. [The caseworker] stated she took the gold chain away from the other child because she did not want the father saying the chain was missing. [The caseworker] stated she is aware of how the father reacts. [The caseworker] stated she has possession of the chain in the office. [The caseworker] stated the father is aware of the chain being here in her office. [The caseworker] stated the father got on 'zoom' and asked about the chain. [The caseworker] reported on the 'zoom' conference [the child] reported he was bullied for his chain. [The caseworker] reported [the child] lied to his father about the chain. [The caseworker] stated [the child] place [sic] the chain in his mouth, and she would have to correct him. [The caseworker] stated the allegations of [the child] being slammed to the ground and [sic] previously been addressed. [The caseworker] stated licensing representative came and addressed those allegations. [The caseworker] reported she has the document from the case being closed. [The caseworker] reported the child slammed [sic] never being slammed or bullied. [The caseworker] stated [the

child] bullies at other children "telling them about your momma don't want you". I interviewed three additional children at the operation who did not make a disclosure of any harm by the staff but report [the child's] behavior. The collateral children reported [the child] has given away their toys. No risk to the child was observed during this investigation along were zero deficiencies. Technical Assistance was provided due to the unoccupied bunk-bed missing boards and screw need be [sic] tighten. Recommended Action: Routine monitoring."

24. Case ID: 2853585

Intake ID: 75907753

Sample File: January 2022

Summary of Intake Allegations: A service provider reported that a child alleged that his foster father hit him with a belt while he was placed in the foster home. According to the child (age 16), the foster father hit him after he was suspended from school. The child alleged that the foster father hit him approximately 30 to 50 other times prior to the alleged incident.

Monitors' Review: The allegation that a foster parent hit a child with a belt meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 – Injury or serious mistreatment of a child.

Minimum Standards Investigation Findings: "Based on evidence gathered during the course of this investigation, the allegation of a youth being subjected to corporal punishment can be confirmed. The foster parent and victim youth both confirmed the foster parent spanked the youth with a belt. The foster parent stated he notified his agency case manager about his actions immediately following the incident. This was confirmed by the case manager and documents reviewed. Per documents reviewed and interviews conducted, the case manager conducted a welfare check on the youth placed in the home the same day of the incident to ensure no additional risks Or [sic] hazards were apparent. Other documents reviewed, indicated the agency took immediate action to implement a safety plan and corrective action plan for the foster parent's prohibited discipline. Overall, a preponderance of evidence obtained indicates the allegation to be true. Recommended Action: Routine monitoring."

As of September 1, 2022, this foster home was closed.

25. Case ID: 2842149

Intake ID: 75862176

Sample File: January 2022

Summary of Intake Allegations: A therapist reported that a child disclosed inappropriate discipline at Hill Country Youth Ranch, an RTC. The child (age 9) stated that a staff member made him stand outside by himself in the cold or at night as a frequent punishment, including on the day this allegation was made to SWI. The reporter stated that following the alleged incident, the child cried "excessively" when he arrived at school and exhibited increased anxiety. A teacher at the school told the reporter that following these alleged incidents, the child struggled to focus on schoolwork.

Monitors' Review: The allegation that a staff member required a child to stand outside in the cold during the winter (the average low temperature in the San Antonio area in January is 40 degrees) or at night as a form of punishment and that this action allegedly caused emotional injury to the child meets the threshold for an Emotional Abuse investigation based upon:

Mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.787(a)(1).

In its discussion of the substantive due process rights of PMC children, the Fifth Circuit stated, "egregious intrusions on a child's emotional well-being—such as, for example, persistent threats of bodily harm or aggressive verbal bullying—are constitutionally cognizable."[3]

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the information gathered through interviews and documents reviewed, it was determined there was not a preponderance of evidence to support the allegations. After interviewing 4 children in care 2 of the 4 stated they do have to stand on the porch as a form of punishment for about 15 mins. The other 2 child [sic] stated they do refocus on the porch if they do not calm down at the first two refocusing stations. 3 of the 4 children interviewed stated they do not refocus on the porch by themselves, if they are on the porch without a staff member they are within line of sight. The 2 house parents interviewed stated having to stand on the porch is not a form of punishment, it is the third station to their refocusing program. The house parents stated a child only stands on the porch for about 15 min or less, this only happens when the child is extremely escalated. House parents stated if it is extremely cold, they will not go outside, but if it just cold they will wear jackets. Four staff members stated if a child is on the porch a staff member is with the child or the child is in line of sight. During the interview with [a child] he stated a staff member had pushed [another] child in care [Child B] to the ground. 2 out of the 4 children interviewed one being [Child B] stated staff member did not push [Child B]. [Child B] stated he was backing up and slipped on a piece of paper. Staff members stated [Child

[3] *M.D. by Stukenberg v. Abbott*, 907 F.3d 237, 251 (2018).

B] was not pushed, but [Child B] did slip on a piece of paper. CPS workers did not have any concerns regarding the operation currently. Recommended Action: Routine monitoring."

26. Case ID: 28521645

Intake ID: 75903631

Sample File: January 2022

Summary of Intake Allegations: A staff member at The Retreat Home for Children, a GRO, reported that a child, who has a history of self-harming, self-harmed at the GRO. According to the reporter, the child (Child A, age 15) locked herself in her bedroom and another child entered Child A's bedroom by breaking a window. Child A allegedly grabbed a piece of broken glass from the window and used it to cut her arms. Reportedly, a staff member then gained access to Child A's bedroom by breaking the door. Once in the bedroom, the staff member attempted to restrain Child A to retrieve the piece of glass. The staff member reportedly struggled to restrain Child A; Child A allegedly resisted the restraint, continued to self-harm and eventually swallowed a piece of the glass. The GRO contacted law enforcement who responded to the incident. Emergency Medical Services (EMS) also responded to the incident and transported the child to a hospital.

Monitors' Review: The allegation that a child, with a history of self-harming behavior, locked herself in her bedroom and self-harmed meets the threshold for Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 – Serious supervision problems.

Minimum Standards Investigation Findings: "Explanation of Disposition: Based on the information gathered through interviews and documents reviewed, it was determined there was a preponderance of evidence to support the allegation. A citation will be given for not providing the level of supervision necessary to ensure each child's safety. After reviewing 6 children in care's service plans, it was found all of them should be supervised by line of sight. After conducting interviews with staff and children it was found when the children are located in their rooms during awake hours, they are checked on every 15 mins. During one of the incidents a child locked their self [sic] in their room and another child went outside. During this time both children were not being supervised according to their service plans. Technical assistance will be given for prudent judgement. Due to the operation being an RTC facility a child should not be able to lock their selves [sic] in their rooms. After reviewing the admission assessment's [sic], it was found that high risk behaviors were listed. After conducting interviews, it was found the children that required medical attention did received [sic] medical attention. After conducting interviews, it was found

that the child to caregiver ratio was in compliance. After reviewing the serious incident reports, it was found the incidents [sic] was reported in a timely manner. CPS workers did not have any concerns regarding the operation. Recommended Action: Routine monitoring."

Intakes Received in February 2022

27. Case ID: 2861268

Intake ID: 75975525

See the summary below about this intake report and a companion intake report with the same allegations, both of which were contained in the Monitors' sample.

28. Case ID: 2861268

Intake ID: 76007509

Sample File: February 2022

Summary of Intake Allegations: SWI received two separate intake reports with related allegations of Physical Abuse of a child placed in a foster home. The monitoring team disagreed with SWI's determination to screen out both reports to HHSC who then assigned them for a joint minimum standards investigation. In the first intake, a therapist at a child placing agency reported that a child (Child A, age 6), with high-functioning autism and limited vocabulary, disclosed that his foster parent hit him with a belt when he got in trouble. According to the reporter, Child A stated that his foster parent "whooped" him. Although the child could not provide a time frame, the reporter stated that there were indications that the child had been struck either the day before or the morning of the intake report. The reporter did not observe any injuries on Child A and stated that the child denied that he was hurt and did not appear scared of his foster parent. The reporter stated that Child A "was abused [in his birth home] in the same manner," and was placed in foster care due to this abuse.

Approximately one week later, a CPA case manager reported to SWI similar allegations related to the foster parent and Child A. According to the reporter, Child A, who was placed in a respite foster home following the prior intake report, disclosed that he did not want to return to the foster home. Child A told the reporter that when he got in trouble, his foster mother hit him with a belt on the bottom. The reporter stated that the child said that he was whooped a lot. According to the reporter, the child stated that he got in trouble for hitting his sibling and that his foster mother told him that if he kept hitting, she would send him away. The reporter did not observe any bruises or marks on the child. The reporter stated that this was the second time the child made an outcry of Physical Abuse.

Monitors' Review: The allegations that a foster parent hit a child in her care with a belt meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Both intakes were assigned Priority 2 – Injury or serious mistreatment of a child.

Minimum Standards Investigation Findings: "On 02/14/2022 a P2 intake was received on Jonathan's Place Foster Family Program regarding the foster home. It alleged a caregiver used corporal punishment on a child in care.

During this investigation I spoke with the victim, both foster parents, one collateral child in the foster home, the victim's OCOK worker, the victim's therapist, and the agency director. I interviewed [the child] in private at his respite home and [the child] reported his mommy is sometimes not nice to him because she whoops him. When asked who his mommy was he stated her name is [foster mother]. [The child] reported he gets whooped when he does something wrong and he got a whooping recently. When asked where on his body he was whooped, [the child] pointed to his chest. [The child] reported he is scared of his mommy because she whoops him. When asked to show me where on his body he was whooped, [the child] stated he did not know. Both foster parents were interviewed in private and both denied any physical discipline has been used on [the child]. Both foster parents reported [the child] had gotten in trouble recently but denied he received a whooping, both reported they only spoke with [the child] about the situation. Both foster parents acknowledged a previous investigation regarding their biological son being spanked and that a safety plan was put on the home stating no physical discipline is to be used on any child in the home. Both foster parents reported they have been and are currently following that safety plan. Both foster parents reported [the child] has past trauma from when he was placed with an aunt and uncle who severely abused [the child] and they believe this is where the claims of getting a whooping are coming from. Permission was given for me to speak with the foster parent's biological son. I interviewed him in private and he denied any knowledge of [the child] getting a whooping or spanking by his parents. The child reported he used to get spanked by his parents but that has not happened in a long time. [The child's] OCOK worker reported no previous concerns of physical discipline in this foster home. She reported [the child] does have a lot of trauma from when he was placed with his aunt and uncle because the aunt and uncle physically abuse [the child]. The OCOK worker reported she is concerned that [the child] has made this outcry twice during this investigation and she is not sure what to think. The agency Director reported she is very familiar with this foster home and was the case manager during the first investigation last spring. She stated she is concerned that [the child] is continuing to make an outcry of the foster mother whooping him so the agency made the decision to go ahead and close this home. She stated she has had no concerns prior to this investigation and she just does not know what to think about these current concerns.

Based on the information gathered, no deficiency will be given but TA will be provided for corporal punishment due to the agency going ahead and closing this foster home. While [the child] did make an outcry of corporal punishment, the outcry was not consistent. Both foster parents deny using corporal punishment on [the child], however; [the child] has continued his outcry and the

home does have a prior investigation regarding inappropriate discipline. Recommended Action: No action."

As of September 1, 2022, this foster home was closed. The foster home opened on May 12, 2017 and closed on March 1, 2022, after the above minimum standards investigation. The child was removed from the foster home on February 28, 2022 and placed in another foster home, which disrupted shortly thereafter due to the foster parents' request for the child's discharge. DFPS placed the child in another foster home, where he currently resides.

29. Case ID: 2859474

Intake ID: 75952371

Sample File: February 2022

Summary of Intake Allegations: A former foster parent and relative of a child reported that the child self-harmed with a blade from a bathroom at Gulf Winds Residential Treatment Center, an RTC. The reporter stated that two days prior to the report, the child (age 16) was involved in a physical altercation with another child at the RTC. Following the altercation, staff members instructed the child to go to his bedroom. In his bedroom, the child allegedly self-harmed using a blade he found in the bathroom. According to the reporter, the child treated the injury himself with ointment. The reporter stated that while the child previously lived with her, the child experienced homicidal and suicidal thoughts and engaged in self-harm and aggressive actions toward others. The child's service level was Intense.

Monitors' Review: The allegation that a child, with a history of self-harm, accessed and used a blade to self-harm meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 – Serious supervision problems.

Minimum Standards Investigation Findings: "After completing my investigation, there is a preponderance of evidence to indicate children in care are not properly supervised. 4 out of 5 residents interviewed disclosed supervision concerns. The victim [Child A], stated staff go to the copy room at the end of their shifts to do their paperwork and leave the residents unsupervised every day. [Child B] stated staff are on their phones an excessive amount while they should be supervising residents. [Child B] stated [Staff 1] leaves the residents alone while he goes outside to smoke cigarettes. [Child B] stated only one of the night staff do room checks but the other does not. [Child C] stated [Staff 1] leaves residents alone while he goes outside for a cigarette break and stated [Staff 1] is on his phone an excessive amount while he should be supervising the

residents. [Child D] stated he does not sleep well at night and is awake a lot. He stated [Staff 2] does not do room checks at all. [Staff 3] stated direct care [Staff 1] is on his cell phone an excessive amount while he is supposed to be supervising the residents. [Child A's] CPS caseworker was notified and did not have any concerns. There were no concerns with the documentation requested from the operation for the investigation. One citation will be issued as a result of this investigation for supervision for 748.685(a)(4). Recommended Action: Routine monitoring."

30. Case ID: 2863760

Intake ID: 76010531

Sample File: February 2022

Summary of Intake Allegations: A DFPS caseworker reported that a staff member at New Hope Youth Center, an RTC, punched and shoved a child to the ground. According to the child (Child A, age 17), he threw a basketball near the staff member's (Staff 1) car and Staff 1 became upset. Reportedly, Staff 1 then threw Child A down to the ground and started punching him. Other staff members allegedly observed the incident. Child A told the reporter that he was not injured. Another child (Child B, age 15) told the reporter that he observed Staff 1 argue with Child A and then press Child A against a car before shoving him to the ground. Child B stated that Staff 1 did not punch Child A. The reporter stated that Child B said that after Staff 1 walked away, other staff members restrained Child A on the ground. According to the reporter, staff members placed Child A face down during the restraint and staff members held his arms to each of his sides. During the restraint, Child A allegedly stated that he could not breathe; staff members allegedly moved Child A's body in response to his outcry.

Monitors' Review: The allegation that a staff member punched a child and shoved him to the ground and punched him meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 – Injury or serious mistreatment of a child.

Minimum Standards Investigation Findings: "Explanation of Disposition: After completing my investigation, there is not a preponderance of evidence to indicate a child in care was inappropriately restrained. There is, however, a concern for inappropriate discipline as multiple residents disclosed that yelling, cursing, and threats are used by [Staff 1] as a form of punishment. [Child C] stated [Staff 1] gets in residents [sic] faces and uses an intimidation technique for discipline. He stated he yells, curses, and has threatened to slap him. [Child B] stated [Staff 1] has gotten into his face yelling, cursing, and threatening him. [Child A] stated [Staff 1] yells, curses and threatens him. [Child D] stated [Staff 1] curses and yells and [Child E] stated [Staff 1] and other staff curse every once in a while. [Child E] stated '[Staff 1] does not play'. Multiple staff

were interviewed, and all claimed cursing or other inappropriate discipline was not used. [Caseworker 1], Child C's CPS caseworker was contacted and did not have any concerns to report. Child A's CPS caseworker, [Caseworker 2] was contacted and did not have any concerns to report. One citation will be issued as a result of this investigation for 748.2307(9) Other Prohibited Punishments-subjecting a child to abusive or profane language. Recommended Action: Routine monitoring."

Intakes Received in March 2022

31. Case ID: 2865071

Intake ID: 76033246

Sample File: March 2022

Summary of Intake Allegations: A DFPS caseworker reported that a child with emotional disorders, intellectual delays, and past trauma from her birth family disclosed that a few months prior to the report, her former foster father hit her with a belt on the stomach and bottom. The reporter stated that the child (age 9) recounted an incident in which she got into trouble with her former foster parents. During the alleged incident, the child reported that her foster father yelled at her to "shut up" and hit her with a belt on the stomach and bottom. According to the reporter, the child stated that the hit left a bruise and that "it hurt." The child also disclosed that her foster parents told her not to tell anyone about the incident and if she did, it would be her "worst nightmare." The reporter expressed concern that the foster parents may have been using inappropriate discipline with the other foster children residing in the home at the time of the report.

Monitors' Review: The allegation that a foster parent hit a child with a belt on the stomach and bottom meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3: Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "After conducting interviews and analyzing the report, the standards were evaluated and determined to be in compliance. The standard regarding corporal punishment was marked compliant based on the interviews conducted with the victim in the home, the alleged foster parents, and the child's cvs worker. Interviews corroborated with the foster parents and the victim still placed in the home that the foster parents didn't use corporal punishment as a form of discipline. The interviews corroborated with the child's cvs worker and the victim in the home that the victim that was removed from the home made untrue statements.

The victim no longer placed in the home [sic] statements could not be substantiated based on the other interviews conducted. The standard regarding child's rights was marked compliant based on their [sic] not being enough preponderance to conclude the standard to be deficient. None of the interviews conducted indicated that the foster parent [sic] were yelling or saying belittling things to the foster children. Recommended Action: No action."

As of September 1, 2022, the foster home was open and serving three children.

32. Case ID: 2870560

Intake ID: 76128661

Sample File: March 2022

Summary of Intake Allegations: A case manager reported that a therapist stated that during a psychological evaluation, a child (age 9) disclosed that she was spanked with a wooden spoon. The reporter met with the child twice in the same month as the intake report; in those meetings, the child stated that she was spanked with a hand. The reporter did not observe any bruises on the child during those meetings. The reporter stated that the agency planned to remove the child from the foster home the next day.

The SWI screening specialist did not ask the reporter to specify who allegedly spanked the child; as result, the intake report allegations failed to include this information. SWI entered the child's foster parents as the alleged perpetrators.

Monitors' Review: The allegation that foster parents hit a child with a wooden spoon meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2: Injury or serious mistreatment of a child.

Minimum Standards Investigation Findings: "Based on the information gathered throughout the investigation there is evidence to support a citation related to corporal punishment. During my interview with alleged victim, [child] (8 years old) she [sic] said that foster mom, hit her with a wooden spoon and yelled at her and her younger sister (2 years old). According to [the child's] psychological evaluation, she reported to the psychologist that her foster parent hit her with a wooden spoon and yelled at her. [The] CPS worker, stated that during her last visit with [the child] she told her that [the foster mother] hit her with a wooden spoon as a form a (sic) of discipline. [The] counselor visited the home weekly and did not witness any inappropriate discipline by the foster parents. [The] Case manager stated that she first became aware of inappropriate discipline after she reviewed [the child's] psychological evaluation. [The child] (2 years old) was limited

verbally to interview. [The] Foster parent(s) denied any use of physical or inappropriate discipline. Recommended Action: Routine monitoring."

As of September 1, 2022, the foster home was closed.

33. Case ID: 2867128

Intake ID: 76072627

Sample File: March 2022

Summary of Intake Allegations: A reporter from the Foster Care Ombudsman (FCO) Hotline reported that staff members at The Settlement Club Home, a GRO, did not respond timely to a child's medical concern. For approximately one month, the child (age 16) alleged that she told staff members at the GRO that her hand hurt and staff members "are just now" scheduling her a medical appointment. The reporter stated that the child required follow-up with a physician.

Monitors' Review: The allegation that staff members failed to secure timely medical care for a child meets the threshold for a Medical Neglect investigation based upon:

Failure to seek, to obtain, or to follow through with medical care for a child, by an employee, volunteer, or other individual working under the auspices of a facility or program that causes or may cause substantial emotional harm or substantial physical injury to a child. 40 TAC §707.801(b)(1)(E).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3: Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on information gathered through the course of the investigation it was determined that minimum standards were violated. There are allegations a child in care is not receiving medical attention when needed, is not receiving therapy, is made to work with chemicals that they are reactive to and are not having their concerns heard.

The concerns for 748.2307(1) Other Prohibited Punishments is [sic] found to be compliant. Based on interviews with the operation staff, children in care, and CPS workers there is not sufficient evidence to show children are being punished or given consequences for having panic attacks. The incident in question occurred during a safety situation in which staff were put out of ratio dealing with an emergency and required the children to go to their rooms so they could be safe and supervised through the cameras. The child continued to leave her room causing an unsafe situation, therefore the child was given a consequence for not following directives not for having a panic attack. No citation will be issued.

The concerns for 748.705(b)(7) Reasonable & prudent parent standard is [sic] found to be compliant. This is based on interviews with children, CPS workers, and staff. The child reported that she has a reaction when dealing with bleach. The operation and the child's records did not indicate there was a bleach allergy. The dorm the child was in previously did not mention any

adverse reactions to bleach. The operation has given the child other cleaning supplies to work with in lieu of bleach and the child still complains. No staff have noticed any adverse physical reactions other than the child not liking the smell of bleach. The children are never given the cleaning supplies to clean with, the staff spray the area to be cleaned and the children wiped. No citation will be issued.

The concern for 748.685(c)(6) Implement and follow the children's service plans is found to be compliant. This is based on interviews with children, staff, CPS, and a copy of the child Service plan. The Service plan indicates the child should have weekly therapy. While the children did complain that their therapy would sometimes be moved around during the week and on one instance was shorter the children always received therapy during the week. There are multiple staff members with counseling degrees on campus that the children could talk to if they needed to check in. No citation will be issued.

The concern for 748.1531(a)(2) Medical care-A child in care must receive medical care as needed for injury, illness, and pain is found to be compliant. This is based on interviews with children in care, staff, CPS workers, and medical documentation. The operation has a nurse on staff who the children can see for illness or injury. If the illness or injury is more than the nurse can adequately treat on site, the children are sent to see other health care professionals. Some of the children expressed they felt they had to exaggerate concerns to receive medical treatment however CPS staff and medical documentation show that when the children had injuries or illnesses, they were treated by health care professionals as needed. No citations will be issued.

The concern for 748.1101(b)(1)(C) Children's rights - Adhere to the child's right to receive fair treatment Is [sic] found to be deficient. This conclusion is based upon interviews with staff and children. Both children and staff stated that a specific child in care has very big reactions to consequences causing staff to not give her consequences out of fear. Three staff members all admitted to seeing this happen one of which admitted to being scared to give consequences to the child. Children in care stated the child in question will act out in ways that if they did they would receive a consequences but she will not receive one. It is unfair that a child would not receive the same consequence for the same inappropriate behavior as their peers due to staff being afraid of their reactions. A citation will be issued. Recommended Action: Routine monitoring."

34. Case ID: 2869547

Intake ID: 76110817

Sample File: March 2022

Summary of Intake Allegations: An attorney ad litem reported that school personnel observed a child running around train tracks unsupervised while placed at Make A Way Residential Treatment Center, an RTC. At the time of the alleged incident, the child (age 9) was waiting for the school bus at her RTC. School personnel also notified the reporter that the RTC did not respond to the school's calls regarding the child's behavior. According to the reporter, the child has a history of running away, hitting, not following directions, and being physically aggressive with staff and other children.

Monitors' Review: The allegation that a child, with a history of running away, was unsupervised around train tracks meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: At intake, the investigation was assigned Priority 3: Minor violation of the law or minimum standards that involve low risk to children. The investigation was later upgraded by RCCR to a Priority 2: Serious supervision problems.

Minimum Standards Investigation Findings: "The following standards were evaluated: 748.685(a)(4) Brief Description: Caregiver responsibility - providing the level of supervision necessary to ensure each child's safety and well-being Based on the preponderance of evidence there will be no citation given for the allegation It [sic] is alleged that a child in care is not properly supervised. 4 out of 4 children interviewed stated that staff watch/ walk with them outside to get on the bus. 4 out of 4 children interviewed stated staff are always outside and are not alone. 3 out of 3 staff interviewed stated staff take the residents outside to catch the bus by groups. According to the original reporter another person was outside with the victim, the reported [sic] stated a girl was with the victim. This operation has boys only. According to the original reporter the victim was not near the train tracks and was siting on the driveway. Recommended Action: Routine monitoring."

Intakes Received in April 2022

35. Case ID: 2873325

Intake ID: 76169947

Sample File: April 2022

Summary of Intake Allegations: An OCOK caseworker reported that during a visit with a child at her school, the child (age 6) disclosed that she received "whoopins" with a belt on her bottom in a foster home. The caseworker stated that the child disclosed that someone hit her multiple times and that her last "whoopin" occurred either "three weeks ago or three years ago." The child also told her caseworker that her siblings (ages 2 and 3) received "soft whoopins with a hand" in the foster home. The caseworker reported that one day prior to the date of the intake report, she attempted an unannounced visit to the foster home; however, the foster mother denied the caseworker entry to the foster home. Lastly, the caseworker reported that the child did not disclose nor appear to have any injuries.

Monitors' Review: The allegation that someone in the foster home hit a child in care with a belt and other children with a hand meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 – Injury or serious mistreatment of a child.

