Appendix 3.2 Maltreatment in Care Case Summaries

RCCI Investigations

1. Investigation ID (CLASS): 2559363

Case ID (IMPACT): 47868118

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The allegations should have been substantiated with a disposition of Reason to Believe. An additional allegation should have been substantiated as related to the administration staff.

Summary of key allegations and investigative findings: Three reports were made by a staff member from the facility and a direct care staff member, alleging the following: that while on an outing to a water park, a child in care grabbed another child in care's buttocks, followed the other child around, and at one point got very close to touching the other child's private parts due to a lack of supervision by the staff members; the same alleged youth inappropriately touched another child on the grounds of the facility and allegedly, these two children engaged in separate incidents of sexually related behavior on the grounds due to a lack a supervision. The youth who is alleged to have inappropriately touched the other two children has a history of "child sexual aggression." However, the investigation found that the child's service plan did not document his status as sexually aggressive nor were staff aware of the child's risk for sexually related behaviors. Despite this child's known history, the administration from the facility rationalized the incident saying, "it should be ok for normalcy reasons for residents to go around [redacted] without an assigned staff," and the administration admitted that it was not in their policy that staff had to be assigned to a group of children on outings. The administration admitted that some staff stay with their assigned groups of children on outings, but not all. The staff placed the unsupervised children at risk of harm by not being in sight when the incident occurred. The RCCI investigator failed to question the children involved in the investigation about which staff were responsible for supervising them at the water park; additional interviews with the other children would have better informed the investigation.

Monitors' reasons for disagreement with RO: The allegations of neglectful supervision should have been substantiated as Reason to Believe against both the administration staff and direct care staff at the facility. As related to administration staff, there was sufficient evidence to support a substantiation of neglect (40 TAC §745.8559) due to inadequate policies and protocols on supervision requirements of children during outings and when on the outside grounds of the facility. As related to direct care staff, the allegations also supported a substantiation of Reason to Believe for neglect (40 TAC §745.8559) as staff admitted they were not present during the incident at the water park, which resulted in a child being inappropriately touched by another child.

Notable Gaps in Investigation Timeframe: None.

2. Investigation ID (CLASS): 2549432

Case ID (IMPACT): 47819928

Category of Maltreatment: Physical Abuse, Sexual Abuse

Monitors' Conclusion: The Physical Abuse allegation should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations and investigative findings: The reporter, a staff person at the camp the alleged victim attended, alleged that a child in care was physically abused by his foster mother for misbehaving and being suspended from camp for misbehaving. It was reported the foster mother hit the child, pushed him onto the ground, and the child had a swollen lip and dried blood near his gums as a result of the incident. The alleged victim confirmed in an interview that he suffered the injury because his foster mother pushed him, and he fell. The investigator showed a picture of the alleged victim to the younger sibling of the alleged victim who had limited verbal ability. The alleged victim's younger sibling was able to identify the alleged victim. The alleged victim's younger sibling was then shown a picture of the alleged victim's lip injury and the younger sibling said, "Mama hit [the alleged victim]" and then he fell to the floor, ostensibly acting out the incident. The foster mother denied all allegations. She spoke negatively about the alleged victim to the DFPS caseworkers, describing him as the worst child she has ever served, and she sold the alleged victim's clothing after he left the home. RCCI never contacted the child victim's therapist about the allegations.

Monitors' reasons for disagreement with RO: These allegation of Physical Abuse (40 TAC §745.8557(1)) should have been substantiated as there was sufficient evidence to support the allegations due to the hitting and pushing of the child victim by the foster mother, which resulted in injuries sustained by the child. The child victim confirmed the pushing and hitting in the interview, and the victim's younger sibling provided corroboration.

Notable Gaps in Investigation Timeframe: None.

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3. Investigation ID (CLASS): 2538863

Case ID (IMPACT): 47762028

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The allegation should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations and investigative findings: A child suffered a sprained elbow due to a restraint administered by a direct care staff person at a facility, which was reported both by the child's teacher and by an operation staff person. The child reported his arm was bent so far up his back that he heard it pop. The first medical diagnosis was an elbow fracture, but then a specialist subsequently diagnosed the child with an elbow sprain. As a result of the discrepancy in diagnoses, the case was submitted to the State's Forensics Child Abuse Team, where the consultant doctor

offered the opinion that the fact that the child suffered a sprained elbow during a restraint indicated that the restraint involved a "fair degree of force." There were no corroborating witnesses and the restraint was conducted without an observer. The allegations were Ruled Out because, although RCCI was concerned that the direct staff used unnecessary force to maintain a restraint and placed the child at risk of injury, the State found there was insufficient evidence to conclude "intentional harm." The staff person who conducted the restraint was forbidden from restraining residents while the investigation was open, put on administrative leave and then terminated at the conclusion of the investigation. The staff person who conducted the restraint remains employed at other facilities in the area. The facility had several investigations regarding improper child restraints within the prior two years. (*See* footnote 151 documenting numerous allegations against staff person B).

Monitors' reasons for disagreement with RO: The allegation of Physical Abuse (40 TAC §745.8557(1)) should have been substantiated against the operation staff who conducted the restraint. There is substantial evidence to render a Reason to Believe disposition, including the doctor from the Forensic Child Abuse Team finding a "fair degree of force" was used to cause the injury; and the child victim sustaining a serious injury as a result of excessive force used during the restraint.

Notable Gaps in Investigation Timeframe: The investigation exceeded thirty days without explanation or approved extension; the investigation took four months to complete. The intake was received on May 13, 2019 and the investigation was completed on September 10, 2019 and; investigation closed on September 25, 2019.

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4. Investigation ID (CLASS): 2534131

Case ID (IMPACT): 47736832

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The allegations should have been substantiated with a disposition of Reason to Believe as related to an additional perpetrator, administration staff.

Summary of key allegations and investigative findings: It was reported by a "House Supervisor" at the GRO facility that a thirteen-year-old boy with a history of inappropriate sexually related behavior had inappropriate sexual contact with his eighteen-year-old male roommate, who has significant intellectual disabilities, and his level of functioning is "minimal," including delayed language skills and an age equivalency "very indicative of a four year old." It was also noted that the older youth has aggressive, and at times violent, behavior that has resulted in injuries to himself and others. The inappropriate sexual contact was discovered when a staff person who was conducting rounds at night discovered and observed the thirteen-year-old on top of the eighteen-year-old in a bed in their shared room. The Monitors found that the thirteen-year-old's Level of Care was identified as "Intense" in his Common Application due to high-risk behaviors; he had been discovered engaging in sexual activity with peers in the past at a different facility; and he had been a victim of sexual abuse in the past. Minimum standards permit a child in care to share a room with an adult in care if there are fewer than two-years in age between the child and the adult.

In this instance, there was a five-year age difference between the child and adult, well above the two-year difference permitted. Neither the thirteen-year-old child victim's DFPS worker nor his therapist was interviewed in the investigation.

Monitors' reasons for disagreement with RO: The allegation of neglectful supervision should have been substantiated as there was sufficient evidence to support the allegations of neglectful supervision. The facts demonstrate that a clear violation of minimum standards occurred when the administrators assigned the thirteen and eighteen-year-old youth as roommates, despite the five-year age difference. Therefore, the allegations supported a finding of neglect under Texas Administrative Code §745.8559(8) for the operation's failure to adhere to regulatory minimum standards requirements for placement of a child and adult as roommates, including age requirements and an assessment of prescribed risk factors, thereby causing substantial emotional harm.

Notable Gaps in Investigation Timeframe: Investigation was not completed timely; no extension was approved, and no explanation for the delay was documented; the investigation took over four months to complete. The intake was received on April 25, 2019 and the investigation was completed on August 23, 2019 and closed on August 30, 2019.

