

## CASE EXAMPLES FROM APPENDICES

### EXAMPLES FROM APPENDIX 3.1 "INTAKE SCREENING RESULTS CASE SUMMARIES":

**Appendix 3.1 contains examples of intake screenings that were improperly downgraded. In many of these examples, the statewide intake system had assigned the incident for further investigation, but RCCI improperly downgraded the incident, resulting in no investigation.**

#### *Overall Themes*

- Inappropriate use of force and restraints resulting in injuries
- Negligence at facilities resulting in self harm, sexual conduct, runaways, poor mental health, aggression at school, racial hate speech, and hunger
- Poor or non-existent investigations of incidents
- Poor oversight of medications

#### *Specific Case Examples:*

- A nine-year-old foster child disclosed that when she was five, her previous foster mother cut her right hand with a knife and a piece of glass while drunkenly playing the game "hangman." The same foster mother pushed her birth child down the stairs while drunk. The Texas Department of Family Protective Services ("DFPS") Department of Residential Child Care Investigations unit ("RCCI") deemed this a priority none ("PN") minimum standards investigation, but the Monitors found these allegations warranted a physical abuse investigation. (Case ID #47972905; Intake ID #72844397; Page 3 of Appendix 3.1)
- An eight-year-old boy with special needs "had a rough day at school" and could not be placed on the bus due to safety concerns. He became extremely fearful when the teachers were about to call his foster mother. He told them that she "restrains" him and "takes me to the garage, makes me put my foot over my head, and puts my arms behind my back." RCCI deemed this a PN minimum standards investigation, but the Monitors found that these allegations warranted a physical abuse investigation. (Case ID #47965135; Intake ID #72821818; Page 7 of Appendix 3.1)
- A 17-year-old female got pills from other foster care residents and tried to overdose because she did not feel safe at the facility and felt mistreated by staff. She also ingested ink that same day. Nobody at the facility took her to the emergency room or to see a doctor. RCCI deemed this a PN minimum standards investigation, but the Monitors found that these allegations warranted a neglectful supervision investigation both because of her self-harming behavior and the fact that residents are keeping their own pills, which is against policy. (Case ID #47964382; Intake ID #72819506; Page 11 of Appendix 3.1)

- A 17-year-old male with a history of cutting reported that a staff member at the facility told him that “if he cuts his arm a certain way he will get results; but if cuts another way, it is just for attention.” A second staff member told him: “I hope you will die quickly.” His case manager called his cutting “no big deal.” The youth also expressed concerns about the facility and not feeling safe. He was assaulted with Icy Hot on his face while sleeping, gangs are present in the facility, and the entire environment has caused him to experience tremendous anxiety. RCCI deemed this a PN minimum standards investigation, but the Monitors found that these allegations warranted a neglect investigation. (Case ID #47926851; Intake ID #72720013; Page 15 of Appendix 3.1)
- The facility owner refused to have the facility exterminated for roaches and bedbugs, an issue for years. Roaches have been seen in youths’ rooms, the cabinets, the bathroom, and all over pots and cereal. Children have been observed with bedbug bites. According to the reporter, the facility owner will inflate and falsify details in reporting to maintain her licensure. (Case ID #47884522; Intake ID #72609079; Page 30 in Appendix 3.1)
- Two girls—16 and 17 years old respectively, who have extensive histories of trying to run away—snuck out of the window of the group home. Two men picked the girls up in their car. One youth reported that her hands were tied to the backseat car door with a shoelace and she was raped. One youth also reported that she was raped about three weeks prior. RCCI deemed this a PN minimum standards investigation, but the Monitors noted that an abuse or neglect investigation was necessary to determine if the youth were subject to adequate supervision. (Case ID #47954066; Intake ID #72792079; Page 33 of Appendix 3.1)
- A 15-year-old female, hospitalized due to self-harm and a suicide attempt, reported sexually-related behavior with men aged 19, 21, 22, 25, 27, and 28. RCCI closed this case without investigation, but the Monitors noted that a neglectful investigation was appropriate, particularly due to her seven previous hospitalizations for self-harming. (Case ID #47980114; Intake ID #72864856; Page 63 of Appendix 3.1)

**EXAMPLES FROM APPENDIX 3.2 “MALTREATMENT IN CARE CASE SUMMARIES”:**

**Appendix 3.2 contains examples of maltreatment in care where RCCI conducted inadequate investigations or improperly ruled out allegations of maltreatment.**

**Pg. 2: 3.2.2: Foster mother physically abused young child for “misbehaving”**

- Foster mother allegedly pushed child to the ground, resulting in swollen lip and bleeding of gums. She “spoke negatively about the alleged victim to the DFPS caseworkers, describing him as the worst child she has ever served,” and “sold the alleged victim’s clothing after he left the home.”
- Monitor’s conclusion: Allegation should have been substantiated with a disposition of Reason to Believe.

**Pg. 3: 3.2.4: Neglectful supervision resulted in inappropriate sexual contact between 13-year-old and intellectually disabled 18-year-old roommate**

- Thirteen-year-old boy with a “history of inappropriate sexually related behavior” had inappropriate sexual contact with his intellectually disabled eighteen-year-old male roommate, who has “minimal” levels of functioning, including delayed language skills and an age equivalency “very indicative of a four year old.” The older youth has “aggressive, and at times violent, behavior that has resulted in injuries to himself and others.”
- Monitor’s conclusion: “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.”