Minimum Standards Investigation Findings: "On April 7, 2022 an intake was received from Statewide Intake on the foster home licensed by Divinity Family Services. It was alleged that a caretaker is using inappropriate discipline on children in care. The following standard was tasked for this investigation: 749.1957(1) Other Prohibited Discipline-Any harsh, cruel, unusual, unnecessary, demeaning, or humiliating discipline or punishment. All of the children placed in the foster home were either interviewed or observed. The two verbal children in the home, were interviewed and both denied being hit by a belt or spanked by the foster parent. [Another child] who is also placed in the home is nonverbal but was observed to be free of any marks and bruises. Both foster parents…were interviewed and denied ever using any type of physical discipline to any of the children in their care. Both foster parents indicated that they are getting ready to adopt the children. Collateral witness who is the sister to [the foster mother] and a babysitter to the children placed in the home denied ever witnessing her sister or her brother-in-law ever use physical discipline on any of the children and she denied ever using any physical discipline while she cared for the children.

Documentation provided by the agency verified that the verbal foster children are asked each month by the case manager regarding disciplinary measures in private and the foster parents are reminded each month about proper disciplinary measures to utilize. Based on the evidence reviewed during this investigation, there is no substantial evidence or witnesses to verify that physical discipline was used on these children. The verbal children in the home denied any type of physical discipline. There will be no recommendations of any citations or deficiencies at this time. Recommended Action: No action."

As of September 1, 2022, the foster home was closed.

36. Case ID: 2872633

Intake ID: 76158732

Sample File: April 2022

Summary of Intake Allegations: A foster parent reported that a child (Child A, age 6) disclosed that his former foster mother spanked him and his siblings (Child B, age 10 and Child C, age 5) with her hand and with a belt. Child A stated that he was afraid of his former foster mother because she spanked him and his siblings and, on at least one occasion, hit him with a belt, which bruised his arm. As of the date of the intake report, Child B and Child C were placed with Child A's former foster mother.

Monitors' Review: The allegation that a foster parent hit children in care with her hand and with a belt meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Explanation of Disposition: An intake was received on 4/4/2022 alleging that children in care are fearful of their caregiver and that a child was inappropriately disciplined. Interviews were completed with children in care while the children lived in San Antonio, including [Child B], [Child C], and [Child A]. Documents provided by Trulight 127 Ministries included emails from the childrens [sic] caseworker, the foster mother, as well as the closing letter for the home. Based on the preponderance of evidence gathered through interviews with the children, a citation for standard 749.1953(a) will be provided, as two of three children confirmed that [Child A's previous foster mother] spanks them on their hands and bottom with a belt or her own hand in San Antonio while the home was licensed through Trulight 127 Ministries CPA. Corporal punishment is not permitted by foster parents, and spanking is not an allowable discipline method. Standard 749.607(1) was evaluated and found to be compliant as the agency will be cited for corporal punish [sic] as children in care admitted they were being spanked by [foster mother]. [Foster mother's] interview would not have changed the outcome of the investigation. While the home is no longer licensed, the incident did take place while the home was licensed through Trulight Ministries [CPA]. Trulight Ministries was reminded that closing homes is ultimately their decision, and they should not refrain from doing so if they feel it is the right decision to make. Recommended Action: Routine monitoring."

As of September 1, 2022, the foster home was still closed.

37. Case ID: 2878056

Intake ID: 76246178

Sample File: April 2022

Summary of Intake Allegations: A staff member reported that other staff members routinely "mistreat[ed]" and "verbally abuse[d]" children placed at Guardian Angels I Residential Treatment Center, a GRO. The reporter stated that staff members allegedly verbally abused eight children (ages 13 to 17) and two young adults (ages 18 and 19) placed at the GRO. According to the reporter, staff members called the children names; threatened to take away the phone; prohibited children from contacting their caseworkers; and refused to provide children with snacks. The reporter stated that a staff member (Staff 1) called a child (age 17) "a pissy little girl" because the child reportedly struggled with bedwetting at night. Staff members and managers were reportedly aware that some staff members verbally abused children at the GRO; however, the reporter alleged that "no one has done anything to protect the children." Due to staff members' inappropriate behavior, the reporter alleged that children were "scared to say anything," the children were "afraid of retaliation, being mistreated or treated differently," and the children "don't want to get up to go to school." The reporter also stated that when HHSC licensing staff members visited the GRO, staff members instructed children what to say to them.

The reporter also provided examples of staff members' verbal mistreatment of two older residents (Ind. B, age 18 and Ind. C, age 19) placed at the GRO.

- The reporter alleged that approximately three weeks prior to the date of the intake report, Ind. B, who was subject to one-to-one supervision due to her mental and behavioral health needs, informed a staff member (Staff 2) that she felt suicidal. According to the reporter, Staff 2 did not attempt to de-escalate or soothe the child. Instead, in response to Ind. B telling Staff 2 that she did not like her; Staff 2 told Ind. B that she did not like her either. Following Ind. B's disclosure of suicidal ideation, staff members allegedly did not secure any mental health treatment for her.

- The reporter stated that Ind. C (age 18) was in a bad mood one day because her mother passed away and Ind. C was allegedly yelling and screaming. In response, a staff member (Staff 3) told Ind. C that Staff 3 "did not care," that Ind. C "just wanted attention," and that Staff 3 would not give Ind. C attention. According to the reporter, Staff 3's behavior further escalated Ind. C's distress. Reportedly, Ind. C wanted to use the phone and Staff 3 "smashed" the phone out of Ind. C's hand and took the phone away from her.

Monitors' Review: The allegations that several staff members subjected children to routine verbal abuse and that these actions allegedly caused emotional injury to children meets the threshold for an Emotional Abuse investigation based upon the standard discussed by the Fifth Circuit:

In its discussion of the substantive due process rights of PMC children, the Fifth Circuit stated, "egregious intrusions on a child's emotional well-being—such as, for example, persistent threats of bodily harm or aggressive verbal bullying—are constitutionally cognizable."[4]

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "During the course of the investigation, documentation was reviewed, and interviews conducted to support the following:

748.1101(b)(4)(A)(vii) regarding Children's rights. Four of the seven children interviewed denied any threatening behavior on behalf of the staff. Victim child, [Ind. B], stated that she acted out due to staff ignoring her. In speaking with 4 staff members, the allegations of staff threatening the children in care 2 denied them [sic]. In speaking to the victim's CPS caseworkers, there were no concerns. This standard was evaluated and determined compliant.

748.1101(b)(7) regarding [sic] Child's Rights-Make complaints/calls/reports w/o interference, coercion, punishment, retaliation, [sic] threats [another] victim child, reported that are [sic] belittling and mistreating children in care. Four of the collateral children interviewed denied hearing staff using belittling remarks or mistreating the children. Three of four staff interviewed denied using belittling remarks or mistreating children in care. In speaking to the girls [sic] caseworkers, all denied having any concerns in regard to the allegations. This standard was evaluated and determined compliant. Recommended Action: Routine monitoring."

Intakes Received in May 2022

38. Case ID: 2880868

Intake ID: 76275406

Sample File: May 2022

Summary of Intake Allegations: A probation officer reported that a child (Child A, age 13), formerly placed at Hands of Healing, an RTC, stated that staff members at the RTC improperly restrained children, including Child A. Based upon the Child A's disclosure, the reporter surmised that during restraints, staff members "used unapproved techniques such as closed-hand hits to gain compliance" of both Child A and the other children at the RTC. According to the reporter, Child A did not disclose the names of staff members who allegedly performed inappropriate restraints nor the dates when these alleged incidents occurred. Lastly, the reporter stated that the child did not report any injuries from the alleged inappropriate restraints.

[4] *M.D. by Stukenberg v. Abbott*, 907 F.3d 237, 251 (2018).

Monitors' Review: The allegation that staff members inappropriately restrained a child meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3: Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "After completing the investigation using interviews and documentation, there is not a preponderance of evidence to indicate a child in care was inappropriately restrained. The victim listed, [the child] was interviewed and stated staff beat him. Nine additional children were interviewed and no concerns arose. No concerns arose after interviewing the three staff members who work different shifts at the operation all stated they did not use a restraint on the victim nor witnessed staff using one. All denied physically hitting or harm [sic] the victim. The child's caseworker did not have any concerns regarding his placement at the operation. [Probation Officer] stated she talked to [the child]'s case worker and once she spoke with her, she stated the case worker stated [the child] makes those allegations every time he is at a placement he doesn't want to be at. [Probation Officer] also stated she does not believe it is a justification behind with the allegation [the child] made. No violations of the minimum standards were found and no citations were issued. Recommended Action: Routine monitoring."

39. Case ID: 2884387

Intake ID: 76328147

Sample File: May 2022

Summary of Intake Allegations: A teacher reported that a child (Child A, age 17) did not appear to be adequately fed in a foster home. The reporter, who has known the child for approximately seven years, described Child A as "very thin," "very obsessed with food," "always hungry," and said the child "always want[ed] to eat the leftovers from other children at school." The child is nonverbal and has an intellectual disability. The reporter stated that, two days prior to the date of the intake report, Child A "was very panicky about having food and needed extra food until he finally calmed down." Reportedly, Child A's foster parents also had two of their children in their home (Child B, age 17 and Child C, age 15) who they adopted; the reporter stated that these children exhibited similar behaviors regarding food as Child A. When compared to Child B's and Child C's physical condition, the reporter observed that Child A looked like he was in the "worst [physical] condition." Lastly, the reporter stated that other teachers expressed concerns related to Child A's physical condition, one of whom previously made a report to SWI.

Monitors' Review: The allegation that foster parents did not provide a child, whose is nonverbal and has an intellectual disability, with adequate food meets the threshold for a Physical Neglect investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2: Serious safety or health hazards.

Minimum Standards Investigation Findings: "On 5/19/22 it was reported that [Child A] and other children in care are very thin and are very obsessed with food, they are always hungry, and very panicky about having food, and [Child A] needed extra food until he finally calmed down and always want to eat the leftovers from other children at school.

The following standards were evaluated 749.3063(a)(1), 749.3061(c), and 749.3061(b).

The inspector observed [Child A] and [another child in the home, Child D, age 10] at school, both children appear to be a healthy weight, there were no physical signs of abuse or neglect and both appeared well-groomed.

This inspector conducted an interview with [Child A's Teacher] and [Child D's Teacher]. [Child A's Teacher] reported [Child A] does eat a lot and he always wants extra food and will eat leftovers from the other students in the class, his appetite has increased. [Child D's Teacher] reported [Child D] does like to eat a lot but it is not a concern. Both teachers reported that the boys are always well-groomed.

This inspector conducted an interview with [Foster Parent], she reported [Child A] has always been a big eater, they have to keep a close eye on him because she [sic] will eat until he makes himself throw up. She expressed she feels like it is a behavior thing and that she has no control over that behavior and that it's impulsive. [Foster Parent] denied the children not being provided adequate nutrition. She reported cooking for children regularly and providing them with the proper meals, seconds, and snacks.

This inspector conducted an interview with [Case Manager] who reported she has observed the family during dinner time and the boys are given seconds and snacks. [Child A] gets really excited when he sees food. She has never seen questionable [sic] during her visits. [Foster Parent] has a good relationship with [Child A], neither boys have any dietary restrictions. She has no concerns with the home.

This inspector conducted an interview with [Child D's CPS Worker] and [Child A's CVS Worker] who both reported having no concerns regarding the [foster] home. [Child D's CPS Worker] shared that she feels like [Foster Parent] feeds the boys regularly, if you put food in front of [Child D] he will eat it, he will eat anything he just loves to eat, she visits the home monthly and has observed dinner time and has no concerns. Agency document support that [Child A] is up to date with medical care and no concerns were reported regarding his health. As a result of the information obtained, both standard numbers 749.3063(a)(1), 749.3061(c), and 749.3061(b) are compliant. Recommended Action: No action."

As of September 1, 2022, the foster home was open and serving two children, including Child A.

40. Case ID: 2880804

Intake ID: 76276312

Sample File: May 2022

Summary of Intake Allegations: A DFPS staff member reported that a child (age 4) stated that "when she [was] bad, she [got] spankings" in a foster home. According to the reporter, the child described that being spanked meant "getting hit with a slipper or belt on the butt."

Monitors' Review: The allegation that a foster parent hit a child in care with a slipper or belt meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 – Injury or serious mistreatment of a child.

Minimum Standards Investigation Findings: "Based on the Preponderance of evidence after reviewing the child's service plan and interviews there was no evidence of corporal punishment used on the victim and this is based on the following information: 749.1953(a)- Corporal Punishment-May not use/threaten corporal punishment, such as hitting/spanking, forced exercise, holding physical position, unproductive work.

Victim stated that corporal punishment was used on them but couldn't remember when it last occurred. The oldest sibling denied any form of corporal punishment on them. The youngest sibling is non-verbal but was observed to be healthy, happy, and no visible marks on them. Both foster parents denied ever having used corporal punishment. [Foster Parent] stated that when it comes to discipline she will place the children in time out for 2 to 5 minutes. [Foster Parent] stated that she will also discipline by removing electronics from the children and redirection by having the child play in their room if misbehaving around the house. The other guardian only demonstrated forms of redirection when the children acted out. Both [the] victim's case manager and CPS worker stated that the victim may have or has had past trauma that could lead to the reason as to why the victim makes those comments. They also stated that after their initial visit with the victim that they would then deny ever being subject to corporal punishment after. After reviewing the service plan, it does not state any physical or mental health concerns on the victim. The interviews also do not state any proof of corporal punishment being used, there is not sufficient evidence to cite on corporal punishment. Recommended Action: Routine monitoring."

As of September 1, 2022, the foster home was closed.

41. Case ID: 2884607

Intake ID: 76332062

Sample File: May 2022

Summary of Intake Allegations: A DFPS staff member reported that a child (age 7), placed at Caring Heart Residential Care Services, a GRO, stated that staff members at the GRO inappropriately restrained children as a means of discipline. The child disclosed that when staff members performed restraints, they allegedly twisted children's arms and hands. The reporter stated that the child did not identify specific staff members who allegedly performed inappropriate restraints; the child instead said that "all staff" did it. The child did not report any injuries to the reporter.

Monitors' Review: The allegation that staff members improperly restrained children as young as seven years old by twisting their arms and hands meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3: Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the information gathered throughout the course of the investigation it was determined that there is no preponderance of evidence that any violation of the minimum standards occurred. The following led to this disposition: -Three collateral children reported that the staff perform restraints such as bear hug. Regarding the alleged incident the victim reported that he was wrongfully restraint [sic], there were no details provided as to how he was restraint [sic]. -Two staff reported that they are always able use de-escalation to calm down a child. The children were not able to provide details of a wrong restraint. Two collateral children stated the staff use a hug restraint. None of the children reported to have been hurt. All the minimum standards have been assessed. There are no minimum standard citations at this time. Recommended Action: No action."

42. Case ID: 2879744

Intake ID: 76256767

Sample File: May 2022

Summary of Intake Allegations: A law enforcement officer reported that some children intentionally locked another child (age 15) outside of Brownstone Residential Care, a GRO where the children lived. After the child was locked outside, the child reportedly left the GRO and became

lost. The child then asked a stranger for help and the stranger contacted law enforcement. When a law enforcement officer returned the child to the GRO, the staff member on duty was reportedly unaware that the child had been missing from the GRO.

Monitors' Review: The allegation that a staff member(s) was unaware that a child was locked outside of a GRO, departed, and was missing from the GRO meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 – Serious supervision problems.

Minimum Standards Investigation Findings: "Explanation of Disposition: During the course of the investigation, documentation was reviewed and interviews conducted to support the following:

748.685(c)(1) regarding Caregiver responsibility - be aware of children's habits, interests, and any special needs including supervision. Four of 4 children interviewed stated there were no issues with supervision. Children stated staff intervened immediately and appropriately. Staff were aware of the child's habits and actions. Statements from staff were consistent with the documentation as well as the statement from children involved. Victim child did not complete the interview to confirm details. Incident reports supports [sic] no restraint. [The child] ran away from the facility. Child was removed from the facility. There is not enough evidence to support children not being properly supervised. This standard was evaluated and determined compliant. This investigation was without citations or deficiencies. No Technical Assistance was provided. Any pictures and/or documentation have been placed in the file. Recommended Action: Routine monitoring."

43. Case ID: 2879591

Intake ID: 76260602

Sample File: May 2022

Summary of Intake Allegations: A staff member at ACH Child and Family Services Emergency Shelter, a GRO, reported that two children (Child A, age 15 and Child B, age 17) engaged in inappropriate sexual contact at the shelter. According to the reporter, at the time of the alleged incident, Child A was sitting beside Child B on bean bag chairs; for approximately eight minutes, Child A's hands were placed under a blanket "inappropriately" touching Child B. Reportedly, the incident was consensual. The staff member (Staff 1) charged with supervising the children allegedly intervened and separated the children after observing the behavior. The reporter stated that Staff 1 was "not paying attention" at the time of the incident. Following the incident, staff members continued to separate Child A and Child B from one another.

Monitors' Review: The allegation that children engaged in inappropriate sexual contact due to a lack of supervision meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Explanation of Disposition: Based on the information gathered during this investigation allegations of children having inappropriate contact due to inadequate supervision could be validated. [Child B] stated that she and [Child A] were just holding hands under the blanket and that [Staff 1] was present. [Child B] stated that [Staff 1] did tell them to stop touching but did not tell them to remove the blanket. Other child involved in the incident [Child A], admitted to touching [Child B] on her private parts under the blanket. [Child A] stated that this went on for 1-3 minutes and that staff member [Staff 1] could not see them because a couch was blocking them, and they were under the blanket. [Staff 1] stated that she does not remember leaving the children alone at any time to go to the restroom. [Staff 1] stated that she was sitting at the table watching the children when she noticed that [Child A] had his hands under [Child B's] blanket. [Staff 1] stated that she was unsure how long they had been touching. [Staff 1] stated that she did not take the blanket or tell them to remove it because the kids said they were not doing anything inappropriate. Operation supervisor [Staff 2/Reporter] stated that she was not present at the time of the incident but watched the video which showed [Child A] touching [Child B] for 5-6 minutes before [Staff 1] walked over to them. [Staff 2/Reporter] stated that you can also see on the video [Staff 1] leave the children alone for 30-45 seconds while she went to the restroom. Operation director [Staff 3] stated that [sic] narrated the video footage as it played. [Staff 3] stated that [Staff 1] was at the table completing an incident report and not properly supervising the children. [Staff 3] stated that [Staff 1] also left the children alone while she went to the restroom. The service plans for both [Child A] and [Child B] state that supervision includes staff being in ratio, alert and responsive, knowing where they are, being able to see and hear them, and being near enough if they need immediate assistance. Video footage observed confirmed that [Staff 1] not only left the children alone but was not alert and supervising the children appropriately therefore the operation will be cited for standard 748.685(a)(4). Technical assistance was provided: To be available for supervision or rescue in an emergency, an adult must be able to hear and see the children. Adults who are involved, attentive, and aware of children's behaviors are in the best position to safeguard their well-being. It is recommended that caregivers use supervision techniques such as being aware of potential safety hazards, standing in a strategic position, scanning play activities and circulating throughout the room. Recommended Action: Routine monitoring."

Intakes Received in June 2022

44. Case ID: 2890029

Intake ID: 76373958

Sample File: June 2022

Summary of Intake Allegations: A therapist at The Bair Foundation - Dallas, a CPA, reported that a foster mother hit a child (age 5) with an unidentified implement in a foster home. During a visit, the child's therapist asked the child whether his foster mother hit him, and the child responded affirmatively. The reporter then asked the child how the foster mother hit him, and the child responded by holding up his fist and "smacking it across his face" while he made a noise that sounded like a punch. According to the child, the foster mother also kept an unknown object under her bed which she used to hit the child across his back. The reporter asked the child whether she could observe his back; the child refused and said that his back "was a private area." The reporter shared additional concerns about the foster home, including that the foster mother made negative comments about the child, the child was afraid to ask the foster mother for food when he was hungry, and multiple instances when the foster mother (or her daughter) did not allow caseworkers to enter either the home or certain rooms in the home.

Monitors' Review: The allegation that a foster mother hit a child in care meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 – Injury or serious mistreatment of a child.

Minimum Standards Investigation Findings: "Explanation of Disposition: Throughout the investigation, 1 child and 7 adults were interviewed. Documents provided by The Bair Foundation were reviewed, which included the service plan and coaching form for [the child], the training records, home study addendum and 2 home visit documents for the [foster] home.

While interviewing [the child] he denied [foster parent] using any inappropriate discipline. [The child] denied knowing of any weapons in the home. During the unannounced inspection to the [foster] home I observed the weapons and ammo stored separately in a locked safe and box. I also looked under the master bedroom bed and did not find any sticks or socks. [Foster parent] denied using inappropriate discipline on [the child], she stated that she uses loss of privileges. The agency provided the most recent de-escalation and TIC training certificates for [foster parent]. The case manager for the home [name removed] did not have any concerns with weapon storage or inappropriate discipline in the [foster] home.

During the interview with [reporter], she mentioned that [foster parent] was supposed to schedule a medical appointment to have his medications refilled and [foster parent] told her at their last visit she had not done so because [the child's] doctor had to give her a referral to a psychiatrist and she was waiting on that.

[T]he Administrator, informed me that she did not have the May medical documents from the primary care doctor that has documentation of the recommendation for [the child] to stop taking his current medications and for a referral to see a psychiatrist. She said that she has been contacting the doctor's office to get the documents but has been unsuccessful.

Based on the preponderance of evidence gathered throughout this investigation, there is insufficient evidence to substantiate the allegations, but there were deficiencies found during the investigation. It is alleged that a child in care is inappropriately disciplined. It is also alleged that a weapon is not properly stored. After conducting a thorough investigation and analyzing the information closely for risk, standard 749.1463(b)(7) [medication management] was found to be non-compliant. Recommended Action: Routine monitoring."

45. Case ID: 2896408

Intake ID: 76422647

Sample File: June 2022

Summary of Intake Allegations: A DFPS staff member reported that a child (age 16) stated that two staff members at Fort Behavioral Health, a GRO, choked her with her hoodie during a restraint. According to the reporter, the staff members restrained the child when she attempted to run away from the GRO approximately four weeks prior to the report. The child said that she did not tell anyone about the incident when it occurred. The reporter stated that one of the staff members involved in the incident was employed at the GRO as of the date of the intake report and the GRO terminated the employment of the other staff member approximately two weeks prior to the report.