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5. Investigation ID (CLASS): 2470766

Case ID (IMPACT): 47382418

Category of Maltreatment: Medical Neglect, Neglectful Supervision

Monitors' Conclusion: The Medical Neglect allegation should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations and investigative findings: Nursing staff for a ten-year-old non-verbal, medically fragile child in care who requires a tracheostomy tube and ventilator reported that when nurses arrived for the daytime shift, they found the child "heaving and having respiratory retractions" due to the foster parents setting the child's heart rate monitor too low and not putting distilled water in the child's ventilator for twelve hours. The nurse referent stated that one of the foster parents told her that the heart rate monitor kept going off and waking them up at night, which is why they set it so low. The nurse also reported there were times when the child did not have necessary medication, including over-the-counter medications. There were concerns that the foster parents claimed they only received partial medical supplies when, according to the nurse, they had received all medical supplies. Subsequent reports to SWI indicated two nurses quit and the nursing agency discharged the child victim from care because they were concerned that the foster parents' actions created liability. There was a total of three calls and one e-report made to SWI within a few days regarding the same or similar allegations made by two visiting nurses and a DFPS employee, but RCCI only interviewed one of the reporters, despite attempts to reach the others. Other medical staff for the child and the child's CPS caseworker also were not interviewed.

Monitors' reasons for disagreement with RO: This allegation of Medical Neglect should have been substantiated against the foster mother as there was sufficient evidence to support the allegations of medical neglect under failure to obtain medical care (40 TAC §745.8559(5)) due to the evidence contained in three separate nurses' accounts outlining foster mother's failure to follow through with medical care for the child that causes or may cause substantial physical injury to the child.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely and no extensions were approved; and the investigation was later rejected. The investigation took over one year to be completed and approved. The intake was received on August 6, 2018 and the investigation was completed on June 24, 2019 and; and investigation was closed on September 18, 2019.).

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6. Investigation ID (CLASS): 2538342

Case ID (IMPACT): 47759460

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The allegations for Neglectful Supervision were appropriately Ruled Out; however, additional allegations should have been substantiated with a disposition of Reason to Believe for Medical Neglect.

Summary of key allegations and investigative findings: A report was made by the nurse practitioner who treated the alleged victim, disclosing that a thirteen-year-old child attempted to hang himself with his karate belt in his room at his foster home. The foster mother found the child when he fell to the floor. The investigation found that instead of calling 911, the foster mother called the CPA administrator who drove to the foster home. The CPA administrator also failed to call 911 upon arrival at the foster home. Instead, the foster mother and the CPA administrator drove the child to a mental health hospital. The mental health hospital then sent the child to a medical hospital for needed medical treatment. The foster mother and the CPA administrator failed to seek immediate, appropriate emergency medical attention for the child when he was found attempting to hang himself in his room at the foster home. Neither the foster mother nor the CPA administrator called the incident into SWI: the medical hospital staff did. This foster mother has been associated with four different CPAs since 2011 and has had allegations of Neglectful Supervision and Failure to Respond adequately to a child's mental health needs in the past. One CPA closed her home as a result. The alleged victim was not interviewed until almost two months after the intake was received. Although the investigator interviewed the other children in the home, he did not gather information regarding the incident. Neither the reporter nor the alleged victim's therapist were interviewed.

Monitors' reasons for RTB of additional allegations: Additional allegations of Medical Neglect should have been substantiated as RTB against both the foster mother and the CPA administrator as there was sufficient evidence to support Failure to Obtain Medical Care (40 TAC §745.8559(5)) due to evidence that both failed to seek appropriate, emergency medical care for the child.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely and no extensions were approved. The investigation took nearly three months to complete. The intake was received on May 10, 2019 and the investigation was completed on August 8, 2019 and closed on August 19, 2019.

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7. Investigation ID (CLASS): 2542647

Case ID (IMPACT): 47784259

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The allegations should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations and investigative findings: It was reported by a law enforcement officer that due to neglectful supervision by the foster mother, three teenage girls took sexually explicit photos and videos of each other and posted them on social media causing substantial emotional harm; the female alleged victims also exposed a six-year-old boy in the same foster home to pornographic content on the mobile devices. A safety plan had recently been implemented with this foster parent relating to the alleged teenage victims, addressing the same allegations of supervision issues with the use of electronic devices and social media. The foster mother continued to allow the three female alleged victims to have unfettered access to electronic devices and social media, despite the safety plan. The investigation found that the foster mother admitted to buying and paying for the cell phones for the alleged teenage victims, admitted she did not know much about social media, and admitted she was unaware of how to properly monitor the alleged teenage victims' cell phone usage. The foster mother was not truthful with the investigation, withheld information, and impeded the investigation.

Monitors' reasons for disagreement with RO: The allegations for neglectful supervision against the foster mother should have been substantiated because there was sufficient evidence to support the allegations due to the foster mother admitting the three alleged teenage victims continued to have unsupervised access to cell phones despite the safety plan. The six-year-old alleged male victim should have been found as the fourth victim in the substantiation of the Neglectful Supervision allegation against the foster mother due to the evidence that he had access to pornography and other adult material. The facts support a substantiation of the following neglect provisions against the foster mother: Repeated failure to comply with service plan (40 TAC §745.8559(11)); Unreasonable failure to act 40 TAC §745.8559(1).

Notable Gaps in Investigation Timeframe: The investigation was not completed timely and no extensions were approved. It took more than two months to complete the investigation. The intake was received on May 29, 2019 and the investigation was completed on August 8, 2019 and closed on August 2, 2019.

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8. Investigation ID (CLASS): 2547860

Case ID (IMPACT): 47814338

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: The foster mother reported two children in care, ages seven and ten, were inadequately supervised, which resulted in inappropriate sexually related behavior. Two days prior to the reported incident, the ten-year-old alleged victim was playing roughly with the seven-year-old victim and was put on a "two steps" rule, meaning he had to be two steps away from his foster mother at all times. The two alleged victims shared a room, but no plan was made for nighttime supervision of the alleged victims. The foster mother reported that the alleged victims' prior foster parents downplayed the children's issues and did not report incidents between the alleged victims to the CPA but told the current foster mother of the concerns. Foster mother reported there may have been an incident in the previous foster home where the ten-year-old attempted to smother the seven-year-old with a pillow and subsequently was admitted to a psychiatric hospital, and was not permitted to return to the prior foster home. The investigator did not seek information regarding the prior incidents the foster mother reported between the alleged victims and did not follow up on the alleged smothering incident between the children.

Monitors' Review: There are many gaps in the investigation. There is missing documentation, including the service plan for the youngest victim. The investigation summarizes the service plan in one sentence stating the ten-year-old was on "close supervision," but does not indicate the reason the alleged victim was on close supervision. The service plan summary is only for the ten-year-old alleged victim; the seven-year-old alleged victim is not mentioned. It was mentioned that a psychological evaluation was completed on the ten-year-old alleged victim two weeks prior to the reported incident, but there is no record of the psychological evaluation in the records. Key witnesses were never interviewed: neither the CPS worker nor the therapist were ever interviewed, although the investigator attempted to contact the therapist twice in a month. More information is needed about what the foster mother and the agency knew about the ten-year-old's aggressive behaviors prior to placement; why the alleged victims were permitted to room together given the ten-year-old was on "close supervision;" and why the alleged victims were permitted to room together given an incident had occurred between the child victims two days prior to the reported incident.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely. No extension was approved, and no explanation given. The investigation took nearly two months to complete. The intake was received on June 24, 2019 and the investigation was completed on August 19, 2019 and closed on August 26, 2019.

9. Investigation ID (CLASS): 2560063

Case ID (IMPACT): 47872076

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: Two reports were made, one by supervisory staff at the operation and one by a law enforcement officer, that a child in care was inappropriately restrained by a staff member and sustained injuries: a black eye, a laceration across her nose, small scratches on both arms, and a bruise on her arm. There was a prior physical abuse allegation involving the same alleged perpetrator where a child sustained minor abrasions while trying to get free from a restraint.

Monitors' Review: The RCCI investigator did not obtain information from the first reporter, a supervisory staff person, about whether the restraint was necessary based on the child's behavior or whether the restraint was done appropriately. RCCI did not interview the doctor who examined the alleged victim at the hospital nor the responding police officer.

