No. 24-

IN THE

Supreme Court of the United States

M. D., BY NEXT FRIEND
SARAH R. STUKENBERG, *et al.*,

Petitioners,

v.

GREG ABBOTT, IN HIS OFFICIAL CAPACITY AS
GOVERNOR OF THE STATE OF TEXAS, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

APPENDIX VOLUME II (Pages 375a-807a)

SAMANTHA BARTOSZ
STEPHEN DIXON
CHILDREN'S RIGHTS
88 Pine Street, Suite 800
New York, New York 10005

MARCIA ROBINSON LOWRY
DAVID BALOCHE
LAURA WELIKSON
A BETTER CHILDHOOD, INC.
355 Lexington Avenue,
16th Floor
New York, New York 10017

R. PAUL YETTER
Counsel of Record
CHRISTIAN J. WARD
ANDREW T. INGRAM
YETTER COLEMAN LLP
811 Main Street, Suite 4100
Houston, Texas 77002
(713) 632-8000
pyetter@yettercoleman.com

Attorneys for Petitioners

379648

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

TABLE OF APPENDICES

If a child moves even across town, they're going to say that they can't get them to the provider that they went to before, let alone these children are bouncing all over the state of Texas and in and out of places outside of the state of Texas.

They never come with their medication. The RTC doesn't give it to them. The caseworker doesn't pick it up. Now they have a new doctor because the RTC had their specific doctor they were using and now they're using a new one. They barely even get their personal items or clothing.

THE COURT: In garbage bags still?

THE WITNESS: Always in garbage bags, yes. Always. They—I mean, to give—to give caseworkers credit, they have no—no ability to force a child to go to school or anything like that, but—

THE COURT: They can't do what they can't do.

THE WITNESS: They can't do what they can't do. But why can't a tutor show up at the CWOP location every day? Why doesn't somebody come in and talk to them about sex education? I mean, I'm a parent. I imagine most people in here are. If you don't make your kid busy, they're going to get into trouble.

(*Id.* at 164:3-24.) Indeed, the Court has difficulty understanding how children placed in CWOP could continue receiving their services, given their practically nonexistent medical and educational records.[149]

And when asked if the children receive mental health or educational services, Ms. Dionne replied "Absolutely not. Nobody ever speaks to them." (*Id.* at 160:1-5.) Later, she elaborated that, based on her experience representing "dozens of CWOP children" or the parents of CWOP children:

> They are not getting any services. If they are—if the Department is telling you they're getting services, they're not meaningful. They're not real. There might be somebody who comes on Zoom for ten minutes and that's therapy. There's no—there's nothing happening except for girls who spend all day walking around the neighborhood, somehow getting drugs, somehow getting alcohol, somehow getting vapes and cigarettes, finding their way to adults who are willing to take them places, and just generally—I mean, imagine what a house would look like if 12-year-old children who are traumatized and dealing with mental health issues actually lived in and ran a house themselves. That's what every CWOP location I've ever been to looks like, or a hotel

149. The lack of medical and educational records is discussed in detail below. *See infra* page 536-42___—___.

> or whatever church they found or whatever. Whatever that location is, it's the children running it.

(*Id.* at 167:23-168:12.)

The Court heard other examples of what passes for services to children placed in CWOP. As noted earlier[150] Ms. Juarez—who was in CWOP numerous times while in PMC—was on an extraordinary psychotropic medication regimen for three years, which caused her to vomit every night and sedated her to such an extent that she slept through eighth grade. (D.E. 1487 at 275:8-12.) Yet every month during that three-year period she had a ten-minute appointment with a doctor, who told her that—despite the disruptive side effects—she needed to continue taking the medication. (*Id.* at 276:18-277:2.)

Another example came courtesy of Ms. Dionne, who described the psychological evaluation given to one of her client's intellectually disabled children: "It was about 105 degrees outside. [The provider] brought [the child] into the driveway and talked to her for ten minutes." (D.E. 1488 at 161:21-23.) Of course, "ten minutes in a hot driveway" "is not adequate to do a psychological evaluation on . . . any child or any human." (*Id.* at 161:25-62:2.)

---

150. *Supra* page 428.

7. The State appears to blame the children for being placed in CWOP

During the Contempt Hearing, the State suggested that children's high needs are the reason they are placed in CWOP. The following colloquy during Ms. Reveile's cross-examination is illustrative:

> Q. Okay. But is it fair to say that some of the children that you were trying to find placements for, it was difficult, that there were homes or caregivers that maybe were reluctant to accept them into their homes?
>
> A. Yes.
>
> Q. Okay. And is that due to behavioral issues?
>
> A. I can't say what their motivations were for denying if they were just a foster home or anything.
>
> Q. Okay. Do you know or was it your experience that children in the category of children without placement typically had more behavioral issues?
>
> A. Typically, yes.
>
> Q. Okay. And was that one of the reasons that they were children without placement in the first instance?

> A. In my opinion, no. I think it's not the kid's fault. I—
>
> Q. And to be clear, I appreciate that and I'm not asking you to blame the children. But there's a point in time when they enter the CWOP program, right? And you've explained that there were issues that you observed while children were in the CWOP program. My question is if some of those children that ended up in the CWOP program also had significant behavioral issues before they entered the CWOP program?
>
> A. Were statistics taken, there would be a correlation.

(D.E. 1487 at 231:19-232:18.)

Relatedly, Ms. Reveile recounted one example of a high-needs child, for whom she repeatedly requested the Child Placement Unit (CPU) to find a placement well in advance of the deadline to find a placement. The child was an eight-year-old boy with severe special needs, and was on Ms. Reveile's regular caseload. (*Id.* at 217:2-12 (his diagnoses included cerebral palsy, autism, vocal cord paralysis, and retinopathy).) This child had made great progress in one foster home but, because the foster parents "had a deadline," they asked Ms. Reveile to find him a new home in the next three months. (*Id.* at 217:7-9.)

Ms. Reveile gave DFPS's "placement search team three months' notice to find him a home. They said, 'That's too much time. Give us 30 days' notice.'" (*Id.* at 217:17-19.) She then emailed the placement search team "every couple of weeks," reminding them that "'this is impending. We need to find him a home. He's going to be hard to find a home for.'" (*Id.* at 217:20-22.)

But when the deadline arrived, DFPS had not secured a placement for this high-needs child. (*Id.* at 217:23-218:7.) So Ms. Reveile and her supervisor "were game planning putting him in a hotel. We were game planning having a Child Watch for this eight-year-old with significant disabilities." (*Id.* at 218:11-13.) Ms. Reveile was "mentally preparing" to stay with the child in a two-bedroom hotel so that he wouldn't lose the progress he made in the foster home—since he was nervous around strangers, he "wouldn't have done well at all" with new Child Watch workers every four hours; "[h]e would have regressed back to where he was before." (*Id.* at 218:15-21.)

Fortunately, they were able to "scrape together" a placement for this child. (*Id.* at 219:4-5.) But the only reason he was at risk of being placed in CWOP—and losing the progress he made in the foster home—was the State's tardiness, not his high needs.

And to the extent children are placed in CWOP because of their high needs, the Monitors have reported time and again that the State is responsible because of the intense trauma that the children have been exposed to in the foster care system. In 2021, the Monitors addressed exactly this issue:

> The children most affected by the [CWOP] crisis are, in many cases, PMC children who were formerly served in the RTCs and GROs that the State closed due to safety problems. Many of the children the monitoring team met during on-site visits to CWOP Settings this summer had cycled through multiple operations closed due to safety violations; some were living in facilities when they closed. Most of these children . . . shuffled for years between RTCs and psychiatric hospitals, retraumatized along the way by unsafe conditions.

(D.E. 1132 at 13.)

For example, male PMC child WW, who was fourteen at the time of the Monitors' September 2021 report, had been placed in CWOP since May 2021, except for a four-day stint in a psychiatric hospital. (D.E. 1132-2 at 1.) WW entered foster care in 2013, at the age of six, after DFPS substantiated allegations of neglectful supervision against his parents. (*Id.* at 1.) The Monitors recounted his placement history prior to CWOP:

> WW has had a number of placements since entering care in 2013, including the kinship placement with his aunt, four foster homes, two emergency shelters, and five RTCs. One of the RTCs where WW was placed, HeartBridges, has since closed due to HHSC's revocation of its license. A GRO where WW was placed in 2015, KCI Servants Heart Residential, later changed

> its name to Whataburger Center. . . . Another RTC, Family Link Treatment Services, has been placed under Heightened Monitoring due to a history of safety violations.

(*Id.* at 1.)

Further, the Monitors report that WW was allegedly an abuse victim at several RTCs:

> During his time at KCI Servants Heart (which later became Whataburger Center), two allegations of Physical Abuse of WW by staff were Ruled Out after investigation by RCCI. One of them involved a report that WW had been injured during restraints. Whataburger Center was placed under Heightened Monitoring prior to its closure due, in part, to a history of violations related to restraints.
>
> WW was also named as a victim in two RCCI investigations during his time at HeartBridges. In the first, DFPS received a referral with several allegations regarding another child at HeartBridges. In that referral it was reported that other children, including WW, had exposed themselves to the child. DFPS found that the child had acknowledged that the children had grabbed themselves, rather than exposed themselves, and later said that one child had pulled another child's pants down on a dare and staff did not see it. DFPS Ruled Out Neglectful

> Supervision. The second investigation followed a report to SWI by WW's adoption worker that an RTC staff member hit and kicked WW, causing bruises on his right arm. DFPS Ruled Out Physical Abuse against the staff, finding that other witnesses did not confirm the abuse. DFPS also Ruled Out Neglectful Supervision and Medical Neglect. HHSC's decision to revoke HeartBridges's license was based, in part, on substantiated allegations of Physical Abuse of children by staff.

(*Id.* at 1-2.) Given this history of placement instability and abuse, it is unsurprising that "WW has had five psychiatric hospitalizations since entering foster care for suicidal ideations with a verbalized plan, self-harm and physical aggression/assault. He wrapped a sheet around his neck, ran out into the middle of the road in an attempt to be hit by a car, and wrapped barbed wire around his arm and said that he wanted to die." (*Id.* at 2.) Nor is it surprising that WW has acted out: DFPS reported that the child "took a taser gun from a school police officer, fought with other children, used profanity and inappropriate language, refused to follow instructions, caused conflict, and has run away from placement." (*Id.* at 2.)

A second child, female PMC youth KK, was fifteen years old at the time of the Monitors' report. (*Id.* at 9.) She first entered the foster system in 2006, when she was five months old, "due to parental drug abuse and abandonment." (*Id.* at 9.) Between 2007 and 2010, KK was placed with two different relatives; in February 2010, she was adopted by a third relative. (*Id.* at 9.)

KK lived with her adoptive family until 2019, when she reentered foster care because her adoptive parents relinquished their parental rights after KK ran away. (*Id.* at 9-10.) The Monitors note a 2017 outcry by KK that her adoptive mother was "physically and emotionally" abusive; this was investigated by CPS, who "rendered an Unable to Determine finding because KK recanted her allegation due to fear of her adoptive mother." (*Id.* at 10.)

After being removed from three families, DPFS recognized that KK "needs to be placed with a caregiver who can 'foster and model' a healthy parent/child relationship for KK while also providing her with structure and consistency." (*Id.* at 10.) Sadly, the Monitors note that since reentering the State's care in 2019, "DFPS has not yet secured such a placement and KK has instead experienced extensive placement instability" (*id.* at 10):

> Since reentering foster care in 2019, KK has been in at least 13 placements, including six congregate care settings, three emergency shelters, two foster homes, one admission to a psychiatric hospital and, on July 17, 2021, an unauthorized placement with the relative who adopted KKs sister. Two of the RTCs where KK was placed, Children's Hope and The Landing, later closed due to a history of safety problems. Another GRO where KK was placed, Hearts with Hope, has since been placed under Heightened Monitoring. Krause Children's RTC, another GRO where KK was placed, closed voluntarily in lieu of having its license

> revoked, following a significant history of safety problems. KK has had at least one psychiatric hospitalization since entering care, and also has had contact with the juvenile justice system. KK had four spells without placement, with the first in October 2020; the length of time for her periods without placement ranged from three days to a little more than a month.

(*Id.* at 10.)

Or take AD, a male PMC child who was seventeen at the time of the Monitors' September 2021 report. (*Id.* at 26.) He "entered care" in 2012 "due to his mother's mental health issues and her lack of housing." (*Id.* at 26.) AD's "level of care when he entered placement was Basic, but during his placement at his first foster home, his level of care moved up to Moderate, and then Specialized. Since then, his care level has bounced between Intense, Specialized, and Moderate almost as often as he has moved among placements." (*Id.* at 27.)

And he has moved placements many times:

> During his nine years in foster care, AD has had eight primary caseworkers, and been in at least 20 placements, including four psychiatric hospitalizations. His placements include four RTCs, all of which have now closed: Five Oaks Achievement Center, Children's Hope RTC, Houston Serenity Place (three times), and HeartBridges. Three of these RTCs closed

> due to safety reasons (Five Oaks Achievement Center, Children's Hope, and HeartBridges), and the other RTC (Houston Serenity Place) closed after having been placed on Heightened Monitoring due to safety violations. AD successfully completed the program at Five Oaks, Children's Hope, and at Houston Serenity twice; each time his LOC dropped and he was placed back into a Therapeutic Foster Home, only to have the placement disrupt, usually in less than a year. AD was placed in seven therapeutic foster homes, and was also placed in an emergency shelter and a respite home.

Another example is B.B., who was discussed earlier[151] with regard to her many and varying psychotropic drug prescriptions. The Monitors interviewed B.B. and reviewed "a complete copy" of her records. (D.E. 1027 at 37.) Though B.B. was not placed in CWOP, her history of placement instability and escalating behavioral problems exemplify the way in which the State's use of unsafe placements causes children to develop high needs.

> In B.B.'s 11 years in DFPS care she has been in 38 placements, including eight psychiatric hospitals and nine RTCs. Two of the RTCs in which B.B. lived are now closed because of systemic safety problems, including substantiated abuse or neglect allegations. Of the 16 foster homes where B.B. was placed, only

151. *Supra* page 399-401.

> four lasted more than 60 days. In 2016 alone, when B.B. was nine years old, she was moved to nine different placements.
>
> Through all of these placements, B.B.'s behaviors have been consistent, although increasing in intensity. Her IMPACT records show that though her behavioral problems were identified early in her time in care, they were not effectively addressed, resulting in a constant cycle of disrupted foster care and adoptive placements, and eventually a cycle between psychiatric hospitals and RTCs. During the monitoring team's interview with her, B.B.'s placements seemed to be a blur to her.[152] She did not seem to remember any placements prior to her first RTC placement at Children's Hope. This is not terribly surprising, since she was seven years old at the time of that placement. She was able to remember the RTCs when prompted with the name and the sequence.

(*Id.* at 40.) During her interview with the Monitors, B.B.:

> [N]oted that she did not think that any of the RTCs had been helpful in addressing her

152. The Court is reminded of trial testimony regarding named plaintiff S.A. who, "because of her many placements," "could not remember all of the places she has been and could not assist" Plaintiffs' expert "in developing a chronology of her life." (D.E. 368 at 89 (citing D.E. 326 at 98:22-99:5).)

> behavioral needs, and said she instead felt she picked up bad behavior from other children in these settings. For example, before going to Hector Garza she had never cut herself but while there she started cutting. These placements have also further exposed B.B. to antisocial behaviors, teaching her about riots and how to protect herself from staff and other residents. While she has been sexually active in some of the recent RTC placements, no notes indicate that she is receiving proper sexual education and health education. When she was interviewed by Monitor Deborah Fowler and a member of the monitoring team, B.B. reported that she had had sex with her boyfriend during the riot at Devereux—League City, but noted that she did not believe she was pregnant because "it doesn't hurt when I sleep on my stomach."

(*Id.* at 40.)

During her first five years in the State's care, B.B. "had already bounced around approximately 18 different placements," at which point she had "her first psychiatric hospital admission." (*Id.* at 43.) She was then placed "at her first RTC, Children's Hope, "from May 16, 2014 until March 11, 2015. This started a cycle between psychiatric hospitalizations and RTCs that continue[d]" to the time of the Monitors' report. (*Id.* at 43.)

The Monitors note that "Children's Hope was a troubled facility, and had been placed under a corrective

action evaluation plan by HHSC Licensing just before B.B. was admitted. Licensing indicated that it took this step due to repeated citations for minimum standards deficiencies. The list of citations that spurred the plan included violations of minimum standards associated with corporal punishment and other prohibited punishment, and citations related to inappropriate restraints." (*Id.* at 43.) And there are indications that B.B. was abused by Children's Hope staff: "B.B.'s case worker made a report to the abuse and neglect hotline when she noticed a mark on B.B.'s face. When asked about it, B.B. told her that a staff person caused the injury during a restraint. B.B.'s case worker noted that the mark on B.B.'s face looked like a rug burn." (*Id.* at 44.) The allegation was ruled out by DFPS, but "two years later (after multiple investigations of allegations against this staff), the facility was issued citations for inappropriate discipline after several children reported that the same staff person hit them with a wooden stick." (*Id.* at 44.) B.B. was eventually discharged from Children's Hope and was then placed in a foster home, where she stayed for around five months before "she was again placed in a psychiatric hospital." (*Id.* at 44.) She then returned to Children's Hope RTC on August 31, 2015, where she stayed "until February 1, 2016, when all the children were removed from the facility by DFPS due to contractual violations which included: improperly restraining children, rooms that "smelled strongly of urine," incomplete medication logs, children injuring other children, punishing children who refused to go to sleep by making them go outside without proper clothing for the weather, a significant number of reports that staff members hit or kicked children, mouse

droppings in the kitchen and bedrooms and dead roaches throughout the facility, diabetic children who had to be hospitalized because the facility did not have appropriate testing equipment, and feces smeared on walls in some rooms." (*Id.* at 45.)

During her interview with the Monitors, B.B. described herself as a "good fighter," and explained that she first learned to fight "at Children's Hope, got better during her stay at Prairie Harbor RTC, but really honed her skills at Hector Garza [RTC]." (*Id.* at 45.)

From 2016 to 2019, B.B. bounced between foster homes, psychiatric hospitals, and RTCs, including around five months in a Florida RTC. (*Id.* at 45-47.) In 2019, she was placed in Prairie Harbor RTC. (*Id.* at 48.) Of her time there, B.B. "recalled that staff at Prairie Harbor often gave the youth in care a hard time, though she said that since she was the youngest child at the facility, staff were not as hard on her." (*Id.* at 48.) She was discharged from Prairie Harbor on November 5, 2019; the following day, she was placed at Hector Garza RTC. (*Id.* at 48.)

Hector Garza was a particularly poor placement for B.B. A Service Plan completed shortly after her placement listed several of B.B.'s triggers, including "'having her arms placed behind her back' and 'men touching her.'" (*Id.* at 48.) Yet both of these triggers were unavoidable at Hector Garza, as the facility "relied on restraints as a primary method of controlling children, restrained children with their arms behind their backs, and allowed male staff to restrain female clients." (*Id.* at 48.) Thus,

it is hardly surprising that "[n]otes in IMPACT indicate that during her placement at Hector Garza, she was 'regressing in her treatment, displaying highly aggressive behaviors.'" (*Id.* at 48.)

Further, "while she was at Hector Garza, in addition to honing her fighting skills, she picked up the habit of cutting (self-harm) from other kids at the facility." (*Id.* at 48.) B.B. also told the Monitors that there was "a lot of 'gang activity' at Hector Garza, and said that in addition to affiliations with outside gangs, the youth at Hector Garza started their own gangs." (*Id.* at 48-49.) Moreover, "B.B. reported that Hector Garza was the first facility she was placed in where riots occurred; she indicated that she was involved in at least one riot during her time there." (*Id.* at 49.)

"On May 20, 2020, DFPS reported that they had decided to end their contractual relationship with Hector Garza after determining that 'while improvements were being made, their particular model was not the direction DFPS was going long-term.' B.B. stayed at Hector Garza until July 30, 2020." (*Id.* at 49.) She was then placed at yet another RTC, Devereux—League City. (*Id.* at 49.)

Devereux—League City described itself as "a safe, structured, and nurturing environment that helps create a sense of community in both clients and staff, a sense of shared expectations and responsibility for the well-being of others as well as one's own." (*Id.* at 49.) It claimed to offer individualized treatment "that addresses their individual mental and behavioral health needs." (*Id.* at

49.) But the reality at Devereux was different: "B.B.'s records related to [her] stay at Devereux—League City show substantial lapses in treatment and safety while at the facility, during which time" B.B. "deteriorated." (*Id.* at 50.)

For example, B.B.'s Devereux—League City records show that the facility was aware of her prior placements and behavioral challenges. (*Id.* at 55.) Her "Devereux—League City files . . . indicated she was supposed to receive a trauma assessment by September 25, 2020, [but] there was no evidence to confirm one was done. Instead, the primary interventions used with B.B. were the same interventions that had been tried at every RTC she had been to, without success—a level system that rewards children with points and penalizes them by withdrawing privileges, along with weekly individual and group therapy." (*Id.* at 55.) Indeed, "during B.B.'s short stay" at the facility:

> [S]he was disciplined, restrained, and placed in seclusion on a regular basis. The monitoring team noted at least 14 instances of restraint or seclusion documented in B.B.'s Devereux—League City records. A Client Service Review Summary from Devereux—League City indicated that during the one-month period between August 27, 2020 and September 30, 2020, B.B. had "demonstrated 55 incidents of Major Behaviors including safety threats (39), physical aggression (9), property destruction (3), elopement (2), and self-injurious behavior

> (2)" though it noted "[h]er behaviors have improved in the several [sic] days."

(*Id.* at 54.)

> [D]espite clear indications . . . that B.B.'s behavioral challenges continued and escalated during her first few weeks at Devereux—League City, aside from the level system used campus-wide as part of Devereux—League City's RISE program, it does not appear that the treatment staff attempted any new strategies, or provided any additional supports and services for addressing B.B.'s behavior as her challenges and safety risks persisted. . . . The Monitors found no evidence that Devereux—League City had scheduled—or even considered—a functional behavioral assessment that would allow B.B.'s treatment team to develop a behavior support plan that treated her serious emotional disorders. . . .

(*Id.* at 54.)

B.B.'s stint at Devereux—League City ended on October 2, 2020, after she was arrested as a result of a riot at the facility. (*Id.* at 37, 56.) "After being discharged from Devereux—League City, B.B. was placed in a foster home, where her behavior resulted in two additional psychiatric hospitalizations. While in the foster home, she again had contact with the juvenile system as a result of misdemeanor assault charges related to an altercation with a member of the foster parent's family." (*Id.* at 56.)

On December 6, 2020, B.B. was placed, for a second time, at the RTC in Florida, though her discharge plan after her first stint "described B.B. as making little progress during her stay at the facility." (*Id.* at 56-57.) A month later, on January 4, 2021, the Monitors learned that "B.B. had twice been assaulted by peers in the month that she had been at the Florida RTC." (*Id.* at 57.) And on January 23, DFPS reported that B.B. "experienced some temporary regression. She reportedly began presenting negative behavior that she hadn't engaged in for over a year. . . . After several years of sustained improvement, B.B. recently experienced some issues with enuresis." (*Id.* at 58.) "Less than a week later, on January 29, 2021, DFPS notified the Monitors that B.B. had been admitted to another psychiatric hospital." (*Id.* at 58.)

8. The State is spending extraordinary sums of money on the harmful CWOP system

A comprehensive accounting of the burden that CWOP imposes on Texas taxpayers is, of course, beyond the scope of this Order. But to get a sense of scale, the Court will discuss two expenditures for which amounts can readily be calculated: the cost of placing private security guards at CWOP Settings and the cost of staffing CWOP Settings with caseworkers.

In early 2022, the State contracted with two private security companies to provide security guards at CWOP Settings. (*See* PX 57 at 1 (contract with "Premier Protection and Investigations, LP, DBA PPI Security"); PX 58 at 1 (contract with "Silver Shield Security Inc.").)

Appendix B

These contracts (the "2022 Contracts") obligated the State to pay up to $27,089,855.40 for services rendered between February 14, 2022 and August 31, 2023. (PX 57 at 1 ("The total amount of this Contract may not exceed $23,219,876.00."); PX 58 at 1 ("The total amount of this Contract may not exceed $3,869,979.40.").) The hourly rates under the 2022 Contracts ranged from $53 per hour (for non-holiday shifts) (*see* PX 57 at 6) to $127.50 per hour (for shifts during holidays) (*see* PX 58 at 6). The rate schedules are reproduced below:

Appendix B

Questions	**DFPS Region 1**	**DFPS Region 2**	**DFPS Region 3**	**DFPS Region 4**	**DFPS Region 5**	**DFPS Region 6**	**DFPS Region 7**	**DFPS Region 8**
What is your **Non-Holiday** Hourly Rate to provide Officers for Service Requests?	$55	$55	$62	$62	$53	$53	$62	$53
What is your **Holiday** Hourly Rate to provide Officers for Service Requests?	$65	$65	$72	$72	$63	$63	$72	$63

Appendix B

Questions	**DFPS Region 9**	**DFPS Region 10**	**DFPS Region 11**				
What is your **Non-Holiday** Hourly Rate to provide Officers for Service Requests?	$72	$58	$53				
What is your **Holiday** Hourly Rate to provide Officers for Service Requests?	$82	$68	$63				

(PX 57 at 6.)

Appendix B

Questions	**DFPS Region 1**	**DFPS Region 2**	**DFPS Region 3**	**DFPS Region 4**	**DFPS Region 5**	**DFPS Region 6**	**DFPS Region 7**	**DFPS Region 8**
What is your **Non-Holiday** Hourly Rate to provide Officers for Service Requests?	$85.00	$85.00	$85.00	$85.00	$85.00	$85.00	$85.00	$85.00
What is your **Holiday** Hourly Rate to provide Officers for Service Requests?	$127.50	$127.50	$127.50	$127.50	$127.50	$127.50	$127.50	$127.50

Appendix B

Questions	**DFPS Region 9**	**DFPS Region 10**	**DFPS Region 11**				
What is your **Non-Holiday** Hourly Rate to provide Officers for Service Requests?	$85.00	$85.00	$85.00				
What is your **Holiday** Hourly Rate to provide Officers for Service Requests?	$127.50	$127.50	$127.50				

(PX 58 at 6.) For context, a conservatorship caseworker's highest possible salary is $72,408[153] which, assuming the caseworker works forty hours per week, fifty weeks per year, is $36.20 per hour. Thus, the lowest-paid security guard gets paid around 50 percent more per hour than the highest-paid caseworker.

The Monitors report that in March 2023, the State issued a "$17 million Request for Proposals (RFP) that extended contracting with the security" companies. (D.E. 1425 at 11.) The RFP specified that the "projected amount of the contract under Historical Compensation"—that is, based on the amounts paid under the 2022 Contracts—"is $17 million per fiscal year." (*Id.* at 11 n.26.) Thus, the State spent nearly the full amount allowed under 2022 Contracts,[154] and expects to continue spending that amount going forward.[155]

---

153. CPS employees whose responsibilities include "serving as conservator of a child" are those classified as Child Protective Services Specialist I-IV. *See, e.g.*, State Auditor's Office, Child Protective Services Specialist IV at 1 (Sept. 1, 2023), *available at* https://hr.sao.texas.gov/Compensation/Job Descriptions/R5026.pdf. The Child Protective Services Specialist IV classification is in Salary Group B19, *see id.* at 1, with a corresponding Salary Range of $45,244 to $72,408, *id.* at 1; *see also* State Auditor's Office, Salary Schedule B, Annual Salary Rates: Effective September 1, 2023 to August 31, 2024, *available at* https://hr.sao.texas.gov/Compensation System/ScheduleAB? scheduleType=2024B.

154. Specifically, $17 million per year means that, over the 18.5 month (1.54 year) duration of the 2022 Contracts, the State paid around $26,180,000.

155. At the Contempt Hearing, it was confirmed that the security services provided under the 2022 Contracts and their

As for cost of staffing, CWOP shifts are staffed by caseworkers working overtime. The overtime paid to these workers can be estimated from the CWOP hours reported by DFPS. In the first ten months of 2023, caseworkers worked an average of 60,427 CWOP hours per month. (PX 107S at 1; *see also* D.E. 1489 at 21:16-19 (noting that hours reported for 2023 covered period from January to October).) Thus, caseworkers worked approximately 725,124 CWOP hours in 2023. The Court will assume that the caseworkers are paid $30 per overtime hour.[156] Thus, staffing CWOP Settings cost the State approximately $21,753,720 in 2023.

---

extension pursuant to the RFP were exclusively for CWOP Settings. (*See* D.E. 1488 at 51:15-52:24.) Thus, while there may be security guards at other facilities, their services would not be paid for from these contracts.

156. As noted in footnote 153, *supra*, CPS employees whose responsibilities include "serving as conservator of a child" are those classified as Child Protective Services Specialist I-IV. The entry level Child Protective Services Specialist, Child Protective Services Specialist I, is in Salary Group B16, *see* State Auditor's Office, Child Protective Services Specialist I at 1 (Sept. 1, 2023), *available at* https://hr.sao.texas.gov/Compensation/JobDescriptions/R5023.pdf, with a corresponding Salary Range of $37,918 to $58,130, *id.* at 1; *see also* State Auditor's Office, Salary Schedule B, Annual Salary Rates: Effective September 1, 2023 to August 31, 2024, *available at* https://hr.sao.texas.gov/Compensation System/ScheduleAB? scheduleType=2024B. Taking the average of this salary range, the Child Protective Services Specialist I is paid $48,024 per year. Assuming such workers work 2000 hours per year (forty hours per week, fifty weeks per year), they are paid $24.01 per hour, and would be "pa[id] for the overtime at the rate equal to 1 ½ times the employee's regular rate of pay," Tex. Gov't Code § 659.015(c)(2), or $36.02 per hour. Thus, the Court's estimate of $30 per overtime hour is very conservative.

Accordingly, in 2023, the State spent approximately $38,753,720 just to CWOP staff and to secure the CWOP Settings, or $106,174.58 per day. Divided by 81.5 children (the number of children, on average in CWOP per day, according to the State (D.E. 1555 at 1)),[157] or $1302.75 per day per child placed in CWOP. Again, this excludes all costs of food, lodging, and transportation. Compare this per day expenditure to the following quoted rates for every other foster care placement. These figures include food, housing, and transportation. It is possible to surmise that CWOP has become financially self-perpetuating.

The following payment rates are effective **September 1, 2023**.

24-Hour Residential Child Care Rates

Service Level	Type of Care	Payment Rate
Basic	Child Placing Agency	$57.71
	General Residential Operation (excluding Emergency Shelters)	$52.65
Moderate	Child Placing Agency	$101.77
	General Residential Operation (excluding Emergency Shelters)	$126.03
Specialized	Child Placing Agency	$126.62
	General Residential Operation (excluding Emergency Shelters)	$227.34

157. The Court notes that these numbers from the State are unreliable as referenced herein. *Supra* page 434-35.

Appendix B

Intense	Child Placing Agency	$218.11
	General Residential Operation (excluding Emergency Shelters)	$324.52
Intense Plus	General Residential Operation/ Residential Treatment Center (GRO/RTC)	$480.86
Other	General Residential Operation/ Emergency Care Services (GRO/ECS)	$153.09
	Intensive Psychiatric Family Care—Agency	$449.20
	Treatment Foster Family Care—Agency	$318.98
	Temporary Emergency Placement (TEP)	$480.86

Minimum Daily Reimbursement to a Foster Family

Service Level	Payment Rate
Basic	$27.07
Moderate	$47.37
Specialized	$57.86
Intense	$92.43
Treatment Foster Family Care	$137.52

The amounts above are the minimum amounts that a child-placing agency must reimburse its foster families for clients receiving services under a contract with the Texas Department of Family and Protective Services.

Appendix B

Supervised Independent Living (SIL)

Service Level	Type of Care	Payment Rate
Host Home Setting	Young Adult Only	$35.21
	Young Adult plus one (1) Child	$47.29
	Enhanced Case Management*	$47.54
Non-College Dorm Setting	Young Adult Only	$45.17
	Young Adult plus one (1) Child	$57.25
	Enhanced Case Management*	$47.54
College Dorm Setting	Young Adult Only	$43.56
	Young Adult plus one (1) Child	$51.82
Apartment or Shared Housing Setting	Young Adult Only	$45.17
	Young Adult plus one (1) Child	$57.25
	Enhanced Case Management*	$47.54

* Enhanced Case Management (ECM) services are not provided in college dorm settings.

Appendix B

Community-Based Care (CBC) Rates

Catchment Area	Blended Rate	Exceptional Care Rate
Catchment Area 1	$99.43	$511.80
Catchment Area 2	$104.13	$511.80
Catchment Area 3W	$100.84	$511.80
Catchment Area 3E	$101.61	$511.80
Catchment Area 4	$101.69	$511.80
Catchment Area 5	$98.23	$511.80
Catchment Area 8b	$102.67	$511.80

DFPS, 24-Hour Residential Child Care Reimbursement Rates, *available at* https://www.dfps.texas.gov/Doing_Business/Purchased_Client_Services/Residential_Child_Care_Contracts/Rates/default.asp.

Of course, the full cost of CWOP is far higher. As discussed in greater detail below, the CWOP crisis is overburdening caseworkers, thus driving an unprecedented 36 percent caseworker turnover rate.[158] (*See* D.E. 1347 at 219:1-7 (April 2023 testimony of Associate Commissioner Banuelos).) And caseworker turnover is staggeringly expensive. In *Stukenberg I*, the Fifth Circuit noted that "[t]urnover is . . . an enormous fiscal burden for DFPS. The Sunset Commission estimated in 2014 that the loss of caseworkers over the prior year resulted in a $72.7 million impact to the agency." 907 F.3d at 258. And that was

158. *Infra* page 522-30.

with a turnover rate of around 25 percent. *See id.* at 257 ("Over 25% of the roughly 2,000 CVS caseworkers leave CPS annually."); (*see also* D.E. 368 at 177-78 n.46 (noting "the Stephen Group's finding that yearly CVS caseworker turnover is 26.7%.")). Thus, the cost of the present turnover rate likely runs into the hundreds of millions of dollars.

And a full accounting would also include, *inter alia*:

- The cost of the hotels and dilapidated houses in which the children are being held.

- The cost of logistics: As Ms. Carrington explained, "There's a whole team that's dedicated to nothing but scheduling CWOP, making sure the hotels have been reserved, making sure that staff have been . . . scheduled to supervise the youth." (D.E. 1488 at 224:18-21.)

- The cost of caring for the many children who have been sex-trafficked out of CWOP Settings. (*See* Court's Ex. 4 at 17 (noting that one can calculate the "net present value of the lifetime cost of care required as a consequence of human trafficking for each child victim").)

In short, the State is spending at least $38 million dollar per year—and, almost certainly, many multiples more—on a system that appears to harm everyone it touches except, evidently, the security companies, the owners of the hotels and residences used as CWOP Settings, and the sex traffickers.

9. Attempts to manipulate data regarding CWOP

During the Contempt Hearing, the Court commented on the State's efforts to "do workarounds of my orders . . . and redefine so they don't connect at all to the constitutional violation they were intended to address." (D.E. 1488 at 191:4-9.) Ms. Dionne informed the Court that Defendants use similar workarounds in Texas state courts:

> . . . . Let me give you an example. One time when Judge Martinez Jones called a contempt hearing, every person who had a child in CWOP in Travis County, every lawyer who had a client in CWOP, was called to that. So there were five of us in there. And the Department said there's only two kids in CWOP. At the same time my client texts me and goes, "Yo, Lindsey, why are they driving me around in a car right now, and why won't they take me back?". . . .
>
> BY MR. YETTER:
>
> Q. What was that about? What was he doing? Why were they driving him in a car?
>
> A. Because their definition of . . . CWOP had changed that day.
>
> THE COURT: And that's what—that's what they were doing, were cutting the numbers down for the hearing day?

> THE WITNESS: Yes.
>
> BY MR. YETTER:
>
> Q. Put a child in a car, and they're not in CWOP—
>
> A. Exactly.
>
> Q.—because they're driving around the city?
>
> A. Now, they were—potentially he was going to get taken to a placement. I put air quotes around that for the record, because that's not really what was going to happen. They dropped him right back off the second the hearing ended.
>
> . . . .
>
> THE COURT: Well, that certainly messes with the numbers, doesn't it?
>
> THE WITNESS: You can't believe the numbers. You can't trust them. You cannot trust whatever they're telling you. Even within—they can't trust each other. Travis County can't trust Williamson County. None of this is interfacing with each other.

(*Id.* at 191:10-193:1.)

This unrebutted testimony is reminiscent of the subject matter of the first contempt motion. At trial in

2014, then-Assistant Commissioner of CPS Lisa Black falsely testified that all group facilities except foster group homes[159] had 24-hour awake-night supervision. (D.E. 725 at 6 (D.E. 300 at 60-62).) As the Court discovered four years later, the first part of Ms. Black's testimony was false: Not all group facilities had 24-hour awake-night supervision, and no group facilities were required to have such supervision. (*Id.* at 8.) Defense counsel heard this testimony, of course, as did then-DFPS Commissioner Specia and other DFPS staff members, but none of them sought to correct it. (*Id.* at 6 (D.E. 300 at 23-29, 43, 48).) Later, the Court and Mr. Specia had a colloquy about 24-hour awake-night supervision, and he again failed to correct Ms. Black's testimony. (*Id.* at 7 (D.E. 300 at 27-28).)

For the next four years Defendants relied on Ms. Black's testimony and made further false representations about 24-hour awake-night supervision before both this Court and the Fifth Circuit. (*Id.* at 7-8 (Reply in Support of Mot. For Stay Pending Appeal at 13 (Feb 5, 2018)).) Specifically, they maintained the position that all other group facilities had 24-hour awake-night supervision. (*Id.* at 7-8.) And after the Court ordered Defendants to "immediately stop placing PMC foster children in unsafe placements, which include foster group homes that lack 24-hour awake-night supervision" (D.E. 368 at 245), they "assured" the Court that all foster group homes except one had such supervision (D.E. 725 at 7).

---

159. Foster Group Home was a classification of childcare facility that provided "care for 7 to 12 children for 24 hours a day." (D.E. 368 at 256.) The classification was eliminated by legislation enacted in 2017. (*See* D.E. 711 at 2 n.1 (citing Act of May 24, 2017, 85th Leg., R.S., ch. 317, § 4 (amending Tex. Fam. Code § 101.0133)).)

Then, in September 2019, the Monitors discovered that the State had not required any group facilities to provide 24-hour awake-night supervision until July 2019. (*Id.* at 8 (D.E. 711 at 2).) On October 9, 2019, Defendants finally conceded "that not all placements in Texas housing more than six children have 24-hour awake night supervision nor were they required to do so at the time of trial." (*Id.* at 9) (D.E. 679 at 8-9 (emphasis omitted).) As the Court noted in its first contempt order, these false statements likely affected the course of trial. (*See id.* at 9 (noting that because of the false testimony, the Court was never presented with evidence about the dangers created by the absence of 24-hour awake-night supervision in larger congregate care settings).) And they were certainly relied upon by the Fifth Circuit in *Stukenberg I*. (*See id.* at 10 (citing to *Stukenberg*, 907 F.3d at 270 (5th Cir. 2018)).)

Affirmative mendacity by those in leadership positions certainly has the potential to skew the data. But so too does an apparent propensity by some CWOP workers to underreport incidents in CWOP Settings. In their Fifth Report, the Monitors note that a member of the monitoring team found an incident report from a CWOP Setting in Beaumont, documenting that a seventeen-year-old child "drank a cleaning product at the CWOP location and, afterwards, an unnamed staff member found the child slumped over on the floor." (D.E. 1318-2 at 56.) This incident was not reported to SWI by any of the CWOP workers on duty at the time; instead, it was reported by the monitoring team member. (*Id.* at 56.)

> When the [DFPS] investigator questioned one of the staff members about the failure to

> report the incident to SWI, the staff member reported that if staff members had to report every incident that occurred "on every shift [at CWOP locations], statewide intake would be blowing up with investigations."

(*Id.* at 56.)

10. The State's commitment to ending CWOP is questionable

As noted above,[160] Defendants know that CWOP is unsafe. And it is clear that resources are available—after all, the State is spending at least tens of millions of dollars annually perpetuating the CWOP crisis. Thus, in a vacuum, Commissioner Muth's assertions that she is working to end CWOP are encouraging. But it is far from clear that the rest of DFPS shares her commitment to this goal. For example, Associate Commissioner Banuelos was notably reluctant to recognize that CWOP was even a problem:[161]

> Q. Now, one of the ongoing issues in the State of Texas is children for which there is no licensed regulated placement. Do you know what I'm

160. *Supra* page 432-33.

161. The Court noticed a major difference in State employees' willingness to call any situation unsafe between testimony in April 2023 and December 2023. The Court can only speculate as to the sea change in the ability and inability to recognize unsafe situations.

talking about? Sometimes the State calls it CWOP.

A. Yes.

Q. That's a big issue in the State of Texas, isn't it?

A. I would say that it's—we do have some children that are without placement.

. . . .

Q. Sure. Good. And that's a problem for the State of Texas today, isn't it?

A. It's a concern.

. . . .

THE COURT: Sorry. It's not a problem?

THE WITNESS: We would prefer that children are in licensed placements.

THE COURT: Because?

THE WITNESS: Because we want children to be placed in a licensed placement—

THE COURT: You want them to be safe?

> THE WITNESS:—where there's different caregivers.
>
> THE COURT: You want them to be safe?
>
> THE WITNESS: We have want them to have a safe and good placements.

(D.E. 1487 at 284:13-86:6.)

Likewise, Ms. Banuelos was reluctant to admit that children were at risk of harm when placed in CWOP:

> Q. And a hotel is no place for a safe, good placement for children, is it?
>
> A. Sometimes.
>
> THE COURT: How is that?
>
> BY MR. YETTER:
>
> Q. Are you—
>
> THE COURT: Sorry. I need to know. Sometimes what?
>
> THE WITNESS: So—can you repeat the question?
>
> BY MR. YETTER:

> Q. Sure. A hotel is no place for a safe and good placement for a child under the care of DFPS?
>
> (Pause)
>
> THE COURT: She apparently has a great deal of trouble answering that.
>
> THE WITNESS: I would say that a hotel can be a difficult place for a child to have as a placement.
>
> BY MR. YETTER:
>
> Q. It can be an unsafe place for a child, can't it, a hotel?
>
> A. Sometimes.
>
> . . . .
>
> Q. And a hotel is no place for a child that has been traumatized severely, is it, as a placement by the State of Texas? That's no place for a child to be safe, is it?
>
> A. I can't say that it's always not safe.

(*Id.* at 286:9-288:9.) In fact, she was remarkably unconcerned about the dangers posed by placement in CWOP:

> Q. Have you been concerned for the safety of children that are put in these unregulated placements based on what you've read in the Monitors' reports? Have you been concerned about their safety?
>
> A. For some situations.
>
> THE COURT: So it's not an all-consuming concern is what you're saying?
>
> MR. YETTER: Just kind of concerning?
>
> THE COURT: It's just sort of hit or miss with you?
>
> THE WITNESS: I said some concerns.

(*Id.* at 291:13-22.)

Indeed, she repeatedly minimized the trauma endured by children in foster care:

> Q. Every child in foster care has been through trauma because they're no longer with their family, right?
>
> A. That could be traumatic.
>
> Q. Some of the children have been through additional trauma, for example, abuse, physical or sexual abuse, true?

> A. That can be additional trauma.
>
> Q. Before they come into the system and after?
>
> THE COURT: Wait a minute. Aren't all the children that you pick up have been traumatized?
>
> THE WITNESS: Yes, they've experienced some trauma.
>
> . . . .
>
> Q. It's not just some. This is kind of the trauma of losing your family.
>
> A. Yes.
>
> Q. That's tremendously severe trauma, isn't it?
>
> A. Yes, it's some trauma. Absolutely.

(*Id.* at 287:12-288:5.) Associate Commissioner Banuelos' reticence at the Contempt Hearing is particularly noteworthy given her candor and forthrightness at previous hearings.[162]

---

162. (*See, e.g.*, D.E. 1347 at 65:14-20 (discussing issue with PMC children having proper medical consenters and conceding that "the error was on the DFPS because we should have never made the provider a medical consenter, it should have been the caseworker").)

Moreover, it is difficult to reconcile Commissioner Muth's stated goal with the State's apparent plan to make CWOP permanent. Ms. Dionne reported that at the meeting convened by the state court judges:

> Q. What has the State said they're going to do?
>
> A. Okay. So Staci Love said, "We have been hesitant to institutionalize CWOP, but we are starting to realize that that is going to be necessary."
>
> THE COURT: Institutionalize?
>
> THE WITNESS: Meaning make rules.
>
> THE COURT: Make it permanent?
>
> THE WITNESS: Make rules around it, have them follow the minimum standards. . . .
>
> THE COURT: So they're thinking about it in September?
>
> THE WITNESS: They're thinking about it. They're thinking about it.
>
> THE COURT: Two months ago?
>
> THE WITNESS: Yes. And—
>
> BY MR. YETTER:

> Q. They said they've been thinking about it for a while but not doing it because they're hesitant.
>
> A. They do not want to. They think it would be a negative thing, because then the children would think, oh, I can just be here because now we've—it's institutionalized.

(D.E. 1488 at 187:19-188:16.)

And DFPS's September 22, 2023 letter to the three state court judges as a result of their meeting with DFPS gives the Court no reason to believe that the Department is taking the problems in CWOP seriously. For example, the letter appears to blame the children and CWOP workers for the problems at CWOP Settings. (*See* Attachment 1 at 1 ("DFPS is updating the expectations of youth temporarily staying at child watch locations. Updates include new guidelines and a system for increased structure to incentivize positive behavior. The updated structure will provide transparency to youth regarding rules and routine and will clarify staff expectations for DFPS employees working child watch.").)[163] The letter also implies that local law enforcement is to blame. (*See id.* at 2 ("DFPS is coordinating with local law enforcement agencies who have jurisdiction over child watch locations to reiterate the critical need for law enforcement support. As part of the discussion, DFPS will share information regarding . . . the need for consistent and prompt law enforcement

163. This letter was submitted at the Contempt Hearing as Plaintiffs' Exhibit 97. It is attached to this Order for the convenience of the reader.

response to address worker safety concerns and missing children reports, trafficking concerns, and support for DFPS children who may have experienced criminal victimization while not in our care and supervision.").) And it blames the Texas legislature. (*Id.* at 3 ("Senate Bill 1930 passed during the 88th Regular Legislative Session. . . . Since the effective date of September 1, discussions and confusion regarding requirements of the court and legal party responsibilities prior to a placement occurs have developed.").)[164]

Conspicuously absent is any recognition that DFPS may have some responsibility for the situation. The letter states that the DFPS is "working with the Department of Public Safety (DPS) to conduct security assessments of all child watch locations in Region 7,"[165] and that the assessments "are specifically targeted to identify risks related to human trafficking." (*Id.* at 2.) But it does not propose any solutions to the trafficking problem—quite the contrary, the letter commits DFPS to nothing more than "review[ing] the results of those assessments to determine *whether additional actions are needed* to ensure the safety of children and youth temporarily staying at child watch locations." (*Id.* at 2 (emphasis added).)

---

164. As noted earlier, *supra* page 437-38, this is not the first time that DFPS has disclaimed responsibility for the CWOP crisis.

165. Of course, the letter does not disclose whether security assessments will be conducted at CWOP locations in the other DFPS regions.

Appendix B

11. One night at a CWOP Setting

In their September 2021 update to the Court, the Monitors reproduced a Serious Incident Report that recounts all the incidents that took place at one CWOP Setting on a single night. The report documents children freely leaving and returning to the CWOP Setting, a child smoking, inappropriate child-on-child sexual behavior, reliance on law enforcement, threats of physical violence, and a child using unaccounted-for pills to attempt suicide. **All in a single CWOP Setting on a single night**.

> At 1:15AM [G] decided to go smoke, staff . . . followed her outside. At this same time [a caseworker and staff person] noticed [T] and [J] go into the room where [R] was laying down. [The caseworker] went into the room and turned on the lights, and it seemed as the teens were trying to be inappropriate with each other they got upset due to [the caseworker] being there and not leaving, [T], [J] and [R] got up and stated they were going to walk to the store. At 1:24AM [R], [T] and [J] were stopped by [a staff person] and [asked] "Hey guys where are y'all going?" [R] responded, "We're going to take a walk to the store." [The staff person] replied, "Its dark guys, it's not a good area and if y'all wanna go to the store, let me call [a Program Director] and see if she approves for me to drive you instead of y'all walking out there as there aren't any close corner stores that are open." [R] said, "No, I don't wanna be seen with . . . you,

you're weak and I'd be embarrassed to be seen with you." They then started walking towards [the road]. [The Program Director] was called and she advised to call law enforcement. [Law enforcement] was called and [a] missing children report was generated.

At 3:10AM the teenagers were seen walking back to location and [law enforcement] spotted them and walked them to the location. [The Program Director] was notified teens refused to be separated. [The Program Director] informed [the staff person] that [R] will need to go to [to another CPS office]. At the same time, [G] and [T] were blowing up gloves and popping them with pencils, they were asked to stop doing that as they can hurt themselves with the pencils, they refused and said they weren't going to be hurt. [Three] min[ute]s later, [G] threw the pencil to [T's] blown glove and pencil bounced and hit [T] in the eye. [T] was asked if she was ok and she stated she wanted medical attention for her eye. [The Program Director] was called and EMS was called at 3:42AM. As EMS called for [T], [J] and [R] got up and started walking down the hall towards the outside door, [the caseworker], [T] and [G] followed. Staff . . . asked them where were they going? They stated mind your business we'll be back later.

Law enforcement was called again at 3:50AM to report [R] and [J]. As they were leaving the

premises, EMS pulled up and [T's] eye was checked, medical staff reported her eye looked fine and he didn't think she needed medical attention, but staff was advised if her eye keeps bothering her to take her to urgent care clinic. About 10 minutes later both [G] and [T] walked back outside. [T] stated to [the caseworker] [G] has pills with her and threatened to beat her up if she is to tell anyone as she is feeling depressed and doesn't feel like living anymore. [T] was scared and told staff, "Don't tell her I told you, but I'm worried about her." [G] was seen walking towards the trash bin. [The caseworker] mentioned to Staff . . . we need to closely monitor [G] as she is acting distant and weird and she was seen putting something in her mouth. [G] was called several times but purposely ignored staff and would not take her ear phones out of her ears while making eye contact at times with staff [who motioned to her] to take them out and hear us. It was stated what [T] had told [the caseworker], then Staff . . . followed [G], she then went behind the bin and made gag sounds and left the scene walking towards building. When Staff . . . arrived at [the] trash bin, I turned on my phone's flashlight and I saw [vomit] on the floor. I was approached by [T] and she informed me [G] had a handful of pink pills and she had taken them and made the following statement to [T], "I'm done with life." Staff . . . approached [G] and she refused to talk to anyone and put her headphones back

on. For precaution, [the Program Director] was called as we didn't physically see her with pills on her hand or taking pills, we were advised to call EMS to check up.

At 4:05AM [R] was seen around the corner running towards CWOP building and police car chasing him down. [R] opened the back door and ran inside, officer got out his car and ran inside after [R]. [The caseworker] and [police officers] walked throughout building as [R] was hiding in front of building and eventually came to CWOP area as [the caseworker] called stating he is back in area [the police officers] then stayed in hallway and placed handcuffs on [R] asking him why is he running away from police. [R] gave smart remarks back to [the police officers] and cooperated being handcuffed and was escorted out of building. Meanwhile, [G] was still outside and laid down on the floor, she was addressed and asked if she was feeling ok and did not respond. Second officer was taking [J] out of the police car and released her. [J] started cussing at the officers and told them she was going to leave. Officer went after her and told her, "get your ass inside the building" and was guiding her towards the door. [R] was then put inside the police car.

[T] came outside and told staff . . . she was fearful as [G] had threatened her if [she] "opened her mouth". [The staff] for safety

precaution told [T] to go inside his car and stay there until it's safe. [The staff] got a call from [the caseworker] that [J] had gotten the water hose out of [the] glass door and was starting to pull it all out of [the] box. [The caseworker] pulled the hose away from [J] and told her to stop to avoid any incidents. [J] got upset and cursed at worker. [J] then walked towards front door of building and was witnessed kicking glass door to building by [the caseworker] who told her repeatedly to stop kicking [the] door as glass was going to shatter on door. [J] cursed at worker and then [G] walked into area and tried to convince her to stop. [J] would not reason with either [the caseworker] or [G] and continued kicking the door.

[G] then walked out of front area. [The caseworker] called . . . [to ask] . . . for assistance by [the police officers,] as they were still on premises[,] to help with [J] kicking glass door and trying to destroy property. During this time, [J] had woken up the rest of the youths from banging on the door. [The police] officer came and spoke to [J] and she calmed down a bit.

Shortly after . . . [p]aramedics walked into the front area with [the police] officer and [the caseworker] requesting [to be directed to the] child that shows signs of overdosing. Paramedics [were] escorted to CWOP area

> where [G] was. [G] refused to be checked, she stated she only had two individual pills of ibuprofen a [caseworker] had given her. [G] repeatedly kept crying stating she only had two pills and she was informed that she can't take pills without staff administering them to teens. EMS asked [T] and [T] reported she did see [G] with a handful amount of pills. EMS and another police officer escorted [G] out as she was refusing to go outside. Once [G was] in the ambulance, [T] was brought back inside the building. [R] was taken to [another CPS office] by law enforcement. [The caseworker] escorted [G] to Texas Children's, while other staff remained. Staff started cleaning [G's] room and a box of 50 coated Ibuprofen 200mg tablets was found, however, the bottle was not found. [Staff] reported to [the Program Director] that [the police officers] stated they were going to call in an intake because staff should have known [G] was suicidal and been watching her so she did not take the pills. [The Program Director] also talked to an officer who asked what was our plan to prevent [J] from destroying property. He asked if we were going to lock her in a room to prevent this from happening. [The Program Director] explained that we cannot lock a child in a room.

(D.E. 1132 at 90-92.)

So goes a night in the "sustained crazy that is CWOP." (D.E. 1488 at 239:8-9.)

* * *

The State is unable to articulate a reason that these facilities could not be licensed and staffed with trained caregivers. Further, all of these issues are directly related to and exacerbated by the requirement that DFPS caseworkers supervise CWOP Settings, leading to unmanageable caseloads, burnout, and turnover. The Court carries forward the Contempt Motion on this issue.

D. Caseworker caseloads

1. The long history of excessive caseworker caseloads in the Texas foster care system

From the outset, excessive caseloads leading to caseworker burnout and turnover have been major features of this litigation. (*See, e.g.*, D.E. 1 at 64 ¶ 266 (alleging that "high caseloads lead to turnover rates among DFPS caseworkers that Texas itself has deemed 'excessive'"); *id.* at 65-66 ¶ 273 ("Despite Defendants' long awareness of these problems, they continue now. An Adoption Review Committee report[166] from December

166. The Texas Adoption Review Committee was formed in 2009 by the Texas Legislature and then-Governor Perry "to take a hard look at the Texas foster care system." (D.E. 368 at 10.) "The Committee conducted a ten-month review, which included testimony from DFPS employees, foster care advocates, policy analysts, foster and adoptive parents, CPAs, and experts from

2010 found that 'caseworkers carry extremely high caseloads, often twice what is deemed best practice. This contributes to high turnover rates and reduces positive outcomes for children.'").)