Monitors' Review: The allegation that two staff members choked a child during a restraint meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the information gathered during this investigation allegations of [the child] being inappropriately restrained by staff members [Staff 1] and [Staff 2] could be validated. [Staff 1] stated that she restrained [the child] because she pushed her and tried to get out the door. [Staff 1] stated that she put [the child] in an upper PRT for 2-5

minutes but let her go when she said she couldn't breathe. [Staff 1] stated that [the child] tried to run again so staff member [Staff 1] put her in another upper PRT for approximately 5 minutes. [Staff 1] stated that she nor [Staff 2] choked or grabbed [the child] by her hoodie. Staff member [Staff 2] stated that she did not want to be interviewed regarding the allegations. Four children were interviewed. [Child B] stated that he saw a girl whose name he did not remember, try to take keys off the staff's neck. [Child B] stated that staff member [Staff 2] held the girls' hands behind her back and while in a seated position [Staff 1] held her legs. Video footage conflicts with what [Child B] stated happened, as neither the child nor the staff were ever in a seated position. [T]he child that was restrained, stated that both [Staff 1] and [Staff 2] started choking her by her hoodie when she was trying to run away and that she couldn't breathe. [Child C] and [Child D] were two children that witnessed the incident and stated that staff members [Staff 1] and [Staff 2] restrained [the child] because she was trying to run away. They both stated that the staff had their arm around [the child]'s neck and [the child] said that she couldn't breathe. Video footage reviewed does show that [the child] was initially trying to run away by going out the back door of the cafeteria. She is then seen running back in and initially just standing watching as another child by the name of [Child D] is being restrained. [The child] takes a step towards where this restraint is occurring, words are exchanged between her, and [Staff 1]and [Staff 2] begins to put [the child] in a restraint. [Staff 1] restrains [the child] first and then when she lets go staff member [Staff 2] restrains [the child]. Both [Staff 1] and [Staff 2] restrained [the child] by placing both her arms behind her back but also by leaning their body weight on her back and pushing her up against the wall. The operations policy on EBI and restraints were requested. The operation uses Handle with Care which does use a procedure of placing the child in an PRT position, with their arms behind their back. However, the procedure manual does not state to do this position while pushing the child up against the wall. Operation Manager…was interviewed and although she states that she walked up after the child had been released from the restraint, their procedure Handle with Care procedure does not say to restrain the children against the wall. Therefore, the operation will be cited for standard 748.2551(c)(2). Technical assistance was provided: The inappropriate use of a restraint can lead to injuries and even death. It is important that staff is fully trained on assessing potential risks, minimizing discomfort, and using the least amount of force necessary which will help ensure fewer injuries for both children and caregivers. It is recommended that the operation retrain staff on the operation's policies and procedures regarding the implementation of restraints. [The child] stated that she was restrained for trying to run away from the operation. Children in care [Child D], [Child C] and [Child B] all agreed that [the child] was restrained for trying to run away. Staff member [Staff 1] stated that she restrained [the child] because she pushed her and tried to grab her badge to run away. Video footage reviewed does show that [the child] was initially trying to run away but she is then seen running back in and initially just standing watching as another child by the name of [Child E] is being restrained. [The child] takes a step towards where this restraint is occurring, words are exchanged between her, and [Staff 1] and [Staff 1] begins to put [the child] in a restraint. This was not an emergency situation as [the child] was not suicidal and there were no other clear safety risks present. The operation will be cited for standard 748.2455(a)(2). Technical Assistance was provided: To prevent harm to children due to the inappropriate use of emergency behavior intervention, caregivers must ensure that these interventions are used only during a crisis, and only when other efforts to defuse the situation have failed. It is recommended that management staff review with direct care staff the circumstances that do meet the definition of an emergency situation. This helps ensure that staff has a clear understanding of when it is appropriate to implement a restraint or if other efforts would be more appropriate based on the

situation. Video footage shows a total of 8 boys sitting at the table observing [the child] being restrained by [Staff 1] and [Staff 2]. No effort was made to remove these boys from this location as they were present during the entire restraint. Due to staff not attempting to provide [the child] with any privacy during this incident the operation will be cited for standard 748.2551(d)(1). While observing the video footage of the restraint performed on [the child]. It was observed that staff member [Staff 2] took her badge from around her neck and threw it on the floor in front of 8 children in care. One male child picked up the badge and held it while [Staff 2] restrained [the child]. A total of 8 children were seen sitting at a table unsupervised while staff members [Staff 1] and [Staff 2] were restraining [the child]. Due to these children not being supervised at all during this time, the operation will be cited for standard 748.685(a)(4). Two incident reports for [the child] and [Child E] were reviewed. The incident reports for both children documents that a restraint was performed however does not note how long the restraints lasted. The operation will be cited for standard 748.2855(a)(6). Technical assistance was provided: The documentation regarding a restraint provides the operation with a record of each emergency behavior intervention incident with a child. This documentation can assist in evaluating emergency behavior intervention incidents for both the specific child and the facility as a whole, therefore it is important that all required information is obtained and included in the report. It is recommended that all staff are retrained on what information must be included in the documentation regarding an emergency behavior intervention. EBI training certificates were received for staff members [Staff 2] and [Staff 1]. The operation will not be cited for standard 748.936(1). Recommended Action: Routine monitoring."

46. Case ID: 2891222

Intake ID: 76388066

Sample File: June 2022

Summary of Intake Allegations: A DFPS staff member reported that the birth parent of two children (Child A, age 4 and Child B, age 2) stated that the foster parent "spanks" Child A with a belt in the foster home. According to the reporter, Child A disclosed this information to the birth parent during a weekend respite visit. On the date of the intake report, the reporter stated that the children were returning to the foster home from the respite visit.

Monitors' Review: The allegation that a foster parent hit a child in care with a belt meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 – Injury or serious mistreatment of a child.

Minimum Standards Investigation Findings: "Based on the information gathered, there are no concerns to regulatory standards found at this time. Intake stated allegations of inappropriate discipline in the house. [Child A] confirmed her foster parents discipline her inappropriately. [Child B] was observed to be non-verbal [sic] child who appeared to be of average weight and active. During my observation no visible mark or bruises were seen on either child in care. Both foster parents confirmed the authorized discipline in the house is time out. Biological mom and aunt both stated they didn't have concerns with [Child A] and [Child B]'s placement until [Child A] made the statement she was disciplined by her foster parents by hitting her with a belt and shoe on her butt area. Children in care and adults confirmed there is [sic] no concerns with a safety and care to include fair treatment. The children in care were relocated with their biological mom in Austin when the allegations were called in on the home. Case worker and case manager both stated they had no concerns with the children in care placement and were shocked when the allegations were made against the home. Recommended Action: Routine monitoring."

Based upon the additional evidence gathered during the above minimum standards investigation, the Monitors disagree with HHSC's decision not to elevate the allegation of Physical Abuse to RCCI (DFPS) for an investigation even after the child (age 4) confirmed with more details that the foster parent hit her multiple times. During the minimum standards investigation, Child A maintained her original allegation that she was subject to Physical Abuse by her foster parent; Child A reported to the investigator that "she doesn't like when [her foster parent] hits her with a shoe or belt." The child further stated that "[the foster parent] has hit her multiple times, on her arm and sometimes on her back." In addition to failing to appropriately elevate the investigation to RCCI (DFPS), HHSC failed to pursue any safety or regulatory actions of the foster home related to the child's consistent outcry of Physical Abuse in the foster home.

Following the Monitors' notification to the State of the above failure, on September 29, 2022, HHSC initiated an intake report to SWI detailing the child's outcry of Physical Abuse in the foster home. SWI assigned the intake report for a Physical Abuse investigation.

As of October 19, 2022, RCCI's Physical Abuse investigation was pending; the home was open and serving one child.

47. Case ID: 2898468

Intake ID: 76438749

Sample File: June 2022

Summary of Intake Allegations: A DFPS caseworker reported that during a home visit, a child (age 5) disclosed that his foster parent (the child's grandmother) previously "hit him with a sandal." The reporter stated that the foster parent would be required to review and re-sign the agency's disciplinary policy.

Monitors' Review: The allegation that a foster parent hit a child in care with a shoe meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 2 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on preponderance of evidence and the information gathered, there are no findings of any deficiencies in the instant case. It must be emphasized that the child, [Child A] denied being physically disciplined or was ever threatened of physical discipline. The child intimated that he feels happy and safe at home and was likewise observed to be not exhibiting any unexplainable marks or bruises which would otherwise be indicative of physical abuse. Similarly, his younger brother, [Child B], appears happy at home and well bonded with their grandmother. Corollary, the grandmother denied ever imploring physical discipline on the children and nor did she ever threaten them of physical discipline. Thus, the foregoing considered, preponderance of evidence clearly points to a compliance with the standards relative to this case. Recommended Action: Routine monitoring."

As of September 1, 2022, this foster home was open and serving two children.

48. Case ID: 2898473

Intake ID: 76439209

Sample File: June 2022

Summary of Intake Allegations: A DFPS staff member reported that a child (Child A, age 5) stated that her foster father "hit" her foster mother and made the foster mother cry. When asked by the reporter whether her foster father harmed her, Child A stated that the foster father hit her on her back and bottom. The reporter did not observe any injuries on Child A. The reporter also reported the following: Child A and her brother (age 6) were allegedly hit by another child in the foster home; and Child A reported that her foster father slept in her bed with her. The child did not make an outcry of being inappropriately touched or hurt by the foster father. The child stated that sometimes her foster father "tickles her on the stomach."

Monitors' Review: The allegation that a foster father hit the foster mother potentially in proximity to the child meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

The allegation that a foster parent hit a child in care meets the threshold for a Physical Abuse investigation based upon:

Physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.789(a)(1).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3: Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on the preponderance of evidence gathered throughout the investigation, it was determined that the there was no violation to the Minimum Standards. The department received a P3 report with concerns to the supervision of the children in care. It was reported that child was hit by another child in care, that foster dad was sleeping in bed with child, and that foster father had slapped child on the back and buttocks. The children in care in the [Foster Family] home were observed and interviewed and the allegations were addressed. The children were interviewed and each one stated that the other children would hit them. The children noted that foster parent would discipline the child that was hitting, by placing them on time out. The child victim, [Child A] made no outcry, she denied that foster parents were using any form of physical discipline. She stated that no one sleeps in the room with her. Foster parents were interviewed and denied the allegations made on the report. They indicated that the children are disciplined when they are hitting the other children in the home. Foster parent staayted [sic] that [Child A] sleeps in her own room and no [sic] shares the bed with her. Foster father…denied he hits, slaps or uses any physical discipline with any of the children in the home. He indicated that he has never slept with [Child A]. Case manager…expressed having no concerns with the children placed at the [Foster Family] home. She indicated that the children [Child A] and [foster sibling] are very active, are diagnosed with ADHD and have behavior issues at school. She indicated that the [Foster Parents] provide appropriate care and supervision to the children. She said that she has visited with the children and they have never made any out cry [sic] of any kind. Recommended Action: Routine monitoring."

As of September 1, 2022, the foster home was open and serving four children.

49. Case ID: 2892528

Intake ID: 76398236

Sample File: June 2022

Summary of Intake Allegations: An RCCR licensing inspector reported that a child (Child A, age 13) disclosed that while previously placed at Adiee Emergency Shelter, a GRO, older youth forced him, by holding him down, to use a nicotine vape that had been placed in the older youths' underwear. Child A also told the reporter that the older youth brought nicotine vapes into the GRO by hiding them in their underwear; the youth reportedly knew that staff members did not pat down that area when the children entered the facility. According to the reporter, Child A appeared

distressed when he recounted the incident. The reporter also reported other concerns related to children who bullied Child A at the GRO.

Monitors' Review: The allegation that two children forced a young child to use a nicotine vape meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3: Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "After completing my investigation, there is not a preponderance of evidence to indicate there are supervision concerns at the operation. The victim, [Child A] as [sic] interviewed and no additional concerns arose. Three collateral residents were interviewed and did not express any supervision concerns or any other concerns. Three staff members from the operation were interviewed and no concerns arose. CPS case workers were contacted and did not express concerns. While reviewing background checks using the staff list given to me upon my arrival to the operation, it was found that one staff member on the list, [Staff 1] did not have an active background check. I, [Investigator], e-mailed the operations background check representative…to confirm. One citation will be issued for 745.621(b)(1)(B) AP Renewal background checks submitted -No later than 2 yrs [sic] from date you last submitted subjects initial or renewal name-based TX criminal hist [sic] check. Recommended Action: Routine monitoring."

50. Case ID: 2902041

Intake ID: 76460608

Sample File: June 2022

Summary of Intake Allegations: An RCCR licensing inspector reported that a child (age 11) disclosed that a female staff member at Legacy Youth, a GRO, took a photograph of her "bare vaginal area" and electronically sent the photograph to the GRO administrator, who, as she understood it, was going to send it to a doctor. The staff member allegedly took the photograph in response to the child's complaint of vaginal discomfort. Reportedly, the child believed the doctor was going to review the photograph to determine whether the child required medical care.

Monitors' Review: The allegation that a staff member took a photograph of child's vaginal area meets the threshold for a Sexual Abuse investigation based upon:

Allowing Creation of Obscene Materials: Causing, permitting, encouraging, engaging in, or allowing the photographing, filming, or depicting of the child if the person knew or should have known that the resulting photograph, film, or depiction of the child is obscene as defined by §43.21,

Penal Code, or pornographic, by a person responsible for a child's care, custody, or welfare. 40 TAC §707.791 (a)(4).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Priority 3: Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on a preponderance of information, there is no evidence to conclude that prudent judgement was not used by a caregiver. The victim stated she thought [Staff 1] took a picture of her private area, but it was just a flashlight. The victim stated she did not feel uncomfortable and was not touched. A collateral child was interviewed and stated she has never seen or heard of staff taking pictures of anyone's private areas. The case manager, [Staff 1] stated the victim came to her about a concern she had regarding feeling uncomfortable in her private areas and that it was turning purple or black. [Staff 1] stated she looked at it and used her flashlight from her phone so she could describe it to the doctor [Medical Personnel] stated he does sometimes requests [sic] pictures and with the patients [sic] permission, ask [sic]that the caregiver take a closer look so they can describe it to him because sometimes it can be difficult to see during a telemedicine visit. [The doctor] stated he has not received any pictures of anyone's genital area. The administrator stated they sometimes take pictures of the children's injuries to send to their telemedicine doctor, but no pictures of the victim have been taken. [Staff 2], the administrator has put a plan in place to prevent any further misunderstandings in situations like this. Violations cited: None Technical assistance was given to the operation for HRC42.04412(a)-Interference with an investigation, due to the case manager speaking to the victim regarding the investigation after being made aware of the investigation and allegations. Recommended Action: Routine monitoring."

51. Case ID: 2890239

Intake ID: 76376433

Sample File: June 2022

Summary of Intake Allegations: A staff member reported that a child (age 14) attempted to choke herself with an ace bandage at Whispering Hills Achievement Center, a GRO. According to the reporter, the child attempted to run away from the GRO after she became upset by a verbal exchange with another child. After the reporter (Staff 1) convinced the child to stay at the GRO, Staff 1 instructed the child to return to her room. Staff 1 allegedly checked on the child "every 30 seconds" or "every 30 minutes" in her room. (In her report to SWI, Staff 1 inconsistently reported the frequency of her checks on the child; the intake specialist failed to clarify this critical inconsistency with Staff 1.) Staff 1 also reported that she "walk[ed] the halls" in between checks. Reportedly, during one of the checks, Staff 1 found the child with an ace bandage around her neck in her room, allegedly trying to choke herself. Staff 1 removed the bandage from around the child's neck and determined that the child was not injured and did not require hospitalization. Following the incident, staff members allegedly instituted five-minute checks on the child and notified the staff supervisor. According to the reporter, the child has the following diagnoses: "intellectual disabilities, child neglect, suicide, [and] disruptive mood swings." The intake specialist failed to

ask the reporter to clarify what she meant when she listed "suicide" in her listing of the child's diagnoses.

Monitors' Review: The allegation that a child accessed and choked herself with an ace bandage meets the threshold for a Neglectful Supervision investigation based upon:

A negligent act or omission by an employee, volunteer, or other individual working under the auspices of a facility or program, including failure to comply with an individual treatment plan, plan of care, or individualized services plan that causes or may cause substantial emotional harm or physical injury to, or the death of, a child served by the facility or program as further described by rule or policy. 40 TAC §707.801(a).

The allegation that following an incident of self-harm, a child was not formally assessed by a trained professional to determine whether she required hospitalization meets the threshold for a Medical Neglect investigation based upon:

Failure to seek, to obtain, or to follow through with medical care for a child, by an employee, volunteer, or other individual working under the auspices of a facility or program that causes or may cause substantial emotional harm or substantial physical injury to a child. 40 TAC §707.801(b)(1)(E).

Summary of RCCR Minimum Standard Investigative Findings: Assigned Intake Priority 2 – Serious supervision problems and downgraded to Assigned Investigation Priority 3 – Minor violation of the law or minimum standards that involve low risk to children.

Minimum Standards Investigation Findings: "Based on information gathered through the course of the investigation it was determined that minimum standards were not violated. The allegations were a child in care attempted suicide. The concerns for 748.685(b)(5) Caregiver responsibility - when deciding how close to supervise, takes into account the child's physical, mental, emotional, and social needs is found to be compliant. The finding of compliance is based upon interviews with the victim child, staff, collateral children and CPS. The facility cares for children with developmental delays, the child was upset after she was corrected by staff for provoking another child. When the child became upset, she left the home but was followed by one of the staff members until she decided to come back in. Once in she wanted to be alone so staff stayed in the hall. Staff saw her attempt to put a medical bandage around her neck. Staff intervened and took the bandage. They then called their supervisors who took her to the hospital. Other children in care stated the staff watch them and CPS stated they did not have concerns with supervision. No citation will be given. The concern for 748.685(c)(6) Implement and follow the children's service plans is found to be compliant. This is based on interviews with staff and a review of the child service plan. The child did not have any special supervision requirements on her service plan and the operation was meeting the plan's needs. No citation will be given. The concern for HRC42.063(a)(1) Reporting incidents and Violations-arrest, abuse, neglect, exploitation, running away, attempted suicide, or death of a child is found to be compliant. This is based on interviews with operation staff and a review of incident report. The child attempted to self-harm on June 1st and the hotline was called on the same day. No citation will be given. Recommended Action: Routine monitoring."

Appendix 2 Maltreatment in Care Case Summaries

The following are summaries of 38 Residential Child Care Investigations (RCCI) identified by the Monitors as inappropriately Ruled Out or substantially deficient of the 753 investigations reviewed and summaries of ten Child Protective Investigations (CPI) identified by the Monitors as inappropriately Ruled Out or substantially deficient of the 151 investigations reviewed.

RCCI Investigations

Investigations in Facilities

1. Investigation ID (CLASS): 2761857

Case ID (IMPACT): 48722636

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors agree with the disposition of Ruled Out for the Neglectful Supervision allegation. The investigation is deficient in relation to a new allegation of Neglectful Supervision that surfaced during the investigation. The record does not include documentation that it was investigated.

Summary of key allegations:

A staff member reported that a child (Child A, age 15) placed at Freedom Place, a GRO, self-harmed. Reportedly, the child located and broke a glass jar and then used the glass shards to repeatedly cut herself. A staff member intervened promptly but was unable to stop the child from self-harming. Following the incident, staff members cleaned the child's injuries, and the child was transported to a hospital.

Monitors' Review:

The Monitors agree with RCCI's determination to Rule Out the allegation of Neglectful Supervision as related to the incident contained in the intake report. However, RCCI did not investigate a new allegation reported by a child (Child B, age 17) that a named staff member (Staff 1) did not adhere to night-time supervision protocols due to falling asleep. Child B alleged that because Staff 1 failed to complete required night-time checks, two children engaged in inappropriate sexual contact on an unknown date. The investigator failed to interview Staff 1 or question other staff members or children about Staff 1's night-time supervision. Moreover, the investigator did not attempt to interview the two named children about the alleged incident involving sexual contact. There is no documentation in the record confirming whether the allegations related to the two children's sexual contact was separately investigated. Additionally, the record does not include evidence that the investigator notified the Residential Contracts Night

unit regarding Staff 1's alleged violation of awake night supervision.[1]

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the child remained placed at the GRO. As of September 1, 2022, the child was placed in a juvenile detention facility.

2. Investigation ID (CLASS): 2739840

Case ID (IMPACT): 48639310

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A staff member reported allegations of Neglectful Supervision at South Texas Adolescent Rehabilitation & Education - STARE, an RTC. The reporter alleged that two children (Child A, age 9 and Child B, age 16) engaged in inappropriate sexual contact.

Monitors' Review:

The Monitors agree with RCCI's determination that while it is unclear whether the alleged incident of sexual contact occurred between Child A and Child B, it is an appropriate safeguard to identify Child B for alleged sexually aggressive behavior due to his past behaviors and the current allegation. Regarding supervision at the time of the alleged incident, the investigator did not sufficiently investigate whether the alleged perpetrator maintained appropriate supervision of the two children to prevent or mitigate sexual contact between the two children. Child A alleged that at the time of the incident, the alleged perpetrator was asleep in the living room. Child B denied that the alleged incident occurred and separately reported that some staff members sleep in the living room, though he did not name the alleged perpetrator. The investigator did not interview a sufficient number of collateral children reported present at the time of the alleged incident to determine whether the alleged perpetrator was asleep at the time of the alleged incident. The investigator interviewed two collateral children, one of whom Child A named as a witness to the alleged incident in his interview. This child denied that the alleged perpetrator was asleep on the day of the alleged incident. The investigator's questioning of the second collateral child did not probe whether the child observed the staff member sleeping at the time of the alleged incident. Next, the investigator should have interviewed additional staff members to probe the allegation

[1] DFPS, *Child Care Investigations,* §6142.11.

that the alleged perpetrator fell asleep while on-duty. The investigator interviewed two collateral staff members; the investigator's questioning of one of these staff members, who was not working on the day of the alleged incident, did not include whether he had previously observed the alleged perpetrator sleeping on duty. Finally, during his interview, Child A alleged that the alleged perpetrator hit him. While the investigator asked the collateral children whether they had ever been hit by a staff member at the RTC, the investigator did not question the alleged perpetrator about the allegation that he hit Child A.

Notable Gaps in Investigation Timeframe:

The investigation took over two months to be completed and closed. A 30-day extension was approved on May 27, 2021; however, the investigation did not meet the extension deadline, in violation of Remedial Order 10. The intake was received on April 27, 2021. The investigation was completed on July 9, 2021 and closed on July 11, 2021.

Placement:

At the initiation of the investigation, both children remained at the RTC. As of September 1, 2022, Child A was placed at Amor Purus, a GRO, and Child B was placed in an HCS Group Home.

3. Investigation ID (CLASS): 2765162

Case ID (IMPACT): 48734776

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The allegation should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations:

A staff member reported allegations of Neglectful Supervision of a child (Child A, age 15) at the Autistic Treatment Center, an RTC. The reporter stated that after a staff member completed a nightly check on Child A, he climbed out of his bedroom window at the RTC. A community member later observed Child A walking outside and contacted law enforcement. A law enforcement officer returned Child A to the RTC allegedly unharmed.

Monitors' Review:

The Monitors disagree with RCCI's determination to Rule Out the allegation of Neglectful Supervision. The investigative record contains a preponderance of evidence that a staff member failed to appropriately conduct a required night check on Child A, who has diagnoses of autism and intellectual disability. In the absence of required night supervision, Child A ran away from the GRO and staff members were unaware of the child's disappearance until they were notified by a community member. The Monitors identified the following evidence in support of substantiating

the allegations of Neglectful Supervision with a disposition of Reason to Believe:

- At 10:05 p.m., a law enforcement officer responded to a report that an individual observed Child A running in a roadway one mile, an approximate 30-minute walk, from the RTC. Due to the child's intellectual disability, the law enforcement officer reported that Child A was unable to provide any identifying information beyond his first name.

- On the night of the incident, two staff members (Staff 1 and Staff 2) were on-duty at the RTC. According to the record, Staff 1 was responsible for conducting night checks. Staff 1 and Staff 2 reported that Staff 1 completed a night check on Child A at 10:00 p.m., as required, and observed Child A in his bed asleep. The staff members reported that Child A must have run away after Staff 1 completed the 10:00 p.m. night check.

Based upon law enforcement's timeline of the incident, it is inconceivable that Staff 1 performed a night check on Child A at 10:00 p.m. as Staff 1 alleged; the child was observed in a roadway, located approximately one mile from the RTC, five minutes after the alleged check occurred. Therefore, the investigative record demonstrates that the allegations of Neglectful Supervision should have been substantiated against Staff 1 who failed to provide adequate supervision to Child A, which caused or may have caused substantial emotional and physical injury.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the child was placed at the Autistic Treatment Center, an RTC. As of September 1, 2022, the child was placed in an HCS Group Home.

4. Investigation ID (CLASS): 2765779

Case ID (IMPACT): 48735633

Category of Maltreatment: Emotional Abuse; Medical Neglect; Neglectful Supervision; and Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition of the Neglectful Supervision allegation due to a deficient investigation. Regarding the Emotional Abuse, Medical Neglect and Physical Abuse allegations, the Monitors agree with the disposition of Ruled Out.

Summary of key allegations:

An anonymous individual reported allegations of Emotional Abuse, Medical Neglect, Neglectful Supervision, and Physical Abuse at Hearts with Hope Foundation, a GRO. The reporter alleged that a staff member (Staff 1) verbally abused a child (Child A, age 17) and this verbal abuse negatively impacted Child A's mental health. The reporter also alleged that two staff members

(Staff 2 and Staff 3) allowed two children to physically harm another child (Child B, age 15). After the alleged incident, the GRO reportedly did not secure medical care for Child B.

Monitors' Review:

Regarding the allegation of Neglectful Supervision, the investigative record failed to determine whether staff members responded timely to a physical altercation between three children. Of the five children the investigator interviewed, four reported that staff members promptly intervened in the physical altercation. However, after the children's interviews had been conducted, RCCI documented in a staffing contact: "There are also concerns the residents may have been bribed and are not truthful with their statements that staff intervened." In response, RCCI documented that the children must be re-interviewed. The record shows that the investigator only re-interviewed two of the five children. The two children who were re-interviewed denied that staff members bribed them, and their representations of the alleged incident were consistent with their first interviews. The record also does not include information related to how the bribery concern came to the attention of the investigator. In the absence of the investigator re-interviewing the three other children and providing documentation about how the allegation of bribery was fully resolved, a disposition cannot be rendered regarding the Neglectful Supervision allegation.

Notable Gaps in Investigation Timeframe:

The investigation took over 30 days to be completed and closed, and there was no approved extension, in violation of Remedial Order 10. The intake was received on July 9, 2021. The investigation was completed on August 11, 2021 and closed on August 25, 2021.

Placement:

At the initiation of the investigation, Child A had been removed from the GRO and placed in a therapeutic foster home and Child B remained at the GRO. As of September 1, 2022, Child A had aged out of DFPS care and Child B was placed at Millcreek, an RTC, in Arkansas.

5. Investigation ID (CLASS): 2752599

Case ID (IMPACT): 48685194

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A DFPS staff member reported that a child (age 9) was subject to Physical Abuse at Lean on Me Family, an RTC. The reporter alleged that a staff member inappropriately restrained the child by twisting his arms behind his back and placing him on the floor. The child told the reporter that he was restrained a month prior to the report. He then told the reporter he was joking.