Notable Gaps in Investigation Timeframe: None.

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10. Investigation ID (CLASS): 2550241

Case ID (IMPACT): 47823414

Category of Maltreatment: Neglectful Supervision; Sexual Abuse

Monitors' Conclusion: The allegations should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations and investigative findings: It was reported by one of the children's therapists that three years prior to the report, three girls allegedly engaged in sexual touching with each other at the foster home due to lack of supervision; this allegation was Ruled Out due to lack of evidence. A new allegation of sex abuse arose alleging that children in care were being touched inappropriately by an adult at the foster home. Six children who were placed in the home at different times made similar allegations; namely, that a man came into the room with a covering on his head and touched them inappropriately. The allegations came to light through various sources including interviews directly with the alleged victims, the alleged victims' therapists, and the alleged victims' DFPS caseworkers. The RCCI investigation found that many young children with a history of abuse and trauma, identified to have a specialized level of need, were often placed at this foster home. Many of the same children were prescribed psychotropic medication. The children's allegations were attributed to their medication, histories of mental health issues, trauma and hospitalizations. The children were often told they were "hallucinating." The investigation documented that children who had no contact with each other and who were placed in the foster home at different times that did not overlap reported the same "hallucination." Two separate DFPS

caseworkers removed two alleged victims who were placed in the foster home because of these concerns, but there was not documentation that the RCCI investigator ever spoke to either of the workers. All the children were removed from the home approximately two weeks into the RCCI investigation; however, approximately four months later in November, 2019, two brothers who are both age eight years old (at ten months apart) were placed in the home. Both siblings are identified as autistic with limited verbal abilities, and muscular dystrophy. The children's records note that the older sibling has the ability to give short answers in conversation but that the younger sibling is not able to engage in conversation. In March 2020, DFPS placed a nineteen-year old and her six-month-old child in this home, as well. The RCCI investigator inappropriately Ruled Out the allegations and documented, "HHSC will however be made aware of concerns involving a reoccurring pattern mentioned by children of hearing voices and seeing things while in the [family's] foster home. HHSC will also be made aware of concerns with the [foster family's] sons and the respite care provided." The monitoring team did not find documentation of any evidence of subsequent monitoring.

Monitors' reasons for disagreement with RO: The facts support substantiating against the foster parent for the following abuse or neglect provisions: Failure to Prevent Abuse (40 TAC §745.8557(2)); Sexual conduct (40 TAC §745.8557(7)); Other abuse (40 TAC §745.8557) due to the substantially similar allegations made by at least six children in care and the corroboration of their stories to various authority figures, including DFPS caseworkers and therapists.

Notable Gaps in Investigation Timeframe: None.

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11. Investigation ID (CLASS): 2546094

Case ID (IMPACT): 47803192

Category of Maltreatment: Neglectful supervision; Physical Abuse

Monitors' Conclusion: The allegations should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations and investigative findings: An anonymous reporter alleged that a six-year-old alleged victim sustained a burn mark on his arm from a metal object rolling into him when his foster parents transported him in the bed of a pickup truck; a second report was made by a law enforcement officer that the child was inappropriately disciplined and sustained injuries to his hands when the foster parents required the child to clean his own pants outside during heavy rain and wind after soiling his pants. Due to the alleged victim's young age and behavioral issues, the alleged victim gave conflicting reports about being placed in the trunk of a car by the foster parents and the investigator did not appear to seek resolution of these facts.

Monitors' reasons for disagreement with RO/UTD: The allegations for neglectful supervision for Other Abuse (40 TAC §745.8557); Unsafe Situation (40 TAC §745.8559(3)); and Violation of Minimum Standards (40 TAC §745.8559(8)) should have been substantiated against the foster parents because there was sufficient evidence to support a finding due to the neglectful action of

transporting the child unrestrained in the back of a pickup truck and the child sustaining injury; the foster parents admitting to transporting the alleged victim in the bed of a truck; and the alleged victim sustaining injury of abrasions and scabbing to his fingers after being forced to wash his soiled clothes by hand as cruel and unusual punishment.

DFPS submitted this case to the Monitors as a Closed Investigations with a disposition of Ruled Out which was also the status of the investigation at the time of the Monitors' review; subsequently, on May 29, 2020, nearly one year after intake in June 2019, DFPS changed the disposition to Unable to Determine. The investigation was completed on August 21, 2019 and on August 29, 2019, CLASS documents a contact by an RCCL Supervisor that states "several concerns are being reviewed regarding the investigation findings that should be Reason to Believe." On September 17, 2019, CLASS documents an email received from the Director of HHSC which stated the agency continued to be in disagreement with the DFPS decision to rule out the allegations.

Notable Gaps in Investigation Timeframe: See above.

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12. Investigation ID (CLASS): 2454636

Case ID (IMPACT): 47065299

Category of Maltreatment: Neglectful Supervision; Sexual Abuse

Monitors' Conclusion: The reviewer cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: The operation's case manager reported that two alleged victims were subjected to inappropriate behaviors by the foster parents; the first alleged victim, a fifteen-year-old girl, stated to the reporter that a six-year-old girl in the same foster home was subjected to corporal punishment by the foster mother with a wooden spoon or backscratcher; the fifteen-year-old alleged victim also reported that the foster father's birth daughter does not visit the home due to being sexually abused by the foster father. The operation previously closed this foster home in 2011 after allegations of maltreatment were confirmed. The foster mother was cited for harsh and unusual punishment of a two-year-old child by grabbing him by the wrist and forcefully placing him in a chair. The operation was concerned about the foster mother's rigid approach and treatment of children as well as her ability to follow Minimum Standards and the operation's policies and procedures.

Monitors' Review: The investigation was not thorough or timely. Interviews conducted, especially with the alleged child victims, did not adequately address the allegations. The report of physical abuse of the younger alleged victim should have been explored thoroughly considering the older alleged victim reported witnessing the younger alleged victim subject to physical discipline with an object. A respite home provider and the CPA case manager stated that the younger alleged victim made outcries that the foster mother hit her with a belt. RCCI did not interview key

collateral parties, specifically the children's CASA volunteers, therapists, and school personnel. The CPA decided to close the home again due to this report combined with the foster parent's prior history with the CPA and to conduct its own investigation.

Notable Gaps in Investigation Timeframe: The intake was received on June 6, 2018 and assigned to an investigator within proper timeframes, but the alleged victims were not interviewed until almost one month after intake on July 2, 2018. There were no extensions approved. The investigation was reassigned to another investigator almost one year later with gaps in investigative activity. The investigation was submitted for supervisor approval on August 2, 2019 but was rejected due to additional principal and collateral interviews needed. The investigation was completed on July 15, 2019; and the investigation was closed on September 4, 2019.

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13. Investigation ID (CLASS): 2438939

Case ID (IMPACT): 46758388

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: The Ombudsman's office reported that a facility staff member did not provide adequate supervision and as a result, child-on-child sexual aggression occurred among four youth; additionally, two staff persons allegedly coached the alleged victims not to make outcries of abuse. The first alleged victim stated another child attempted to rape him, that he told staff, and staff did nothing after being notified. The second alleged victim stated he was raped by two other youth. One of the alleged aggressor's plan of service noted he had poor boundaries and was at risk of acting out sexually. Another alleged aggressor had two juvenile referrals for indecency with child-sexual contact and a history of sexually related behaviors, but his treatment plan did not indicate high-risk behavior.

