

ROADMAP OF REPORT

OVERVIEW OF STATE DATA AND DATA SYSTEMS CHALLENGES (pgs. 24-31)

The state's data management systems that are intended to support its foster care system are fragmented, lacking in functionality and incomplete in data capture. The disjointed data systems pose a safety risk for children and have also impeded the Monitors' efforts to evaluate the state's compliance with the Court's order. The state's data system puts kids at risk of harm in at least the following ways:

- There are challenges in tracking alleged perpetrators and child victims between systems. (Pg. 27)
- The fragmentation of data collection and reporting consumes limited investigator time and makes it more difficult to track investigation histories about children and facilities. The lack of uniform identifiers between the state's data systems also makes it more difficult to identify patterns of maltreatment, and contract and policy violations. (Pgs. 25).
- It is not possible to establish a coherent dataset about child maltreatment and investigations related to a single organization or a single facility. (Pg. 26).
- Due to the database systems in use currently, tracking investigation histories by child, perpetrator or facility across the two data platforms is complicated and inefficient. (Pg. 31).
- Efforts to report on performance associated with the remedial orders have been hindered by limited functionality. The State had to add, or is in the process of adding, several enhancements to be able to report on and comply with the remedial orders. For example, as a result of the bifurcated system used to process and store data associated with referrals to Statewide Intake, the State was unable to provide the Monitors with a unified dataset of all referrals of abuse and neglect in which a PMC child is the subject. (Pgs. 26-28).

RECEIVING, SCREENING, AND INVESTIGATING REPORTS OF ABUSE AND NEGLECT (pgs. 32-75)

The state has a pattern of inappropriately downgrading and ruling out allegations of abuse and neglect. As a result, the state fails in its fundamental responsibility to protect children in abusive and neglectful environments. The Monitors uncovered the following significant systemic failings in the state's screenings and investigations into child maltreatment:

- The State's policy imposes a higher threshold than Texas law for investigating the abuse, neglect and exploitation of PMC children in licensed placements. As a result, DFPS' Residential Child Care Investigations unit (RCCI) inappropriately screens out allegations for abuse, neglect or exploitation investigations, placing children in the PMC class at risk of harm. (Pg. 36).
- Of a sample of 174 reports that RCCI downgraded from being assigned for an abuse or neglect investigation by the Statewide Intake to being assigned for no investigation, the Monitors determined that RCCI inappropriately downgraded 33%. Because of these downgrades, perpetrators were able to secure employment at other Child Placing Agencies and General Residential Operations because their culpability had not been established as part of a child abuse, neglect or exploitation investigation. (Pgs. 49-50).
- In some of the inappropriate downgrades, RCCI appears to have determined that behaviors like consensual sexual conduct between children or self-harming that is not suicidal were not

serious, without consideration of the action or lack of action by caregivers to prevent the incident, even when the behavior caused or may have caused harm. (Pg. 52).

- Of a sample of 122 investigations where RCCI Ruled Out all the allegations, the Monitors determined that RCCI did so inappropriately in 11 cases (9.1%) and conducted investigations with such substantial deficiencies in 24 cases (19.7%) that the Monitors were prevented from reaching a conclusion. Many of these RCCI child abuse and neglect investigations were deficient because of long gaps in investigative activity and substantial delays in completion. In sum, the Monitors identified 35 cases (28.7%) among a sample of 122 investigations that were Ruled Out by RCCI between August 1, 2019 and November 30, 2019 which had substantial deficiencies or were inappropriately resolved by RCCI. (Pgs. 63-64).
- In one case, the Monitors identified ten separate allegations of physical abuse against an individual who bounced around as an employee between different facilities over the course of five years. (Pg. 64). The employee was seen punching and kicking children, placing their hands around children's throats and allowing other children to punch and kick a child while they restrained the child. (Footnote 157). There was no evidence that the state took into account, or was even aware of, these ten separate allegations, except for during the very last investigation. (Pg. 66).