Monitors' Review:

Due to a dearth of interviews with collateral children and staff members, the investigator was unable to sufficiently determine whether staff members appropriately administered restraints at the GRO. This deficiency is critical because the alleged victim was uncooperative during his interview and did not identify the staff member(s) who allegedly restrained him. The alleged victim reported that he was restrained "hard" and that the restraint "hurt." Additional interviews with collateral staff members and children may have provided the investigator with information to either confirm or refute the alleged victim's allegation. Next, a staff member reported that another staff member "used to" perform excessively forceful restraints on children. The investigator did not investigate this allegation. Finally, the investigator did not interview the reporter who may have had additional information about the allegation. Due to these deficiencies, it is unknown whether a staff member(s) Physically Abused the alleged victim at the GRO.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the child remained at the RTC. As of September 1, 2022, the child was placed in a therapeutic foster home.

6. Investigation ID (CLASS): 2749088

Case ID (IMPACT): 48674675

Category of Maltreatment: Neglectful Supervision; Medical Neglect

Monitors' Conclusion: The Monitors cannot determine the disposition of the Neglectful Supervision allegation due to a deficient investigation. The Monitors agree with the disposition of Ruled Out for the Medical Neglect allegation.

Summary of key allegations:

A DFPS staff member reported allegations of Neglectful Supervision and Medical Neglect at A Fresh Start, an RTC whose license was revoked by HHSC due to a poor child safety record during the investigation. The DFPS staff member reported that staff members at the RTC took the children to a park the week prior to the date of the intake report. While at the park, staff members slept inside the RTC van. The reporter alleged that while at the park, a child (Child A, age 12) "passed out" from the heat and staff members did not secure the child medical attention. It was also alleged that staff members smelled of marijuana and appeared to "be high."

Monitors' Review:

This investigation is deficient due to missing interviews with key individuals who were at the park

on the day of the alleged incident. Due to these missing interviews, it is unclear whether staff members appropriately supervised the children at the park. According to the investigative record, approximately 13 children attended the outing to the park; however, the investigator only interviewed four children. Interviews with these additional children may have provided the investigator with information related to supervision at the park, particularly whether staff members fell asleep in the van. Of the four children interviewed, one child reported that staff members supervised the children from the van; the other three children reported no concerns with supervision at the park. A professional who provides services to the children independent of the RTC reported that she observed staff members in the van at the park. She also reported that a child's father was also present at the park and he observed poor staff supervision of the children. The investigator did not attempt to interview the child's father to evaluate the veracity of the professional's allegation. As a result of these deficiencies, the investigator failed to establish whether staff members provided the children with appropriate supervision during an outing.

Notable Gaps in Investigation Timeframe:

The investigation took approximately three months to be completed and closed, and there was no approved extension, in violation of Remedial Order 10. The intake was received on May 21, 2021. The investigation was completed on August 19, 2021 and closed on August 19, 2021.

Placement:

One week after the initiation of the investigation, Child A was removed from the RTC. As of September 1, 2022, Child A was placed in an HCS Group Home.

7. Investigation ID (CLASS): 2737566

Case ID (IMPACT): 48632078

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Neglectful Supervision allegation should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations:

Two intakes were reported to SWI with allegations of Neglectful Supervision at Connections Inc. Emergency Shelter, a GRO. In the first intake, a law enforcement officer reported that a child (Child A, age 17) disclosed that she entered another child's room (Child B, age 14) and the children engaged in sexual contact. In the second intake, a staff member at the GRO reported that Child A disclosed to school personnel that she engaged in a sexual act with Child B. The reporter stated that the sexual act was consensual. At the time of the incident, Child A was reported to be subject to a safety plan and staff members were required to check on her every 30 minutes during the night.

Monitors' Review:

The Monitors found that the record contains a preponderance of evidence that a staff member failed to conduct night supervision checks as required and this failure enabled two children to sleep in the same bed and allegedly engage in sexual contact. The Monitors identified the following evidence in support of substantiating the allegation of Neglectful Supervision with a disposition of Reason to Believe:

- Child A and Child B consistently reported that Child A entered Child B's bedroom in the evening and they slept together in a bed all night. Child B's roommate, Child C (age 12), reported that she observed Child A in Child B's bed during the night.

- Child A reported that she engaged in a sexual act with Child B. Child C stated that she observed Child A and Child B engaged in a sexual act. Child B denied engaging in any sexual act with Child A.

- On the night of the alleged incident, the staff member responsible for supervision of the children reported that she conducted nighttime checks every 15 to 30 minutes as required. She reported that the children were in their appropriate beds throughout night. The staff member reported that while she is expected to enter each bedroom during night checks, she did not adhere to this requirement because two of the children slept without clothing. Instead, the staff member reported that she opened each bedroom door and shined a flashlight quickly into the room to minimize observing the children without clothing.

Based upon consistent statements provided by Child A, Child B, and Child C, there is a preponderance of evidence that Child A slept in Child B's bed all night and the staff member either failed to perform night checks or conducted the night checks in such an ineffectual manner that she failed to observe Child A in Child B's bed. Therefore, the investigative record demonstrates that the allegation of Neglectful Supervision should have been substantiated against the staff member who failed to provide adequate supervision to Child A and Child B which caused or may have caused substantial emotional harm or substantial physical injury.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, Child A and Child B remained at the GRO. As of September 1, 2022, Child A had aged out of DFPS care and Child B was placed at Adore Living Child Services, an emergency shelter.

8. Investigation ID (CLASS): 2748625

Case ID (IMPACT): 48672759

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

School personnel reported allegations of Neglectful Supervision at Independence Farm, an RTC. The reporter alleged that two children (Child A, age 6 and Child B, age 7) engaged in sexual contact at night. Reportedly, a child observed Child A's and Child B's behavior and notified a staff member. The staff member subsequently found Child A and Child B in a bed undressed. Following the incident, the reporter stated that the staff member separated the two children.

Monitors' Review:

This investigation is deficient because the investigator failed to adequately assess supervision prior to the alleged incident. While the investigator found that the alleged perpetrator responded promptly once she was informed about the alleged incident, the investigator did not appropriately question the alleged victims, the alleged perpetrator and collateral children about supervision prior to the alleged incident. The investigator reviewed the facility's night supervision log; however, because the log failed to include critical information, such as the specific bedrooms and the identities of children for which staff members performed night checks, it cannot be used to confirm or refute whether the alleged perpetrator appropriately performed checks prior to the alleged incident. As a result, it is unknown whether the alleged perpetrator appropriately supervised the children prior to the alleged incident to prevent or mitigate the alleged incident.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation and as of September 1, 2022, both children remained placed at Independence Farm, an RTC.

9. Investigation ID (CLASS): 2761903

Case ID (IMPACT): 48722868

Category of Maltreatment: Physical Abuse; Emotional Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A child (Child A, age 14) reported allegations of Emotional Abuse and Physical Abuse at Have Haven, an RTC. Child A disclosed that a staff member (Staff 1) grabbed his throat for approximately two minutes and tried to take him outside. Child A also reported that a different staff member (Staff 2) "bull[ied]" him and called him "buster." Finally, Child A alleged that Staff 1 pinched another child's (Child B, age 13) arm and leg and pushed him to the ground. As a result, Child B reportedly sustained a small bruise on his left thigh.

Monitors' Review:

The Monitors agree with RCCI's determination to Rule Out the Physical Abuse allegation as related to Child B. The investigation is deficient regarding the Emotional Abuse and Physical Abuse allegations related to Child A. Regarding the Emotional Abuse allegation, the investigator failed to interview a sufficient number of collateral children and staff members to assess whether any of these individuals observed Staff 2 speak in a degrading manner to Child A. The investigator interviewed two collateral children and two collateral staff members; one of the interviewed staff members reported that Child A disclosed to her that Staff 2 used emotionally abusive language toward the child. Due to the investigator failing to fully investigate the allegation of Emotional Abuse, the record is unclear regarding whether Staff 2 used degrading language toward Child A.

Regarding the Physical Abuse allegation, the investigator failed to reconcile conflicting descriptions of the alleged incident between the alleged perpetrators and Child A. Next, the investigator did not adequately question the owner of the RTC to determine his involvement in the alleged incident and potentially resolve some of the conflicting descriptions of the incident. Due to these deficiencies, it is unknown whether Staff 1 physically abused Child A. Additionally, the record indicates that Child A exhibited significant behavioral health needs while placed at the RTC. During her interview, Staff 1 acknowledged that "[the RTC] cannot provide the help that he [Child A] needs."

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, both children remained at Have Haven, an RTC. As of September 1, 2022, Child A was placed at Paloma Place, an RTC, and Child B was placed at Bledsoe, an RTC.

10. Investigation ID (CLASS): 2745272

Case ID (IMPACT): 48658562

Category of Maltreatment: Sexual Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition of the allegation due to a deficient investigation.

Summary of key allegations:

Two intakes were reported to SWI with allegations of Sexual Abuse of a child placed at T E P Unity Girls, an RTC. In the first intake, an individual reported that a child (Child A, age 17) disclosed to her that an unnamed staff member (Staff 1) forced her to touch him inappropriately. Staff 1 reportedly worked on the day the intake report was made. In the second intake, Child A's probation officer reported that the child stated during the prior week that an unnamed staff member inappropriately touched her. Child A reported that she wanted to run away from the RTC; however, she was concerned that if she ran away, she would violate her probation.

Monitors' Review:

Although Child A did not identify the name of the staff member who allegedly touched her inappropriately, she provided the investigator with specific dates that the unnamed staff member reportedly worked and dates when he touched her inappropriately. The investigator did not review the RTC shift records to determine which staff members worked on these identified days and whether any staff members worked all the days identified by Child A. Next, in her interview, the administrator of the RTC reported that at the time of the alleged incidents, Child A was subject to one-to-one supervision. The investigator did not ask the administrator the name of the staff member responsible for Child A's supervision. An interview with this staff member, who allegedly maintained close supervision of Child A, may have provided the investigator with critical information about whether any other staff members had access to the child. Due to these deficiencies, the Sexual Abuse allegation cannot reasonably be Ruled Out. Finally, interviews with staff members, collateral children and Child A's caseworker indicated that Child A has a history of telling falsehoods; however, none of these individuals reported concerns related to Child A's current allegations.

Notable Gaps in Investigation Timeframe:

The investigation took over two months to be completed and closed. A 30-day extension was approved on June 5, 2021. The intake was received on May 10, 2021. The investigation was completed on July 7, 2021 and closed on July 19, 2021.

Placement:

At the initiation of the investigation, the child remained at the RTC. As of September 1, 2022, the child had aged out of DFPS care.

11. Investigation ID (CLASS): 2776321

Case ID (IMPACT): 48767749

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A child's caseworker reported allegations of Physical Abuse of a child at Bluebonnet Haven, LLC, an RTC. The caseworker reported that a child (Child A, age 15) disclosed that when she attempted to run away from the RTC, a staff member (Staff 1) ran after her. When Staff 1 allegedly reached the child, he grabbed her by the hair and pushed her down onto the ground. The child reported that she had a large bruise from the incident. Another staff member (Staff 2) allegedly observed the incident.

Monitors' Review:

This investigation is deficient due to a missing interview with a reported child witness. In her interview, Child A reported that two children observed the alleged incident of Physical Abuse; the investigator only interviewed one of these children. The child witness (Child B, age 13), who was interviewed, initially reported that she did not observe the alleged incident; however, subsequently she reported that she observed an unnamed staff member "tackle" Child A to the ground. The investigator's failure to interview the other child witness (Child C, age unknown) is critical because Child C may have provided the investigator with information to either corroborate or refute the allegation by Child A and Child B. The investigative record stated that Child C may have had COVID-19 at the time of the investigation; the record does not include evidence that the investigator attempted to determine Child C's health status and ability to participate in an interview.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the child remained at Bluebonnet Haven, LLC, an RTC. As of September 1, 2022, the child was on runaway status.

12. Investigation ID (CLASS): 2730495

Case ID (IMPACT): 48612916

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

School personnel reported that a child (Child A, age unknown) disclosed allegations of Neglectful Supervision at Sheltering Harbour, an RTC. The reporter stated that Child A alleged that an unnamed child "raped" another child (Child B, age 14) at the RTC. The reporter did not discuss or confirm the allegation with Child B.

Monitors' Review:

This investigation is deficient due to a missing interview with Child A, who reported the allegation to school personnel. The investigator did not attempt to interview Child A; the child was no longer placed at Sheltering Harbour at the time of the investigation. This missing interview is problematic because Child B, the alleged victim, was not cooperative during his interviews and did not provide the investigator with sufficient and consistent information about the allegations. If interviewed, Child A may have provided the investigator with useful information about the allegations and his credibility. During interviews, collateral staff members and children denied any knowledge that Child B was inappropriately touched or sexually assaulted at the RTC.

Notable Gaps in Investigation Timeframe:

The investigation took over two months to be completed and closed. A 30-day extension was approved on May 5, 2021. The intake was received on April 8, 2021. The investigation was completed on June 7, 2021 and closed on June 14, 2021.

Placement:

At the initiation of the investigation, the child remained at the RTC. As of September 1, 2022, the child was placed at Thompson's Residential Treatment Center.

13. Investigation ID (CLASS): 2792096

Case ID (IMPACT): 48804038

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A HHSC employee reported that a child (Child A, age 16) disclosed allegations of Physical Abuse at the Autistic Treatment Center, an RTC. Child A reported that a staff member (Staff 1) slapped her. The reporter stated that Child A was observed with bruise on her face. The reporter did not know when or where the alleged incident occurred.

Monitors' Review:

This investigation is deficient for the following reasons. First, the investigator did not question the director of the placement about the allegations related to Child A. In reporting the incident to SWI, the reporter stated that she learned about the incident from the placement director and this individual may have more details about the allegations. Second, the investigator did not ask Child A how Staff 1 threw a water bottle at her. Staff 1 and a child witness reported that Staff 1 threw a water bottle to Child A in a non-aggressive manner. Third, the investigator failed to interview named teachers who reportedly interacted with Child A after the alleged incident. If interviewed, these individuals may have had information about the allegations and whether Child A was observed with a bruise or redness on her face. Because of the verbal limitations of the children involved in this investigation, it was incumbent upon the investigator to thoroughly interview all identified collateral staff members and teachers prior to rendering a disposition.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation and as of September 1, 2022, Child A was placed at the Autistic Treatment Center, an RTC.

14. Investigation ID (CLASS): 2788028

Case ID (IMPACT): 48794090

Category of Maltreatment: Medical Neglect

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A law enforcement officer reported allegations of Medical Neglect at T E P Promise House, an emergency placement. The officer reported that a child (Child A, age 10) bit herself and then stabbed a staff member with a pencil. While responding to the incident, the officer reported that Child A disclosed to him that the day before she also bit herself and the facility did not report the incident. The officer observed bite marks, bruises and scrapes on Child A's body.

Monitors' Review:

RCCI did not adequately investigate whether Child A self-harmed prior to the incident that prompted the intake report and whether staff members provided appropriate supervision to prevent or mitigate any prior self-harm incidents. The investigator did not ask Child A whether she had previously self-harmed as she alleged to law enforcement. In addition, the investigator did not ask collateral staff members and children about Child A's history of self-harming at the placement. The investigator also failed to sufficiently question Child A, staff members and children about supervision at the placement. Due to these deficiencies, it is unclear whether Child A self-harmed multiple times at the placement and whether staff members took appropriate measures to both prevent and respond to any self-harming behavior.

As of September 1, 2022, T E P Promise House was subject to Heightened Monitoring.

Notable Gaps in Investigation Timeframe:

None.

Placement:

On the date that the investigation was initiated, the child was removed from T.E.P. Promise House, an emergency placement, and placed under DFPS Supervision at a CWOP location. As of September 1, 2022, the child was placed in a treatment foster home.

15. Investigation ID (CLASS): 2793345

Case ID (IMPACT): 48805754

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A staff member reported allegations of Neglectful Supervision at Brookhaven Youth Ranch, an RTC. Three children (ages 15, 15 and 16) disclosed to staff members at the RTC that they engaged in consensual sexual contact on at least two prior occasions. The reporter stated that because the children's statements varied, it was unclear when the incidents occurred.

Monitors' Review:

Due to the investigator's failure to adequately investigate supervision at the time of the alleged incidents, the allegation of Neglectful Supervision could not be Ruled Out. First, the investigator did not adequately question each child about when the alleged incidents occurred and whether they occurred on the same or separate days. The investigator also did not sufficiently question the

children about supervision to determine whether staff members completed timely checks when the alleged incidents occurred. Therefore, the record does not include information to determine how long the children were without direct staff supervision and whether this unknown duration of time conformed with the children's required supervision levels. The investigator also failed to interview a staff member who reportedly worked on a day an alleged incident may have occurred. Next, the four alleged victims provided inconsistent statements about the alleged incidents of sexual contact. Through more probative questioning of the children, the investigator may have been able to resolve some of the children's conflicting statements about the alleged incidents. Moreover, the investigator did not request that the children participate in a forensic interview; this specialized interview may have provided the investigator with additional information about the alleged incidents. Lastly, the investigative record does not contain evidence that a Child Sexual Aggression (CSA) staffing occurred. The children involved in this investigation have histories of sexual abuse and sexual aggression that should have been considered during a CSA staffing about the allegations. Due to these deficiencies, the allegations of Neglectful Supervision could not be Ruled Out.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the children remained at Brookhaven Youth Ranch, an RTC. As of September 1, 2022, two of the children remained at the RTC; one child was placed at The Burke Foundation – Pathfinders, an RTC; and the fourth child was placed under DFPS Supervision at Child Watch House.

16. Investigation ID (CLASS): 2793750

Case ID (IMPACT): 48808392

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The allegation should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations:

A DFPS employee reported an allegation of Neglectful Supervision at Concho Valley Home for Girls, a GRO. The reporter stated that she is required to make unannounced night visits to facilities to verify that staff members are awake as required. When she arrived at the GRO, the reporter stated that she knocked on the door for several minutes but there was no answer. She proceeded to contact the GRO's executive director to gain access to the GRO. The executive director telephoned the on-duty staff member; however, this individual did not answer the telephone. The executive director arrived at the facility approximately 27 minutes after the reporter's arrival to the GRO. Upon entry into the GRO, the reporter found the staff member asleep on the couch with her cell

phone on her chest. The staff member alleged that she was not feeling well and had taken medication and fell asleep. The reporter observed the night log and the staff member had not completed any checks during the night. The reporter stated that she is required to make a report to SWI when a facility did not comply with 24-hour awake night supervision protocols.

Monitors' Review:

The Monitors found that the record contains a preponderance of evidence that a staff member fell asleep during the night shift at the GRO. The Monitors identified the following evidence in support of substantiating the allegation of Neglectful Supervision with a disposition of Reason to Believe:

- The investigative record shows that the staff member was asleep from approximately 12:00 p.m. until 1:30 a.m. During this time, the staff member was the sole caregiver responsible for the supervision and well-being of five children at the GRO. Both DFPS and the GRO prohibit staff members from sleeping at night at this GRO.

The investigator found that the staff member's failure to stay awake did not result in any reported harm or injury to the children. However, by falling asleep for an extended period of time, and thereby failing to provide required supervision, the staff member placed the children in a situation that may have caused substantial emotional harm or physical injury. Based upon this, an allegation of Neglectful Supervision should have been substantiated against the staff member.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the children remained at Concho Valley Home for Girls, a GRO. As of September 1, 2022, two children were placed together in a relative's home; the third child was placed at Gladney Center, an RTC; the fourth child was placed in a foster home; and the fifth child had aged out of DFPS care.

17. Investigation ID (CLASS): 2848011

Case ID (IMPACT): 48986111

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A DFPS staff member reported an allegation of Neglectful Supervision at Sweeten Home for Children, Inc., a GRO. The reporter stated that the GRO placed two children (Child A, age 15 and

Child B, age 17), who allegedly engaged in prior sexual contact with one another at the GRO, in the same bedroom as roommates.

Monitors' Review:

This investigation is deficient for missing interviews with two key individuals. Due to these missing interviews, the investigator was unable to determine whether Child A and Child B previously engaged in inappropriate sexual contact and, if so, whether the operation was negligent in later placing the two children in the same bedroom as roommates. When interviewed, a staff member (Staff 1) reported that she heard from two other staff members (Staff 2 and Staff 3) that Child A and Child B engaged in sexual contact in a bathroom at the GRO. According to Staff 1, the alleged incident of sexual contact occurred months prior to the investigation and prior to the GRO placing the children in the same bedroom. The investigator did not attempt to interview Staff 2 and Staff 3, who were reportedly present at the time of the alleged sexual incident between Child A and Child B at the GRO; neither staff member remained employed at the operation at the time of the investigation. These missing interviews were particularly important for the investigation because the operation was unable to provide the investigator with any documentation related to the alleged incident to assist the assessment and understanding of the incident. The GRO administrator informed the investigator that they reviewed Child A's and Child B's incident reports from 2019 to the present and did not locate any incident reports which involved alleged sexual contact between Child A and Child B. In their interviews with the investigator, both Child A and Child B denied engaging in any sexual contact with one another. Other staff members and the children's caseworkers reported knowledge of an alleged incident when Child A and Child B were alone in a bathroom; however, these individuals did not believe that the children engaged in inappropriate contact while in the bathroom. In the absence of interviews with Staff 2 and Staff 3, RCCI did not gather sufficient evidence to render a disposition of Ruled Out.

As of September 1, 2022, Sweeten Home for Children, Inc. was subject to Heightened Monitoring.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation and as of September 1, 2022, the children were placed at Sweeten Home for Children, Inc., a GRO.

18. Investigation ID (CLASS): 2800924

Case ID (IMPACT): 48832261

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The allegation should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations:

School personnel reported an allegation of Physical Abuse of a child at A.B.E. Residential Services, a GRO. The reporter stated that a staff member (Staff 1) punched a child (Child A, age 13) in the mouth one day prior to the report. The reporter stated that he observed a small abrasion on Child A's lip that resembled a canker sore.

Monitors' Review:

The Monitors disagree with RCCI's finding of Ruled Out for the allegation of Physical Abuse by Staff 1. The Monitors found that the record contains a preponderance of evidence that Staff 1 hit Child A in the face. The Monitors identified the following evidence in support of substantiating the allegations of Physical Abuse with a disposition of Reason to Believe:

- Child A consistently reported to the investigator, his caseworker, and a teacher that Staff 1 hit him in the face during a restraint;
- Two children, who observed the beginning of the incident, corroborated Child A's account of the incident and stated that they observed Staff 1 hit Child A in the face; and
- The collateral staff member, who assisted in the restraint of Child A and who denied that Staff 1 hit Child A in the face during the incident, reported that she was not present at the beginning of the incident.

Based upon Child A's consistent disclosure of abuse to three professionals and two child witnesses' corroboration of Child A's disclosure, the investigative record includes a preponderance of evidence that Staff 1 Physically Abused Child A when he hit the child in the face, which caused or may have caused substantial emotional harm or physical injury to the child.

Notable Gaps in Investigation Timeframe:

The investigation took over a month to be completed and closed, and there was no approved extension, in violation of Remedial Order 10. The intake was received on September 23, 2021. The investigation was completed on November 2, 2021 and closed on November 2, 2021.

Placement:

At the initiation of the investigation, the child remained at the GRO. As of September 1, 2022, the child was placed at Cedar Crest, an RTC.

19. Investigation ID (CLASS): 2825930

Case ID (IMPACT): 48957874

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The allegation should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations:

A staff member reported allegations of Neglectful Supervision of a child placed at The Settlement Club Home, a GRO. The reporter stated that a child (age 17) experienced an allergic reaction after consuming food containing peanuts. Due to the allergic reaction, the child required administration of her Epi-Pen and hospital care.

Monitors' Review:

The Monitors found that the record contains a preponderance of evidence that the administrator of the GRO failed to take actions that a reasonable member of the profession should take to reduce the likelihood that a child, with a potentially lethal reaction to peanuts, would be exposed to and physically harmed by this food. The Monitors identified the following evidence in support of substantiating the allegations of Neglectful Supervision with a disposition of Reason to Believe:

- A volunteer brought food prepared in peanut oil to the GRO. The child, who has a known, potentially lethal allergy to peanuts, consumed the food. As a result, the child experienced a serious allergic reaction that required medical care.

- A few weeks prior to the incident, a staff member at the GRO emailed the volunteer with instructions related to bringing food to the GRO, including a list of the foods that some of the children, including Child A, could not eat due to allergies. The volunteer reported to the investigator that while she did receive the email, she did not open it, as she was unfamiliar with the identity of the sender. Because the volunteer never opened the email and did not receive additional contact from the GRO confirming receipt of the email, the volunteer reported that she was unaware of any of the children's dietary restrictions and potentially lethal allergic reactions when she brought the food, prepared in peanut oil, to the GRO.

- After eating the food supplied by the volunteer, Child A informed a staff member that her throat was scratchy. The staff member promptly administered the child's Epi-Pen, which reportedly reduced the child's symptoms. The staff member then contacted Emergency Medical Services (EMS).