By the time of trial, the State was well aware that tracking caseworker caseloads and keeping them within a manageable range was crucial to maintaining a workforce that would keep foster children safe. As the Court explained in the 2015 Memorandum Opinion and Verdict:

> DFPS has known for almost two decades that overburdened caseworkers cause a substantial risk of serious harm to foster children. DFPS also admitted, "An overloaded case worker is bad for the children they are supposed to protect" and high caseloads "put[] a burden on the worker" and "can have a number of negative consequences. Further, DFPS's external consultants have told DFPS that manageable caseloads are crucial to foster children's well-being. Numerous reports echo this sentiment.
>
> In addition, DFPS has long been aware that its caseloads are too high. As early as 1996, the Governor's Committee to Promote Adoption told DFPS that it needed to reduce CVS caseworker caseloads.

---

ten areas of DFPS." (*Id.* at 10.) The Adoption Review Committee's December 2010 report was submitted by Plaintiffs as trial exhibit 1964.

. . . .

> DFPS has also known for a long time that caseworker turnover poses a substantial risk of serious harm to foster children. . . . An internal study done by DFPS in December 2012 found that two of the main factors contributing to CPS caseworker turnover were "poor working conditions and environment (safety and work-related stress)" and "workload concerns making it difficult to perform adequate work."

(D.E. 368 at 186-87, 189-90 (citations omitted).)

Indeed, the importance of tracking and managing caseworker caseloads was made clear to the State by both internal and external reports. In 2007, for example, a report by Texas Appleseed explained that "[w]hen those caseworkers are inadequately trained, inexperienced, or overburdened, the system breaks down and children in the system are harmed." (*Id.* at 163 (citing to trial exhibit PX 1966 at 11).) A 2014 DFPS audit likewise reported that "[t]he single most important improvement any system can make is to ensure it has a well-trained workforce with workloads that meet national standards." (*Id.* at 163 (citing to trial exhibit PX 1880 at 16).) Indeed, CPS's then-Director of Systems Improvement wrote in an article that "'[w]ith respect to CVS, historically, a fairly direct relationship exists between caseloads and voluntary turnover.' In support of that statement, [she] cited data showing that when 'caseloads declined 16 percent from 2006 to 2008 . . . CVS voluntary turnover declined 10

percent.'" (*Id.* at 177 (citing to trial exhibit PX 1871 at 11) (ellipsis retained).)

Yet, at the time of trial, Texas' child welfare system was unique, in that it "put[] no limits on the caseload size that a conservatorship worker can carry." (*Id.* at 163 (D.E. 305 at 27:22-24).) Nor was the State tracking its caseworkers' caseloads in an intelligible way. Instead, it tracked caseloads "in terms of 'stages,' each of which represent[ed] an aspect of the work that needs to be done with a child or her family, rather than by individual children." (*Id.* at 162.) This method of counting caseloads—which was "unique to Texas"—gave little useful information: "Defendants' and Plaintiffs' experts could barely understand the stage-counting approach, let alone explain it to the Court. It is therefore difficult to compare DFPS caseworker caseloads to national and professional standards." (*Id.* at 162 (D.E. 327 at 38-39; D.E. 325 at 124-125; D.E. 305 at 45-51).)

And while this "nebulous" approach to caseload tracking already muddied the waters, DFPS padded the numbers to further obfuscate the true extent of its caseload problem. For example, DFPS would count as caseworkers "people that are not there, such as workers on maternity or medical leave." (*Id.* at 164 (D.E. 305 at 41:7-9) (quotation marks omitted).) DFPS's computer system would count secondary workers as conservatorship caseworkers, even though secondary workers had nowhere "close to the responsibility of a primary caseworker." (*Id.* at 164.) DFPS even counted "fictive workers who are 'created out of all the overtime,' which 'are not actually even people.'" (*Id.* at 164 (D.E. 310 at 67).)

DFPS could not, however, hide the views of its caseworkers, over half of whom reported that they were overworked. (*Id.* at 165.) One former CVS caseworker testified at trial that she worked "approximately 50 hours in a typical week" and that "overtime was the rule, not the exception." (*Id.* at 165 (D.E. 323 at 34-35).) She stated that "this caseload was typical and unmanageable." (*Id.* at 165 (D.E. 323 at 34).) It caused her to "experience '[e]xtreme stress, burnout, wearing down, [and] anxiety,' and affected her relationship with her family." (*Id.* at 165 (D.E. 323 at 38) (brackets retained).) And she explained that PMC children were the ones most affected by her high caseload. "This was because TMC children's cases have 'many [more] moving parts' and 'many aspects that are demanding for services,' while PMC children are generally already in a placement and at least appear to be relatively settled. As a result, . . . 'when something else [was] blowing up,' PMC children were 'the first ones to . . . get pushed to the side.'" (*Id.* at 165-66 (D.E. 323 at 37) (brackets and ellipsis retained).) "In a survey, 70% of the caseworkers that left listed 'Workload' as the first or second reason." (*Id.* at 177 (citing to trial exhibit PX 1993 at 306).)

Many other consequences of excessive caseloads and turnover were also made apparent at trial. For example, overburdened caseworkers are "often too busy to keep up with their documentation responsibilities, even though they considered them vital." (*Id.* at 168 (D.E. 323 at 36; D.E. 324 at 16).) Again, DFPS was "well aware that its caseworkers often cannot keep up with required documentation when their caseloads are high," as it was discussed in an internal memorandum in October 2012.

(*Id.* at 168 (citing to trial exhibit PX 1825 at 2).) The lack of documentation became "especially problematic when caseworkers left and their cases were redistributed," as the "remaining caseworkers could not immediately assess the needs, and appropriately monitor the safety of, the new children on their caseload if their files did not contain thorough and up-to-date documentation." (*Id.* at 168 (D.E. 324 at 16).)

Paperwork delays can also prevent children from finding a permanent home: The Court learned that several potential adoptions of named plaintiff S.A. never materialized because of "her caseworkers' failure to update" paperwork that was required "before any adoption can go forward." (*Id.* at 86 (citing to trial exhibit DFPS #49445-61, #49123).) More broadly, an audit of DFPS reported that "[n]umerous transitions in caseworker assignments disrupt momentum toward permanency by forcing children/youth and their families to 'start over' repeatedly with new caseworkers"; and then-DFPS Commissioner "Specia admitted that foster children are '[a]bsolutely' harmed when they do not achieve permanence." (*Id.* at 178 (citing to trial exhibit PX 1880 at 5; D.E. 229 at 39) (brackets retained).)

The Court also learned of other ways in which excessive caseloads and consequent high turnover can harm PMC children. For example, it prevents foster children from building a trusting relationship with their caseworker. "[A] CVS caseworker is often a foster child's 'only continuous and stable relationship.' Given that PMC children have been removed from their home and likely

shuttled between placements, CVS caseworkers are one of the few people that foster children look to for support and guidance." (*Id.* at 172 (citing to trial exhibit PX 1871 at 1; D.E. 326 at 85).) "Trust is 'highly important' between a foster child and their primary caseworker because children need to feel comfortable telling them their problems." (*Id.* at 172 (D.E. 326 at 85).) Yet "repeated turnover in PMC children's caseworkers 'contributes to the child[ren]'s difficulties in establishing trust' with their caseworkers." (*Id.* at 179 (citing to trial exhibit PX 1988 at 67) (brackets retained).) A "rotation of overburdened caseworkers only causes 'despair,' 'isolation,' and 'helplessness.' Instead of becoming a stable influence in a child's life, foster children 'don't want to have a relationship with [caseworkers] . . . they lose confidence, they lose trust,' and see caseworkers as just a 'number.'" (*Id.* at 178-79 (citing to trial exhibit PX 2015 at 4 (sealed); D.E. 324 at 20-21) (brackets and ellipsis retained).) Thus, children are less likely to report abuse to their caseworker, and the caseworker is unlikely to be familiar enough with the child to perceive that there is something wrong. (*See id.* at 179-81.)

The Court also learned that caseworker turnover can disrupt a foster child's healthcare, with disastrous consequences: Turnover "contributed to disruptions" in named plaintiff Z.H.'s "medication regimen, which resulted on at least one occasion in a psychiatric hospitalization that exacerbated" his "already-disturbed condition and behaviors." (*Id.* at 131 (citing to trial exhibit DFPS #33580).)

Overall, at the time of trial, the turnover rate among CVS caseworkers was 26.7 percent, and was 28 to 38

percent for first-year caseworkers. (*Id.* at 176-77 (citing to trial exhibit PX 1993 at 16-18; D.E. 300 at 38-39).)

The Court entered several remedial orders to resolve the excessive caseworker caseload problem. First, Remedial Order A1 required:

> DFPS, in consultation with and under supervision of the Monitors, shall propose a workload study to generate reliable data regarding current caseloads and to determine how many children caseworkers are able to safely carry, for the establishment of appropriate guidelines for caseload ranges. The proposal shall include, but will not be limited to: the sampling criteria, timeframes, protocols, survey questions, pool sample, interpretation models, and the questions asked during the study.

(D.E. 606 at 8 ¶ 1.)

Remedial Order A2 required DFPS to:

> [P]resent the completed workload study to the Court. DFPS shall include as a feature of their workload study submission to the Court, how many cases, on average, caseworkers are able to safely carry, and the data and information upon which that determination is based, for the establishment of appropriate guidelines for caseload ranges.

(*Id.* at 9 ¶ 2.)

Remedial Order A3, in turn, required DFPS to:

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

(*Id.* at 9 ¶ 3.)

On December 17, 2019, the Court approved an agreed motion submitted by the parties that in lieu of conducting a workload study pursuant to Remedial Orders A1 and A2, DFPS would use as the caseload guideline:

- "14-17 children per . . . DFPS conservatorship caseworker." (D.E. 772 at 2.) The order specified that DFPS "will use these guidelines to satisfy the requirements in the November 20, 2018 order, which require DFPS . . . to establish generally applicable internal caseload standards." *Id.* at 2 (citing D.E. 606 at 9-10 ¶¶ 3, 4 (Remedial Orders A3 and A4)).

In accordance with this order, DFPS implemented the "caseload guideline of 14-17 children per conservatorship caseworker." DFPS, Generally Applicable Caseload Standards—Guidelines for Conservatorship (CVS) 1 (July 2020), *available at* https://www.dfps.texas.gov/handbooks/CPS/Resource_Guides/CPS_Generally_Applicable_Internal_Caseload_Standards.pdf.

Further, to address turnover among newly hired caseworkers, the Court entered Remedial Order 2, which provides:

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

(D.E. 606 at 2 ¶ 2.)[167]

Under DFPS policy implementing graduated caseloads, a newly hired caseworker must proceed through

---

167. A substantially similar provision was validated by the Fifth Circuit in *Stukenberg I*. *See* 907 F.3d at 273, 273 ¶ 3. Therefore, in its November 2018 Order implementing *Stukenberg I* on remand, the Court restated that provision as Remedial Order 2. The Fifth Circuit's opinion in *Stukenberg II* did not disturb Remedial Order 2, and it became effective upon the Fifth Circuit's July 30, 2019 Mandate. *See* 929 F.3d at 276 (listing issues on appeal, none of which pertain to Remedial Order 2).

two phases of training before being eligible to hold a full caseload. During the first phase, caseworkers are trained "using the CPS Professional Development (CPD) training model," which "includes a 12 to 13-week training period, during which time new caseworkers are paired with a mentor (a tenured caseworker) who works with the new caseworker to prepare them to work cases independently." DFPS, Generally Applicable Caseload Standards—Guidelines for Conservatorship (CVS) 12-13 (July 2020), *available at* https://www.dfps.texas.gov/handbooks/CPS/Resource_Guides/CPS_Generally_Applicable_Internal_Caseload_Standards.pdf.

During this first phase of training, caseworkers are not eligible for a caseload; they "are deemed case assignable" only upon "the successful completion of CPD." *Id.* at 6. But they are not yet eligible for a full caseload. Instead, for the first two months after becoming case-assignable they are gradually ramped up to a full caseload: Specifically, caseworkers "will be assigned no more than 6 children in the first month of becoming case assignable and no more than 12 children in the second month after they are deemed case assignable at the successful completion of CPD. In the third month after being determined eligible for case assignments, the caseworker may receive a full caseload." *Id.* at 6. This two-month period of graduated caseloads allows new caseworkers some time to adjust to a caseload.

2. DFPS's failure to count CWOP shifts in caseworkers' caseloads is once again driving excessive caseworker caseloads, burnout, and turnover

At the Contempt Hearing, Doctor Miller noted that the agreed-upon guideline of fourteen to seventeen children is "a full load. And anything you put on top of that is going to take away from" caseworkers' ability to care for children. (D.E. 1488 at 272:2-4.) Thus, failing to count CWOP shifts in a caseworker's caseload effectively renders the agreed-upon guideline of fourteen to seventeen children per caseworker meaningless:

> Q. If you have a system in the State of Texas with caseworkers—let's just assume they were all within the 14 to 17 child caseloads. They're not. Let's assume they were. And then you ask them to work another half of a week in CWOP shifts. What's—how meaningful is the fact that they have a caseload between 14 and 17 children?
>
> A. Well, it's not meaningful at all, because they no longer—that isn't their workload any longer. It's like they have a job and a half.
>
> Q. And can you just ignore the other half of the job and actually make sure that the caseworkers have the time to safely manage their children?
>
> A. No.

(*Id.* at 272:6-18.)

Yet that is precisely how DFPS is handling CWOP shifts—while caseworkers are required to work up to sixteen CWOP overtime hours per week, DFPS is neither counting these shifts as part of their caseloads nor prorating their caseloads to account for the shift as an "other function." (D.E. 606 at 9.) As a result, caseworkers are being overburdened on an unprecedented scale.

As Ms. Carrington explained at the Contempt Hearing, working CWOP shifts (also called "Child Watch" shifts) is "an essential job function." (D.E. 1488 at 211:3.) As a result, CWOP shifts are mandatory, and caseworkers can be penalized if they refuse a CWOP assignment:

> Q. . . . What's the importance of designating CWOP shifts as an essential job function for a caseworker?
>
> A. So as a caseworker, you have consequences if you don't work CWOP. . . .
>
> Q. What kind of consequences?
>
> A. I mean, consequences being written up, consequences up to being terminated if you don't show up for a shift for CWOP. . . .
>
> Q. So if you're—if you're a caseworker and have a very busy normal caseload and you just physically or emotionally can't take more CWOP shifts, do you have the option of just saying, "No, I can't do them"?

> A. You have an option of maybe trying to find someone to replace you in that shift, but you can't just say, "No, I'm not going to work the shift." The only way you can not work a CWOP shift at all is if you have a reasonable accommodation, and that's—you know, you have to go through civil rights and do all of that.

(*Id.* at 210:25-211:17.) Thus, most caseworkers have no choice in whether they take these overtime shifts.

Associate Commissioner Banuelos testified that caseworkers are only required to take CWOP shifts "if we don't have enough people who volunteer." (D.E. 1487 at 323:16-19.) But Ms. Reveile explained that CWOP shifts were never actually voluntary:

> Q. How did you look at your [CWOP] overtime work?
>
> A. It was like a very stressful part-time job.
>
> Q. Did you—did you volunteer for each of those shifts?
>
> A. No. Whenever I first started, we were allowed to sign up for our preferred times, but it was still the expectation. It was mandatory. They told me in my interview that it was mandatory. And then after a while, eventually they didn't even let you sign up for your preferred shift. They just assigned you.

> Q. And was this true all the way until you finished working at the department in the summer of 2023, just six months ago?
>
> A. Yeah.
>
> Q. That it was mandatory?
>
> A. CWOP had always been mandatory the whole time I worked there, and we progressively got assigned more and more shifts each month.

(*Id.* at 200:10-25.)

Moreover, mandatory CWOP shifts are assigned without reference to the caseworker's regular caseload. Ms. Reveile explained that for much of her tenure as a DFPS caseworker, she "had the highest caseload in the office at 16 kids." (*Id.* at 202:6-7.) And eight of the children had "special needs, so they were complex cases." (*Id.* at 202:8.) Nonetheless, her regular caseload was not considered when CWOP shifts were assigned—she "had to work the same amount of shifts" as everyone else. (*Id.* at 202:11-12.) Consistent with Ms. Reveile's testimony, the Monitors have reported that caseworkers whose regular caseloads exceed the agreed-to guideline range are responsible for CWOP shifts, as are new caseworkers who should have a graduated caseload. (D.E. 1318 at 123-24.)

In fact, Ms. Reveile's testimony indicates that caseworkers are assigned CWOP shifts before they become eligible for any caseload. She testified that within

a month of being hired as a DFPS caseworker, she was required to work CWOP shifts. (D.E. 1487 at 196:12-16.) This is contrary to DFPS's caseload standards: As noted above,[168] newly hired caseworkers must complete CPS Professional Development, which takes twelve to thirteen weeks, before they are eligible for any caseload. Thus, Ms. Reveile was working CWOP shifts at least two months before she was eligible to be assigned any caseload.[169]

Moreover, these mandatory shifts are not rare—they a routine part of the life for a DFPS caseworker. Ms. Reveile testified to an increasing CWOP burden over time: At the start of her tenure, she was assigned "maybe one or two" four hour "shifts per month." (*Id.* at 204:14-15, 24.) The number of CWOP shifts "eventually increased to three and then eventually to four, and then towards the very end it was five or six" per month. (*Id.* at 204:19-20.) Ms. Carrington testified that caseworkers are now responsible for five to ten five-hour Child Watch shifts each month. (D.E. 1488 at 225:7-9.) This is consistent with the Monitors' October 2023 CWOP report, which noted that caseworkers interviewed by the monitoring team

168. *Supra* page 522.

169. Ironically, DFPS refers to new caseworkers as protégés. DFPS, Generally Applicable Caseload Standards—Guidelines for Conservatorship (CVS) 13 (July 2020). Based on the way DFPS treats them, this term seems rather inapt. *See Protégé*, Webster's II New Riverside University Dictionary 946 (1st ed. 1984) (a person "whose welfare, training, or career is advanced by an influential person"); *Protégé* (def. 1), Black's Law Dictionary (11th ed. 2019) ("A person protected by or under the care or training of another person or an entity. . . .").

"indicated that they are required to supervise anywhere from six to eleven four-hour shifts each month, depending on the number of caseworkers and other staff available to supervise CWOP." (D.E. 1425 at 41.)

Of course, DFPS's "Child Without Placement Supervision and Overtime Policy" (the "CWOP Overtime Policy") gives little relief, as it permits caseworkers to "work a maximum of 16 CWOP overtime hours per week,"—*i.e.*, sixty-four CWOP overtime hours per month. (PX 114 at 1.) Thus, assigning a caseworker ten five-hour overtime shifts each month is—according to the State—perfectly acceptable. So too is assigning a five-hour overtime shift immediately after a regular shift: The CWOP Overtime Policy explains that "On a weekday that an employee is scheduled to work on a regular eight-hour shift of non-CWOP responsibilities, they may work that regular shift and up to six hours of additional CWOP time." (*Id.* at 2.)

Evidence presented at the Contempt Hearing revealed the full scope of the burden imposed on caseworkers. As noted earlier,[170] DFPS's data show that in 2023, caseworkers worked around 725,124 hours of CWOP overtime. Based on this, Plaintiffs calculated that CWOP workers worked about 1988 CWOP overtime hours per day. (PX 107S at 1.) In other words, "every day," caseworkers worked the equivalent of "248 full-time shifts just for CWOP." (D.E. 1489 at 21:14-19.)

170. *Supra* page 508.

This does not, however, mean that DFPS is just 248 caseworkers short, as full-time employees do not work seven days per week. A full-time caseworker—one working forty hours per week, fifty weeks per year—would work 2000 hours in 2023. Thus, DFPS would need to hire 363 additional full-time caseworkers—725,124 hours divided by 2000 hours per caseworker—to cover all of that overtime. Or, to put it in more concrete terms, Associate Commissioner Banuelos testified that she has "about 1200" caseworkers, including new caseworkers who have a graduated caseload. (D.E. 1487 at 313:14-16.) Thus, these 1200 caseworkers are doing the work of 1563 full-time caseworkers. In other words, their caseloads are being undercounted by about 30 percent.

At trial, the Court heard testimony that DFPS was underestimating caseworker caseloads by counting, as real caseworkers, "fictive workers who are 'created out of all the overtime'" worked by actual caseworkers, but "'are not actually even people.'" (D.E. 368 at 164 (citing D.E. 310 at 67)); *Stukenberg I*, 907 F.3d at 257 (noting DFPS's use of "non-human workers 'created out of overtime'" in "calculating caseload distribution," helping DFPS arrive at an "exceedingly generous" caseload estimate). Here, the Court is, in essence, using the fictive caseworker calculation, but in reverse, to demonstrate that DFPS is 363 workers short. Further, no cases are attributed to these 363 "fictive" workers—nor, therefore, to the actual caseworkers who work the CWOP shifts—thereby creating an unsafe workaround to the agreed-upon guideline of fourteen to seventeen cases per caseworker.

This mandatory overtime burden is, no doubt, the main reason why DFPS is currently facing a 36 percent turnover rate among caseworkers. (*See* D.E. 1347 at 219:3-7 (testimony of Associate Commissioner Banuelos).) But related DFPS policies and practices undoubtedly exacerbate the discontent felt by caseworkers, and thus, the turnover rate.

For example, as noted above, the CWOP Overtime Policy permits the assignment of up to six hours of CWOP overtime on the same weekday as a "regular eight-hour shift." (PX 114 at 2.) But the CWOP Overtime Policy contains no provision that would allow a caseworker some time to recover after working up to fourteen hours in a single day. And both Ms. Reveile and Ms. Carrington testified that caseworkers are afforded no such recovery time. (D.E. 1487 at 205:3-11; D.E. 1488 at 228:4-7.) Ms. Reveile never got time to recover after working a CWOP night shift, she "would work part of the night and then have to start [her] day job, [her] full-time job, the very next morning" (D.E. 1487 at 205:9-11)—she had to "[j]ust keep going" (*id.* at 205:8).

Ms. Reveile also explained that a CWOP shift that was supposed to be four hours might be extended at last minute. For example, "if the person that was scheduled after you" failed to show up to their shift, "you would be asked and volun-told to take their shift." (*Id.* at 204:24-205:1.)

Likewise if there is an emergency. Ms. Reveile recounted arriving at one shift at the CWOP Setting in

Temple, and finding one of the children in the front yard "in her underwear, screaming that she was drunk." (*Id.* at 207:20-23.) After law enforcement and paramedics arrived, the child made a sexual assault outcry and was taken to the hospital "to get evaluated, all the tests that they do after that." (*Id.* at 208:13-17.) Ms. Reveile's supervisor was sent to watch the child in the hospital; Ms. Reveile and the other CWOP worker completed the relevant incident reports, updated the shift log, and notified the child's caseworker, all while supervising the other children held at the CWOP Setting. (*Id.* at 208:19-25.)

By the end of the shift, Ms. Reveile was "exhausted." (*Id.* at 209:1.) Yet, as she was driving home, she was instructed to relieve her supervisor at the hospital. (*Id.* at 209:3-6.) Thus, she spent a further two and a half hours on this extended CWOP shift before she herself was relieved. (*Id.* at 209:7-10.)

While DFPS can underreport and obfuscate caseload data, it cannot hide the discontent expressed by its caseworkers—as the Court noted in the 2015 Memorandum and Opinion, "Despite DFPS's deception, the caseworkers themselves say that they are overworked." (D.E. 368 at 165.) The same is true now—the toll on caseworkers is quite apparent from their universal dissatisfaction with CWOP. As the Monitors recently reported:

> Interviews with stakeholders, which included caseworkers and staff present during the monitoring team's September 18, 2023, site visit, and others who later contacted the

> Monitors, describe their intense frustration and anger over the ongoing requirement that they supervise CWOP Settings in addition to their existing responsibilities and without adequate training. All the caseworkers expressed the difficulty that the supervision requirements create for completing the regular tasks associated with their positions.

(D.E. 1425 at 41 (footnote omitted).) "[O]ne DFPS caseworker said that '[CWOP] has turned into such a cancer it has taken the joy out of everything else' and, in speaking of DFPS, said 'at the end of the day it feels like they don't care about us.' Another DFPS caseworker said that the DFPS staff and caseworkers have 'been worked so hard that their passion burns out and they become angry.'" (*Id.* at 41 n.57.) Further, "the caseworkers and staff with whom the monitoring team spoke all expressed exhaustion, noting that many of their peers had quit their jobs due to the requirement that they supervise CWOP Settings." (*Id.* at 43.) And, as noted earlier,[171] the caseworkers also complained about the lack of training to care for the high-needs children that tend to predominate in CWOP Settings, and their consequent concern for their own safety and that of the children placed in CWOP.

Unsurprisingly, mandatory overtime, combined with inadequate training and lack of support, make for unbearably stressful working conditions. Ms. Reveile explained:

---

171. *Supra* page 440-41.

> . . . . [I]t was almost impossible to get through a shift on a lot of days. It would—it would be scary driving in, and it would be a long drive too. . . . [I]t's easily an hour, hour and a half drive. So waking up at 2:00 in the morning, getting to Belton or Temple by 4:00, you're stressed your whole drive.
>
> You're building up your cortisol levels and your adrenaline, all that. And then you get to your shift, and you have only the amount of time that you had maybe sitting in your car before you walked in to kind of read about what happened with the kids on the previous shift.
>
> And you may or may not actually know the kids. You may or may not know what they like or what they like to do if you don't fully read that shift log before you go in. So you always try to get there even earlier than your shift starts, and then anything could happen on your shifts.

(D.E. 1487 at 197:25-198:17.)

And Ms. Reveile testified that CWOP was equally exhausting and demoralizing to her colleagues:

> Q. Were your fellow coworkers, your other caseworkers, were they driving as much as you and exhausted as much as you based on your personal interaction with them?

A. Yeah. Everybody was exhausted.

Q. How do you think this affected the morale of the caseworkers, at least yours and the ones that you interacted with closely?

A. There was little, if any, morale left.

(*Id.* at 201:1-8.)[172]

---

172. Indeed, caseworkers' dissatisfaction was apparent even to the children at the CWOP sites. Ms. Juarez recounted:

Q. Did any of the caseworkers that you came in contact with, were they—did they seem happy to be there, excited to be working on these CWOP shifts?

A. No.

Q. What were they—what was their attitude?

A. Every time my caseworker—my caseworker I had before the one I have now, she would take me to her office, because I didn't have any place to go to. And every time they will mention CWOP, everyone would be like, "Oh, no," like, "I don't—I don't want to work CWOP," but they had to. And they were like—they would say the curse word, "Oh, no, I don't want to go." And they were like, "There's some bad—" Can I say the word?

THE COURT: Yes.

THE WITNESS: "There's some bad ass kids in there."

BY MR. YETTER:

Q. Okay. So your older—your prior caseworker sometimes would take you to her office?

Finally, Ms. Reveile explained that working as a DFPS caseworker was her dream job, which made her eventual decision to resign because of CWOP all the more difficult:

> Q. . . . [W]as this the job that you had been looking forward to as your dream job of working for Child Protective Services?
>
> A. Yeah. Wanting it for ten years and then finding out that it's just a system that's broken and breaks people. It was awful. It was a really hard decision. I tried really hard to stick it out, tried to make it better for the other workers, and it just—I couldn't do it anymore.
>
> It felt like—you know, they say don't burn the candle at both ends. I had my candle, and I was burning it on one end, but then the system came in with like a flamethrower. But then they would just blame me and say it was like—because I wasn't doing self-care when I was.

> A. Yes.
>
> Q. And you would hear the other caseworkers talking?
>
> A. Yes.
>
> Q. And were they happy about doing CWOP shifts?
>
> A. No caseworker was happy to do CWOP.

(D.E. 1487 at 257:21-258:19.)

> Q. Did it affect your health?
>
> A. Yes.
>
> Q. How so?
>
> A. I know I mentioned my blood pressure being four points away from hypertension, but since leaving the department I've actually had time to have my own mental health appointments and have since been diagnosed with moderately severe depression and severe anxiety.

(*Id.* at 206:14-207:9.)

Given the crushing burden under which caseworkers operate, it is no surprise that their turnover rate is "about 36 percent." (D.E. 1347 at 219:6.)[173] Indeed, Doctor Miller was "surprised that the turnover rate isn't higher." (D.E. 1488 at 270:13-14.)

And turnover is not the only problem created by excessive caseloads; as both the Court's trial findings and the Contempt Hearing testimony indicate, the burden significantly degrades caseworkers' ability to care for the children on their caseload. Doctor Miller explained why adhering to the caseload guidelines is "critically important" to the safety of the children (*id.* at 269:16):

---

173. In June 2022, then-DFPS Commissioner Jaime Masters testified that the caseworker turnover rate was "between 30 and 35 percent." (D.E. 1267 at 103:14-16.)

> Because casework is very difficult, and your number one resource in a child welfare system are those case managers. That's—that's your front line. And if they are overloaded . . . , they cannot do that work. It's not that they don't want to. It's simply they cannot. There are only so many hours.

(*Id.* at 269:18-270:1.) She "absolutely agreed" with Ms. Carrington's observation that exhausted caseworkers cannot keep children safe (*id.* at 270:2-6): Caseworkers are a child's "first line of defense" (*id.* at 270:25-271:1). The caseworker is the person that "is going to make certain" that the child's needed services are available and are, in fact, being provided, and that the child "is safe in their environment." (*Id.* at 271:1-4.) But when caseworkers are exhausted and stressed, they simply "don't have the capacity to do the work . . . that needs to be done." (*Id.* at 271:5-8.) Adherence to caseload guidelines prevents caseworkers from reaching that point, as it ensures that "caseworkers have the time to safely manage the children." (*Id.* at 271:9-12.)

Ms. Carrington noted that, between their regular caseloads and CWOP duties, caseworkers "work Monday through Sunday. You literally work Monday through Sunday, because your visits with your primary casework—case, your cases, those are mandatory. You have to do those visits." (*Id.* at 228:4-7.) And she explained how this schedule "impact[s] the caseworkers' ability to take care of the children" (*id.* at 228:8-9):

> A. Well, they're exhausted. And . . . every time we visit a family, visit a child, interact with a child, we're supposed to be assessing for risk. We're supposed to be assessing for safety. We're supposed to be really observing a lot of different factors when we're interacting with our families and interacting with our children.
>
> Q. How are—
>
> A. Exhausted people can't do that.
>
> Q. I'm sorry. Exhausted people can't do what?
>
> A. Exhausted people miss safety threats. They miss risk factors. They miss them, because they're tired. It's just as simple as that. They're too tired literally to do their jobs.
>
> Q. Can exhausted caseworkers keep children—
>
> A. Can't keep children safe.

(*Id.* at 228:10-24.)

In sum, DFPS's failure to properly count CWOP shifts in caseworkers' caseloads is driving dedicated caseworkers to leave the job in dangerously high numbers. And those who stay cannot adequately serve either the children on their caseload or the children who should be on their caseload (*i.e.*, the children placed in CWOP). But

the testimony of Associate Commissioner Banuelos gives the Court little reason to believe that DFPS is taking the problem seriously. She explained that one of her roles as Associate Commissioner of Child Protective Services is to monitor caseworker caseloads and track trends:

> Q. Your—among other responsibilities, part of your role is to monitor caseloads for conservatorship caseworkers in the State of Texas, is it not?
>
> A. That's one of my roles.
>
> Q. And to identify trends in caseloads across the state?
>
> A. Correct.
>
> Q. In other words, are they getting too much, too little?
>
> A. That's correct.

(D.E. 1487 at 284:1-8.) And she agreed that the burden created by CWOP "on the system and specifically caseworkers" "falls right within [her] wheelhouse of responsibilities." (*Id.* at 294:13-18.) Nonetheless, she was blithely unaware of even the most basic statistics:

BY MR. YETTER:

Q. Didn't—in 2021, wasn't there a significant increase in the amount of time that the State asked its caseworkers to devote to this [CWOP] program in 2021?

A. I—I don't have the total amount of time that they spent in 2021 doing [CWOP].

Q. Nor do you, as you're sitting here today, even though you are in charge of watching trends, you don't know the numbers for 2022?

A. I'm sorry, the numbers of—

Q. Total time that the State asked its caseworkers in overtime to devote to [CWOP].

A. I don't have those numbers with me today.

Q. And you don't know them for 2023 either?

A. I don't know the total numbers for 2023.

(*Id.* at 311:8-21.)[174] Yet alarmingly—and contrary to the State's own data[175]—she believed that the CWOP burden "has gotten better." (*Id.* at 295:7-8.)

Moreover, Ms. Banuelos appeared to understand the significance of following the agreed caseload guideline vis-à-vis child safety and caseworker turnover:

---

174. This is quite out of character given her mastery of the facts at prior hearings. (*See, e.g.*, D.E. 1395 at 88:2-6 ("Good morning, Your Honor. So, in reviewing the Monitors' Report, I did see their percentage. We went back and looked at, for the last two years, we had an 85 percent approval rate given prior to the child being placed."); *id.* at 91:2-7 ("[W]hen we looked at the last eight months, out of 31,345 placements, we only placed 3,212 children into heightened monitoring placements. So, we are thoroughly reviewing those. We are making decisions based on the safety of the child and those that are currently placed at those particular placements."); D.E. 1321 at 47:3-49:23 (describing current placement and treatment being provided to child discussed in Monitors' report, and providing additional details as to the incident addressed by the Monitors); *id.* at 107:9-11 (discussing grants for expansion of treatment foster care and explaining that "we had a total of $19 million, but we divided it amongst 23 providers"); *id.* at 159:11-15 (volunteering that "I know at one of the last hearings there was also a concern" that foster parents who were found to be abusive could move to a different Child Placement Agency, and noting that DFPS had changed IMPACT so that Agencies "get an alert so that they know this foster parent has a reason to believe").)

175. From 2019 to 2023, the number of CWOP hours went from 25,057 (July to December 2019), to 87,360 (2020), to 693,364 (2021), to 667,048 (2022), to 604,273 (January to October 2023). (PX 107S at 1.)

> Q. Do you understand, Ms. Banuelos, that the caseload guidelines are designed to make sure that the caseworkers have the time to safely manage their children? Do you understand that's the purpose?
>
> A. I would agree that the guideline—yes, the guideline is so that workers can have time to work on their caseloads.
>
> Q. And it's—
>
> THE COURT: But you can't take a worker that's already got 16, 17 cases and give them a shift a week with somebody else's case—casework, case child, without counting it for them. Don't you understand that? . . . [T]he whole reason we've got the 14 to 17 guidelines is because you were having this huge turnover when we did the trial, because the workload was too stressful. Now you've created it again with this workload for the CWOP children. So you have a huge turnover once again, don't you, in caseworkers?
>
> THE WITNESS: Our turnover continues to be a concern. It goes up and down.

(*Id.* at 329:9-330:3.) But despite this, and even after the Court explained that under the remedial order, DFPS "can't force the caseworkers to do these mandatory overtimes and not count it toward their caseload" (*id.* at

331:7-8), she was unwilling to commit to any change in policy:

> BY MR. YETTER:
>
> Q. Ms. Banuelos, you're not going to—you're not prepared to make any change in how you're counting caseloads. Am I right?
>
> A. I will follow the Remedial Order of counting caseloads by the number of child that—the workload is counted by the number of children—
>
> THE COURT: I just told you what it is.
>
> THE WITNESS:—on our primary caseload.
>
> THE COURT: I just told you what to do. Are you going to do it?
>
> THE WITNESS: Your Honor, I'm going to follow the Remedial Order—
>
> THE COURT: I just told you what it was.
>
> THE WITNESS:—of counting case loads—

(*Id.* at 332:6-19.)

3. Harms to caseworkers working CWOP shifts

Stress, high blood pressure, and depression are far from the only risks to the health and safety of CWOP workers. The Monitors report that "without adequate services and support, children placed in CWOP Settings—many of whom have significant mental and behavioral health needs—frequently become dysregulated and act out, harming the caseworkers and staff supervising them. Caseworkers are verbally and physically assaulted, and in some cases, sexually assaulted." (D.E. 1425 at 41.) The Monitors discuss several illustrative incidents in which CWOP workers either feared for their safety or were physically harmed:

- "The night before the monitoring team visited the Belton CWOP Setting, the children became dysregulated and began to engage in property damage throughout the house. There was no law enforcement officer or security on site during the shift. The staff who were supervising the setting feared for their own safety and waited outside for law enforcement to arrive after calling 911." (*Id.* at 43.)

- As discussed in more detail earlier,[176] LD threatened that "the next time the caseworker came to the CWOP Setting, LD would 'shoot [him] in the head' and 'that [he] would be stabbed' and that 'all of the boys in the house were going to give [him] a beat down.'" (*Id.* at 43.)

176. *Supra* footnote 132.

- "The monitoring team also learned of a recent incident during which a DFPS staff person was physically assaulted and suffered a concussion while she was supervising a Bell County CWOP Setting. The staff person had to be hospitalized and, close to a month after the incident, was still recovering from her injuries. The child who was involved in the altercation was already on probation due to similar behavior." (*Id.* at 43.)

Perhaps most disturbing is an incident in which RH, a sixteen-year-old male PMC child, sexually assaulted a CWOP worker:

> [RH] was not at the location when worker arrived for the shift. When he returned to the house, he noticed worker and said [worker's name] and ran over to worker and gave her a hug. Worker had the words, "[RH], we only fist bump" coming out of her mouth, but he ran up so quickly there wasn't time to finish the sentence. Worker immediately told him, "we only fist bump from here on out, ok?" [RH] said, "whatever [name omitted]" smiled and walked away. Worker has had several shifts with [RH] where he does not respect personal boundaries.
>
> LE was present at this time, so [RH] did not approach worker for the next hour or so. At approximately 2:15 pm, LE left the child watch house and there was no replacement LE officer for the rest of this shift.

Appendix B

Around 3pm, [RH] sat down with the worker at the table. [RH] told worker, "I love you [name omitted]" and "I love your face" and then started touching Worker and she repeatedly asked him to stop. Worker continued to tell [RH] that he could not touch her without permission. Worker told [RH] that they could only fist bump, but he had to ask first. [RH] asked for a fist bump, so worker put up her hand. [RH] clinched his fist and punched workers hand forcefully instead of a "bump". Worker said, "oww, [RH] we're not doing that anymore either if you punch my hand." [RH] continued telling worker, "I love you, [name omitted]" and said this multiple times. Worker ignored [RH].

[RH] then started saying very sexually explicit things at the table. They were very sexual in nature and made worker feel extremely uncomfortable. He said things like, "put my disk so deep make her ass go to sleep," "I'd eat it out from the front and the back," "my dick so deep I'd make it bleed," "sit on it," "and send me a big hair pic." He said these things while laughing and grunting. [RH] was told to stop. . . . [RH] continued to say sexually aggressive things while thrusting his pelvis in his chair.

[RH] was redirected to make some food. [RH] remained in the kitchen with worker for about 5 minutes and then came back into the common area (where the table is) and sat by the . . .

> worker. The first thing he said was, "I love you [name omitted]." And then put his head on worker['s] shoulder. Worker immediately pulled away and [RH] got closer and began touching worker. Worker told him, "[RH], stop touching me" and he continued to do so. Worker repeatedly and sternly asked [RH] to stop touching her.
>
> Worker looked at the table where Law Enforcement usually sits. [RH] saw worker look over there and he looked right into worker's eyes and said, "he left, there isn't anyone here. There is nobody here to help you." [RH] was touching worker's arms, shoulders, trying to play with worker's hair, poking worker with his fingers, rubbing worker's back, arms shoulders, etc. Worker stood up to get away from [RH] and he stood up and moved closer. Worker asked him repeatedly to stop and he would not. He said, "what [name omitted], I just love you." [RH] was told to stop. [RH] backed away and sat in the chair on the side of the table. He kept telling worker, "I love you." As soon as worker sat down, [RH] began grabbing the back of [her] chair and was dragging it towards him. Worker jumped up and when she did, [RH's] hands went from the bottom of worker's breasts all the way down her stomach past her belly button. Law enforcement was contacted.

(*Id.* at 42-43 (paragraph breaks and some ellipsis added).) Notably, DFPS knew that RH had a history of engaging in

this sort of behavior—"RH's IMPACT records document a history of engaging in sexually inappropriate behavior from a young age, including 'acting out sexually towards . . . female staff at the school' which included attempting to touch their breasts and disrobing in the classroom." (*Id.* at 43.) The Monitors conclude their discussion of the incident by noting that "[d]espite a history of acting out sexually, RH has not been flagged by DFPS with an indicator for sexual aggression or a sexual behavior problem, even after the incident described above." (*Id.* at 43.)

At the Contempt Hearing, Ms. Carrington testified bluntly that Child Watch workers "get assaulted all the time." (D.E. 1488 at 219:10-11.) She knew of one worker who "was stomped in the face," another whose "hair was pulled out," and a third whose "ribs were broken." (*Id.* at 219:13-19.) And Ms. Carrington herself was nearly hit with a fire extinguisher. When she arrived at a CWOP site, a girl around ten or eleven years old was "walking around in her underclothes." (*Id.* at 233:22-23.) So Ms. Carrington instructed the child to put some clothes on. (*Id.* at 233:22-23.)

> [T]hroughout the night she was upset with me because I made her go put clothes on. And, you know, it—you know, she's screaming at me and all of that. That's fine. That's not a big deal. She took the snacks, she threw them at me. It's not a big deal.
>
> Finally because I wasn't responding the way she wanted me to respond, she picked up the fire

> extinguisher. So she has the fire extinguisher, and she has it over her head, and she was walking towards me. And I'm sitting there. I'm trying to stay calm and not, you know, do anything to get her further upset.

(*Id.* at 234:7-17.) Fortunately, crisis was averted because the other youth informed Ms. Carrington and the other CWOP worker that this child "likes Cocomelon":

> So the caseworker is on YouTube. She's trying to find it. She does find it. [The child] has the fire extinguisher above her head. She hears Cocomelon, and she says, "Oh, Cocomelon," drops the fire extinguisher, runs over to the couch and sits with the caseworker, you know. And she's happy for, you know, 20 minutes, or, you know, until something else happened.

(*Id.* at 234:19-235:14.) Ms. Carrington emphasized that this was not a one-off event: "[T]hat's just one example of CWOP. It's not the worst example. This is what people deal with all the time." (*Id.* at 235:15-16.)

* * *

DFPS caseworkers are overworked, undertrained, and unprepared to provide day-to-day care for high needs children. Yet, every day, they go above and beyond, doing their utmost to care for both the children on their caseloads and the children placed in CWOP. They are truly the unsung heroes of the foster care system.

The State, on the other hand, has utterly failed to learn the lessons made clear at trial and discussed at length in the Court's Memorandum Opinion and Verdict regarding the need to ensure that caseworkers' caseloads are manageable. Indeed, all credible evidence indicates that the State is treating its caseworkers with at least the same indifference that was revealed at trial. If anything, the fact that the caseworker turnover rate is now significantly higher than it was at trial suggests that the State's indifference is now worse.

The Court carries forward the Contempt Motion on the issue of caseworker caseloads.

E. Defendants are failing to appropriately apprise PMC children of the ways to report abuse and neglect

Remedial Order A6 provides:

> Within 30 days of the Court's Order, DFPS shall ensure that caseworkers provide children with the appropriate point of contact for reporting issues relating to abuse or neglect. In complying with this order, DFPS shall ensure that children in the General Class are apprised by their primary caseworkers of the appropriate point of contact for reporting issues, and appropriate methods of contact, to report abuse and neglect. This shall include a review of the Foster Care Bill of Rights and the number for the Texas Health and Human Services Ombudsman. Upon

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

(D.E. 606 at 11 ¶ 6.)

1. History of Remedial Order A6

The requirement that caseworkers apprise PMC children of the appropriate point of contact and methods of contact to report abuse, including a review of the Foster Care Bill of Rights and Ombudsman's number, resulted from evidence at trial indicating that abuse and neglect in foster care facilities were being underreported. (*Id.* at 11-12; D.E. 368 at 205.) One reason for this is that foster children "often do not know to whom they should report abuse and neglect." (D.E. 368 at 205.) The Fifth Circuit expressly affirmed the approach taken by Remedial Order A6, finding that "[t]o the extent that the court is worried about underreporting, this can be remedied by mandating that caseworkers provide children with the appropriate point of contact for reporting issues."*Stukenberg I*, 907 F.3d at 279.

Ahead of their First Report, in order to facilitate their assessment of the State's compliance with Remedial Order A6, the Monitors asked DFPS to provide information regarding abuse and neglect reports made by children. (D.E. 869 at 125-26.) The information provided by DFPS was, however, "not responsive to the Monitors'

request." (*Id.* at 126.) Because "DFPS's responses to the Monitors included blanket representations of compliance with Remedial Order A Six, and the data provided by the State was not adequate to support validation," the Monitors validated the performance through "face-to-face interviews with and case record reviews of PMC youth in care, and interviews with caregivers," made during unannounced monitoring visits. (*Id.* at 127.)

In their First Report, the Monitors noted that 28 percent of 163 children interviewed[177] had heard of or knew of the Foster Care Ombudsman. (*Id.* at 128.) And even fewer children—19 percent of the 163 children interviewed—knew how to contact the Ombudsman. (*Id.* at 129.)

The numbers were somewhat better for the SWI hotline. The Monitors reported that 60 percent of children who were asked about the SWI hotline reported having heard of it. (*Id.* at 129.) But only two children interviewed reported actually having called the hotline. (*Id.* at 129.)

As for the Foster Care Bill of Rights, only 48 percent of the children were aware of it. (*Id.* at 127.) The Monitors noted that children "under the age of thirteen were less likely to know about the Foster Care Bill of Rights." (*Id.* at 127.)

In their Third Report, the Monitors visited twenty-five unlicensed settings (*i.e.*, CWOP sites) and interviewed

177. The children interviewed for the First Report were in licensed facilities. (D.E. 869 at 127.)

fifty-six children without licensed placement. (D.E. 1165 at 68.) They reported that 75 percent of the children were aware of the SWI hotline, but only 55 percent knew how to reach the hotline if they needed to report abuse or neglect. (*Id.* at 70.) Only 31 percent of children were aware of the Foster Care Ombudsman, and only 29 percent knew how to reach the Ombudsman. (*Id.* at 70.)[178]

2. Current concerns regarding noncompliance with Remedial Order A6

In their Fifth Report, the most recent report to address Remedial Order A6, the Monitors noted "serious concerns regarding the ability of children in some facilities to reach out for help if they encounter safety risks." (D.E. 1318 at 80.) Between January 1, 2022 and August 31, 2022, the monitoring team visited eight operations, interviewed seventy-eight children[179] and reviewed 112 child files. (*Id.* at 73-74.) They also interviewed eight case managers across five of the operations. (*Id.* at 75.)

Four of the eight case managers stated that they "'always' (3 [of 8] or [37.5]%) or 'sometimes' (1 of 8 or [12.5]%) reviewed the Bill of Rights with children at intake/admission." (*Id.* at 75.) Forty-one of seventy-six children (54 percent) had heard of the Bill of Rights, but seventeen of those children said they had heard of it only

178. The Third Report did not provide data regarding the Foster Care Bill of Rights.

179. Not all children answered all questions from the Monitors. (D.E. 1318 at 72 n.130.)

after a description was offered by the interviewer. (*Id.* at 75.) Thirty-five (46 percent) children had not heard of the Bill of Rights even after a description was offered by the interviewer.[180] (*Id.* at 75.) A higher percentage of younger children answered that they had not heard of the Bill of Rights than older children.[181] (*Id.* at 75.) Younger children were also less likely to report having read the Bill of Rights or having had the Bill of Rights explained to them.[182] (*Id.* at 75.)

Thirty-one of seventy-six (41 percent) children had heard of the Ombudsman, but eleven of those only reported having heard of the Ombudsman after a description was given by the interviewer. (*Id.* at 76.) Forty-five of seventy-six children (59 percent) had not heard of the Ombudsman even after a description was given. (*Id.*) As with the Bill of Rights, younger children were less likely to report having heard of the Ombudsman than older children.[183] (*Id.* at

---

180. Since only half of the case managers reviewed the Bill of Rights with the children, it makes sense that only about half of the children had heard of the Bill of Rights. (*Id.* at 75 n.131.)

181. Sixty-nine percent of nine-and ten-year olds (11 of 16) had not heard of the Bill of Rights compared to 15 percent of fifteen- to seventeen-year-olds (2 of 13). (*Id.* at 75.) Twenty-three of the thirty-five children who had not heard of the Bill of Rights were twelve years old or younger. (*Id.* at 75.)

182. Forty-five percent of children (9 of 20) twelve years old or younger had never read the Bill of Rights nor had the Bill of Rights explained to them compared to 37 percent (7 of 19) of children who were older than twelve years. (*Id.* at 76.)

183. Seventy-five percent (12 of 16) of nine-and ten-year-old children had not heard of the Ombudsman compared to 31 percent (4 of 13) of fifteen-to seventeen-year-old children. (*Id.* at 77.)

77.) Twenty-five of the thirty-one (81 percent) children who had heard of the Ombudsman knew how to contact the Ombudsman. (*Id.* at 77.) Overall, only twenty-five of seventy-six (33 percent) children knew how to contact the Ombudsman. (*Id.* at 77.)

Thirty-seven of seventy-five children (49 percent) reported having heard of the SWI hotline, with four so reporting only after a description was given by the interviewer. (*Id.* at 77-78.) Thirty-eight of seventy-five (51 percent) children had not heard of the hotline even after a description was given. (*Id.* at 78.) As with the Ombudsman and the Bill of Rights, younger children were less likely to have heard of the hotline than older children and less likely to know how to call the hotline.[184] (*Id.* at 78.) Twenty-six of the thirty-seven (70 percent) children who had heard of the hotline knew how to call the hotline.[185] (*Id.* at 78.) In total, only twenty-six of seventy-five (35 percent) children knew how to call the hotline. (*Id.* at 78.) Worryingly, eight of the children reported that they needed to call the SWI hotline at some point during their current placement, but only two of them were able to call the hotline. (*Id.* at 79.)

In sum, 46 percent of the children interviewed had not heard of the Foster Care Bill of Rights even after a

184. Seventy-seven percent (10 of 13) of fifteen-to seventeen-year-olds had heard of the hotline but 80 percent (12 of 15) of nine-and ten-year-olds had not heard of the hotline even after a description was given. (*Id.* at 78.)

185. Eighty-five percent (11 of 13) of fifteen-to seventeen-year-olds knew how to call the hotline compared to 12 percent (2 of 17) of nine-and ten-year-olds who knew how to call the hotline. (*Id.* at 78.)

description was given. (*Id.* at 75.) Fifty-nine percent of children had not heard of the foster care ombudsman even after a description was given. (*Id.* at 76.) And 51 percent of the children interviewed had not heard of the SWI hotline even after a description was given. (*Id.* at 78.) In their response to the Contempt Motion, Defendants argued that the Monitors' data showed only that the children "hadn't *retained*" that information. (D.E. 1429 at 37.) But that assertion does not account for the fact that another subset of children did report having heard of the Foster Care Bill of Rights, the ombudsman, or the SWI hotline after those things were described. (*See* D.E. 1318 at 75 (17 of 76 children responded that they had heard of the Foster Care Bill of Rights only after a description was offered by the interviewer); *id.* at 76 (11 of 76 children reported having heard of the ombudsman after a description was given by the interviewer); *id.* at 77-78 (4 of 75 children who initially indicated having not heard of the hotline changed their answer after a description was given).)

And even if it were a problem of retention, that would not absolve Defendants of their responsibility to explain the Bill of Rights, Ombudsman, and SWI hotline to the children, given that it is "critically important" "that children actually know . . . who to contact, who to call, who to make a report, an outcry of abuse and neglect." (D.E. 1488 at 286:18-21.) Doctor Miller explained that information must be conveyed to children in a way that they are likely to understand:

> This is another place in any system where you have got to have redundancy. With kids, think

> about this. You give them a piece of paper—you know, my granddaughter is 11 years old. I give her a piece of paper, the first thing that's going to happen to it is it's going to be lost. And if I say, "This is really important, and I need you to remember this," I might ask her two weeks later and she doesn't even remember that piece of paper. So there's got to be redundancy in the system. . . . We've got to think about how we get this information through to a child and that brain in a way that they can use that information effectively.

(*Id.* at 286:25-287:12.) This is especially true when the information is first conveyed under circumstances that are not conducive to retention. The Bill of Rights, for example, enumerates the rights of children in foster care in forty-eight numbered paragraphs, some of which are further subdivided, stretching across five pages. (DX 22 at 1-5.) The phone numbers for SWI and the Ombudsman are listed in the forty-sixth paragraph, along with two other hotlines. (*Id.* at 5 ¶ 46.) And the language introducing the list of four hotlines—"Depending on the nature of the complaint, I have the right to call: . . . " (*id.* at 5 ¶ 46)—suggests that each hotline addresses different types of complaints, and that the child must determine which is the correct hotline before calling.

Moreover, the Bill of Rights is presented to children when "they come into care" and "when a placement change is made into a DFPS FAD home." (*Id.* at 1.) But, as the Monitors have observed, the Bill of Rights is just one of

many documents a child is required to review during these stressful events, and their Fifth Report explained that "many of the children interviewed by the monitoring team reported having to sign so many documents at intake that the children did not always absorb the information relayed in documents signed during intake." (D.E. 1318 at 75 n.131.) Indeed, a child can hardly be expected to retain information if the child does not first absorb it. To that end, Doctor Miller required her caseworkers, every time they met with a child on their caseload, "to talk with that child . . . and to go over . . . if you have any problems, this is how you handle it." (D.E. 1488 at 287:13-21.)

Given Defendants' ongoing failure to apprise PMC children of the means by which to report abuse and neglect, it is almost certain that abuse and neglect continue to be underreported, thereby interfering with proper investigations and the monitoring thereof. The Court is carrying forward the Contempt Motion on this issue.

F. PMC children's medical and educational records continue to be inadequate

Like the other problems identified in this Order, the State's failure to keep adequate medical and educational records has been known since at least the start of this case.

Inadequate medical records was one of the issues identified in the 2004 Strayhorn Report. Citing a study by the federal Office of Inspector General, the 2004 Report noted that the caregivers of nearly half the Texas foster children studied "never received medical histories of

the children in their care." (D.E. 1486-8 at 20.) This was true for both children with basic needs and those with "serious medical conditions," and "made it difficult for [the caregivers] to effectively care for foster children." (*Id.* at 20-21.) Accordingly, the 2004 Report recommended that the State "develop 'Medical Passports' for foster children," which "would accompany the child on every doctor and therapist visit and would provide information on their complete medication, medical and therapy history. This passport would stay with the child during their entire time in foster care, even if they change placements, physicians, therapists, etc."[186] (D.E. 1486-8 at 21.)

This issue was also a topic discussed in the 2006 Strayhorn Report, where it was identified as a "significant medical concern[] within the state's foster care system." (D.E. 1486-10 at 7.) "DFPS still does not provide its foster children with a 'medical passport' explaining their medical history, including diagnoses and prescriptions although the passport is required by law.[187] Instead, foster children often move from one placement to another, seeing new physicians or counselors who have little or no knowledge of their past medical histories. A medical passport would help provide more consistent care for these children."

186. This was not a novel idea. The 2004 Report notes that "Florida and San Diego have created 'medical passports' to ensure that each physician seeing a foster child has a complete record of his or her medical treatment. This medical passport stays with each child as they change placements and/or physicians." (D.E. 1486-8 at 18.) And "[i]n San Diego, all of the passport information is also automated and placed into a database." (*Id.* at 18.)