TIMELINESS OF INVESTIGATIONS (pgs. 75-98)

The state frequently moves far too slowly in investigating allegations of abuse and neglect, leaving children at risk of harm. Notably, the state had reported that it was in compliance with the Court's orders on timeliness, when in fact, it was not. (Pg. 78). The monitors found the following examples of delays in investigations and incomplete data keeping:

Pg. 97: Remedial Order Five (Initiation within Twenty-Four Hours in Priority One Investigations):

- Only 68% of investigations were initiated within twenty-four hours of intake through face-to-face contact with all alleged child victims.

Pg. 97: Remedial Order Six (Initiation within Seventy-Two Hours in Priority Two Investigations):

- Only 81% of investigations were initiated within seventy-two hours of intake through face-to-face contact with all alleged child victims.

Pg. 97: Remedial Order Seven (Initial Face-to-Face Contact with Alleged Victims within Twenty-Four Hours in Priority One Investigations):

- Only 68% of investigations included initial face-to-face contact with all alleged victims within twenty-four hours of intake.

Pg. 98: Remedial Order Eight (Initial Face-to-Face Contact with Alleged Victims within Seventy-Two Hours in Priority Two Investigations):

- Only 81% of investigations included initial face-to-face contact with all alleged victims within seventy-two hours of intake.

Pgs. 89-90: Remedial Order Nine (DFPS Track and Report Investigations that Are Not Initiated on Time)

- DFPS was unable to track and report to the Monitors if and when face-to-face contact was made with all alleged child victims within an investigation.

Pg. 98: Remedial Order Ten (Completion of Priority One and Priority Two Investigations within Thirty Days):

- 79% of investigations were not completed timely.

Pg. 93: Remedial Order Eleven (DFPS Track and Report Investigations that Are Not Completed on Time):

- The DFPS data submitted in association with closed and open investigations do not provide the Monitors with a list of investigations that includes an indicator of timeliness as defined by Remedial Orders Ten and Eleven. DFPS does not report on the timeliness of investigation completion by relying on an IMPACT or CLASS report, but instead must rely on case read reports.

Pg. 98: Remedial Order Sixteen (Timeliness of Completion and Submission of Documentation in Priority One and Priority Two Investigations):

- 37% of investigations did not include evidence that documentation was completed and submitted timely and 3% of investigations were categorized as unknown due to missing documentation.

Pg. 98: Remedial Order Eighteen (Notification to Referent):

- Only 78% of investigations included evidence that notification letters to referent(s) were mailed within five days of investigation closure.

Pg. 98: Remedial Order Eighteen (Notification to Provider):

- Only 65% of investigations included evidence that notification letters to provider(s) were mailed within five days of investigation closure.

INFORMING CHILDREN OF THEIR RIGHTS AND HOW TO REPORT ABUSE OR NEGLECT (pgs. 99-108)

The state fails to adequately inform children of their rights in foster care and to ensure they are aware of the Abuse/Neglect hotline and the Foster Care Ombudsman should they need to seek protection. Children must have access to this information and to private telephone access so that they can report abuse and neglect from placements. Data reflecting these failings include:

- A majority of the 164 youth interviewed do not know who or what the Foster Care Ombudsman (FCO) is or how to contact that office to make a complaint. (Pg. 108).
- Most of the 117 youth interviewed were aware of the Hotline, but of children asked during the interviews about the protocol for using the phone, most indicated they are unable to make calls twenty-four-hours a day and free from observation. (Pg. 108).
- 42% of the children interviewed by the Monitors in Cottage Homes indicated they were aware of the Foster Care Bill of Rights. 57% interviewed by the monitoring team in other types of GROs (which include three residential treatment centers (RTCs)) indicated they were aware of the Foster Care Bill of Rights. Even when a child was aware of the FCO, they did not always know how to contact the FCO. For example, of the 101 youth interviewed in cottage homes,

30% were aware of the FCO, and 23% knew how to reach the FCO. And, of the sixty-three youth interviewed in other types of GROs/RTCs, only 24% were aware of the FCO, and only 13% actually knew how to reach the FCO. (Pg. 108).