The two alleged victims who made outcries were forensically interviewed. During the first alleged victim's interview, he stated another child tried to touch him, denied any other incidents of inappropriate touching, and reported a staff person asked him not to tell and took him to Sonic. The second alleged victim denied any sexual contact and made false statements during the interview (for example, he stated that he had a child but he did not). The third youth made no outcries of abuse and denied the allegations. The fourth youth (one of the alleged aggressors) refused to be interviewed. Both staff persons identified as alleged perpetrators denied that they witnessed residents engaging in sexualized behaviors and denied coaching the residents against making abuse outcries. Administrative staff at the facility denied any issues with the alleged staff perpetrators. The operation administrators minimized the incidents, which were reported and attributed by them to "boy play." Three collateral residents were interviewed: two residents stated they witnessed other residents being sexually inappropriate with each other, but the third resident made no outcries. A former staff member interviewed disclosed that one of the administrative staff changed incident reports to minimize concerns of residents acting out sexually and residents were

taken on outings to encourage them not to disclose information during investigations. A law enforcement officer expressed concern because he received many reports of sexual assaults at the facility. In the two years prior to this report, there were five neglectful supervision allegations reported at the same facility; one of the allegations was neglectful supervision by the same staff identified in this report and related to child-on-child sexual activity, which was Ruled Out.

Monitors' Review: While initial interviews resulted in denials, interviews with some of the alleged victims were delayed by almost one year after SWI received the intake. By the time the additional interviews were attempted, one victim turned eighteen-years-old, was no longer in care and refused to be interviewed. The risk assessment was not completed until May 2018, over one year after the alleged incident and at that point, most of the alleged victims had left the facility. Because of the delay between the initiation of the investigation, follow-up, and completion of the investigation, it is difficult to determine if other collateral sources could have been identified. Many of the parties eventually interviewed did not have recall of the details of the events and the investigator could not reconcile the conflicting information that was eventually obtained.

Notable Gaps in Investigation Timeframe: The investigation was initiated by RCCI in April 2018 (the intake was received on April 16, 2018) and forensic interviews were conducted for two of the alleged victims. One extension was approved on May 15, 2018; then, no further investigative activity occurred for nine months until February 19, 2019 and a result, the integrity of the investigation was compromised. The investigation was completed on July 18, 2019 and closed on October 21, 2019.

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14. Investigation ID (CLASS): 2483618

Case ID (IMPACT): 47453373

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: The administrator of a GRO reported children were not supervised appropriately, resulting in a fifteen-year-old alleged victim attempting suicide by cutting herself while in the shower; sustaining serious injuries to her leg and wrist, requiring fifty stitches. The Monitors learned that the child had been at the facility for only six days prior to the reported incident and her Level of Care was "Intense." The fifteen-year-old alleged victim reported she drank "Lysol" or "Fabuloso" the day before the reported attempted suicide, but it was not clarified in the investigation if this occurred while the alleged victim was doing chores under staff supervision or if the residents had access to cleaning solution. The investigator did not discern if the cleaning supplies were properly stored and locked. Other residents reported that staff members stay in the office, looking at their cell phones rather than supervising the residents; this allegation was not resolved in the investigation. One resident reported witnessing a child-on-child sexual assault and stated "staff didn't do anything to protect [the alleged victim], they just moved her to a different room." The investigator did not follow up

on this allegation. There were a number of allegations regarding a lack of supervision at this operation in the two years prior to this reported incident. The operation was cited for inadequate supervision during overnight hours in September 2017; and there was an allegation, which resulted in a Reason to Believe disposition for Neglectful Supervision in August 2017 when a staff member left children unattended while she took another resident off-campus for an unauthorized visit.

Monitors' Review: An on-duty staff member who reported the incident was not interviewed; parties who were interviewed did not recall details of the reported incident. Other issues raised by residents were not fully explored to determine if neglect was evident.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely. No extension was approved, and there was an eight-month delay in investigative work. It took about ten months to complete the investigation. The intake was received on September 27, 2018 and the alleged victim was observed or interviewed on September 28, 2018. The investigation was completed on June 14, 2019 and closed on August 19, 2019.

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15. Investigation ID (CLASS): 2525060

Case ID (IMPACT): 47681168

Category of Maltreatment: Sexual Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: The reporter, an operation staff member, alleged there was inappropriate contact between three female residents and a female staff member. The investigation found that a staff person exercised questionable judgment by allowing residents access to her personal cell phone, possibly changed her clothing in view of the residents, and participated in a provocative dance with the residents.

Monitors' Review: Key interviews were missed with the therapist, CPS workers, final law enforcement officers, and the reporter. A fourth intake was received on May 10, 2019 and linked to this case, but the allegations were not adequately addressed. Further interviews with victims were warranted before the disposition could be sufficiently rendered. The risk assessment was not completed until four months after SWI received the intake. The investigation was closed before the RCCI investigator received the law enforcement report and a forensic interview of an alleged victim.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely. The first intake was received on March 21, 2019 and assigned to a special investigator, but the investigation was incomplete with a number of deficiencies noted. An extension was approved on April 19, 2019 for thirty days only. The last contact in the case by the special investigator was April 23, 2019, then the case was reassigned to another investigator on July 8, 2019. The investigation was completed on July 24, 2019 and closed on September 4, 2019.

16. Investigation ID (CLASS): 2525999

Case ID (IMPACT): 47685589

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: Reporter, the child's CPS worker, reported a thirteen-year-old female was elbowed to the face during a restraint. The investigation found evidence of injuries to the alleged victim's face. Statements made in investigative interviews and records indicate that the alleged victim reported the injuries were sustained multiple ways: either by being hit with a door at school, being accidentally elbowed as she resisted during a restraint, or during a physical altercation with a resident. More information is needed and could have been identified at the time, but evidence has been lost and is unlikely to be recovered to support a Reason to Believe disposition.

Monitors' Review/Notable Gaps in Investigation Timeframe: The case was initially assigned to a special investigator when the intake was received on March 25, 2019. The child victim was interviewed within the required timeframe (on March 26, 2019), but no further contacts were made for at least two months. Four months later, on July 30, 2019 the case was reassigned to RCCI to address several deficiencies before the investigation was completed and the case was closed. The safety and risk assessments were completed well after the child moved to another placement, and did not accurately assess risk. Since interviews with other residents at the facility were untimely, occurring five months after the incident on August 21, 2019, their recall of the victim and reported incident were unreliable.

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17. Investigation ID (CLASS): 2531411

Case ID (IMPACT): 47717145

Category of Maltreatment: Physical Abuse; Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: A report was made by a DFPS staff member alleging physical discipline of alleged victims within the facility. The reporter also alleged child-on-child sexual activity between three alleged female victims, ages sixteen, seventeen, and fourteen, due to inadequate adult supervision. This facility has a pattern of reports involving Neglectful Supervision and Inappropriate Discipline; the alleged perpetrator in this investigation was suspended during the investigation while prior allegations were resolved.

Monitors' Review: Key interviews were missed including with the reporter; an alleged victim's therapist; an alleged victim's CPS caseworker; and other residents who were identified as victims. The interviews conducted by the special investigator did not adequately address the allegations and there is a serious gap in documentation. RCCI attempted to complete the investigation but there were still missing components.

Notable Gaps in Investigation Timeframe: The case was originally assigned to a special investigator on April 16, 2019, then reassigned to RCCI three months later on July 8, 2019 as a backlogged investigation. The work done by the special investigator was incomplete and not thorough. The investigation was completed on August 2, 2019 and closed on August 19, 2019.

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18. Investigation ID (CLASS): 2550793

Case ID (IMPACT): 47825393

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: Reporter, a medical staff person, called in a report of physical abuse of a seven-year-old child in care because of unexplained patterned abrasions across the front of her neck; the treating physician's main concern was for physical abuse by a strangulation-type mechanism, from rope, cord, string, etc. The alleged victim's bruising around her neck remained six days after the injury was discovered. After the investigator interviewed the child and others in the home, no one reported concerns for physical discipline.

Monitors' Review: The medical staff person who made the report was not interviewed and no reason was given for failing to complete the interview. The investigator received the medical report, which may or may not have been sufficient: no notes regarding the sufficiency of the report are included in the investigative record. The medical staff should have been interviewed, particularly after the investigator completed interviews with the child and the others in the home.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely; no extension was approved, and no explanation given. The investigation took two months to complete. The intake was received on July 2, 2019 and the investigation was completed on September 4, 2019 and closed on September 24, 2019.