187. *See* Tex. Fam. Code § 266.006.

(*Id.* at 7.) And as of "September 2006, DFPS stated that it 'is working with HHSC on the development of the health passport, scheduled to be implemented September 2007.'" (*Id.* at 7 (The Report notes that September 2007 was "more than three years after the Comptroller's first published recommendation" for a health passport).) The 2006 Report also made a new recommendation on this topic: that each foster child's medical passport "should be updated consistently and should document all medical treatments, prescriptions, psychological diagnoses and counseling to provide continuity of care." (*Id.* at 13.)

In short, the two Strayhorn reports recommended that each child's medical records be electronically stored in a centralized database that would be updated regularly and accessible to the child's physician and caregiver.

The 2006 Report also observed that "On July 20, 2006, HHSC issued a request for proposals (RFP) 'to contract with a single Managed Care Organization (MCO) to develop a statewide Comprehensive Health Care Model for Foster Care.'" (D.E. 1486-13 at 37 (endnote omitted).) The RFP "instructs the MCO to address" issues identified in the 2004 Strayhorn Report, including "the need for a medical passport." (*Id.* at 37.)

As noted earlier in this Order, the State's MCO is Superior HealthPlan. And Superior HealthPlan does maintain a medical passport system, called Health Passport. But, nearly twenty years on, Health Passport falls far short of the comprehensive database recommended in the Strayhorn reports: As Doctor Van Ramshorst

described the situation in June 2022, "we're still a ways away from . . . what we'd all like to have, which is all of that information in one place." (D.E. 1267 at 185:11-13.)

The Court first broached this topic during a March 2017 hearing when it asked then-DFPS Commissioner Whitman how caseworkers "access the medical, dental, and mental health records of the children?" (D.E. 701 at 26:2-3.) Mr. Whitman replied that the medical information was kept in the IMPACT system; this was quickly corrected by then-Deputy Commissioner Woodruff, who explained that the information was "kept in a system . . . called the Health Passport." (*Id.* at 26:7-10.) He elaborated that caseworkers "and health providers have access to those records," as do foster parents. (*Id.* at 29:19-21.) Later, the Court asked "how many different places" one would have to look "to get a complete record of the child's case" (*id.* at 52:24-25); Mr. Woodruff replied that one would have to review "the IMPACT system, the [child's] external file, and the Health Passport" (*id.* at 53:1-2). He represented that Health Passport has dental and medical records, and that "[i]f there's any mental health services, they should be in there." (*Id.* at 53:3-8.)

Later in the hearing, Mr. Woodruff called Cheryl Valenzuela, a conservatorship caseworker, to give the Court a live demonstration of the State's various databases. (*See id.* at 70:11-15 ("[W]e have one of our excellent local caseworkers, Cheryl Valenzeula . . . , here if the Court would like to see IMPACT live and . . . would like to see Health Passport.").) She explained that health records would be uploaded to Health Passport, if at all,

by the healthcare provider. (*Id.* at 114:24-115:3 (discussing a child's psychological evaluation); *see also id.* at 115:2-3 ("THE COURT: So you rely on them to upload it? MS. VALENZUELA: Into the health passport, correct.").) Ms. Valenzuela demonstrated the Health Passport data for one child, and found that "none of her medical records are actually there." (*Id.* at 121:17-19.) And she elaborated that, while DFPS maintains all the medical records in paper format in the child's "external case file,"[188] "[w]e don't have access to upload it [to Health Passport]. To my knowledge the doctors' offices would have to upload this information." (*Id.* at 121:2-11.) The Court noted that "what I need to do is find out if you're going to be able to get these uploaded and make it a requirement for your health care providers to make sure that all these records are current in the Passport." (*Id.* at 122:25-123:3.) The Court reminded Defendants that physicians and other healthcare providers were already required by federal law[189] to keep electronic records. (*Id.* at 127:15-18.) The Court noted that "this is an area for improvement," and suggested that "the quickest fix" to the dearth of medical records in Health Passport—one that would also come at no cost to the State—would be to contractually obligate healthcare providers to "upload these documents" (*id.* at 127:11-14).

---

188. (*See also* D.E. 701 at 124:15-20 ("THE COURT: Okay, let's say Megan—it was your PMC child in Corpus Christi area. She went to doctors, she attempted suicide, and went through psychological evaluation. All of those records are in your external file, in hand, in paper form, in your office? MS. VALENZUELA: Correct.").)

189. *See* HITECH Act, Pub. L. No. 111-5, 123 Stat. 115, 226-79 (2009).

Then-Commissioner Whitman replied "I have it so noted; two stars by it." (*Id.* at 127:23-24.)

Five years later, in January 2022, the Court noted that Defendants had yet to provide any further information regarding medical records in Health Passport. (*See* D.E. 1175 at 113:1-5 ("[S]o I said, 'How about you have them E-file into the health passport, which are the medical records for the children?' [Then-Commissioner Whitman] said, 'I'm putting two stars by that,' and that's the last we heard. So we have no medical records to speak of. . . .").)

And in March 2022, the Court remarked on the still-inadequate nature of PMC children's medical records. (D.E. 1225 at 74:6-8 ("You know, to this day . . . the medical records . . . are paper, and they're very insufficient.").) By that time, Mr. Whitman was no longer with DFPS;[190] the Court reminded his successor, Jaime Masters, of Mr. Whitman's promise to "put two stars by" the e-filing issue and "get that done." (*Id.* at 74:20-21.) When asked if that was ever taken care of, then-Commissioner Masters replied "No, I don't think so, Your Honor."[191] (*Id.* at 74:22-

190. In June 2023, the Court prepared a chart showing the name and length of tenure for each of the seven DFPS Commissioners since this litigation began, and each of the eight HHSC Commissioners since this litigation began. (*See* D.E. 1384 at 2.)

191. The Court notes that Mr. Whitman served as Commissioner for two years after making this promise to the Court. (*See* D.E. 701 at 1 (noting that the hearing took place on March 16, 2017); D.E. 1384 at 2); *see also Hank Whitman Steps Down as DFPS Commissioner*, DFPS (May 28, 2019), https://www.

24.) When asked if someone could "follow-up on that," Commissioner Masters replied "Yes, Your Honor." (*Id.* at 74:25-75:2.)

Three months later, at the June 2022 hearing, the Court again explained that doctors were not e-filing medical records with Health Passport, so there was little to no information on diagnoses, evaluations, or medical tests. (D.E. 1267 at 180:1-20.) Also absent were things like medication and immunization records, "and particularly lacking are the mental healthcare records." (*Id.* at 180:21-22.) And to the extent information was entered in Health Passport, it was so abbreviated that it was unhelpful. (*Id.* at 180:23-24.) The Court noted that it "is not safe for children not to have medical records readily available" (*id.* at 183:10-11), and asked how difficult it would be to require healthcare providers to put all the information into Health Passport (*id.* at 181:1-5).

Doctor Van Ramshorst explained that incomplete Health Passport information was a problem of which the State and Superior HealthPlan are "well aware." (*Id.* at 182:22.) He elaborated that it was a "linkage issue":

> [T]here are multiple electronic medical record vendors out there and even for clinics that might use the same vendor for their electronic medical records, some practices have more bells and whistles than others, and that just makes

---

dfps.texas.gov/About_DFPS/News/press_releases/2019-05-28_Hank_Whitman_Steps_Down.pdf (noting that Mr. Whitman "is stepping down . . . on June 30").

> it difficult for multiple sources to feed into the one singular Health Passport.

(*Id.* at 184:15-20.) And he explained that Superior HealthPlan "is working on . . . better connecting that Health Passport with health information exchanges and the electronic medical records that providers use on a day-to-day basis." (*Id.* at 181:18-21.) The Court inquired as to the cost of solving this linkage issue,[192] and Doctor Van Ramshorst promised several times that he would "get back to you with an estimate." (*Id.* at 182:4-5; *see also id.* at 183:4-5 ("[W]e can look into that, Your Honor."); *id.* at 184:5-6 ("We can certainly get back to you with a cost estimate.").)

In January 2023, the Court again noted that the medical records in Health Passport continued to be inadequate. (D.E. 1321 at 83:16-17; *see also id.* at 181:2-13 ("On the medical records that are in Health Passport, I keep asking you-all and I still don't get an answer. There's an electronic recording act that I think all these things are supposed to be recorded electronically. And you have like a contract with these providers, for mental and physical health providers. And I keep asking if you-all can put in your contract that they have to enter directly into Health Passport what happens at each of these meetings. Like, there are not proper immunization records for these children. Mental health records just say

192. The Court so inquired because Plaintiffs had money held in trust for the benefit of the children, and some of that money could be used to solve the issue. (*See* D.E. 1267 at 183:6-7); *see also supra* footnote 92 (discussing trust fund).

mental health visit or psychiatric visit, and no indication of what kind of treatment the children are getting, either mental or physical. Some do, but most do not.").) The Court again asked whether the State would require healthcare providers to electronically submit medical records to Health Passport. (*Id.* at 181:24-82:1, 184:18-21.) Doctor Van Ramshorst did not answer the question. Nor did he give the Court the cost estimate he had promised three times in June 2022. Indeed, the Court learned that—five years after the topic was first broached—Defendants apparently did not even understand the problem:

> COMMISSIONER YOUNG: Your Honor, this is Commissioner Young. Can I request that we could spend some time with Monitors so we understand what it is they are looking for? Most of these things are supposed to be in the Health Passport, so I want to understand if there's something else that is not showing up in there.

(*Id.* at 182:3-8.)[193]

And at the Contempt Hearing, the Court heard more of the same. The Court reminded Doctor Van Ramshorst of his statement in June 2022 that Superior HealthPlan was working to better connect Health Passport with health information exchanges and electronic medical records. (D.E. 1489 at 201:20-25.) He replied that Superior "pursued a variety of enhancements, just not to the level

193. The Court notes that by January 2023, Commissioner Young had been in charge of HHSC for nearly three years. (*See* D.E. 1384 at 2.)

that I know you've discussed before, Your Honor." (*Id.* at 202:10-12.) The Court then reminded Doctor Van Ramshorst of his promise to give the Court an estimate as to the cost of that Health Passport enhancement; his response was rather disappointing:

> THE COURT: You said you're looking at that as a possible enhancement for the future. So I said, "How much does that cost? Have you got an estimate? Can we find a workaround on this?" And you said, "Judge, I'm happy to work with the team and get back to you with an estimate." What is it?
>
> THE WITNESS: Your Honor, I don't have the estimate.
>
> THE COURT: Did you ask for one?
>
> THE WITNESS: Your Honor, that was awhile ago. Again, I do recall having conversations about this.

(*Id.* at 202:13-23.) Apparently, Doctor Van Ramshorst—and Defendants generally—need to be reminded that this is federal litigation, not a Socratic seminar; here, "conversations" are a means to an end—namely, results—not an end unto themselves.

And because of Defendants' ongoing failure to do anything more than "hav[e] conversations," PMC children's medical records continue to be inadequate and

unsafe. Doctor Bellonci explained that clinicians need a great deal of information to properly diagnose and care for children. For example, the clinician should know the family's history of medical conditions, as the clinician can glean if a child is at an increased risk of developing any medical conditions, and if the child might be at an increased risk of side effects from medications. (D.E. 1489 at 37:18-38:9.) Maternal health, drug use, and stress during the pregnancy are likewise factors which should be known to the clinician. (*Id.* at 37:17-23.) And, of course, it is important that the clinician "know when did this condition first present, when were symptoms first manifest, what did it look like." (*Id.* at 39:5-7.)

"[A]ll of that information, that historical information, that rich kind of detail" "goes into formulating" a diagnosis. (*Id.* at 39:7-17.) Ordinarily, a clinician would get that information from a parent. (*Id.* at 39:18.) But "the challenge in the child welfare system" is that "often . . . there's no parent for me to be talking with," so the only source of information is medical records. (*Id.* at 39:15-24("And so I'm left to . . . dig through significant piles of records . . . in order to then formulate my opinion.").) Of course, a clinician's opinion "is only going to be as good as the data [they] have to formulate that understanding of what's going on." (*Id.* at 39:24-40:1.) And the medical records of PMC children continue to be inadequate to help clinicians "understand what's going on" with their patients: Doctor Bellonci assessed the medical record system for PMC children from a physician's perspective, and concluded that "as a child psychiatrist, I wouldn't know how to function in that system." (*Id.* at 98:10-11.)

Like all the other shortcomings documented thus far, Defendants' failure to adequately maintain children's educational records has been known for years, yet the problem remains unresolved. Plaintiffs noted from the outset of this litigation that inadequate handling of PMC children's educational records "impede" their "ability to advance with their peers in school." (D.E. 1 at 46 ¶ 181.) At trial, the Court learned that named plaintiff Z.H.'s education log "seems to indicate that Z.H. went directly from second grade to fourth grade, although there does not appear to be any explanation for that in the record." (D.E. 368 at 131.) Named plaintiff K.E.'s education log likewise had "no record of K.E.'s sixth or eighth grades and there are date gaps after leaving one school and beginning another." (*Id.* at 132.)

Like medical records, inadequate and inaccessible educational records has been an ongoing topic of inquiry since trial. In March 2017, the Court was told that educational records were kept as "paper records" in a child's "external file." (D.E. 701 at 53:21-25.) In January 2022, the Court noted that educational records continued to be kept only as hard copies that were "hand carried, I don't know by whom, from placement to placement to placement." (D.E. 1175 at 111:17-20.) The Court further noted that those children who frequently moved between placements simply "don't have any" of their educational records. (*Id.* at 111:21-22.)

In March 2022, the Court again noted that "all the educational records are paper." (D.E. 1225 at 74:7.) Indeed, nothing had changed since 2017—the records were still

"not in any system whatsoever," and continued to be "hand-delivered," if at all. (*Id.* at 75:20-21.)

In January 2023, the Court reiterated that "educational records . . . are in paper form and they go from place to place." (D.E. 1321 at 83:23-24.) The Court also noted the Monitors' report that very few residential facilities they visited had "any educational records whatsoever" for the children in their care. (*Id.* at 83:25-84:1, 185:6-9; *see also id.* at 186:15-18 (one of the Monitors explaining that "It is true that we rarely see educational records from the children's previous placements when we're in a congregate care setting, and we ask to see everything that they have for that child").) The Court explained that these incomplete and inaccessible educational records are "a huge, huge issue of concern." (*Id.* at 83:23-84:2.) Associate Commissioner Banuelos informed the Court that DFPS has "education specialists that do follow-ups on ensuring that" educational records "are sent over to the next placement." (*Id.* at 185:15-17.) Further, Ms. Banuelos said that she "will go back and look at" whether educational records were, in fact, being provided and, if not, that DFPS "will work on some more processes" to ensure that the records were provided. (*Id.* at 185:21-23.) Since then, the Court has heard nothing more from Defendants about educational records.

VI. CONTEMPT

Pursuant to Federal Rule of Civil Procedure 52(a), the Court makes the following findings of fact and conclusions

of law. Any finding of fact that also constitutes a conclusion of law is adopted as a conclusion of law. Any conclusion of law that also constitutes a finding of fact is adopted as a finding of fact. All of the Court's findings of fact and conclusions of law are based upon clear and convincing credible evidence.

A. The Court finds Defendant Cecile Erwin Young, in her official capacity as Executive Commissioner of the Health and Human Services Commission of the State of Texas, in contempt of Remedial Order 3 and Remedial Order 10[194]

Remedial Order 3 provides:

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

194. Because the contempt underpinnings of Remedial Order 3 and Remedial Order 10 are many times interchangeable, the two will be discussed together.

> Order and conducted taking into account at all times the child's safety needs.

(D.E. 606 at 2.)[195]

At trial, the Court found that, despite the importance of "correct decisions" in investigations of potential abuse and neglect of children, "faulty investigations" were putting children at an "unreasonable risk of harm."[196] (*See* D.E. 368 at 201, 208; D.E. 301 at 28:20-23.) The Fifth Circuit agreed in *Stukenberg I*, observing that it "seems painfully obvious" that "high error rates in abuse investigations . . . place children at a substantial risk of serious harm." 907 F.3d at 267. When investigations are flawed or untimely, "children are left with their abusers without receiving necessary treatment, and adult perpetrators continue to house foster children with nothing indicating a risk." (*See* D.E. 368 at 212.) It is not enough under Remedial Order

195. The text of Remedial Order 3 also implicates other remedial orders. Specifically, the requirement that allegations of abuse and neglect be "investigated; commenced and completed on time consistent with the Court's Order; and conducted at all times taking into account the child's safety needs" (D.E. 606 at 2) implicates Remedial Order 7 and Remedial Order 8, which require investigators to make face-to-face contact with alleged victims "no later than," respectively, "24 hours after intake" of "Priority One . . . investigations" (*id.* at 3 ¶ 7), or "72 hours after intake" of "Priority Two . . . investigations" (*id.* at 3 ¶ 8).

196. Of course, the applicable standard in the final injunction is that: "The Defendants SHALL implement the remedies herein to ensure that Texas's PMC foster children are free from an **unreasonable risk of serious harm**." (D.E. 606 at 2 (emphasis added).)

3 that an investigation just occur. It must be conducted at all times considering the safety of the child.

The first element for a finding of civil contempt requires a movant to establish by clear and convincing evidence that a court order was in effect. *See LeGrand*, 43 F.3d at 170. In order to remedy the deficiencies in the State's investigation processes found at trial, the Court ordered the Special Masters to "help craft . . . reforms and oversee their implementation." (*See* D.E. 368 at 245; *see also id.* at 246-48, 250, 252.) In its January 2018 Order, the Court adopted the Special Masters' proposed remedies to address DFPS's failure to adequately investigate allegations of abuse and neglect giving rise to an unreasonable risk of harm to children. (D.E. 559 at 39 ¶ D2; *see also* D.E. 546 at 13 ¶ 2.) In *Stukenberg I*, the Fifth Circuit held that "[m]ost of the injunction provisions relating exclusively to the monitoring and oversight violation are reasonably targeted toward remedying the identified issues," and expressly validated those provisions. *See* 907 F.3d at 276, 276 ¶ 1. Therefore, in its November 2018 Order implementing *Stukenberg I* on remand, the Court restated one of those validated Remedial Orders as Remedial Order 3.[197] (D.E. 606 at 2.) The Fifth Circuit's opinion in *Stukenberg II* did not disturb Remedial Order

197. Remedial Order 3 repeats the language of the corresponding Remedial Order from the Court's January 2018 Order, with only slight revisions to the wording. (*Compare* D.E. 559 at 39 ¶ D2 (referring to "the Court's Final Order," the "monitor(s)," and "Items 9-6 of this Section of the Court's Final Order"), *with* D.E. 606 at 2 ¶ 3 (referring to "the Court's Order," the "Monitors," and "this Order").)

3, and it became effective upon the Fifth Circuit's July 30, 2019 Mandate. *See* 929 F.3d at 276 (listing issues on appeal, which did not pertain to Remedial Order 3). Thus, the Court finds by clear and convincing evidence that the first element of civil contempt, that an order was in effect, *see LeGrand*, 43 F.3d at 170, is satisfied as to Remedial Order 3, which Defendant does not dispute.

The second element of civil contempt requires a movant to establish by clear and convincing evidence that the order requires certain conduct. *See LeGrand*, 43 F.3d at 170. The text of Remedial Order 3 makes clear that it requires Defendant to "investigate[]" all "reported allegations of child abuse and neglect involving children in the PMC class," and ensure that such investigations are completed "on time" and "conducted taking into account at all times the child's safety needs." (D.E. 606 at 2.) Remedial Order 3 contains specific language detailing required conduct by Defendant. Hence, the Court finds by clear and convincing evidence that Remedial Order 3 "require[s] certain conduct" by Defendant and fulfills the second element of civil contempt. *See LeGrand*, 43 F.3d at 170.

Remedial Order 10 provides:

> Within 60 days, DFPS shall, in accordance with DFPS policies and administrative rules, complete Priority One and Priority Two child abuse and neglect investigations that involve children in the PMC class within 30 days of intake, unless an extension has been

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

(D.E. 606 at 3.)

At trial the Court found that, "[b]esides being full of errors, RCCL's investigations were often late. Only 58% of investigations were completed within the required 45-day timeframe." (D.E. 368 at 211 (citing trial exhibit PX 1118).) Delays in completing investigations can create risk of harm for children because alleged perpetrators might remain free to continue causing harm to children until the investigation is finally completed. "Due to RCCL's systemic failures,"[198] the Court found that "children are left with their abusers without receiving necessary treatment, and adult perpetrators continue to house foster children with nothing indicating a risk." (*Id.* at 212.)

In its 2015 Opinion and Verdict, the Court ordered the Special Masters to propose remedies that would address the problems with the inappropriately lengthy and delayed investigations identified at trial. (*See* D.E. 368 at 245-48, 251-52.) In its January 2018 Order, the Court adopted the provision proposed in the Special Masters' Implementation Plan. (*See* D.E. 546 at 15 ¶ 15; D.E. 559 at 43 ¶ D15.) The Fifth Circuit validated this Remedial

198. The 2015 Memorandum Opinion and Verdict was entered before the legislature separated HHSC and DFPS into independent agencies.

Order from the January 2018 Order in *Stukenberg I*, 907 F.3d at 277, and the Court restated it as the substantially similar[199] Remedial Order 10 in its November 2018 Order (*see* D.E. 606 at 3 ¶ 10). Remedial Order 10 was not at issue and therefore remained undisturbed in *Stukenberg II*, so it became effective upon the Fifth Circuit's July 30, 2019 Mandate. *See* 929 F.3d at 276. Therefore, the Court finds by clear and convincing evidence that the first element of civil contempt is established as to Remedial Order 10: "a court order was in effect." *See LeGrand*, 43 F.3d at 170.

The problem of untimely and delayed investigations did not end with the imposition of Remedial Order 10. Each Monitors' report discussing Remedial Order 10 has outlined investigations that were compromised by significant delays. (*See* D.E. 869 at 13-14 (reporting that there are "numerous examples where [abuse and neglect investigations] languish for months or even years with no activity"); D.E. 1165 at 47 (reporting that "[c]onsistent with the Second Report, the Monitors observed that while the investigations were generally initiated timely . . . investigative activity often ceased after these initial tasks were completed—sometimes for many months").) And while DFPS's compliance with Remedial Order 10 has improved over time (*see* D.E. at 65) the same cannot be said for PI.

---

199. Remedial Order 10 repeats the language of the corresponding Remedial Order from the January 2018 Order but with a different specified timeframe for compliance. (*Compare* D.E. 559 at 43 ¶ 15 ("Effective March 2018. . . ."), *with* D.E. 606 at 3 ¶ 10 ("Within 60 days. . . .).)

The text of Remedial Order 10 is clear that it requires Defendant to "complete Priority One and Priority Two child abuse and neglect investigations" involving PMC children "within 30 days of intake," absent an "extension . . . approved for good cause and documented in the investigative record." (D.E. 606 at 3.) Therefore, the Court finds by clear and convincing evidence that Remedial Order 10 "require[s] certain conduct" by Defendant, which satisfies the second element of contempt. *See LeGrand*, 43 F.3d at 170. Defendant does not argue otherwise.[200]

1. Background of HHSC's Provider Investigations (PI) unit

In the Contempt Motion, Plaintiffs argue that Defendant has failed to comply with Remedial Order 3 due to the "chronic failure" by HHSC's Provider Investigations (PI) unit to timely investigate, commence and complete investigations of abuse and neglect of PMC children. (*See* D.E. 1427 at 12.) Meanwhile, Plaintiffs argue, "state bureaucracy grinds on, checking boxes while children suffer." (*Id.* at 11.) Therefore, Plaintiffs urge the Court to find that Defendant has failed to comply with Remedial Order 3 as to abuse and neglect investigations conducted by PI. (*Id.* at 16.)

---

200. One heading in Defendant's response to the Contempt Motion states "Plaintiffs haven't carried their burden to make a *prima facie* showing of contempt as to Remedial Order[] . . . 10." (D.E. 1429 at 15.) In the text that follows, however, Defendant only disputes the sufficiency of the evidence showing noncompliance with Remedial Order 10. (*Id.* at 18-19.)

Appendix B

In 2015, Senate Bill (SB) 1880 transferred jurisdiction for investigating allegations of abuse, neglect, and exploitation (ANE) involving individuals in Home and Community Support Services Agencies (HCSSA) from the Department of Aging and Disability Services (DADS) to the Department of Family and Protective Services (DFPS). (*See* PX 106 at 1.) Also in 2015, SB 200 transferred "PI and DADS Long-Term Care Regulation (LTCR) as separate departments" from DFPS to HHSC, though PI continued to use DFPS's IMPACT system. (*Id.* at 1.) In September 2020, PI became fully integrated into HHSC LTCR. (*Id.* at 1.)

PI's jurisdiction was expanded by SB 1880 and SB 760, from the same session, to include investigating ANE allegations involving "[i]ndividuals residing in an HCS 3- or 4-person residence (group home), regardless of whether the individual is receiving services under the waiver program[201] from the provider." (*Id.* at 1.)

The Home and Community-Based Services (HCS) waiver program is a Medicaid program authorized under § 1915(c) of the Social Security Act for the provision of

---

201. In the 1980s, the U.S. Health Care Financing Administration, now the Centers for Medicare & Medicaid Services (CMS), granted waivers from the existing Medicaid rules. (PX 43 at 1.) The waivers allowed states flexibility in designing alternatives to institutional services. (*Id.* at 1.) In 1985, Texas developed the Home and Community-based Services (HCS) waiver program which allows "flexibility in the development of services for individuals who have intellectual and developmental disabilities that choose to receive their services in the community." (*Id.* at 1.)

services and support to individuals with intellectual disabilities or related conditions and allows them to live in community-based settings and avoid institutionalization. (*See* PX 85 at 3; PX 91 at 1; PX 82 at 63.) These settings include homes managed by private HCS providers that are contracted by HHSC to coordinate and monitor the delivery of individualized services to Medicaid beneficiaries. (PX 82 at 63.) HCS program providers managing three-and four-person homes must comply with HHSC's certification standards[202] (*id.* at 63) that establish "the minimum health and safety expectations and responsibilities of a HCS program provider."[203] 26 Tex. Admin. Code § 565.2(a). "Eligibility for HCS waiver services requires that an individual has an Intellectual disability under state law or a diagnosis of a 'related condition' with an IQ of 75 or below as further defined in the Code of Federal Regulations, Title 42, § 435.1010."[204] (D.E. 1412 at 3.) These individuals, both adults and children, receive around-the-clock residential assistance from staff employed by the HCS program provider, who help the individuals in care perform various essential

---

202. HCS providers are certified by HHSC and not licensed.

203. HCS program providers also undergo annual surveys conducted by HHSC LTCR to ensure continuous compliance with the HCS program certification principles and standards outlined in 26 Tex. Admin. Code §§ 565, 566. (*Id.* at 63; *see* DX 33 at 126.)

204. Ms. Juarez, who did not have any documented intellectual or developmental disability, testified that she was placed at Forever Family, an HCS Group Home, for "a couple months." (D.E. 1487 at 243, 245.) But it is unclear why, as she would not qualify for HCS Group Home placement. *See* 42 C.F.R. § 435.1010.

tasks of daily living. (*See* PX 82 at 63.) The Monitors report that there are eighty-eight PMC children in HCS group homes.[205] (D.E. 1380 at 28 n.33.)

PI is responsible for conducting "time-sensitive, evidence-based" investigations of allegations of ANE of individuals that receive services from certain providers, such as HCS Group Homes that house three or four residents. (DX 33 at 106; D.E. 1412 at 3.) But PI investigations do not use the same parameters as RCCI or RCCL, as will become obvious in the investigations as outlined below. For instance, "[u]nlike DFPS investigations into child maltreatment, PI investigations do not involve a review of the referral history of the placement location, the supervising agency or owner, or of specific group home locations, despite its relevance to the fact-finding endeavor." (D.E. 1412 at 8.) "PI investigators are instructed to review the case history of alleged perpetrators and victims; however, the referral history of abuse, neglect, and exploitation allegations at a specific placement location, such as an HCS Group Home or the agency overseeing it, is not available in IMPACT." (*Id.* at 9.) "HHSC confirmed that it does not consider that history during PI investigations."[206] (*Id.* at 9.) Further,

---

205. The number of PMC children in HCS has not changed significantly over time. (*See, e.g.*, D.E. 1318 at 21 n.24 (ninety-three children); D.E. 1248 at 20 n.20 (101 children); D.E. 1165 at 20 n.23 (seventy-three children).)

206. In contrast, DFPS instructs RCCI investigators to review prior referral history at "an operation or at other operations supervised by the same administrator, director, owner, or other person in charge." (D.E. 1412 at 8 n.17.) DFPS investigators are also "instructed to consider operational referral history to determine culpability of administrators." (*Id.* at 8 n.17.)

PI investigators do not verify that there are current background checks for staff that may be identified as alleged perpetrators, thereby failing to ensure the safety of the children with whom the staff are in daily contact.[207] 26 Tex. Admin. Code § 745.605.

In response to the inquires by the Monitors about locating the referral history for HCS Group Homes over which PI has jurisdiction, HHSC explained that it does not consider this information for the fact-finding process of the investigation, but when it performs a sampling of PI investigations at an operation during the *recertification* process, "the process *might* lead to an additional inquiry into systemic concerns and *might* result in additional inquiry into the operational history." (*Id.* at 9 n.19 (emphasis added).)

207. Mr. Pahl, the HHSC executive who oversees PI, admitted that PI investigators do not conduct background checks for placement staff:

> THE COURT: One other thing I understood is that these children—you didn't—you didn't have your investigators check to make sure these staff had criminal history backgrounds even after the rape—this Child C accused and identified a staff member of rape. You did not have your staff check for the—make sure they had criminal history background checks. Did you know that?
>
> THE WITNESS: I read that in the report, yes, ma'am.
>
> THE COURT: Is that true?
>
> THE WITNESS: I believe that's true.

(D.E. 1487 at 147:19-148:3.) This is different from the requirement that a private provider conduct background checks for applicants before hiring them for employment. *See* 40 Tex. Admin. Code § 49.304.

Also notable, the Monitors "have observed examples of jurisdictional confusion between SWI, CPI[,] and PI during the intake and investigation process." (*Id.* at 3 n.5.) If ANE is alleged in a HCS host home setting, HHSC has authority to investigate the allegations relating to an individual (child or adult) who receives HCS waiver services. (*Id.* at 3.) But if the allegations involve children in those residences who do not receive HCS waiver services, DFPS's CPI investigates the allegations. (*Id* at 3.) Because of this bifurcation of investigative responsibility, allegations of abuse and neglect can fall through the cracks, even when both agencies receive reports of the allegations.

For example, SWI received two reports of neglectful supervision of a PMC child, Child A (age 14), who was placed at D&S Residential Services, an HCS residence. (D.E. 1486-1 at 29.) In the first intake, the child's current foster mother reported that the child engaged in sexual activity with the son of his prior caregiver (Child B, age 15, not in DFPS care) while placed in the HCS residence. (*Id.* at 29.) The second intake was reported by a psychologist, who stated that Child A made an outcry that he engaged in oral and anal sex with Child B multiple times at the previous placement. (*Id.* at 29.)

SWI assigned the first intake to HHSC PI, and PI determined that it did not have jurisdiction to investigate the neglectful supervision allegation. (*Id.* at 29.) Then, the intake was re-entered and assigned to DFPS RCCI, which also determined that it did not have jurisdiction to investigate the neglectful supervision allegation. (*Id.* at

30.) When the intake was re-entered a second time, it was not assigned to an investigation; as a result, the intake was closed and the allegations in the first intake were not investigated. (*Id.* at 30.) The psychologist reported the second intake with similar allegations one week later, and it was assigned to DFPS CPI for an abuse and neglect investigation. (*Id.* at 30.) "If SWI had not received this second intake, it appears that DFPS would not have investigated the allegations included in the first intake since it had been closed without investigation at that point." (*Id.* at 30.)

Further, even if SWI correctly assigns an intake to HHSC PI, PI can nonetheless determine that it lacks jurisdiction, resulting in the alleged victim remaining in an unsafe placement because the allegation remains without investigative activity. *Cf. Stukenberg I*, 907 F.3d at 266 ("[R]eports of abuse may receive only cursory [] follow-up, and some are never investigated at all. This means that children could make an abuse outcry and then languish in the offending placement indefinitely."). For example, Child A, discussed below,[208] placed at Educare, an HCS Group Home, was the subject of an intake report alleging emotional abuse, neglect, and physical abuse of the child. (D.E. 1412 at 13.) Although the report contained serious allegations related to neglect by a staff member—who allegedly instructed Child A to sleep in the same bed as another resident of the group home—the PI investigation was concluded with a determination that "PI did not have

208. *See infra* page 580-81.

jurisdiction over the Neglect allegation."[209] (*Id.* at 13.) Although the investigative record stated that the intake was referred to the provider for appropriate action, the Monitors were unable to find additional documentation that any action was taken to investigate the allegation that Child A was told to share a bed with another resident. (*Id.* at 14.) Thus, children continue to face an unreasonable risk of serious harm while in the PMC of the State.

PI maintains a prioritization system for investigations conducted in provider settings. (PX 7 at 34.) Priority One intakes "have a serious risk that a delay in investigation will impede the collection of evidence" or "allege that the victim has been subjected to abuse, neglect, or exploitation by an act or omission that caused, or may have caused, serious physical or emotional harm." (*Id.* at 34.) Priority Two intakes "have some risk that a delay in investigation will impede the collection of evidence" or "allege that the victim has been subjected to abuse, neglect, or exploitation by an act or omission that caused, or may have caused, non-serious physical injury or emotional harm not included in Priority I." (*Id.* at 34.) Statewide Intake (SWI) assigns priorities to investigations when an intake is received. (*Id.* at 35.)

When an investigation is completed, PI investigators are to close the case with one of four dispositions:

---

209. The investigator failed to cite a specific provision of the Administrative Code in reaching this conclusion. (D.E. 1412 at 13 n.32.)

> Confirmed—There is a preponderance of credible evidence to support that abuse, neglect or exploitation occurred.
>
> Inconclusive—There is not a preponderance of credible evidence to indicate that abuse, neglect or exploitation did or did not occur due to lack of witnesses or other available evidence.
>
> Unconfirmed—There is a preponderance of credible evidence to support that abuse, neglect or exploitation did not occur.
>
> Unfounded—Evidence gathered indicates that the allegation is spurious or patently without factual basis.

(D.E. 1412 at 4 (citing 26 Tex. Admin. Code § 711.11-711.23).) A fifth disposition—"Other"—is used when PI determines that it does not have jurisdiction over any of the allegations. (*Id.* at 4.) Notably, "Other" is not defined in the Texas Administrative Code, but is listed as a disposition for investigations in the IMPACT database and in data reports submitted to the Monitors by HHSC. (*Id.* at 4.)

When PI reports investigation results to the Monitors, the overall disposition is reported as "Inconclusive" only if there is no finding of "Confirmed" or "Unconfirmed" as to any allegation within the investigation. (*Id.* at 4, 5 nn.8, 12.) Thus, "for PI investigations with allegations resulting in both Unconfirmed and Inconclusive dispositions,

the overall disposition appears as Unconfirmed in the HHSC data reports submitted to the Monitors." (*Id.* at 5 n.12.) "This approach is unlike DFPS, which assigns an overall disposition of Unable to Determine (similar to PI's disposition of Inconclusive) in those situations." (*Id.* at 5 n.12.)

In their Sixth Report, the Monitors identified that on December 31, 2022, there were 88 PMC children living in "HCS Group 1-4." (D.E. 1380 at 28 n.33.) These children have various documented developmental and intellectual disabilities, and the full IQ score of the children identified in Monitors' reports range from 40-71.

Between January 1, 2023, and April 30, 2023, HHSC opened 77 new PI investigations involving at least one PMC child, and closed 101 investigations into abuse and neglect allegations that were analyzed by the Monitors. (D.E. 1442 at 4.) Of the 101 investigations closed between January 1, 2023 and April 30, 2023, ninety-nine resulted in no findings of abuse and neglect by HHSC PI: sixty-four of the investigations were closed with dispositions of Inconclusive or Unconfirmed, and thirty-five were assigned a disposition of Other. (*Id.* at 5.)

In order to assess the appropriateness of PI investigations of alleged maltreatment of PMC children, the monitoring team conducted in-depth reviews of all sixty-four investigations—that is, 100 percent of the investigations—that PI closed with a disposition of Unconfirmed or Inconclusive between January 1, 2023, and April 30, 2023. (*Id.* at 2.) Additionally, the Monitors

reviewed five PI investigations that were closed prior to 2023[210] "but involved the same PMC children and allegations related to the investigations that closed during the referenced period in 2023," for a total of sixty-nine. (*Id.* at 2.)

Of these, the Monitors disagreed with thirty-eight (55 percent). Those thirty-eight are discussed in detail below; all involve violations of Remedial Order 3, and thirty-one involve violations of Remedial Order 10.

The deficiencies reported were serious and egregious, especially considering the alleged victims were children with severe intellectual and developmental disabilities. The investigative failures were outrageous, leaving PMC children to endure harm in dangerous placements while the investigations sat without activity for prolonged periods of time.

The Monitors discovered various deficiencies among the thirty-eight investigations that were inappropriately resolved. (*Id.* at 2.) "Often the deficiencies began at the start of the investigations during the expected assessment of the alleged victim's current safety and recounting of the allegations. These problems included a failure to promptly interview children face-to-face and, in some instances, a failure to conduct interviews with children at all, despite this Court's orders." (*Id.* at 7 & n.12; *see* D.E. 606 at 3 ¶¶ 7, 8.).

---

210. One of these investigations was assigned a disposition of Confirmed, but the investigation was not completed for over sixteen months.

Other investigative deficiencies were common, further demonstrating PI's failure to conduct investigations in a manner that "account[s] at all times [for] the child's safety needs." (D.E. 606 at 2 ¶ 3.) In many cases, interviews with both alleged perpetrators and witnesses were significantly delayed. In some cases, the investigator's first attempt to interview the alleged perpetrator was so delayed that the alleged perpetrator no longer worked at the facility and either could not be located or refused to speak with the investigator. In other cases, investigators failed to obtain documentation that would have resolved factual discrepancies. And many of the investigations—nine of thirty-eight—were initiated with a telephone or FaceTime call, rather than with face-to-face contact.

Further, the majority of the investigations were not completed timely. "The Monitors discovered lengthy, unexplained delays in PI's completion of investigations that impacted child safety, including in Priority One investigations. Among the investigations the Monitors reviewed, very few were completed in 30 days and many had egregious delays, remaining open without activity for extended periods even in situations where the child was an alleged victim in newer additional serious allegations at the same placement." (D.E. 1442 at 7.) Indeed, thirty-one of the thirty-eight deficient investigations (82 percent), were not completed in a timely manner. (*Id.* at 6.) And of those thirty-one, twenty-nine investigations (94 percent) "had approved extensions but there was no information regarding the extension length in IMPACT." (*Id.* at 6.) Notably, even when extensions were documented and approved, the delays in investigative activity

exceeded reasonable periods of time without documented justifications; the child's safety was not accounted for during these lapses in investigations. (*Id.* at 7.) For example, the Monitors "discovered a child was an alleged victim in three investigations that remained open for more than 20 months," meanwhile "several new allegations of child abuse and neglect arose, resulting in three new additional investigations." (*Id.* at 7.)

Moreover, the Monitors reported that, in many instances, PI investigators do not appropriately facilitate the child's meaningful participation in investigative interviews. (*Id.* at 7.) For example, the Monitors recounted that one investigator conducted telephone interviews with one child who "was 'non-verbal'" and another child with serious speech impediments. (D.E. 1412 at 53-54.) The Monitors reported many such examples. Doctor Miller wondered how the investigator would "get anything like the kind of information that they would need" through these telephone interviews. (D.E. 1488 at 264:17-19.) PI's frequent failure to accommodate the disabilities of children being interviewed is particularly baffling because the children are "eligib[le] for HCS services"—and thus, within PI's investigative jurisdiction—because of the very "documented intellectual disabilities" that the investigators "were so frequently ill-equipped to accommodate." (D.E. 1412 at 7.) It is also emblematic of PI's failure to conduct investigations in a manner that "account[s] at all times [for] the child's safety needs." (D.E. 606 at 2 ¶ 3.)

Without ensuring the child's participation in investigation interviews by accommodating their limited capacities, investigators cannot accurately determine whether the child is safe in a particular placement. For example, PI investigated a physical abuse allegation of Child M after she made an outcry that a staff member "attacked" her and "hit her all over her body and face with metal kitchenware."[211] (*See* D.E. 1442 at 16-17.) The Monitors reported that she is "deaf or hard of hearing," and has communication issues and an IQ of 57; yet the investigator interviewed Child M on the telephone after failing to conduct a face-to-face interview. (*Id.* at 17 & n.26 ("The investigator attempted a timely face-to-face interview with the child at the placement; however, the child was unavailable at that time. The investigator did not attempt any other face-to-face interviews with the child.").) Without accommodating Child M's special needs during the phone interview, the investigator assigned a disposition of Unconfirmed to the allegation that a staff member attacked the child. (*Id.* at 17.) The Monitors were not able to determine a disposition due to the investigator's failure "to confirm whether or not the child was injured and safe at the group home." (*Id.* at 17.)

After noting the need for policies and practices addressed specifically to children with special needs, Doctor Miller concluded that PI's came up short:

---

211. This was one of the few investigations in which the allegation was reported by a facility staff member. (D.E. 1442 at 16.) It was also one of the many in which the investigator failed to make face-to-face contact with the child. (*Id.* at 17.)

> Q. Did you see any—in all of your reading, in all the testimony you've heard so far, have you seen anything among the practices or policies of Provider Investigations that tailored the investigations to the needs and the realities of developmentally disabled children?
>
> A. Absolutely not. Quite the opposite.

(D.E. 1488 at 264:22-265:2.)

For his part, Mr. Pahl agreed that if PI investigators are accommodating the communication needs of the children they interview, then the accommodation would be documented by the investigator in IMPACT. (D.E. 1487 at 141:7-13.) Tellingly, the Monitors found few examples of investigators utilizing special assistance when communicating with children who have limited capacities.

Finally, Mr. Pahl conceded that PI was underperforming:

> THE COURT: Could you—can you answer my question? Could you have done a better job for these children with the resources you had at hand?
>
> THE WITNESS: I think we can always—
>
> THE COURT: Could you have done a better job?

THE WITNESS: Yes, ma'am.

(*Id.* at 133:13-18.)

2. HHSC's PI unit conducts deficient investigations that are not in compliance with Remedial Order 3 or Remedial Order 10

PI's failure to properly investigate allegations of abuse and neglect by or involving HCS program providers presents safety risks for the PMC children who are housed in these settings. This is, perhaps, best illustrated by the experience of a fifteen-year-old PMC child, referred to by the Monitors as Child C, during her placement at C3 Christian Academy, a private HCS group home, as discussed in detail below.

At the Contempt Hearing, the Court heard testimony from Trisha Evans, the owner and administrator of C3 Christian Academy, who owned and operated eight 24/7 facilities that were classified as "3 bed person Group Home[s]" (D.E. 1412 at 41) that housed up to three adults and/or children in each home (D.E. 1488 at 72:4-6, 17-18). Ms. Evans testified that "on occasion," her group homes housed intellectually and developmentally disabled adults and children in the same home. (*Id.* at 72:20-22.) Further, it appears that these three-bedroom residences house both males and females together—in one investigation concerning Child C, she made an outcry that a male resident at the placement punched her. (D.E. 1412 at 34.) Notably, this resident "had previously been incarcerated for 'assaulting his mother.'" (*Id.* at 34 n.65.)

Ms. Evans is a registered—and, at the time of the Contempt Hearing, licensed—nurse. (D.E. 1488 at 127:3-6.) As for her experience working with developmentally disabled children, she explained that she worked "with children" "at a couple of the psychiatric facilities . . . in the Dallas area." (*Id.* at 126:17-20.) Specifically, "sometime between 2006 and 2020, [she] worked at Green Oaks." (*Id.* at 128:8-9.) She also worked at a facility called "Hickory Trail" "sometime in that same . . . timeframe [2006-2020]." (*Id.* at 128:10-12.) And she "believe[d]" that in the "1990s," she worked at "a facility in Bedford." (*Id.* at 127:1-2.) The job at Hickory Trails was part-time, and lasted "[p]robably less than a year." (*Id.* at 128:18-23.) At Green Oaks, Ms. Evans "worked with the psychiatrists there that were seeking the children," where she was responsible for "anywhere from five to 12" children. (*Id.* at 129:1-2, 13-14.) She worked at Green Oaks for "probably over a year"; she did not state whether this job was full-or part-time, but she was also running her company during that time. (*Id.* at 128:16-19.)

In 2006, she began operating "a licensed or certified facility for the State of Texas." (*Id.* at 88:1-3.) She did not elaborate on the nature of the facility, but did note that they "include[d] children." (*Id.* at 88:5-6.)

In 2014, Ms. Evans became certified to operate HCS Group Homes to care for developmentally disabled children and adults. (*Id.* at 87:14-16.) Her HCS homes were limited to three inhabitants with separate bedrooms. (*Id.* at 106:6-7.) Frequently, these homes mixed children and adults, males and females. She generally "had between 15

and 20 staff" working in two shifts. (*Id.* at 74:3-4, 18-19.) During the day shift, all residents from the eight group homes were brought to "the day habilitation center," where they were under the care and supervision of five to six staff. (*Id.* at 74:19-20; 75:10-11.) During the night shift, the residents were returned to their respective group homes, and Ms. Evans "had just one caregiver, one staff member for up to three residents in each home." (*Id.* at 74:24-75:1.)

Chapter 565 of the Tex. Admin. Code establishes the "minimum health and safety expectations and responsibilities of a HCS program provider." HCS program providers, like C3 Academy, must abide by certification standards to ensure the health and safety of individuals placed with the program provider; violations of the certification standards are subject to administrative penalties. 26 Tex. Admin. Code § 565.3. One of the certification standards is an individual's right to "live free from abuse, neglect, or exploitation in a healthful and safe environment." *Id.* at § 565.5. Further, Defendant previously agreed that "a General Class member should receive the same protections under the Court's remedial orders regardless of the licensed or unlicensed nature of the facility where the member is housed, unless the remedial order at issue specifies that it applies only to the LFC subclass or licensed or unlicensed facilities." (D.E. 1137 at 3.)

C3 Christian Academy lost its certification in 2023 (D.E. 1488 at 73:24-75:2) due to its repeated failure to keep children and adults with intellectual and developmental disabilities free from physical or emotional harm,

including abuse and neglect at the hands of staff members responsible for their care.

Below, this Order details several PI investigations into abuse and neglect of PMC children housed in HCS Group Homes. It is notable that most of the reports leading to these investigations were made by persons other than the child's caregiver. Caregivers' failure to report abuse or neglect is a common occurrence, and Ms. Evans' testimony suggests a reason for this. Ms. Evans explained that she conducted her own investigations into outcries made by the children (and adults) in her care; she frequently chose not to report[212] these outcries to Statewide Intake because "every allegation doesn't make for an investigation." (*Id.* at 88:24-89:1.) Tellingly, she "believed that these children or these adults manipulate the system because they want a change of scenery, they just want to go into the hospital, or they're getting better food or getting more food over there than they're getting here." (*Id.* at 90:1-4.)

Ms. Evans explained the methodology of her internal investigations: She would speak with the person who made the outcry "in regards to the situation and when their recount of a situation was not clear or was not consistent, then we thought that there was something that was incorrect going on." (*Id.* at 90:13-16.) In such cases, Ms. Evans would not report the outcry to SWI: "It's not that we don't believe it. We know the history of some of these individuals, which is to make false outcries so that they can manipulate their situation." (*Id.* at 90:21-23.)

---

212. *See supra* footnote 72.

In information provided by the State, the Monitors found no calls to SWI by Ms. Evans or her staff for any of the investigations involving Child C. (*Id.* at 138:5-12.) As evidenced by Ms. Evans' testimony and the reporters identified in the investigations detailed below, many caregivers are not reporting outcries made by children in their care, making it clear that the words of children alone are not enough to confirm a finding of abuse and neglect.[213]

---

213. For several years, the Court has asked the State to present evidence of an investigation that resulted in a disposition of Confirmed or Reason to Believe "from just a child's outcry without any other witnesses." (D.E. 1488 at 26:1.) The State "ha[s] never found one." (*Id.* at 26:2.) The Monitors prepared a document detailing investigations by DFPS RCCI, CPI, and HHSC PI in which PMC children maintained their allegations of abuse or neglect during the course of the investigation, but the investigation resulted in no findings of ANE. (*See* D.E. 1486-1 (Court's Exhibit 1).) It is the Court's ongoing concern that direct caregivers are not reporting abuse and neglect allegations as required, and as evidence of this ongoing issue the Court identified that out of fifty-eight investigations contained in the report, forty-seven were opened after someone other than a child's direct caregiver reported an outcry or allegation of abuse and/or neglect to SWI. (*See id.* at 1-2.) The following are some of the more egregious abuse and neglect allegations, including the types of allegations reported, the classification of the reporter, and the disposition of the investigation.

- Medical personnel reported that the child (age 13) disclosed that a staff member at New Horizons Ranch (RTC) stood on one of his legs. (*Id.* at 4.) The child also disclosed to the reporter that he no longer discussed the alleged incident because "no one believed him." (*Id.* at 4.) The RCCI investigator Ruled Out the allegation of physical abuse. (*Id.* at 5.)

- A school counselor reported that a child (age 9) disclosed that her foster parent (the child's aunt) grabbed her neck and scratched her. (*Id.* at 8.) Reportedly, the counselor observed "deep scratches on the child's neck and the scratches limited the child's ability to turn her head." (*Id.* at 8.) RCCI Ruled Out the physical abuse allegation despite all three children in the home making consistent outcries of the physical abuse. (*Id.* at 9.) The Monitors disagreed with the RCCI investigator's disposition of Ruled Out for the physical abuse allegation and instead determined that "the record contains a preponderance of evidence that a foster parent hit three children with a belt on the forearm." (*Id.* at 9.)

- A caseworker reported an allegation of physical abuse of a child (age 16) diagnosed with Juvenile Onset Huntington's Disease who is "physically fragile and has an 'S shape'" due to his disability. (*Id.* at 25.) The child made an outcry to the caseworker that a staff member at The Wilson Family Caring Center, Inc. (HCS Group Home) pushed the child "'hard' using his two hands" down on his bed because the staff member "thought the child was about to throw an object at him." (*Id.* at 25.) The CPI investigator closed the case with a disposition of Ruled Out and the Monitors could not determine a disposition due to substantial investigative deficiencies. (*See id.* at 25-26.)

- An "individual" reported to SWI that a child (age 17) made an outcry that a staff member at T E P Unity Girls RTC forced the child to touch him inappropriately. (*Id.* at 68.) In the second intake, the child's probation officer reported that the child disclosed that an unnamed staff member inappropriately touched her and that she wanted to run away but was concerned about violating her probation. (*Id.* at 68.) The RCCI investigator Ruled Out the sexual abuse allegation but the Monitors could not determine a disposition due to the investigative deficiencies. (*Id.* at 69.)

Ms. Evans stated that she did not report outcries until she conducted her own investigation because "every allegation doesn't make for an investigation." (D.E. 1488 at 88:24-

---

- School personnel reported that a child (age 13) made an outcry that a staff member at A.B.E. Residential Services (GRO) punched him, and the reporter observed a small abrasion on the child's lip that "resembled a canker sore." (*Id.* at 71.) The Monitors disagreed with the RCCI investigator's disposition of Ruled Out and determined it should have been substantiated as a Reason to Believe. (*Id.* at 71.) Reportedly there was a preponderance of evidence that the staff member hit the child as the child remained consistent in his disclosure of the abuse to three professionals and two children. (*Id.* at 71.)

- A therapist reported that child (Child A, age 15) made an outcry that another child (Child B, age 16) sexually assaulted her at Krause Children's Residential (RTC). (*Id.* at 84.) Reportedly, the children were playing a game of truth or dare when Child B asked Child A to touch and kiss her, which Child A agreed to. (*Id.* at 84.) Thereafter, Child B pushed Child A to the ground and Child A reportedly told Child B, "No, stop, please don't." (*Id.* at 84.) Child A disclosed that she "passed out" and "when she awoke her shorts were around her knees, her bra was unclipped, [] her shirt had been lifted[, and she] experienced pain all over her body, including her vaginal area." (*Id.* at 84.) The child stated that she believed she had been "penetrated by an unknown object." (*Id.* at 84.) RCCI Ruled Out the neglectful supervision allegation and the Monitors could not determine the disposition due to investigative deficiencies. (*Id.* at 85.) Reportedly, "it is unclear why DFPS did not conduct a Child Sexual Aggression Staffing in light of the allegations and Child A's consistent statement that Child B's actions included sexual acts that were forced and unwanted." (*Id.* at 85.)

89:1.) It is the Court's ongoing concern that caregivers' failure to report as required is a systemic issue and not merely anecdotal. The State has a responsibility to follow-up and investigate outcries made by the children in its care and ensure each child's safety and well-being.[214]

The following are a sampling of PI investigations reviewed by the Monitors that were closed with a disposition of Unconfirmed or Inconclusive, and one closed with a disposition of Confirmed. The Monitors' detailed reports of these investigations were not objected to by HHSC, except where noted. All the investigations were conducted with serious deficiencies that caused some of the most vulnerable PMC children to remain in dangerous placements for long periods of time. Where an investigation violated both Remedial Order 3 and Remedial Order 10, both violations are discussed together.

But first, the Court will briefly address the policies that HHSC has promulgated regarding the completion of PI investigations. The PI Handbook[215] provides that Priority One and Priority Two investigations in

214. Certainly, investigations may implicate an alleged perpetrator's due process rights. But respecting an alleged perpetrator's rights need not come at an expense of properly investigating abuse, neglect, and exploitation allegations.

215. Defendant submitted the Provider Investigations Handbooks for Fiscal Years 2022, 2023, and 2024 as, respectively, Defense Exhibit 39, Defense Exhibit 40, and Defense Exhibit 34. (*See* D.E. 1490 at 3 (Defendants' exhibit list).)

most settings, including HCS group homes,[216] must be completed in "30 calendar days."[217] (*See* DX 39 at 159; DX 40 at 162; DX 34 at 146.) This is consistent with Remedial Order 10's requirement that Priority One and Priority Two abuse and neglect investigations involving children in the PMC class be completed within thirty days of intake. (D.E. 606 at 3.)

The PI Handbook also addresses extensions. It explains that "request[s] for additional time to complete an investigation must be for good cause." (*See* DX 39 at 161; DX 40 at 164; DX 34 at 148.) And it provides a list of "reasons [that] constitute good cause" (DX 39 at 161; DX 40 at 164; DX 34 at 148), most of which appear to be specific grounds that would legitimately warrant a delay in the investigation's completion (*e.g.*, DX 39 at 161; DX

---

216. The PI Handbook provides different timeframes for the completion of investigations in State Supported Living Centers ("10 calendar days"), State Hospitals ("14 calendar days" or "21 calendar days" depending on the priority of the intake), and "All other provider types" ("30 calendar days"). (*See* DX 39 at 159; DX 40 at 162; DX 34 at 146.) HCS placements are included in the last category. (*See* DX 34 at 16 (definition of "Provider" including both "a facility" and "a person who contracts with a health and human services agency or managed care organization to provide home and community-based services"); *see also* DX 39 at 17-18 (same); DX 40 at 17 (same).)