INVESTIGATIONS TO KEEP CHILDREN SAFE (PGS. 111-124)

RCCI investigators need to timely and thoroughly investigate allegations that children are being abused in foster care. Failing to stop abuse in care causes already abused or neglected children to experience a deep sense of fear and betrayal at the hands of the very system that is responsible for protecting them.

- The State is failing to protect children from the very start of investigations. In 50% of cases reviewed by the Monitors, the investigators failed to timely notify children's caseworkers that an investigation had been begun due to danger signs. (Pg. 111).
- Often investigations are not initiated because a remote worker, without face-to-face contact with the children, has determined there is insufficient reason to launch an investigation. This screening out process has been determined to be significantly flawed. [See **Screening in Maltreatment in Care Reports for Investigation**]. As a further check on whether these homes or facilities are in fact safe, caseworkers are responsible for doing a home history review [HHR] by looking at the history of allegations made against a home or facility to see if there is a pattern which indicates something is going on which in fact endangers children. Unfortunately, the Monitors found that in 21% of the cases there was not evidence of a home review [HHR] after investigations of abuse or neglect were remotely determined to be unnecessary. Moreover, only 39% of completed home reviews were approved by a supervisor. (Pgs. 126-127).
- And, even when backstop checks were performed, children are too often left in dangerous environments. Several of the cases reviewed by the Monitors in which the caseworker and supervisor reviewed the HHR and determined no action was needed were deeply concerning. In one case an 11 year-old boy and his younger brother, age 10 were both observed to be suffering from injuries. The older brother was observed with a whelp on his neck. He was unable to explain how the injury occurred. Both children have been seen with black eyes in the past. Also, both became emotional when questioned and were frightened to speak in front of the foster parents. Both children were alleged to have black eyes, and that the younger child had what looked like a belt bruise on his face/neck. Despite the HHR for this particular home including 13 instances of suspicious, sometimes brutal, injuries to children in the home over the last four years, the caseworker and supervisor determined that no further action was needed because, as the caseworker reasoned, the children could not explain how the injuries occurred and the neck injury was already in the process of healing. The caregiver also denied any wrongdoing largely blaming the children for the injuries. (Pgs. 121-124).

CASEWORKER, INVESTIGATOR, AND INSPECTOR CASELOADS (PGS. 136-169)

- New caseworkers particularly need to have graduated caseloads so they do not become overwhelmed and fail to keep children safe and healthy. The Monitors found that new caseworkers, if measured by the new agreed upon caseload guidance, would have been carrying unsafe caseloads a majority of the time. (Pgs. 136-137).

- Keeping foster children safe requires that caseworkers have caseloads that they can manage. Otherwise, children's cases can slip through the cracks. Children are not visited regularly and trusting relationships between caseworkers and children are not established. A little over half of the children had workers who had admittedly unsafe caseloads. (Pgs. 148.)
- Like caseworkers, investigators can become overwhelmed and fail to keep children safe when they are working on too many investigations. The Monitors found that over 46% of investigators had caseloads at unsafe levels. This would mean that when allegations of abuse in foster care were investigated a careful look at the evidence could not be done. It is not surprising then to find high levels of mistakes leaving children exposed to continued abuse. (Pg. 169) [cite above section **Investigations to Keep Children Safe**]
- Similarly, workers who do the routine inspections of placements making sure that safety and health standards are being followed are burdened with excessive caseloads. The Monitors found that 59% of inspectors had caseloads at unsafe levels. (Pg. 169)

SEXUALLY ABUSED & SEXUALLY AGGRESSIVE YOUTH (PGS. 175-189)

The Court ordered the State to end the epidemic of child on child sexual aggression in foster care. To achieve this urgent goal, the Court ordered the State to create a clear policy on what constitutes child on child sexual abuse and ensure that all staff who are responsible for making the determinations on what constitutes child on child sexual abuse are trained on the policy.