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19. Investigation ID (CLASS): 2547084

Case ID (IMPACT): 47808412

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: Reporter, the alleged victim's parent, reported physical discipline of a fourteen-year-old child in care; reporter also alleged the child was subject to demeaning remarks by a caregiver. The alleged victim reported a female staff member hit him and later the alleged perpetrator staff member resigned. There were prior concerns of physical abuse alleged against different staff members at the facility.

Monitors' Review: The investigator did not interview the alleged perpetrator, but police did so and forwarded the documentation to the investigator. RCCI closed the investigation before viewing the video footage of the alleged incident. It is unknown why the RCCI investigator did not view the video footage from the day in question or other days involving the alleged perpetrator staff member(s); or why the investigator did not view the video footage from the day the alleged perpetrator staff member, who allegedly hit the victim, resigned. Based on interviews, the alleged victim had no injuries. There were inconsistent allegations from the alleged victim involving different staff at different times.

Notable Gaps in Investigation Timeframe: None.

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20. Investigation ID (CLASS): 2534697

Case ID (IMPACT): 47738357

Category of Maltreatment: Neglectful Supervision; Physical Abuse; Sexual Abuse; Emotional Abuse;

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: Three intake reports were made by staff from a facility, an anonymous source, and a hospital social worker alleging that at least five children in care ranging in age from thirteen to eighteen-years-old were not provided appropriate or safe care by a caregiver putting the children at risk of abuse (physical abuse, sexual abuse, emotional abuse, and neglectful supervision). One report alleged the boys were afraid to talk about issues of concern due to threats of being kicked out of the home. The hospital social worker reported that a child treated at the hospital for pain in his testicles reported the pain resulted from an altercation with his foster father a week prior when the foster father grabbed and pulled his testicles. One of the alleged victims, a fifteen-year-old boy, maintained throughout the investigation that he was subjected to inappropriate conversations and contact with the alleged perpetrator. No other parties interviewed expressed concerns with this home or provider, but the investigation was deficient regarding completion of collateral interviews. Neither of the identified reporters were interviewed.

Monitors' Review: Collateral interviews including those with the reporter and with the fifteen-year-old alleged victim's therapist, teacher, and grandmother (with whom the alleged victim had regular contact) should have been completed to provide additional information regarding the

allegations and the fifteen-year-old alleged victim's behavior. This information might have helped reconcile the contradictory information provided by all parties in the investigation and might have been helpful in rendering a disposition. The State's disposition was prematurely rendered without these collateral interviews.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely and no extension was approved. The intake was received on April 28, 2019 and was completed and closed on September 17, 2019.

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21. Investigation ID (CLASS): 2548861

Case ID (IMPACT): 47817261

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: It was reported by an operation staff member at the GRO that three alleged victims, all aged thirteen, were not properly supervised; as a result, there was a physical altercation and allegations of inappropriate sexual contact at night between children in care. One alleged victim sustained injuries of a bloody nose and "knots" on his head. The extent of the alleged victim's physical injuries is unknown: no medical report was included in the investigation documentation. Staff and children reported "hearing" about one of the alleged victims trying to force other children to engage in sexual activity, but the RCCI investigator did not explore when they heard this or if any action was taken. Two staff persons who broke up the physical altercation gave different accounts of what happened. One staff person said they all fell to the floor while trying to pull the alleged victims apart; the other denied the same. The investigator did not ask the staff interviewed about any of the other children who were allegedly hitting one of the alleged victims. There is no documentation included in the investigation of the GRO's policy regarding the frequency of staff nighttime bed checks.

Monitors' Review: The reporter was never interviewed, and no explanation was given as to why the investigator failed to do so. The investigator found that one alleged victim involved in the physical altercation received an ice pack and was told the nurse would be informed of the alleged victim's physical injury. But there is no documentation of a medical report or evaluation included in the investigation documentation. Further interviews are necessary with staff persons present during the physical altercation incident to reconcile the contradictory statements, with children and staff who reported "hearing" about the inappropriate sexual contact between alleged victims, and with children who witnessed the physical altercation.

Notable Gaps in Investigation Timeframe: None.

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22. Investigation ID (CLASS): 2530922

Case ID (IMPACT): 47715303

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The allegations should have been substantiated with a disposition of Reason to Believe against an additional perpetrator, the CPA Administration.

Summary of key allegations and investigative findings: Multiple reports were made by hospital medical staff, staff from the facility, and a law enforcement officer: it was alleged when a 14-year-old child in care returned to the facility after curfew making suicidal statements, she was taken to the hospital and there stated she was raped by a seventeen-year-old resident at the same facility the day prior and wanted to harm herself as a result of the rape. It was alleged that both youth in care ran away and the assault occurred in an abandoned building. This facility maintains a "hands-off" or "no touch" policy with the residents and its doors are unlocked, allowing residents to leave at any time. The staff are instructed to encourage residents not to leave, but residents who leave can return after being reported missing to the police, CPS, and SWI. The investigation found that the fourteen-year-old alleged rape victim had a history of suicidal ideations and the seventeen-year-old had a history of sexual aggression. There were various neglectful supervision investigations at this facility as a result of the facility's lax policies in the two years prior to this report.

Monitors' reasons for disagreement with RO: The facts support substantiation of an RTB finding due to an unsafe situation (40 TAC §745.8559(3)) against the CPA owner/operator/administrator for placing a child with suicidal ideations in a facility that does not have the ability to closely monitor the child's actions; and for placing a child who is designated as a sexual aggressor in a facility that does not have the ability to closely monitor their actions with other residents.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely (took seven months to complete); an extension was approved but the investigation was not completed within the extension timeframe. The intake was received on April 15, 2019 and interviews were conducted from April to May 2019. There were two monthly staffings in July and August, then additional interviews in September, October, and November, when the case was finally closed.

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23. Investigation ID (CLASS): 2504375

Case ID (IMPACT): 47570077

Category of Maltreatment: Medical Neglect, Physical Abuse, Neglectful Supervision

Monitors' Conclusion: Although some allegations were substantiated in this case, the Physical Abuse allegation related to one perpetrator should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations and investigative findings: On December 26, 2018, DFPS staff, law enforcement, and hospital staff reported a three-year-old victim was transported to the hospital by

ambulance after the foster parent called 911 indicating the child was turning gray and having what appeared to be a seizure. The child was admitted to the hospital with suspicious injuries including bruises on his forehead, a rib fracture, treated clavicle and leg fractures, scratches and bruises on his penis, and a bruise on lower back. The alleged victim had a history of self-inflicted head banging and throwing himself out of the previous foster parent's arms. In the two months the child was placed in the foster home, multiple visits to the hospital were made due to unexplained and, in some cases, extensive injuries to the child. On December 7, 2018, the child was brought to the hospital after allegedly falling out of his bed. The child suffered a broken left foot, which required a cast. Later on December 7th, the child returned to the hospital after complaining of shoulder pain. He was diagnosed with a clavicle facture and was sent home with a sling. The hospital reported, "[e]ven if he did have a fall/jump from the bed on 12/7/18, it is highly unlikely that this single event caused both the leg fracture and the clavicle fracture, especially as his shoulder was normal after the event, but later became bruised and painful to move."

On December 26, 2018, the child was admitted to the hospital again for injuries to his body. The hospital's assessment of the child's numerous injuries stated, "Overall, [the child] has a multitude of significant injuries to multiple areas of his body, caused by multiple mechanisms. The findings are extremely concerning for inflicted injuries and child physical abuse." The assessment continued to rule out the foster parent's explanation of the child's head banging as the cause of the head injury: "The bruising with swelling to his forehead is consistent with blunt force trauma. The severe swelling is not consistent with head banging or self-injurious behavior in a 3 year old child." The report's conclusion states that "Child physical abuse remains at the top of the differential diagnosis at this time." In its investigative findings, the State argues that the child sustained a "multitude of questionable injuries" while in the care of the foster parents, and that the foster parents attributed these injuries to his "rambunctious behavior." However, the State points out that the child did not have these behaviors prior to placement and never required medical attention, and the child has not displayed any of these reported behaviors at his new foster home nor required medical attention.