- After they arrived at the GRO, EMS personnel informed the staff member that the Epi-Pen she had used had expired a few months prior. A staff member at the GRO reported to the investigator that the medical personnel at the facility were aware that the child's Epi-Pen was expired and, prior to the incident, they had requested a new Epi-Pen. Medicaid allegedly denied the GRO's request. In response to this information, the investigator requested that the GRO administrators provide documentation to confirm that the GRO staff members had

taken appropriate steps to secure a new, unexpired Epi-Pen for Child A. The investigator documented that the GRO was unable to provide any documentation in response to the request.

Based upon the above evidence, the allegation of Neglectful Supervision should have been substantiated against the GRO administrator for failing to ensure there were reasonable precautions to protect the safety of a child with severe food allergies (such as requiring acknowledgment and confirmation from the volunteer that she, in fact, received and reviewed the information) and for failing to ensure that the child's life-saving medical device was unexpired. Due to these failures, the GRO administrator caused or may have caused substantial emotional harm or physical injury to the child.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation and as of September 1, 2022, the child remained at The Settlement Club Home, a GRO.

20. Investigation ID (CLASS): 2843383

Case ID (IMPACT): 48981229

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A law enforcement officer reported an allegation of Neglectful Supervision of two children placed at Sheltering Harbour, an RTC. According to the reporter, local law enforcement officers responded to a physical altercation that occurred between two children (Child A, age 13 and Child B, age 13) at the RTC. The reporter stated that Child B allegedly stabbed Child A in the back with a pair of scissors and that staff members intervened immediately to end the altercation. Following the incident, Child A was transported to a hospital and Child B was arrested.

Monitors' Review:

Regarding supervision at the time of the children's physical altercation, RCCI appropriately found that a staff member responded promptly to the altercation and separated the children. However, the investigator did not thoroughly probe whether staff members secured medical care for Child A after the incident. The investigative record shows that staff members timely notified law enforcement after the incident; however, law enforcement officers did not arrive at the facility for

approximately four hours. Once law enforcement officers arrived at the facility, the officers transported Child A to a hospital for treatment. Due to insufficient questioning of key individuals, the investigator failed to determine whether Child A received or required immediate medical care by staff members prior to law enforcement officers' arrival to the facility. Next, the investigator failed to sufficiently investigate whether staff members' actions, or inaction, constituted Neglectful Supervision in relation to Child B's access to scissors. Because the RTC was aware of Child B's history of aggression, the investigator should have closely explored the possibility of Neglect by staff members. Due to these deficiencies, the investigative record failed to gather sufficient evidence to render a disposition of Ruled Out.

As of September 1, 2022, Sheltering Harbour was subject to Heightened Monitoring.

Notable Gaps in Investigation Timeframe:

The investigation took over a month to be completed and closed. A 14-day extension was approved on February 8, 2022. The intake was received on January 15, 2022. The investigation was completed on February 22, 2022 and closed on February 25, 2022.

Placement:

At the initiation of the investigation, the children remained at Sheltering Harbour, an RTC. As of September 1, 2022, Child A remained at the RTC and Child B was placed at Dream Residential Treatment Center, an RTC.

21. Investigation ID (CLASS): 2805856

Case ID (IMPACT): 48850196

Category of Maltreatment: Neglectful Supervision; Medical Neglect

Monitors' Conclusion:

The Monitors cannot determine the disposition of the Neglectful Supervision allegation due to a deficient investigation. The Monitors agree with the disposition of Ruled Out for the Medical Neglect allegation.

Summary of key allegations:

School personnel reported two separate intakes to SWI with allegations of Neglectful Supervision of a child (Child A, age 14) placed at Guiding Light Residential Treatment Center, an RTC. The reporters stated that another child (Child B, age 17) allegedly poured water on Child A during the night on two separate occasions and that staff members failed to respond to the incidents appropriately. Child A told one of the reporters that he did not feel safe at the RTC because staff members failed to supervise the children. The reporters expressed concern that Child A may be bullied by other children at the RTC and that Child A has a history of suicidal ideation and self-harm.

Monitors' Review:

The investigation is deficient due to the investigator's failure to thoroughly investigate whether staff members appropriately supervised Child A to prevent or mitigate the risk of harm from other children. First, the investigator did not review any of Child A's incident reports at the RTC to assess whether the child's health and safety was at risk due to actions by other children and whether staff members responded appropriately to these incidents to ensure Child A's safety and well-being. Because the investigative record did not include any evidence that the investigator reviewed Child A's incident reports, it is unclear how the investigator arrived at the conclusion that there were "no documented incident reports" that involved other children pouring water on Child A. Next, during his interview, Child A alleged that another child hit him at the RTC. The investigator did not investigate this alleged incident to determine whether staff members appropriately supervised Child A and the other child at the time Child A reported that another child hit him. In the absence of the investigator conducting a thorough investigation into the allegation of Neglectful Supervision, the investigative record failed to include sufficient evidence to Rule Out the allegation.

Notable Gaps in Investigation Timeframe:

The investigation took over a month to be completed and closed, and there was no approved extension, in violation of Remedial Order 10. The intake was received on October 6, 2021. The investigation was completed on November 15, 2021 and closed on November 15, 2021.

Placement:

At the initiation of the investigation, the children remained at the RTC. As of September 1, 2022, Child A was placed at Sheltering Harbour, an RTC, and Child B was in an unauthorized arrangement.[2]

22. Investigation ID (CLASS): 2808303

Case ID (IMPACT): 48860598

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: Due to RCCI's failure to add the operation's administrator as an alleged perpetrator, and fully investigate whether this individual was negligent in the care of children, the Monitors found this investigation is deficient. The Monitors agree with the disposition of Ruled Out for the Neglectful Supervision allegation against the staff member.

[2] DFPS defines an unauthorized arrangement as a residential situation in which a youth lives independent of an approved caregiver without CPS's or the court's permission. When a youth in CPS's managing conservatorship begins living in an unauthorized arrangement, CPS cannot approve or pay for the arrangement. The youth's caseworker, however, must try to remain involved enough in the youth's plans to ensure the youth's safety and welfare. *See e.g.*, DFPS, DFPS Foster and Licensed Facility Placements Resource Guide, 39 (Updated September 2022).

Summary of key allegations:

A child's adoption worker reported an allegation of Neglectful Supervision at the Autistic Treatment Center, an RTC. The caseworker reported that a child (Child A, age 16) punched another child (Child B, age 14) at the RTC. Due to the altercation, the reporter observed the following injuries on Child B: a swollen face, a laceration across his left cheek and along his hairline, and a bloody lip. The reporter did not know the cause of the physical altercation or the date when the incident occurred.

Monitors' Review:

This investigation is deficient for failing to add and investigate the operation's administrator as an alleged perpetrator. Based upon information gathered by the investigator, Child A and Child B "were left unsupervised" for approximately 27 minutes. At this time, the only staff member on-duty at the RTC was getting dressed for the day in the restroom; this staff member reportedly lived at the operation. Due to the lapse in supervision, Child A and Child B engaged in a physical altercation that resulted in physical injury to Child B. The investigative record supports RCCI's determination to Rule Out Neglectful Supervision by the staff member. The record indicates that the staff member's failure to maintain appropriate supervision of the children was very likely due to inadequate staffing levels put in place by the administration. As such, the investigator should have investigated the operation's administrator's culpability in the incident. The investigator should have explored whether the operation's administrator adhered to the RTC's contractual requirements regarding staffing levels at the time of the incident, including whether the RTC's contract permitted the facility to operate with only one on-duty staff member, particularly if this individual lived at the operation and presumably required time to perform basic hygiene requirements at the beginning of the day. The investigator's failure to explore the administrator's potential neglect is critical because of Child A's and Child B's supervision requirements. Child A's service plan indicated that his level of care was "Intense." According to DFPS, "[a] child needing intense services has severe problems in one or more areas of functioning that present an imminent and critical danger of harm to self or others." As a result, children assigned to this service level require "24-hour supervision … which includes frequent one-to-one monitoring."[3] Child B's service plan failed to stipulate his level of care of "Specialized;" however, the plan documented that, "Due to severity and unpredictability of his behavior he requires the structure and supervision of the residential setting with 24-hour supervision and intervention." Both Child A and Child B were diagnosed with, among other diagnoses, autism. The investigative record's finding that Child A and Child B were left unsupervised for approximately 27 minutes constitutes a failure to adhere to the children's required supervision levels and requires RCCI to explore the administrator's culpability.

Next, three months prior to the physical altercation, Child A and Child B engaged in inappropriate sexual contact. Through its investigation of the incident of sexual contact, RCCI substantiated the allegations of Neglectful Supervision with a disposition of Reason to Believe that a different staff member failed to appropriately supervise the children to prevent or mitigate the sexual contact. In its current investigation, RCCI reported that the RTC was unable to produce "any documentation

[3] DFPS, *Service Levels for Foster Care, available at* https://www.dfps.state.tx.us/Child Protection/Foster Care/Service Levels.asp#: :text Description 20of 20the 20Intense 20Service,necessary 20to 20protect 20the 20child.

to confirm that direct care staff [were] instructed to provide increased monitoring of [Child A and Child B] to prevent future incidents." In the latter investigation under review, the investigator should have investigated whether the operation administrator failed to implement increased supervision of Child A and Child B following the incident of sexual contact; if implemented, increased supervision of Child A and Child B may have reduced the likelihood or severity of the physical altercation and likely would have required that additional staff members were on-duty at the time of the physical altercation. Due to the investigator's failure to add and investigate the operation's administrator as an alleged perpetrator, this investigation is deficient.

Notable Gaps in Investigation Timeframe:

The investigation took over a month to be completed and closed. A 14-day extension was approved on November 11, 2021; however, the investigation did not meet the extension deadline, in violation of Remedial Order 10. The intake was received on October 13, 2021. The investigation was completed on December 8, 2021 and closed on December 20, 2021.

Placement:

At the initiation of the investigation and as of September 1, 2022, both children remained at the RTC.

23. Investigation ID (CLASS): 2753810

Case ID (IMPACT): 48691165

Category of Maltreatment: Physical Abuse; Neglectful Supervision; Physical Neglect

Monitors' Conclusion: One allegation of Physical Abuse should have been assigned a disposition of Unable to Determine. The Monitors agree with the dispositions of Ruled Out for the other allegations in this investigation.

Summary of key allegations:

A private citizen reported allegations of Physical Abuse and Neglectful Supervision of a child placed at Hearts with Hope Foundation, a GRO. The reporter stated that she observed the child (Child A, age 16) outside a store in the community and inquired whether the child was okay. The child told the reporter that, three hours earlier, she had left the GRO because an unnamed staff member choked her. The reporter observed red marks around the child's neck. The child also disclosed to the reporter that she was hungry and had not eaten that day.

Monitors' Review:

The Monitors disagree with RCCI's finding of Ruled Out for an allegation of Physical Abuse which emerged during the investigation. During her interview with RCCI, Child A alleged that, during a restraint, a staff member (Staff 1) punched her in the nose, causing it to bleed, and another staff member (Staff 2) placed her knee on her back. Based upon the information gathered by the

investigator, the Monitors found that the investigative record supports a disposition of Unable to Determine for the allegation of Physical Abuse for the following reasons:

- In the investigative record, RCCI documented, "Staff are very inconsistent with the information regarding the restraint involving the child getting her nose hit [sic] causing it to bleed. Staff do not appear to be telling the truth about the incident at this point." In their interviews with RCCI, Staff 1 and Staff 2 provided inconsistent and, at times, vague accounts of the alleged incident. Staff 1 provided the investigator with a different account of the alleged incident from what she documented in the incident report. In both of her accounts, Staff 1 denied hitting Child A. Staff 1 reported that, during the restraint, Child A was physically aggressive, and that Staff 1 may have unintentionally hit Child A in the nose when attempting to contain the child. Other staff members and Child A confirmed that Child A exhibited physical aggression during the restraint.

- Multiple staff members observed the alleged incident and their accounts of the alleged incident also varied. While staff members reported conflicting accounts of the alleged incident, Staff 1, Staff 2, and all staff witnesses reported that Staff 1 and Staff 2 did not physically abuse Child A.

- To resolve the discrepancies in staff members' and Child A's accounts of the incident, the investigator requested that the operation provide video footage of the alleged incident. The GRO responded that they did not have cameras installed in the area where the alleged incident occurred.

Given the disparate accounts of the alleged incident, the investigative record contained insufficient evidence to determine whether Staff 1 and Staff 2 physically abused Child A. While this phenomenon is usually grounds for a disposition of Ruled Out when there are no qualitative deficiencies in the investigation, the Monitors found that the investigative record raised concern regarding the veracity of staff members' statements about the alleged incident. This concern was heightened by information surfaced by Child A's caseworker during the investigation. The caseworker reported to the investigator that, on an unknown date, he had a telephone conversation with Child A at the GRO. While on the telephone, the caseworker overheard Staff 1 say to Child A, "don't hit me because I'll hit you back." Due to concern regarding staff members' credibility, RCCI could not reasonably Rule Out the allegation of Physical Abuse by Staff 1 and Staff 2 and, thereby, should have assigned the allegation a disposition of Unable to Determine.

Notable Gaps in Investigation Timeframe:

The investigation took over two months to be completed and closed, and there was no approved extension, in violation of Remedial Order 10. The intake was received on June 3, 2021. The investigation was completed on August 6, 2021 and closed on August 6, 2021.

Placement:

At the initiation of the investigation, the child was living with her birth parent in an unauthorized arrangement. As of September 1, 2022, the child was placed under DFPS supervision.

24. Investigation ID (CLASS): 2781281

Case ID (IMPACT): 48779274

Category of Maltreatment: Neglectful Supervision; Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition of one of the Neglectful Supervision allegations related to Staff 1 due to a deficient investigation. Moreover, an additional allegation of Physical Abuse should have been added to the investigative record against Staff 1; due to a deficient investigation, the Monitors cannot determine the disposition of this Physical Abuse allegation. Lastly, the Monitors agree with the dispositions of Ruled Out for other Neglectful Supervision and Physical Abuse allegations contained in the investigation.

Summary of key allegations:

SWI received four intakes with allegations of Neglectful Supervision and Physical Abuse at Bluebonnet Haven LLC, an RTC. In the first intake, a staff member reported that a child (Child A, age 13) used a pencil to stab another child (Child B, age 15) near her eye during a physical altercation. Staff members transported Child B to the hospital where she received six stiches on her face. A staff member (Staff 1) was identified as the alleged perpetrator. In the second intake, another child's (Child C, age 14) caseworker reported that staff members encouraged children to fight with one another and did not intervene in the children's altercations. In the third intake, the caseworker for a child (Child D, age 17) reported that there had been multiple fights "daily" at the RTC between children. Child D stated that staff members attempted to stop the physical altercations but not as much as they should have. In the fourth intake, another child's (Child E, age 17) caseworker reported that Child E disclosed that Staff 1 encouraged other children to physically assault her. Reportedly, a group of five children attempted to physically assault Child E the week prior to the report. Child E refused to go to school for fear that other children would harm her.

Monitors' Review:

This investigation is deficient due to the investigator's failure to investigate appropriately some of the allegations of Neglectful Supervision and Physical Abuse by Staff 1, namely: his alleged encouragement of assault between children, his failure to intervene when those alleged assaults occurred, and his alleged shove of a child. Regarding the allegation of Neglectful Supervision by Staff 1, the investigator failed to interview key individuals to determine whether Staff 1 encouraged children to engage in physical altercations (i.e., "green lighting") with one another. Specifically, the investigator failed to interview a child (Child F, age 16) who Staff 1 allegedly instructed to physically assault Child E, as alleged by Child E during her interview. The record demonstrates that Child F physically assaulted Child E. If interviewed, Child F may have been able to confirm or refute whether Staff 1 instructed her to physically assault Child E. Next, Child E alleged that Staff 1 did not promptly intervene in the altercation between Child F and Child E. According to the record, another staff member (Staff 2) intervened in the altercation; however, the investigator did not interview this individual. If interviewed, Staff 2 may have provided the investigator with additional information about Staff 1's response to the altercation. Finally, the investigator did not interview a child who was present with Child E at the time Child F attacked her. The investigator's failure to rigorously investigate the allegation that Staff 1 provoked

physical altercations between children is particularly troublesome because numerous children—six of nine children interviewed—reported knowledge that Staff 1 instructed children to physically assault other children.

Next, the investigator failed to add to the investigative record and fully investigate a new allegation of Physical Abuse disclosed by Child E during the investigation. In her interview with RCCI, Child E alleged that Staff 1 shoved her and then picked her up; at that point, another staff member (Staff 3) allegedly intervened and stopped the incident. The investigator did not attempt to interview Staff 3. Child E stated that there was video footage of the alleged incident, and the record contains no evidence that the investigator requested or reviewed the footage. The investigator also did not request or review an incident report related to this allegation. Finally, the investigator noted that, during his interview, Staff 1 had a "withdrawn demeanor," "appeared annoyed," and provided "little to no detail" in his responses to the investigator's questions. Given Staff 1's unwillingness to fully participate in the interview, it was incumbent upon the investigator to ensure all relevant individuals were interviewed and to review all potential evidence to reach the appropriate disposition.

Notable Gaps in Investigation Timeframe:

The investigation took over three months to be completed and closed. A 30-day extension was approved on September 14, 2021; however, the investigation did not meet the extension deadline, in violation of Remedial Order 10. The first intake was received on August 16, 2021. The investigation was completed on November 4, 2021 and closed on November 22, 2021.

Placement:

At the initiation of the investigation, Child A, Child B, Child D, and Child E remained placed at the RTC. At the time of the later intake related to Child C, she was removed from the RTC. As of September 1, 2022, Child A was placed at Hearts with Hope Foundation, a GRO; Child B was placed at Cumberland Presbyterian Children's Home, a GRO; Child C had returned home and was no longer in DFPS custody; Child D was placed at Kinder Emergency Shelter; and Child E had aged out of DFPS care. Child F was never in DFPS care.

25. Investigation ID (CLASS): 2825971

Case ID (IMPACT): 48945528

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

SWI received two intakes with allegations of Neglectful Supervision of children placed at Turning Point Children's Social Service, a GRO. In the first intake, a DFPS staff member reported that a

child (Child A, age 13) disclosed that, approximately six months to a year ago, another child (Child B, 10) asked Child A to perform oral sex on him and Child A complied with the request. Child B reportedly then performed oral sex on Child A. According to Child A, staff members found the children engaged in the sexual act and promptly separated them. In the second intake, Child A reported to SWI that another child (Child C, age 12) came into his bedroom during the night and "made" Child A perform oral sex on him. Child A disclosed that the children also engaged in anal sex. The children allegedly engaged in this behavior over a course of four to five nights. Child A reported that he notified a named staff member about the incidents; however, the staff member told Child A that he was lying. Lastly, Child A alleged that a third child (Child D, age 13) also engaged in inappropriate sexual contact with him. Child A did not provide any details related to his alleged sexual contact with Child D.

Monitors' Review:

This investigation is deficient for flawed interviews with key individuals. Due to this deficiency, the investigator failed to sufficiently probe whether the alleged incident of sexual contact between Child A and Child B occurred and whether staff members appropriately supervised the children at the time of the alleged incident. First, the investigator failed to adequately question Child C and a staff member who was on duty; both individuals reportedly engaged with Child A and Child B shortly after the alleged incident of sexual contact and may have had relevant observations. With adequate questioning by the investigator, these individuals may have been able to confirm or refute conflicting statements made by Child A and Child B about the alleged incident of sexual contact. Second, the investigator did not sufficiently question Child A, Child B and staff members about supervision at the time of the alleged incident, including whether staff members performed 15-minute checks as required. Due to these deficiencies in the investigation, RCCI did not gather sufficient evidence to Rule Out the allegation of Neglectful Supervision.

Notable Gaps in Investigation Timeframe:

The investigation took approximately two months to be completed and closed. A 30-day extension was approved on January 8, 2022. The intake was received on December 14, 2021. The investigation was completed on February 9, 2022 and closed on February 14, 2022.

Placement:

At the initiation of the investigation, the children remained at Turning Point Children's Social Service, a GRO. As of September 1, 2022, Child A and Child B remained at the GRO; Child C was placed in a kinship foster home; and Child D was placed in a therapeutic foster home.

26. Investigation ID (CLASS): 2737840

Case ID (IMPACT): 48633455

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition of Neglectful Supervision allegation related to the GRO administrator due to a deficient investigation. The Monitors agree with the disposition of Ruled Out for the allegation of Neglectful Supervision related to staff members.

Summary of key allegations:

SWI received five intakes involving allegations of Neglectful Supervision at the Children's Shelter, an emergency shelter. The five intakes contained the following similar allegations:

- Staff members at the Children's Shelter struggled to maintain supervision of children;
- Two children (Child A, age 17 and Child B, age 12) engaged in inappropriate sexual contact on the shelter campus at night;
- Child A forced other children to engage in inappropriate sexual contact; and
- Child A instructed a group of children to "jump" another child (Child C, age 13) and then Child A forced Child C to have sex with another child.

Monitors' Review:

Due to a deficient investigation, the investigator failed to establish whether the Children's Shelter licensing administrator's actions, or inaction, constituted Neglectful Supervision of Child A and Child B. RCCI entered a disposition of Unable to Determine against the administrator, stating that the record contained insufficient evidence that the administrator breached his duty. During the investigation, the investigator gathered substantial evidence which showed that the shelter was understaffed at night. According to the investigator, the critical lack of appropriate nighttime staffing "led to the resident children with high-risk behaviors eloping out of the windows in groups placing direct care staff in a compromising position to either choose to remain inside the building with the other resident children [ages 2 – 17] or leave the younger and more vulnerable children inside of the facility unattended to chase after and locate the teenage children who eloped…". The RCCI investigator found that staff members on duty attempted to supervise the children "to the best of their ability with the resources provided to them by the administrative personnel."

On the night of the alleged incident of sexual contact between Child A and Child B, the record demonstrated that inadequate staffing levels enabled Child A and Child B to leave their bedrooms during the night and convene, unsupervised, outside on the shelter campus. Following the alleged incident, Child B reported to a law enforcement officer, who was present at the operation related to a separate incident at the facility, that he engaged in sexual contact with Child A that night. Child A and Child B refused to discuss the allegation of sexual contact during their interviews with RCCI.

Given the evidence that the Children's Shelter was understaffed at the time of the alleged incident of sexual contact between Child A and Child B, the investigator added the shelter's licensing administrator as an alleged perpetrator to the investigation. The investigator reviewed the administrator's documented job responsibilities and found that he was responsible for ensuring child-to-staff ratios were maintained at the operation. The investigator found no evidence that the administrator maintained appropriate nighttime staffing levels as stipulated by his job description.

In a related companion investigation opened at the same time as this investigation, the same investigator interviewed the same administrator about similar allegations.[4] During this interview, the administrator reported that he worked alongside three other senior staff members, who were not assigned as alleged perpetrators in either investigation. The administrator reported that these individuals "had the decision-making powers for the program" and that his requests, including for hiring, required their approval. When these individuals denied his requests, he reported that his hands were "tied." Given this information, the investigator should have asked this administrator to describe the specific actions he took to address the staffing shortages experienced during the night shifts and the actions taken by the other senior staff members in relation to his efforts. The investigator also should have interviewed the other three senior staff members. Through these interviews, the investigator could have gained pertinent information related to the actions, or inaction, of all four of the individuals and their authority to address the ongoing safety concerns at the Children's Shelter during the night shifts. Based upon the information gathered from these interviews, the investigator could have determined whether it was appropriate to add the other three senior staff members to the investigation as alleged perpetrators and whether there was a preponderance of evidence that these senior staff members' actions, or inaction, constituted Neglectful Supervision.

Due to the above deficiencies, the record failed to sufficiently consider and determine which senior individual or individuals failed to take the necessary actions to remediate the ongoing supervision issues at the Children's Shelter which exposed children to serious harm.

Notable Gaps in Investigation Timeframe:

The investigation took approximately five months to be completed and closed. A 30-day extension was approved on May 19, 2021. Another 30-day extension was approved on June 15, 2021; however, the investigation did not meet the extension deadline, in violation of Remedial Order 10. The intake was received on April 22, 2021. The investigation was completed on September 20, 2021 and closed on September 23, 2021.

Placement:

At the initiation of the investigation, the children had been removed from the placement. As of September 1, 2022, Child A and Child D had aged out of DFPS care; Child B was no longer in

[4] On January 27, 2022, RCCI overturned its initial disposition of Reason to Believe in the related companion investigation (48625599). As RCCI documented in the overturn decision, the original investigation was deficient and did not gather sufficient evidence to substantiate the administrator for Neglectful Supervision and the Monitors agree, as described in greater detail in Appendix 3. The Monitors identified and detailed similar investigative deficiencies in both investigations.

DFPS custody; and Child C was placed at Bluebonnet Haven, an RTC.