217. The PI Handbook provides that if the "30th day falls on a weekend or holiday," "the investigation must be completed and approved in IMPACT by the next business day." (*See* DX 39 at 159; DX 40 at 162-63; DX 34 at 146.) The Court needs not, and therefore does not, address whether this is consistent with Remedial Order 10.

40 at 164; DX 34 at 148 (reasons constituting good cause include "Witnesses have not been available for interviews"; "Processing of evidence by an outside entity requires additional time"; or "Law enforcement requests that an investigation temporarily be discontinued").)

But one of the listed reasons—"Extraordinary Circumstances" (DX 39 at 161; DX 40 at 164; DX 34 at 148)—does not, by itself, demonstrate good cause for an extension. The PI Handbook defines "extraordinary circumstance" as "an unexpected event or external factor that delays the completion of an investigation; it is something that could not have been prevented even if reasonable measures had been taken." (DX 39 at 161; DX 40 at 165; DX 34 at 148.) Certainly, an "unexpected event or external factor" "that could not have been prevented even if reasonable measures had been taken" may well warrant extending the deadline for an investigation. Not so, however, simply stating that "Extraordinary Circumstances" exist; a showing of "good cause" under Remedial Order 10 requires that the facts warranting the extension be elaborated.[218] *Cf. Cause* (def. 2), Black's

218. The PI Handbook also provides a non-exclusive list of extraordinary circumstances:

Extraordinary circumstances include:

- inclement weather or natural disasters;
- a death in the primary investigator's family;
- excessive workload due to Pl employee vacancies or an uncommon rise in intakes; or
- IMPACT errors that prevent the investigation from being closed.

Law Dictionary (11th ed. 2019) (noting that "Good cause is often the burden placed on a litigant (usu. by court rule or order) to show why a request should be granted").

Indeed, it appears that the State recently concluded that "extraordinary circumstances," without elaboration, does not demonstrate good cause under Remedial Order 10. Pursuant to an October 2023 revision, the section of the PI Handbook titled "Completion and Approval of Extension Requests" now provides that "For investigations involving a child or young adult under DFPS CPS conservatorship, the investigator cannot submit an extension with the reason being *Extraordinary Circumstances.*" (DX 34 at 149; *cf.* DX 40 165-66 (similarly titled section not containing such provision).) It is also notable that this revision came just one month after the Monitors' first report on deficient PI investigations. (*See* D.E. 1412 (filed on Sept. 19, 2023).)

(*See* DX 34 at 148; DX 40 at 165; DX 39 at 161.) Inclement weather or natural disasters would likely demonstrate good cause for an extension. On the other hand, "excessive workload due to PI employee vacancies would likely not rise to the level of good cause, at least without the elaboration of additional facts. This is so even under the Handbook's definition of "extraordinary circumstance" (DX 34 at 148; DX 40 at 165; DX 39 at 161), given that the fact of employee turnover is neither "an unexpected event" nor an "external factor" (DX 34 at 148; DX 40 at 165; DX 39 at 161).

Moreover, it is unclear why an investigator would need to use the general term "Extraordinary Circumstances" when a brief factual statement—for example, "Law enforcement requests that an investigation temporarily be discontinued" (DX 34 at 148; DX 40 at 165; DX 39 at 161)—will typically suffice.

The PI Handbook also addresses the timeframes that apply to extensions. Pursuant to the PI Handbooks for fiscal years 2022 and 2023, an extension for an investigation in an HCS group home had "no specific time frame" within which the investigation would have to be completed.[219] (DX 39 at 160; DX 40 at 164.) In other words, an extension granted pursuant to the 2022 and 2023 Handbooks would be of an indefinite duration.

Extensions of indefinite duration are, of course, contrary to the purpose for which the Court entered Remedial Order 10—namely, ending the practice by which investigations were unreasonably delayed, resulting in harm to PMC children as abundantly demonstrated herein. Moreover, indefinite extensions are contrary to the text of Remedial Order 10, the last sentence of which provides that "[if] an investigation has been extended more than once, all extensions for good cause must be documented in the investigative record." (D.E. 606 at 3.) This provision presupposes that any first extension granted for good cause will be of limited duration; otherwise, an investigation would never be "extended more than once," and the provision would be superfluous.

219. In contrast, the PI Handbook provided that "[f]or investigations in state supported living centers, the extension may be in 1 to 10 calendar day increments depending on the situation but should not exceed 10 days." (DX 39 at 160; DX 40 at 164.) Likewise, "[f]or investigations in state hospitals, the extension may be in 1 to 14 calendar day increments depending on the situation but should not exceed 14 days." (DX 39 at 160; DX 40 at 164.) In other words, the length of an extension for an investigation in either setting could not exceed the maximum length of an unextended investigation in that setting.

See Antonin Scalia & Bryan A. Garner, Reading Law: The Interpretation of Legal Texts 174 (2012) ("Whenever a reading arbitrarily ignores linguistic components or inadequately accounts for them, the reading may be presumed improbable."). Thus, an indefinite extension is invalid under Remedial Order 10.

And again, it seems that Defendant came to the same conclusion. Shortly after the Monitors filed their September 2023 report on PI investigations, the PI Handbook for fiscal year 2024 was revised to limit the duration of extensions to a maximum of thirty days. (DX 34 at 147 (specifying that "the extension may be in 1 to 30 calendar day increments depending on the situation but should not exceed 30 days").)

a. Child C

Like many PMC children, Child C entered the foster care system traumatized at a young age. Child C was three years old when she was removed from the care of her biological mother due to physical and mental abuse. (*See* PX 117 at 1.) Prior to her placement at C3 Christian Academy, she was adopted at the age of five and lived with her adoptive mother, grandmother, and six-year-old cousin. (*Id.* at 1.) When she was placed at C3 Academy from April 4, 2021, to May 4, 2022, Child C was fourteen years old, performed at a two-to four-year-old level, and had an IQ of 55. (*See id.* at 21, 36; *see also* D.E. 1412 at 27.)

Roughly two years before her placement at C3 Academy, a Determination of Intellectual Disability

(DID) assessment noted that Child C had "significant speech impediments and . . . difficultly expressing herself verbally." (*See* PX 117 at 2.) At the time of the assessment, Child C could "ask[] simple questions but [did] not speak in three or four word sentences." (*Id.* at 5.) Ms. Evans stated that Child C could "make herself understood" and put together a sentence, as well as "curse" the staff at the placement (D.E. 1488 at 98:24-99:2); however, Child C's school records indicate that, one month before her discharge from C3 Academy, she had a speech impairment and required additional testing to determine the need for speech therapy (PX 117 at 12). The records provided by Ms. Evans for Child C, which she stated were complete, did not contain any documentation of additional testing for speech therapy. (*See* D.E. 1488 at 70:11-23.)

According to her Plan of Service, Child C is diagnosed with Unspecified Disruptive Behavior Disorder, Language Disorder, ADHD-Combined Presentation, and Intellectual Disability-Mild (provisional). (D.E. 1412 at 27.) Additionally, she suffers from major depressive disorder, recurrent severe psychotic symptoms, mood dysregulation disorder, and posttraumatic stress disorder. (D.E. 1488 at 99:6-9.) In the records provided by Ms. Evans, Child C's speech quality was described as slow, her cognitive impairment was severe, and she experienced delusions, hallucinations, and suicidal ideations. (*See* PX 117 at 121.)

Child C's medication regimen remained largely consistent during her year at C3 Academy and consisted of her taking approximately twelve pills every day, with some medications administered multiple times a day. (*See id.* at

145-195.) The medications include: benztropine (commonly known as Cogentin), Abilify (antipsychotic medication), clonidine (blood pressure medication), banophen, valproic acid (an anticonvulsant commonly known as Depakene), and desmopressin (for enuresis). (*See id.* at 147, D.E. 1489 at 96:1-100:18.)

PI opened twelve investigations of abuse and neglect of Child C while she was placed at C3 Academy. (D.E. 1486-3 (Court's Exhibit 3).) Child C remained at C3 Academy for approximately one year after the first abuse and neglect allegation was reported. (*See* D.E. 1412 at 27-28.)

i. Investigation 1

"On May 24, 2021, six weeks after Child C was placed at C3 Academy, PI initiated its first investigation . . . of Physical Abuse by a named staff member." (*Id.* at 29.) The reporter of this allegation is not identified in the Monitors' report, but the reporter was not a staff member or administrator of C3 Academy. (*See id.* at 138:8-12 ("MR. RYAN: Your Honor, based on all the data and information the State has provided to us with respect to the 12 investigations involving Child C, there is no evidence that we found that either the witness [Ms. Evans] or anyone at C3 called the outcries to trigger the investigations.").)

PI initiated a Priority One physical abuse investigation which—after seventeen months—was assigned a disposition of Confirmed, as the investigator "found a preponderance of evidence that a staff member tasered Child C on her arm while she was in bed" (*id.* at 29):

> Testimony from [Child C] supports that [Child C] identified [Staff 1] by name and that [Staff 1] held a taser to [Child C's] inner left forearm multiple times. Photographs of [Child C's] inner left forearm support there were burn, signature or taser marks. Testimony from Officer [name removed] supports that after review of the photographs of [Child C] by Officer [name removed] that he could confirm the marks were signature marks or burn marks from a taser and it looked like when someone would touch a taser to skin and the person would pull away and then the taser would be touched again to the skin harder. Although a taser could not be recovered, Incident/Investigation Report supports that at one point [Staff 1] did have a taser even though she had not seen it since December of 2020.

(*Id.* at 29 (footnote omitted).)

The investigator obtained Child C's testimony during a face-to-face interview using an American Sign Language (ASL) interpreter to accommodate Child C's limited speech.[220] (*Id.* at 30.) "With the assistance of

220. The use of an interpreter is notable only because, in the subsequent investigations that occurred during the year that Child C was at C3 Academy, "investigators routinely failed to accommodate Child C's limited speech through methods such as an ASL interpreter; this failure in subsequent investigations may have reduced the child's ability to communicate and report allegations of abuse or neglect during her subsequent interviews with investigators." (D.E. 1412 at 30.)

the interpreter, Child C used some signs, gestures, and language to communicate to the investigator that Staff 1 held something against her forearm twice and that it hurt." (*Id.* at 30.)

The intake was received on May 24, 2021; an extension was approved thirty-one days later, on June 25, and was therefore untimely under Remedial Order 10. (*Id.* at 30.; D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").) The documented reason for the extension—"Other: Need to interview collaterals and alleged perpetrator" (D.E. 1412 at 30)—failed to establish "good cause" as required by Remedial Order 10 (*see* D.E. 606 at 3). Indeed, it also failed to show good cause under PI's own policies. (*See* DX 39 at 161 (listing "reasons [that] constitute good cause").) Moreover, the investigation was not completed until October 2022, sixteen months after the extension was approved. (D.E. 1412 at 30.) As explained earlier,[221] a single extension cannot, consistent with Remedial Order 10, extend an investigation more than thirty days. For these reasons, the investigation violated Remedial Order 10.

Because of the lengthy and inadequately approved delay, the investigation was not "completed on time consistent with the Court's Order." (D.E. 606 at 2 ¶ 3.) Further, the "significant delay in the resolution of these serious allegations as eleven new investigations emerged

221. *See supra* page 555-56.

naming this child as an alleged victim, evidences a profound failure to conduct the investigation" (D.E. 1412 at 30) "taking into account at all times" Child C's "safety needs" (D.E. 606 at 2 ¶ 3). Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

ii. Investigation 2

On July 19, 2021, a law enforcement officer reported that Child C ran away from the C3 Academy. (D.E. 1412 at 31.) After law enforcement located and returned her to the placement, Child C "attempted to strangle herself by placing a sheet around her neck. According to the officer, the child stated that she was trying to kill herself and that she wanted to be admitted to a hospital." (*Id.* at 31.) This incident was not reported by any caregivers or staff members.

These allegations resulted in a Priority Two neglect investigation of Child C by Staff 2, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 31.) The Monitors disagreed—as a result of the "substantial investigative deficiencies" discussed below, they concluded that "a disposition regarding the Neglect allegation cannot be determined." (*Id.* at 31.)

First, the "investigator did not attempt to gather sufficient evidence to determine whether Staff 2 adequately supervised Child C at the time of the incident." (*Id.* at 31.) During the investigator's face-to-face interview with Child C—conducted eight days after the intake was

received, in violation of Remedial Order 8 (*id.* at 31; *see* D.E. 606 at 3)—she conveyed through an ASL interpreter that she "ran away from the group home and wrapped a sheet around her neck in response to verbal and physical altercations with the other residents in the home." (D.E. 1412 at 31.) After this interview, the investigation laid dormant for eighteen months without investigative activity; only after this long delay did the investigator identify Staff 2 as "the staff member responsible for Child C's supervision at the time of the incident." (*Id.* at 31.) Still, the investigator "did not attempt to interview this key individual." (*Id.* at 31.) "The investigator also did not attempt to identify and interview any other staff members or other residents who may have been present on the day that" Child C "attempted to kill herself." (*Id.* at 31.)

Thus, "the investigator did not assess whether" Staff 2 "appropriately supervised Child C prior to her elopement," and "failed to determine whether staff members took appropriate actions to minimize, address, or contain any verbal or physical altercations between Child C and the other residents or whether supervisory failures contributed to the conflicts in other ways." (*Id.* at 31-32.)

The investigation was completed on January 26, 2023, eighteen months after intake; one extension was approved on November 2, 2021, four months after intake. (*Id.* at 32.) Thus, both the extension and the investigation were untimely under Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

Besides, the documented reason for the extension—"Need to talk to collaterals, Ap, request documentation and police report" (D.E. 1412 at 32)—failed to establish "good cause" as required by Remedial Order 10 (*see* D.E. 606 at 3). Indeed, it failed to show good cause under PI's own policies. (*See* DX 39 at 161 (listing "reasons [that] constitute good cause"); DX 40 at 164-65 (same).) Thus, the investigation failed to comply with Remedial Order 10. (*See* D.E. 606 at 3.)

And because of the above-described investigative deficiencies, the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child C's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

iii. Investigation 3

On August 7, 2021, less than three weeks after the prior incident, a law enforcement officer reported that Child C eloped from C3 Academy. (D.E. 1412 at 32.) No one from C3 Academy reported this.

> According to the reporter, law enforcement observed Child C running down a busy street and a staff member was running after her. The reporter expressed concern that Child C was a "flight risk" and that the staff members at the placement may not have provided adequate care for her. The reporter noted that other residents

> had allegedly wandered off "unnoticed" from the placement. Lastly, the reporter stated that he observed marks on Child C's arm, but he did not know whether the marks were injuries.

(*Id.* at 32.)

PI initiated a Neglect investigation related to Child C by an unknown staff member, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 32.) The Monitors disagreed—as a result of the "substantial investigative deficiencies" discussed below, they concluded that "a disposition regarding the Neglect allegation cannot be determined." (*Id.* at 32.)

First, the investigator failed to make face-to-face contact with Child C. The investigator attempted to interview Child C three days after the intake report while she was in the hospital,[222] but she was asleep. (*Id.* at 32.) The investigator "documented that she observed Child C asleep in the emergency room with a blanket over her and that she did not observe any marks or bruises on the child, presumably because the blanket covered" Child C's body. (*Id.* at 32-33.) The investigator made no further attempts to interview or otherwise have face-to-face contact with Child C (*id.* at 33), thus violating Remedial Order 8 (*see* D.E. 606 at 3).[223] "In the absence of interviewing and

---

222. "The Monitors could not determine why" Child C "was hospitalized from the available records." (*Id.* at 32 n.60.)

223. An instructional PowerPoint for PI investigators, dated October 24, 2023, states that for an initial face-to-face contact, if

adequately observing the child, the investigator failed to assess the child's safety and gather information about the allegation, particularly given the reporter's observation that the child had marks on her arms and was not receiving adequate care at C3 Academy." (D.E. 1412 at 33.)

Second, "[t]he investigator concluded the investigation without identifying and interviewing an alleged perpetrator or any other staff members who may have been present on the day of the alleged incident." (*Id.* at 33.)

Third, "the investigator did not consider highly relevant information about the allegations, including reports by a law enforcement officer that residents wandered off from the property 'unnoticed.'" (*Id.* at 33.) And "[t]he investigator did not consider whether the group home's referral history included similar allegations that the group home failed to provide adequate care to and supervision of children." (*Id.* at 33.)

In sum, "[b]ecause the investigator did not gather any evidence related to the allegations . . . the assigned disposition of Unconfirmed to the allegation of Neglect is baseless and inappropriate." (*Id.* at 33.)

---

the victim is asleep, the investigator is to "come back later or the next day." (PX 98 at 53; *see* D.E. 1471 at 4.) The Monitors note that a separate neglect investigation of Child C during the same time period referenced a visitor suspension at C3 Academy due to COVID-19, but the record indicates the investigator did not attempt to observe or speak to the child through any other means. (D.E. 1412 at 33 n.61.)

The investigation was completed on January 26, 2023, seventeen months after intake, with no approved extensions.[224] (*Id.* at 33.) Thus, the investigation failed to comply with Remedial Order 10. (*See* D.E. 606 at 3.)

And because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child C's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

iv. Investigation 4

On August 13, 2021, a law enforcement officer:

> [R]eported another allegation of Neglect of Child C at C3 Academy. The law enforcement officer reportedly spoke to Child C while she was admitted to a hospital (a different hospital stay from the one referenced above, during which time the investigator failed to return to interview the child). The child was hospitalized after she allegedly jumped out of a van and attempted to tie sheets around her neck for the second time in approximately four weeks. Child C disclosed to the law enforcement officer that

224. The investigator requested an extension on September 9, 2021, but it was not approved by the supervisor. (*Id.* at 33 n.63.)

> she was punched a lot at her placement. The law enforcement officer observed a laceration near the child's right eye. The child then reported that a named resident (Individual 1, age 20) [who had previously been incarcerated for assaulting his mother] punched her and she bled a lot. The child reported that she did not receive medical care for the injury to her eye.

(D.E. 1412 at 33-34, 34 n.65.) This incident was not reported by any caregivers or staff members.

The physical abuse and neglect allegations resulted in a Priority Two neglect investigation of Child C by Staff 2, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 34.) The Monitors disagreed—as a result of the "substantial investigative deficiencies" discussed below, they concluded that "a disposition regarding the Neglect allegation cannot be determined." (*Id.* at 34.)

The investigator failed to make face-to-face contact with Child C, instead interviewing her using FaceTime[225] (*id.* at 34)—in violation of Remedial Order 8 (*see* D.E. 606 at 3). Further, the investigator did not document any efforts to accommodate Child C's limited speech during this interview, despite two prior investigations documenting the use of an ASL interpreter. (D.E. 1412 at 34.) "[I]t is unclear how this investigator determined that

225. FaceTime interviews do not rule out that C3 Academy staff members are present with the child, and they should never be substituted for face-to-face contact absent exigent circumstances.

she could ensure Child C's meaningful participation" in the interview without aid. (*Id.* at 34.) Nonetheless, Child C conveyed "that she jumped out of the van because Staff 2 poured out her soda." (*Id.* at 34.) Child C then made an outcry that Individual 1 scratched her and caused her lip to bleed. (*Id.* at 34.) The investigator took screenshots of Child C on FaceTime, but the record does not indicate whether those pictures were of her face or whether any injuries were observed. (*Id.* at 34.)

Shortly thereafter, the investigator interviewed the case manager at C3 Academy. (*Id.* at 34.) Though the case manager was unaware of any incidents between Individual 1 and Child C, she corroborated that Child C "jumped out of the van" and eloped. (*Id.* at 34.) Of the elopement, the case manager explained that Child C was gone for an unknown duration,[226] and that law enforcement

226. After Child C jumped out of the van, she ran into a stranger's backyard and jumped into their pool. (*Id.* at 34.) Fortunately, "Child C knew how to swim and was able to safely exit the pool by herself" (*id.* at 34); other PMC children have drowned or nearly drowned due to inadequate supervision. (*See, e.g.*, D.E. 1380 at 208 n.244 (recounting that an "autistic and non-verbal child" with "a history of running away" "ran away from" a Residential Treatment Center "unnoticed and was found in a neighbor's pool. . . . The neighbor who found the child in the pool said that as the child neared the deep end, 'he began to struggle in the water and could not swim.'"); D.E. 1380-2 at 22 (six-year-old child nearly drowned, and "[t]he caregiver's whereabouts were unknown when the child went under water and started floating face down"); D.E. 1079 at 373 (infant drowned in foster parents' above-ground swimming pool—"her licensed foster parents inadvertently left the ladder in place" and "each [foster parent] thought the other was supervising the child"); *id.* at 341 (child

located the child and returned her to C3 Academy. (*Id.* at 34.) Finally, the case manager explained that upon Child C's return, and while law enforcement was still present, Child C "attempted to tie a sheet around her neck in another room" at the home, where a staff member later discovered her and intervened. (*Id.* at 34-35.) The Monitors note that the police report recounts that Child C "wrap[ped] a bed sheet around her neck and state[d] that she wanted to kill herself," causing officers to place Child C under an emergency detention, restrain her with "double lock handcuffs," and take her to the hospital. (*Id.* at 35.) The Monitors note that Child C was subject to routine supervision at this time. (*Id.* at 35.)

Despite the serious allegations and the consistency of these accounts, "the investigator did not pursue any investigative activity for one year and five months." (*Id.* at 35.) The investigator then "attempted to locate the alleged perpetrator (Staff 2) and Individual 1 for interviews," but "[l]ikely due to the significant delay, the investigator was unable to locate and interview these key individuals." (*Id.* at 35.) The investigator then re-interviewed the case manager—who could not recall the incident—and the responding law enforcement officer, who reported similar information to that in the intake report. (*Id.* at 35.)

"Due to these deficiencies, the investigator failed to gather sufficient information to render a disposition for the allegation of Neglect." (*Id.* at 35.)

---

with Down Syndrome, placed in a different foster home, almost drowned in family's pool—foster mother was in the pool but was "making adjustments to the pool pump and was not supervising the child").)

The investigation was completed on January 26, 2023, seventeen months after intake; one extension was approved on October 29, 2021, more than two months after intake. (*Id.* at 35.) Thus, both the extension and the investigation were untimely as per Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegations of physical abuse and neglect were not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child C's "safety needs." (D.E. 606 at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

v. Investigation 5

Between August 20, 2021, and October 28, 2021, SWI received eight reports of physical abuse regarding Individual 2 (an adult resident at C3 Academy) which PI merged into a single investigation. (D.E. 1412 at 35.) "The reporters, including a law enforcement officer, medical facility staff, and Individual 2's service coordinator, reported that Individual 2 stated a staff member (Staff 3) 'punched,' 'beat up,' 'assaulted,' and 'hit' her on her arms and face," causing injuries.[227] (*Id.* at 35.) Four

227. Staff 3 was identified as Rodney McCuin, who is discussed in further detail below. This was the first abuse and neglect investigation that identified Mr. McCuin as the alleged

days after receipt of the first intake, the investigator interviewed Individual 2 who stated that she and another adult resident, Individual 3 (age 18), engaged in a physical altercation with Child C while Staff 3 was driving them in a van on two occasions. (*Id.* at 35-36.)

As a result, a neglect allegation as to Child C was added to the existing Priority Two investigation (*id.* at 35), to which the investigator assigned a disposition of Inconclusive (*id.* at 36). The Monitors disagreed—as a result of the "substantial investigative deficiencies" discussed below, they concluded that "a disposition of the Neglect allegation cannot be determined." (*Id.* at 36.)

The Monitors identified several "critical deficiencies" in this investigation. (*Id.* at 36.) First, "the investigator did not conduct an interview of Child C related to the allegations contained in this investigation." (*Id.* at 36.) "Instead, the investigator included in the investigative record an interview that was conducted with Child C on September 1, 2021 for a separate investigation . . . regarding unrelated allegations" (*id.* at 36), in violation of Remedial Order 8's requirement for initial face-to-face contact within 72 hours of intake (*see* D.E. 606 at 3).

Second, "the investigator failed to interview the alleged perpetrator; having waited 18 months to attempt the interview, the investigator was unable to locate him." (D.E. 1412 at 36.)

---

perpetrator. (D.E. 1412 at 28.) Subsequently, Mr. McCuin was identified as the alleged perpetrator in four more abuse and neglect investigations of Child C. (*Id.* at 28.)

Third, the investigator failed to obtain adequate information about the altercation from Individual 2 and Individual 3. Individual 2 referenced the physical altercation with Child C, but "the investigator never asked Individual 2 to describe the physical altercation. As a result, the nature and severity of the alleged altercation between the two adults and Child C is unknown." (*Id.* at 36.) And the "investigator did not document that she asked Individual 3 any questions related to the alleged physical altercations in the van." (*Id.* at 36.)

In sum, "the investigator gathered almost no information about the allegation related to Child C and the disposition of Inconclusive for the allegation of Neglect is baseless and inappropriate." (*Id.* at 36.)

The investigation was completed on March 20, 2023, took one year and seven months after intake; an extension was approved on September 21, 2021, thirty-two days after the intake was received. (*Id.* at 36-37.) Thus, both the extension and the investigation were untimely under Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child C's "safety needs." (D.E. 606 at 2 ¶ 3.) Accordingly, this investigation was conducted

in a manner that violated Remedial Order 3 and Remedial Order 10.

vi. Investigation 6

On August 29, 2021, a social worker at a hospital reported that Child C ran away after an unnamed staff member at C3 Academy hit her, and that Child C informed the law enforcement who located her that she wanted to kill herself with a knife. (D.E. 1412 at 37.) This incident was not reported by any caregivers or staff members. Law enforcement officers transported Child C to the hospital, where she was seen by a psychiatrist who observed that Child C was "'extremely dirty,' not wearing underwear, with feces in her pants" and had "'lots' of scarring on her body due to self-injurious behavior." (*Id.* at 37.) "At this time, there were five separate investigations opened regarding allegations of Physical Abuse and/or Neglect of Child C, with both distinct and similar allegations." (*Id.* at 37.)

These allegations resulted in a Priority Two investigation related to physical abuse and neglect of Child C by a named staff member, Staff 2. (*Id.* at 37.) Seventeen months later, PI "entered a disposition of Unconfirmed for the allegation of Neglect and a disposition of Inconclusive for the allegation of Physical Abuse." (*Id.* at 37.) The Monitors disagreed; due to the "substantial investigative deficiencies" discussed below, dispositions as to both allegations "cannot be determined." (*Id.* at 37.)

First, the investigator's interview with Child C was inadequate.[228] The investigator made no effort to accommodate Child C's limited speech and comprehension during the interview. (*Id.* at 38.) Despite this, Child C confirmed that a staff member hit her on the arm and, when asked who hit her, pointed toward "'the staff' present in the home." (*Id.* at 37.) The investigator also questioned Child C about the scratches on her face, and she responded that she got into a fight with another individual in the home, who she pointed out. (*Id.* at 37.) But the record does not document which staff member or individual Child C pointed out to the investigator. (*Id.* at 37.) Further, Child C appeared to have stopped responding to the investigator's questions, and the record is unclear whether that was due to her limited speech and comprehension. (*Id.* at 37.)

Second, the "investigator did not appear to consider whether Child C's allegation that a resident scratched her was related to the" intake dated August 13, 2021.[229] (*Id.* at 38.) "Based on the documentation in the record, the two investigators failed to collaborate and jointly staff the two investigations; this failure limited both investigators' ability to gather and assess information about the safety of Child C in her placement." (*Id.* at 38.)

---

228. The report does not indicate whether the investigator's face-to-face contact with Child C was within the seventy-two hours required by Remedial Order 8 for a Priority Two investigation. (*See* D.E. 606 at 3.)

229. *Supra* page 560-62.

Third, and "even more confounding" (*id.* at 38):

> [A]fter completing an interview with Child C, during which the investigator observed injuries on the child, the investigator did not conduct any additional investigative activity for more than 16 months. When the investigation resumed on January 23, 2023, the investigator assigned in the record an alleged perpetrator based upon the staff member who was working on the date of the intake report (August 29, 2021) and completed the investigation four days later. As noted above, the investigator observed the child point at a staff member(s) who allegedly hit her, but the record does not clarify the connection between the two and it is not clear the child was hit on the date of the intake report. Before completing and closing the investigation, the investigator did not attempt to interview the alleged perpetrator nor the other individual to whom the child pointed during her interview.

(*Id.* at 38.) "As a result of these substantial deficiencies, the investigator failed to determine whether a staff member hit Child C; and whether a staff member's inadequate supervision allowed a resident to scratch Child C." (*Id.* at 38.)

Finally, the allegations reported by the psychiatrist—that Child C was "dirty, had no underwear on, and had feces on her pants"—were not investigated because PI determined these "general complaints regarding [Child

C] being unkept do not meet the definition of neglect."[230] (*Id.* at 38.) There was nothing in the record about the resolution of those allegations. (*Id.* at 39.)

The investigation was completed on January 27, 2023, seventeen months after intake; one extension was approved on October 7, 2021, more than a month after the intake. (*Id.* at 39.) Thus, both the extension and the investigation were untimely under Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegations of physical abuse and neglect were not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child C's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

---

230. The Monitors note that neglect, as defined in the Texas Administrative Code, includes a failure to "provide adequate nutrition, clothing, or health care to a specific individual receiving services in a residential or inpatient program if such failure results in physical or emotional injury or death to an individual receiving services or which placed an individual receiving services at risk of physical or emotional injury or death." (D.E. 1412 at 38-39 n.66 (quoting 26 Tex. Admin. Code § 711.19(b)(2)).)

vii. Investigation 7

On August 26 and September 1, 2021, a law enforcement officer reported two separate allegations of abuse and neglect related to Individual 2, which were similar in nature to those alleged in the fifth ANE investigation—namely, that Staff 3 hit Individual 2. (D.E. 1412 at 39.) Child C was not mentioned in the reports but was added to the Priority Two physical abuse investigation as an additional victim during the investigation. (*Id.* at 39.)

"Following receipt of the two intake reports, PI initiated a Priority Two Physical Abuse investigation related to Child C by Staff 3, which became its seventh concurrent open investigation into Physical Abuse and/or Neglect of Child C." (*Id.* at 39.) The investigator assigned the allegation a disposition of Inconclusive. (*Id.* at 39.) The Monitors disagreed; because of the "substantial investigative deficiencies" described below, "a disposition of the Physical Abuse allegation related to Child C cannot be determined." (*Id.* at 39.)

First, "the investigator did not document her reason(s) for adding Child C as a victim," so "it is unclear why the investigator added Child C as an alleged victim to this investigation." (*Id.* at 39.) "[T]he absence of this central information" alone renders the "investigation . . . deficient" as to Child C. (*Id.* at 39.)

Second, the investigator failed to make face-to-face contact with Child C, in violation of Remedial Order 8. (D.E. 606 at 3.) Instead, the investigator "used a

separate interview of Child C that occurred during a different investigation . . . to document her initial face-to-face contact with Child C for the instant investigation." (D.E. 1412 at 39-40.) "[B]ecause the investigator did not interview Child C related to the instant allegation, the investigator did not gather any information about it." (*Id.* at 40.)

Third, the investigator not only failed to interview the alleged perpetrator (Staff 3) until sixteen months after intake, but when the investigator finally interviewed him, she "did not document whether she asked the alleged perpetrator any questions related to Child C." (*Id.* at 40.) Likewise, her "interviews with other collateral staff members . . . did not discuss any allegations related to Child C." (*Id.* at 40.)

For these reasons, "the basis for the investigator's [disposition] of Inconclusive for the allegation of Physical Abuse of Child C is unknown." (*Id.* at 40.)

The investigation was completed on February 7, 2023, seventeen months after intake; one extension was approved on October 7, 2021, more than thirty days after intake. (*Id.* at 40.) Thus, both the extension and the investigation were untimely under Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of physical

abuse was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child C's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

viii. Investigation 8

On September 1, 2021, SWI received multiple allegations that Child C and another resident had been locked in a bedroom together and left unsupervised, and that Child C was observed with multiple bruises on her face. (D.E. 1412 at 40.)

First, a law enforcement officer reported that he responded to a 911 call at 3:29 am, made by two residents at C3 Academy. (*Id.* at 40.) Individual 2 and Child C, both intellectually disabled females, disclosed that at an unknown time during the night, Staff 4 locked them in a bedroom[231]

231. At the Contempt Hearing, Ms. Evans conceded that Child C and Individual 2 were locked in, but suggested that they were locked in separate bedrooms. (D.E. 1488 at 108:14-109:16.) On the other hand, the police report from the incident states that Staff 4 locked Child C and Individual 2 in a bedroom together. (*See* D.E. 1412 at 41.) Indeed, all the evidence reviewed by the Monitors indicates that Child C and Individual 2 were locked in the same room together. (D.E. 1488 at 108:11-12, 109:11-14.)

This must not have been an unusual occurrence as Mr. McCuin (Staff 3), the husband of Ms. Evans' assistant, was fired and rehired a few times after promising to mend his ways regarding bringing lady friends to stay with him on his overnight shifts. (*See id.* at 76:16-77:3.) It is presumed that he was using one of

and left the HCS residence.[232] (*Id.* at 40.) Child C and Individual 2 were stuck in the bedroom until Individual 2 broke the bedroom door in half; Child C and Individual 2 then went to a neighbor's home and called law enforcement. (*Id.* at 40.)

When law enforcement officers arrived at the home at approximately 4:00 am, "no staff members were present in the home nor did they observe any posting or other information to inform law enforcement who to contact regarding Individual 2 and Child C's care." (*Id.* at 40.) After the first report was called in, a different law enforcement officer reported a similar allegation and stated that the staff member (Staff 4) left the group home due to a purported family emergency. (*Id.* at 40.) According to Ms. Evans, the reason why the staff member—whom she identified as "Anthony Curly" (D.E. 1488 at 106:20)—left the residents locked alone in the bedroom was to "be with a woman on a love rendezvous"—clearly, not a family emergency (*id.* at 107:1-2). Ms. Evans testified that the Mr.

---

the three bedrooms for this purpose, requiring two residents to stay together.

232. Staff 4, who left the home after locking the residents in the room, called another staff member supervising residents in a different HCS group home owned and operated by Ms. Evans to watch his residents while he was away. (*Id.* at 111:9-12.) The other staff member was responsible for the care of up to three developmentally disabled residents in her group home that night, whom she left alone to come care for Staff 4's residents. (*Id.* at 111:23-25 ("Q.[BY MR. YETTER] . . . [Y]our other staff member, left up to three developmentally disabled residents in her group home alone? A: She did.").)

Curly did return to the placement but when "he saw the police [he] did not go back to the house." (*Id.* at 107:24-25.)

Approximately thirty minutes after the second report, the same officer reported that Child C had multiple bruises and cuts on her eyelids and face and that Individual 2 had a cut under her left eye. (D.E. 1412 at 40.) Both Child C and Individual 2 disclosed that Staff 3 punched them. (*Id.* at 40.) None of the intakes were reported by a caregiver or staff member.

The allegations were referred to PI for a Priority One physical abuse and neglect investigation related to Child C by Staff 3 and Staff 4, respectively. (*Id.* at 41.) The investigator assigned dispositions of Inconclusive as to both the Neglect and Physical Abuse allegations. (*Id.* at 41.) The Monitors disagreed with both dispositions. (*Id.* at 41.)

As to the Neglect allegation, the Monitors concluded that it "should have been substantiated with a disposition of Confirmed as related to Staff 4." (*Id.* at 41.)

Notably, the police report for the incident "confirmed Individual 2's allegation that Staff 4 locked Child C and Individual 2 in a bedroom and exited the premises and left them unattended for over two hours." (*Id.* at 41.) The police report further noted that "the residents did not have access to a telephone in the home and had to exit the home during the night to access a telephone in a neighbor's home, further exposing the residents to risk of physical or emotional injury. They also did not have

access to a bathroom or any means of exit should there have been an emergency." (*Id.* at 41.) The police report also reflects that officers "attempted to contact numerous numbers associated with the group home's management, C3 Christian Academy," but that the officers "were unable to reach anyone." (*Id.* at 41-42.) The Monitors note that "after law enforcement arrived on the scene, it took approximately two hours before a C3 Academy staff member was located and arrived at the home." (*Id.* at 42.) Based on this evidence, "the investigative record includes a preponderance of evidence that Staff 4 was negligent when he locked Child C and Individual 2 in a bedroom and left them unattended with no access to an exit, bathroom or means to summon help for over two hours in the night, which placed Child C at risk of physical or emotional injury or death." (*Id.* at 42.)

The Monitors also faulted the investigator for failing to interview Staff 4[233] and failing to consider whether C3 Academy's administration was at fault. Specifically, the Monitors considered it "confounding that the investigator failed to consider whether administrators at C3 Academy were also neglectful when they failed to 'provide a safe environment for [the child], including the failure to maintain adequate numbers of appropriately trained staff.'"[234] (*Id.* at 42.)

---

233. "The investigator was unable to locate Staff 4 for an interview and at the time he attempted to do so 16 months after the investigation began, according to C3, he was no longer employed there." (D.E. 1412 at 42.)

234. *See* 26 Tex. Admin. Code § 711.19(b)(3).

Regarding the physical abuse allegation, the Monitors concluded that, for the following reasons, "the investigator did not adequately investigate whether Staff 3 hit Child C causing injury to her face" (*id.* at 42), so "a disposition cannot be determined" (*id.* at 41).

First, the interview with Child C was inadequate, as the investigator documented no attempt to accommodate Child C's documented communicative limitations. (*Id.* at 42.) Child C "did not want to discuss the allegations," and having accommodations available "may have encouraged Child C's participation in the interview." (*Id.* at 42.) Moreover, the investigator "did not document whether she observed any injuries on Child C." (*Id.* at 42.) Thus, the investigator failed to gather any information from Child C.

Likewise, the investigator failed to gather any information about the physical abuse of Child C when she interviewed Individual 2. This is so because "the investigator did not ask Individual 2 any questions related to whether Staff 3 hit her or Child C and did not document whether she observed any injuries on Individual 2." (*Id.* at 42.)

Further, the interview with Staff 3, the alleged perpetrator, was severely delayed, taking place sixteen months after intake. (*Id.* at 42.) And when the investigator finally did get around to interviewing Staff 3, the investigator "did not ask Staff 3 any questions related to the allegation of Physical Abuse and the injuries the officer observed on Individual 2 and Child C. Instead, the investigator asked Staff 3 questions related to the

allegations that Staff 4 locked Child C in the room with an adult also living at the home." (*Id.* at 42.)

Finally, the Monitors note that the day after Child C and Individual 2 were locked in the bedroom, "law enforcement returned to the group home to conduct a welfare check. According to the police report, 'While on scene, medics assessed [Child C] as she complained of not feeling well. [Child C's] heart rate and blood pressure vitals were elevated to the point that medics determined she needed to go to the hospital.'" (*Id.* at 42.) Yet the investigator did not consider whether Child C's medical issues were related to the physical abuse or neglect. (*Id.* at 42.)

The investigation was complete on February 7, 2023, seventeen months after intake; an extension was approved on November 1, 2021, two months after the intake. (*Id.* at 43.) Thus, both the extension and the investigation were untimely under Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegations of physical abuse and neglect were not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child C's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

ix. Investigation 9

On October 2, 2021, approximately one month after the prior incident, a law enforcement officer reported that Child C eloped from the placement and was hit by a staff member. (D.E. 1412 at 43.) No staff members or caregivers reported this incident.

The officer was called to locate Child C after she ran away from the placement while a staff member was spoon feeding another resident. (*Id.* at 43.) He found Child C walking with her shirt off on a busy street approximately a mile and a half away from C3 Academy. He also noted that she had issues with her speech and was unable to enunciate her name or address well. (*Id.* at 43.) When the officer located her, Child C appeared happy to see the officer. (*Id.* at 43.) But as they neared the placement, the officer observed Child C's mood change and noted that she became "sad" and was "whimpering." (*Id.* at 43.) "Child C told the officer that Staff 3 hit her." (*Id.* at 43.) She "demonstrated the hit by making a fist and putting it on her chin. The officer did not observe any injuries on Child C." (*Id.* at 43.)

This was the third time that Child C made an outcry of physical abuse at C3 Academy, and the second time that Child C specified it was Staff 3 who hit her. (*Id.* at 43.) And this was the fifth abuse or neglect investigation related to Child C that identified Staff 3 as the alleged perpetrator. (*Id.* at 28.) All previous four investigations were still open, and no correlation was made between this allegation and the previous four involving the same staff member and type of allegations.

PI initiated a Priority Two neglect and physical abuse investigation of Child C by Staff 3. (*Id.* at 43.) Sixteen months later, PI "entered a disposition of Unconfirmed for the allegation of Neglect and a disposition of Inconclusive for the allegation of Physical Abuse." (*Id.* at 43.) The Monitors disagreed with both; for the reasons discussed below, "[t]he investigator failed to appropriately investigate the allegations of Neglect and Physical Abuse of Child C by Staff 3" (*id.* at 44), so the disposition as to both allegations "cannot be determined" (*id.* at 44).

First, despite the serious allegations, the investigator failed to establish face-to-face contact with Child C within the timeframe required by Remedial Order 8 (D.E. 606 at 3)—the investigator did not conduct a face-to-face interview with Child C until five days after the intake[235] (D.E. 1412 at 44). Further, the investigator "did not document any efforts to accommodate Child C's limited speech and comprehension during the interview." (*Id.* at 44.) Nonetheless, Child C was able to confirm that when she ran away Staff 3 was caring for another resident, and that Staff 3 hit her with a closed fist on the right side of her face. (*Id.* at 44.) Also, the investigator observed discoloration on Child C's face, but discounted it as dark skin pigmentation rather than a bruise.[236] (*Id.* at 44.)

---

235. "The investigator made a first attempt to interview Child C three days after the receipt of the intake report at the location she attended for treatment services; however, the child was no longer present at that location when the investigator arrived. The investigator did not attempt to interview her at the group home later that day." (D.E. 1412 at 44 n.69.)

236. The Monitors reviewed the photographs documenting the discoloration and explained that it was "difficult to discern"

Second, despite Child C's disclosure that Staff 3 hit her in the face, the investigator "inexplicably . . . did not pursue any investigative activity for 16 months." (*Id.* at 44.) It should be noted that Child C remained at C3 Academy for approximately six months after this investigation commenced,[237] and "[i]t is unclear from the investigative record whether Staff 3 had access to Child C during this extended timeframe." (*Id.* at 44.) Relatedly, the investigator did not attempt to interview Staff 3 for sixteen months; but at that point Staff 3 no longer worked at C3 Academy and did not respond to the investigator's attempts to conduct an interview. (*Id.* at 44.)

Third, the investigator failed to consider that this was not the first physical abuse allegation Child C had made against Staff 3; indeed, the investigator "deemed" the case history of the alleged perpetrator to be "not relevant."[238] (*Id.* at 44.) "This conclusion is unreasonable and inappropriate and raises questions regarding whether required case history reviews are performed." (*Id.* at 44.)

---

from the photographs "whether Child C had a bruise on her right temple or whether it was a spot of dark skin pigmentation." (*Id.* at 44.) It should go without saying that if face-to-face contact had been established within 72 hours as required by Remedial Order 8 (*see* D.E. 606 at 3) rather than 120 hours, any bruise on Child C's face would have been more easily discernible.

237. Child C left C3 Academy on April 28, 2022, when C3 Academy staff left her at a hospital with a broken jaw. (D.E. 1412 at 49.)

238. HHSC requires PI investigators to review the case history of the alleged victim and perpetrator at the commencement of all investigations because "the prior case history search may be used to inform the current investigation." (PX 7 at 176.)

Fourth, the sixteen-month delay impaired the investigator's ability to gather information from "a nurse who reported that she saw Child C daily and assessed her after any incidents" (*id.* at 44):

> The nurse reported that she no longer had access to her notes related to Child C, presumably due to the investigator's significant delay interviewing her. Based on her recollection 16 months later, she stated that she did not observe any injuries on Child C that were consistent with being hit or punched in the face during the time around October 2, 2021, when the child eloped from the placement. However, Child C did not provide a date or timeframe for when Staff 3 allegedly hit her and the delay and lack of access to her notes rendered the utility of the nurse's statement limited at best.

(*Id.* at 44.)

The investigation was completed on January 27, 2023, sixteen months after intake; one documented extension was approved on November 2, 2021, thirty-one days after intake. (*Id.* at 45.) Thus, both the extension and the investigation were untimely under Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegations of physical abuse and neglect were not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child C's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

x. Investigation 10

Approximately one month later, on November 7, 2021, a clinical therapist at a hospital reported an allegation of sexual abuse of Child C—that a staff member forced Child C to have sex with him. (D.E. 1412 at 45.) The reporter stated that Child C locked herself in her room at C3 Academy and, after an unknown period of time alone, used her hand to break a window and ran away from the home. (*Id.* at 45.) After she was located, she was taken to the hospital for "aggression and running away." (*Id.* at 45.) While at the hospital, Child C "made an outcry that an unnamed staff memberforced her to have sex with him and attempted to force [her] to have sex with his girlfriend." (*Id.* at 45.) Child C did not name the staff member in her outcry, so he was recorded as an "unnamed staff member" in IMPACT. (*Id.* at 47 n.71.) The investigative record shows that Staff 2 was identified as the alleged perpetrator, and Ms. Evans confirmed at the Contempt Hearing that Child C accused Staff 2—Jonathan Jones—of sexually abusing her. (D.E. 1488 at 141:6-10, 17-23.) This incident was not reported by any caregivers or staff members at C3 Academy.

PI initiated a Priority One sexual abuse investigation. (D.E. 1412 at 45.) After thirteen months (*id.* at 48), the investigator "assigned the allegation a disposition of Inconclusive" (*id.* at 45). The Monitors disagreed; they concluded that "[d]ue to a dangerous delay and an utter disregard for child safety by the State, a disposition of the Sexual Abuse allegation related to Child C cannot be determined." (*Id.* at 45.)

First, the investigator failed to establish face-to-face contact within the timeframe required by Remedial Order 7. (D.E. 606 at 3.) The investigator attempted to conduct a timely face-to-face interview of Child C at the hospital. (D.E. 1412 at 45.) But due to her "difficult behaviors" a nurse asked the investigator not to speak with her, to which the investigator agreed.[239] (*Id.* at 45.) "It is unclear from the investigative record whether the investigator observed Child C" at this time. (*Id.* at 45.)

Ten days later, the investigator attempted to schedule a forensic interview of Child C by the Children's Advocacy Center (CAC).[240] (*Id.* at 46.)

---

239. In such situations, the PI Handbook directs the investigator to "speak[] to the administrator and the facility medical director to ensure that all parties at the facility agree with the clinician's recommendations" and "obtain[] a written statement from the clinician making the request, outlining why it is not advisable for PI to interview the individual receiving services." (DX 34 at 86.)

240. The PI Handbook states that CACs "provide specialized forensic interviews conducted by trained, neutral professional using research and practice-informed techniques as part of a

> The CAC informed the investigator that only a law enforcement officer or detective who was assigned to Child C's case could request a forensic interview of a child. The investigator did not document any other efforts to secure a forensic interview. As a result, Child C did not participate in a forensic interview with a skilled interviewer who was competent in speaking with children who report allegations of Sexual Abuse.

(*Id.* at 46.)

Second, the investigation languished for a year without activity, at which point the investigator "finally attempted to identify an alleged perpetrator through interviews with administrative staff members at C3 Academy." (*Id.* at 46.) The administrators identified a male staff member, Staff 2 (Jonathan Jones), and the investigator added him as the alleged perpetrator. (*Id.* at 47.)

Of course, long before these interviews there were signs that Staff 2 might have been the perpetrator, had the investigator only been looking for them. For example, while PI's investigation languished without activity, Staff 2 "was investigated by DFPS's CPI for Sexual Abuse of his stepdaughter (*id.* at 46):

---

larger investigative process." (*Id.* at 80.) The Handbook directs investigators to notify the CAC "within 24 hours or by the next business day after determining the victim meets the criteria for a forensic interview." (*Id.* at 81.)

> [O]n June 22, 2022, . . . DFPS had received an intake report that Staff 2 [Jonathan Jones] sexually abused his stepdaughter and substantiated the allegations on September 28, 2022. When the [PI] investigator resumed in November 2022 and Staff 2 had already been substantiated by DFPS for the Sexual Abuse of his stepdaughter, the investigator appeared entirely unaware of these developments.

(*Id.* at 47.) And the PI investigator likewise "failed to review or discuss" a sexual abuse investigation into Staff 2 "from November 2018 while [he was] employed by C3 Academy." (*Id.* at 47.) That investigation was opened by PI after "a young woman resident at the home alleged that Staff 2 masturbated while she was showering."[241] (*Id.* at 47.)

Because the investigator missed all of this, and thus failed "to timely identify" Staff 2 "as an alleged perpetrator and conduct this investigation, it appears that Staff 2 had access to all of the residents at the HCS home, including Child C for some period of time." (*Id.* at 47.) Indeed, Child C's records establish that Staff 2 continued to have access to Child C, as he was administering her medications from December 2021 until March 2022, shortly before her discharge from the placement. (*See* PX 117 at 145-50, 153-61.)

---

241. PI assigned a finding of Unconfirmed to this allegation. (D.E. 1412 at 47.)

Third, when Child C was interviewed over a year after the investigation commenced (by different investigators), the investigators "did not facilitate Child C's participation in the interviews through appropriate accommodations for her limited speech and comprehension." (D.E. 1412 at 46.) Despite this, Child C's responses were consistent with they outcry she made in the hospital the year prior:

> Child C confirmed over the computer [the interview was conducted through a Microsoft Teams video call] that an unnamed individual sexually abused her. Child C additionally stated that the abuse occurred in a living room and she nodded affirmatively that the unnamed individual's girlfriend was present at the time, as she alleged in the original intake. Child C was reportedly unable or unwilling to provide the name of the alleged perpetrator to the investigator.

(*Id.* at 46.) Remarkably, the interview was cut short: this investigator—who, it bears repeating, failed to secure accommodations for Child C—"documented the following: 'Investigator ended the interview due to [Child C's] limited speech and lack of response.'" (*Id.* at 46.)

Fourth, the investigator failed to "interview any other staff members or residents who may have had information related to Child C's allegation." (*Id.* at 46.) This may have been due to the long investigative delay: "When the investigator asked one of the administrators to provide the names of other residents who lived in the home at the

same time as Child C one year prior, the administrator reported that she did not remember their names and when the investigator followed up for records of their names, there is no documentation indicating that she ever received it from the administrator." (*Id.* at 46.)

Fifth, the investigator failed to secure documentation that may have helped the investigation, such as "such as timesheets, Staff 2's employment application, names and numbers of other residents, and Child C's incident reports and hospital records." (*Id.* at 46.)

Finally, "the investigator did not review any of Child C's nine prior investigations," each of which "included names and contact information of other residents and staff members who lived or worked in the home during that time period." (*Id.* at 46.)

The intake was received on November 7, 2021, and an extension was approved more than thirty days later, on December 10, 2021. (*Id.* at 48.) The investigation was completed on December 21, 2022, thirteen months after intake. (*Id.* at 48.) Thus, both the extension and the investigation were untimely under Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of sexual abuse was not "investigated; commenced and completed

on time consistent with the Court's Order; [or] conducted taking into account at all times" Child C's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

It should also be noted that despite PI assigning a disposition of Inconclusive, Ms. Evans testified at the Contempt Hearing that she believed Child C was sexually abused as this was "the first time that [Child C] actually complained of sexual abuse." (D.E. 1488 at 125:4.) She also asserted that "we took the necessary steps" in response to Child C's outcry. (*Id.* at 125:5.) But Ms. Evans clearly lacked a sense of urgency—the alleged abuse occurred on November 7, but Child C was not taken to a doctor until December 30. (*Id.* at 125:12-13.) And then, all Child C received was a pregnancy test.[242] (*Id.* at 125:14-15.)

xi. Investigation 11

On April 6, 2022, a caseworker reported an allegation of physical abuse of Child C; specifically, that Staff 5 hit Child C on the leg with a cord because she was "behaving

242. Ms. Evans claimed that Child C received a gynecological exam. (D.E. 1488 at 105:12-13.) But Child C's records, which Ms. Evans testified are complete (*id.* at 70:11-23), clearly indicate that only a urine pregnancy test was administered on December 30, 2021. (*See* PX 117 at 55.) There are no records of a rape kit, a medical forensic exam conducted by a Sexual Assault Nurse Examiner (SANE), or a gynecological exam. (*Id.* at 55.) The pregnancy test was negative, which is not indicative of a lack of sexual abuse, and upon discharge Child C was prescribed two medications to treat dysuria. (*Id.* at 54.)

'bad.'" (D.E. 1412 at 48.) The caseworker also reported observing a thin bruise on Child C's left thigh that was "about two inches long." (*Id.* at 48.) A week later, school personnel reported that Child C "did not want to return to C3 Academy because she was being abused there." (*Id.* at 48.) The reporter also stated that the school nurse observed circular bruises on the child's thigh, one of which "was approximately two inches in length." (*Id.* at 48.) "Child C said the injury occurred in the group home," but would not state the name of the person who caused the injury. (*Id.* at 48.) This became the eleventh pending abuse and neglect investigation related to Child C while she was placed at C3 Academy, and the sixth allegation of physical abuse of Child C. (*Id.* at 48.) No caregivers or staff members at C3 Academy reported the incident to SWI.

PI initiated a Priority Two physical abuse investigation of Child C by Staff 5. (*Id.* at 48.) More than nine months after intake, the investigator assigned the allegation a disposition of Inconclusive. (*Id.* at 48.) The Monitors disagreed; due to the "substantial investigative deficiencies" described below, they concluded that "a disposition of the allegation cannot be determined." (*Id.* at 48.)

First, the investigator failed to make face-to-face contact with Child C until nine-days after the first intake report (*id.* at 48), in violation of Remedial Order 8 (*see* D.E. 606 at 3).[243] During the interview Child C

243. Apparently, "[t]he investigator attempted a timely face-to-face interview with Child C," but "the attempt was unsuccessful because no one at the group home allegedly opened the door to

recounted—consistent with her original allegation—that "on an unknown date, she went in the bathroom at C3 Academy and hit her head on the wall; after Staff 5 heard Child C hit her head, Child C stated that Staff 5 entered the bathroom and hit her with a white cord on her leg." (*Id.* at 48-49.) Child C stated that no one observed the incident" and, "[a]ccording to the investigator, Child C did not allow her to observe whether she had any bruising nor photograph her." (*Id.* at 49.)

Second, even though Child C confirmed both the allegation of physical abuse and the identity of the alleged perpetrator, Staff 5, the investigator failed to take any further investigative activity for nine months. (*Id.* at 49.) Further, the investigative record does not document whether Staff 5 continued to work at C3 Academy and have access to Child C and the other residents during the investigative delay. (*Id.* at 49.) Indeed, because of the delay, the investigator failed to interview Staff 5 at all—"Nine months after Child C's interview . . . the investigator first attempted to contact Staff 5. At that point, Staff 5 reportedly no longer worked at C3 Academy and did not respond to the investigator's late attempt for an interview." (*Id.* at 49.)

Third, to compound the "absence of this key interview with Staff 5," "the investigator did not attempt to interview collateral staff members nor residents [of C3 Academy] to gather information about the allegation." (*Id.* at 49.)

---

the investigator." (D.E. 1412 at 49 n.74.) "The investigator did not attempt to interview Child C again until nine days after the date of the first intake report." (*Id.* at 49 n.74.)

In sum, "[d]ue to significantly delayed and missing interviews, the investigator failed to gather sufficient information to determine whether Staff 5 physically abused Child C." (*Id.* at 48.)