- Experts in sexual abuse prevention relied upon by the Monitors expressed concern regarding whether the training modules were sufficient to appropriately prepare investigators, CPS supervisors, and program administrators or directors to prevent or appropriately respond to child-on-child sexual aggression.
- Incredibly, the State's response to this assessment amounted to a denial that the court's order included a requirement to prevent sexual abuse. (Pgs. 175-176).
- The Monitors also fear a large, dangerous gap in the system due to finding none of the children reviewed in a large case review sample were confirmed as sexual abuse victims due to abuse by another child while in care. This was despite the Monitors' findings that one-third of intakes that include allegations of neglectful supervision for PMC children involved reports of sexual contact between at least two children in a GRO or foster home. Hence, it is quite significant that the Monitors' review of data from DFPS identifying children with confirmed allegations of sexual victimization included *only* abuse that occurred prior to entrance into care. The clear implication is that the epidemic of child on child abuse will continue to rage until child on child abuse in foster care is recognized by DFPS as truly harmful to children. (Pgs. 187-189).

VICTIMS OF SEXUAL ABUSE/SEXUALLY AGGRESSIVE YOUTH (PGS. 225-226)

Many children in foster care were victims of sexual abuse in their family homes. Sadly, many of these kids were in also have experienced sexual abuse while in foster care. These children all have undergone significant trauma and, oftentimes, react to the sexual abuse they have suffered by becoming sexually reactive themselves. It is vital that the foster care system carefully tracks individual

histories of sexual victimization and sexual aggression so that it can make appropriate placement decisions for kids and assure adequate safety oversight by caretakers. The monitors have found that the state is not consistently documenting or notifying foster caretakers of kids with sexual abuse histories. For example:

- Each method of validating performance for the Remedial Orders related to caregiver notification revealed gaps in notification. The cross-match of data for the mass notification undertaken by the State in response to the Court’s November 5, 2019 order showed 5% (53 of 1025) of children identified who did not match to the list of caregivers notified.
- Gaps in notification exist between CPS and Program Administrators, and between Program Administrators and direct care staff. While Program Administrators interviewed by the Monitors during unannounced visits indicated that they alert direct caregivers on their staff when they receive notification from the State that a child is a victim of sexual abuse or is identified with an indicator for sexual aggression, only 57% of direct caregivers interviewed indicated that they received notice when a child had been identified as sexually aggressive, and 50% indicated they received notice when a child had been identified as having a history of sexual abuse. This suggests that the information may not make it to the direct care staff who are engaged in protecting children’s safety on a daily basis.
- A gap in notification exists for children identified in IMPACT records as having a history of abuse or aggression, but whose placement does not change. The State uses the “Common Application” and “Placement Summary” as the primary method of notifying caregivers. However, these forms are generated only when children move to a new placement. When a child is identified without their placement changing, notification does not always appear to take place. In addition, the Monitors review of case records in IMPACT revealed that these forms are not provided to psychiatric hospitals when children are admitted for care, because these settings are not considered placements.
- Even for children who have a change in placement after being identified, information about their history of sexual abuse or sexual aggression is not always added to the “Common Application” and “Placement Summary.” Additionally, the Monitors’ on-site reviews of children’s files revealed that, quite often, one or both of these forms are missing from a child’s file altogether, even for children who appear on the list generated by the State of children with a history of sexual aggression or victimization.

AWAKE NIGHT SUPERVISION (pgs. 226-239)

Last fall, the state was found in contempt and fined for its failure to assure the presence of awake night staff at placements with more than 6 children. The monitors have reviewed the presence and function of awake night staff within the state’s foster care system, including making unannounced inspections. Though awake night staff has been found present at facilities requiring it, the monitors identified unacceptable performance at certain placements such as awake night staff sleeping on the

job or being drawn away from their posts such that the children are left for periods without. The Monitors found:

- The State's own certifications and placement self-reports indicate ongoing issues related to awake-night supervision. While the Monitors and their staff did find awake-night staff at all GROs visited, during one visit the awake-night staff in one house appeared to be sleeping and during another, a riot broke out and monitoring staff were left alone on a wing with more than twenty children.