Investigations in Foster Homes

27. Investigation ID (CLASS): 2783037

Case ID (IMPACT): 48782895

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A school counselor reported allegations of Neglectful Supervision of two children placed in a foster home. The counselor alleged that a child (Child A, age 8) arrived at school with a golf sized bump on his face and bruises. Child A reported that another child in the foster home (Child B, age 10) punched him eight times in the face during the prior night. In the morning, the foster mother allegedly observed Child A's injuries and provided him with medicine. Child A reported that his face hurt.

Monitors' Review:

The Monitors agree with RCCI's determination to Rule Out the allegation of Neglectful Supervision as related to the incident included in the intake report. However, RCCI did not adequately investigate new information learned from interviews with the children in the foster home. Child B and two other children in the home (Child C and Child D, ages 11) reported that the children in the foster home routinely hit one another. Child B and Child C stated that the foster mother either failed to intervene during the children's physical altercations or did not check on the children for extended periods of time while they were in their bedrooms. The investigator did not adequately question the foster mother regarding the allegation to determine whether her supervision in the foster home conformed with Child A's and Child B's required supervision level; the children's service plans specified that a caregiver must be within visual or hearing distance from them at all times. In the absence of this information, it is unclear whether the foster mother appropriately supervised the children in the foster home to best ensure their safety.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the children remained in the therapeutic foster home. As of September 1, 2022, the children were placed in two different therapeutic foster homes. In addition, the foster home subject to this investigation was open but not serving any children.

28. Investigation ID (CLASS): 2721056

Case ID (IMPACT): 48580004

Category of Maltreatment: Neglectful Supervision; Physical Abuse

Monitors' Conclusion: The Physical Abuse allegation should have been substantiated with a disposition of Reason to Believe. The Monitors agree with the disposition of Ruled Out for the Neglectful Supervision allegation.

Summary of key allegations:

Two intakes were reported to SWI with allegations of Neglectful Supervision and Physical Abuse in a foster home. In the first intake, a law enforcement officer reported that a child (Child A, age 16) disclosed that the prior night her foster mother took her to a club and Child A became sick and the foster mother took her home. In the morning, Child A reported to her foster mother that an unnamed individual touched her inappropriately approximately a month prior to the intake report. Child A disclosed that her vagina hurt after the alleged incident. The unnamed individual also provided Child A with marijuana and pills and the foster mother was reportedly aware of this. The foster mother and Child A allegedly had a verbal argument after Child A made the above disclosures. In the second intake, Child A's case manager reported that on the prior evening, she performed an emergency removal of Child A from the foster home in response to allegations Child A made in the first intake report. The case manager reported similar allegations to SWI as those reported in the first intake and she also provided the following additional information: Child A reported that when the foster mother took her to the club, Child A drank alcohol, and became intoxicated. In addition, while at the club, the foster mother allegedly left the other children in the foster home in the care of her 19-year-old son. Regarding the alleged sexual assault of Child A by an unnamed individual, the case manager stated that on an unknown night, this unnamed individual, the foster mother and Child A smoked marijuana together and Child A took two unknown pills and "passed out." When Child A woke up in the morning, her vagina hurt.

Monitors' Review:

The Monitors agree with RCCI's finding of Ruled Out for the allegation of Neglectful Supervision as the record did not contain a preponderance of evidence that the foster mother failed to provide adequate supervision of Child A as related to the alleged sexual assault of the child by an unnamed individual. However, the Monitors found that the record contains a preponderance of evidence that the foster mother allowed the child to consume alcohol. The Monitors identified the following evidence in support of substantiating the allegation of Neglect with a disposition of Reason to Believe:

- The child reported that the foster mother brought her to a club and at the club she drank an alcoholic beverage. The foster mother confirmed the child's allegation.

- The investigator reviewed video footage that showed the child and the foster mother in a setting that RCCI stated "appear[s] to be a bar" and both the child and the foster mother "have a clear cup with a dark colored liquid in it [sic] appearing to be a shot." RCCI further documented that the video shows them "holding the drink to their mouth[s]." RCCI

documented that it does not appear that the child swallowed the liquid.

Based upon this evidence, the allegation of Neglectful Supervision should have been substantiated against the foster mother for allowing a child, with documented high-risk behaviors, to consume alcohol which caused or may have caused substantial emotional and physical injury.

The investigation also raised concerns that the foster mother left the other foster children in the home unsupervised or in the care of her 19-year-old son; the foster mother was unprepared or ill-suited for caring for a child with extensive behavioral needs; and that the CPA may have attempted to interfere in the investigation.

Notable Gaps in Investigation Timeframe:

The investigation took over a month to be completed and closed. A 30-day extension was approved on April 7, 2021. The intake was received on March 13, 2021. The investigation was completed on May 12, 2021 and closed on May 14, 2021.

Placement:

A few days after the initiation of the investigation, the therapeutic foster home was closed and the children were removed: Child A returned home to a parent and the other three foster children, a sibling group, were placed in two different therapeutic foster homes. As of September 1, 2022, Child A had aged out of DFPS care; and the other three foster children were placed together at The Children's Home, a GRO. In addition, the foster home was closed.

29. Investigation ID (CLASS): 2810970

Case ID (IMPACT): 48876126

Category of Maltreatment: Neglectful Supervision; Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition of the Physical Abuse allegation due to a deficient investigation. The Monitors agree with the disposition of Ruled Out for the Neglectful Supervision allegation.

Summary of key allegations:

A CPA case manager reported allegations of Neglectful Supervision and Physical Abuse of a child placed in a foster home. The reporter stated that on the morning of the intake report, the foster family was watching church services on the television when the child (Child A, age 12) began tearing out pages of his Bible. In response, the foster mother asked Child A to hand her his Bible. Reportedly, Child A then physically attacked the foster mother and other family members. The reporter stated that she did not know whether Child A had any injuries from the incident. The foster mother told the reporter that Child A may have been bruised on his ribs from when she attempted to physically remove Child A from his position on top of her daughter. Following the incident, law enforcement and the paramedics arrived at the home; the paramedics allegedly

assessed Child A before law enforcement transported him to a juvenile detention center. According to the reporter, the foster mother sustained the following injuries from the altercation: broken bones in her foot and hand, dislocated left and right hands, a large hematoma on her elbow, and a cut to her eye.

Monitors' Review:

Regarding the Physical Abuse allegation, the investigation is deficient due to missing and flawed interviews with key individuals. In his interview, Child A alleged that during the physical altercation with the foster mother, the foster mother hit him with a bat. The investigator did not ask the other children involved in the incident whether the foster mother hit Child A with a bat during the altercation. The foster mother denied that she hit Child A with a bat. Next, the reporter stated that EMS responded to the incident and medically evaluated Child A after the incident. The investigator did not attempt to interview nor request any documentation from EMS to determine whether Child A had sustained any injuries from the altercation that may have been consistent with being hit by a bat. Lastly, the investigator did not attempt to interview the law enforcement officer who responded to the incident. Child A reported to the investigator that the responding law enforcement officer observed the bat the foster mother allegedly used to hit him. During their interviews with the investigator, the foster mother and two children who were involved in the incident consistently reported to the investigator that Child A physically attacked the foster mother and that he then attacked the other two children when they came to the foster mother's aid. Due to the investigator's failure to thoroughly investigate whether the foster mother hit Child A with a bat, the Monitors found that the allegation of Physical Abuse could not be Ruled Out.

Notable Gaps in Investigation Timeframe:

The investigation took over a month to be completed and closed, and there was no approved extension, in violation of Remedial Order 10. The intake was received on October 24, 2021. The investigation was completed on December 8, 2021 and closed on December 8, 2021.

Placement:

At the initiation of the investigation, the child was removed from the foster home and placed in a juvenile detention facility. As of September 1, 2022, the child was placed in a therapeutic foster home. As of this date, the foster home subject to this investigation was open and serving two children.

30. Investigation ID (CLASS): 2810976

Case ID (IMPACT): 48874634

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A physical therapy supervisor reported an allegation of Physical Abuse of a non-verbal child (age 8) in a foster home. Approximately one month prior to the intake report, the reporter stated that one of her staff members observed bruising on the non-verbal child's arms and legs. The reporter stated that the bruises appeared fingerprint sized. Allegedly, the reporter's staff member showed the child's bruises to a nurse in the foster home and this individual reported that she did not know how the child sustained them. The nurse stated that she would speak to the child's foster parent about the child's bruises. The reporter stated that she did not know the cause of the child's bruises.

Monitors' Review:

This investigation is deficient due to a missing Forensic Assessment Center Network (FACN) consultation. The investigator attempted to interview key individuals, including the child's nurses and physical therapist; however, these individuals did not respond to requests for interviews. In the absence of interviews with these critical individuals who may have had information related to the allegation, the investigator should have sought an FACN consultation to determine whether the child's bruises were indicative of abuse or neglect. The investigator interviewed the child's pediatrician, CASA advocate, CPA assistant director, and caseworker; none of these individuals reported any concerns for the child's care and well-being in the foster home. Additionally, the investigator inspected the child's body and found no bruising at the time of the investigation. However, because the child is non-verbal and unable to disclose whether she was subject to Physical Abuse in the foster home, the investigator should have obtained an FACN consultation prior to Ruling Out the allegation of Physical Abuse.

Notable Gaps in Investigation Timeframe:

The investigation took over a month to be completed and closed, and there was no approved extension, in violation of Remedial Order 10. The intake was received on October 23, 2021. The investigation was completed on November 20, 2021 and closed on December 9, 2021.

Placement:

At the initiation of the investigation, the child was not removed from the foster home. As of September 1, 2022, the child was no longer in DFPS care and the foster home was closed.

31. Investigation ID (CLASS): 2760633

Case ID (IMPACT): 48717545

Category of Maltreatment: Physical Abuse; Medical Neglect

Monitors' Conclusion: The Monitors cannot determine the disposition of the Medical Neglect allegation due to a deficient investigation. The Monitors agree with the disposition of Ruled Out for the Physical Abuse allegation.

Summary of key allegations:

A DFPS Heightened Monitoring staff member reported that two children disclosed that their foster mother and her paramour hit them in their foster home. The reporter also expressed concern that the foster mother did not appropriately administer the children's medication. While in the foster home, the reporter observed full bottles of the children's prescription medications from prior months. The reporter reviewed the children's medication logs and did not identify any concerns.

Monitors' Review:

Regarding the allegation of Medical Neglect, this investigation is deficient due to a missing FACN consultation. The investigative record documented that some of the children's prescription medication bottles included a surplus of pills based upon the date the prescription was most recently refilled. At the conclusion of the investigation, the investigator was unable to provide a reason(s) why some of the children's prescription bottles included too many pills. To address this concern, the investigator should have requested an FACN consultation to assist in determining whether the foster mother administered the children's medications appropriately. The foster mother, her paramour, and all five children reported that the foster mother provided the children with their daily medications as prescribed. The children's CVS caseworkers reported no concerns with the foster home and some of the children's CVS caseworkers noted that the foster home provided these children with greater stability and well-being than any prior placements. In the absence of an FACN consultation, it is unknown whether the foster mother provided the children with their prescription medications as required.

Notable Gaps in Investigation Timeframe:

None.

Placement:

A few days after the initiation of the investigation, one of the children was removed from the therapeutic foster home. As of September 1, 2022, he was placed back in the home after one year of placements elsewhere. The other child remained in this placement at the initiation of the investigation and continued to be placed there as of September 1, 2022, along with three other children.

32. Investigation ID (CLASS): 2825930

Case ID (IMPACT): 48945168

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

An RTC staff member reported allegations of Neglectful Supervision of a child when she was previously placed in a foster home. The reporter stated that a child (Child A, age 12) disclosed that when she was six years old, an unnamed child (Child B, approximate age 16) inappropriately touched her one time. According to Child A, this is the first time she disclosed this information.

Monitors' Review:

It is difficult to conduct an investigation of an alleged incident that occurred approximately six years ago. Nonetheless, this investigation is deficient due to missing interviews with key individuals. During her forensic interview, Child A alleged that Child B sexually assaulted her during a barbecue hosted by her foster family approximately seven years prior to the interview. At the time of the alleged incident, Child A stated that Child B lived with another foster family who attended the barbecue. During the investigation, Child A reported that she told both her sister and her former caseworker about the alleged incident after it occurred. The investigator did not attempt to interview either of these individuals, who may have had pertinent information regarding the allegation and supervision in the foster home. Next, the investigator did not attempt to interview any of the children who previously lived in the foster home with Child A to gather information about the allegation. The investigator interviewed the foster children currently living in Child A's former foster home and these children did not report any concerns related to the foster parent's supervision or care. Due to a deficient investigation, the investigative record does not include sufficient evidence to Rule Out the allegation of Neglectful Supervision by the foster parent.

As of September 1, 2022, the CPA, Caring Hearts for Children, was subject to Heightened Monitoring.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation and as of September 1, 2022, the child was placed at New Horizons Audrey Grace House, a GRO. As of September 1, 2022, the foster home was open and serving one child.

33. Investigation ID (CLASS): 2800907

Case ID (IMPACT): 48832087

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A DFPS caseworker reported allegations of Neglectful Supervision of a child placed in a foster home. The reporter alleged that a child (age 14) was bitten by the foster parents' dog on his face and arm and that the child's injuries required stiches. The reporter stated that the foster parent was aware of the dog's aggressive behavior. Reportedly, the dog lived in the garage. The reporter stated that the foster parents' dog had bitten the child previously, as well. The foster parent initially informed the reporter that a stray dog bit the child.

Monitors' Review:

Due to flawed and missing interviews, the investigator did not determine whether the child's bite was from the foster parents' dog or a stray dog in the neighborhood. First, the investigator did not sufficiently attempt to resolve the child's inconsistent statements about the alleged incident. In his first interview, the child told the investigator that the foster parents' dog bit and injured him; the child also disclosed that the foster parents promised him a gift card if he told the investigator that a stray dog bit him, not the family dog. In his second interview, the child stated that "something hit him and knocked him down" and denied that the foster parents' dog bit him. According to the child's case manager, the child disclosed to her the day after the incident that a stray dog bit him. To potentially address these inconsistencies, the investigator should have attempted to promptly interview a key witness to the alleged incident who the child identified during the investigation; instead, the investigator waited nearly a month after the investigation was initiated to attempt to interview this individual, who may have been able to confirm the identity of the dog that bit the child. Likely due to this delay, this individual did not respond to the investigator's multiple requests for an interview. Next, the investigator's interview of the foster parents was flawed for several reasons. First, the investigator interviewed the foster parents together. If interviewed separately, the foster parents may have provided the investigator with additional information regarding the allegation; in their joint interview, the foster parents denied that their dog bit the child. Second, the investigator did not question the foster parents about allegedly bribing the child to falsely report that a stray dog bit him. Third, the investigator did not adequately attempt to resolve some inconsistencies in the foster parents' statements regarding their location at the time of the alleged incident. If the investigator had pursued better questioning of the foster parents, the investigator may have gleaned more insight into their and the child's credibility. Lastly, the investigator failed to adequately explore whether the family's dog previously bit the child and, if so, whether DFPS previously required the foster parents to take additional safety precautions to ensure the child's safety around the dog. Due to these deficiencies, the investigator cannot Rule Out the allegation of Neglectful Supervision by the foster parents.

Notable Gaps in Investigation Timeframe:

The investigation took over a month to be completed and closed, and there was no approved extension, in violation of Remedial Order 10. The intake was received on September 23, 2021. The investigation was completed on October 29, 2021 and closed on November 4, 2021.

Placement:

At the initiation of the investigation, the child was not removed from the therapeutic foster home. As of September 1, 2022, the child was placed at Pegasus Schools, Inc., an RTC, and the foster home was open but was not serving any children.

34. Investigation ID (CLASS): 2800937

Case ID (IMPACT): 48832363

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition of the Neglectful Supervision allegation due to a deficient investigation. The Monitors agree with the disposition of Ruled Out for the Medical Neglect allegation.

Summary of key allegations:

Two intakes were reported to SWI with allegations of Medical Neglect and Neglectful Supervision of two children (Child A, age 15 and Child B, age 17) placed in a foster home temporarily. In the first intake, a medical doctor reported that the foster parent cancelled the children's medical appointment because the foster parent had decided to replace the prescriptions of Child A and Child B with an alternative, over-the-counter medication. The reporter stated that the alternative medication could negatively impact Child B, who had a history of substance abuse. The reporter also stated that, when the pediatrician's office attempted to contact the foster parent by telephone, the foster parent yelled and cursed at the receptionist. In the second intake, a DFPS caseworker reported that, after leaving the foster home, Child A and Child B disclosed that they engaged in concerning self-harming behaviors while placed in the home. The reporter stated that both children stated that, while in the foster home, they superficially cut themselves from their wrists to their elbows with a razor and gave themselves nose piercings with a thumbtack. According to the reporter, the cuts were superficial and did not require medical treatment beyond first aid. The reporter stated that the children also disclosed that they had met an "older man" in the neighborhood near the foster home; this individual reportedly purchased alcohol for them with the understanding that the children would provide sexual favors to him in return. Child A and Child B told the reporter that they did not provide sexual favors to this individual. Lastly, Child A and Child B stated that they engaged in sexual contact with two other children while placed in the home. The reporter did not know whether the foster parents were aware of any of these alleged incidents.

Monitors' Review:

RCCI adequately investigated and Ruled Out the allegation related to Medical Neglect, as well as the allegation related to Neglectful Supervision of Child A. The investigator did not sufficiently investigate the allegation of Neglectful Supervision related to Child B. Specifically, the investigator did not determine Child B's required level of supervision in the foster home to evaluate whether the foster parents adhered to her required level of supervision to prevent or mitigate the high-risk behaviors in the allegations. The investigator reviewed Child B's service plan; however, the service plan did not provide information about Child B's required supervision level. The service plan instead referred the reader to an external plan of service completed by the CPA for the information; however, the investigator did not include this external child plan of service in the record, nor did the investigator document the child's supervisory needs purportedly found in that plan. In the absence of the investigator determining Child B's required supervision level, the investigator cannot evaluate whether the foster parents were neglectful in their supervision of Child B while she was placed in the foster home.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the children were still placed in the therapeutic foster home. As of September 1, 2022, Child A was placed at Bluebonnet Haven, an RTC, Child B had aged out of DFPS care and the foster home was open and serving two children.

35. Investigation ID (CLASS): 2828213

Case ID (IMPACT): 48954916

Category of Maltreatment: Physical Abuse; Neglectful Supervision

Monitors' Conclusion: The Neglectful Supervision allegation should have been substantiated with a disposition of Reason to Believe. The Monitors agree with the disposition of Ruled Out for the Physical Abuse allegation.

Summary of key allegations:

A DFPS caseworker reported allegations of Physical Abuse and Neglectful Supervision of a child placed in a foster home. During an unannounced visit to the foster home, the reporter observed that the child (Child A, age 15) had a black eye. The reporter stated that Child A was unable to provide a coherent explanation for the injury; however, it appeared from the child's statement that Child A was involved in a physical altercation with another child in the home approximately one week prior to the date of the intake. The reporter also stated that Child A had not previously experienced similar injuries in the foster home. Lastly, according to the reporter, the foster father stated that Child A was injured while playing sports.

Monitors' Review:

The Monitors disagree with RCCI's finding of Ruled Out for the allegation of Neglectful Supervision by the foster father. The Monitors found that the record contains a preponderance of evidence that the foster father failed to provide adequate supervision to ensure child safety. The Monitors identified the following evidence in support of substantiating the allegations of Neglectful Supervision with a disposition of Reason to Believe:

- During the investigation, the investigator found that the foster father hired another individual (Individual 1) to assist with the care of the foster children in the home, particularly Child A, who required one-to-one supervision 24 hours per day. The investigator identified that Individual 1's background check results were provisional and stipulated that Individual 1 could not be left alone with the foster children in the home. The background check also stated that Individual 1's job duties included, "Cleans and cooks for the foster parent" and did not state that Individual 1 would be charged with caregiving for the foster children. During their interviews, the foster children reported that Individual 1 cared for them when the foster father left the home.

- The investigator documented the following concerns with the condition of the foster home in the record: common area, bedrooms, and restrooms were "unclean," mold in the upstairs bathroom, "trash, clothing and other objects on the floor of the 2nd story," a broken recliner, and roaches in the kitchen.

- Some of the foster children reported that the foster father did not routinely go upstairs to supervise the children, which is in violation of Child A's one-to-one supervision requirement. This is especially concerning since Child A and another child allegedly engaged in a physical altercation upstairs, which may have resulted in Child A's black eye. The foster father has a physical disability which appears to limit his mobility in the foster home.

- The foster home has an extensive investigative history that raises the following concerns related to the foster father: alleged use of inappropriate discipline, alleged use of intimidation and threats of retaliation against foster children for disclosing abuse or neglect, and alleged unapproved individuals living in the foster home.

Based upon the above evidence, the investigative record demonstrates that the allegations of Neglectful Supervision should have been substantiated against the foster father. Due to these investigative findings, the foster home was closed following the investigation. In addition to the concerns with the quality and condition of the foster home, the record raised concerns related to whether the CPA, The Grandberry Foundation, maintained appropriate oversight of the foster home given the issues surfaced in the home during the investigation. The investigator documented that the HHSC Regulatory Service Division was notified of the concerns related to The Grandberry Foundation.

As of September 1, 2022, the CPA, The Grandberry Intervention Foundation, was subject to Heightened Monitoring. In addition, DFPS placed the foster home on its Disallowances List.

Notable Gaps in Investigation Timeframe:

The investigation took over two months to be completed and closed. A 21-day extension was approved on January 18, 2022; however, the investigation did not meet the extension deadline, in violation of Remedial Order 10. The intake was received on December 21, 2021. The investigation was completed on March 7, 2022 and closed on March 7, 2022.

Placement:

At the initiation of the investigation, the child remained at the therapeutic foster home. As of September 1, 2022, the child was placed at Dallas Behavioral Healthcare Hospital and the foster home remained closed.

36. Investigation ID (CLASS): 2864139

Case ID (IMPACT): 49039474

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The allegation should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations:

A therapist reported that a child disclosed Physical Abuse in a foster home. The therapist stated that a child (Child A, age 5) alleged that his foster mother and foster father "whipped" him on the bottom with a belt and "slapped" his twin sister (Child B, age 5) on the face. The reporter stated that neither child had visible injuries, marks, or bruises. Reportedly, the disclosure took place during a therapy session in the foster home while the foster parents were present; therefore, the reporter did not ask the children additional questions. The reporter stated that she did not feel the alleged incidents occurred recently.

Monitors' Review:

The Monitors disagree with RCCI's finding of Ruled Out for the allegation of Physical Abuse by the foster father. The Monitors found that the record contains a preponderance of evidence that the foster father hit a child in his care with a belt in the foster home on at least one occasion. The Monitors identified the following evidence in support of substantiating the allegations of Physical Abuse with a disposition of Reason to Believe:

- When interviewed, Child A maintained his original allegation that his foster father "whooped" him with a belt. Child C (age 5) appeared to corroborate Child A's claim and reported to the investigator that the foster father hit Child A with a belt. At the beginning of her interview, Child C denied that general physical discipline was used in the home. Child B did not report that physical discipline was used in the foster home, however, when asked what she did not like about living in the foster home she reported "spankings."

Finally, Child D (age 8) reported consistently to the investigator that the foster parents did not use physical discipline in the home and that neither he nor his siblings were Physically Abused.

- During a Minimum Standards investigation that occurred six months prior to this investigation, both Child A and Child C disclosed to the investigator that Child A was subject to physical discipline in the foster home by the foster father. It does not appear the investigator considered Child A's and Child C's prior disclosures of inappropriate discipline when Ruling Out the allegation of Physical Abuse in this investigation.

- In addition to the above Minimum Standards investigation, the foster home was subject to three prior Physical Abuse investigations in 2015, 2019 and 2021 as well as to one other Minimum Standards investigation in 2018 for inappropriate discipline. The latter two Physical Abuse investigations (2019 and 2021) involved the same group of children as the investigation under review. The foster home's referral history reveals a pattern of outcries by children suggesting that inappropriate discipline was likely used in the foster home.

Based upon Child A's and Child C's disclosures that the foster father used physical discipline in in the foster home, including hitting with a belt, and the foster home's prior referral history, the investigative record demonstrates that the allegations of Physical Abuse should have been substantiated against the foster father.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation and as of September 1, 2022, the children remained placed in the therapeutic foster home.

37. Investigation ID (CLASS): 2808492

Case ID (IMPACT): 48861441

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: An additional allegation of Neglectful Supervision should have been added to the investigative record. Due to a deficient investigation, a disposition for this allegation could not be rendered. The Monitors agree with the disposition of Ruled Out for the Physical Abuse allegation.

Summary of key allegations:

School personnel reported an allegation of Physical Abuse of two children in a foster home. The

reporter stated that two children (Child A, age 7 and Child B, age 8) disclosed that their foster mother "hit them in the back" sometimes. The children also disclosed that their foster mother was often angry and yelled at them. The reporter stated that the school nurse did not observe any marks or bruises on the children.