The intake was received on April 6, 2022. (*Id.* at 49.) Two extensions were approved; but because the first was approved more than thirty days after the intake (on May 11, 2022) (*id.* at 49), they were untimely. The extensions were also inadequate because the documented reason for each—"Extraordinary Circumstances" (*id.* at 49)—does not demonstrate "good cause."[244] And, of course, the investigation was not completed until January 27, 2023, nearly ten months after intake. (*Id.* at 49.) For all these reasons, the investigation violated Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of physical abuse was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child C's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

---

244. As explained earlier, *supra* page 554-56, simply stating "Extraordinary Circumstances," without providing the facts that make the circumstances extraordinary, does not demonstrate "good cause" under Remedial Order 10.

Appendix B

xii. Investigation 12

On April 28, 2022, Child C's caseworker reported that Child C was at the hospital with a broken jaw. (D.E. 1412 at 49.)

> The caseworker reported that on the date of the intake report hospital staff notified her that an unnamed staff member dropped Child C off at the hospital. The unnamed staff member reported to the hospital that Child C had been restrained at the group home; the staff member reportedly did not provide any other information to the hospital before departing and no one stayed with the child at the hospital. While at the hospital, medical personnel determined that Child C had a fractured jaw, which required surgery. The reporter stated that it was unclear how or when Child C was injured. One day later, on April 29, 2022, medical personnel from the hospital reported that Child C had a fractured mandible (lower jaw) in two places and Child C was unable to explain how she was injured.

(*Id.* at 49-50.) The Monitors also noted that no administrator or staff member from C3 Academy stayed with Child C at the hospital. (*Id.* at 49.) At the Contempt Hearing, Ms. Evans averred that her administrative assistant, Georgia McCuin, accompanied Child C to Urgent Care, but could not say if anyone visited Child C once she was moved to the hospital. (D.E. 1488 at 130:21-131:20.)

Appendix B

PI initiated a Priority One physical abuse investigation of Child C by Staff 6. (D.E. 1412 at 50.) "This investigation became the twelfth pending concurrent investigation of abuse and neglect of Child C at C3 and the seventh allegation of Physical Abuse." (*Id.* at 50.) Nine months after intake, the physical abuse allegation was assigned a disposition of Inconclusive. (*Id.* at 50.) Per the Monitors, this disposition was inappropriate—the "allegation of Physical Abuse should have been substantiated with a disposition of Confirmed." (*Id.* at 50.) Indeed, notwithstanding the deficiencies in the investigation, the Monitors concluded that "the record contains a preponderance of evidence that Staff 6 hit child C, causing substantial injury to the child by fracturing her jaw." (*Id.* at 50.)

First, there was no question that Child C was seriously injured: "Medical personnel reported that Child C was diagnosed with a fractured jaw in two places after a C3 staff member dropped the child off at the hospital." (*Id.* at 50.)

Second, both Child C and a C3 Academy administrator identified Staff 6 as the perpetrator. "When the investigator asked Child C what Staff 6 'did to her,' Child C 'clearly stated' that Staff 6 hit her." (*Id.* at 50.) Likewise:

> An administrator of C3 Academy, who was interviewed six months after the intake, reported that another resident informed her that she observed Staff 6 hit Child C in the face with his fist multiple times the day before the

> child was taken to the hospital.[245] According to the administrator, after the child was physically abused by Staff 6, presumably the only staff member on-duty for that evening's shift, Child C reportedly went to bed with untreated and substantial injuries. The following day, a different staff member and the administrator observed blood and bruising on Child C's face. At this time, the administrator instructed a staff member to transport the child to a hospital and the administrator reportedly notified law enforcement. . . .[246] The administrator reported that Staff 6 was immediately terminated.

(*Id.* at 50 (footnote omitted).) Thus, "the investigative record contains a preponderance of evidence that Staff 6 used inappropriate and excessive force when he hit Child C and fractured her jaw in two places." (*Id.* at 50-51.)

---

245. The Monitors note that C3 Academy refused to provide the resident's contact information, and it is "unclear whether the investigator could have obtained the witness's contact information independent of C3 Academy." (D.E. 1412 at 50 n.75.) In any event, the investigator did not interview the resident. (*Id.* at 50 n.75.) The Monitors also note that the refusal to provide contact information was not an isolated act of contumacy—"C3 Academy also failed to comply with the investigator's request for other documentation related to Child C and the allegations." (*Id.* at 50 n.75.)

246. "The Monitors were not able to locate any documentation confirming that anyone at C3 Academy notified SWI of the critical incident of abuse and the investigator did not attempt to corroborate the administrator's claim that the group home notified law enforcement." (*Id.* at 50.)

The Monitors note that Child C's broken jaw could have been prevented had another PI investigation of physical abuse by Staff 6 been conducted and completed timely:

> The monitoring team's review identified that on February 24, 2022, two months prior to Staff 6 hitting and significantly injuring Child C, PI initiated a separate investigation . . . involving allegations that Staff 6 physically abused an adult resident at the group home. Because PI did not conduct a timely or adequate investigation of the Physical Abuse allegation related to the adult resident, Staff 6 continued to work at the group home and two months later was able to physically assault Child C.

(*Id.* at 51 (footnote omitted); *see also id.* at 51 n.76 (summarizing investigation of Staff 6's abuse of adult resident).)

Of course, like the other eleven abuse and neglect investigations related to Child C that remained pending when Child C's jaw was broken, this one was not without deficiencies, though the deficiencies here were "particularly egregious given the severity of the incident of Physical Abuse suffered by Child C." (*Id.* at 51.)

First, as noted above, the investigator did not interview a "key individual[]"—the C3 Academy administrator—until six months after intake.

Second, the investigator failed to "investigate the following allegations of Neglect made by the child's caseworker during the investigation. These allegations raised significant concern for the safety and well-being of the residents placed at C3 Academy." (*Id.* at 51.)

- The caseworker "reported that when law enforcement arrived at the group home a few hours after Child C arrived at the hospital, 'C3 Academy had completely cleaned out the house.'" (*Id.* at 51.) The investigator failed to ask questions that would clarify or elaborate on this statement. (*Id.* at 51.) Further, the investigator waited eight months to contact the responding police station to request additional information, and the investigative record did not include a police report. (*Id.* at 51.)

- The caseworker "reported that when law enforcement arrived at the group home they observed that one on-duty staff member had an ankle monitor and was reportedly 'out on bond for felony stalking' and another on-duty staff member was a registered sex offender."[247] (*Id.* at 51 (footnote omitted).) Yet the "investigator made no attempts to identify the names of these staff members, to determine whether they

247. The Monitors note that the registered sex offender may have been Staff 2 (Jonathan Jones) who was incarcerated for sexually assaulting his stepdaughter. (*Id.* at 51 n.77). But "[d]ue to investigative failures," the registered sex offender's identity could not be determined from the investigative record. (*Id.* at 51 n.77.)

continued to be employed at C3 Academy and had access to residents, nor to corroborate or explore the information about the staff members' alleged criminal charges." (*Id.* at 51.) Indeed, the investigator merely "documented . . . that 'It is a concern that the agency is employing registered sex offenders.' The investigator did not appear to take any action regarding this serious safety concern." (*Id.* at 51.)

- The caseworker "reported that C3 Academy terminates staff members after allegations of abuse or neglect are made against them" and will rehire the staff members "after an investigation has closed." (*Id.* at 52.) "The investigator did not investigate this allegation and did not appear to discover evidence that, in this instance, it was not accurate." (*Id.* at 52.)

- The caseworker "reported that C3 Academy did not provide her with any of Child C's paperwork, medications, or belongings after Child C left the placement. The caseworker reported that she threatened to call law enforcement in order for the group home to provide Child C's medications, which she ultimately received. The group home never provided Child C's belongings or paperwork." (*Id.* at 52.)

- Finally, the caseworker "reported in her intake report that according to hospital personnel, a staff member from C3 Academy dropped the

> child off at the hospital and departed without providing additional information on behalf of the child, leaving the child alone. She also indicated that she learned of the child's status through hospital personnel, as opposed to notification from anyone at the placement. The investigative record failed to clarify or confirm the duration of time C3 Academy left the child alone at the hospital with a fractured jaw nor whether anyone attempted to notify the caseworker or law guardian." (*Id.* at 52.)

But PI's complete failure to protect Child C (and the other residents of C3 Academy) is perhaps best exemplified by the statement of "a detective for the local police department," who reported to the investigator that "the department was presently attempting to 'shut down' C3 Academy." (*Id.* at 52.) Remarkably, it seems that the detective's statement fell on deaf ears—at the very least, "the investigator did not document that she took any additional action to safeguard the children and adults still placed at C3 Academy." (*Id.* at 52.)

The intake was received on April 28, 2022. (*Id.* at 52.) One extension was approved, but was approved more than thirty days after the intake (on June 8, 2022) (*id.* at 52), and was thus untimely. The extension were also inadequate because the documented reason—"Extraordinary Circumstances" (*id.* at 52)—does not demonstrate "good cause." And, of course, the investigation was not completed until February 7, 2023, nine months after intake. (*Id.* at 52.) For all these reasons, the investigation violated Remedial

Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of physical abuse was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child C's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10. Indeed, this significantly deficient investigation was conducted with clear and utter disregard for Child C's safety.

This investigation and the underlying events were discussed at the Contempt Hearing. Ms. Evans testified that there was "no doubt" in her mind that Staff 6 punched Child C because "[t]he evidence was there that the child had been abused." (D.E. 1488 at 103:24; 104:12.) Indeed, Ms. Evans terminated Staff 6's employment and stated he was in police custody following the incident. (*Id.* at 115:1-3.) Ms. Evans claimed she appealed the disposition of Inconclusive (*id.* at 103:8-11), but the Monitors found nothing to indicate that an appeal was filed by Ms. Evans or anyone at C3 Academy (*id.* at 196:15-197:2).

This incident is also further evidence that direct caregivers are not reporting abuse and neglect. Child C's records indicate that on April 21, 2022, one week before the incident was reported by a caseworker to SWI, Ms.

Evans filled out a "Nurse Services Delivery Log-Billable Activities" for Child C stating:

> [Child C] came to the [day hab] this am instead of going to school. She presented w/the lt side of face swollen. It appeared that she had a dental abscess. On further examination, bruising was seen at the lt temple and she c/o pain. . . . Mr. Byron was the caregiver the evening before and was questioned. He informed us she had an altercation w/another client in the GH. Upon further investigation, Mr. Byron's account was completely fabricated. He caused the swelling to her face . . . An attempt to notify APS via phone was made.

(PX 117 at 53.) The Monitors' review of SWI records revealed no phone call to SWI by Ms. Evans and her staff until the caseworker reported the incident.

* * *

As noted by the Monitors, all of the investigations had extensive, unexplained delays which created a risk of harm for Child C and other residents in the placement because alleged perpetrators remained free to continue causing harm while investigations were pending. (D.E. 1412 at 29.) Staff 6 broke Child C's jaw nearly one year after she was tasered, seven months after she was locked in the bedroom, and five months after her outcry of sexual abuse by a staff member who was subsequently incarcerated for sexually abusing his stepdaughter. (*Id.* at 52.)

Further, PI investigators consistently failed to consider or discuss whether administrators at C3 Academy were neglectful, particularly for a failure to "provide a safe environment for [Child C], including the failure to maintain adequate number of appropriately trained staff, if such failure results in physical or emotional injury . . . to [Child C] or which placed [Child C] at risk of physical or emotion injury or death." *See* 26 Tex. Admin. Code § 711.19(b)(3).

Certainly, Ms. Evans' staffing practices contributed to the unsafe environment at C3 Academy. Ms. Evans explained that C3 Academy had a "revolving door" of staff members coming and going. (D.E. 1488 at 76:6-8.) Sometimes, she would rehire former staff that she had fired for "inappropriate conduct." (*Id.* at 76:9-15.) One such staff member was Rodney McCuin, identified as Staff 3 in PI investigations involving Child C:

> Q. [BY MR. YETTER] For example, Mr. McCuin, you terminated him two or three times?
>
> A. I did.
>
> Q.. . . . But then you hired him back two or three times[248] because he promised to do better?

248. This is consistent with the caseworker's report, noted in the Monitors' discussion of the twelfth investigation into abuse of Child C, that "C3 Academy terminates staff members after allegations of abuse or neglect are made against them; however, the group home will then hire these same staff back after an investigation is closed." (*Id.* at 52.)

> A. He promised not to bring women in at night.
>
> Q. Got it. And his—the thing he did that was wrong is that he had inappropriate sexual relationships at your—or interactions with women at your facilities,[249] at the homes?
>
> A. At the group homes.
>
> Q. And, of course, he was married,[250] too, wasn't he?
>
> A. He was.
>
> Q. And these were women that were not his wife, right?
>
> A. Right.

(*Id.* at 76:16-77:5.) Thus, Ms. Evans repeatedly rehired a man who conducted extramarital affairs instead of doing his job—caring for the children and adults with disabilities who were present in the residence. (*See id.* at 74:10-13.) Apparently, "bringing women in at night and

249. This group home was a three-person home, presumably with three bedrooms, one for each resident. Unless Mr. McCuin was using one of the common areas to conduct his extramarital affairs, it seems likely that two residents were placed together in one room while Mr. McCuin and his paramours commandeered one of the resident's bedrooms.

250. Mr. McCuin's wife, Georgia McCuin, was Ms. Evans' "number two person in the business." (*See* D.E. 1488 at 120:5-17.)

having sex with them" (*id.* at 80:21) was acceptable at C3 Academy.

So too was molesting the clients. Ms. Evans explained that female clients complained that Mr. McCuin "had touched them inappropriately." (*Id.* at 81:16-24.) Yet she did not fire him—quite the contrary, her testimony indicates that he continued to "assist clients with bathing, dressing, and things to that nature."[251] (*Id.* at 82:6-7.) Ms. Evans disbelieved the complaints because these women had made similar complaints at other facilities. (*Id.* at 82:23-83:1 ("THE COURT: Okay. Now, why did you not believe the women that complained about inappropriate touching? THE WITNESS: Because in our receiving of the history of these clients, that was typical of their behaviors. . . .").)

Ms. Evans also knew about Child C's outcry that Mr. McCuin "touched her inappropriately." (*See id.* at 83:10-14.) But, Ms. Evans did not report the outcry to SWI because Child C "had the typical behavior of undressing

---

251. Ms. Evans stated that Mr. McCuin did not bathe female clients, he would only "make sure that they had their towels and toiletries." (*Id.* at 82:13-15.) She did not, however, elaborate on his role in "dressing" clients, or what "other things of that nature" he was responsible for.

The Court notes that since the C3 Academy group homes only had one staff member present during the nights and mornings, the times when residents would be showering, the residents would be supervised by a male staff member. Moreover, Ms. Evans was unfazed when she said that naked females were supplied with towels and supervised by men.

completely in front of everybody in the day hab,"[252] and Mr. McCuin was merely "trying to put a towel or something on her." (*Id.* at 83:20-21; 84:16-17.) Ms. Evans noted that "[t]here were other male staff" who "were trying to cover" Child C as well. (D.E. 1488 at 84:21-25.) She did not explain how this fact made Child C's outcry less credible. Overall, SWI received five reports of ANE allegations of Child C for which Mr. McCuin was listed as the alleged perpetrator. (*See* D.E. 1486-3 (naming Staff 3 as the alleged perpetrator); D.E. 1488 at 101:2-6 (Ms. Evans verifying Staff 3 to be Mr. McCuin).)

Ms. Evans described Mr. McCuin and some of her other staff as "unsavory employees," and observed that the "child and adult care industry" "kind of reeks of scamsters and schemers.". (D.E. 1488 at 86:7-16.) Certainly, Ms. Evans proves the veracity of this statement through her own example.

Further, Ms. Evans testified that she did not report Child C's outcries to SWI because either she disbelieved them, or because the outcry would have been reported to Adult Protective Services (APS),[253] which is the same

252. A "Patient Safety Plan" included in Child C's record filled out during a stay at the hospital states that undressing is one of the "Warning Signs" that she may be "nearing an emotional crisis." (*See* PX 117 at 107.)

253. According to the PI Handbook, DFPS's APS has the following jurisdiction:

> [APS] investigates allegations of abuse, neglect, and financial exploitation of persons that: are aged 65 or older, or are aged 18-65 and have mental, physical, or

number as SWI. (*Id.* at 244:6-7.) The Monitors reviewed Child C's records and concluded that neither Ms. Evans nor her staff called in a report to SWI and APS, despite the multiple ANE allegations that arose during Child C's placement at the facility. (*Id.* at 244:8-14.)

Even Mr. Pahl was able to agree that improper delays and deficient investigations are harmful to children like Child C:

> THE COURT: Okay. So what did the—what do you think the delay—she stayed in that same place the whole time until she was dumped at the hospital with a broken jaw, alone. Now, what do you think the delay of all your investigations—how do you think that affected Child C?
>
> THE WITNESS: I would say that it did not affect the child positively.
>
> THE COURT: Oh, my.
>
> . . . .
>
> Q. [BY MR. YETTER]: Well, you know that the Court's Remedial Orders require either

---

> developmental disabilities that substantially impair their ability to live independently or provide for their own self-care or protections; and reside in the community, e.g., private homes, unlicensed adult foster homes, unlicensed board and care homes, etc.

(DX 34 at 25.)

> 24-hour face-to-face interviews or 72-hour face-to-face interviews. You know that, right?
>
> A. Yes, sir.
>
> Q. So if it's months late, it's completely in violation of the Court's Remedial Orders, right?
>
> A. That's correct.
>
> Q. And it's dangerous for the child?
>
> A. It can be, yes, sir.
>
> THE COURT: Well, it turned out to be dangerous, didn't it? Can you answer that? Just look at Child C. It was dangerous. The delays were dangerous to her, weren't they?
>
> THE WITNESS: It appears so, yes, ma'am.
>
> THE COURT: They kept her in a dangerous placement for a year after 12 outcries, didn't it?
>
> THE WITNESS: It appears so, yes, ma'am.

(D.E. 1487 at 136:1-8; 143:14-144:4.)

C3 Academy remained open for more than a year after Child C was removed from the placement, despite substantial evidence that staff members and other individuals in the placement put her safety at risk. Doctor

Miller found it incomprehensible that the State allowed C3 Academy to operate for nine years:

> Q. Based on your knowledge of the child welfare system and how safe homes are run, was—did you have—were you surprised that the group homes run by C3 Academy were allowed to stay in this system in Texas for nine years with the kind of practices that they told us about today?
>
> A. That's just incredible. It's impossible to understand that.
>
> . . . .
>
> Q. [Ms. Evans] said [PI] wouldn't come out for six to 12 months. And then we saw that with Child C in each of the investigations how long it took. Do you have any opinion about that?
>
> A. Well, once again, it—it's just intolerable. And, again, you're talking about developmentally delayed kids. The urgency and the need for a sense of urgency with those kiddos to get in there, get the information that they have available, and do that in a very sensitive way is just crucial. You wait that much time and you're not going to get any information. And the kids are put at increased risk.

(D.E. 1488 at 266:5-11; 266:25-267:9.)

Although the delay was substantial, HHSC revoked Ms. Evans' certification to run group homes under the HCS program in 2023, and no children will be placed at C3 Academy any longer. (*See* D.E. 1488 at 73:24-74:1.)

b. Child A

Child A is a fifteen-year-old PMC child with an IQ of 56.[254] (D.E. 1412 at 11.) According to Child A's Plan of Service she has Fetal Alcohol Spectrum Disorder, Persistent Depressive Disorder, Intellectual Disability, Mild, Disruptive Mood Dysregulation Disorder, and Intermittent Major Depressive Episodes. (*Id.* at 11.) She was placed at various HCS facilities operated by Educare from May 11, 2020 to April 30, 2021.[255] (*Id.* at 11.) During this year, "Educare moved her among at least four of its different group home locations." (*Id.* at 11.) Five of the six abuse and neglect investigations reviewed by the Monitors "appear to have occurred at the final Educare location."

254. The Monitors reported the IQ of the children "due to its significance to the discussion about the investigative deficiencies surrounding child interviews and assessment of child safety and risk, though it is not the only relevant factor." (D.E. 1412 at 11 n.23.)

255. The Monitors reported that Child A's last day at Educare was listed on the placement log as May 10, 2021, but her actual last day at the Educare facility was April 30, 2021. (*Id.* at 11 n.26.) Child A appears to have been hospitalized for "ongoing mental and behavioral health issues" from April 20, 2021 to May 10, 2021. (*Id.* at 11 n.26.) Around September 1, 2022, Child A was placed at another HCS group home where she was an alleged victim in one open neglect investigation since January 5, 2023. (*See id.* at 11 n.24.) She remained at this placement as of September 1, 2023. (*Id.* at 11 n.24.)

(*Id.* at 11.) PI opened six investigations of alleged abuse and neglect of Child A between March 7, 2021 and May 4, 2021. (*Id.* at 11.) Child A remained at Educare group homes for more than seven weeks after the first abuse and neglect allegation was reported. (*Id.* at 11-12.)

i. Investigation 1

On March 7, 2021 a DFPS caseworker reported allegations of physical abuse, emotional abuse, and neglect of Child A that resulted in a Priority One investigation. (*Id.* at 13.) Child A made an outcry that three days prior, a staff member (Staff 1) "provided her with money and allowed her to walk alone to a nearby store where she purchased a bottle of Tylenol containing 24 pills (*Id.* at 13.) Child A returned to the placement, went to her bedroom, and ingested all 24 pills. (*Id.* at 13.) "[A]t the time the intake report was made, the child was at a hospital for ingesting the pills." (*Id.* at 13.) An incident report written by an unnamed staff member documented that when Child A returned from the store, she "showed a 20oz soda and a small bottle that contain[ed] 24 pills of migraine medication. Staff told her she can't have it[,] she said she don't give a fuck[,] she keeping them and that's when she left to walk to the other group home again after the site manager told her not to leave. She then walked back in the house[,] walk to the backyard and said she wants to die and that she already took all the medications." (*Id.* at 14.)

When the caseworker went to visit Child A at the hospital, Child A made an outcry that, on an unknown date, a staff member instructed Child A to sleep in the

same bed as another individual in the home (Individual 1, age unknown)[256] and she complied. (*Id.* at 13.) The caseworker also reported that Child A disclosed she engaged in self-harming behavior by cutting herself with a plastic pen while at the placement, and the caseworker observed scratches on Child A's wrists. (*Id.* at 13.) When a staff member (Staff 3) at Educare observed her self-injurious behavior, Staff 3 "yelled at [Child A] to stop cutting herself" and threatened to hit her. (*Id.* at 13.) Finally, Child A "told the reporter that staff members did not provide her with her morning medications." (*Id.* at 13.)

PI initiated a Priority One investigation of emotional abuse, neglect, and physical abuse of Child A by three named staff members and two unknown staff members.[257] (*Id.* at 13.) The investigator assigned a disposition of Unconfirmed to all the allegations except the allegation that staff instructed Child A to sleep in the same bed as Individual 1, which was given a disposition of Other.[258] (*Id.*

256. The Monitors reported that the investigator in this case failed to determine or document whether this individual was an adult or a child; however, Child A provided the first name of the individual and the Monitors discovered the name in another investigation at Educare that suggests the individual is an adult, but the monitoring team could not confirm this information. (*Id.* at 13 n.31.) This is yet another example of a critical lapse in investigating the allegation and assessing the risk to Child A.

257. The Monitors were unable to find any documentation in the record that any staff member or administrator called-in these incidents to SWI. (*Id.* at 13.)

258. The disposition of "Other" was made because the PI investigator concluded that PI did not have jurisdiction over the

at 13.) The Monitors disagreed; due to the "substantial investigative deficiencies" discussed below, the Monitors concluded that "a disposition of the allegations cannot be determined." (*Id.* at 13.)

First, the investigator's interviews with staff members were severely delayed—taking place twenty-one months after the investigation commenced—and failed to gather vital information. Further, the investigative record contained an incident report (quoted from above) by an unnamed staff member documenting Child A's "departure from the home and ingestion of pills, during which time the staff member documented that he was the only staff member on site." (*Id.* at 14.) Yet, during the interviews, the investigator failed to reference this incident report. (*Id.* at 14.) Indeed, the investigator "did not attempt to identify the staff member who authored the . . . incident report nor the person responsible for" Child A's "supervision at the time of the elopement and self-harming behavior. Instead, the investigator's interviews with staff members and her documentation thereof appeared to lack detailed questioning about the alleged incident, including a failure to identify which staff member(s) was on duty." (*Id.* at 14.)

Second, the Monitors noted that the investigator failed to gather other information necessary to "inform an assessment of the allegation of Neglect" (*id.* at 14):

---

neglect allegation according to Title 26 of the Texas Administrative Code, § 711.7. (*Id.* at 13.) But the investigator failed to identify which provision of § 711.7 warranted the conclusion that PI was without jurisdiction. (*Id.* at 13 n.32.)

- "How many children or other residents was the single, on-duty staff member responsible for supervising at the time of the incident? What was the group home's contractual staff-to-client ratio and was the group home in compliance with this ratio at the time of this incident?" (*Id.* at 14.)

- "What efforts, if any, did a staff member make to prevent the child from leaving the placement, particularly given that the child possessed a bottle of pills and had a documented history of self-harming behavior and suicidal ideation? Additionally, given the child's history of frequent elopement, what safety precautions had the group home implemented to prevent, as best as possible, the child from eloping?" (*Id.* at 14.)

- "Given that the child left the placement with pills, did the staff member notify the other HCS Group Home that the child was walking toward the home and had pills with her?" (*Id.* at 15.)

The investigator assigned a disposition of Unconfirmed despite failing to acquire (or even attempt to acquire) this critical information. The Monitors note that the disposition appears to have been based solely on "evidence that the child was not subject to heightened supervision at the time of the incident. Statements and conclusions in the investigative record seemed to suggest that any acts and omissions by staff members did not rise to the level of Neglect when, as here, the child eloped and self-harmed so

long as a staff member adhered to her 'routine' supervision level."[259] (*Id.* at 15.)

Third, despite "the record includ[ing] documentation" that Child A "exhibited emotional dysregulation, suicidal ideation leading to inpatient hospitalization and . . . a serious incident of self-harm," the investigator did not "explore or discuss" "whether Educare failed to 'establish or carry out an appropriate individual program plan or treatment plan' for Child A that resulted in or placed her at risk of physical or emotional injury or death." (*Id.* at 15 (quoting 26 Tex. Admin. Code § 711.719(b)(1)).)

Fourth, the investigator learned from an Educare case manager that despite Child A's "ongoing high-risk behaviors," she "did not have a Behavior Support Plan while at the placement nor did staff members have 'special training' or instruction about caring for" her. (*Id.* at 15.) Yet the investigator "did not discuss or further explore whether" these failures were "tantamount to or at least evidence of Neglect due to a failure by Educare 'to provide a safe environment for [the child], including the failure to maintain adequate numbers of appropriately trained staff' that resulted in or created risk of physical or emotional

259. The Monitors explain that under "routine" supervision, staff were not required to maintain either one-to-one or line of sight supervision. (D.E. 1412 at 15 n.33.) Thus, "[w]hile supervising Child A, a staff member was permitted, according to facility documentation, to care for and supervise other residents and this care for other residents may occur in a separate room or part of the HCS Group Home from where Child A was located." (*Id.* at 15 n.33.)

injury or death for this child." (*Id.* at 15 (quoting 26 Tex. Admin. Code § 711.719(b)(3)).)

The Monitors concluded that due to the lengthy investigative delay, the investigation was also deficient as to "the remaining allegations of Physical Abuse, Emotional Abuse, and Neglect related to the administration of medication and instructing the child to sleep in a bed with another resident." (*Id.* at 15.) Child A later denied many of the disclosures she made to her caseworker regarding these allegations, and "the investigation's delay of one year and nine months made it impossible to reconcile the child's outcries to her caseworker (the reporter) with her statements to the investigator." (*Id.* at 15.) "For example, regarding the allegation her medication was not administered appropriately, the investigator's lack of activity precluded the opportunity to probe the records at the group home and timely review the information with staff." (*Id.* at 15-16.)

Finally, the Monitors disagree with the investigator that PI lacked jurisdiction over the allegation that Child A was instructed to sleep in a bed with another resident, as it was "an allegation of Neglect and should have been investigated for placing the child at risk of physical or emotional injury." (*Id.* at 16 (quoting 26 Tex. Admin. Code § 711.719(a)).)

The intake was received on March 7, 2021. (*Id.* at 16.) The one approved extension was inadequate, both because it was untimely (the "extension was approved on September 14, 2022," over eighteen months after the

intake) and because the there was no demonstration of good cause (the "record did not include any explanation for the extension"). (*Id.* at 16.) And, of course, the investigation was not completed until December 21, 2022, twenty months after intake. (*Id.* at 16.) For these reasons, the investigation violated Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegations of abuse and neglect were not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child A's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

ii. Investigation 2

On April 14, 2021, the parents of an eleven-year-old child (Child B, not in DFPS care) reported that her son came to school with cuts on his wrists that he said were caused by Child A. (D.E. 1412 at 16.) Child B also informed his mother that Child A had "cuts all over her wrists." (*Id.* at 16.) The children were at Educare when the incident occurred. (*Id.* at 16.)

PI initiated a Priority One neglect investigation related to Child A and Child B by an unknown staff member. (*Id.* at 16.) After twenty-one months, the

investigator assigned a disposition of Unconfirmed. (*Id.* at 16.) The Monitors disagreed; given the "substantial investigative deficiencies" noted below, "a disposition for the Neglect allegation related to Child A cannot be determined." (*Id.* at 16.)

First, Child B verified that "Child A used a broken piece of glass to cut his wrist," that "he and Child A were in the group home's backyard at the time of the incident," and that "staff members were allegedly inside the facility while the children were allegedly cutting one or both of their wrists outside." (*Id.* at 17.) Yet, "[d]uring the investigation, the investigator did not attempt to establish the date and duration of time Child A and Child B were reportedly alone outside in the backyard using glass to cut Child B's wrist and possibly Child A's wrist; nor how Child A, a child known to self-harm, had access to a broken piece of glass." (*Id.* at 17.)

Second, the investigator failed to interview staff members until eighteen months after the intake, so they "were unable to recall the alleged incident with any detail."[260] (*Id.* at 17.) They were, however, able to recall "that the children were not subject to a heightened level of supervision" at the time of the incident; on this basis, "the investigator reported no concern for Neglect." (*Id.* at 17.)

260. The investigator conducted timely interviews with the case manager, administrator, and nurse but none of these individuals were directly involved in the alleged incidents. (*Id.* at 17 n.40.)

The intake was received on April 14, 2021. (*Id.* at 17.) The one approved extension was inadequate because the documented reason—"Extraordinary Circumstances" (*id.* at 17)—does not demonstrate good cause. And, of course, the investigation was not completed until January 20, 2023, twenty-one months after intake. (*Id.* at 17-18.) For these reasons, the investigation violated Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child A's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

iii. Investigation 3

Two days after the prior intake, on April 16, 2021, a law enforcement officer reported that Child A self-harmed and eloped from the placement. (D.E. 1412 at 18.) The officer reported that a staff member at the group home contacted law enforcement to report Child A as a runaway. (*Id.* at 18.) The officer also noted that Child A informed the officer "that she cut herself but that she did not want to kill herself, she 'only wanted to feel the cuts.' The child reportedly had superficial wounds to her right wrist." (*Id.*

at 18.) This incident was not reported by any caregivers or staff members.

PI initiated a Priority Two neglect investigation related to Child A by an unknown staff member. (*Id.* at 18.) Twenty-one months later, the investigator assigned a disposition of Unconfirmed. (*Id.* at 18.) The Monitors disagreed; because of the "substantial investigative deficiencies" "evidenc[ing] a serious disregard for child safety," the Monitors concluded that a disposition cannot be confirmed. (*Id.* at 18.)

First, the investigator failed to make timely face-to-face contact with Child A. On the day of the intake, the investigator attempted to make contact with Child A in connection with an earlier intake. (*Id.* at 18.) But when the investigator arrived at the placement, Child A was in an ambulance due to a different incident of self-harm. (*Id.* at 18.) The investigator spoke with her briefly, but "was not able to speak to Child A about the allegations" in this investigation (*id.* at 17 n.38), and "did not document whether he observed any injuries on the child's body" (*id.* at 18). Three days later, the investigator made another attempt to conduct a face-to-face interview with Child A at the placement, but the interview did not occur at that time and the investigator did not document the reason.[261] (*Id.* at 18.) Thus, the investigator failed to make face-to-face contact with Child A as required by Remedial Order 8. (D.E. 606 at 3.)

---

261. The Monitors noted that Child A was placed at a behavior unit of a local hospital at this time. (*Id.* at 18.)

Over the following five months, "the investigator attempted" but apparently failed to "interview Child A at her placement." (D.E. 1412 at 18.) On December 8, 2022—twenty months after the intake—an investigator finally conducted an interview with Child A using FaceTime. (*Id.* at 18.) Once again, due to the extensive delay, Child A had a difficult time remembering the incident, which staff member was responsible for her during that time, and the reasons for her self-harm and elopement. (*Id.* at 19.) "In the absence of a timely face-to-face interview, the investigator failed to assess and address, as appropriate, the child's safety at the placement, observe the child's alleged injuries and gather information from the child about the allegation of Neglect." (*Id.* at 19.)

Second, severely delayed interviews with staff members—conducted twenty months after the intake—likewise inhibited the investigation, as they could not recall the incident with any detail. (*Id.* at 19.) Thus, the investigator "was unable to identify an alleged perpetrator who was responsible for Child A's supervision at the time of the incident." (*Id.* at 19.) On the other hand, the staff members were able to recall that Child A was not subject to increased supervision at the time of the incident. (*Id.* at 19.) "The investigator documented and appeared to adopt the view of Child A's case manager at Educare that Child A was not likely subject to 'abuse or neglect because there was not an increased level of supervision that required staff to see [Child A] at all times.'" (*Id.* at 19.)

The Monitors noted that the substantial delay made it difficult for the investigator to determine whether

Educare failed to "establish or carry out an appropriate individual program plan or treatment plan" for Child A that resulted in placing her at risk of physical injury or death.[262] (*Id.* at 20.)

The intake was received on April 16, 2021. (*Id.* at 20.) The one approved extension was inadequate because the documented reason—"Extraordinary Circumstances"[263] (*id.* at 20)—does not demonstrate good cause. And, of course, the investigation was not completed until January 12, 2023, twenty-one months after intake. (*Id.* at 20.) For these reasons, the investigation violated Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child A's "safety needs." (*Id.* at

---

262. *See* 26 Tex. Admin. Code § 711.719(b)(1).

263. The PI Handbook defines extraordinary circumstances as "[A]n unexpected event or external factor that delays the completion of an investigation; it is something that could not have been prevented even if reasonable measures had been taken." These circumstances include: "inclement weather or natural disasters; a death in the primary investigator's family; excessive workload due to PI employee vacancies or an uncommon rise in intakes; or IMPACT errors that prevent the investigation from being closed." (DX 34 at 148; DX 39 at 161; DX 40 at 165.)

2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

iv. Investigation 4

Six days after the prior investigation began, on April 22, 2021 a law enforcement officer reported that he was dispatched to the Educare placement because of a "suicidal person"—a staff member contacted law enforcement "because Child A was cutting herself with a knife and the staff member was unable to recover it from the child."[264] (D.E. 1412 at 20.) When law enforcement arrived they were able to take the knife away from Child A, and then observed that she had "carved the word 'fake' into her left leg." (*Id.* at 20.) Thereafter, an officer accompanied the child and EMS paramedics to the hospital. (*Id.* at 20.) This incident was not reported to SWI by any caregivers or staff members.

PI initiated a Priority Two neglect investigation related to Child A by Staff 4, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 20.) The Monitors disagreed; due to the "substantial investigative deficiencies" described below, "a disposition of the Neglect allegation related to Child A cannot be determined." (*Id.* at 20.)

---

264. These allegations were related to the incident that occurred on April 16, 2021 when Child A was observed in the ambulance by the investigator. (D.E. 1412 at 20.)

First, the investigator failed to make timely face-to-face contact with Child A. The Monitors note that the investigator attempted to make timely contact with Child A at her placement, but she was in the hospital at the time "and the investigator did not attempt to interview the child at the hospital." (*Id.* at 21 n.44.) Thus, face-to-face contact did not occur until "six days after the date of the intake" (*id.* at 21), in violation of Remedial Order 8 (D.E. 606 at 3).

Second, the investigator failed to assess several crucial facts:

- "Given Child A's frequent engagement in self-harming behavior at the placement, which at this point was well-known and well-documented, the investigator did not assess whether the administrators of the HCS Group Home implemented any preventive safety measures to reduce the likelihood that the child could gain access to both a knife and a glass jar in a single day and then use one of those items to self-harm." (D.E. 1412 at 21.)

- "The investigator did not assess how often Staff 4 was required to conduct checks on Child A and whether Staff 4 adhered to this requirement on the date of the incident." (*Id.* at 21.)

- "The investigator did not assess how long the child went unsupervised in the backyard when she cut herself with the jar." (*Id.* at 21.)

- "The investigator did not assess why the child was permitted to be alone in the backyard after having acquired a knife within the past hour requiring intervention from law enforcement to recover it." (*Id.* at 21.)

The investigator likewise failed to consider, in her assessment of the neglect allegation, Staff 4's statements evidencing administrative failures. Specifically, Staff 4 explained that "she was the only staff member on duty" on the day of the incident "and that she was also responsible for the care of another resident who was attempting to elope from the placement." (*Id.* at 21.) Further,

> Staff 4 reported that she had asked the administrators of the placement "constantly" for an additional staff member to assist in the care of the residents; however, the placement administrators had not yet hired another staff member. Staff 4 also reported that while she was aware of Child A's history of self-harming behavior, administrators did not provide her with any training related to Child A's care.

(*Id.* at 21.) Of this, the investigator merely stated that "[i]t is a concern that there was no record to show that [Staff 4] was trained on [Child A's] Special Needs or Person-Directed Plan." (*Id.* at 21.) Thus, "the investigator failed to discuss or further explore whether Educare administrators were neglectful due to their 'failure to provide a safe environment for [Child A], including failure to maintain adequate numbers of appropriately trained

staff' that resulted in or created risk of physical or emotional injury or death for this child." (*Id.* at 22 (citing 26 Tex. Admin. Code § 711.719(a)-(b)(3)).)

Third, the investigator noted that, despite the now well-documented risk of self-harm, Child A was still "not subject to any heightened supervision." (*Id.* at 22.) Further, a case manager reported to the investigator "that the placement personnel were presently in the 'observation and data collection stages' of creating Child A's Behavior Support Plan and once the plan was completed, the staff member(s) responsible would conduct a meeting and potentially set certain restrictions, such as 'locked sharps' and an increased level of supervision." (*Id.* at 22.) Yet the investigator "failed to consider whether Educare failed to 'establish or carry out an appropriate individual program plan or treatment plan' for Child A that resulted in or placed her at risk of physical or emotional injury or death." (*Id.* at 22 (citing 26 Tex. Admin. Code § 711.719(a)-(b)(1); 26 Tex. Admin. Code § 711.423(c)).)

The investigation was completed on June 15, 2021, seven weeks after the intake was received. (*Id.* at 22.) An extension was approved thirty days after intake but the documented reason—"A statement from the Area Site Supervisor is required to make a determination in this case" (*id.* at 22)—failed to establish "good cause" as required by Remedial Order 10 (*see* D.E. 606 at 3). Indeed, it failed to show good cause under PI's own policies. (*See* DX 39 at 161 (listing "reasons [that] constitute good cause"); DX 40 at 164-65 (same).) Thus, the investigation failed to comply with Remedial Order 10. (*See* D.E. 606 at 3.)

And because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child A's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

v. Investigation 5

On May 1, 2021, approximately one week after the prior investigation began, a law enforcement officer reported that when law enforcement was dispatched to the placement, they found Child A "emotionally upset and argumentative." (D.E. 1412 at 23.) The officer observed "numerous cuts" on Child A's forearms and thighs, most of which "seemed older, although some appeared new." (*Id.* at 23.) The officer observed that "Child A was hiding a small orange knife on her person," which she surrendered at law enforcement's request. (*Id.* at 23.) Law enforcement then "instructed the on-duty staff member to hide all knives and scissors from" Child A. (*Id.* at 23.) This incident was not reported to SWI by any caregivers or staff members.

PI initiated a Priority Two neglect investigation related to Child A by Staff 5, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 23.) The Monitors disagreed; due to the "substantial investigative deficiencies" described below, "a disposition of the Neglect allegation related to Child A cannot be determined." (*Id.* at 23.)

First, the investigator failed to gather several pieces of "pertinent information necessary for the investigator to make an informed disposition for the allegation of Neglect" (*id.* at 23):

- "The investigative record showed that Child A likely obtained the knife from school and hid the knife in her room." (*Id.* at 23.) Yet despite Child A's "recent self-harming behavior, the investigator did not determine or inquire whether Educare administrators provided training for staff members or communicated to them policies or directives to minimize the risk that a harmful object, such as a knife, could be hidden in the child's room." (*Id.* at 23.)

- The investigator determined that Staff 5, "who was responsible for" Child A's "supervision on the day of the incident," had not previously worked with Child A. (*Id.* at 23.) Further, "the investigative record showed that [Educare] failed to adequately train Staff 5 on Child A's Person-Directed Plan and special needs prior to her shift caring for Child A." (*Id.* at 23.) Yet the investigator "did not appear to consider Educare's failure to" provide adequate training. (*Id.* at 23.)

Second, the investigator learned that Child A continued to be "on 'routine' supervision" which, as noted earlier, "permitted a staff member to complete other tasks while supervising the child and assist other residents who

were not in the same room as Child A." (*Id.* at 24.) The investigator also learned that Educare "was still in the process of creating Child A's Behavior Support Plan." (*Id.* at 24.) Yet, the investigator failed to "question the case manager regarding when Child A's Behavior Support Plan was required to be completed," "what actions the HCS placement had taken to ensure Child A's safety" in the meantime, or whether Edcuare had adjusted "Child A's supervision." (*Id.* at 24.) The Monitors also note that, as with the other investigations, "the investigator failed to consider whether personnel at Educare failed to 'establish or carry out an appropriate individual program plan or treatment plan' for Child A that resulted in or placed her at risk of physical or emotional injury or death." (*Id.* at 24 (citing 26 Tex. Admin. Code § 711.719(b)(1)).)

Third, "Staff 5 reported that she was not able to properly supervise Child A and did not have the training to do so, but again this investigator failed to assess whether Educare administrators had evidenced a failure to 'provide a safe environment for [the child], including the failure to maintain adequate numbers of appropriately trained staff' resulting in or creating risk of physical or emotional injury or death for this child." (*Id.* at 24 (citing 26 Tex. Admin. Code § 711.719(b)(3)).)

The investigation took over two months to be completed with no approved extensions (*id.* at 24); one extension was requested but was never approved (*id.* at 24 n.52). Thus, the investigation violated Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child A's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

* * *

During the eleven months Child A was placed at various Educare facilities, PI opened six investigations of alleged ANE related to Child A. (D.E. 1412 at 11-12.) Most of the investigations sat dormant for long periods of time—the longest investigation remained open for twenty-one months before completion. (*Id.* at 12.) Four of the six investigations contained documented extensions, but the investigations were not completed within the extended time frame. One of the investigations had no documented extension and was not completed within the time frame required by the remedial orders, and one investigation had a documented extension and was completed within the extended time frame. (*See id.* at 12-27.) All the reports made to SWI regarding Child A were called in by non-caregivers, with caseworkers, law enforcement officers, and another child's (not in foster care) parents reporting the ANE allegations to SWI. (*See id.* at 12-27.) The deficiencies highlighted are severe and egregious and lead to the Court's finding that HHSC is not "ensur[ing] that reported allegations of child abuse and neglect . . . are investigated; commenced and completed on time . . .

and conducted taking into account at all times the child's safety needs." (D.E. 606 at 2 ¶ 3.)

c. Child D

Child D, a fifteen-year-old PMC child with an IQ of 47,[265] was placed at Exceptional Employment Service, an HCS Group Home, on April 23, 2018. (D.E. 1412 at 53.) Child D is diagnosed with Autism Spectrum Disorder, Moderate Intellectual Disabilities, speech impairment, Attention-Deficit/Hyperactivity Disorder, urinary incontinence, and Mitochondrial Metabolic disease which causes gastrointestinal and respiratory problems. (*Id.* at 53.) Child D's mental age is between that of a six-to nine-year-old; his records indicate that he is primarily non-verbal and is "only able to use a few words and gestures." (*Id.* at 54 n.79.) The Monitors reviewed three abuse and neglect investigations of Child D that were closed with a disposition of Unconfirmed. (*Id.* at 53.) As of September 19. 2023, Child D remained at Exceptional Employment Service—twenty-three months after the first abuse and neglect allegation of Child D was reported at the placement. (*See id.* at 53.)

265. HHSC characterizes the intellectual functioning of children with an IQ between 40 to 55 as: "Children experience a marked difference in communicative behavior from their peers and their social judgment and decision-making abilities are limited Children in this group reach elementary academic skill development." (D.E. 1412 at 11 n.23.)

Appendix B

i. Investigation 1

On October 20, 2021, a law enforcement officer reported an allegation of neglect of a child (age 13, not in DFPS care) at Exceptional Employment Service, stating that the child ran away and that "[t]his [was] not the first or second time a special needs child ran away or escaped" from the group home. (*Id.* at 53.) No caregivers or staff members from the group home reported this incident to SWI.

PI initiated a Priority Two neglect investigation of the child. (*Id.* at 53.) Nearly four months later, the investigator added Child D and another PMC child (Child E, age 15), to the investigative record as alleged victims because they lived at the HCS residence at the time of the incident. (*Id.* at 53.) The investigation was completed fifteen months later, with a disposition of Unconfirmed assigned to the neglect allegation as to Child D (and Child E as well). (*Id.* at 53.) The Monitors disagreed; due to the "substantial investigative deficiencies" described below, "a disposition regarding the Neglect allegation cannot be determined." (*Id.* at 53.)

First, the investigator failed to "identif[y] the other residents who lived in the home at the time the primary victim ran away" until four months after the investigation commenced. (*Id.* at 53.) This, in turn, delayed by four months the identification of Child D and Child E as potential victims. (*Id.* at 53.)

Second, the investigator never conducted a face-to-face interview with Child D (or with Child E), in clear violation of Remedial Order 8. (*Id.* at 53; *see* D.E. 606 at 3.) Instead, the PI investigator conducted a telephone interview with Child D and Child E; this despite the investigator having been informed that Child D is "non-verbal" and that Child E knows "one or two words or [can] mimic a full sentence,[266] but he wouldn't understand what you are saying." (D.E. 1412 at 54 (brackets in original).) Unsurprisingly, the investigator documented that Child D did not respond to any of the questions asked and Child E was able to answer some initial questions but "became distracted and was not able to answer" further questions. (*Id.* at 54.) Thus, "the investigator did not gather any relevant information from either Child D or Child E regarding the allegation or their safety at the placement." (*Id.* at 54.)

Second, the investigator waited nearly four months before first attempting to interview the alleged perpetrator. (*Id.* at 54.) By then, the perpetrator was no longer employed at the group home and did not respond to the investigator's attempts to conduct the interview. (*Id.* at 54.)

Third, the "investigator did not investigate the reporter's allegation that multiple children eloped from the home due to repeated concerns for a lack of supervision." (*Id.* at 54.)

---

266. Child E's records document that he is "diagnosed with severe autism and exhibits echolalia, meaning that the child is prone to repeating words spoken by another person." (*Id.* at 54 n.79.)

The intake was received on October 20, 2021, and the investigation was not completed until fifteen months later on January 27, 2023. (*Id.* at 54.) One extension was approved thirty-one days after intake and was thus untimely, and the documented reason—"Extraordinary Circumstances" (*id.*)—failed to establish "good cause" as required by Remedial Order 10 (*see* D.E. 606 at 3). Thus, the investigation failed to comply with Remedial Order 10. (*Id.* at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child D's or Child E's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

ii. Investigation 2

On March 12, 2022, a law enforcement officer reported an allegation of neglect of Child D, stating the child eloped from the Exceptional Employment Service group home while a staff member was using the bathroom. (D.E. 1412 at 54.) Law enforcement officers found Child D "on the median of a roadway during rush hour at 5:45 pm" "approximately a mile and a half from" the placement. (*Id.* at 54.) The officer also noted that law enforcement had

responded to "multiple incidents of Child D running away from the home and that they were familiar with Child D." (*Id.* at 55.) The reporter was concerned that the home may not be equipped to properly take care of Child D. (*Id.* at 55.) No caregivers or staff members from the group home reported this incident to SWI.

PI initiated a Priority Two neglect investigation related to Child D, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 55.) The Monitors disagreed; due to the "substantial investigative deficiencies" described below, the Monitors concluded that "a disposition regarding the Neglect allegation cannot be determined." (*Id.* at 55.)

First, while the investigator conducted a timely face-to-face interview with Child D, the investigator did not document any efforts to accommodate Child D's limited communication; instead, the investigator asked Child D a "series of questions" about the incident," to which the child was unable to respond." (*Id.* at 55.) "As a result, the investigator did not gather any information from the child about the allegations." (*Id.* at 55.)

Second, the investigator "failed to reconcile conflicting descriptions of the incident between law enforcement and staff members." (*Id.* at 55.) The investigator interviewed the on-duty staff member and case manager ten months after the start of the investigation, both of whom reported that the child ran away at night. (*Id.* at 55.) The accounts given by the staff conflicted with the account given by the law enforcement officer who, as noted above, reported

that Child D was found on a median at 5:45 pm. Thus, if the officer was correct, Child D could not have run away at night. Yet the investigator failed to reconcile these conflicting descriptions of the incident. (*Id.* at 55.) "This discrepancy impacts the investigator's assessment of supervision because during the day the child was subject to one-to-one supervision whereas during the night, while asleep, the child was not subject to one-to-one supervision."[267] (*Id.* at 55.)

Third, the investigator failed to identify and interview other individuals present, if any, at the home about the incident or Child D's supervision during the time of his elopement. (*Id.* at 55.)

Finally, despite the report by law enforcement that staff members appeared unable to adequately supervise the residents in the home, the investigator did not consider whether administrators failed to "provide a safe environment for [the child], including the failure to maintain adequate numbers of appropriately trained staff" that resulted in a risk of physical or emotional injury or death to Child D.[268] (*Id.* at 55.)

The intake was received on March 12, 2022, and the investigation was not completed until January 26, 2023, ten months later. (*Id.* at 56.) One extension was

---

267. The Monitors note that the investigator could have requested a police report to confirm when Child D was found. (D.E. 1412 at 55.)

268. *See* 26 Tex. Admin. Code § 711.719(b)(3).

approved a month after intake, but the documented reason—"Extraordinary Circumstances" (*id.* at 56)—failed to establish "good cause" as required by Remedial Order 10 (*see* D.E. 606 at 3). Thus, the investigation failed to comply with Remedial Order 10. (*Id.* at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child D's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

iii. Investigation 3

On May 16, 2022, school personnel reported that Child D was observed "with three marks on his right cheek, two bruises on his left hip, and a small bruise on his right hip." (D.E. 1412 at 56.) Additionally, the reporter disclosed that two weeks prior, the school nurse documented that Child D had a bruised knuckle that "appeared to suggest that someone had bent the child's finger back." (*Id.* at 56.) Three days earlier, another school personnel observed bruising on Child D's Adam's apple and left upper cheek and stated her belief that a staff member or resident of the group home was causing Child D's injuries. (*Id.* at 56.) No caregivers or staff members from the group home reported these injuries to SWI.

PI initiated a Priority Two physical abuse investigation related to Child D, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 56.) The Monitors disagreed; because of the "substantial investigative deficiencies" discussed below, "a disposition regarding the Physical Abuse allegation cannot be determined." (*Id.* at 56.)

First, during the initial face-to-face interview, the investigator yet again failed to document any efforts to interview non-verbal Child D in a manner that facilitated his participation in the interview; instead, "she asked Child D a series of questions related to his injuries and the allegations, and the child was unable to respond to any of the questions." (*Id.* at 56.) The investigator also "observed and photographed the injuries on Child D's body," which depicted injuries that were consistent with the allegations.[269] (*Id.* at 56.)

Second, despite observing Child D's injuries, the investigator "inexplicably . . . did not pursue any investigative activity for nearly nine months." (*Id.* at 56.)

Third, when the investigator finally "conducted interviews with, among other individuals, the child's caseworker, school and facility nurses, facility staff and administration" and the reporter (*id.* at 56-57), the investigator's questions:

---

269. The Monitors viewed the investigator's photographs of Child D's injuries and reported that "they were consistent with the injuries the reporter described in the intake report." (D.E. 1412 at 56.)

> focused on Child D's history of reportedly difficult and "aggressive" behaviors which often resulted in injury to Child D and others. The investigator did not document any attempts during the interviews to gather information regarding the cause(s) of the specific injuries to Child D as of the report date.

(*Id.* at 57.) Additionally, the investigative record included several incident reports from the group home that involved Child D around the date of the intake, but the "investigator did not explore these incidents with the individuals interviewed to determine whether any of these incidents resulted in injuries to Child D nor whether staff members supervised and cared for Child D appropriately during these incidents." (*Id.* at 57.) And the investigator failed to interview "staff members who were responsible for the supervision of Child D," as well as "two other residents reportedly involved in the incident." (*Id.* at 57.)

The intake was received on May 16, 2022, and the investigation was not completed until February 10, 2023, nearly eight months later. (*Id.* at 57.) One extension was approved a month after intake, but the documented reason—"Extraordinary Circumstances" (*id.* at 57)—does not establish "good cause" as required by Remedial Order 10 (*see* D.E. 606 at 3). Thus, the investigation failed to comply with Remedial Order 10. (*Id.* at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of physical abuse was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child D's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

iv. Investigation 4

On February 27, 2023, a law enforcement officer reported an allegation of neglect of Child D, stating that they had recovered Child D after he ran away from the Exceptional Employment Service group home. (D.E. 1442 at 10.) The officer "expressed concern that law enforcement had observed 'ongoing issues' regarding the child's repeated elopement from the placement, which in some instances involved the child crossing a highway to reach a store, which placed the child at risk of being hit by a car." (*Id.* at 10.) Further, the officer noted that Child D "is 'very big in stature,' easily triggered, and staff members at the facility could not physically control the child." (*Id.* at 10.) The officer believed that Child D "required placement in 'a more secure facility' and was concerned that the child could 'be hurt running away from the facility or by the police if there is an officer who does not know [the child's] diagnosis.'" (*Id.* at 10.) This incident was not reported by any caregivers or staff members at the facility.

PI initiated a Priority Two neglect investigation related to Child D by an unknown staff member, to which

the investigator assigned a disposition of Unconfirmed. (*Id.* at 10.) The Monitors disagreed; due to the "substantial investigative deficiencies" discussed below, "a disposition regarding the Neglect allegation cannot be determined." (*Id.* at 10.)

> Due to untimely interviews with key individuals, the investigator did not gather sufficient information to determine whether a staff member(s) adequately supervised the child when he eloped twice from the facility on the same date. The question of supervision was highly relevant because at the time of the incidents, the child was subject to one-to-one supervision due to his history of elopement and the high risk presented to the child when he eloped; the child does not understand pedestrian safety rules.
>
> Likely due to the investigator's delayed interviews with staff members one month after the intake, the investigator did not establish which staff member(s) was assigned to one-to-one supervision of the child on the specified dates and times that the child eloped. Since the investigator did not identify the staff member(s) responsible for the child's care at the time of the incidents, the investigator did not gather any information related to the child's supervision at the time of the incidents to assess the allegation of Neglect.