FIVE YEAR RETROSPECTIVE REPORT (PG. 251)

The court's injunction order requires RCCL to consider a private provider's 5-year compliance history when conducting licensing oversight. Understanding a provider's overall track record is essential to assuring safety. The monitors found that there are many providers with long histories and high rates of licensing violations or substantiated events of abuse in care. These agencies absolutely must undergo more intensive scrutiny and oversight if children are to be safeguarded. Nevertheless, the state is not consistently compiling and considering extended compliance histories in conducting its licensing oversight. The Monitors determined that:

- Only 28% of inspections associated with an investigation of a minimum standards violation contained a completed five-year retrospective report:
- 29% of the operations (twenty-two of ninety-two) had no five-year retrospective reports in CLASS.
- Only 7% of the operations (six of ninety-two) had a five-year retrospective report for all (100%) of the investigations or inspections conducted during the period under review.
- RCCL rarely completes the five-year retrospective review prior to or on the same day as the RCCL inspection, making it impossible for the information to be considered during the inspection, as required by Remedial Order Twenty-Two. Interviews with inspectors confirmed that 40% (16 of 40) understood the purpose or the process for compiling and using the information required by the extended compliance history review.

TIMELINESS OF RCCL LICENSING INVESTIGATIONS (PGS. 252-266)

The monitors measured the timeliness of RCCL licensing investigations. Timeliness is important because it supports the agency's capacity to address dangerous conditions before they cause further harm and it allows evidence to be gathered before it becomes stale.

- Remedial Order Twelve: HHSC reported one Priority One investigation with an intake date between August 1, 2019 and December 31, 2019. This investigation did not include face-to-face contact with an alleged child victim within twenty-four hours.

- Remedial Order Thirteen: HHSC reported 628 Priority Two investigations with an intake date between August 1, 2019 and December 31, 2019. Fifty-nine percent (59%) (369) of investigations included first face-to-face contact with an alleged child victim within three days of intake.
- Remedial Order Fourteen: HHSC reported 629 Priority One and Priority Two investigations with an intake date between August 1, 2019 and December 31, 2019; HHSC completed 95% (598) of investigations within thirty days of intake.
- Remedial Order Fifteen: HHSC reported 1,602 Priority Three, Four, and Five minimum standards investigations with an intake date between August 1, 2019 and December 30, 2019; HHSC completed ninety-six percent (1,537) of the investigations within sixty days of intake.
- Remedial Order Sixteen: HHSC reported 629 Priority One (1) and Priority Two (628) completed investigations with an intake date between August 1, 2019 and December 31, 2019; in 96% (603) of the investigations, the documentation was completed on the same day the investigation was completed.
- Remedial Order Seventeen: HHSC reported completion of 1,602 Priority Three (1,158), Priority Four (11), and Priority Five (433) investigations with intake dates between August 1, 2019 and December 15, 2019; in 96% (1,518) of the 1,602 investigations, HHSC completed documentation within sixty days of the intake date.
- Remedial Order Eighteen: HHSC reported completion of 629 Priority One (1) and Two (628) minimum standards investigations with intake dates between August 1, 2019 and December 31, 2019; 77% (482) of the investigations included notification to the referent and provider within five days of completion of the standards investigation.
- Remedial Order Nineteen: HHSC reported 1,602 Priority Three (1,158), Four (11) and Five (433) minimum standards investigations with intake dates during the period August 1, 2019 and December 31, 2019; of the 1,602 investigations, 79% (1,266) investigations included notification to the referent and provider within sixty days of intake.

LICENSING REMEDIAL & ENFORCEMENT ACTION (PGS. 283-301)

The monitors conducted a thorough review of the state's licensing and contract oversight practice to determine whether there is sufficient accountability in the child welfare system to assure child safety. In conducting this review, the monitors determined the average rate of substantiated abuse in care events and minimum standards violations events within the pool of private providers and identified numerous providers whose individual rates far exceeded the statewide average. In other words, there are known poor performers in the state whose practice poses a serious danger to kids. Yet, the state makes minimal use of licensing and contract remedies to obtain acceptable performance. Significantly, the state did not revoke a single license over a five year period of time though dangerous

facilities existed and were being utilized to house kids.” The Monitors found:

- Despite a significant number of small, medium, and large GROs and CPAs that have a high rate of RTBs and minimum standards violations, little meaningful enforcement action is taken by RCCL. Between September 30, 2014 and March 31, 2020, RCCL placed thirty-nine operations on evaluation and twenty were placed on probation. Seventy-one were placed on a voluntary plan of action. Though six operations were issued a letter of intent to revoke, RCCL did not revoke any licenses during this period. A case study of four operations with a high rate of RTBs and minimum standards violations shows the inconsistent nature of RCCLs risk analysis and enforcement scheme.
- The information that the Monitors received from DFPS similarly indicates little formal enforcement action taken by the division of the agency that oversees contracts. During the three years for which DFPS has provided information to the Monitors (September 30, 2016 through September 30, 2019), DFPS appears to have suspended placements at fourteen operations, and later lifted the placement suspension in eight of those. DFPS appears to have cancelled only four contracts during this period, though it has terminated four contracts since monitoring began.

LICENSE REVOCATION (PGS. 301-323)

The monitors reviewed the state’s history of revoking the license of poorly performing providers. The state rarely imposes this remedy, leaving children at risk in dangerous placements.

- While the State did not issue a single license revocation in the five years preceding September 30, 2019 (the date of the Monitors’ first data and information request), RCCL has notified two operations of its intent to revoke their license since December 2019. One of those facilities, Children’s Hope – Lubbock, was allowed to voluntarily relinquish its license after requesting an administrative review of the decision. The other facility, North Fork Educational Center, has requested an administrative review of the decision, and the review is pending. A third facility, one of the Children’s Hope campuses in Levelland, Texas, has also voluntarily relinquished its license.

CHILD FATALITIES (PGS. 325-341)

The monitors have reviewed case files of the child fatalities occurring in the state’s foster care system for the nine-month period ending on April 20, 2020. These tragedies raise serious questions about DFPS practice that require thorough investigation and attention.

- DFPS has notified the Monitors that eleven children in the PMC General Class died between July 31, 2019 and April 30, 2020. The Monitors reviewed the children’s case records, including healthcare records, and investigative records. Three children’s deaths raise serious concerns about the care and supervision provided by DFPS:

- K.C. died of pulmonary thromboembolism due to deep venous thrombosis. She had been complaining of leg pain for months but did not receive medical attention. The RTC staff waited an extensive period of time (thirty-seven minutes) to call 911 after K.C. began to experience a medical emergency.
- A.B.: In the month prior to A.B.'s death, which remains under investigation and is suspicious for child abuse, A.B.'s injuries sparked multiple referrals to SWI alleging physical abuse. Those referrals led to two investigations for abuse and neglect, neither of which caused DFPS to remove the child from the placement.
- Fourteen-year-old C.G. hanged herself in the bathroom of a shelter where she was placed by DFPS following her discharge from a psychiatric hospital on March 4, 2020. C.G.'s seven-year passage through foster care was marked by increasing psychological distress and harm. Each of her three hospitalizations, all during 2019 and 2020, was precipitated by suicidal behavior and self-harm risk. DFPS moved C.G. from a hospital - a highly structured and clinically expert environment - to a shelter with a troubled regulatory history that did not provide adequate mental health care or supervision. The shelter had received the third highest number of cited standards deficiencies among all GROs in Texas over the past five years. C.G. underwent a Child and Adolescent Needs and Strengths (CANS) Evaluation fourteen days into her stay, which noted she was "Overall Suicidal Risk," and "requires" a same day safety plan, and further recommended a full assessment for suicide risk. That did not happen. The videos show that C.G. entered the bathroom by herself and remained alone for thirty minutes before staff unlocked the door and discovered her. The videos show a staff person knocking on the door to the bathroom after C.G. was in the bathroom for eighteen minutes. Although there is no audio available from the video recordings on the night of C.G.'s death, a staff member stated that when she knocked on the bathroom door, C.G. said she was okay and the staff member told her she had five more minutes in the bathroom. Twelve minutes later, the staff member returned, unlocked the door and discovered her.

See Monitoring Report at pp. 325-341 for more complete fatality summaries.