Monitors' Review:

The investigator adequately investigated and Ruled Out the allegation related to Physical Abuse. The investigator did not adequately investigate a new allegation of Neglectful Supervision that Child A and Child B reported during the investigation. During their interviews, both Child A and Child B told the investigator that at nighttime, they slept on the floor in their foster mother's room and did not sleep in a bed in a bedroom. When questioned regarding this allegation, the children's caseworker told the investigator that the foster family had recently moved to a new home and the furniture had not yet been delivered; as a result, the children slept on the floor for a few nights. Following this interview with the caseworker, the investigator did not re-interview the children to clarify whether they slept on the floor prior to moving to their new home or only since they had moved to the new home a few days prior. The investigator also did not directly question the foster mother about the children's allegation. Instead, the investigator asked the foster mother whether the children had their own bedroom and their own bed; the foster mother responded affirmatively and noted that each had their own bed, and the children will share a bedroom in the new home. As a result of flawed interviews, the investigator did not gather sufficient evidence to determine a disposition for the new allegation of Neglectful Supervision. The investigator referred the concern that Child A and Child B slept on the floor in the foster home to the HHSC Regulatory Service Division.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the children remained in the foster home. As of September 1, 2022, the children were no longer in DFPS care and the foster home was not serving any foster children.

38. Investigation ID (CLASS): 2820602

Case ID (IMPACT): 48920553

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

An individual reported an allegation of Physical Abuse of three children placed in a foster home. The reporter, who lived in the foster home and is the children's uncle, alleged that the foster parent, his mother, physically punished the three children (Child A, age 13; Child B, age 12 and Child C, age 11) "by popping them with her hand and with a belt." The reporter stated that due to this physical discipline, the children had bruises on their arms and the back of their legs. The reporter also stated that the foster parent treated Child B differently from the other two children and that Child B was afraid of the foster parent as a result. According to the reporter, the foster parent took Child B to a mental health hospital on the day of the intake report. The foster parent is the children's grandmother, and the reporter is the foster parent's adult son.

Monitors' Review:

This investigation is deficient because the investigator did not adequately investigate a new allegation of Physical Abuse that emerged during the investigation. During his interview, Child B made a new outcry that his uncle hit him with a belt in the foster home. The investigator did not add this new allegation and alleged perpetrator to the investigative record. Child B also indicated in his interview that his foster mother coached the children to not disclose abuse or neglect during the investigation. The investigator asked Child C whether anyone told him what to say in his interview, which the child denied. The investigator did not ask Child A the same question in his interview. In the absence of the investigator asking Child A whether he was coached prior to his interview, it is unknown whether the child's statement that physical discipline was only used once in the home was credible. Next, following Child B's outcry during his interview that his uncle hit him, the investigator did not re-interview Child A or Child C to ask more probative questions regarding the uncle's alleged use of physical discipline. In their first interviews, neither Child A nor Child B made an outcry to the investigator that the uncle used physical discipline. During these interviews, the investigator asked the children more general questions about whether "any adult" in the home used physical discipline (such as hitting or spanking), as opposed to specific questioning related to the uncle and his alleged use of physical discipline. Due to these deficiencies, it is unclear whether the uncle used inappropriate physical discipline in the foster home.

Notable Gaps in Investigation Timeframe:

The investigation took over one month to be completed and closed, and there was no approved extension, in violation of Remedial Order 10. The intake was received on November 24, 2021. The investigation was completed on December 25, 2021 and closed on December 31, 2021.

Placement:

At the initiation of the investigation, the children remained in the therapeutic foster home. As of September 1, 2022, the children remained in the home, which became a kinship placement (unlicensed).

CPI Investigations

Investigations in Unlicensed Foster Homes

1. Case ID (IMPACT): 48760881

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A DFPS caseworker reported that two children (ages 5 and 8) were subject to inappropriate discipline in a kinship foster home. The reporter stated that the foster parents hit the children's hands with a belt and, if the children moved their hands when the fosters parents hit them with the belt, the foster parents hit the children's hands twice. According to the reporter, DFPS previously instructed the foster parents not to use this type of discipline. The children have been placed in the foster home since 2020 and the children refer to the foster parents as their parents.

Monitors' Review:

This investigation is deficient due to the investigator's failure to either interview one of the alleged victim children in private or, if not possible, to document her efforts to do so and the reasons the interview was not conducted privately.[5] The audio recording of the investigator's interview with the eight-year-old child captured background noise and conversation among unknown individuals present during the child's interview. The investigator did not document whether she made attempts to interview the child in private nor the reason(s) she conducted the interview in a public space in the foster home. In their interviews with the investigator, the children denied that their foster parents physically disciplined them and, therefore, CPI issued a disposition of Ruled Out. It is unknown whether the eight-year-old child may have felt more comfortable disclosing Physical Abuse to the investigator if interviewed in a private room.

[5] A private interview is also consistent with DFPS policy. DFPS, *Child Protective Services Handbook §2244.4* (Updated October 2019), *available at* https://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_2200.asp#CPS_2244_4.

Notable Gaps in Investigation Timeframe:

The investigation took over one month to be completed and closed, and there was no approved extension. The intake was received on July 30, 2021. The investigation was completed on September 9, 2021 and closed on September 9, 2021.

Placement:

At the initiation of the investigation, the children remained placed in the kinship foster home. As of September 1, 2022, the children were no longer in DFPS care.

Investigations in Facilities

2. Case ID (IMPACT): 48547359

Category of Maltreatment: Neglectful Supervision; Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition of the Physical Abuse allegation due to a deficient investigation. CPI assigned the Physical Abuse allegation a disposition of Unable to Determine. The Monitors agree with the disposition of Unable to Determine for the Neglectful Supervision allegation.

Summary of key allegations:

SWI received four intake reports related to an alleged incident of Neglectful Supervision and Physical Abuse at Forever Families, Inc., an HCS Group Home. In the first intake, a staff member reported that while another staff member (Staff 1) was in the restroom, a child (age 17) started a fire in the group home kitchen. Reportedly, Staff 1 promptly extinguished the fire and was then "attacked" by the child. Following the alleged incident, law enforcement officers arrested the child and placed her in a juvenile detention center. Due to the alleged incident, Forever Families personnel requested the child's discharge from its facility. In the second intake, a staff member at a juvenile detention center reported that the child disclosed that Staff 1 physically abused her. The child alleged that Staff 1 pushed her twice, grabbed her hair, threw her to the ground, and banged her head on the ground three times. The child also reported that Staff 1 punched her. The child told the reporter that she did not start the fire in the kitchen. The child said that Staff 1 blamed her for things she did not do and routinely "pick[ed]" on her. The reporter observed the following injuries on the child: multiple scratches and bumps on her face and a reddened and swollen forehead that continued to increase in swelling. In the third intake, a law enforcement officer reported that the child allegedly started a fire in the kitchen and subsequentially physically attacked Staff 1. When Staff 1 restrained the child, the child allegedly pulled Staff 1's hair and scratched Staff 1's face. The law enforcement officer reported that the child was observed with a bruise on her forehead and a scratch on her face; the officer transported the child to a hospital for assessment and, subsequently, took her to a juvenile detention center due to a decision to arrest her. In the last intake, an individual reported that the child disclosed that Staff 1 banged the child's head on the ground, which resulted in a "knot" on the child's forehead. Another child reportedly observed the alleged incident.

Monitors' Review:

Regarding the Physical Abuse allegation, CPI entered a disposition of Unable to Determine, stating, "Due to conflicting information [between Staff 1 and the child] allegations are being found unable to be determined." First, due to COVID-19 restrictions, the investigator's initial attempt to speak with the child was unsuccessful. The investigator did not make a second attempt to interview the alleged victim child until five months after the investigation began. When the investigator finally interviewed the child, the investigator did not ask the child detailed questions about the alleged incident, nor did he attempt to address the inconsistencies between the child's and Staff 1's descriptions of the alleged incident. The investigator's interview of Staff 1 did not include specific and probing questions about the alleged incident and did not explore how the child sustained injuries to her head. Next, the investigator failed to interview a key witness. In the fourth intake report, the reporter identified a child by name who allegedly observed Staff 1 bang the child's head on the ground. The investigator did not attempt to interview this child witness. Lastly, the record indicates that law enforcement officers responded to the alleged incident and observed and photographed the child's injuries. The investigator did not request any information from law enforcement; this information may have provided the investigator with additional insight into the alleged incident and the child's injuries. Moreover, it could have informed the interviews with the alleged perpetrator in probing how the child obtained said injuries. Due to these deficiencies, it is unclear whether the child was subject to Physical Abuse by Staff 1.

Notable Gaps in Investigation Timeframe:

The investigation took nine months to be completed and closed, and there was no approved extension. The first intake was received on February 16, 2021. The investigation was completed on November 10, 2021 and closed on November 11, 2021.

Placement:

At the initiation of the investigation, the child was removed from the HCS Group Home and placed in a juvenile detention facility. As of September 1, 2022, the child had been on runaway status for six months.

3. Case ID (IMPACT): 45428186

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A probation officer reported an allegation of Physical Abuse at Forever Families, Inc., an HCS Group Home. The reporter stated that a child (age 15) was arrested for assaulting a staff member at the group home and placed in a juvenile detention facility. The child alleged that an unnamed staff member pulled her hair and hit her when she attempted to leave the group home. The reporter

did not know whether the child was injured during the incident.

Monitors' Review:

This investigation is deficient for missing and flawed interviews with key individuals. The investigator was able to identify the unnamed staff member who was the alleged perpetrator but did not attempt to interview the alleged perpetrator until approximately four months after the intake report was made to SWI. By that time, the alleged perpetrator was no longer working at the operation and the investigator was unable to locate and interview this key individual. Next, the child reported to her caseworker that two other staff members were involved in the alleged incident. The investigator did not attempt to interview one of these staff members. The investigator also failed to interview other children at the group home to determine whether they observed the alleged incident. As a result of these missing interviews, the investigator was unable to gather critical information about the alleged incident to evaluate whether the staff member Physically Abused the child. Next, the investigator did not interview the alleged victim until one month after the intake report. When the investigator interviewed the child, she did not disclose any abuse by the alleged perpetrator; it is possible that the investigator's lengthy delay in interviewing the child impacted the information the child reported to the investigator. The investigator interviewed the child again two months after the first interview and the child disclosed an additional allegation of Physical Abuse by an unnamed staff member. The investigator did not ask adequate follow-up questions to probe this new allegation. As a result of these deficiencies, the investigator failed to gather sufficient information to determine whether the child was subject to Physical Abuse at this facility.

Notable Gaps in Investigation Timeframe:

The investigation took four months to be completed and closed, and there was no approved extension. The intake was received on June 9, 2021. The investigation was completed on October 11, 2021 and closed on October 13, 2021.

Placement:

At the initiation of the investigation, the child remained in the HCS Group Home. As of September 1, 2022, the child was placed in another HCS Group Home.

4. Case ID (IMPACT): 48798349

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition of the Neglectful Supervision allegation due to a deficient investigation. Moreover, an additional allegation of Neglectful Supervision should have been added to the investigation record. Due to a deficient investigation, the Monitors also cannot determine the disposition of this allegation.

Summary of key allegations:

A DFPS staff member reported an allegation of Neglectful Supervision of a child (Child A, age 16) placed at Family Choice, an HCS group home. The reporter alleged that Child A ran away from his placement and subsequently started a fire in a nearby wooded area. The reporter stated that Child A was arrested for arson and placed in a juvenile detention facility. According to the reporter, the child had a history of starting fires.

Monitors' Review:

This investigation was deficient because the investigator failed to determine whether staff members appropriately supervised Child A to prevent or to mitigate his ability to run away from the placement and set a fire. First, the investigator did not determine Child A's required level of supervision at the time of the incident. Due to the child's extensive behavioral and mental health needs and history of starting fires, this information was critical to the investigation. Second, the investigator failed to identify and interview the staff member(s) responsible for Child A's supervision at the time of the incident. This failure prevented the investigator from learning additional relevant information regarding Child A's supervision prior to the incident. Third, the investigator failed to interview a supervisor who was allegedly present at the time of the incident and other staff members who may have had knowledge about the incident or supervision of Child A at the placement. Next, during his interview, Child A made an outcry that another child (Child B, age 16) attempted to engage in inappropriate sexual contact with him in the bathroom. Child A told the investigator that he informed a staff member (Staff 1) about the alleged incident after it occurred. During his interview with the investigator, Staff 1, who was no longer employed with the group home, acknowledged that he failed to report the alleged incident to SWI and to Family Choice. Based upon this evidence, the investigator should have added to the investigative record and investigated an allegation of Neglectful Supervision. Lastly, the investigator failed to investigate the following additional new allegations which emerged during the investigation: Child A alleged that an unnamed staff member "grabbed" him, which resulted in a scar on his chest; and a former staff member (Staff 2) alleged that there were lapses in the administration of children's medications, including that some children did not receive their medication as prescribed. In addition to the above investigative deficiencies, the record surfaced concerns regarding whether HHSC maintained adequate oversight of the placement. The investigative record documented the following unsubstantiated concerns: inadequate staffing levels, lack of food variety, minimal training for staff members, unprofessional behavior by staff members, and delays in wage payments to staff members due to insufficient organizational funds.

Notable Gaps in Investigation Timeframe:

The investigation took three months to be completed and closed. A 21-day extension was approved on September 23, 2021. A second 21-day extension was approved on October 22, 2021. A third 21-day extension was approved on November 12, 2021. The intake was received on August 30, 2021. The investigation was completed on December 1, 2021 and closed on December 1, 2021.

Placement:

At the initiation of the investigation, the child was placed in a juvenile detention facility. As of

September 1, 2022, the child was placed in a kinship foster home.

Investigations of Children Under DFPS Supervision (Child Without Placement (CWOP))

5. Case ID (IMPACT): 48771645

Category of Maltreatment: Sexual Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition of the Sexual Abuse allegation due to a deficient investigation. Moreover, an additional allegation of Neglectful Supervision should have been added to the investigative record and substantiated against Staff 1.

Summary of key allegations:

A DFPS caseworker alleged that a DFPS employee (Staff 1), a Human Services Technician charged with supervising children without an authorized placement, inappropriately touched a child (age 17) at a CWOP location, an HHSC office in Copperas Cove. According to the reporter, during Staff 1's shift at the CWOP location, Staff 1 allowed the child to drive her car. In the car, Staff 1 and the child inappropriately touched one another. The child reported that he and Staff 1 were intimately involved and that they exchanged text messages. The child also stated to the reporter that when he met Staff 1's husband, the husband allegedly told him that once he turns 18 years old, the child could be with his wife. At the time of the intake report, Staff 1 was no longer employed with DFPS.

Monitors' Review:

This investigation is deficient due to a missing interview. During the investigation, both Staff 1 and another staff member reported that a security guard was present when the child and Staff 1 were in Staff 1's car in the parking lot of the CWOP location. The investigator did not attempt to identify or interview the security guard, who may have been able to provide pertinent information about the allegation, including his observations regarding the demeanor of Staff 1 and the child when they entered and exited the car. During his multiple interviews, the child refused to discuss the allegation and, during her interview, Staff 1 denied the allegation that she inappropriately touched the child and instead reported that the child attempted to touch her while in the car. In the absence of an interview with the security guard, the investigator did not gather sufficient information to Rule Out the allegation of Sexual Abuse by Staff 1. Next, the investigative record clearly established that Staff 1 allowed the child to drive her car. Based upon this evidence, the investigator should have added an allegation of Neglectful Supervision to the investigative record and entered a disposition of Reason to Believe against Staff 1. After this incident, DFPS immediately terminated Staff 1. Lastly, the investigator established that at the time of the alleged incident, Staff 1 had been employed with DFPS as a Human Services Technician for less than one month.[6] The record indicates that Staff 1 did not have the training or experience to be charged with

[6] According to the DFPS website, Human Services Technicians work to support caseworkers by transporting children, engaging with families, and performing clerical and administrative tasks. DFPS, *What is a Human Services Technician?, available at https://www.dfps.state.tx.us/Jobs/cps/human_services_tech.asp.*

supervising a child with behavioral health needs.

Notable Gaps in Investigation Timeframe:

The investigation took two months to be completed and closed, and there was no approved extension. The intake was received on August 9, 2021. The investigation was completed on October 4, 2021 and closed on October 4, 2021.

Placement:

At the initiation of the investigation, the child remained under DFPS Supervision at this CWOP location. As of September 1, 2022, the child had aged out of DFPS care.

6. Case ID (IMPACT): 48894468

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A DFPS caseworker reported allegations of Neglectful Supervision of two children under DFPS Supervision at a CWOP location, a house in Von Ormy. The reporter stated that a child (Child A, age 14) disclosed that another child (Child B, age 15) entered her bedroom and inappropriately touched her at night on more than one occasion. Child A also reported that Child B threatened her, however, she did not provide any further detail regarding how Child B threatened her. After Child A's outcry, DFPS staff members charged with supervision of the children at the CWOP location reportedly separated the children from one another.

Monitors' Review:

This investigation is deficient due to the investigator's failure to conduct any interviews with DFPS staff members who worked shifts supervising children at this location during the time period that Child A and Child B were living under DFPS Supervision. As a result of this critical deficiency, the investigator was unable to gather or assess any information related to the supervision of Child A and Child B at the time(s) of the alleged sexual contact. Even though the children did not provide the investigator with a consistent timeframe when the alleged incident(s) occurred, nor which staff members were working at the time, the investigator could have reviewed the supervision schedule for this location to identify and interview those staff members who worked a shift during the different timeframes during which the children alleged the incident(s) occurred. The investigator's failure to interview any staff members to identify those responsible for supervising the children was particularly problematic because Child A and Child B provided the investigator with conflicting information about the alleged incident(s) and refused to participate in forensic interviews. In the absence of the investigator attempting to interview all relevant individuals who may have been responsible for the supervision of Child A and Child B at the time of the alleged

incident(s), a disposition on this investigation could not be rendered.

Notable Gaps in Investigation Timeframe:

None.

Placement:

Shortly after the initiation of the investigation, Child A was removed from DFPS Supervision and placed in a kinship foster home and Child B remained under DFPS Supervision. As of September 1, 2022, Child A was placed at HMIH Cedar Crest, an RTC, and Child B was placed under DFPS Supervision.

7. Case ID (IMPACT): 49021477

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A DFPS staff member reported that a child (Child A, age unknown) disclosed that another child (Child B, age 15) engaged in sexual contact with another child (Child C, age 16) while under DFPS Supervision at a CWOP location, SAFE Harbor (shelter) in Austin. Child A also reported that Child B previously engaged in sexual contact with another child at the CWOP location.

Monitors' Review:

This investigation is deficient for flawed and missing interviews. First, the investigator did not adequately question Child C to determine whether Child B and Child C engaged in sexual contact. Specifically, the investigator's questioning focused exclusively on whether Child C engaged in unwanted sexual contact with Child B and did not explore whether the children engaged in consensual sexual contact. For example, the investigator asked Child C, "Nobody has done anything to you inappropriate, things you don't want to happen," to which Child C responded, "Not unwanted." Potentially due to the investigator's flawed questioning, Child C did not report sexual contact with Child B. During the investigation, Child B refused to be interviewed. Next, the investigator did not interview any DFPS staff members who worked a CWOP shift while Child B and Child C were placed together at the location. The children did not provide the investigator with a specific time period when the alleged incident occurred. In the absence of interviews with any DFPS staff members, the investigator did not gather any information regarding staff members' supervision of the children at the CWOP location. Due to these deficiencies, the investigator failed to gather sufficient evidence to Rule Out the allegation of Neglectful Supervision.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the children remained under DFPS Supervision at this CWOP location. As of September 1, 2022, Child B was placed at Camp Worth, an RTC, and Child C was placed in a foster home.

8. Case ID (IMPACT): 48961042

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A DFPS caseworker reported allegations of Neglectful Supervision of two children under DFPS Supervision at a CWOP location, a house in Belton. According to the reporter, two children (Child A, age 15 and Child B, age 16) engaged in sexual contact in their room while a staff member was in the living room. At the time of the alleged incident, reportedly a few days prior to the date of the intake, Child A and Child B were roommates. The reporter stated that staff members conducted room checks every 30 minutes or every hour.

Monitors' Review:

This investigation is deficient due to the investigator's failure to identify and interview those DFPS staff members who worked shifts supervising children under DFPS Supervision at this location when the alleged incident of sexual contact occurred between Child A and Child B. As a result of this deficiency, the investigator failed to gather any information from staff members regarding their supervision of Child A and Child B at the time of the alleged incident. During their interviews, Child B and a collateral child witness reported no concerns regarding supervision at the CWOP location; Child A indicated that "sometimes" supervision at the CWOP location could be stronger. The investigator's decision to Rule Out the allegation of Neglectful Supervision appeared to rest primarily upon a lack of sufficient evidence that Child A and Child B engaged in any sexual contact and not upon a thorough inquiry of whether staff members provided the children with appropriate supervision to prevent or mitigate any sexual contact. Therefore, in an absence of interviews with DFPS staff members who were responsible for the children's supervision at the location, the investigative record is incomplete, and a disposition could not be rendered.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the children were under DFPS Supervision. As of September 1, 2022, Child A was placed at Camp Worth, an RTC, and Child B was placed in a juvenile detention facility.

9. Case ID (IMPACT): 48918410

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A member of the monitoring team reported an allegation of Neglectful Supervision of a child under DFPS Supervision at a CWOP location, Buckner Children's Village in Beaumont. While reviewing incident reports from the CWOP location, the reporter identified an incident which occurred four months prior to the intake date and did not appear to have been reported to SWI. According to the incident report, a child (age 17) drank a cleaning product at the CWOP location and, afterwards, an unnamed staff member found the child slumped over on the floor. An unnamed staff member contacted EMS, who transported the child to the hospital.

Monitors' Review:

This investigation is deficient because the investigator did not adequately investigate whether the staff members who were supervising the child at the time of the incident adhered to the child's required supervision level. According to the child's Preliminary Service Plan for Children Without Placement, the child required "close proximity/line of sight" supervision at the CWOP location. According to record, prior to the incident, the child was in his bedroom alone; he then entered the nearby bathroom and drank the cleaning product. The investigator did not sufficiently identify and interview the staff members charged with supervising the child to determine whether the child was permitted to be in his bedroom alone given his supervision level and, if allowed to be in his bedroom alone, whether staff members routinely checked on the child before he drank the cleaning agent. In the absence of this information, it is unknown whether the staff members appropriately supervised the child to prevent or mitigate the incident. Next, the investigator documented in his findings that the child was permitted access to the cleaning agent at the CWOP location due to his age and lack of any "medical or mental health diagnosis" that would impair his ability to have access to such cleaning chemicals. The investigator did not include any supporting policy in the investigative record to substantiate this claim. As a result of these deficiencies, the investigative record failed to gather sufficient evidence to Rule Out the allegation of Neglectful Supervision. Lastly, the investigation raised additional safety concerns for children under DFPS Supervision at CWOP locations. When the investigator questioned one of the staff members about the failure to report the incident to SWI, the staff member reported that if staff members had to report every incident that occurred "on every shift [at CWOP locations], statewide intake would be blowing up with investigations."

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the child was under DFPS Supervision. As of September 1, 2022, the child had aged out of DFPS care.

10. Case ID (IMPACT): 48926297

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations:

A child's caseworker reported an allegation of Neglectful Supervision of a child under DFPS Supervision at a CWOP location, a hotel in Dallas. The reporter alleged that upon a child's (age 16) return to a CWOP location from a visit home, the DFPS staff members charged with supervising the child allowed the child to return to her room unattended with her travel belongings. The child then retrieved from her travel belongings her medication and ingested a "handful of pills." After the incident, the staff members contacted 911 and EMS transported the child to the hospital for treatment.

Monitors' Review:

The investigator did not adequately investigate whether the staff member was negligent in her care of the child at the time the child ingested numerous pills, primarily over the counter pain medication, in the bedroom of the hotel. The investigator determined that when the child arrived to the CWOP location with her belongings, including prescription and over the counter pain medications, from a visit with her family, the staff member greeted the child and took her photograph and temperature as required. The staff member did not attempt to locate or secure the child's medications from her belongings before leaving the child alone in the bedroom to unpack. As a result, shortly thereafter, the child began ingesting her pills; the two staff members on duty responded quickly to the incident. To assess whether the staff member was negligent in her care of the child, the investigator did not identify whether she was subject to, and trained regarding, any policies or protocols that stipulated that upon a child's arrival to a CWOP location, staff members must identity and secure any medications in the child's possession. In the absence of this information, the investigator could not determine whether the failure to adhere was unreasonable. The staff member reported to the investigator that she was unaware that the child's belongings stored her prescription medications and that the child's caseworker did not provide her with any notification that the child traveled with her medication. The child's CWOP binder, which staff members are expected to review at the beginning of their shifts, enumerated the numerous medications the child was prescribed. The investigator failed to question the staff member

regarding whether she appropriately reviewed the child's lengthy binder prior to her shift to learn this important information about the child. As a result of these critical deficiencies, a disposition on this investigation could not be rendered.

Notable Gaps in Investigation Timeframe:

None.