(*Id.* at 10-11 (paragraph break added).)

The investigator also failed to "consider whether the reporter's concern that staff members were unable to safely care for the child evidenced that the facility administrators failed to ensure the facility was adequately staffed and trained to care for the child." (*Id.* at 11 (citing 26 Tex. Admin. Code § 711.719(b)(3)).)

Defendant objected to the Monitors' statement that "Due to untimely interviews with key individuals, the investigator did not gather sufficient information to determine whether a staff member(s) adequately supervised the child when he eloped twice from the facility on the same date." (D.E. 1460 at 2 (quoting D.E. 1442 at 10).) Defendant asserted:

> Defendant[] respectfully disagree[s] with the Monitors' view that the investigator didn't gather sufficient information to support the disposition of "unconfirmed" neglect. The investigator's report includes a time sheet showing which two staff members were on duty on the date of the intake report, February 27, 2023. The investigator interviewed both of those staff members. Law enforcement also stated that staff members were with the child both times the child eloped and were trying to intervene and prevent the child from eloping. Finally, when the home supervisor arrived on scene, she couldn't remember which staff member called her—but stated that the staff member who was present with the child was trying to gain cooperation to prevent the child

> from eloping. Under these circumstances, an "unconfirmed" disposition was appropriate. *See* 26 Tex. Admin. Code § 711.421 ("preponderance of credible evidence to support that abuse, neglect, or exploitation did not occur").

(*Id.* at 2-3.) In their response to the objection, the Monitors pointed out that "The PI investigator never established which staff member was assigned one-to-one supervision with Child D at the time of the incident and did not conduct a sufficient inquiry into supervision to assign an Unconfirmed disposition." (D.E. 1461 at 3.)

The intake was received on February 27, 2023, and the investigation was completed thirty-one days later, on March 30, without any documented extensions. (D.E. 1442 at 11.) Thus, the investigation failed to comply with Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child D's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

* * *

PI opened four investigations into allegations of abuse and neglect of Child D, with the longest investigation not completed until fifteen months after intake. (*See* D.E. 1442 at 10-11, D.E. 1412 at 54-57.) Three investigations had documented extensions but were not completed within the extended time frame. (D.E. 1412 at 54-57.) Additionally, none of the four allegations were reported by the staff or caregivers: three were reported by law enforcement officers, and the fourth by school personnel. (*Id.* at 54-57; D.E. 1442 at 10.)

d. Child F

Child F is a sixteen-year-old PMC child with an IQ of 71.[270] (D.E. 1412 at 57.) She was identified as an alleged victim in four investigations related to her placement at Educare Group Home (*see id.* at 57-61; D.E. 1442 at 11-12), and an alleged victim in one investigation at her subsequent placement, Ability Options, LLC, another HCS Group Home (*see* D.E. 1412 at 62). Child G, another child placed at Educare and involved in the first investigation, is a seventeen-year-old with an IQ of 57.[271] (*Id.* at 62.) Child F

270. HHSC characterizes children with an IQ score between 70 and 80 as: "Children may need assistance with complex tasks, navigating social nuances, judgment and decision-making. Children may require special education services while remaining mainstreamed." (*Id.* at 11 n.23.)

271. HHSC characterizes children with an IQ score between 55 and 70 as: "Children's memory, judgment and decision-making are impaired. Children with IQ scores in this range have a concrete problem-solving approach and may struggle to use academic skills in daily life." (*Id.* at 11 n.23.)

remained at Educare for almost five months after the first abuse and neglect allegation was reported. (*See id.* at 61.)

i. Investigation 1

On June 5, 2021, a staff member (Staff 1) reported allegations of neglect of Child F and Child G, explaining that when she arrived at work to relieve another staff member (Staff 2), Staff 1 became the sole caretaker of six residents, including one other individual who required one-on-one supervision. (*Id.* at 57.) She reported that Educare "was short-staffed," that she "could not properly supervise" the residents in her care alone, and that "she needed help." (*Id.* at 57.) Staff 1 also reported that five residents had not received their medication that day. (*Id.* at 57.)

PI initiated a Priority One neglect investigation related to Child F and Child G by Staff 2, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 58.) The Monitors disagreed, concluding that "[d]ue to substantial investigative deficiencies" discussed below, "a disposition regarding the Neglect allegation cannot be determined." (*Id.* at 58.)

First, the investigator attempted to conduct timely face-to-face interviews with Child F and Child G, but documented that when she knocked on the door of the group home, nobody answered. (*Id.* at 58.) Thereafter, the investigator did not attempt to interview the children for nineteen months, in violation of Remedial Order 7 (*id.* at 58; *see* D.E. 606 at 3), at which point the children

were interviewed by telephone. (D.E. 1412 at 58.) Child G refused to participate in the interview and Child F stated that she "didn't remember anything"—indeed, Child F "was unable to recall living at the" group home. (*Id.* at 58.)

Second, the investigator likewise failed to interview Staff 2 until nineteen months after the intake. (*Id.* at 58.) Staff 2 "reported that he was also unable to recall the alleged incident 19 months later." (*Id.* at 58.)

In sum, due to the nineteen-month delay in investigative activity, "the investigator failed to gather any information regarding the allegations." (*Id.* at 58.)

The intake was received June 5, 2021, and the investigation was not completed until January 20, 2023, nineteen months later. (*Id.* at 58.) One extension was approved less than a month after intake, but the documented reason—"Extraordinary Circumstances" (*id.* at 58)—does not establish "good cause" as required by Remedial Order 10 (*see* D.E. 606 at 3). Thus, the investigation failed to comply with Remedial Order 10. (*Id.* at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child F's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in

a manner that violated Remedial Order 3 and Remedial Order 10.

ii. Investigation 2

On September 30, 2021, a law enforcement officer reported that Child F ran away from the group home to visit an adult male (Individual 1, age 37), the husband (or boyfriend) of an Educare staff member (Staff 2). (D.E. 1412 at 58.) Per the officer, "Staff 2 provided law enforcement with an audio recording" in which Child F disclosed "that she had a sexual relationship with Individual 1." (*Id.* at 58-59.) The officer also reported that law enforcement was investigating Individual 1's alleged sexual assault of Child F. (*Id.* at 59.)

The next day, school personnel reported to SWI that Child F believed she was pregnant and reported "experiencing cramps and morning sickness and" that she "missed her period." (*Id.* at 59.) "Child F reported that she had sexual intercourse with Individual 1 multiple times over the past few months." (*Id.* at 59.) "Reportedly, Individual 1 brought Child F lunch at school and the two were observed hugging in his car." (*Id.* at 59.) No caregivers or staff members reported these incidents to SWI.

Following the two intakes, PI initiated a Priority One investigation of sexual abuse as to Individual 1 and neglect as to an unnamed staff member. (*Id.* at 59.) As to the sexual abuse allegation, PI assigned a disposition of "Other" because the investigator determined that Individual 1

did not meet the definition of direct provider, "as he was not providing any direct care to [the child] and was not working under the auspices of a volunteer or care provider while in [the child's] home."[272] (*Id.* at 59.) The Monitors note that law enforcement's criminal investigation into the sexual assault of Child F resulted in Individual 1 being charged and subsequently incarcerated. (*Id.* at 59.)

As to neglect, the investigator assigned a disposition of Unconfirmed; the Monitors disagreed—because of the "substantial investigative deficiencies" discussed below, they concluded that "a disposition of the neglect allegation cannot be determined." (*Id.* at 59.)

First, the investigative record shows that during his visits to the group home to see Staff 2,[273] Individual 1 "was able to meet and interact with Child F." (*Id.* at 59.) Another staff member, Staff 3, reported seeing Child F and Individual 1 "together on the back porch of the group

---

272. The Monitors reported that the investigator made this disposition despite confirming that Individual 1 was employed by two different agencies to work at HCS Group Homes, Daybreak and D&S Residential, at the time of the allegation. (*Id.* at 59 n.84.) Nonetheless, PI maintained that Individual 1 did not qualify as a direct provider for Child F. *See* 26 Tex. Admin. Code § 711.3(15) (defining a direct provider as "[a] person, employee, agent, contractor, or subcontractor of a service provider responsible for providing services to an individual receiving services.").

273. "Staff 2 reported to the investigator that . . . that she let [individual 1] come into the group home because he was reportedly suspicious of her cheating on him and she intimated that she was fearful of disallowing his visits because he was physically violent with her in her own home." (D.E. 1412 at 59 n.85.)

home and Staff 3 observed the child with her arms on Individual 1's shoulders." (*Id.* at 59.)

> The investigator did not adequately explore whether staff members permitting Individual 1 to visit the group home and their subsequent failure to immediately remove Individual 1 from the group home constituted Neglect. Furthermore, given that it was the central factor that led to the sexual assault of Child F by Individual 1, the investigator did not adequately explore or probe Educare's training, policies and procedures associated with allowing third parties into the home. The investigator instead noted it only as a concern and suggested future training for staff members about related protocol.

(*Id.* at 59.)

Second, the investigator "failed to adequately and timely investigate whether staff members appropriately supervised the child to prevent or address her elopements from the group home." (*Id.* at 59.) Specifically, though "the investigative record includes specific instances when" Child F ran from the group home "to meet with Individual 1," the investigator failed to adequately question staff or Child F "to determine whether staff members maintained appropriate supervision of" Child F in those "specific instances," or at "any other times." (*Id.* at 60.) Without this "key information regarding supervision, the investigator cannot render a finding for the allegation of Neglect." (*Id.*

at 60.)

Third, staff reported that there was inadequate training to care for Child F, that Child F was difficult to manage, that the group home was "inadequately staffed for increased supervision of" Child F, and that "the group home 'cannot keep staff' due to the long hours staff members are expected to work." (*Id.* at 60.) Yet "the investigator failed to consider whether Educare administrators failed to 'provide a safe environment for [the child], including the failure maintain adequate numbers of appropriately trained staff' and whether this failure contributed to the alleged harm and risk of harm to Child F."[274] (*Id.* at 60.)

Fourth, the investigator noted that Child F "did not have a Behavior Support Plan in place at the group home." (*Id.* at 60.) Yet, once again, as in other investigations containing allegations of potential neglect by administrators, the investigator failed to appropriately apply the applicable definition requiring consideration of administrative failures; the investigator "failed to consider whether administrators at Educare failed to 'establish or carry out an appropriate individual program plan or treatment plan' for the child and whether this failure contributed to the alleged harm and risk of harm to the alleged victim." (*Id.* at 60.)

The intake was received on September 30, 2021, and the investigation was not completed until January

274. *See* 26 Tex. Admin. Code § 711.719(b)(1), (3).

24, 2023, one year and three months later. (*Id.* at 60.) One extension was approved with a documented reason of "Law enforcement requests that an investigation be temporarily discontinued," but was not approved until thirty-four days after intake. (*Id.* at 60.) Thus, while the documented reason established good cause, the extension was untimely as per Remedial Order 10. (*See* D.E. 606 at 3 ¶ 10.) The Monitors note that "[l]aw enforcement permitted the investigation to resume in early March 2022," yet no further extensions were granted. (D.E. 1412 at 60.) Thus, even overlooking the untimeliness of the documented extension, the investigation failed to comply with Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegations of abuse and neglect were not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child F's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

iii. Investigation 3

On October 10, 2021, Staff 3 reported that between 11:00 a.m. and 12:00 p.m., Child F ran away from the group home twice to meet Individual 1. (D.E. 1412 at 60.) After the first runaway episode, "law enforcement located

Child F with Individual 1 in his vehicle." (*Id.* at 60-61.) "Due to these incidents, the group home placed Child F on one-to-one supervision." (*Id.* at 61.)

After intake, PI initiated a Priority Two neglect investigation of Child F by an unnamed staff member, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 61.) The Monitors disagreed; because of the "substantial investigative deficiencies" discussed below, they concluded that "a disposition of the Neglect allegation cannot be determined." (*Id.* at 61.)

The Monitors note that "PI investigators appear to have conducted" this and the prior investigation[275] together, so "the investigative flaws detailed for the [prior] investigation apply to this investigation." (*Id.* at 61.) The Monitors identified the following deficiencies specific to this investigation.

First:

> During interviews with staff members and the child, the investigator did not adequately explore staff members' supervision of the child on October 10, 2021 when she ran away twice to meet Individual 1. In her interview, the child stated that she exited the group home from her bedroom window when staff members were attending to other residents. The question of supervision is highly relevant

275. *Supra* page 596-98.

> to this investigation because these runaway incidents occurred after the group home administrators and staff members were clearly aware of Individual 1's involvement with, and alleged sexual assault of, the child.

(*Id.* at 61.)

Second, as noted above, the group home placed Child F on one-to-one supervision only after the two runaway incidents that led to this investigation. The investigator "should have explored whether the group home administration's failure to immediately increase the child's supervision level after they were informed of the criminal investigation involving Individual 1 and the child had disclosed sexual contact by Individual 1 in September 2021 constituted Neglect." (*Id.* at 61.)

The intake was received on October 10, 2021, and the investigation was not completed until January 24, 2023, one year and three months later. (*Id.* at 61.) One extension was approved thirty-three days after intake. (*Id.* at 61.) Further, the documented reason—"Extraordinary Circumstances"[276] (*id.* at 61)—does not establish "good cause" as required by Remedial Order 10 (*see* D.E. 606 at 3). Thus, the investigation failed to comply with Remedial Order 10. (*Id.* at 3 (requiring investigations to be

276. The Monitors attribute part of the delay—from October 2021 to March 2022—"to law enforcement's request that the above, related investigation be temporarily discontinued." (D.E. 1412 at 61.) The delay from April 2022 to January 2023 is unexplained, and no additional extension was granted. (*Id.* at 61.)

completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child F's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

iv. Investigation 4

On October 24, 2021, an Educare administrator reported that the on-duty staff member (Staff 1) left Child F and two adult residents unattended for an unknown duration of time. (D.E. 1442 at 11.) According to the reporter, Staff 1 administered medication before leaving the group home and the three residents did not have any injuries due to Staff 1's absence. (*Id.* at 11.) The administrator stated that one of the residents called the administrative number and notified an Educare case manager that they were alone. (*Id.* at 11.)

PI initiated a Priority Two neglect investigation related to Child F by Staff 1. (*Id.* at 11.) The Monitors concluded, for the following reasons, that "the investigator's assignment of a disposition of Inconclusive to the allegation was inappropriate," and that "allegation of Neglect should have been substantiated with a disposition of Confirmed."

(*Id.* at 11.)

First, Child F confirmed during her interview that "Staff 1 left the group home in the morning and did not return," leaving Child F and "two adult residents in the home alone." (*Id.* at 12.) She also confirmed "contact[ing] 911 and the Educare case manager" and recalled that either law enforcement or the case manager arrived "ten minutes after her phone call." (*Id.* at 12.)

Second, "[t]here is no evidence in the record that Staff 1 ever returned to the group home. Child F could have been left alone for a much longer period of time" had she "not called for help." (*Id.* at 12.)

Third, when the case manager was interviewed one year after intake, she corroborated Child F's account of the incident, including that she arrived at the home "ten minutes" after Child F called her. (*Id.* at 12.) The case manager also noted that "a staff member was required to be present to 'ensure [the residents] have someone meeting their needs and in case of an emergency.'" (*Id.* at 12.)

For these reasons, "the record contains a preponderance of evidence that Staff 1 left the group home premises during her shift, and thereby, left the children and two adult residents alone for approximately ten minutes, which placed the child at risk of physical or emotional injury or death." (*Id.* at 11.)

The intake was received on October 24, 2021, and the investigation was not completed until January 27,

2023, one year and three months later. (*Id.* at 12.) One documented extension was approved on November 23, 2021, with the documented reason of "Additional time is required to complete this investigation due to unusually high caseloads and an increase in PI staff vacancies." (*Id.* at 12.) This reason is similar to one of the reasons for an extension request that constitutes good cause in the then-current version of the PI Handbook. (*See* DX 39 at 161 (providing that "excessive workload due to PI employee vacancies or an uncommon rise in intakes" qualifies as good cause for an extension).) But because hiring and retention of investigators, and thus, caseloads, are largely within PI's control, the Court is not convinced that "unusually high caseloads" and "staff vacancies" constitute good cause for an extension under Remedial Order 10. Regardless, the investigation remained pending for over a year after the extension was approved without further documented extensions. (D.E. 1442 at 12.) Because indefinite extensions are not consistent with Remedial Order 10,[277] this investigation failed to comply with Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child F's "safety needs." (*Id.* at

277. *See supra* page 555-56.

2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

Four days after this incident was called into SWI, DFPS removed Child F from Educare "due to concerns with the placement and services not received in the home." (D.E. 1412 at 61.)

v. Investigation 5

On February 7, 2023, a case manager reported an allegation of neglect of Child F, who was now placed at an HCS Group Home run by Ability Options, LLC. (*Id.* at 62.) The reporter stated that Ability Options staff members had "failed to secure medical care for Child F when she had a urinary tract infection (UTI)." (*Id.* at 62.) The reporter stated that both Child F and her caseworker requested that a staff member take Child F to the doctor because she was experiencing "pain when using the bathroom." (*Id.* at 62.) Because no one at Ability Options did so, the caseworker took the child to the doctor and she was prescribed medication for a UTI. (*Id.* at 62.) But "no one at the placement provided the child with the prescribed medication needed to treat the UTI following the doctor appointment." (*Id.* at 62.) This incident was not reported to SWI by any caregiver or staff member at the group homr.

PI initiated a Priority Two neglect investigation of Child F by a named and unnamed staff member,

to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 62.) The Monitors disagreed; due to "substantial investigative deficiencies," they concluded that the "disposition of the Neglect allegation cannot be determined." (*Id.* at 62.)

The Monitors based this conclusion on the fact that the investigator failed to resolve a discrepancy that emerged during the investigation:

> During interviews, staff members and a different caseworker reported to the investigator that, [contrary to the reports of Child F and her caseworker, which were consistent with the case manager's report to SWI], someone at the placement secured a medical appointment for the child in a timely manner three months prior and during the appointment, the child received a urinalysis and a birth control shot. Prior to entering a disposition of Unconfirmed, the investigator did not resolve the discrepancy of whether anyone at the home secured the child a medical appointment. While the investigator requested that the placement provide the child's medical records, it appears the placement did not comply with this request as the investigative record does not confirm it. There is no evidence that the child received medical care at the time she requested it.

(*Id.* at 62.)[278]

Because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated . . . consistent with the Court's Order; [or] conducted taking into account at all times" Child F's "safety needs." (D.E. 606 at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3.

* * *

PI opened five investigations into allegations of abuse and neglect of Child F, with the longest investigation remaining open for nineteen months before completion. (*See* D.E. 1412 at 57-62, D.E. 1442 at 11-12.) Four investigations had documented extensions but were not completed within the extended time frame. (D.E. 1412 at 57-62.) Additionally, two allegations were reported by non-caregivers: one by law enforcement and one by a case manager. (*Id.* at 57-62.)

e. Child L

Child L is a fourteen-year-old PMC child with an IQ of 61. (D.E. 1442 at 15.) "SWI received three intakes alleging physical and emotional abuse of Child L while he was placed at Forever Home Living Center, Inc., an HCS Group Home. (*Id.* at 15.)

278. By the time the Monitors reviewed this investigation, Child F had aged out of foster care. (D.E. 1412 at 62 n.86.) Thus, the Monitors could not access Star Health Passport to review her medical appointments while in foster care. (*Id.* at 62 n.86.)

"In the first intake, on January 13, 2023, a former adult client of the HCS Group Home reported that the day before the intake, a staff member hit the child on the back of the head with her fist and on his back. The intake report did not specify how the child was allegedly hit on the back. The child reportedly has a 'scratch on [his] back that is a scar.'" (*Id.* at 15.)

"On January 18, 2023 and on January 26, 2023, a mental health professional from the Office of Ombudsman for Behavioral Health and an HHSC staff member reported similar allegations as contained in the first intake." (*Id.* at 15-16.) They also reported that "a staff member hit" Child L "with a dustpan, which caused a scar on the child's back," and that "the same staff member hit the child with her hand and a broom stick" during a separate incident. (*Id.* at 16.) Child L "reportedly stated that 'he is scared and doesn't want to live in the group home.'" (*Id.* at 16.)

PI initiated a Priority Two physical abuse and emotional abuse investigation related to Child L by Staff 1 (*Id.* at 16.) The investigator assigned a disposition of Unconfirmed as to the physical abuse allegation. (*Id.* at 16.) The Monitors disagreed; due to the "substantial investigative deficiencies" discussed below, "a disposition regarding the Physical Abuse allegation cannot be determined."[279] (*Id.* at 16.)

Despite the alleged physical injury to Child L, the investigator failed to conduct a face-to-face interview with the child, in violation of Remedial Order 8. (*Id.* at 16.;

279. The Monitors agreed with the disposition of Unconfirmed assigned to the emotional abuse allegation. (D.E. 1442 at 16.)

see D.E. 606 at 3.) "Instead, the investigator conducted two telephone interviews" with Child L and "requested a staff member (Staff 2) . . . electronically send photos of the child's back, face, and body to the investigator."[280] (D.E. 1442 at 16.) "Because the photographs were reportedly taken and sent by Staff 2 and not by the investigator, the credibility of the photographs is questionable and do not replace the investigator's observation of the child." (*Id.* at 16.) Besides, the photographs were too poor in quality to be useful. (*Id.* at 16 ("Staff 2's photograph of the child's back (the location of the child's alleged injury) lacked adequate light and clarity for the investigator to determine whether the child had an injury on his back.").) During both his telephone interviews, Child L "remained consistent in his allegation that Staff 1 hit him once with a dustpan in the garage and hit him with a closed fist" because he was "'acting up' one night." (*Id.* at 16.)

Defendant objected to the Monitors' assessment that, during his telephone interviews, Child L "remained consistent in his allegation that Staff 1 hit him once with a dustpan in the garage and hit him with a closed fist in response to the child 'acting up' one night." (D.E. 1460 at 3 (quoting D.E. 1442 at 16.).) Specifically, "Defendant[] respectfully disagree[d] with the Monitors' view that the child's testimony remained consistent. The child's

280. The PI Handbook states that investigators should take photographs when helpful to the investigation as they "provide an accurate, objective representation of the existence or absence of injuries." (PX 7 at 123.) But the Handbook does not state that a photograph can be used as a substitute for observing the child in person.

testimony contained contradictory statements, including denying and affirming the allegations." (*Id.* at 3.)

In response, the Monitors noted:

> The key elements of Child L's interview described by the Monitors were consistent: namely that the child said a named staff member hit him with a dustpan and a closed fist. Other parts of Child L's statement appear inconsistent based on the PI investigator's notes, but because PI does not record victim interviews, it is not possible for the Monitors to confirm whether those inconsistencies were due to inadequate note taking by the investigator or caused by PI's decision to conduct the interview with a child (with an IQ of 61) by phone and without any documented effort to accommodate the child's intellectual and developmental disabilities.

(D.E. 1461 at 4.) Further, they reiterated concerns about PI investigations raised in their September 19, 2023 filing:

> Often the deficiencies identified by the Monitors began at the start of the investigations during the expected assessment of the alleged victim's current safety and recounting of the allegations; these problems included a failure to promptly interview children face-to-face and, in some instances, a failure to conduct interviews with children at all, despite the Court's orders. PI

> frequently failed to conduct the investigations in a manner that appropriately accommodated and considered the limited capacities, verbal or otherwise, among this population of PMC children. Due to the children's documented developmental challenges and accompanying eligibility for HCS services, it is unclear why PI investigators were so consistently ill-equipped to accommodate or consider them during investigations into allegations about the children.

(*Id.* at 4 (footnotes omitted).) The Monitors also noted that, in one of their earlier reports,[281] they "uncovered significant discrepancies between the information conveyed to State investigators by alleged child victims, collateral children or staff, or witnesses (including members of the monitoring team) and the summaries of these interviews found in IMPACT contact notes. In some cases, the misinformation included in the contact notes appears to have informed the disposition of the case." (*Id.* at 5 (footnote omitted).) The Monitors concluded their response to the objection by pointing out that "PI's failure to accommodate the special needs of PMC children who receive HCS services may contribute to reported inconsistencies in children's accounts, and PI's failure to record their interviews makes it impossible to assess the extent to which that occurs." (*Id.* at 5.)

---

281. Specifically, their Update to the Court Regarding Site Visits Conducted between December 1, 2021, and December 31, 2022, and the Reopening of The Refuge for DMST. (D.E. 1337.)

Because of the above-described investigative deficiencies, it is apparent that the allegation of physical abuse was not "investigated; [or] commenced . . . on time consistent with the Court's Order; [or] conducted taking into account at all times" Child L's "safety needs." (D.E. 606 at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3.

f. Child N

Child N is a sixteen-year-old PMC child with an IQ of 40, placed at Able Living, an HCS Group Home. (D.E. 1442 at 17.) On February 16, 2023, "school personnel reported that" Child N "was hungry, 'really sleepy,' and 'slept the whole day in school' because the child stated that staff members at Able Living . . . did not feed her as punishment for 'being bad in school.'" (*Id.* at 17-18.) Child N also told the reporter "that she could not sleep during the night because she was hungry." (*Id.* at 18.) No staff members or caregivers from the group home reported to SWI.

Following intake, PI initiated a Priority Two Physical Neglect investigation related to the child by an unknown staff member, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 18.) The Monitors disagreed; due to the "substantial investigative deficiencies" described below, they concluded that "a disposition regarding the Neglect allegation cannot be determined." (*Id.* at 18.)

First, the investigator failed to establish face-to-face contact with Child N (*id.* at 18), in violation of Remedial

Order 8 (*see* D.E. 606 at 3). Further, the investigator "did not document any efforts to conduct a face-to-face interview with the child." (D.E. 1442 at 18 n.28.) In lieu of a face-to-face interview, the investigator interviewed Child N "on the telephone one month after the intake, on the same date the investigation was completed." (*Id.* at 18.)

Second, while the investigator "documented that the child denied the allegations during the delayed phone interview," the investigator failed to "document whether she interviewed the child in English or Spanish." (*Id.* at 18.) This is significant because Child N's record indicates that while she "speaks and understands Spanish," "her English-speaking skills are limited." (*Id.* at 18.)

Third, the investigator "also failed to timely interview the alleged perpetrator, collateral staff members, and collateral individuals in the group home; the earliest phone interview in the investigation took place three weeks after the intake." (*Id.* at 18.) "Due to these deficiencies, the investigator did not gather adequate information to render a disposition of Unconfirmed for the allegation of Physical Neglect." (*Id.* at 18.)

Because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated; [or] commenced . . . on time consistent with the Court's Order; [or] conducted taking into account at all times" Child N's "safety needs." (D.E. 606 at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3.

g. Child O

Appendix B

Child O, a seventeen-year-old PMC child with an IQ of 51, was placed at Forever Home Living Center, Inc., an HCS Group Home. (D.E. 1442 at 18.) "Child O aged out of DFPS care while incarcerated in a county jail." (*Id.* at 19.)

Between March 5 and March 17, 2023, SWI received five intakes with allegations of neglect of Child O and another child, Child P (age 13, not in DFPS care), that resulted in sexual contact between the children. (*Id.* at 18.) The reporters—a staff member, a law enforcement officer, a nurse, a DFPS caseworker, and a worker at the local Children's Advocacy Center (CAC)—"similarly alleged that Child O sexually assaulted Child P." (*Id.* at 18.) "The reporters stated that staff members took Child P to the hospital for a SANE examination," which revealed that Child P sustained "'abrasions to his anal region' and contusions on his anal fold and rectal area." (*Id.* at 18-19.) Further, "Child P stated that on the date of the incident staff members were watching the children 'for a while' and that the children were able to go to the bathroom together without a staff member present." (*Id.* at 19.) The reporters also stated that Child O was arrested for aggravated sexual assault and was incarcerated. (*Id.* at 19.)

PI initiated a Priority One investigation of neglect by Staff 1, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 19.) The Monitors disagreed; due to the "substantial investigative deficiencies" discussed below, "a disposition regarding the Neglect allegation cannot be determined." (*Id.* at 19.)

First, "the investigator failed to determine whether

Staff 1 appropriately supervised the children prior to the sexual assault." (*Id.* at 19.) "According to documentation gathered by the investigator, both children required 24-hour supervision and routine room checks at night when asleep." (*Id.* at 19.) Yet the investigator failed "to gather critical information from" Staff 1 "about her supervision at the time of the incident." (*Id.* at 19.) For example, the investigator "failed to determine" whether Staff 1 "adhered to the children's supervision requirements." (*Id.* at 19.) The investigator likewise failed to establish "how Child O entered the bathroom . . . where Child P was already located, undetected by the staff member and why the staff member was unaware that the children were alone in the bathroom together when the assault occurred." (*Id.* at 19.) These investigative failures were "particularly problematic because the children were unable to provide a detailed account of the night." (*Id.* at 19.)

Second, the incident occurred on Staff 1's first night caring for the children. (*Id.* at 19.) Yet the investigator "did not consider whether the facility administrators provided her with adequate training and support to care for the children alone on her first night, particularly in light of the children's significant behavioral health needs and an incident that led to a sexual assault and arrest." (*Id.* at 19.)

Because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated . . . consistent with the Court's Order; [or] conducted taking into account at all times" Child O's "safety needs." (D.E. 606 at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated

Remedial Order 3.

h. Child H

Child H, a fifteen-to sixteen-year-old PMC child with an IQ of 40, was placed at an HCS group home operated by Educare. (D.E. 1442 at 12.)

i. Investigation 1

SWI received three intakes alleging sexual abuse of Child H when he was fifteen years old. (*Id.* at 12.) On May 17, 2022, "school personnel reported that Child H made an outcry that a staff member (Staff 1) had sex with him." (*Id.* at 12.) "According to the reporter, Staff 1 allegedly sexually abused the child more than once in Staff 1's bedroom and that she wore a condom." (*Id.* at 12-13.) On May 18, 2022, a law enforcement officer reported that Child H "disclosed the same allegations regarding Staff 1 and also disclosed that he had sexual contact with his special education aide at school." (*Id.* at 13.) That same day, a Sexual Assault Nurse Examiner (SANE) reported that Child H "used diagrams to show where he and Staff 1 touched one another, and that the child stated that having sex meant 'when you hump someone.'" (*Id.* at 13.) The Sexual Assault Nurse Examiner also reported that Child H "made an outcry that his special education aide touched him on the penis." (*Id.* at 13.) None of these reports were made by caregivers or staff members of the group home.

PI initiated a Priority One sexual abuse investigation

related to Child H by Staff 1, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 13.) The Monitors disagreed; due to the "substantial investigative deficiencies" described below, "a disposition regarding the Sexual Abuse allegation cannot be determined." (*Id.* at 13.)

In particular, many of the interviews were delayed until many months after the investigation commenced. The Monitors explain that "[t]he investigator did not attempt to interview the residents who lived at the placement at the time of the alleged incident(s) until nearly nine months after the intake," and that the delay "may have impeded the quality of information the investigator was able to gather from these individuals about the allegation." (*Id.* at 13.) Likewise, the investigator "did not attempt to interview school personnel and law enforcement until two months after the intake," and did not obtain responses from these individuals until eight months after the intake. (*Id.* at 13.) These investigative delays were especially significant here because Child H "confirmed the allegation of Sexual Abuse" during his interview with the investigator, "but did not confirm the allegation in subsequent interviews with law enforcement." (*Id.* at 13.) Indeed, the Monitors note that because of the "significantly delayed interviews with key individuals, the fact-finding process of this investigation was impaired and resulted in a deficient investigation." (*Id.* at 13.)

Moreover, the investigation was not completed timely. The intake was received on May 17, 2022, and the investigation was not completed until nine months later. (*Id.* at 13.) One extension was approved, on June

16, 2022, but the documented reason—"Extraordinary Circumstances" (*id.* at 13)—failed to establish "good cause" as required by Remedial Order 10 (*see* D.E. 606 at 3). Further, the investigation remained pending for eight months after the extension was approved without further documented extensions. (D.E. 1442 at 12.) And indefinite extensions are not consistent with Remedial Order 10. For these reasons, this investigation failed to comply with Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, the sexual abuse allegation was not "investigated; . . . completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child H's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

ii. Investigation 2

On October 19, 2022, school personnel reported several allegations of neglect related to Child H. First, the reporter explained that "[f]or the first two months of school, the Educare HCS Group Home did not pick up the child from school on time. Staff members from the home reportedly did not arrive at the school until approximately 5:30 p.m., despite the school allegedly conducting several face-to-face conversations with staff members regarding an appropriate pick-up time for the child." (D.E. 1412 at

63.) Second, on "Saturday, October 15, 2022, a school paraprofessional observed" Child H "running alone along a roadside. After stopping the child, the school personnel observed that the child was wearing a diaper that was 'saturated,' had no shoes on, and 'seemed lost.'" (*Id.* at 63.) Third, "[f]or the month preceding the report," Child H "had been 'extremely' tired in school." (*Id.* at 63.) When asked about his fatigue, Child H explained "that his 'mother has been giving him melatonin in the mornings.'" (*Id.* at 63.) Finally, the reporter explained that Child H "arrived at school appearing unbathed" and that he was "'constantly hungry and begging for food' from teachers and classmates." (*Id.* at 63.)

The following day, "a DFPS staff member reported similar allegations of Neglect" as to Child H. (*Id.* at 63.) The staff member added some new information:

- The name of the Educare staff member who was administering the melatonin. (*Id.* at 63.)

- That melatonin was "not on the child's list of prescribed medications." (*Id.* at 63.)

- That Child H "ran away from the placement" on October 15, the day the paraprofessional found him running along a roadside. (*Id.* at 63.)

The DFPS staff member also "stated that the child is 'low functioning' and should not have been on a busy street alone," "alleged that staff members at the home were not aware that the child had eloped for at least 35 minutes,"

and expressed concern that Child H "could have been seriously injured while unsupervised." (*Id.* at 63.)

Following the two intakes, PI initiated a Priority Two "Neglect investigation of the child by two named staff members," to which the investigator assigned a disposition of Unconfirmed (*Id.* at 63.) The Monitors disagreed; due to the "substantial investigative deficiencies" described below, the Monitors concluded that "a disposition of the Neglect allegation cannot be determined." (*Id.* at 63.)

First, the investigator "did not attempt to reconcile conflicting descriptions" of Child H's elopement. (*Id.* at 63.) Specifically, Child H reported during his interview that the staff member named as the alleged perpetrator "was asleep at the time of the elopement." (*Id.* at 64.) The alleged perpetrator, on the other hand, "reported that she was in a separate room attending to the hygiene needs of two other individuals living in the home." (*Id.* at 64.) Yet the investigator "did not attempt to interview the other two individuals who may have been able to resolve this discrepancy." (*Id.* at 64.)

Second, the investigator failed to determine "the duration of time" between Child H's elopement and the alleged perpetrator's discovery that Child H had eloped. (*Id.* at 64.)

> In the second intake report, the [DFPS staff member] alleged that the [alleged perpetrator] was unaware the child ran away for at least 35 minutes; however, delayed interviews with the

> on-duty staff member and an assisting staff manager suggest that they responded timely to the elopement. The investigator did not attempt to corroborate the staff members' accounts during interviews with school personnel. The investigator also did not attempt to interview the responding law enforcement officer who may have been able to provide information on the timeframe and whether the child was observed in a "saturated" diaper.

(*Id.* at 64.)

Third, as to the allegations regarding the provision of unprescribed melatonin, the investigator again did not attempt to resolve conflicting accounts. During his interview, Child H "confirmed his allegation and stated that a named staff member provided him with melatonin." (*Id.* at 64.) The staff member "denied the allegation." (*Id.* at 64.) Again, the investigator "did not interview any other residents to obtain information regarding whether a staff member provided the child or other residents melatonin." (*Id.* at 64.) Further, the investigative record shows that Child H "was prescribed multiple medications" that listed "drowsiness" as a side effect, yet the investigator "did not attempt to interview" his nurse or prescribing physician to determine if his prescribed medications could have caused his drowsiness in school. (*Id.* at 64.)

"Due to these lapses in investigative practice, the investigator did not gather sufficient information to assign a disposition for the allegation of Neglect." (*Id.* at 64.)

Further, the investigation was not completed in accordance with Remedial Order 10. The intake was received on October 19, 2022, and the investigation was not completed until three months later. (*Id.* at 64-65.) One extension was approved, on November 18, 2022, but the documented reason—"Need to interview AP and potential collateral witnesses" (*id.* at 64)—does not establish "good cause" as required by Remedial Order 10 (*see* D.E. 606 at 3).[282] Further, the investigation remained pending for over two months after the extension was approved without further documented extensions (D.E. 1412 at 65 (investigation completed on January 27, 2023)), and indefinite extensions are not consistent with Remedial Order 10. For these reasons, this investigation failed to comply with Remedial Order 10. (D.E. 606 at 3 (requiring investigations to be completed "within 30 days of intake, unless an extension has been approved for good cause and documented in the investigative record").)

And because of the above-described investigative deficiencies, the allegation of neglect was not "investigated; . . . completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child H's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

---

282. Nor is this consistent with the "reasons [that] constitute good cause" enumerated in the then-current version of the PI Handbook. (*See* DX 40 at 164-65.)

i. Child I

Child I is a sixteen-year-old PMC child with an IQ of 60. (D.E 1442 at 14.) She was placed at Brenham State-Supported Living Center when the following allegations were reported. (*Id.* at 14.)

On June 17, 2022, a counselor at Brenham reported "that a staff member (Staff 1) witnessed another staff member (Staff 2) asleep while caring for" Child I. (*Id.* at 14.) "At the time of the alleged incident," Child I "was subject to one-to-one supervision due to a history of eloping and suicidal behavior; the child was also reported to have an intellectual disability and 'psychiatric issues.'" (*Id.* at 14.) "The reporter stated that Staff 1 woke up Staff 2 and that the child was not injured during the incident." (*Id.* at 14.) This incident was not reported by any caregivers or staff members.

Following intake, PI initiated a Priority Two Neglect investigation of Child I by two staff members, to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 14.) The Monitors disagreed; because of the "substantial investigative deficiencies" described below, the Monitors concluded that "a disposition regarding the Neglect allegation cannot be determined." (*Id.* at 14.)

First, the Monitors note that after conducting a timely face-to-face interview with Child I,[283] "the investigator did

283. Child I "confirmed that she was sleeping at the time of the alleged incident and was not harmed." (D.E. 1442 at 14.)

not pursue any investigative activity for three months" (*id.* at 14); only after this delay did the investigator interview the reporter or the alleged perpetrators. (*Id.* at 14.) Second, the investigator failed to resolve inconsistencies that surfaced during the interviews. During her interview, the reporter "clarified that she observed two staff members sleeping and that the child was subject to two-to-one supervision at the time of the incident." (*Id.* at 14.) The investigator subsequently interviewed both alleged perpetrators, who "denied the allegation that they were asleep and provided additional information about the allegation." (*Id.* at 14.) "Based on this additional information, the investigator should have re-interviewed the reporter to reconcile the conflicting accounts of the alleged incident. Due to the above-described deficiencies, a disposition on the allegation of Neglect cannot be rendered." (*Id.* at 14.)

The intake was received on June 17, 2022, and the investigation was completed four months later on October 21. (*Id.* at 14.) "Thirteen extensions were approved approximately every ten days between June 27, 2022 and October 16, 2022 with documented reasons that included 'Further interviews need to be completed,' 'Witnesses have not been available for interviews,' and other similar reasons."[284] (*Id.* at 14.) The Court notes that "further interviews need to be completed" is not good cause for an extension, even under PI's then-controlling extension

284. Since Child I was placed in a State Supported Living Center, the maximum extension length permitted under Provider Investigations' policy was ten days. (*See* DX 39 at 160; DX 40 at 164.)

policy. (*See* DX 39 at 161 (listing the "reasons [that] constitute good cause"); DX 40 at 164 (same).) Likewise, the fact that interviews need to be completed does not, by itself, establish "good cause" for an extension under Remedial Order 10. (D.E. 606 at 3.)

As for the second documented reason, that witnesses "have not been available for interviews," under the circumstances of this investigation it is pretextual. As noted two paragraphs prior, the investigator "did not pursue any investigative activity" for the three months following the timely face-to-face interview with Child I. Thus, the investigative record indicates that the investigator did not attempt, during that three-month period, to verify whether the witnesses were available.[285] Since the investigator had no apparent basis on which to assert that witnesses were not available to interview, it

285. The Court notes that, per the Monitors' report, unsuccessful interview attempts are documented in the investigative record. (*See, e.g.*, D.E. 1412 at 25 (recounting investigator's attempts to interview Child A); *id.* at 42 ("The investigator was unable to locate Staff 4 for an interview and at the time he attempted to do so 16 months after the investigation began, according to C3, he was no longer employed there."); *id.* at 44 n.69 ("The investigator made a first attempt to interview Child C three days after the receipt of the intake . . . however, the child was no longer present at that location when the investigator arrived."); *id.* at 49 ("Nine months after Child C's interview and when Child C was no longer placed at the group home, the investigator first attempted to contact Staff 5. At that point, Staff 5 reportedly no longer worked at C3 Academy and did not respond to the investigator's late attempt for an interview."); *id.* at 49 n.74 ("The investigator attempted a timely face-to-face interview with Child C. . . .").)

does not establish "good cause" for an extension under Remedial Order 10. (*Id.* at 3.)

In sum, the investigation was not completed within thirty days, and at least some of the extensions were not approved for "good cause." (*See* D.E. 606 at 3 ¶ 10 (requiring that "If an investigation has been extended more than once, all extensions for good cause must be documented in the investigative record").) Accordingly, the investigation violated Remedial Order 10. (*Id.* at 3 ¶ 10)

And because of the above-described investigative deficiencies, the allegation of neglect was not "investigated; . . . completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child I's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

j. Child K

Child K is a seventeen-year-old PMC child with an IQ of 61 placed at D&S Community Services, an HCS Group Home. (D.E. 1442 at 14-15.) Child K's records indicate she "is unable to grasp simple conversations" and needs to have conversations "repeated to [her] in the most basic verbiage, to ensure [she] is able to understand and follow along." (*Id.* at 15.)

On December 28, 2022, a D&S Community Services staff reported an outcry by Child K that "an adult resident (Individual 1, age 23) 'grabbed'" Child K's "breast over

her clothing when the child attempted to block Individual 1 from leaving the group home. The reporter stated that staff members in the home did not witness the contact." (*Id.* at 15.)

Following intake, PI opened a Priority Two investigation of Neglect of Child K "by a staff member," to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 15.) The Monitors disagreed; because of the "substantial investigative deficiencies" described below, "a disposition regarding the Neglect allegation cannot be determined." (*Id.* at 15.)

In particular, the investigator failed to adequately interview Child K. First, the investigator "failed to conduct a face-to-face interview" with Child K. The child's record indicates that she has difficulty with verbal communication—specifically, "she 'is unable to grasp simple conversations' and 'things must be repeated to [her] in the most basic verbiage, to ensure [she] is able to understand and follow along.'" (*Id.* at 15 (brackets retained).) Yet the investigator not only interviewed Child K via telephone, but did so without any documented "efforts to accommodate the child's limited communication needs." (*Id.* at 15.) The Monitors also note that the lack of an in-person interview "prevented the investigator from observing the child and assessing her safety at the HCS Group Home." (*Id.* at 15.)

The intake was received on December 28, 2022. (*Id.* at 15.) An extension was approved on January 27, 2023, but the investigation was not completed until thirty-one days

later. (*Id.* at 15.) Thus, the investigation was not completed timely under Remedial Order 10. (*See* D.E. 606 at 3.)

And because of the above-described investigative deficiencies, the allegation of neglect was not "investigated; commenced and completed on time consistent with the Court's Order; [or] conducted taking into account at all times" Child K's "safety needs." (*Id.* at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3 and Remedial Order 10.

k. Child J

Child J is a seventeen-year-old PMC child with an IQ of 57 placed at Meridian Living Center, Inc., an HCS Group Home. (D.E. 1412 at 65.) "On April 3, 2023, a DFPS staff member reported that" Child J "was located by law enforcement in a Target store. The officer believed the child was experiencing homelessness." (*Id.* at 65.) When the staff member discovered that Child J was missing, the staff member "called 911 and gathered the other residents into a car to search for the child." (*Id.* at 66.) But he did not report Child J's elopement to SWI.

Following intake, PI opened a Priority Two investigation of Neglect of Child J "by a staff member," to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 66.) The Monitors disagreed; because of the "substantial investigative deficiencies" described below, "a disposition regarding the Neglect allegation cannot be determined." (*Id.* at 66.)

First, the investigator's interview of Child J was inadequate. "The investigator documented that the child 'presented with limited verbal ability' and his language was 'difficult to understand.'" (*Id.* at 66.) Yet the "investigator did not appear to contact the HCS Group Home or the child's caseworker prior to the interview to identify whether the child had speech and/or intellectual limitations that may require accommodation." (*Id.* at 66.) And the investigator "did not document efforts to accommodate the child's limited speech and comprehension during" the interview. (*Id.* at 66.) As a result, "the investigator did not appear to gather any information from the child related to the allegation or to the child's safety at the placement." (*Id.* at 66.)

Second, the investigator's interview with the alleged perpetrator was similarly inadequate. "According to the staff member, at the time the child eloped, the staff member was grooming and bathing another resident. When the staff member completed this task, he could not locate the child in the home." (*Id.* at 66.) Yet the investigator failed to "adequately probe whether the staff member adequately supervised the child prior to the child eloping; for example, the investigator did not determine the child's proximity to the staff member." (*Id.* at 66.)

Third, the investigator failed to consider whether Meridian had sufficient capacity to meet Child J's "supervisory needs to ensure his safety." (*Id.* at 66.) Child J's "records documented that he has a history of 'high risk behaviors,' including frequently running away from placements and that, as a result, the child must

be monitored 'at all times.'" (*Id.* at 66.) And it "d[id] not appear that one staff member would have been able to prevent" Child J's elopement "or other similar instances under the current staffing capacity in use at Meridian." (*Id.* at 66.) Yet "the investigator did not discuss or further explore whether the allegations were due to a failure by Meridian to 'provide a safe environment for [the child], including the failure to maintain adequate numbers of appropriately trained staff' that resulted in or created risk of physical or emotional injury or death for this child." (*Id.* at 66 (citing 26 Tex. Admin. Code § 711.719(b)(3)).) Instead, the investigator merely "documented that 'It is recommended that [the child's] level of supervision be re-evaluated.'" (*Id.* at 66.)

Because of the above-described investigative deficiencies, it is apparent that the allegation of neglect was not "investigated . . . consistent with the Court's Order; [or] conducted taking into account at all times" Child J's "safety needs." (D.E. 606 at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3.

l. Child M

Child M is a seventeen-year-old PMC child with an IQ of 57 placed at Forever Home Living Center, Inc., an HCS Group Home. (D.E. 1442 at 16.) "On March 14, 2023, a staff member reported that" Child M made an outcry "that a different staff member (Staff 1) 'attacked' her and 'hit her all over her body and face with metal kitchenware' on the weekend prior to the intake report," though the reporter

"did not observe any visible injuries on the child." (*Id.* at 16.) Per the reporter, Child M further "stated that Staff 1 did not allow her to call her caseworker nor her CASA worker when she asked to do so. Lastly, the child also stated that there was not enough food in the home. The reporter observed that the child appeared to be healthy." (*Id.* at 16-17.)

Following intake, PI opened a Priority Two investigation of Physical Abuse of Child M "by Staff 1," to which the investigator assigned a disposition of Unconfirmed. (*Id.* at 17.) The Monitors disagreed; because of the "substantial investigative deficiencies" described below, "a disposition regarding the Physical Abuse allegation cannot be determined." (*Id.* at 17.)

Specifically, the investigator failed to adequately interview Child M. First, the investigator failed to establish face-to-face contact with Child M (*id.* at 17), in violation of Remedial order 8 (D.E. 606 at 3). The investigator "attempted a timely face-to-face interview with the child at the placement," but Child M "was unavailable at that time," and the investigator made no further attempts at establishing face-to-face contact." (D.E. 1442 at 17 n.26.)

Second, Child M's record states that "she is deaf or hard of hearing, has a 'minor speech issue,' and 'needs to work more on her communication to make sure trusted adults know when she is confused.'" (*Id.* at 17.) Nonetheless, the investigator chose to interview Child M via telephone. (*Id.* at 17.) And despite Child M's "hearing

and communication disabilities, the investigator did not document any attempt to accommodate the child's special needs during the phone interview." (*Id.* at 17.) Thus, although Child M "denied her outcry during the phone interview with the investigator, an interview by phone was not a reliable method . . . and did not allow the investigator to confirm whether or not the child was injured and safe at the group home." (*Id.* at 17.)

Because of the above-described investigative deficiencies, it is apparent that the allegation of physical abuse was not "investigated[or] commenced . . . consistent with the Court's Order; [or] conducted taking into account at all times" Child M's "safety needs." (D.E. 606 at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3.

m. Child Q

Child Q is a sixteen-year-old PMC child with an IQ of 59 and a "diagnosed . . . intellectual disability," placed at Meridian Living Center, Inc., an HCS Group Home. (D.E. 1442 at 20.) "On March 20, 2023, the Program Director at Meridian . . . reported an allegation of Sexual Abuse of" Child Q. (*Id.* at 20.) "According to the reporter, the child stated that a staff member (Staff 1) at the group home 'took her to a strip club' to have sex with an unknown male (Individual 1, age unknown)." (*Id.* at 20.)

Following intake, PI opened a Priority One investigation of Sexual Abuse of Child Q "by Staff

1,"[286] to which the investigator assigned a disposition of Inconclusive. (*Id.* at 20.) The Monitors disagreed; because of the "substantial investigative deficiencies" described below, "a disposition regarding the Sexual Abuse allegation cannot be determined." (*Id.* at 20.)

Though the investigator's face-to-face interview with Child Q did not support the specific allegation in the intake report, "the investigation surfaced a new allegation made by collateral staff members that Staff 1 transported the child and another child (age 12, not in DFPS care) to her apartment during her shift and while at the apartment," Child Q "had sex with a male (Individual 2, name and age unknown)." (*Id.* at 20.) "Allegedly, the child disclosed this information to the collateral staff members; however, during her interview with the investigator, the child denied the allegation that she engaged in sexual activity with anyone. During her interview, Staff 1 confirmed that she transported the children to her apartment, but she denied that the child engaged in sex with anyone." (*Id.* at 20.)

"Regarding this new allegation that surfaced during the investigation, the investigator failed to establish whether Staff 1 transporting the child to her apartment exposed the child to a risk of harm. The investigator also

---

286. "The Administrative Code definition of Sexual Abuse includes when an alleged perpetrator requests, solicits, or compels an individual receiving services to engage in sexual contact. As such, PI assigned the staff member as the alleged perpetrator to the allegation of Sexual Abuse." (D.E. 1442 at 20 n.30 (citing 26 Tex. Admin. Code § 711.13).)

failed to gather a timeline or factual understanding of the visit to the apartment to attempt to assess the veracity of the child's initial allegation that she engaged in sexual activity at the apartment. In addition, the investigator did not attempt to identify and interview Individual 2. Finally, the investigator did not attempt to interview the child's therapist nor caseworker; these individuals may have provided insight regarding the child's initial disclosure of Sexual Abuse and subsequent denial." (*Id.* at 20-21.)

Because of the above-described investigative deficiencies, it is apparent that the allegation of sexual abuse was not "investigated . . . consistent with the Court's Order; [or] conducted taking into account at all times" Child Q's "safety needs." (D.E. 606 at 2 ¶ 3.) Accordingly, this investigation was conducted in a manner that violated Remedial Order 3.

* * *

As the foregoing examples demonstrate, PI investigations frequently were beset by "lengthy and severe unexplained delays in investigations' completion that impacted child safety, including in Priority One investigations." (D.E. 1412 at 7.) The Monitors observed that "very few [investigations] were completed in 30 days and many had egregious delays, remaining open without activity for extended periods even in situations where the child was an alleged victim in newer additional serious allegations at the same placement." (*Id.* at 7.) Further, the "lack of management, diligence and coordination across many PI investigations fails to prioritize child

safety and creates or exacerbates serious risk of harm for PMC children." (*Id.* at 8.) In other words, because PI failed to "do[] a better job for these children with the resources [it] had at hand" (D.E. 1487 at 133:14-15), some of the most vulnerable PMC children languished in unsafe placements as PI bungled investigation after investigation. Or, in Defendant's words: "The Monitors' report [referring to D.E. 1412] recounts many heartbreaking stories. There's no excuse for what many of these children went through." (D.E. 1418 at 3.) Later, Defendant developed some objections.

3. The leadership of HHSC's PI unit lacks basic knowledge of the unit

The first witness to testify at the Contempt Hearing was Stephen Pahl. Mr. Pahl is the Deputy Executive Commissioner of HHSC's Regulatory Services Division, a position that, as the time of the Contempt Hearing, he had held for around two and a half years. (D.E. 1487 at 105:16-18.)

As the Deputy Executive Commissioner of the Regulatory Services Division, Mr. Pahl is "in charge of" Provider Investigations. (*Id.* at 105:13-15.) Or at least, he is supposed to be in charge of Provider Investigations. Mr. Pahl's testimony left no doubt that he lacks even a casual familiarity with the department or its policies, and he certainly lacks the knowledge needed to provide meaningful oversight. Indeed, at the conclusion of Mr. Pahl's testimony, it was quite apparent that PI's failings start right at the top.

As an initial matter, the basis on which Mr. Pahl was selected to serve as Deputy Executive Commissioner of HHSC's Regulatory Services Division is unclear. Certainly, it was not based on his work history—before serving in his current role, Mr. Pahl was an Assistant Deputy Inspector General. (*Id.* at 105:22-23.) Before that, he "served as associate commissioner for the Consumer Protection Division at the Texas Department of State Health Services," where he "overs[aw] the licensing of EMS providers, radiation machine technicians and people who handle hazardous environmental substances."[287] And before that, he "spent 18 years" "at the Texas Department of Agriculture" "developing and implementing the agency's diverse consumer protection programs."[288] In other words, his "background is not in child welfare," and he has "no prior work experience in child welfare."[289] (*Id.* at 106:1-5.)

---

287. Deputy Executive Commissioner for Regulatory Services, Stephen Pahl, HHSC, https://www.hhs.texas.gov/about/leadership/executive-teams-organizational-charts/deputy-executive-commissioner-regulatory-services-stephen-pahl.

288. *Id.*

289. This is not the first time a person with no background in child welfare has been appointed to a senior position. At trial, for example, then-Commissioner Specia testified that he selected one "Mr. Morris" to serve as the Assistant Commissioner of Licensing. (D.E. 331 at 30:16-31:2.) Before serving in this role, Mr. Morris was a program auditor. (*Id.* at 30:18-21.) Commissioner Specia also liked Mr. Morris because "[h]e also is a commander in the Coast Guard and had significant responsibilities in the Katrina matter. And so he's pretty cool under pressure. And so I felt like he would be a very good person to take that job." (*Id.* at 31:3-6.)

Likewise, the State hired Sergio Gamino as "in[t]er-agency lead between HHSC and DFPS," a position created to help resolve

Perhaps, then, Mr. Pahl was appointed with the understanding that he would learn on the job. He did, after all, agree that, as a person in "an administrator's role . . . that is over the operations of a division," he is "supposed to know" what those "operations are," because they are "ultimately [his] responisb[ility]." (*Id.* at 169:10-16.) But if that was the understanding, Mr. Pahl has not upheld his end of the bargain—from his testimony, it is evident that he has learned almost nothing about PI in the two and a half years he has been on the job.