Monitors' reasons for disagreement with UTD for Physical Abuse: The Reason to Believe findings for Medical Neglect against the foster parents and Neglectful Supervision by the foster parents are appropriate. The Monitors also found that the evidence is sufficient to support a finding of Physical Abuse (40 TAC §745.8557(1)) for the foster father due to the findings reached by medical professionals treating the child victim.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely; no extension was approved. The intake date was December 26, 2018. The investigator conducted interviews from December to May 2019, then the case sat untouched and was approved for closure in October 2019 with no documented reason for the delay. IMPACT incorrectly listed the date for investigation closure as May 8, 2019.

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24. Investigation ID (CLASS): 2569609

Case ID (IMPACT): 47924353

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: Allegations should have been substantiated with a disposition of Reason to Believe.

Summary of key allegations and investigative findings: Two reporters, a DFPS caseworker and a GRO campus supervisor, alleged that children in care were not properly supervised resulting in four alleged victims engaging in inappropriate sexual contact; it was also alleged that staff use profanity and have threatened a child.[1]

It was reported that a ten-year-old alleged victim stated that a fourteen-year-old alleged aggressor told her she had to be the alleged aggressor's girlfriend; the alleged aggressor reportedly touched the alleged victim's leg, thigh, and vaginal area while getting ready for bed the weekend prior to the report. Staff was not present when this occurred. Additionally, when the ten-year-old alleged victim (who has a history running away) was initially placed at the facility, one of the staff members allegedly told her if she ran away, this staff person would tackle her so hard her head would bust open and her brain would bleed. It was reported that the staff monitor phone calls and the ten-year-old alleged victim was only permitted to call her caseworker, attorney ad litem, or CASA worker once per week. It was then reported the ten-year-old alleged victim from the first report and two eleven-year-old alleged victims were playing in their room and the ten-year-old alleged victim touched the other two alleged victims in their vaginal areas over clothing while two staff members were on duty; the three girls are now separated.

The investigation found that the ten-year-old alleged victim from the first report, who was also involved in the second report's alleged incident, was recently admitted to the facility with a Specialized Level of Care and, upon placement, had a safety order in place requiring close supervision due to a history of suicidal and running away behaviors. While the facility's program administrator stated in an interview that the victim's safety order had been lifted, the investigation did not explore if the safety order was in effect at the time of alleged incident. While investigation did not overtly state the level of supervision required by the safety order, it can be inferred from interviews with two facility staff that the safety order required line-of-sight supervision at all times for the victim. The other two residents who were involved in the alleged incident of inappropriate sexual behaviors in the bedroom had Levels of Care of Intense and Specialized and required auditory supervision at all times and eyesight supervision when upset or escalated. The residents' behaviors were documented in their individual Service Plans, including that the eleven-year-old alleged aggressor, who "has a history of aggression and sexualized behaviors [and] counselors will need to be mindful of these behaviors and intervene as necessary to ensure the safety of everyone and [child]," and the operation was fully informed of the required Level of Care for each alleged victim.

The investigation found that the ten-year-old was in her room with her two eleven-year-old roommates after showering and asked one of the eleven-year-old alleged victims to demonstrate a restraint that staff used on residents. While the eleven-year-old wrapped her arms around the ten-

[1] This case was originally sent for a minimum standards investigation and later referred by RCCL for review by RCCI as an abuse or neglect investigation.

year-old's body, the other eleven-year-old grabbed her butt and touched her vagina over her clothes. The staff person who was supposed to be supervising the residents from the hallway had, according to the staff person, left his post for reportedly two minutes, and the children were left unsupervised. The investigation did not corroborate whether the staff person was only gone from his post for two minutes. The investigation also found the staff person responsible for supervision at the time of the alleged incident, a new employee, needed additional training and more awareness of "which girls are the sexual aggressors" and tenured staff need to heighten supervision of children when working with a new staff person. The allegations of staff threatening residents or cursing at them was not sufficiently addressed in the investigation.

Monitors' reasons for disagreement with RO: There is sufficient evidence to support a disposition of Reason to Believe for Neglectful Supervision against the operation staff due to the evidence that the three alleged victims, one of whom has documented sexualized behaviors, engaged in inappropriate sexual activities while in their room; staff left the three alleged victims unsupervised; and, it appears the operation staff person was not adhering to strict guidelines requiring close supervision of the alleged victim due to heightened supervision outlined in a safety order for one of the children.

Note: The Monitors requested a copy of the ten-year-old alleged victim's forensic interview and neither DFPS nor the CAC could locate the interview to provide it to the Monitors for review.

Notable Gaps in Investigation Timeframe: None

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25. Investigation ID (CLASS): 2553393

Case ID (IMPACT): 47836332

Category of Maltreatment: Physical Abuse; Physical Neglect

Monitors' Conclusion: As to physical abuse, the Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings:

In another investigation reviewed by the monitoring team involving physical abuse, SWI received three intakes which were all linked together because they involved related allegations of physical neglect and physical abuse of both TMC and PMC children. The first report alleged that two staff members subjected children to physical discipline by slapping them in the face. The reporter also alleged children in care were not being fed appropriately and as a result, were losing weight. The second report alleged that due to dehydration, a child placed at the facility had seizures and fainted; when the alleged victim reported to a staff member that he had a seizure, the staff member did not believe him and told him to stop faking seizures, which was linked to this investigation but treated as a minimum standards investigation. The third report, from a DFPS employee, stated that a child found a cockroach on his pizza.

The allegations related to substantial weight loss were ruled out due to the investigator's conclusion that the issue pertained to the quality of the food noting:"[t]he operation is monitored by the Health Department and concerns will be shared with HHSC Inspector to monitor." There are concerns, however, with the quality and thoroughness of the investigation related to allegations of physical abuse (slapping) of a resident by a direct care staff. During the alleged victim's interview, the youth maintained his allegation of being slapped by the staff person. The youth stated that during a restraint by a staff person, the alleged perpetrator was called in for assistance, and subsequently slapped the youth. The staff person who performed the restraint was not asked about the slapping incident when interviewed during the investigation. The youth also reported that the alleged perpetrator had slapped three other residents. Only one of these three other residents were interviewed, and, in the interview with the one resident, the investigator did not question the youth about whether he had been slapped by the direct care staff or had any other concerning incidents with the staff person. The investigation did interview the alleged perpetrator, who denied slapping the alleged victim or using any form of physical discipline. The alleged perpetrator was not questioned about the use of physical discipline or slapping with the other three residents. Other staff were interviewed and denied any knowledge of the alleged perpetrator slapping the alleged victim. However, two staff reported previous investigations related to the alleged perpetrator and slapping children. Finally, one staff person reported that the alleged perpetrator had been observed "cussing" in the presence of the children.

There were six other abuse and neglect investigations open concurrent to this report and multiple minimum standards investigations. The operation has two Reason to Believe findings in its past and has an extensive history of investigations for both minimum standard violations and abuse and neglect allegations.

Monitors' Review: The investigator did not question a staff witness about the slapping allegation during the course of an interview into the physical abuse allegation. Similar allegations by the victim regarding slapping of other children by the alleged perpetrator were not explored with the perpetrator nor with the other children in care who she allegedly slapped.

Notable Gaps in Investigation Timeframe: Two victims from the first intake (intake received July 12, 2019) were interviewed and some notifications were made, but there was no activity on this case from July 19, 2019 to September 8, 2019 when the case was transferred to another investigator. The investigation was completed on September 27, 2019 and closed on October 15, 2019.