Placement:

At the initiation of the investigation, the child was placed at Perimeter Behavioral Hospital. As of September 1, 2022, the child was placed in a juvenile detention facility.

Appendix 3 Maltreatment in Care Case Summaries: Overturned Investigations

RCCI Investigations

The following is a summary of the six investigations (of 21 reviewed) subject to DFPS's Administrative Review and Appeals of Investigative Findings (ARIF) process from January 1, 2021 through April 30, 2022 and identified by the Monitors as inappropriately overturned or substantially deficient.

1. Case ID (IMPACT): 48325006

Case ID (CLASS): 2646953

Monitors' Conclusion: The Monitors disagree with RCCI's decision to Rule Out child maltreatment in this investigation. The Monitors agree with RCCI's original determination that a disposition of Reason to Believe was appropriate against the foster parent, but the allegations should have been substantiated for Physical Abuse rather than Neglectful Supervision for Child A and Child B.

Summary of RCCI's Original Findings in Support of RTB: On October 28, 2020, in support of its substantiation for Neglectful Supervision, RCCI concluded there was a preponderance of evidence that a foster mother hit four children in her care with a belt. The investigation listed the following children as confirmed victims: Child A, age 5; Child B, age 7; Child C, age 10; and Child D, age 9.

Monitors' Review:

On March 15, 2021, the alleged perpetrator requested an administrative review of RCCI's disposition of Reason to Believe for Neglectful Supervision. On October 21, 2021, RCCI overturned its initial decision and entered a disposition of Ruled Out in relation to all four children. The Monitors agree with RCCI's decision to overturn the disposition of Reason to Believe in relation to two of the four child victims. As RCCI documented during the administrative review process, the record did not contain a preponderance of evidence that the foster parent hit Child C and Child D. However, the Monitors disagree with RCCI's decision to overturn the disposition of Reason to Believe in relation to Child A and Child B. As discussed below, the record contains a preponderance of evidence that the foster parent Physically Abused Child A and Child B.

On July 9, 2021, RCCI conducted an Administrative Review of Investigation Findings (ARIF) conference by telephone with the foster parent. Below is a summary of the conference:

> The foster parent reported concerns with the investigative process, including that the investigation took four months to complete, that RCCI did not tell her about the "charges," and that despite her requests, the investigator did not explain the investigative process.
>
> In relation to Child A's disclosure of Physical Abuse by the foster parent, the foster parent

> reported that Child A was "her baby" and "if you ask him enough, he will say it" because he is "delayed."
>
> The foster parent stated that the findings were "heartbreaking." She reported that "all of the love, redirection, and repetitive nature of trying to teach is completed [sic] disregarded [by the investigation]." After the investigation closed, the foster parent adopted Child A and Child B.

During the administrative review, the reviewer also examined the original investigative record and documented the statements the children made during their interviews regarding the allegation of Physical Abuse (which DFPS assigned as Neglectful Supervision). Based upon the information examined during the administrative review process, the reviewer overturned the disposition of Reason to Believe. In its Final Disposition supporting the overturn, RCCI concluded, "A preponderance of the evidence was not gathered to substantiate that [the foster parent] neglected [the children]. Although, there are concerns that physical discipline may have been used on children in care, this is a minimum standards violation and consistent and credible information was not gathered to prove that the use of physical discipline was indeed used and that it rose to the level of abuse or neglect."

The Monitors disagree with RCCI's rationale about concerns for physical discipline versus Physical Abuse: Physical Abuse includes "exposing the child to any risk of physical suffering," including, but not limited to, "striking, shoving, shaking, or hitting a child, whether intended as discipline or not."[1] The record includes children's disclosures that the foster mother hit them, including with a belt, and there was a preponderance of evidence to support a disposition of Reason to Believe for Physical Abuse.

RCCI also supported its decision to overturn by observing that some of the children's disclosures to the investigator were inconsistent. As the initial investigation found, some children provided consistent and credible disclosures of Physical Abuse in the foster home. Specifically, the investigative record documented that Child A made a consistent outcry that the foster mother hit him and Child B with a belt. During her interview, Child D corroborated Child A's outcry that the foster mother hit Child A and Child B with a belt. Child C also reported that the foster mother hit Child A. Child B denied the allegation of Physical Abuse by the foster mother. Lastly, the foster mother reported during her interview that she "spanked" Child A on one occasion.

Based upon the above information, the record contains a preponderance of evidence that the foster mother hit Child A, and likely Child B, with a belt and the investigation should have resulted in a disposition of Reason to Believe for Physical Abuse.

The below investigation is a companion to the above discussed investigation. The investigations involved the same sibling group who were placed in two different foster homes. Child and Child were placed in the foster home discussed above Case I : 4 2 Child C and Child were placed in the foster home discussed below Case I : 4 . ecause the four children fre uented both foster homes, CCI assigned all four children as alleged victims in both

[1] 40 TEX. ADMIN. CODE §707.789(b)(2).

investigations. CCI substantiated the allegations of eglectful Supervision in both investigations originall and, subse uentl , overturned the decisions as to both foster homes. CCI documented a similar rationale for these determinations in both investigative records. The Monitors findings in relation to both investigations are similar.

2. Case ID (IMPACT): 48331867

Case ID (CLASS): 2647984

Monitors' Conclusion: The Monitors disagree with RCCI's decision to Rule Out child maltreatment by the foster mother in this investigation. The Monitors agree with RCCI's original determination that a disposition of Reason to Believe was appropriate against the foster mother, but the allegations should have been substantiated for Physical Abuse rather than Neglectful Supervision of Child C and Child D. The Monitors agree with RCCI's decision to Rule Out child maltreatment by the foster father.

Summary of RCCI's Original Findings in Support of RTB: On February 26, 2021, in support of its substantiation, RCCI concluded there was a preponderance of evidence that both of the foster parents Neglectfully Supervised four children in a foster home. RCCI documented that the foster parents breached their duty as caregivers when they used physical discipline in the foster home. The investigation listed the following children as victims: Child A, age 5; Child B, age 7; Child C, age 10; and Child D, age 9.

Monitors' Review:

On March 15, 2021, the alleged perpetrators requested an administrative review of RCCI's disposition of Reason to Believe for Neglectful Supervision and, on October 21, 2021, RCCI overturned its initial decision and entered a disposition of Ruled Out as to both alleged perpetrators. The Monitors agree with RCCI's decision to overturn the disposition of Reason to Believe in relation to two of the four child victims. As RCCI documented during the administrative review process, the record did not contain a preponderance of evidence that the foster parents Physically Abused Child A and Child B. However, the Monitors disagree with RCCI's decision to overturn the disposition of Reason to Believe in relation to the foster mother and Child C and Child D. As discussed below, the record contains a preponderance of evidence that the foster mother Physically Abused Child C and Child D.

On July 9, 2021, RCCI conducted an ARIF conference by telephone with the foster parents. Below is a summary of the conference:

> The foster mother reported that she never hit Child C and Child D. The foster mother reported that she does not believe in physical discipline.
>
> She also reported concerns with Child D's credibility, including that he previously made false allegations. The foster mother believed that Child D did not want his other siblings to be adopted without him and, as a result, he falsely reported allegations of Physical Abuse in the foster home. The foster mother stated that the investigator did not consider Child D's

> mental and behavioral health histories during the investigation or the help she sought for Child D while he was in her home. Lastly, the foster mother reported that Child D never disclosed Physical Abuse to his therapist.
>
> The foster father reported that he and his wife "did the best thing" for Child D and that he did not understand the investigation's findings.

During the administrative review process, the reviewer also examined the original investigative record and summarized the children's interviews. Based upon the information examined during the administrative review process, the reviewer overturned the disposition of Reason to Believe related to the foster parents. In support of its decision to overturn its disposition, RCCI stated:

> "A preponderance of the evidence was not gathered to substantiate that [the foster parent] neglected [the children]. Although, there are concerns that physical discipline may have been used on children in care, this is a minimum standards violation and consistent and credible information was not gathered to prove that the use of physical discipline was indeed used and that it rose to the level of abuse or neglect."[2]

In relation to RCCI's statement that the investigator did not gather "consistent and credible information" that the foster mother used physical discipline in the foster home which rose to the level of Physical Abuse, the Monitors disagree. Some of the children's disclosures that the foster mother hit them, including with a belt, meet the definition of Physical Abuse. While Child D did not consistently report that the foster mother used inappropriate discipline during her multiple interviews, the child made an outcry to the RCCI investigator during one interview that the foster mother spanked her with a stick or a hand. Three other children (Child A, Child B,[3] and Child C) confirmed that the foster mother hit Child D. Child C also disclosed that the foster mother "whooped" him with a tree branch. As such, the record contains a preponderance of evidence that the foster mother hit Child D, and likely Child C, with a belt and/or stick and the investigation supported a disposition of Reason to Believe for Physical Abuse.

3. Case ID (IMPACT): 48684878

Case ID (CLASS): 2751951

Monitors' Conclusion: The Monitors disagree with RCCI's decision to overturn its disposition of Reason to Believe for Physical Abuse by a foster parent.

Summary of RCCI's Original Findings in Support of RTB: On July 7, 2021, in support of its substantiation, RCCI concluded there was a preponderance of evidence that a foster parent Physically Abused a child (age 4) in a foster home. RCCI cited as evidence the findings of a Forensic Assessment Center Network (FACN) assessment, which addressed an unexplained injury

[2] RCCI followed the same reasoning it employed in Case ID: 48323540 described in the prior summary.
[3] During his interview, Child B reported that Child D was hit, however, Child B was unable to report who hit Child D.

on the child's face. The FACN found that the child's injury was "most consistent with being hit with a linear object (such as a hand, belt, cord, etc.). In absence of accidental explanation, these findings are concerning for child physical abuse."

Monitors' Review:

On July 22, 2021, the alleged perpetrator requested an administrative review of RCCI's disposition of Reason to Believe for Physical Abuse and, on December 21, 2021, RCCI overturned its initial decision and entered a disposition of Ruled Out. The Monitors agree with the RCCI Administrative Review finding that the investigative record lacked sufficient evidence to explain how the child sustained the specific injury to his face that was at issue in the FACN report. However, the record contains a preponderance of evidence that the foster parent Physically Abused the child. During his interview, the child disclosed that the foster parent hit him, including on the bottom, with a belt. In support of its decision to overturn its disposition, RCCI stated, "Only after [the child] was directly asked in a leading question, [the child] agreed with the investigator" that the foster mother hit him. The Monitors agree that the investigator asked the child two leading questions and the child responded affirmatively both times. However, during subsequent questioning by the investigator, the child provided additional information about the Physical Abuse in the foster home and the child confirmed multiple times to the investigator that the foster mother hit him. In addition, the child disclosed more than once to school personnel that he was "whooped" on the bottom. Based upon the child's outcries of Physical Abuse, the Monitors disagree with RCCI's decision to overturn the disposition of Reason to Believe for Physical Abuse by the foster parent.

4. Case ID (IMPACT): 48283180

Case ID (CLASS): 2637260

Monitors' Conclusion: The Monitors disagree with RCCI's decision to overturn its disposition of Reason to Believe for Neglectful Supervision by four senior staff members at an RTC.

Summary of RCCI's Original Findings in Support of RTB: On March 22, 2021, in support of its substantiation, RCCI concluded that there was a preponderance of evidence that four senior administrative staff members (the Regional Executive Director, the Associate Executive Director and Administrator, the Clinical Director and the Program Director) Neglectfully Supervised "an entire cohort" of children during an outbreak of COVID-19 at Krause Children's Residential, an RTC that relinquished its license in July 2021. RCCI cited the following evidence that surfaced during the investigation:

> The four administrative staff members failed to follow the RTC's Emergency Preparedness and Disaster Plan after a direct care staff member tested positive for COVID-19 at the RTC. Specifically, the leadership staff did not "provide oversight and guidance to the staff under each of their command" and, as a result, children were not appropriately screened and tested for COVID-19 and isolated from other children, when necessary, to reduce the spread of the contagious disease in a congregate care setting.

> The investigator found that the leadership "allowed children in [their] care to continue to live amongst each other with no precautions in place." According to the investigator, "This oversight and guidance failure by the administration" resulted in a total of 58 residents at the RTC testing positive for COVID-19 between July 7, 2020 and September 2, 2020.
>
> During an investigative staffing, RCCI documented that, "It was noted that other facilities and providers have been impacted by COVID-19, however the extent and magnitude of the outbreak that was seen in this investigation at Krause Children's Residential was not seen at any other operation in the state of Texas."

Monitors' Review:

On April 6, 2021, the alleged perpetrators requested an administrative review of RCCI's disposition of Reason to Believe for Neglectful Supervision. On January 7, 2022, RCCI upheld its original disposition of Reason to Believe. On February 28, 2022, the alleged perpetrators requested a second administrative review of RCCI's disposition of Reason to Believe for Neglectful Supervision.[4] RCCI overturned its decision to substantiate maltreatment and its original ARIF decision to uphold it on the same day, February 28, 2022. Based upon the investigative and administrative records, the Monitors disagree with RCCI's decision during the second review to overturn the disposition of Reason to Believe for Neglectful Supervision by the administrative staff members. The administrative review process did not invalidate the investigative record's original conclusion that four administrative staff members failed to follow the emergency preparedness plan, which they created and agreed to implement, for mitigating COVID-19 cases in a congregate care setting. The record specifically demonstrated that the administrative staff members did not ensure that all children, including some of whom were symptomatic, quarantined while awaiting their COVID-19 test results for multiple days. Because the staff members did not place these children under quarantine, as stipulated by the emergency preparedness plan, there was an increased spread of COVID-19 throughout the facility. Between July and September 2020, 58 children tested positive for COVID-19 at the facility.

During the second administrative review, RCCI gathered the following information which informed its decision to overturn the initial disposition of Reason to Believe against the four administrative staff members. RCCI documented that the administrative staff members' failure to appropriately quarantine all children was due to the challenges presented by the global pandemic. RCCI stated, "It is unreasonable to have expected an operation and administrative team to have a fully functioning facility that is prepared for a widespread global pandemic and the ability to isolate and quarantine all residents." RCCI stated that the facility was constrained by limited physical space. In addition, RCCI reported that the original investigation incorrectly "assume[d]" that the administrative staff members were "solely" at fault for the spread of COVID-19 at the facility and did not appropriately interrogate other explanations for the outbreak of COVID-19, including that front line staff entered and exited the facility daily.

While the challenges presented to the facility during the global pandemic were enormous, the

[4] Neither the Texas Administrative Code nor the RCCI Handbook specify a process by which a designated perpetrator is able to request and receive more than one administrative review of a substantiated finding of abuse, neglect, or exploitation. 40 TEX. ADMIN. CODE §§707.815-831; DFPS, *Child Care Investigations Handbook* § 7000, *available at* https://www.dfps.state.tx.us/handbooks/CCI/Files/CCI_pg_7000.asp.

record demonstrated that the four administrative staff members did not make reasonable efforts to prepare for the inevitability that children and staff members would be exposed to and contract COVID-19. According to the record, the facility developed the emergency preparedness plan in March 2020, three months prior to the outbreak of COVID-19 at the facility. During those three months, the record indicates that the senior administrative members did not begin to create spaces for children to safely quarantine to minimize the spread of COVID-19. As a result, in early July 2020 when the COVID-19 outbreak began at the facility, the administrative staff members did not have a secured location for children to safely quarantine. By mid-July 2020, senior administrative staff members, in consultation with medical personnel, had developed appropriate spaces for children to isolate and quarantine. However, this development was too late; as of July 16, 2020, the investigator found that 45 children had tested positive for COVID-19. In total, between July and September 2020, 58 children tested positive for COVID-19 at the facility. Based upon the administrative and investigative records, there was a preponderance of evidence that the four administrative staff members' failure to fully implement the facility's emergency preparedness plan caused or may have caused substantial emotional and physical injury to the children placed at the facility.

5. Case ID (IMPACT): 48625599

Case ID (CLASS): 2735529

Monitors' Conclusion: The Monitors cannot determine the appropriate disposition due to a deficient investigation and, therefore, agree with the conclusion that the record does not support a disposition of Reason to Believe for Neglectful Supervision by a GRO administrator. Due to a deficient investigation, RCCI did not gather sufficient evidence to determine whether allegations of Neglectful Supervision should have been substantiated against this administrator or others.

Summary of RCCI's Original Findings in Support of RTB: On August 18, 2021, in support of its substantiation, RCCI concluded that there was a preponderance of evidence that an administrator (a program director) at The Children's Shelter, a GRO, Neglectfully Supervised eight children in care at the operation. RCCI cited the following evidence surfaced during the investigation:

> For a few months, direct care staff members struggled to manage ongoing supervision issues at night at the GRO. Due to inadequate supervision at night, children engaged in the following high-risk behaviors: the children ran away from the GRO; children jumped out of their windows and ran around the GRO campus unsupervised; while unsupervised on the campus at night, children engaged in sexual contact with one another; and children damaged property.
>
> The investigator reviewed the administrator's documented job responsibilities and found that the administrator was responsible for ensuring that the facility maintained child-to-staff ratios at the operation. In his interview, the administrator reported that the child-to-staff ratio during overnight hours was one staff member to 24 children. However, if children were awake during the night hours, the administrator stated the ratio "should" be reduced to one staff member to eight children. To meet the reduced ratio, the administrator

reported that the evening shift staff members "should" remain on site at the facility after the evening shift ended at 11:00 p.m. to support the night staff member. He reported that the night staff member would alert them to come on shift as needed.

However, the investigator found that when children were awake at night, the GRO did not meet the reduced ratio of one staff member to eight children. Staff members and supervisors informed the administrator that additional staffing was needed during the nightshift to meet the reduced ratio when children were awake. Due to limited staffing at night, staff members were unable to prevent or respond to groups of children routinely jumping out their windows to engage in other high-risk behaviors.

The investigator found that the administrator's failure to adequately staff the night shift led to the serious harm of a child (age 13) who was the victim of a sexual assault and then physical assault during a one-week period. Both incidents occurred at night, after the children jumped out their windows.

Monitors' Review:

On September 7, 2021, the alleged perpetrator requested an administrative review of RCCI's disposition of Reason to Believe for Neglectful Supervision. RCCI overturned its initial decision on January 27, 2022. Due to investigative deficiencies in the original investigation, the Monitors agree with RCCI's decision to overturn the original finding. The record failed to gather a preponderance of evidence about whether the GRO administrator or others at the facility breached their duty as caregiver(s).

According to the administrative record, when the GRO administrator requested an administrative review, he stated that "he did everything that was in his power to provide safety to the children at [the GRO] and the investigator did not accurately consider all the facts in making a decision." On January 13, 2022, RCCI conducted an ARIF conference by telephone with the GRO administrator. Below is a summary of the conference.

The administrator stated that the investigation incorrectly concluded that he did not respond to the ongoing issues at the facility, including the staffing shortage during the overnight shifts. In response to concerns, the administrator reported that he took the following actions: requested assistance from senior administrators, including on a weekly basis he informed his immediate supervisor that the GRO required additional staffing, as well, as during various management level meetings, phone calls and emails. The administrator also reported that he went to the GRO "day or night" in response to direct care supervisors' requests for assistance, including "many occasions where he stayed [at the GRO] for hours including overnight until the needs of staff and children in care were met."

The administrator reported that the following three positions held the "decision powers" at the facility: Vice President of Residential Services, Chief Operations Officer and the Chief Executive Officer.

The administrator reported that his requests for assistance to the above senior staff members were denied or ignored. The administrator stated that his supervisors informed

> him to "tone down" his need for assistance.
>
> Lastly, the administrator reported that some children were admitted to the facility with a basic level of service; however, these children's behavioral health needs far exceeded the basic level. Due to the children requiring a higher level of care, the facility submitted discharge notices for these children; however, the discharge notices were ignored, and the administrator was informed by his supervisors that "he had no choice but to keep the children."

The reviewer also examined the original investigative record and the operation's investigative and monitoring inspection histories. Based upon the information the reviewer examined during the administrative review process, the reviewer concluded that there was not a preponderance of evidence that the administrator "was neglectful in his duties."

The Monitors' review found that if the original investigator had conducted a more through inquiry into the culpability of the GRO administrator and the other senior leadership, the investigative record may have yielded sufficient evidence to substantiate Neglectful Supervision against one or more senior leadership staff.[5] The Monitors identified the following investigative deficiencies in the original investigation:

> Despite the GRO administrator stating to the investigator that he reported to three senior staff members and that these individuals "had the decision-making powers for the program," the investigator did not explore whether the administrator had the authority to address the staffing shortage.
>
> The investigator should have interviewed the three senior staff members. Through these interviews, the investigator could have gained pertinent information related to the actions or inactions of all four of the individuals and their authority to address the ongoing safety concerns during the night shifts. Based upon the information gathered from these interviews, the investigator could have determined whether it was appropriate to add the other three senior staff members to the investigation as alleged perpetrators and whether there was a preponderance of evidence that these senior staff members' actions, or inactions, constituted Neglectful Supervision.

Due to the above deficiencies, the record failed to sufficiently consider and determine which senior individual or individuals failed to take the necessary actions to remediate the ongoing supervision issues at the Children's Shelter which resulted in serious harm to a child.

[5] During the original investigation, the investigator conducted an expansive investigation into the numerous child safety issues alleged to have occurred at the Children's Shelter. The investigator's inquiry into administrator culpability was deficient; it is possible that the investigator had less training and experience on investigations that included an administrator as an alleged perpetrator.

6. Case ID (IMPACT): 48395180

Case ID (CLASS): 2660970

Monitors' Conclusion: The Monitors cannot determine the appropriate disposition due to a deficient investigation and, therefore, agree with the conclusion that the record does not support a disposition of Reason to Believe for Neglectful Supervision by a staff member. Due to a deficient investigation, RCCI did not gather sufficient evidence to substantiate the staff member for Neglectful Supervision.

Summary of RCCI's Original Findings in Support of RTB: On April 19, 2021, in support of its substantiation, RCCI concluded that there was a preponderance of evidence that a case manager (Staff 1) at Guardian Angels I Residential, an RTC, failed to appropriately supervise a child, which resulted in the child attempting to self-harm. RCCI cited the following evidence from the investigation:

> On the day of the incident, the child informed Staff 1 that she felt like self-harming. After this disclosure, Staff 1 was required to attend to another issue in a separate cottage. The investigator found that prior to Staff 1's departure from the child and cottage, she failed to inform other staff members about the child's disclosure and need for heightened supervision as a result.
>
> After Staff 1 left the cottage, another staff member, who was unaware of the child's disclosure, allowed the child to go to the restroom and shower unmonitored. While in the restroom, the child attempted to self-harm. The child was reportedly uninjured.

Monitors' Review: On March 4, 2021, the alleged perpetrator (Staff 1) requested an administrative review of RCCI's disposition of Reason to Believe for Neglectful Supervision. RCCI overturned its initial decision on October 22, 2021. On June 15, 2021, RCCI conducted an ARIF conference by telephone with Staff 1. During the conference, Staff 1 reported that Staff 1 took appropriate action after the child disclosed the desire to self-harm; specifically, that Staff 1 instructed a named staff member (Staff 2) to stay seated with the child until Staff 1 had returned to the cottage and secured the child a hospital bed. Based on the information presented during the conference, in its Final Disposition, RCCI documented that the investigator failed to gather sufficient evidence to render a disposition of Reason to Believe against Staff 1. The Monitors agree that the following investigative deficiencies negate the disposition of Reason to Believe:

> The investigator's interview of Staff 1 was brief (approximately ten minutes) and lacked detailed questioning to identify and assess whether Staff 1 responded appropriately to the child's outcry to prevent or mitigate the child's attempt at self-harm. Specifically, the investigator did not ask Staff 1 whether she notified the other on-duty staff members that the child had expressed the desire to self-harm prior to when Staff 1 left the cottage to attend to another issue. During her interview, Staff 1 stated that she took the child's disclosure "seriously" and, as a result, told the child to "sit by the staff while [Staff 1] had to go handle something next door and [Staff 1] was getting her into the hospital as quickly as [Staff 1] could." The investigator did not ask Staff 1 any follow-up questions related to this statement, including which staff member Staff 1 instructed the child to sit beside and

whether Staff 1 informed this staff member about the child's disclosure. During her interview, the child confirmed that Staff 1 instructed her to stay seated at the table until Staff 1 returned.

During his interviews with the other two on-duty staff members (Staff 2 and Staff 3), the investigator's questioning also failed to explore whether Staff 1 had notified either of them of the child's disclosure prior to leaving the cottage and whether they had any knowledge about which staff member Staff 1 allegedly instructed the child to stay seated beside until Staff 1 returned. A third staff member was reportedly on duty at the time of the child's attempted self-harm; however, this individual did not respond to the investigator's multiple requests for an interview.

Based upon the above investigative deficiencies, there is insufficient evidence to determine whether Staff 1 failed to appropriately supervise the child, which resulted in the child attempting to self-harm in the bathroom. If the investigator had attempted to address the above deficiencies during the investigation, the investigative record may have yielded sufficient evidence to either substantiate Neglectful Supervision against Staff 1 or another staff member.