Throughout Mr. Pahl's testimony, his limited understanding of PI's policies, procedures, and guidelines became abundantly clear:

- When asked if PI had an auditing group since its establishment in 2015, Mr. Pahl replied "I've been here for about 28 months. I don't know what happened eight years ago." (*Id.* at 156:11-15.) When asked if he looked into the history of PI at the time he assumed the position, he responded "No, I did not look." (*Id.* at 156:22-24.)

- When questioned by Plaintiffs' counsel whether HCS homes house intellectually disabled adults and children together, Mr. Pahl stated, "I don't know that to be correct."[290] (*Id.* at 111:13.)

---

the CWOP crisis. (D.E. 1225 at 77:22.) Prior, he was "an integrity and compliance officer" at the Department of Veteran Affairs. (*Id.* at 77:23-78:2.) Before that, he "ran a public transit department for one of the counties in southern Oregon." (*Id.* at 78:16-17.)

290. After repeated questioning by the Court and Plaintiffs' counsel, Mr. Pahl admitted that he did, in fact, know that adults and children reside together in HCS homes. (D.E. 1487 at 111:5-24.)

- He was "not sure" whether children placed in CWOP ever stay in HCS homes. (*Id.* at 112:13.)

- Mr. Pahl recognized that PI's backlog of investigations was due, at least in part, to a shortage of investigators. (*Id.* at 115:4-12.) He noted that "filling our vacancies" has "been a priority of ours." (*Id.* at 118:7-8.) Indeed, Mr. Pahl explained that reducing the number of vacancies was a personal priority of his. (*Id.* at 118:12-13 ("Your Honor, reducing our vacancies is a priority of mine for my division.").) Yet, when asked whether any new staff had been hired in the prior three months to address PI's backlog issue—which, if remedied, would enable PI to conduct investigations in a thorough, accurate, and timely manner—Mr. Pahl stated, "I don't know if we've hired any new staff in this area in the last three months."[291] (*Id.* at 115:23.) Likewise, he was unaware how many interviews have been conducted in the last three months for new staffing, because he "delegate[s] interviews down." (*Id.* at 118:14-20.)

- When asked if he knew that ANE allegations concerning children in HCS residencies were not

---

291. In order to address the staffing issue, funds have been appropriated by the legislature for this specific purpose; the concern is whether they are being utilized. (*See id.* at 117:25-118:17; *see also* PX 106 at 12 ("To help address ongoing staff resource challenges, the 88th Legislature appropriated HHSC's Regulatory Services Division, including LTCR, $17 million to make equity adjustments to recruit and retain staff.").)

investigated because PI determined that it lacked jurisdiction, Mr. Pahl responded, "I'm not aware of that, ma'am." (*Id.* at 121:13-19.) He did know that "someone within our Provider Investigations unit" would know the answer, but he could not name the person with any degree of certainty. (*Id.* at 121:22-25; *see id.* at 122:1-7 ("THE COURT: But you don't know who? THE WITNESS: I believe some of them may be here today. THE COURT: Who would you think might know what happens to these children investigations where you say that you don't have jurisdiction? THE WITNESS: I would think Jenny Crowson.").)

- When asked if PI "ha[s] a category in your reports that . . . says no investigations . . . because we don't think we have jurisdiction?" Mr. Pahl responded, "I'm not sure, ma'am. I don't know." (*Id.* at 122:8-11.)

- Mr. Pahl recognized that "there may be confusion at times" within Provider Investigations as to the unit's investigative jurisdiction. (*Id.* at 120:16-19.) When asked if "providers, the facilities are confused, too," about "who's going to investigate [them] for . . . allegation[s] of abuse, neglect, or exploitation," however, Mr. Pahl "wouldn't be able to speak on what confuses providers." (*Id.* at 120:23.) Presumably, as the person "ultimately responsible" for PI (*id.* at 169:14-16), he should have been aware that "[p]roviders . . . have long voiced concerns about staff from both agencies

conducting dual investigations based on different sets of statutes and regulations, which creates confusion." (PX 106 at 2.)

- Next, Mr. Pahl was asked about a recently adopted[292] policy directing PI investigators to make Unconfirmed and Inconclusive findings without documenting an explanation. (D.E. 1487 at 125:24-126:10.) He was shown the document describing the policy and then asked questions about it, and his responses indicated that he was unfamiliar with the policy—instead of answering questions with a yes or no, he responded with "That's what it says." (*Id.* at 129:8, 14.) Mr. Pahl was then asked "[w]hen you say that's what it says, are you not familiar with any of this?" to which he responded, "I'm not familiar with all of our policies and procedures." (*Id.* at 129:15-18.)[293]

- He likewise responded "I don't know," both when asked about the purpose of the policy and who

---

292. The "Temporary Management Directive: Efficient Investigative Procedures and Documentation Practices in All Settings" first took effect on September 22, 2022. (PX 6 at 1.) The version discussed during the Contempt Hearing went into effect on June 1, 2023. (*See id.*)

293. In fact, Mr. Pahl became aware of this policy for the first time at his deposition for the Contempt Hearing. (*See* Attachment 2 at 5 (page 14:12-23) ("Q. [BY MR YETTER] This summer, one of the things that came out is a temporary managing directive dated June 1, 2023. Do you know what I'm talking about? A. No, sir. . . . Q. You've seen this before, have you not? A. I don't recall seeing this.").)

came up with the policy. (*Id.* at 138:14-139:8.) He did, however, acknowledge that the policy "would have been [created by] someone within my Provider Investigations unit." (*Id.* at 139:13-14.) Of concern, there is no change in the policy to require the history of the facility to be taken into account during investigations or even additional staff background checks. The only new policy change is to direct investigators to remove their reasons for not finding ANE.

- Perhaps unsurprisingly, Mr. Pahl conceded that he does not "promulgate . . . and approve" "all policies and procedures" issued by his department. (*Id.* at 129:19-23.)

- Mr. Pahl was asked about PI's investigation into Child C's broken jaw. Given that Child C's jaw was broken in two places after a named staff member "hit [her] in the face with his fist multiple times," that she was put to bed with the broken jaw, and that she did not receive treatment until the following day after different staff members "observed blood and bruising on Child C's face" (D.E. 1412 at 50), this investigation certainly stands out from the rest; even more so because of the incongruity between the evidence and the disposition of Inconclusive assigned by the investigator (*id.* at 50). Nonetheless, Mr. Pahl could not recall the disposition made by the investigator. (*See* D.E. 1487 at 137:11-14 ("Q. And at the end of the nine months, do you remember

what the conclusion, the finding was of this child that ended up in the hospital with a broken jaw in two places, by herself? A. Not specifically, I don't recall.").)

- When questioned by the Court regarding PI investigators' ongoing failures to accommodate children's limited speech and comprehension capabilities during interviews, Mr. Pahl stated that there are "policies and procedures that lay out when and how investigations are conducted, including instances where children may have difficulty communicating."[294] (*Id.* at 142:8-10.) When asked whether these accommodation policies require investigators to document how they have accommodated the child's limitations, Mr. Pahl responded, "I'm not sure." (*Id.* at 142:20) Upon further questioning by Plaintiffs' counsel whether, in light of the new policy that allows for no explanations on Unconfirmed or Inconclusive findings, the investigators would be required to document on the form whether they used proper resources to communicate with a child that has limited capacities, Mr. Pahl responded he was not aware of the form requiring any such action. (*Id.* at 145.)

---

294. This is an improvement from his deposition, where Mr. Pahl stated he was "not aware of whether [there is] a requirement or not" for HHSC investigators to take into account the alleged victim's disabilities when conducting investigations. (*See id.* at 8 (page 28:10-18).) The PI Handbook directs investigators to "consider the person's unique abilities and needs when selecting methods of communication." (DX 40 at 33.)

- Plaintiffs' counsel questioned Mr. Pahl on PI's repeated failure to review the history of the facility at which ANE allegedly. (*Id.* at 145:10-18.) He responded that they were making changes,[295] but he was not certain whether the changes had already gone into effect. (*Id.* at 146:3-10 ("THE WITNESS: I believe that has already gone into effect, but I'll have to check with my staff to make sure. THE COURT: But you're not sure? THE WITNESS: Yes, ma'am. THE COURT: Okay. But you knew it wasn't in effect during all these cases reported by the Monitors, that you did not check the history of the facility? THE WITNESS: That's true.").)

- When questioned by Plaintiffs' counsel whether he is aware of an auditing or quality assurance group reviewing PI investigations, Mr. Pahl responded, "I'm not personally aware of any." (*Id.* at 157:6-9.) The PI Handbook for fiscal year 2024 added a section titled "Quality Assurance

295. A directive issued to staff at HHSC PI on October 24, 2023, states that under the new policy, investigators are now "required to review all case history for principals when the victim is a child or young adult in PMC/TMC." (PX 98 at 40.) For all other alleged victims, the investigator "may" consider such history. This directive, while emphasizing existing policy, does not resolve the problem discussed above regarding PI's failure to consider referral history more broadly (as is the well-settled practice for DFPS). Therefore, PI investigations continue to exclude other relevant critical information regarding past patterns of abuse, neglect, or exploitation in an operation's history and in the history of its owners and administrators.

> Mandatory Submission," pursuant to which "all cases involving . . . [a] child, regardless of DFPS CPS conservatorship status" must be approved by Quality Assurance. (DX 34 at 190-91.) But when asked whether the policy is in the Provider Investigations Handbook Mr. Pahl responded, "I'm not sure if it is or if it isn't." (D.E. 1487 at 157:22.)

Notably, Mr. Pahl expressed "no disagreement" with the conclusions reported by the Monitors in their review of PI investigations that were inappropriately conducted. (*See id.* at 132:13-15.) Further, Mr. Pahl was able to agree that the PI unit could be doing a better job investigating abuse and neglect allegations of PMC children with the resources at its disposal. (*See id.* at 132:19-133:18.)

Mr. Pahl's unfamiliarity with PI is worrying—it is, after all, difficult to competently oversee a unit one knows nothing about. More worrying, however, is the fact that Mr. Pahl is, apparently, the person most knowledgeable about the PI unit.

Under Federal Rule of Civil Procedure 30(b)(6), a party may provide "a governmental agency" with a list of "matters for examination," and the agency must designate one or more "officers [or] directors" that "must testify about information known or reasonably available to the organization." The purpose of Rule 30(b)(6) is "to enable the responding organization to identify the person who is best situated to answer questions about the matter, or to make sure that the person selected to testify is able to

respond regarding that matter." Wright & Miller, 8 Fed. Prac. & Proc. § 2103.

During discovery ahead of the Contempt Hearing, Plaintiffs designated Mr. Pahl, as a named deponent. (*See* D.E. 1431 at 1.) Plaintiffs also asked Defendant to designate one or more "Rule 30(b)(6) witness(es)" (*id.* at 1) who were best situated to answer questions about the following topics concerning the Provider Investigations unit:

> 1. Policies relating to investigations by Provider Investigations, including policies and guidance relating to accommodations for children with developmental challenges and limited capacities.
>
> 2. Policies relating to Provider Investigations criteria for approving investigation extensions for good cause.
>
> 3. Policies or practices of Provider Investigations to forgo review of the referral history of the placement location, the supervising agency or owner, or specific group home locations.

(D.E. 1431-3 at 2.) Defendant failed to designate another witness for these topics at deposition, thereby asserting that Mr. Pahl is the person most knowledgeable as to those topics. Further, Mr. Pahl was asked and answered questions on two of these topics during his deposition. (*See* Attachment 2 at 7-8 (page 13:19-14:8, 23:18-25:8, 26:6-28:24)

(Deposition of Stephen Pahl).) Yet, as detailed above, Mr. Pahl's performance at the Contempt Hearing makes clear that even though he serves in an official capacity as the head of the department responsible for PI, his knowledge of the policies and procedures guiding PI is scant at best. His performance at his deposition and Contempt Hearing underscores both his lack of knowledge of his department and his complete disinterest in acquiring this knowledge. As Mr. Pahl was the only person designated by the State to respond to these three policy areas, it must be assumed that nobody in the department has any more knowledge than he does regarding these policy areas.

The Monitors' review of PI investigations indicated the need for PI to have reviewed other essential information in order to adequately assess whether children were subject to maltreatment. Mr. Pahl claimed his department has identified issues and is "working to address the problems," but the only change identified at the Contempt Hearing was the implementation of the Temporary Managing Directive. (D.E. 1487 at 136:13-14.) Issued on June 1, 2023, the "Temporary Management Directive: Efficient Investigative Procedures and Documentation Practices in All Settings" is implemented to provide "temporary[296] procedures that allow Provider Investigations (PI) to complete investigations in all settings more efficiently." (PX 6 at 1.) Under the "Background" heading, it states: "In

296. Mr. Pahl was asked at his deposition whether this policy is still in effect, to which he responded, "I'm not sure. You would have to ask the leadership within PI if this is still in effect." (Attachment 2 at 6 (page 18:4-6).) Notably, the policy does not include an expiration date. (*See* PX 6.)

an effort to assist with PI's backlog, PI leadership reviewed ways to make the investigative process *more efficient* while not compromising the quality of PI's investigations. To reduce the number of open investigations and maintain quality in investigations, PI management has approved the following procedures." (*Id.* at 1 (emphasis added).) One of these procedures, addressing documentation of Unconfirmed or Inconclusive findings, states "[T]he investigator will no longer explain how the evidence does or does not satisfy the element when documenting the *Analysis of Evidence.*"[297] (*Id.* at 1 (emphasis in original).) Thus, if a PI investigator determines that the proper disposition of an ANE allegation should be Unconfirmed or Inconclusive, the investigator is not required to explain what evidence was evaluated to reach that conclusion, nor what evidence supports each element of the allegation. (*See* D.E. 1487 at 130:15-131:14.)

Of course, if a quality assurance team were to review the investigation to determine whether the proper disposition was reached, it is unclear how this review could function effectively to approve or give complete guidance about the dismissal of allegations of ANE, given the lack of information about how the investigator reached the conclusion. (*See* DX 41 at 50 (listing as one purpose of Quality Assurance Provider Investigations (QAPI), "to analyze case actions in the field and provide constructive

297. The Analysis of Evidence is the section of the Provider Abuse/Neglect Report in which the investigator "reviews and discusses the credibility of the evidence collected to determine whether there is a preponderance of evidence to support or refute the allegation." (DX 34 at 156.)

feedback for each live investigation" on whether the specific elements of an allegation are addressed).)

Doctor Miller opined that the Temporary Management Directive "puts children at risk of harm" because "there are no quality dimensions . . . [t]here are no qualitative efforts to try to—to keep kids safe by getting the kind of information that you need and holding people accountable." (D.E. 1488 at 268:9-13.) The current quality of PI's investigations is seriously deficient—as detailed by the Monitors' reports—and the State did not explain how the quality of investigations will improve by reducing the amount of documentation. Even Mr. Pahl agreed this policy does not make children safer. (*See* D.E. 1487 at 134:2-5 ("Q. [BY MR. YETTER]. . . . How does it make children safer for investigators not to explain their findings? A. I suppose it doesn't.").)[298] This cannot be interpreted as progress for the children. Defendant points to statutory changes such as HB 4696 which will "correct[] some jurisdictional issues within two different codes" leading to more efficient investigations into ANE allegations.[299] (D.E. 1487 at 169:19-170:7.) However, HB

298. When questioned whether there was any "good child safety reason for this new policy of no explanation" Mr. Pahl responded, "Sitting here today, I can't think of any." (D.E. 1487 at 144:20-23.) On cross, he further admitted that he was unaware whether this policy changes how, if at all, PI investigators collect evidence in an investigation. (*See id.* at 175:16-21.)

299. HB 4696 will, among other things, require HHSC to "generate a single intake to be investigated by one surveyor, who will be fully cross-trained to both investigate the ANE allegation and assess the provider's regulatory compliance." (PX 106 at 3.)

4696 will not be fully implemented until the end of 2024 or early 2025. (*See id.* at 170:8-11.)

In response to the Contempt Motion, Defendant asserted that "plaintiffs haven't met their burden on the second element of contempt—*i.e.*, that Remedial Order 3 requires the conduct that plaintiffs allege DFPS failed to undertake" (D.E. 1429 at 16):

> . . . it must "include an express or clearly inferrable obligation" to take the specific action in question. *Hornbeck Offshore Servs.*, 713 F.3d at 793. Plaintiffs' post-hoc disagreements on judgment calls about which steps should have been taken in a particular investigation or how the standard of neglect should have been applied to a certain set of facts aren't grounded in the order's command to "investigate[]" while accounting for "the child's safety needs." Dkt. 606, at 2. *See Baum*, 606 F.2d at 593 (contempt still improper even though deposition was taken despite court's order vacating deposition notice because the order "did not explicitly direct that the deposition not take place").

(D.E. 1429 at 16-17.) Defendant then averred that for "these same reasons, plaintiffs' allegations . . . concerning HHSC's Provider Investigations don't carry plaintiffs' *prima facie* burden to show contempt. Those allegations rely on a Monitors report that expresses the same type of post-hoc disagreements discussed [earlier in the response], which find no basis in Remedial Order 3 itself.

Nor do the additional criticisms of investigations have a basis in any order." (*Id.* at 18.)

But Plaintiffs did explain that Remedial Order 3 addresses deficient abuse and neglect investigations, a complex and multifaceted problem. (*See* D.E. 1427 at 10-11.) Notably, the Fifth Circuit recognized that the State's investigations suffered multifarious flaws:

> As the district court correctly pointed out, . . . the investigators in question were failing to interview all of the necessary parties, ask pertinent questions, gather all evidence and key information, and address risks. In other words, the main issue with the investigations was not merely that there was competing evidence or that reports were uncorroborated. Rather, the information gathering process was fundamentally flawed.

Stukenberg I, 907 F.3d at 265-66 (footnote and quotation marks omitted). In such situations, the Fifth Circuit has been clear that a court need not, as Defendant seems to imply, "anticipate every action to be taken in response to its order, nor spell out in detail the means in which its order must be effectuated." *Am. Airlines, Inc.*, 228 F.3d at 578. It is not enough that the State conduct a rudimentary investigation to satisfy the requirements of Remedial Order 3.

For example, *North Alamo Water Supply Corp. v. City of San Juan* affirmed an injunction requiring the transfer,

from the defendant to the plaintiff, of the provision of water service to several residential subdivisions. 90 F.3d 910, 913, 917-18 (5th Cir.) (per curiam), *cert. denied*, 519 U.S. 1029, 117 S.Ct. 586, 136 L.Ed.2d 515 (1996), *overruled on other grounds by Green Valley Special Util. Dist. v. City of Schertz*, 969 F.3d 460 (5th Cir. 2020). The court reasoned:

> Transferring water service from the City to the Utility will be a relatively complicated logistical task, requiring a coordinated effort by both parties. The burdens of any disruption in service will fall more heavily on the residents than on the parties. With an eye on these potential pitfalls, the district court instructed the City to continue uninterrupted water service until the Utility is prepared to commence service, then to cease providing water service immediately upon commencement of service by the Utility. Although this order does not choreograph every step, leap, turn, and bow of the transition ballet, it specifies the end results expected and allows the parties the flexibility to accomplish those results.

Id. at 917. Likewise, abuse and neglect allegations take many forms, so investigating them is "a relatively complicated . . . task." *Id.* at 917. Remedial Order 3 specifies the end results expected—that Defendant investigates allegations of abuse and neglect, does so timely and consistent with the Court's orders, and conducts the investigations "taking into account at all times the child's

safety needs." (D.E. 606 at 2.) Thus, Remedial Order 3 need not "choreograph" "which steps should . . . be[] taken in a particular investigation. . . ." 90 F.3d at 917 (first quotation); (D.E. 1429 at 16 (second quotation)).

Defendant cites *Baum* for the proposition that contempt was "improper even though deposition was taken despite court's order vacating deposition notice because the order 'did not explicitly direct that the deposition not take place.'" (*See* D.E. 1429 at 16-17 (citing 606 F.2d at 593).) But *Baum* is distinguishable because the bankruptcy court's order on which the contempt finding was based neither explicitly required nor explicitly prohibited any conduct—it stated only that "the notice of deposition mailed on August 3, 1976 noticing the deposition of Howard E. Samuel be vacated and set aside, same not being reasonable notice as required by the Federal Rules of Civil Procedure." 606 F.2d at 593. Remedial Order 3, on the other hand, clearly and unambiguously sets forth "an unequivocal command." *Id.* at 593 (quoting *H.K. Porter Co., Inc. v. Nat'l Friction Prod. Corp.*, 568 F.2d 24, 27 (7th Cir. 1977)).

Indeed, *Baum* indicated that a command may have been inferable from the bankruptcy court's order with sufficient clarity to support the contempt finding had the order merely been "addressed specifically to" the alleged contemnor. *Id.* at 593 ("In the present case, appellant Baddock did not violate a specific and unequivocal order of the bankruptcy court. The bankruptcy judge's order vacating the notice of deposition was not addressed specifically to Baddock."). Remedial Order 3 certainly clears that hurdle.

Tellingly, in the context of HHSC's Provider Investigations unit, the only example Defendant provides of an investigative step that "find[s] no basis in Remedial Order 3" is a review of a placement's referral history. (D.E. 1429 at 18.) Yet Mr. Pahl clearly inferred that a placement's referral history is relevant when investigating an allegation of abuse or neglect in that placement and, thus, implicates the alleged victim's safety needs. (D.E. 1487 at 147:1-4 ("Q. You know that it's relevant, it's important to know the track record of the facility, the operation where the abuse, the alleged abuse took place? That's relevant, isn't it? A. Yes, sir.").) Indeed, the relevance of a placement's referral history when investigating abuse or neglect allegations is so obvious that it was already a step required by DFPS of its Residential Child Care Investigations (RCCI) investigators. (*See* D.E. 1412 at 8 & n.17.)

Further, Defendant's assertion that the Monitors merely report "post-hoc disagreement" (D.E. 1429 at 18) with PI's investigators is inaccurate. In fact, the Monitors conducted an in depth "review of State records" to "assess[] . . . investigation[s] of reports of abuse, neglect and exploitation of children in Permanent Managing Conservatorship (PMC) conducted by" PI. (D.E. 1412 at 1, 2.) As the foregoing summaries make clear, the Monitors reported facts about each investigation, including when it was commenced and completed, when the alleged victim, perpetrator, and witnesses were interviewed, and any acts or omissions by the investigator that indicated a failure to account for the alleged victim's safety needs. None of these topics "find no basis in Remedial Order 3 itself." (D.E.

1429 at 18; *see* D.E. 606 at 2 ¶ 3.) Further, these are the most vulnerable of an already vulnerable group of PMC children. To say that this entire cohort of children is so small as to be entirely disregarded by HHSC is absurd and inexcusable.

The third element of civil contempt requires a movant to establish by clear and convincing evidence that the respondent failed to comply with the Court's order. *See LeGrand*, 43 F.3d at 170. Defendant has not presented evidence that counteracts the substantial weight that the Court affords to information verified and reported by the Monitors, the factual basis of which Defendant did not refute during the Hearing. The Court finds the continued recalcitrance by HHSC PI to conduct thorough, accurate, and timely abuse, neglect, and exploitation (ANE) investigations to ensure the safety of PMC children in their care as clear and convincing evidence of their failure to comply with the remedial orders. As demonstrated by the stories of the children and PI's failure to take any action to remedy the egregious flaws identified by the Monitors, PI represents a significant, systemic failure that increases the risk of serious harm to PMC children. The substantial rate at which the State's investigations are inappropriately resolved or deficiently conducted indicates that the State is failing to "ensure that reported allegations of child abuse and neglect involving children in the PMC class are investigated; commenced and completed on time consistent with the Court's Order; and conducted taking into account at all times the child's safety needs," as required by Remedial Order 3. (D.E. 606 at 2.)

Appendix B

The Monitors' reports and the testimony at the Contempt Hearing establish by "clear and convincing evidence," *see Hornbeck I*, 713 F.3d at 792, that Defendant has failed to comply with Remedial Order 3 and continues to expose PMC children to an "unreasonable risk of serious harm" (*see* D.E 606 at 2). The information in the Monitors' reports demonstrate that HHSC's Provider Investigations has failed to "ensure that reported allegations of child abuse and neglect involving children in the PMC class"—indeed, some of the most vulnerable children in the PMC class—"are investigated; commenced and completed on time consistent with the Court's Order; and conducted taking into account at all times the child's safety needs." (*Id.* at 2.) Thus, the third element of civil contempt-that Defendant has failed to comply with the Remedial Order-is established by clear and convincing evidence as to this aspect of Remedial Order 3. *See LeGrand*, 43 F.3d at 170.

Defendant makes the same arguments regarding Remedial Order 10 as she did regarding Remedial Order 3. Defendant argues that "[t]he Monitors have reported overwhelming *approval* of defendants' investigations of allegations of abuse and neglect—observing that investigations have 'measurably improved over time' and 'often resulted in an appropriate disposition.'" (D.E. 1429 at 20 (quoting D.E. 1318 at 47) (emphasis retained).) But that comment by the Monitors was directed at DFPS, and is inapplicable to PI's compliance with Remedial Order 10.

Further, Defendant argues, "The recent Monitors' report on which plaintiffs rely recounts investigations involving only nine PMC children, so it's far too limited

to be clear and convincing evidence of contempt." (*Id.* at 11 (citing *Travelhost, Inc. v. Blandford*, 68 F.3d 958, 961 (5th Cir. 1995).).) Although the Monitors did commend the improvements made by DFPS as to investigating ANE allegations in licensed placements, the Monitors continue to find deficiencies in HHSC PI investigations such as inconsistently investigating each allegation contained in an investigation, failing to adequately interview, or interview at all, individuals relevant to the allegation, failing to review the history of the operation, failing to complete investigations in a timely manner, and failing to require updated staff criminal histories. (D.E. 1318 at 47.) The failure to adequately investigate within the time frame required by Remedial Order 10 leads to significantly delayed interviews with key individuals, thereby impairing the fact-finding process of the investigation. (D.E. 1442 at 13.) Additionally, as stated previously, the Monitors specifically note that HHSC PI "repeatedly addressed allegations of Sexual and Physical Abuse of some of the State's most vulnerable children with shocking carelessness, leaving PI investigations open with no activity for months on end—in numerous instances for more than one year—while children with significant developmental disabilities were left in harm's way." (*Id.* at 2-3.) The Monitors' reports identified deficient PI investigations of alleged abuse and neglect of vulnerable children, and the lapses in investigations are clearly against the Court's express remedial orders. For example, Child C remained in a placement like C3 Academy for approximately one year after the first abuse and neglect allegation of Child C was reported. (D.E. 1412 at 27-28.) PI's failure to conduct timely, accurate,

and thorough investigations repeatedly resulted in PMC children remaining in unsafe placements for prolonged periods of time. Based on the foregoing, it appears that PI "investigators are not encouraged to complete investigations quickly, leaving children in potentially dangerous situations. Staff fail to interview parties, review evidence, or address continuing risks to children." *Stukenberg I*, 907 F.3d at 292.

In sum, most of the PI investigations reviewed by the Monitors were not compliant with Remedial Order 10 and its requirement that investigations must be completed within thirty days unless they have an approved and documented extension for good cause. (*See* D.E. 606 at 3.) Defendant has failed to rebut the "clear and convincing evidence," *see Hornbeck I*, 713 F.3d at 792, provided in the Monitors' Report that Defendant has failed to comply with Remedial Order 10's requirement that Priority One and Priority Two investigations be completed within thirty days of intake barring a documented extension for good cause. (D.E. 606 at 3.) Therefore, the Court finds by clear and convincing evidence that the third element of civil contempt, "failure to comply with the court's order" is satisfied as to Remedial Order 10. *See LeGrand*, 43 F.3d at 170.

4. Defendant failed to establish defenses to contempt

Once the three elements of civil contempt have been established, the respondent may defend against a finding of civil contempt by justifying noncompliance, rebutting

the conclusion, demonstrating an inability to comply, asserting good faith in its attempts to comply, or showing mitigating circumstances or substantial compliance. *See LeGrand*, 43 F.3d at 170 (noting that an inability to comply is a defense against civil contempt); *Petroleos Mexicanos*, 826 F.2d at 401 (holding that good faith and inability to comply are defenses to civil contempt); *Whitfield*, 832 F.2d at 914 (holding that burden falls on defendants "to show either mitigating circumstances that might cause the district court to withhold the exercise of its contempt power, or substantial compliance with the consent order.").

As an initial matter, the Court notes that Defendant did not attempt to demonstrate any of these defenses at the Contempt Hearing through evidence, presenting their own witnesses, or cross-examination of Plaintiffs' witnesses. This despite Defendant indicating that she would present such witnesses.[300] (*See supra* footnote 12; *see also* D.E. 1488 at 340:16-19 (Defense counsel explaining that "the evidence is not final at this point, and we haven't put on our case-in-chief").)

Defendant did raise several defenses in her response to the Contempt Motion. (D.E. 1429.) Defendant attempted to rebut the conclusion of contempt by arguing that the number of PMC children discussed in the Monitors' PI reports is too "small [of a] sample . . . to prove that Defendant[is] in contempt as to Remedial Order 3." (D.E. 1429 at 18.) First, these children being abused in HCS

300. The Court also notes that Defendant did not claim lack of notice.

group homes are not just a data set, they are some of the most vulnerable children in the State's care—children who suffered for months or years while the State bungled investigation after investigation. Second, the fifteen children discussed in the Monitors' reports[301] represent a substantial portion of the eighty-eight PMC children in HCS group homes.[302] (D.E. 1380 at 28 n.33.) And the Monitors reviewed not just a sample of the PI investigations involving PMC children during the assessment period, they reviewed "all PI investigations involving PMC children that closed with an overall disposition of Unconfirmed or Inconclusive between January 1, 2023 and April 30, 2023." (D.E. 1461 at 2.) And they concluded that over half of those investigations—55 percent—were deficient. (*Id.* at 2.) In other words, the Monitors uncovered a pattern of inadequate PI investigations. Indeed, these numbers belie Defendant's claim to "diligently strive to ensure the welfare of each and every child in . . . care." (D.E. 1429 at 18; *cf.* D.E. 1412 at 2 ("In one of the most appalling failures by the State, [Child C] was the subject of multiple reports of abuse and neglect leading to 12 PI investigations, all pending simultaneously, over a one-year period at the same placement, C3 Academy, LLC." In the "twelfth investigation of alleged abuse and neglect of the same child at that same placement—a staff member

301. Children A, C, D, E (discussed in the first investigation of Child D, *supra* page 359-60-), F, G, H, I, J, K, L, M, N, O, and Q. (D.E. 1412; D.E. 1442.)

302. The number of PMC children in HCS has not changed significantly over time. (*See, e.g.*, D.E. 1318 at 21 n.24 (ninety-three children); D.E. 1248 at 20 n.20 (101 children); D.E. 1165 at 20 n.23 (seventy-three children).)

allegedly broke the child's jaw in two places. The child and a witness identified the staff member who attacked the child. . . . Nonetheless, PI took nine months to complete the investigation with long periods of inactivity and it ultimately determined the allegations were Inconclusive, despite a preponderance of evidence that the staff member abused the child.").)

Defendant argues that she has substantially complied with Remedial Order 3 because the Monitors "agreed with RCCI's disposition" of abuse and neglect investigations "95 percent of the time and CPI's disposition 94 percent of the time." (D.E. 1429 at 21.) But RCCI and CPI are both units of DFPS, so these statistics have no relevance to PI's compliance with Remedial Order 3. Indeed, if one were to use the rate at which the Monitors agreed with the agency's disposition as the metric for substantial compliance, then PI would certainly fall short—after all, the Monitors agreed with PI's disposition of just 45 percent of abuse and neglect investigations. Indeed, juxtaposing the rates of agreement only highlights PI's failure to comply—substantially or otherwise—with Remedial Order 3.

In any event, the touchstone of substantial compliance is "whether the defendant[] took 'all reasonable steps within [its] power to insure compliance with the orders.'" *Alberti*, 610 F. Supp. at 141. And given Mr. Pahl's concession that PI could have done a better job with the resources at hand (D.E. 1487 at 133:13-16), the Court does not find that HHSC took all reasonable steps within its power to comply with Remedial Order 3. For the same reason, the

Court does not find that HHSC took all reasonable steps within its power to comply with Remedial Order 10.

Defendant also highlights her "good faith efforts to comply with Remedial Order 3." (D.E. 1429 at 22.) Defendant did not offer a definition of "good faith" in her brief. But based on the context in which she uses the term, the Court understands Defendant to have been arguing that she acted with "faithfulness to [her] duty or obligation" under the remedial order. *Good faith* (def. 2), Black's Law Dictionary (11th ed. 2019). Specifically, Defendant notes that "DFPS has created a 'child sexual aggression' training course that thousands of investigators have completed to help them better recognize sexual abuse" and that "DFPS has also changed its policy to greatly reduce which intakes may be downgraded to 'priority none' for PMC children and has restructured its secondary review for intakes about licensed placements to ensure that reports lacking key information were still properly investigated." (D.E. 1429 at 22.) But, as with the statistics Defendant offers as evidence of substantial compliance, these steps were taken by DFPS, not HHSC. Therefore, they say nothing about HHSC's good faith effort to comply with Remedial Order 3.

Indeed, PI's most notable policy change—directing investigators not to explain their reasons for assigning a disposition of Inconclusive or Unconfirmed—hardly demonstrates good faith. Mr. Pahl agreed that this policy did not make children safer. (D.E. 1487 at 134:2-5.) And it would be difficult to conclude otherwise, given that the purpose of the policy change is to "reduce the number

of open investigations" by "mak[ing] the investigative process more efficient." (PX 6 at 1.) In other words, the change allows investigators to close cases more quickly. But the Court already explained, the last time it held Defendants in contempt of Remedial Order 3, that:

> [S]imply checking the boxes of commencing and completing investigations by certain times is not sufficient for Defendants to implement this Remedial Order in a way that "ensure[s] that Texas's PMC foster children are free from an unreasonable risk of harm," as required by the Court's injunction. Defendants must also "conduct" investigations in such a way that "tak[es] into account at all times the child's safety needs." Defendants must approach allegations of abuse and neglect involving PMC children in such a way that "taking into account at all times the child's safety needs" is the main objective.

(D.E. 1017 at 77-78 (emphasis and citations omitted).) Of course, the practical effect of the no explanation policy is to insulate dispositions of Inconclusive or Unconfirmed—the ones that result in the child remaining in the group home at which the abuse or neglect was alleged—from review by the Monitors or PI's internal quality control team.[303]

303. It is telling that the no explanation policy does not apply when the investigator assigns a disposition of Confirmed. (*See* PX 6 at 1 ("When the evidence demonstrates an unconfirmed or inconclusive finding, the investigator will no longer explain how the evidence does or does not satisfy the element when documenting

This hardly bespeaks an approach to allegations of abuse and neglect in which "taking into account at all times the child's safety needs" is the main objective.

In support of the claim of good faith compliance, Defendant cites *Anderson v. School Board of Madison County* for the proposition that contempt is inappropriate where the "alleged contemnor 'devoted considerable time and resources in a good faith effort' to comply." (D.E. 1429 at 22 (quoting 517 F.3d 292, 301-02 (5th Cir. 2008)).) But *Anderson* also noted that "if the evidence showed that the [defendant] disregarded known facilities' deficiencies, it likely would have failed in its duty to act in good faith." 517 F.3d at 301. Since at least 2018, the State has known that its investigations into abuse and neglect allegations were "fundamentally flawed," as investigators "were failing to interview all of the necessary parties, ask pertinent questions, gather all evidence and key information, and address risks." *Stukenberg I*, 907 F.3d at 265-66. Indeed, the Monitors reports reveal that every one of these fundamental flaws is common among PI investigations.

In sum, Defendant offered no evidence that HHSC acted with "faithfulness to [its] duty or obligation" under Remedial Order 3. *Good faith* (def. 2), Black's Law Dictionary (11th ed. 2019).

---

the *Analysis of Evidence.* This does not apply to investigations when the evidence demonstrates a confirmed or confirmed-reportable conduct finding.").) Presumably, this is to allow the finding to survive administrative review if it is challenged by the perpetrator.

Defendant also argues that "mitigating circumstances weigh heavily against contempt." (D.E. 1429 at 51.) As mitigating circumstances, Defendant highlights "extensive efforts and successes" in complying with other of the remedial orders (*id.* at 51-52), and asserts she has "expended enormous efforts and millions of taxpayer dollars to implement and comply with the Court's many remedial orders" (*id.* at 51). But Defendant does not explain why these claims would mitigate Provider Investigations' failure to comply with Remedial Order 3 and 10. And the cases upon which Defendant relies show that the grounds alleged do not establish mitigating circumstances, as the defense requires a showing that circumstances beyond the contemnor's control prevented compliance.

Defendant cites *Anderson v. School Board*, 517 F.3d 292, 301 (5th Cir. 2008), and suggests that the Fifth Circuit "affirm[ed] dissolution of [the] desegregation order where school district 'devoted considerable time and resources in a good faith effort' to comply." (D.E. 1429 at 51.) But this only tells half the story—in the paragraph immediately prior, the Fifth Circuit noted that "the failure of the [magnet school] program to attract white students was not attributable to the [school district]'s actions or lack of good faith. Instead, the [district] court found that the magnet program's goal of attracting white students was doomed because of location and cultural factors that were not attributable to the [school district]." 517 F.3d at 301. Here, Defendant has not alleged that Provider Investigations' efforts to comply were similarly "doomed" by an exogenous factor. Indeed, quite the contrary, Stephen Pahl agreed that Provider Investigations "[c]ould have done a better

job for these children with the resources . . . at hand." (D.E. 1487 at 133:14-18.)

And in *Little Tchefuncte River Association v. Artesian Utility Co.*, the mitigating circumstances were not, as Defendant claims, Artesian's successful compliance "with other numerous provisions" of the injunction. (D.E. 1429 at 51.) Instead, the court found mitigating circumstances because Artesian's violations were the result of discrete, unexpected events, and because Artesian "instituted corrective measures after every" violation. 155 F. Supp. 3d 637, 664 (E.D. La. 2015); *see, e.g., id.* at 663 (defendant testified "that the fecal coliform exceedances in July and August 2014 were caused by a decomposing turtle in the chlorine contact chamber" and "that in order to prevent the problem in the future Artesian has added a screen over the chlorine contact chamber and mesh at the inlet pipe to ensure that turtles do not enter the chamber"). The only corrective measure (to use the term loosely) instituted by Provider Investigations is to omit information from investigative reports, which is unlikely to prevent further faulty investigations.

Defendant concludes the brief by quoting an unpublished Eleventh Circuit opinion:

> As the Eleventh Circuit commented in another institutional-reform case involving a state's child-welfare system, "[t]he system is not yet perfect and may never be, but its improvement has been tremendous." *R.C. ex rel. Ala. Disabilities Advoc. Project v. Walley*, 270 F.

> App'x 989, 992-93 (11th Cir. 2008) (dissolving injunction of state's foster-care program). So too here.

(D.E. 1429 at 52.) It is certainly true that Texas's foster care system "is not yet perfect and may never be," but Defendant presented no evidence that Provider Investigations has made a "tremendous" improvement, as that term was used in *Walley*. 270 F. App'x at 992. There, the district court found that "the Alabama child welfare system had undergone radical changes and was on secure footing to continue its progress in the years to come, without court supervision." *Id.* at 992. The record makes clear that the same cannot be said of Provider Investigations.[304]

---

304. Defendant's reliance on *Walley* is also curious because the Eleventh Circuit suggested that a district court should be given special deference when overseeing a long-term structural injunction: "[T]he district court was in the unique position to rely on its personal experience with the parties and its knowledge of this case to emphasize the State's history of good faith and its present commitment to remedying remaining problems as mitigating factors when assessing substantial compliance and sustainability thereof." 270 F. App'x at 993 (citing *Rufo v. Inmates of the Suffolk County Jail*, 502 U.S. 367, 394, 112 S.Ct. 748, 116 L.Ed.2d 867 (1992) (O'Connor, J., concurring in the judgment) ("Our deference to the District Court's exercise of its discretion is heightened where, as in this litigation, the District Court has effectively been overseeing a large public institution over a long period of time.")). This reasoning would suggest that a district court is likewise in a unique position to rely on its experience with the parties and knowledge of the case to emphasize the State's history of failing to comply with remedial orders, and its lack of commitment to remedying the remaining problems.

Thus, Defendant has failed to establish that she has substantially complied or made good faith efforts to comply with Remedial Order 3 or Remedial Order 10, nor has she established mitigating circumstances. *See LeGrand*, 43 F.3d at 170; *Petroleos Mexicanos*, 826 F.2d at 401. Defendant did not assert either an inability to comply or justify her noncompliance, *Petroleos Mexicanos*, 826 F. 2d at 401, in her pleadings or otherwise. This leads to the Court's finding that HHSC has failed to ensure investigations of serious abuse and neglect allegations are "investigated; commenced and completed on time . . . and conducted taking into account at all times the child's safety needs." The Court therefore holds, based on clear and convincing credible evidence, that Defendant Cecile Erwin Young, in her official capacity as Executive Commissioner of the Health and Human Services Commission of the State of Texas, is in contempt of Remedial Order 3 and Remedial Order 10.

VII. CONCLUSION

For the foregoing reasons, the Court finds Defendant Cecile Erwin Young, in her official capacity as Executive Commissioner of the Health and Human Services Commission of the State of Texas, in contempt of Remedial Order 3. It is hereby ordered that Commissioner Cecile Erwin Young, in her official capacity, is ORDERED to pay $50,000 per day until HHSC agency leadership certifies that all PI investigations involving at least one PMC child closed from December 4, 2023 until the date

of the State's certification, are substantially compliant [305] with the Remedial Order 3 AND concurrently produce to the Monitors the list of all PI investigations involving at least one PMC child closed between December 4, 2023 and the date of the State's certification. The fine will be suspended upon complete submission by the State of the foregoing. The Monitors will conduct a case record review of the cases identified by the State in its submission and report their findings to the Court.

The Court further finds Defendant Cecile Erwin Young, in her official capacity, in contempt of Remedial Order 10. Defendant Cecile Erwin Young, in her official capacity, is ordered to pay $50,000 per day until HHSC agency leadership certifies that all open PI investigations involving at least one PMC child are substantially compliant with Remedial Order 10 AND concurrently produce to the Monitors the evidence upon which the verification is based including, but not limited to:

- A list of all open PI investigations involving at least one PMC child; and
- For each of these investigations:
  - The date and time of intake;
  - The date and time the investigation was opened; and
  - The date of any and every extension, with copies to the Monitors of the documentation in the PMC child's record providing the good cause basis for the extension.

---

305. This in no way waives the Court's retention of jurisdiction for a period of three years after full compliance as certified by the Monitors. (*See* D.E. 606 at 19.)

The fine will be suspended upon complete submission of the foregoing by the State. The Monitors will review the State's submission and report their findings to the Court.

Defendant Cecile Erwin Young, in her official capacity, is ordered to pay any and all fines levied in accordance with this Order into the Registry of the Court at:

Clerk, U.S. District Court
Attn: Finance
1133 N. Shoreline Blvd., Ste. 208
Corpus Christi, TX 78401

The Court hereby directs the Clerk of the Court to segregate and preserve all funds paid in accordance with this Order for the benefit and use of PMC foster care children, to be determined by future order of the Court.

The Court is carrying forward Plaintiffs' motion for partial receivership. The Court is also carrying forward Plaintiffs' Contempt Motion as it relates to CWOP, caseworker caseloads, heightened monitoring, psychotropic medications, and appropriately apprising PMC children of the ways in which to report abuse and neglect. A compliance hearing will be held on June 26, 2024, at 8:30 a.m. CST, at which time, absent substantial compliance, any previously abated fines may be reinstated.

SIGNED and ORDERED this 15th day of April, 2024.

/s/ Janis Graham Jack
Janis Graham Jack
Senior United States District Judge

Appendix B

VIII. GLOSSARY

ANE—Abuse, Neglect, and Exploitation.

CCI—Child Care Investigations. A division of CPI within DFPS that investigates abuse, neglect, and exploitation allegations regarding children in licensed care. CCI contains RCCI, which investigates allegations of abuse, neglect, and exploitation regarding children in licensed residential foster care (*see also* **RCCI**).

CCL—Child Care Licensing. A division of HHSC (previously a division of DFPS within HHSC) responsible for establishing minimum standards for foster care operations and licensing such operations.

CHIP—Children's Health Insurance Program. A program under HHSC that covers children in families that earn too much money to qualify for Medicaid but cannot afford to buy private insurance.

CLASS—Child Care Licensing Automation Support System. The electronic case file system used by HHSC-RCCL.

CPA—Child Placement Agency. A private agency contracted by DFPS to place foster children in homes.

CPI—Child Protective Investigations. A division of DFPS that investigates abuse, neglect, and exploitation allegations regarding children. CPI contains CCI, which investigates allegations of abuse, neglect, and exploitation regarding children in licensed care (*see also* **CCI**).

Appendix B

CPS—Child Protective Services. A division of DFPS responsible for providing services to children and families, and for placing children in foster care.

CVS—Conservatorship (i.e., foster care).

CWOP—Children Without Placement. A term used by DFPS to refer to foster children that are housed in unlicensed, unregulated settings. Also referred to as "Child Watch" or "DFPS Supervision" (*see also* **CWOP Setting**).

CWOP Setting—Refers to the leased homes, hotel rooms, and other locations at which children are housed.

DFPS—Department of Family and Protective Services. A Defendant, and the Texas State agency responsible for protecting the State's children, elderly, and disabled.

GRO—General Residential Operation. A child-care facility that provides care for more than 12 children for 24 hours a day. GROs include RTCs, halfway houses, emergency shelters, and therapeutic camps, and may be a single building or a campus with multiple cottages.

HHSC—Health and Human Services Commission. A Defendant and the Texas State agency responsible for overseeing licensing and minimum standards for foster care operations.

HHSC-RCCL (*see also* **RCCL**)—Residential Child Care Licensing within HHSC. A division of CCL that

regulates, licenses, and investigates residential foster care operations. This division is currently in HHSC and separate from DFPS, but at the time of trial, RCCL was a division of DFPS, which fell within HHSC.

HM—Heightened Monitoring. Refers to the increased scrutiny given to operations that have demonstrated a pattern of contract or policy violations.

Home and Community-based Services (HCS) Waiver Program—Medicaid program authorized under § 1915(c) of the federal Social Security Act for the provision of services to persons with an intellectual or developmental disability described by the Texas Government Code Section 534.001(11)(B).

IMPACT—Information Management for the Protection of Adults and Children in Texas. An automated system, included in case files, in which DFPS staff record casework related activities.

MCO—Managed Care Organization. A health care organization of medical service providers who offers managed care health plans. HHSC contracts with MCOs and pays them a monthly amount to coordinate and reimburse providers that deliver health services to Medicaid members enrolled in their health plan. The State's MCO is Superior HealthPlan (Superior).

PI—Provider Investigations. A program within HHSC Regulatory Services Division, Long-Term Care Regulation that investigates allegations of abuse, neglect, and

exploitation of individuals receiving services from certain providers.

PMC—Permanent Managing Conservatorship. A type of legal custody granted by the courts to DFPS. The legal status for children typically progresses to PMC from TMC, 12-18 months after the child enters foster care.

PMU—Performance Management Unit. At trial, a unit within CCL that performs internal quality control.

PMUR—Psychotropic Medication Utilization Review. A secondary review system that should be conducted under the PMU Parameters for certain psychotropic medication regimes that trigger "red flags." Also referred to as "PMU Review" or "PMUR process" (*see also* **PMU Parameters**).

PMU Parameters—Psychotropic Medication Utilization Parameters. Best-practice guidelines based on medical literature developed by a panel of child and adolescent psychiatrists, psychologists, and other mental health experts that address many topics including general use of psychotropics, their use in young children, and evidence for short-and long-term efficacy of psychopharmacological treatment. Also referred to as "Parameters."

PMUR Report—A report generated by Superior HealthPlan when a PMUR is conducted.

PN—Priority None. A "downgraded" investigation prioritization in which an allegation of abuse, neglect, or exploitation is determined to involve either (a) a

minimum standard violation but not the abuse, neglect, or exploitation of a child; or (b) a past risk to a child without current abuse, neglect, or exploitation.

RCCI—Residential Child Care Investigations. A division of CCI that investigates abuse, neglect, and exploitation allegations regarding children in licensed residential foster care (*see also* **CCI, CPI**).

RCCL—Residential Child Care Licensing. A division of CCL that regulates, licenses, and investigates residential foster care operations.

R/O—Ruled Out. An investigation disposition, meaning that a preponderance of evidence indicates that abuse, neglect, or exploitation did not occur.

RTB—Reason to Believe. An investigation disposition, meaning that a preponderance of evidence indicates that abuse, neglect, or exploitation occurred.

RTC—Residential Treatment Center. A type of GRO for children with more serious physical and mental health needs.

SIR—Serious Incident Report.

STAR Health—A statewide healthcare program run by Superior HealthPlan that provides Medicaid covered medical and behavioral health services for children in DFPS conservatorship and young adults in DFPS paid placements.

SWI—Statewide Intake. A division of DFPS that is responsible for receiving reports of abuse, neglect, and exploitation and referring those reports to the appropriate program for investigation.

TMC—Temporary Managing Conservatorship, a type of legal custody granted by the courts to DFPS. A child may remain in the State's TMC for 12 months, although a court can order a 6-month extension.

UTD—Unable to Determine. An investigation disposition, meaning that a determination could not be made because of an inability to gather enough facts. The investigator concludes that there is not a preponderance of evidence that abuse or neglect occurred; but it is not reasonable to conclude that abuse or neglect did not occur.

Appendix B

ATTACHMENT 1

Texas Department of Family and Protective Services

Commissioner
Stephanie Muth

September 22, 2023

Sent via electronic mail

The Honorable Aurora Martinez Jones,
126th State District Court Judge
Travis County Civil and Family Courts
aurora.martinezjones@traviscountytx.gov

The Honorable Brandy Hallford,
County Court at Law One, Williamson County
brandy.hallford@wilco.org

The Honorable Cheryll Mabray,
Child Protection Court of the Hill Country
Cheryll.Mabray@txcourts.gov

Dear Judges,

The Department of Family and Protective Services (DFPS) appreciates the opportunity to engage in constructive dialogue during the recent meeting regarding concerns raised for our children and youth in conservatorship who are without licensed placement in Region 7.

Appendix B

We understand that frequent and robust communication between DFPS and judges is critical to our joint efforts. During our meeting, DFPS committed to providing you information related to the topics discussed. While our work in these areas is ongoing, we would like to provide an update on our efforts to address child watch:

1. **Changes to Child Watch Structure**

   In partnership with multiple local mental health authorities across the state, DFPS is updating the expectations of youth temporarily staying at child watch locations. Updates include new guidelines and a system for increased structure to incentivize positive behavior. The updated structure will provide transparency to youth regarding rules and routine and will clarify staff expectations for DFPS employees working child watch. In preparation for implementation, DFPS will deploy specialized clinical coordinators to meet and discuss the changes with youth so that they are prepared and understand the new expectations. Clinical coordinators have established relationships with children and youth temporarily staying at child watch locations and are best equipped to help children and youth transition to the new structure. Implementation of the new structure will begin in October 2023 once staff training and youth communication is complete. Moving forward, if a youth is placed in child watch, this structure will be relayed to the individual youth when they are initially assigned to a child watch location.

Additionally, as of September 15, a new escalation requiring elevated approval for specific youth entering child watch began. The new process requires Child Protective Services and Child Protective Investigation Associate Commissioner notification if any child up to 10 years of age is at risk of entering child watch for any reason.

2. **Safety at Child Watch Locations**

The health and safety of youth and staff is of the highest priority. As of September 1, 2023, new contracts for child watch security services were initiated to support DFPS staff and youth awaiting placement. DFPS is consistently reviewing new processes and engaging staff and contracted providers to better intervene when necessary while remaining trauma-focused and supportive to prevent dysregulation, serious incidents, and youth leaving child watch locations without permission.

3. **Law Enforcement Engagement at Child Watch Locations**

DFPS is coordinating with local law enforcement agencies who have jurisdiction over child watch locations to reiterate the critical need for law enforcement support. As part of the discussion, DFPS will share information regarding child watch locations, the need for consistent and prompt law enforcement response to address worker safety concerns and missing children reports, trafficking concerns, and support for DFPS children who may have experienced

criminal victimization while not in our care and supervision. The intent of this communication is to reiterate and support our ongoing law enforcement communication on these topics.

4. **Security Assessments at Child Watch Locations**

DFPS is currently working with the Department of Public Safety (DPS) to conduct security assessments of all child watch locations in Region 7. Those assessments are specifically targeted to identify risks related to human trafficking. DFPS expects the initial assessments to be conducted by September 30, 2023 and will work with DPS to continue these assessments on an ongoing basis. DFPS will review the results of those assessments to determine whether additional actions are needed to ensure the safety of children and youth temporarily staying at child watch locations.

5. **Central Texas Data on Children who are Missing**

As of September 18, 2023, there were eight children and youth missing from care in Region 7. Of the eight children and youth missing, two have known sex trafficking history.

6. **Recent Legislative Impact to Placements**

Senate Bill 1930 passed during the 88th Regular Legislative Session. The bill amended law relating to policies and procedures regarding children placed by DFPS in a residential treatment center

> or qualified residential treatment program. Since the effective date of September 1, discussions and confusion regarding requirements of the court and legal party responsibilities prior to a placement occurs have developed. As a result, DFPS will meet with the Children's Commission and the stakeholder workgroup who focused on the bill to reduce confusion and ensure consistent implementation and partnership with Texas judges and legal parties.

We understand that the successful implementation of the actions outlined will require ongoing communication and cooperation from all parties involved. We are committed to an open line of communication and look forward to working closely with the courts, local mental health authorities, law enforcement entities, staff, and youth to monitor progress and make necessary adjustments.

Thank you again for your dedication to the children and youth in our care. We are confident that collaborative efforts will lead to positive outcomes.

Sincerely,

/s/ Jennifer Sims
Jennifer Sims
Deputy Commissioner

Appendix B

ATTACHMENT 2

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
CORPUS CHRISTI DIVISION

CIVIL ACTION NO. 1:19-CV-01610

M.D., B/N/F SARAH R. STUKENBERG, *et al.*,

Plaintiffs,

v.

GREG ABBOTT, IN HIS OFFICIAL CAPACITY AS
GOVERNOR OF THE STATE OF TEXAS, *et al.*,

Defendants.

ORAL DEPOSITION OF
STEPHEN PAHL
NOVEMBER 21, 2023

ORAL DEPOSITION OF STEPHEN PAHL, produced as a witness at the instance of the Plaintiffs and duly sworn, was taken in the above styled and numbered cause on Tuesday, November 21, 2023, from 1:04 p.m. to 1:58 p.m. before TAMARA CHAPMAN, CSR, RPR-CRR in and for the State of Texas, reported by computerized stenotype machine, at the offices of Haynes & Boone LLP, 98 San Jacinto Boulevard, Austin, Texas, pursuant to the Federal Rules of Civil Procedure and any provisions stated on the record herein.

Appendix B

[INDEX INTENTIONALLY OMITTED]

[4] MS GDULA: Paul, can we get an agreement on the record that "objection; form" will be sufficient and I'll provide more detail if and when you ask for it.

MR. YETTER: Yes.

MS. GDULA: Thank you.