**Pg. 8: 3.2.10: Children told they were “hallucinating” sexual abuse**

- “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.”
- Many of the young children placed in this foster home had a history of abuse and trauma, some specialized level of need, and/or were prescribed psychotropic medication, and the allegations were attributed to these factors. The children were often told they were “hallucinating” the same instance of sexual abuse despite the fact that the children had no contact with each other and did not overlap at the foster home.

- Monitor’s conclusion: The allegations should have been substantiated with a disposition of Reason to Believe.

**Pg. 9: 3.2.11: Six-year-old child transported in bed of pickup truck and forced to clean his own pants outside during heavy rain and wind after soiling his pants.**

- “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.”
- Monitor’s conclusion: “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.”

**Pg. 16: 3.2.20: Reports of caregiver abuse including foster father who pulled child’s testicles so forcefully as to require hospitalization**

- “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.”
- Monitor’s conclusion: “Cannot determine the disposition due to a deficient investigation. 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."

**Pg. 18: 3.2.22: Fourteen-year-old child raped by seventeen-year-old resident at same facility**

- Multiple reports made by hospital medical staff, staff from the facility, law enforcement officer that a 14-year-old child in care was hospitalized after returning to the facility after curfew, and at the hospital stated that she was "raped by a seventeen-year-old resident at the same facility and wanted to harm herself as a result."
- "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." "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."
- Monitor's conclusion: The facts support substantiation of reason to believe finding "due to an unsafe situation (40 TAC §745.8559(3)) against the [child placing agency] 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."

**Pg. 18: 3.2.23 – Foster parents abused three-year-old child requiring multiple hospitalizations for extensive injuries**

- 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 fracture and was sent home with a sling... On December 26, 2018, the child was admitted to the hospital again for injuries to his body."

- The foster parents attribute these injuries due to the child's "rambunctious behavior." However, 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."
- Monitor's conclusion: Reason to believe disposition for medical neglect and neglectful supervision were appropriate. Allegations of physical abuse should have been substantiated with a disposition of reason to believe.

**Summary of Monitor's Visit to Hector Garza Residential Treatment Center**  
**(ID# 959366) (Appendix 6.1.a)**

Hector Garza Residential Treatment Center ("Hector Garza") is located at 620 E Afton Oaks Blvd in San Antonio, TX. Hector Garza is a four-story building that is licensed to serve up to 139 male and female residents between the ages of ten to seventeen. Hector Garza is licensed to serve children with an emotional disturbance and also to provide transitional living services.

- Hector Garza is a four-story facility licensed to serve up to 139 male and female residents between the ages of ten to seventeen, including children with emotional disturbances.
- "Hector Garza is the only facility that the monitoring team visited, as of May 2020, where no children reported they liked living there." 43% of interviewed children felt physically unsafe, and 95% reported physical fights between children.
- During an unannounced night-time visit lasting only 90 minutes (11:45-1:15AM), monitors immediately noticed the facility was understaffed, found children sleeping on bare mattresses in the hallway, and witnessed two separate disturbances – one resulting in a child being forcefully restrained by three staff members, and another where a youth said the other youth were trying to "jump" him. According to that youth, the unit was "worse than prison." Children were physically searched, had their rooms searched, and were punished for crossing a set of lines that were drawn in front of their doors when not allowed to do so. The facility had called in police to assist containing a "riot" that past Saturday night.
- During the follow-up daytime tour, monitors observed a "flurry of activity to clean and repair the damage the monitoring team saw during the night," and noticed that one of the check-in logbooks had been modified such that a 45-minute gap no longer existed. "A review of the histories of the four staff members revealed thirty-two previous reports where they were identified as alleged perpetrators. Of those thirty-two reports, three resulted in a citation to the facility for standards violations."

**Summary of Monitors' Visit to Fresh Start Treatment Center**  
**(ID #849130) (Appendix 6.1.c)**

Located at 7809 Winship Street in Houston, Texas, A Fresh Start Treatment Center (Fresh Start or the facility) is comprised of two independent structures- the Orville House and Winship, located on the same grounds as a church. It only serves males between the ages of six and seventeen, and is licensed to serve thirty youth.

- This facility received a citation on more than one-third of the 199 standards by which they are reviewed (most citations fell into the categories of inappropriate restraints, inappropriate discipline, or neglectful supervision).
- 29 percent of children interviewed did not feel safe at the center.
- Children noted that fights occurred on campus and in the dorms. Staff would not always intervene to break up the fights.
- Staff frequently sleep instead of supervising or monitoring the children, which can result in more fights or sexual activity between residents. Staff also punch and slap children causing injuries (one example: a staffer hit a child in the face, breaking his glasses and causing him to bleed).
- Staffers would not always provide inhalers to children with asthma when they were struggling to breathe.
- When disciplined, children noted that restraints were so tight they could not breathe and would almost pass out.
- One child brought up religious freedom concerns since the youth was forced to attend church on Sundays with a staffer who worked there too.