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26. Investigation ID (CLASS): 2570949

Case ID (IMPACT): 47931775

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: RTC staff reported a fifteen-year-old girl told the case manager that her fifteen-year-old female roommate had been coming to her bed for a week asking the alleged victim to touch her inappropriately. The alleged victim reported she touched her roommate once; the alleged victim reported her alleged aggressor roommate has not been caught because when the roommate hears staff coming to do nightly checks every fifteen minutes, the roommate jumps back into her own bed. The facility staff noted that the level of supervision provided would not allow time for an incident to occur. Additionally, because of the small size of the cottage, the facility staff asserted that staff would have heard the alleged victim if she cried for help; staff can reportedly hear when one of the girls turns in her bed and can hear residents whispering in their room. The alleged victim was consistent with her allegations of inappropriate contact by the alleged aggressor (that the aggressor forcefully touched and kissed her breasts and vagina while they were supposed to be sleeping, five to six times in one week); the alleged aggressor was equally emphatic in her denial. The alleged victim's DFPS caseworker and the staff on duty at the time of the reported incident both cast doubts upon the reliability of the alleged victim's story. The DFPS worker noted the alleged victim has made similar, false allegations in the past. The alleged victim was moved to the living area with a mattress after the reported incident as a condition of the Safety Plan; the reviewer questioned the prudence of moving the alleged victim.

Monitors' Review: Key collaterals were not interviewed in the course of the investigation including: the alleged aggressor's DFPS caseworker, the reporter/RTC case manager, other direct care day staff at the RTC, the alleged victim's therapist, and other residents at the RTC. The alleged victim was not interviewed because although she was referred for a forensic interview, the CAC declined to interview her since she had been interviewed twice in the past, with the most recent interview in August 2019 for similar allegations. The results of the most recent forensic interview with the alleged victim were not included in the record or considered in investigative decision-making discussions. The results or conclusions that could be drawn from the missed key interviews are unknown and should have been considered when making the final disposition. The report alleged staff provided inadequate, neglectful night-time supervision, but the investigator did not review facility video footage to verify the veracity of this allegation. There have been several Neglectful Supervision allegations and reports of inappropriate contact among residents at this facility in the prior two years; all were Ruled Out.

Notable Gaps in Investigation Timeframe: None.

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27. Investigation ID (CLASS): 2501635

Case ID (IMPACT): 47552316

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: DFPS reported a ten-year-old developmentally delayed child in care was found by the police walking a mile away from his home. The police returned the child to his school and the foster parent was unaware he was missing. There were prior neglectful supervision investigations that were Ruled Out on this foster home in the two years prior to this report.

Monitors' Review: No attempts were made to interview the DFPS caseworker who reported the incident. Key collaterals who could have provided important information were not interviewed including: the CPA worker, the doctor who saw the child after the incident, and various nurses/aides who were in the home the morning of the incident. There may have been information collected during these collateral interviews to indicate that no one was attentively supervising the child in the morning when he should have been placed on the school bus. The foster mother had already left for work when the alleged incident occurred; the nurses and aides who were on duty on the date of the alleged incident were interviewed seven months after the intake in July 2019; and an alleged perpetrator respite provider could not recall the specific details regarding who was responsible for the alleged victim on the day of the incident due to the delay. The investigator failed to interview the alleged victim, claiming the child was non-verbal, but the foster mother and the child's aide indicated that when the child was found by the police, he told the police he was going to school, which conflicts with the reporting that the child was non-verbal.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely and took over nine months to complete. The intake was received on December 11, 2018 and interviews were conducted between December 2018 and January 2019, and a documentation of the history of the home was prepared in March 2019. Following March 2019, the record shows there were no subsequent interviews until July 2019, and the investigation sat dormant for one month. The investigator then continued interviews in September and October 2019 and closed the case in October 2019.

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28. Investigation ID (CLASS): 2494594

Case ID (IMPACT): 47515667

Category of Maltreatment: Physical Abuse; Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: A special investigator reported that a seventeen-year-old child in care stated one staff member at the operation grabbed him by his neck to direct him into a room and complained that his neck hurts. The seventeen-year-old child in care also reported that a sixteen-year-old makes sexual advances (grabbing his butt) and the staff knows about it. There are fourteen prior physical abuse allegations regarding the same alleged staff perpetrator between 2015 and 2020; and the facility had a total of ten Neglectful Supervision allegations investigated in the two years prior to the report.

Monitors' Review/Notable Gaps in Investigation Timeframe: The investigation was not thorough; it was a backlogged investigation, which took almost one year to complete. The intake was received on November 11, 2018 and interviews were conducted during the first month. Following the first month, there was no investigative activity for ten months (from December 2018 to October 2019), when it was reassigned in October 2019 for completion. A child witness who was allegedly involved was not interviewed, nor were any other child residents at the facility, nor other relevant staff who worked at the facility. There is no documentation of the investigator's attempts to locate key collaterals to interview. The individuals who were interviewed one year later could not recall details. The Monitors also note that the supervisor allowed the reporter's interview with the alleged victim be considered the initial face-to-face interview that is required for initiation of an investigation.

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29. Investigation ID (CLASS): 2569011

Case ID (IMPACT): 47919456

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: An attending physician at a hospital reported a blind three-year-old medically fragile child diagnosed with cerebral palsy is being mistreated; the alleged victim came to the hospital's attention when he was admitted for treatment of a viral infection. The foster parent was observed pushing the alleged victim's head down to force him to go to sleep and tied his arms down with ACE bandages, for unknown reasons. Foster parent refers to the child's medications as his "sleeping juice," and stated the child "cries more than he is allowed to cry." The foster parent has requested the alleged victim receive medication to make him sleep. Staff are concerned that the foster parent is misusing medication when the alleged victim is home with her. The investigation revealed that several collateral interviews reported that the foster parent provides good care and is loving and attentive to the alleged victim. In response to hospital staff's concern that the foster parent was "too rough" with the alleged victim, the foster parent explained that because of the alleged victim's cerebral palsy, his muscles do not function properly and are often rigid, so it may look like the foster mother is being rough, but she has to forcefully maneuver his body to position him. While the hospital staff were concerned that the foster parent may be misusing the child's Clonidine to make him sleep, the child's primary care physician had no concerns of misuse and confirmed that the foster parent collaborated to wean the child off of a number of medications including the child's daytime PRN dose of Clonidine. The investigator should have followed up with necessary interviews to rule out concerns. An additional concern surfaced during an interview with the child's visiting nurse, which was not addressed in the investigation: the nurse expressed concerns that the foster parent loves the child but is not always receptive to advice or instruction from the nurse. On the day the child was admitted to the hospital, the nurse administered a breathing treatment to the child due to the child's labored breathing and congestion. The foster parent entered the room and discontinued the

treatment saying she had already given the child a breathing treatment. The nurse suggested there was something wrong and the child needed oxygen, but the foster parent was dismissive at first. The nurse suggested calling 911, but the foster parent chose to drive the child to the Emergency Room herself.

Monitors' Review: Due to concerns of a professional reporter and the child's young age and medically fragile condition, it is especially important that the investigation is thorough. Some information gathered during the investigation differed from the concerns of the reporter and hospital staff, which should have been reconciled with follow-up interviews or interviews with additional individuals who could provide further insight into the quality of care provided to the alleged victim. The following key collaterals were not interviewed: the attending physician/reporter, the hospital nurse who expressed concerns about the foster home to the attending physician, the foster care worker, the CPS worker, and the foster parent's birth child.

Notable Gaps in Investigation Timeframe: None.

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30. Investigation ID (CLASS): 2478246

Case ID (IMPACT): 47423764

Category of Maltreatment: Neglectful Supervision; Sexual Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: DFPS reported that a seventeen-year-old female foster child alleged a sixteen-year-old male foster child raped her in the foster home and touched her inappropriately.

Monitors' Review: The investigator failed to interview a child witness and two other possible witnesses who were in the foster home at the time of the alleged incidents to determine whether the incident occurred and whether the alleged victims were appropriately supervised. The investigator interviewed the foster parents together and never interviewed them separately. Instead of questioning a child witness about the specific details of this alleged incident, the investigator used the interview of the same child witness from a prior investigation that occurred five months before this investigation began.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely and was a backlogged case. The intake was received on September 6, 2018. Interviews were conducted from September to November 2018, and no additional investigative activity occurred until January 2019. Interviews continued from January to March 2019, then the case sat with no investigative activity until June 2019. There were no further interviews in August, then investigative activity resumed in September. The investigation was completed and closed on September 23, 2019.

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31. Investigation ID (CLASS): 2458972

Case ID (IMPACT): 47146807

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: The relative of a child in care reported that a thirteen-year-old child reported in therapy that he engaged in inappropriate sexual activity with a twelve-year-old foster child. No specific details were provided.

Monitors' Review: Key interviews with the DFPS caseworker, child's therapist, and CPA worker were missed. The CPA worker could have assisted in determining the accuracy of reported behavioral issues for the alleged victim. The foster parents refused to allow the investigator to question their adopted children in the home, including the alleged victim who indicated he engaged in inappropriate sexual activity. There have been prior allegations of Neglectful Supervision with child-on-child sexual contact at other foster homes licensed by the same CPA; there were no prior allegations against this particular foster home.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely and; no extensions were approved and there is no other explanation in the documentation. The intake was received on June 21, 2018. The investigation was completed on October 21, 2019 and closed on November 4, 2019.

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32. Investigation ID (CLASS): 2490417

Case ID (IMPACT): 47490021

Category of Maltreatment: Sex Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: It was reported that a sixteen-year-old child in care alleged he engaged in inappropriate sexual contact with a staff member when the staff member allegedly performed oral sex on him when he was getting ready to take a shower.

Monitors' Review: The investigation was not thorough and specific details about the alleged incident were not obtained from the alleged victim or the operation administrator. The investigator did not obtain a list of staff employed throughout the time of the child's placement at the operation. Even if the staff were no longer employed at the operation at the time of the investigation, it is possible staff members were still working in that field and potentially reachable at another GRO. Additionally, child witnesses were not interviewed because the investigator could not locate them, and no documentation from the time period in question was obtained. No attempts were made to determine who the alleged victim's roommate was during the alleged incident or to obtain the therapist's notes from her sessions.

Notable Gaps in Investigation Timeframe: The investigation was not completed timely; no extensions were approved nor was there an explanation given. The intake was received on October 24, 2018 after which some investigative activity occurred. There was then no investigation work undertaken between November 4, 2018 and October 7, 2019, at which time the case was reassigned to another RCCI investigator to complete. Only then were the major collateral contacts and child witness contacted. The investigation was completed on October 29, 2019 and closed on October 30, 2019.

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33. Investigation ID (CLASS): 2352154

Case ID (IMPACT): 45366246

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: Facility staff reported a sixteen-year-old female in care banged on the walls after becoming upset that staff woke her at night with a flashlight in her eyes; the alleged victim reportedly became belligerent with staff and punched a staff person in the eye. Staff then restrained her inappropriately by grabbing her around her body and the alleged victim fell with the staff person on top of her. The alleged victim claimed that the alleged staff perpetrator restrained her by placing a knee into her back and then hit her in the back and banged her head on the floor. She alleged staff then threatened her and said she is going to pay for what she did. This facility has numerous investigations regarding physical abuse and minimum standards violations for using inappropriate restraints with residents.

Monitors' Review: The initial investigator assigned to the case only interviewed the victim, four child residents, and the reporter. The statements documented by the first investigator from the initial interviews are vague and incoherent. Staff, including the alleged perpetrator, were interviewed two years after the alleged incident and could not recall the specific details of the case due to the delay in investigation. Neither medical staff nor the therapist for the alleged child victim was contacted. Key child and staff witnesses were not interviewed and there were conflicting statements between the alleged victim's account of the incident and the alleged perpetrator's account of the incident that needed to be clarified. No specific questions were asked of the residents regarding what occurred the evening of the alleged incident. No information was gathered from a medical professional about how the alleged victim's injury, a contusion in the middle of her back, could have occurred (especially from a standing restraint).

Notable Gaps in Investigation Timeframe: The intake was received July 11, 2017 and interviews were conducted in July 2017, then an extension was approved in August 2017, but the investigation was not completed within the extension timeframe. The investigation sat dormant from August 2017 until October 2019 when it was reassigned as a backlogged case. The investigation was completed on October 22, 2019 and closed on October 24, 2019.

34. Investigation ID (CLASS): 2321050

Case ID (IMPACT): 45171759

Category of Maltreatment: Neglectful Supervision

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: The mother of one of the children in care reported that an eight-year-old boy indicated he engaged in inappropriate sexual contact with three of his roommates at the facility: boys ages seven, ten, and ten-years-old. The investigation discovered one alleged victim has a history of exposing himself in front of others; and another alleged victim had incidents of exposing himself to others and making lewd gestures about his genitals. Between November 2017 and December 2017, there were four reported incidents of sexually inappropriate behaviors between residents at this facility.

Monitors' Review: The investigation was not thorough and was extremely tardy. Two of the victims were interviewed within the first two months of the intake between February and April 2017. The third victim was interviewed within five months of the intake in July 2017, and the last victim was interviewed by telephone, two and a half years after the intake was received, in October 2019. The investigator's notes were unclear who made some of the original statements. The reporter was never interviewed; the investigator attempted to call the reporter once, two and a half years after the intake was received. The investigator failed to interview the following key collaterals: all the staff who worked at the facility at the time of the alleged incidents; the caseworkers for all of the children involved to obtain the children's histories; the therapists at the facility assigned to the children involved. The investigator did not obtain clear information from the facility administrator regarding night-time supervision requirements for residents, even after previous incidents of inappropriate sexual activity.

Notable Gaps in Investigation Timeframe: The intake was received February 27, 2017 and one extension was approved on March 20, 2017 to interview additional victims. There was no documentation in the investigation from July 2017 until October 2019 when the case was reassigned to an investigator to complete. The investigation was completed on October 16, 2019 and closed on October 21, 2019.

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35. Investigation ID (CLASS): 2547095

Case ID (IMPACT): 47808390

Category of Maltreatment: Physical Abuse

Monitors' Conclusion: The Monitors cannot determine the disposition due to a deficient investigation.

Summary of key allegations and investigative findings: An "I See You" worker reported that upon returning from a therapy session, a fifteen-year-old child in care was upset when not permitted to play with his toys due to the residents cleaning the house. The alleged victim blurted out obscenities and was instructed to go to his room by a staff person. The alleged victim reportedly continued to tear up his clothes in anger, curse, and refuse to calm down when instructed. The alleged victim reported that the alleged perpetrator staff member punched the victim on his left shoulder and shoved him against the wall, then held him around his neck or throat area, and shoved him, causing him to fall, hitting the back of his head on the floor and chipping a tooth. A nurse saw the alleged victim the day after the reported incident and advised she would make the child a dentist appointment. The alleged victim complained of dizziness from hitting his head the night of the reported incident but was never taken to a doctor for medical treatment. The alleged perpetrator took a photo of the alleged victim tearing up his clothes but did not take a photo of the victim allegedly banging his own head. This facility has various allegations of inappropriate discipline with numerous cases Ruled Out, but there was one case from December 2018 where it was found Reason to Believe. There were four previous allegations against the same alleged staff perpetrator between 2017 and 2019, which were all Ruled Out—some of the other alleged incidents also occurred where there were no cameras.

Monitors' Review: The nurse who saw the alleged victim was never interviewed, nor did the investigator obtain the nurse's documentation of the alleged victim's injuries. The investigator did not obtain documentation that the dentist appointment was made for the alleged victim. The alleged incident occurred in a bedroom at the facility where there are no cameras; the investigation did not determine if there was a need for the alleged perpetrator to go into the room without ensuring that staff witnessed him supposedly holding the back of the child's head to keep him from banging his head on the wall. The investigator should have questioned the facility's failure to have the child medically evaluated on the night of the alleged incident because the child complained he was dizzy and did not feel well, which are signs of a concussion. There may be evidence to support a finding of Failure to Obtain Medical Care (40 TAC §745.8559(5)) for the alleged victim against the operation staff for failing to have the child examined, but deficiencies in the investigation prevent the Monitors from reaching a conclusion.

Notable Gaps in Investigation Timeframe: The intake was received on June 18, 2019 and, interviews were conducted from June to July 2019. No extension was approved. The investigation remained dormant from July to November 2019, and the investigation was completed and closed on November 7, 2019.