STEPHEN PAHL, having been first duly sworn, testified as follows:

EXAMINATION

BY MR. YETTER:

Q. Would you introduce yourself to the Court, sir, please.

A. Yes, sir. My name is Stephen Pahl.

Q. Thank you, sir.

You're currently an employee of the Department of Family and Protective Services, I—excuse me. Scratch that.

You're currently an employee of Health and Human Services—

A. Yes, sir.

Q. —I understand?

A. That is correct.

Q. And how long have you worked for the State?

A. For the State of Texas?

[5] Q. Correct.

A. Going on 26 years. I believe.

Q. Among your responsibilities, as I understand it, you were an Assistant Deputy Inspector General for a period of time?

A. That is correct.

Q. I think it was 2016 to 2018?

A. That sounds right.

Q. And you've been in this role for about two years, since 2021?

A. A little over two years. That's correct.

Q. Your current title is Deputy Executive Commissioner, Regulatory Services, for the Services Division for the—for HHSC?

A. Yes. I would say that Deputy Executive Commissioner for the Regulatory Services Division for HHSC. If that's what you were trying to say, yes, sir.

Q. Yes, that's what I was trying to say.

A. All right.

Q. Your boss currently is Jordan Dixon, who is the chief policy and regulatory officer, I believe?

A. That's correct.

Q. And his boss is Commissioner Young?

[6] A. Jordan Dixon is a female.

Q. I didn't catch what you just said.

A. Jordan Dixon is a female. You referred to her as "he," I believe.

Q. I'm sorry. Her boss is Commissioner Young?

A. That's correct.

Q. Is this role as Executive Commissioner of Regulatory Services the first role you've had in child welfare?

A. Yes, sir.

Q. I don't believe you have any education in child welfare. Am I correct about that?

A. You are correct.

Q. And prior to 2021, did you have any work experience in the child welfare profession?

A. No, sir.

Q. Part of your responsibilities as Deputy Executive Commissioner of the Regulatory Services Division would include investigations of providers subject the HHSC regulation. Am I correct?

A. Yes, sir.

Q. And those investigations are done through a group called Provider Investigations, which is part of HHSC?

[7] A. Provider Investigations, they do conduct investigations. Yes, sir.

MR. YETTER: I'm having trouble hearing his response. I'm sorry. I don't know if it's your issue, Mr. Pahl, or maybe we just need to move that mic closer to you.

THE WITNESS: Is that better?

MR. YETTER: That's better.

Q. So in our role as Deputy Executive Commissioner do you have responsibility for Provider Investigations, the group that does investigations of certain providers?

A. Yes, sir.

A. Those providers for which the group Provider Investigations applies include homes that are staffed or called, within HHSC, the home and community-based services?

MS. GDULA: Objection; form.

A. That's correct.

Q. And that—those providers are all private providers. Am I right about that?

A. I believe that is correct. Yes, sir.

Q. Now, we can agree, can we not, Mr. Pahl, that investigations of reports of abuse, neglect, or exploitation of children are significant and [8] imporant undertakings. True?

MS. GDULA: Objection; form.

A. I would say that's true.

Q. And you know that because if there has been a report of abuse, neglect, or exploitation, the investigation will determine whether the report was accurate and the child remains at risk in that placement. Right?

A. Would you mind repeating that question?

Q. Sure. You agree that these investigations are significant because upon a report of abuse, neglect, or exploitation, if the investigation determines that it was well-founded, then that child remains—at least could remain in a placement that puts the child at risk. True?

MS. GDULA: Objection; form.

A. You used the "well-founded." Could you explain what you mean by that?

Q. Sure. "Well-founded" meaning "confirmed."

A. Okay.

Q. That the report of abuse, neglect, or exploitation is confirmed.

A. Okay. Then I would agree.

Q. So having accurate investigations really [9] is a matter that directly relates to child safety, does it not?

A. I would say yes.

Q. Now, Provider Investigations at HHSC, is there a—a specific executive that is in charge just of that group?

A. By "executive," explain what you—

Q. Or manager or administrator?

A. Yes.

Q. And who is that person?

A. That person ultimately is Michelle Dionne-Vahalik. She is the Associate Commissioner over the long-term care regulatory department.

Q. And does she report to you or Ms. Dixon?

A. She reports to me.

Q. I'm sorry?

A. She reports to me.

Q. All right. And I didn't catch her last name. Could you spell it for me?

A. I'm going to try my best. D-I-O-N-N-E, hyphen, V-A-H-A-L-I-K, I believe.

Q. All right. And since she reports to you, then, you have—and her title, by the way, excuse me, is what?

A. Associate Commissioner for long-term care [10] regulation.

Q. Now, this issue of the quality of Provider Investigations, this group, has obviously come front and

center in the foster care litigation in recent months. Do you know that?

MS. GDULA: Objection; form.

A. I'm aware of that.

Q. And have you read the monitor reports that came out in September, and another one in November, that touch on this issue of Provider Investigations?

A. I've read through most of that report, yes, sir.

Q. And which report have you read through most of?

A. It's a report that is—concerns the Remedial Order 3. I don't know if that's the exact title, but I'm sure you know what I'm talking about.

Q. I do. Let me put that in front of you. It's Tab No. 5. We'll mark this as Plaintiffs' Exhibit No. 3, I believe. 4.

(Exhibit 4 was marked.)

Q. And, Mr. Pahl, do you have in front of you Plaintiffs' Exhibit No. 4, which is titled: Monitors' Update to the Court Regarding Remedial [11] Order No. 3.

And it's dated September 19th, 2023.

A. I do, yes.

Q. Is this the document that you've read most of?

A. I believe it is. Yes, sir.

Q. Let me hand you Plaintiffs' Exhibit 5, which is Tab 6.

(Exhibit 5 was marked.)

Q. Mr. Pahl, we've handed you Plaintiffs' Exhibit No. 5, which is a supplemental update to the Court dated—from the monitors, dated November 10, 2023. Do you see that?

A. Yes, I do.

Q. Have you had a chance to read this document?

A. I have not.

Q. I'm sorry. Did you say you have not?

A. That is correct. I have not.

Q. Now, the—do you recall that one of the issues in the first monitors' report in September, Plaintiffs' Exhibit No. 4, is that Provider Investigations, that group, was not conducting timely investigations.

Do you recall that was one of the [12] concerns?

MS. GDULA: Objection; form.

A. I recall that being one of the concerns, yes.

Q. Do you know, as one of the executives at HHSC responsible for Provider Investigations, what the timeline is that's required by the Federal Court's remedial orders for face-to-face contact with the alleged child victim?

Do you know what that timeline is?

A. I believe it depends on what priority is given. So it depends.

Q. Let's start with Priority 1. What's the timeline or deadline?

A. I believe it's 24 hours.

Q. How about a Priority 2 report?

A. I believe that is within 72 hours.

Q. And you understand those requirements come from a federal court order in the foster care litigation, do you not, Mr. Pahl?

A. I'm not sure that I was aware of where those originated.

Q. In your position as Executive Commissioner of Regulatory Services at HHSC, have you read the Federal Court's remedial orders?

[13] A. I have read some of them, I recall. I don't believe I've read all of them in their entirety.

Q. Now, when you read the monitors'—or at least most of the monitors' report in September, which is Plaintiffs' Exhibit No. 4, were there any factual statements in the report that you can tell us today were inaccurate?

A. I don't believe that I am able to tell you if there's any inaccuracies in the report. I have not reviewed the report to—that extensively.

Q. I didn't quite catch the tail end of your answer. But did you receive any reports from your colleagues, your associate commissioner or any of her staff that there were inaccurate facts in the September 2023 update to the Court, which is marked as Plaintiffs' Exhibit No. 4?

A. I don't recall any.

Q. Now, some of the work that the monitors did in checking on the—Provider Investigations confirmed that these—this—these investigations were sometimes months late. Did you—do you recall reading that?

MS. GDULA: Objection; form.

A. I recall reading in the report that there [14] was some concerns that some of them were late, yes.

Q. And since you read that in September of 2023, have you, as executive commissioner of the regulatory services

division, instituted a new policy or practice for Provider Investigations to ensure that their investigations are done according to the deadlines of the federal court order?

A. I personally have not, no, sir.

Q. One of the things that has come out since the September report by the monitors is a temporary management directive—excuse me. Scratch that.

This summer, one of the things that came out is a temporary management directive dated June 1st, 2023. Do you know what I'm talking about?

A. No, sir.

Q. It is Tab No. 7 and let's mark that as Plaintiffs' Exhibit No. 6.

(Exhibit 6 was marked.)

Q. What you have in front of you now, Mr. Pahl, is Plaintiffs Exhibit No. 6, which is a June 1, 2023 temporary management directive. You've seen this before, have you not?

A. I don't recall seeing this.

Q. It deals with efficient investigative procedures. Do you see that in the title?

[15] A. I do.

Q. And that obviously, then, would—and it is from your agency, the Texas Health and Human Services agency. Right?

A. Correct.

Q. And this would be for Provider Investigations, would it not, as it says in the first paragraph for purpose?

A. As stated in the purpose, yes, sir.

Q. Okay. So this is about five months ago and a new directive—directive means—am I correct it would mean a policy or a requirement for Provider Investigations?

A. That would be a fair characterization.

Q. Okay. And this says it—that the directive, in the first paragraph, actually started in September of 2022. So it's been—do you see that?

A. Yes, sir.

Q. It's been going on now for about 15 months. Right?

A. About, yeah. Yes, sir.

Q. And in the background paragraph, it says that this new directive was issued in an effort to assist with a backlog in Provider Investigations.

[16] Do you see where I'm reading?

A. I do. Yes.

Q. And a backlog meaning investigations—reports of abuse, neglect, and exploitation were not being investigated timely and they were stacking up. Right?

A. That's fair.

Q. Then it says PI leadership, so Provider Investigations' leadership. And would that include your colleague, the associate commissioner?

A. I would assume so. Yes, sir.

Q. And would it—since you're ultimately in charge of Provider Investigations, would it include you?

A. Not necessarily.

Q. So this is saying that the PI leadership review ways to make the process—investigative process more efficient. Right?

A. That's what it says, yes.

Q. And then in the procedures paragraph, it says in the—I'm still on Page 1 of Plaintiffs Exhibit No. 6. It says: When the evidence demonstrates an unconfirmed or inconclusive finding, the investigator will no longer explain how the evidence does or does not satisfy the element when [17] documenting the Analysis of Evidence.

Do you see where I was reading?

A. Yes, I do.

Q. So basically, if the investigator concludes that or finds that the report of abuse, neglect, and—or exploitation is unconfirmed or inconclusive, the investigator is told by HHSC not to explain why the evidence does or doesn't show the finding of the investigator.

MR. WATKINS: Objection—

Q. Did I read that right?

MS. GDULA: Objection; form.

A. I believe you read that correctly, yes, sir.

Q. Okay. Now, why would it be, Mr. Pahl, in your experience now and as basically the top agency executive in charge of Provider Investigations, why is it a good idea not to explain the evidence that supports an investigator's finding? Do you have any idea?

A. I would say no. I don't—I don't have any idea why.

Q. Now, is this directive, to your knowledge, still in place at HHSC telling investigators not to explain why they find that a [18] report of abuse, neglect, or exploitation is unconfirmed or inconclusive?

A. I'm not—

Q. Is it still in place?

A. I'm not sure. You would have to ask the leadership within PI if this is still in effect.

Q. Now, one of the things that has come out from your group since the September report of the monitors is an updated Provider Investigations handbook, has it not?

A. I'm not aware.

Q. Let me show you Exhibit No. 7, which is Tab No 8.

(Exhibit 7 was marked.)

Q. And we have just handed you Plaintiffs Exhibit No. 7, which is called "Provider Investigations Handbook."

Do you have that, sir?

A. Yes, sir.

Q. And this obviously is an official policy document of the—your employer, Texas Health and Human Services. True?

A. I would say it's an official investigations handbook.

Q. Right. I mean, these are the—this is [19] the—these are the formal policies for this group issued or adopted by the Texas Health and Human Services agency. Right?

A. I'm not aware of the—if this is a policy handbook or a procedures handbook without reviewing it any further.

Q. Okay. As the ultimate head of Provider Investigations, you can confirm for the Court that this handbook is what the investigators in this group are required to follow. True?

A. It appears so. Yes, sir.

Q. Because it says in the front page this document is for the Provider Investigations staff, including administrative assistants, investigators, program managers, assistant regional directors, regional directors, and other Provider Investigations employees. So everybody's supposed to follow it. Right?

A. As you have described, yes.

Q. And it says: This document is intended to provide direction. Right? So this is not, kind of, voluntary. This is mandatory. True?

A. I would agree with that.

Q. Okay. Now, if you look at the—on the bottom right-hand corner, it says that it—this is [20] for fiscal year 2024 and what is the fiscal year of the HHSC? Is it a calendar year or some other year?

A. Repeat the question, please.

Q. What's the fiscal year for HHSC? Is it a calendar year or summer to summer, or do you know?

A. It starts—it starts in September and ends in August.

Q. Okay. So fiscal year 2024 would—we would be in fiscal year 2024 right now. It started in 2023 and it ends in August 2024?

A. Yes.

Q. So what we're looking at, Exhibit No. 7, is the—to your knowledge, the current handbook for Provider Investigations?

A. It appears so, yes.

Q. And this was issued on October 23, 2023. You see that date?

A. I do.

Q. So this would be about a month after the monitors' update to the Court that you read most of on September 19th, 2023. True?

A. It appears so, yes.

Q. Now, in the monitors' report, am I—would I be correct to say that you read—the Exhibit No. 4, the September 2023 report, you read [21] some very troubling results of the monitors' investigations?

MS. GDULA: Objection; form.

A. By "troubling," can you explain what you mean by "troubling"?

Q. Meaning that you personally were upset and concerned about the things you read in the monitors' update in September, were you not?

A. I don't know that I would say I was upset, but concerned is fair.

Q. Okay. Concerned, not upset?

A. I would say that's correct, yes.

Q. Okay. Got it.

Because children's lives are at stake. Right?

A. That's right.

Q. And after you read these findings in the monitors' report in September 2023 which caused you concern for children's safety, did you make a point of telling your staff to—in the new edition of the handbook, to deal with those concerns that you had?

A. That would not be my role to—to make that announcement. That would—that would lie somewhere within Provider Investigations. Some [22] management staff within Provider Investigations would have done such.

Q. All right. So am I—would it be fair to say that you, Mr. Pahl, as executive commissioner, did not initiate any changes to the Provider Investigations handbook based on the monitors' September 2023 report? Is that accurate?

MS. GDULA: Objection; form.

A. That is accurate, yes.

Q. Now, did your colleague, your assistant commissioner who you say is kind of focused entirely on Provider Investigations, did she report to you on any changes that were made in the Provider Investigations handbook in order to address the concerns that you had from the monitors' September 2023 update to the Court?

A. I don't recall.

Q. So as you're sitting here today, since the September 2023 report of the monitors to the Court about Provider Investigations, are you aware of any changes in practice or policy at HHSC with regard to Provider Investigations to address the concerns that were raised by the monitors, any changes?

A. Not apart for those that are—been [23] updated in the handbook, I'm not aware of any.

Q. All right. Let's go through the handbook and let's see what's there. And have you read the handbook any time recently?

A. No, sir.

Q. Would you agree that an investigation by your group, Provider Investigations, of a report of abuse, neglect, or exploitation of a child in a provider facility should take into account the history of the provider agency, good, bad, or indifferent?

A. In the—in the scope of Provider Investigations?

Q. Yes.

A. I'm not sure.

Q. Well, let me give you an example.

A. Okay.

Q. If a particular provider agency had a history of violations or confirmed reports of abuse, neglect, or exploitation of children, wouldn't you think, Mr. Pahl, as Executive Commissioner of Regulatory Services that the investigator in Provider Investigations, should consider that bad track record of the provider agency when assessing the new report of alleged abuse, neglect, and [24] exploitation?

MS. GDULA: Objection; form.

A. My understanding is that Provider Investigations is focused on the perpetrator and not the provider. Maybe—

Q. I'm not sure if that was an answer to my question.

Is the answer to my question is, no, you do not think that a bad track record of a provider agency should be considered in investigating a new report of alleged abuse, neglect, and exploitation at the same agency?

A. Would you mind repeating the question.

Q. I didn't catch that answer.

A. Would you mind repeating the question?

Q. Certainly. Are you saying that a bad track record, a—a troubled history of a provider agency should not be considered by Provider Investigations when investigating a new report of alleged abuse, neglect, or exploitation of a child at the very same agency?

A. I would say, yes, if they're given the authority to do so.

Q. And that's logical because history can repeat itself, can't it?

[25] MS. GDULA: Objection; form.

A. I suppose history can repeat itself, yes, sir.

Q. And just like a bad or troubled history of a particular perpetrator, a particular caregiver, can be relevant to an investigation. You'd agree with that, wouldn't you?

A. Yes. Yes.

Q. A bad track record or history of a provider agency where there is a new report of alleged abuse, and neglect, or exploitation at the same agency is relevant. Right?

A. I would say so, yes.

Q. Now, do you know that the children at facilities that are being investigated by Provider Investigations can be disabled, and maybe they're all disabled, but at least some of them, many of them are disabled—intellectually disabled. Do you know that?

MS. GDULA: Objection; form.

A. Yes, sir.

Q. And likewise, at many of these home and community-based facilities, there are adults that reside there and they too are intellectually disabled?

[26] A. That's my understanding. Yes, sir.

Q. Did you realize that these what are, I think, called HCS homes, can have both children and adults residing at the same home?

A. I was not aware of that.

Q. Now, if—you'd agree, wouldn't you, that if your investigators in Provider Investigations are going to do an

investigation of alleged abuse, neglect, or exploitation of chi-—an intellectually disabled child, that the investigator from HHSC needs to take account of the child's disability in making the investigation. You'd agree with that, wouldn't you?

A. Yes, I would.

Q. For example, if a child's limitations are such that they are nonvocal, that their disability is such that they don't speak, the investigator would need to take account of that so that they could actually comm—that the investigator could communicate with the alleged child victim. Wouldn't you agree with that?

A. Yes, sir.

Q. And if you—if your group of Provider Investigations is not taking account of the individual disabilities of the alleged victims, then [27] you're not going to be completing accurate investigations, are you?

MS. GDULA: Objection; form.

A. I'm not sure that I agree with that.

Q. I'm sorry. What—how would—what about that would you disagree? If you can't talk to the child or communicate with the child, how do you complete an investigation?

A. I don't know that that is always necessary to obtain your evidence in such a manner. There may be other ways that you obtain evidence there and I think that each investigation would probably be very different.

Q. All right. Mr. Pahl, let me see if I understand the answer you just gave to us.

You're not sure as the ultimate executive for Provider Investigations that it is always necessary to communicate with the alleged child victim in order to have a reliable and accurate investigation and—did I hear you correctly?

A. Yes. There may be other ways that you can obtain evidence that you would need without having to speak with a—with the victim.

Q. Sure. And I'm not saying necessarily speak like converse, but just communicate, just to [28] be able to understand what the child victim—his or her perspective is, you're saying that is not a necessary part of an investigation by your group Provider Investigations of—of alleged abuse, neglect, and exploitation?

A. It may be—it may be necessary for certain investigations. As I said before, I think all investigations are different and aren't conducted the same way.

Q. Now, do you know whether it is a requirement of HHSC to take into account the—an alleged child victim's unique capabilities and disabilities in order to best communicate with the child in a situation of a report

of alleged abuse, neglect, and exploitation? Do you know whether that's a requirement of HHSC?

A. I'm not aware of whether it's a requirement or not.

Q. And given what you were saying about it may not be actually necessary to communicate with the alleged child victim, you're not sure there's really even a requirement to try to communicate with the alleged child victim. Am I right?

A. I'm not aware of a requirement, yes.

Q. Let—let's move from the child vic-—[29] the alleged child victim to the alleged perpetrator. Do you believe, Mr. Pahl, as—in your position as kind of the head man or the top executive of Provider Investigations that understanding the track record or the history of the alleged perpetrator is vital information for an accurate and reliable investigation?

A. I would agree.

Q. And that track record that is so vital would include the criminal history and the criminal history records of the alleged perpetrator, wouldn't it?

A. I would assume it would.

Q. Because I can't—can you think of any sort of information about an alleged perpetrator's history that would be, perhaps, more relevant than their criminal record involving similar conduct?

A. I can't think of any.

Q. Would you agree that an investigation done months later is likely to be a less reliable and less accurate investigation than one done timely and near the—near the alleged abuse, neglect, and/or exploitation?

A. Would you mind repeating that question?

Q. Sure. Would you agree that an [30] investigation done months after an outcry of alleged abuse, neglect, or exploitation is likely to be less accurate and reliable than one that is done timely?

MS. GDULA: Objection; form.

A. I think it's possible but maybe not always.

Q. I want to change topics slightly, Mr. Pahl. There is—there are situations where an investigation involves allegations of multiple violations. You understand that that can happen, do you not?

A. Yes.

Q. And the investigation of multiple violations may result in different findings on different violations. You can appreciate that that might happen as well—

A. Yes.

Q.—would you not?

A. Yes.

Q. For example, if you had two or more violations and some of the violations were found to be inconclusive and others were found to be unconfirmed—and do you know what those categories mean?

A. I believe I do, yes.

[31] Q. Do you have any good reason to explain to us why HHSC or Provider Investigations would take the lesser finding and apply it to the investigation as opposed to the more serious finding?

MS. GDULA: Objection; form.

A. I do not.

Q. Can we agree that there is no reason why children that are intellectually disabled should receive less thorough and accurate investigations of their outcries of alleged abuse, neglect, and exploitation than children who do not have the same intellectual disabilities?

A. I would agree.

MR. YETTER: Excuse me. I'm moving to a new topic. I apologize for the pause. Can we take a five-minute break to make sure that I'm finished. But I think I'm about ready to wrap up and then we can let Mr. Pahl go.

MS. GDULA: Sure. So we'll be back here at 1:55?

MR. YETTER: That sounds fine.

THE STENOGRAPHER: Rough today. Final as soon as possible.

MR. YETTER: Thank you for your time today. We pass the witness.

[32] MS. GDULA: We'll reserve our questions.

(Deposition concluded at 1:58 p.m.)

THE STENOGRAPHER: Rough draft?

MS. GDULA: No. Final when the other side gets it. When will it be ready?

THE STENOGRAPHER: Tomorrow.

MS. GDULA: Okay.

[33] CORRECTION PAGE

WITNESS NAME: STEPHEN PAHL DATE: 11/21/2023

PAGE LINE CHANGE REASON

_____

_____

_____

_____

_____

Appendix B

[34] SIGNATURE PAGE

I, STEPHEN PAHL, have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted on the correction page.

_____

STEPHEN PAHL

Job No. HOU6322893

Appendix B

[35] IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
CORPUS CHRISTI DIVISION

CIVIL ACTION NO. 1:19-CV-01610

M.D., B/N/F SARAH R. STUKENBERG, *et al.*,

Plaintiffs,

v.

GREG ABBOTT, IN HIS OFFICIAL CAPACITY AS
GOVERNOR OF THE STATE OF TEXAS, *et al.*,

Defendants.

REPORTER'S CERTIFICATION
DEPOSITION OF STEPHEN PAHL
TAKEN NOVEMBER 21, 2023

I, TAMARA CHAPMAN, Certified Shorthand Reporter in and for the State of Texas, hereby certify to the following:

That the witness, STEPHEN PAHL, was duly sworn by the officer and that the transcript of the oral deposition is a true record of the testimony given by the witness;

That the original deposition was delivered to R. PAUL YETTER;

That a copy of this certificate was served on all parties and/or the witness shown herein on _____.

[36] I further certify that pursuant to FRCP No. 30(f)(i) that the signature of the deponent:

X was requested by the deponent or a party before the completion of the deposition and that the signature is to be returned within 30 days from date of receipt of the transcript. If returned, the attached Changes and Signature Page contains any changes and the reasons therefor;

was not requested by the deponent or a party before the completion of the deposition.

I further certify that I am neither counsel for, related to, nor employed by any of the parties in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of the action.

Certified to by me this 22nd of November, 2023.

/s/_____
Tamara Chapman, CSR, RPR-CRR
CSR NO. 7248; Expiration Date: 12-31-23
Veritext Legal Solutions
Firm Registration No. 571
300 Throckmorton Street, Suite 1600
Fort Worth, Texas 76102
800-336-4000
[37] kimberly.gdula@oag.texas.gov

Appendix B

November 22, 2023

RE: MD, Et Al v. Abbott, Greg, Et Al.
DEPOSITION OF: Stephen Pahl (# 6322893)

The above-referenced witness transcript is available for read and sign.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those on the attached Errata Sheet.

The witness should sign and notarize the attached Errata pages and return to Veritext at errata-tx@veritext.com.

According to applicable rules or agreements, if the witness fails to do so within the time allotted, a certified copy of the transcript may be used as if signed.

Yours,
Veritext Legal Solutions

Appendix B

ATTACHMENT 3

- The investigative record did not include any information related to the investigator's decision to change the final disposition of the allegation of Physical Abuse from Inconclusive to Unconfirmed.[53] Because the investigator was unable to obtain information that confirmed when and how the child sustained the injury, the allegation of Physical Abuse should have been assigned a disposition of Inconclusive.

With regard to the allegation of Neglect, the Monitors also find the investigation was deficient. The investigative record raises the same critical concerns highlighted in the above investigations (most notably, IMPACT IDs: 48632744 and 48646196): namely, that Educare failed to train and support the single, on-duty staff member (Staff 4) to adequately care for Child A. Due to these failings, Staff 4 was unable to effectively intervene to protect Child A and other residents when Child A's behavior escalated on the date of the alleged incident. The responding law enforcement officer to the incident reported that Staff 4 "could not control" Child A and that the group home appeared "understaffed." Similar to other investigations, the investigator again failed to discuss or further explore whether Educare administrators had failed to "provide a safe environment for [the child], including the failure to maintain adequate numbers of appropriately trained

53. The monitoring team did not locate any supporting documentation for this investigation in PI's external storage database, NeuDocs.

staff" resulting in or creating risk of physical or emotional injury or death for this child.[54]

Finally, when Child A entered the hospital on April 30, 2021, Educare discharged the child from its care. According to a physician who treated Child A at the hospital, staff members brought the child to the hospital with her all of her belongings.

Notable Gaps in Investigation Timeframe:

The investigation took four months to be completed. The intake was received on May 4, 2021. An extension was approved on June 14, 2021, with documented reasons of "Extraordinary Circumstances" and "More time is needed to identify and interview collaterals, company has not provided requested information." The investigation was completed on September 2, 2021, approved on September 2, 2021, and closed on November 3, 2021.

Child C, age 14-15, IQ Unknown

The monitoring team reviewed 12 investigations into abuse or neglect of Child C (age 14-15) while she was placed at C3 Academy, LLC, an HCS Group Home. Eleven of the investigations resulted in an overall disposition of Unconfirmed or Inconclusive; in one investigation of Physical Abuse, PI entered a disposition of Confirmed for the allegation that a staff member physically abused Child C when she tasered the child.

---

54. *See* 26 Tex. Admin. Code § 711.719(b)(3).

Child C was placed at C3 Academy for one year from April 4, 2021 to May 4, 2022. According to Child C's Plan of Service, Child C is diagnosed with: Unspecified Disruptive Behavior Disorder; Language Disorder; ADHD-Combined Presentation; and Intellectual Disability-Mild (provisional). Child C's Full-Scale IQ is unknown because she was unable to participate in IQ testing.

As the following table shows, PI opened ten of the 12 investigations related to allegations of abuse and neglect of Child C between May 24, 2021 and November 7, 2021. The last two investigations opened in April 2022, with the final investigation opening on April 28, 2022 after a staff member dropped Child C off at a hospital with a broken jaw. The 12 investigations involved six unique alleged perpetrators, two of whom were involved in more than one investigation. PI did not complete all of the investigations until March 20, 2023, with the longest investigation spanning 19 months prior to completion. Due to substantial delays in PI's completion of these investigations, Child C was no longer placed at C3 Academy when these investigations closed.[55]

55. Child C is currently placed at a State Supported Living Center. As of September 1, 2023, Child C is an alleged victim in three open investigations into allegations of Sexual Abuse and Physical Abuse. She is also an alleged victim in three additional investigations in her current placement that opened between June 11, 2023 and July 16, 2023 and closed with dispositions of Unconfirmed.

Title 2: PI Abuse or Neglect Investigations of Child C

Case ID	Intake Date	Completed Date	Closed Date	Months open prior to Completion	Allegation Type	Alleged Perpetrator
48677387	5/24/2021	10/15/2022	10/17/2022	16+ months	Physical Abuse	Staff 1
48746511	7/19/2021	1/26/2023	1/30/2023	18 months	Neglect	Staff 2
48769719	8/7/2021	1/26/2023	1/30/2023	17 months	Neglect	Unknown
48777670	8/13/2021	1/26/2023	1/30/2023	17 months	Neglect	Staff 2
48785934	8/20/2021	3/20/2023	3/21/2023	19 months	Neglect	Staff 3
48797313	8/29/2021	1/27/2023	1/30/2023	17 months	Neglect Physical Abuse	Staff 2 Staff 2
48794924	8/26/2021	2/7/2023	3/24/2023	17 months	Physical Abuse	Staff 3

48801178	9/1/2021	2/7/2023	4/13/2023	17 months	Neglect Physical Abuse Physical Abuse	Staff 4 Staff 4 Staff 3
48846045	10/2/2021	1/27/2023	1/30/2023	16 months	Neglect Physical Abuse	Staff 3 Staff 3
48896408	11/7/2021	12/21/2022	12/23/2022	13 months	Sexual Abuse	Staff 2[56]
49096014	4/6/2021	1/27/2023	1/30/2023	9+ months	Physical Abuse	Staff 5
49131249	4/28/2022	2/7/2023	4/13/2023	9 months	Physical Abuse	Staff 6

56. According to IMPACT, the investigator did not formally assign a named alleged perpetrator to this investigation. However, within the investigative record, the investigator named Staff 2 as the alleged perpetrator.

Appendix B

In eleven of the 12 investigations, the investigator requested and received an extension; however, there is no documentation in the record to explain the delays or reasons for the extensions. The monitoring team identified that these significant investigative delays and egregiously deficient investigations left Child C at great risk of harm while she continued to be placed at C3 Academy. The State's lack of action on behalf of Child C and the decision to have her remain in the care of this entity is confounding in the face of these allegations.

The investigative records included the following dangerous investigative practices in the face of serious allegations of abuse and neglect of Child C: an overarching failure to prioritize and take into account the child's safety needs at all times; failure to timely and adequately interview Child C, if at all, particularly considering her documented speech and comprehension limitations; and unexplained investigative delays of over a year that significantly impeded the quality and quantity of information investigators gathered to assess whether the child had suffered abuse or neglect. In many instances, the failure to pursue the allegations for months at a time displayed an abject indifference to child safety. Further, as described more fully below, in addition to the deficiencies identified by the monitoring team within each of the individual investigations, HHSC and its investigators also failed to appropriately coordinate their work among investigations involving Child C and her repeated outcries and reports of abuse and neglect. This and other critical lapses in investigative practice left Child C at serious risk and, ultimately, allowed for further harm to occur to the child.

Appendix B

The State's unexplained and extensive delays and inactivity turned a deaf ear to Child C's repeated outcries of abuse or neglect across investigations. As a result, the State did not identify patterns and concerns related to Child C's care while placed at C3 Academy, which began with an incident of confirmed Physical Abuse when the child was tasered by a staff member and culminated one year later when Child C suffered a broken jaw from Physical Abuse that PI should have Confirmed. Due to these failures, PI investigators did not appropriately investigate nor mitigate risk of harm to Child C following allegations of abuse or neglect at C3 Academy. Moreover, HHSC conducted the investigations with an utter and shocking disregard for child safety.

Confirmed Physical Abuse of Child C

7. IMPACT Case ID: 48677387

Summary of Key Allegations and Monitors' Review:

On May 24, 2021, six weeks after Child C was placed at C3 Academy, PI initiated its first investigation (IMPACT ID: 48677387) of Physical Abuse of Child C by a named staff member.

Assigned Priority and Disposition:

Significantly delayed, PI completed the Priority One investigation nearly 17 months later on October 15, 2022 with a disposition of Confirmed and found a preponderance of evidence that a staff member tasered Child C on her arm while she was in bed:

> Testimony from [Child C] supports that [Child C[57]] identified [Staff 1] by name and that [Staff 1] held a taser to [Child C's] inner left forearm multiple times. Photographs of [Child C's] inner left forearm support there were burn, signature or taser marks. Testimony from Officer [name removed] supports that after review of the photographs of [Child C] by Officer [name removed] that he could confirm the marks were signature marks or burn marks from a taser and it looked like when someone would touch a taser to skin and the person would pull away and then the taser would be touched again to the skin harder. Although a taser could not be recovered, Incident/Investigation Report supports that at one point [Staff 1] did have a taser even though she had not seen it since December of 2020.

As of September 1, 2023, the staff member is not registered on the Employee Misconduct Registry where such instances are confirmed for future employers.

Monitors' Review:

As noted below in the investigation timeline, there is no documentation in the record to explain the extensive delay nor the lack of investigative activity for more than thirteen months. The investigation incorporated evidence from

---

57. The investigator wrote Staff 1 in this location of the text, not Child C. This appears to be a typo.

law enforcement's criminal investigation but there is no indication in any of the records that the investigative delay was caused by such coordination with law enforcement. The significant delay in the resolution of these serious allegations as eleven new investigations emerged naming this child as an alleged victim, evidences a profound failure to conduct the investigation consistent with the child's safety needs as required by Remedial Order 3.

During Child C's interview, the investigator used an American Sign Language (ASL) interpreter due to Child C's documented limited speech. With the assistance of the interpreter, Child C used some signs, gestures, and language to communicate to the investigator that Staff 1 held something against her forearm twice and that it hurt; the investigator ultimately determined that the object the staff member used on Child C's arm was a taser. As discussed in the following investigations involving Child C, investigators routinely failed to accommodate Child C's limited speech through methods such as an ASL interpreter; this failure in subsequent investigations may have reduced the child's ability to communicate and report allegations of abuse or neglect during her subsequent interviews with investigators.[58]

---

58. Child C's records indicate that she has varying communication capacities, including some ability to speak in short sentences and answer questions. To accommodate Child C's communication, the child's record documents that she has "some sign language" and that a communication board was requested for her "as she is not able to fully communicate." It is not evident from the records that Child C was provided a communication board nor that any PI investigators considered the use of such a tool to

Appendix B

Notable Gaps in Investigation Timeframe:

The investigation took one year and four months to be completed. The intake was received on May 24, 2021. An extension was approved on June 25, 2021, with a documented reason of "Other: Need to interview collaterals and alleged perpetrator." The investigation was delayed without activity between June 2021 and August 2022. The record did not include any explanation for the lack of investigative activity for more than thirteen months and substantial delay in completing the investigation. The investigation was completed on October 15, 2022, approved the same day on October 15, 2022, and closed on October 17, 2022.

Following the Physical Abuse of Child C by a staff member using a taser, Child C remained at the C3 Academy for ten additional months and was identified as an alleged victim in 11 other investigations. Of those additional investigations, six included further allegations of Physical Abuse of Child C. PI failed to appropriately investigate these allegations and, as a result, did not safeguard Child C's safety. In two of the investigations, the monitoring team disagreed with PI's finding of Inconclusive, instead finding that the investigative records included a preponderance of evidence of Physical Abuse or Neglect. In the first investigation, the record showed that a staff member neglected Child C when he locked the child and another adult resident in a bedroom at night and left the premises, and in the

---

encourage Child C's ability to report information to investigators to safeguard her safety.

second investigation, the record showed that a different staff member physically abused Child C by breaking her jaw. In all other instances, the investigations were substantially deficient.

Unconfirmed and Inconclusive Allegations of Abuse or Neglect of Child C

8. IMPACT Case ID: 48746511

Summary of Key Allegations:

On July 19, 2021, two months after a staff member used a taser on Child C's left forearm in a manner consistent with it being "pulled away and . . . touched again to the skin harder," a law enforcement officer reported an allegation of Neglect of Child C at C3 Academy. The reporter stated that Child C ran away from the placement. After law enforcement located and returned the child to her placement on the same day, the child allegedly attempted to strangle herself by placing a sheet around her neck. According to the officer, the child stated that she was trying to kill herself and that she wanted to be admitted to a hospital.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority Two investigation, PI initiated a Neglect investigation related to Child C by a named staff member, Staff 2. Due to substantial investigative deficiencies, most notably the 18 months to complete the investigation, a

disposition regarding the Neglect allegation cannot be determined, despite the investigator's assignment of a disposition of Unconfirmed.

Monitors' Review:

The investigator did not attempt to gather sufficient evidence to determine whether Staff 2 adequately supervised Child C at the time of the incident. The investigator conducted a face-to-face interview with Child C eight days after PI received the intake with the assistance of an ASL interpreter. During her interview, Child C reported that she ran away from the group home and wrapped a sheet around her neck in response to verbal and physical altercations with other residents in the home. Following this interview, the investigator did not conduct any additional investigative activity for 18 months, during which time the investigation alleging another staff member tasered the Child also remained open.[59] Once the investigation resumed a year and a half later, and nine months after Child C had been moved from the HCS Group Home, the investigator identified the staff member responsible for Child C's supervision at the time of the incident but did not attempt to interview this key individual. The investigator also did not attempt to identify and interview any other staff members or other residents who may have been present on the day that the child attempted to kill herself.

---

59. PI closed the investigation involving a staff member tasering Child A nearly 17 months after it was initiated in October 2022 and three months before the instant investigation (IMPACT ID: 48746511) closed in January 2023.

The investigator interviewed the responding law enforcement officer to the incident; the officer reported that the staff member contacted law enforcement promptly after Child C eloped and responded appropriately when Child C attempted to place the sheet around her neck. Although the law enforcement officer and Child C did not appear to report any concerns for Neglect to the investigator, the investigator did not assess whether the staff member appropriately supervised Child C prior to her elopement.Moreover, the investigator failed to determine whether staff members took appropriate actions to minimize, address, or contain any verbal or physical altercations between Child C and the other residents or whether supervisory failures contributed to the conflicts in other ways. Because the investigator did not interview key individuals involved in the alleged incident, including the alleged perpetrator, the investigator failed to gather sufficient evidence to determine whether the alleged perpetrator neglected Child C prior to her elopement.

Notable Gaps in Investigation Timeframe:

The investigation took one year and six months to be completed. The intake was received on July 19, 2021. An extension was approved on November 2, 2021, with a documented reason of "Need to talk to collaterals, Ap, request documentation and police report." The investigation was delayed without activity between July 2021 and January 2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on January 26, 2023,

approved the same day on January 26, 2023, and closed on January 30, 2023.

9. IMPACT Case ID: 48769719

Summary of Key Allegations:

On August 7, 2021, nearly three weeks after SWI received the above intake report, a law enforcement officer reported that he responded to another incident of Child C eloping from the placement. According to the reporter, law enforcement observed Child C running down a busy street and a staff member was running after her. The reporter expressed concern that Child C was a "flight risk" and that the staff members at the placement may not have provided adequate care for her. The reporter noted that other residents had allegedly wandered off "unnoticed" from the placement. Lastly, the reporter stated that he observed marks on Child C's arm, but he did not know whether the marks were injuries.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority Two investigation, PI initiated a Neglect investigation related to Child C by an unknown staff member, which became its third open investigation involving Child C. Due to substantial investigative deficiencies, most notably the 17 months to complete the investigation, a disposition regarding the Neglect allegation cannot be determined, despite the investigator's assignment of a disposition of Unconfirmed.

Appendix B

Monitors' Review:

The investigator did not gather sufficient evidence to render a disposition regarding the allegation of Neglect of Child C. First, the investigator attempted to interview Child C three days after the date of the intake report while the child was hospitalized;[60] the child was asleep when the investigator arrived at the hospital to conduct the interview. The investigator documented that she observed Child C asleep in the emergency room with a blanket over her and that she did not observe any marks or bruises on the child, presumably because the blanket covered the child's body. The child returned to the placement after a few days in the hospital; the record did not document the length of her hospital stay and the investigator did not attempt to interview Child C again, at the hospital nor at the group home.[61] In the absence of interviewing and adequately observing the child, the investigator failed to assess the child's safety and gather information about the allegation, particularly given the reporter's observation that the child had marks on her arms and was not receiving adequate care at C3 Academy, in addition to pending allegations she had been tasered by a staff member nine weeks earlier, had eloped previously, and had then tried to tie a sheet around her neck. Following

60. The Monitors could not determine why the child was hospitalized from the available records.

61. While a separate investigation of Neglect during this time-period referenced a visitor suspension at C3 Academy due to COVID-19, there is no such documentation in this record explaining why the investigator never spoke to nor fully observed the child in-person or through other means.

the attempted visit with Child C, the investigator did not pursue any additional investigative activity for 17 months and, shortly thereafter, closed the investigation with a disposition of Unconfirmed. The investigator concluded the investigation without identifying and interviewing an alleged perpetrator or any other staff members who may have been present on the day of the alleged incident. Finally, the investigator did not consider highly relevant information about the allegations, including reports by a law enforcement officer that residents wandered off from the property "unnoticed." The investigator did not consider whether the group home's referral history included similar allegations that the group home failed to provide adequate care to and supervision of children;[62] as noted previously, a review of those patterns is not part of PI's practice unless it involves the same alleged perpetrator or victim.

Because the investigator did not gather any evidence related to the allegations, including a failure to communicate with the child, the assigned disposition of Unconfirmed to the allegation of Neglect is baseless and inappropriate.

Notable Gaps in Investigation Timeframe:

The investigation took one year and five months to be completed and there was no approved extension.[63] The

62. *See e.g.*, DFPS, *Preponderance of the Evidence*, 1, 5 (undated training manual) (on file with the Monitors).

63. IMPACT shows that the investigator requested an extension on September 9, 2021; however, it appears that a supervisor did not approve this extension.

intake was received on August 7, 2021. The investigation was delayed without activity from August 2021 to January 2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on January 26, 2023, approved on January 26, 2023, and closed on January 30, 2023.

10. IMPACT Case ID: 48777670

Summary of Key Allegations:

Nearly a week after law enforcement reported the above allegations (IMPACT ID: 48769719), on August 13, 2021, a different law enforcement officer reported another allegation of Neglect of Child C at C3 Academy. The law enforcement officer reportedly spoke to Child C while she was admitted to a hospital (a different hospital stay from the one referenced above, during which time the investigator failed to return to interview the child). The child was hospitalized after she allegedly jumped out of a van and attempted to tie sheets around her neck for the second time in approximately four weeks. Child C disclosed to the law enforcement officer that she was punched a lot at her placement. The law enforcement officer observed a laceration near the child's right eye. The child then reported that a named resident (Individual 1, age 20) punched her and she bled a lot. The child reported that she did not receive medical care for the injury to her eye.

Appendix B

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority Two investigation, PI initiated a Neglect investigation related to Child C by a named staff member, Staff 2, which became its fourth open investigation regarding Child C. Due to substantial investigative deficiencies, most notably that it took 17 months to complete the investigation, a disposition regarding the Neglect allegation cannot be determined, despite the investigator's assignment of a disposition of Unconfirmed.

Monitors' Review:

Due to a substantially delayed investigation and missing interviews with key individuals, the investigator failed to determine the following information to inform the disposition.

- Whether Staff 2 adequately supervised the child to prevent or mitigate the child from jumping out of the van and whether the staff member promptly notified law enforcement following her exit from the van;

- Whether Staff 2 adequately supervised the child prior to her tying a blanket around her neck for the second time in four weeks: and,

- Whether the child's injury near her eye was due to a lack of supervision.

First, the investigator interviewed Child C by video call using the application FaceTime.[64] The investigator did not document any efforts to accommodate Child C's limited speech during the interview; in two other investigations, the record documented that PI conducted the interview with the assistance of an ASL interpreter and it is unclear how this investigator determined that she could ensure Child C's meaningful participation in the video interview without aid. During her interview, Child C reported to the investigator that she jumped out of the van because Staff 2 poured out her soda. Child C also reported that Individual 1[65] scratched her and caused her lip to bleed, as she alleged in the intake report. During the video call, the investigator reportedly took screenshots of the child; the investigative record did not document whether the screenshots were of the child's face nor did the investigator document whether she observed any injuries on the child. When interviewed shortly after Child C, the case manager at C3 Academy reported that she was unaware of any incidents between Individual 1 and Child C. Regarding Child C's elopement, the case manager reported that after the child jumped out of the van, the child ran into someone's backyard and jumped into their pool. Reportedly, Child C knew how to swim and was able to safely exit the pool by herself. After an unknown duration of time had passed, a law enforcement officer located the child and returned her

64. According to the investigative record, the group home case manager reported that the placement suspended visitors due to the COVID-19 pandemic.

65. According to a C3 administrator, Individual 1 had previously been incarcerated for assaulting his mother.

to C3 Academy. Once she returned to the placement and law enforcement was still present at the facility, the child attempted to tie a sheet around her neck in another room at the home. When the staff member checked on the child after an unknown period, he reportedly intervened and removed the sheet from the child's neck. According to the police report, after the child "wrap[ped] a bed sheet around her neck and state[d] that she wanted to kill herself," a law enforcement officer placed Child C under an "emergency detention and into double lock handcuffs." Law enforcement then transferred Child C to a hospital. At the time of this incident, the child was subject to "routine" supervision.

After completing initial interviews with Child C and the case manager, the investigator did not pursue any investigative activity for one year and five months. After this significant delay, and several months after the child was moved from the placement, the investigator attempted to locate the alleged perpetrator (Staff 2) and Individual 1 for interviews. Likely due to the significant delay, the investigator was unable to locate and interview these key individuals. The investigator then re-interviewed the case manager who reported that she did not recall the details surrounding the alleged incident. The investigator also interviewed the responding law enforcement officer at this delayed time. She reported similar information to the investigator as contained in her initial intake report that was made nearly a year and a half prior.

Due to these deficiencies, the investigator failed to gather sufficient information to render a disposition for the allegation of Neglect.

Appendix B

Notable Gaps in Investigation Timeframe:

The investigation took one year and five months to be completed. The intake was received on August 13, 2021. An extension was approved on October 29, 2021, with a documented reason of "Additional interviews needed with collateral and alleged perpetrator." The investigation was delayed without activity from August 2021 to January 2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on January 26, 2023, approved on January 26, 2023, and closed on January 30, 2023.

11. IMPACT Case ID: 48785934

Summary of Key Allegations:

During a nine-week period between August 20, 2021 and October 28, 2021, SWI received eight reports of Physical Abuse regarding an adult resident (Individual 2, age 29) at C3 Academy which PI merged together into a single investigation that eventually involved Child C as an alleged victim, as well. The reporters, including a law enforcement officer, medical facility staff, and Individual 2's service coordinator, reported that Individual 2 stated a staff member (Staff 3) "punched," "beat up," "assaulted," and "hit" her on her arms and face and that she had injuries as a result.

Assigned Priority and Disposition:

Child C was not named in any of the initial allegations; however, a PI investigator added her as an alleged victim

after initiation of the Priority Two investigation. During an interview on August 24, 2021, Individual 2 relayed that she and another adult living in the home (Individual 3, age 18) engaged in a physical altercation with Child C while Staff 3 drove them in a van on two occasions. Individual 2 also alleged that Staff 3 "punched" her in the van after she fought with Individual 3 and Child C.

Due to substantial investigative deficiencies, most notably that it took 19 months to complete the investigation, a disposition of the Neglect allegation related to Child C by Staff 3 cannot be determined. The investigator assigned the allegation a disposition of Inconclusive.

Monitors' Review:

Regarding the allegation of Neglect involving Child C, the investigative record demonstrated the following critical deficiencies. First, the investigator never interviewed Child C about the allegations related to her. Second, the investigator failed to interview the alleged perpetrator; having waited 18 months to attempt the interview, the investigator was unable to locate him. Finally, the interviews that did occur with the adult alleged victims, Individuals 2 and 3, failed to include sufficient questioning (if any) about the physical altercation related to the alleged victimization of Child C and one of them was conducted three months after PI received the intake.

As noted above, the investigator did not conduct an interview of Child C related to the allegations contained in this investigation. Instead, the investigator included in the

investigative record an interview that was conducted with Child C on September 1, 2021 for a separate investigation (IMPACT ID: 48801178, discussed below) regarding unrelated allegations made by law enforcement on a later date; that report alleged that a different staff member locked Child C in a bedroom with Individual 2 in the home and left the premises. During that interview attempt in the other investigation, Child C was reportedly unwilling to speak to the investigator about the allegations of abuse and neglect in that investigation. The investigator did not attempt to interview Child C about the allegations contained in the instant investigation and, therefore, the investigator did not gather any information from Child C about the allegation under investigation in this investigation.

Individual 2 stated during her interview that she engaged in a physical altercation with Child C while Staff 3 transported them in a van on two specified dates; however, it appears that the investigator never asked Individual 2 to describe the physical altercation. As a result, the nature and severity of the alleged altercation between the two adults and Child C is unknown. When the investigator interviewed Individual 3 approximately three months after the date of this intake report, the investigator did not document that she asked Individual 3 any questions related to the alleged physical altercations in the van. Finally, when the investigator attempted to locate Staff 3 18 months after the investigation opened, the contact person at the placement reported that the alleged perpetrator was no longer employed there. Staff 3 did not respond to the investigator's delayed attempts

to interview him. Due to these critical deficiencies and a severely flawed investigative approach, the investigator gathered almost no information about the allegation related to Child C and the disposition of Inconclusive for the allegation of Neglect is baseless and inappropriate.

Notable Gaps in Investigation Timeframe:

The investigation took one year and seven months to be completed. The intake was received on August 20, 2021. An extension was approved on September 21, 2021, with a documented reason of "Additional interviews and documentation needed." The investigation was delayed without activity from December 2021 to March 2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on March 20, 2023, approved on March 21, 2023, and closed on March 21, 2023.

12. IMPACT Case ID: 48797313

Summary of Key Allegations:

On August 29, 2021, two weeks after the initial intake reports were received by SWI for the investigation above, a social worker at a hospital reported allegations of Physical Abuse and Neglect of Child C at her placement. According to the reporter, Child C reportedly ran away from the placement and law enforcement located her within an hour of her elopement. The child allegedly informed law enforcement that she wanted to kill herself with a

knife. According to the reporter, the child stated that she ran away from the placement because an unnamed staff member at the facility hit her. (At this time, there were five separate investigations opened regarding allegations of Physical Abuse and/or Neglect of Child C, with both distinct and similar allegations). After law enforcement located Child C, they transported her to a hospital where she was seen by a psychiatrist. The psychiatrist observed Child C to be "extremely dirty," not wearing underwear, with feces in her pants, and allegedly "had not eaten all day." Reportedly, the psychiatrist did not observe any injuries on the child's body that were consistent with a staff member hitting her; however, the psychiatrist observed that the child had "lots" of scarring on her body due to self-injurious behavior.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority Two investigation, PI initiated a Neglect and Physical Abuse investigation related to Child C by a named staff member, Staff 2, which became its sixth open investigation involving allegations of Physical Abuse or Neglect of Child C. In its investigative findings 17 months later, PI entered a disposition of Unconfirmed for the allegation of Neglect and a disposition of Inconclusive for the allegation of Physical Abuse. Due to substantial investigative deficiencies, a disposition for the Physical Abuse and Neglect allegations related to Child C cannot be determined.

Appendix B

Monitors' Review:

During her face-to-face interview with the investigator, Child C confirmed that a staff member hit her and added that the staff member hit her on the arm. When the investigator asked who hit her, the record states that the child pointed toward "the staff" who was present in the home. The investigator did not document in the investigative record which staff member(s) the child identified. Next, the investigator asked the child how she obtained the scratches on her face. The child responded that she got into a fight and pointed to another individual in the home. Again, the investigator did not document who the child identified when she pointed. The investigator documented that she attempted to ask Child C additional questions, but the child did not respond. Based upon the investigative record, it is unclear whether the child no longer responded to the investigator's questions due to her limited speech and comprehension. The investigator did not make any efforts to accommodate Child C's limited speech and comprehension during the interview.

The investigator did not appear to consider whether Child C's allegation that a resident scratched her was related to the allegation included in the above investigation with an intake date of August 13, 2021 (IMPACT ID: 48777670); as noted above, a different investigator conducted a deficient investigation in that instance, as well. It is also unclear whether the scratches the investigator observed on the child's face in the current investigation were related to or separate from the laceration the law enforcement officer observed on the child's face in the above investigation.

Based on the documentation in the record, the two investigators failed to collaborate and jointly staff the two investigations; this failure limited both investigators' ability to gather and assess information about the safety of Child C in her placement.

But even more confounding, after completing an interview with Child C, during which the investigator observed injuries on the child, the investigator did not conduct any additional investigative activity for more than 16 months. When the investigation resumed on January 23, 2023, the investigator assigned in the record an alleged perpetrator based upon the staff member who was working on the date of the intake report (August 29, 2021) and completed the investigation four days later. As noted above, the investigator observed the child point at a staff member(s) who allegedly hit her, but the record does not clarify the connection between the two and it is not clear the child was hit on the date of the intake report. Before completing and closing the investigation, the investigator did not attempt to interview the alleged perpetrator nor the other individual to whom the child pointed during her interview.

As a result of these substantial deficiencies, the investigator failed to determine whether a staff member hit Child C; and whether a staff member's inadequate supervision allowed a resident to scratch Child C. The investigation demonstrates an egregious example of the State's failure to conduct abuse and neglect investigations in a manner that takes into account at all times the child's safety needs.

Finally, regarding the allegation that Child C was "dirty, had no underwear on, and had feces in her pants" when she arrived at the hospital, PI determined that:

> Health and Human Services Commission (HHSC) Regulatory Services Provider Investigations (PI) will not investigate this matter further. The general complaints regarding [Child C] being unkept do not meet the definition of neglect. This information is being referred back to the provider and, if applicable, forwarded to the appropriate regulatory program, law enforcement, or Office of Inspector General, for appropriate action.[66]

---

66. Neglect by a direct provider of an individual in this setting is defined as "a negligent act or omission which caused or may have caused physical or emotional injury or death to an individual receiving services or which placed an individual receiving services at risk of physical or emotional injury or death. (b) Examples of neglect may include, but are not limited to, the failure to: (1) establish or carry out an appropriate individual program plan or treatment plan for a specific individual receiving services, if such failure results in physical or emotional injury or death to an individual receiving services or which placed an individual receiving services at risk of physical or emotional injury or death; (2) provide adequate nutrition, clothing, or health care to a specific individual receiving services in a residential or inpatient program if such failure results in physical or emotional injury or death to an individual receiving services or which placed an individual receiving services at risk of physical or emotional injury or death; or (3) provide a safe environment for a specific individual receiving services, including the failure to maintain adequate numbers of appropriately trained staff, if such failure results in physical or emotional injury or death to an individual receiving services or

There is no additional documentation in the record about the resolution of those allegations.

Notable Gaps in Investigation Timeframe:

The investigation took one year and five months to be completed. The intake was received on August 29, 2021. An extension was approved on October 7, 2021, with a documented reason of "Principal interviews are needed as well as documentary evidence." The investigation was delayed without activity from September 2021 to January 2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on January 27, 2023, approved on January 27, 2023, and closed on January 30, 2023.

13. IMPACT Case ID: 48794924

Summary of Key Allegations:

On August 26 and September 1, 2021, one law enforcement officer made two separate reports of abuse and neglect to SWI related to Individual 2, the adult resident discussed above. The reporter's allegations were similar in nature to those captured in the above investigation (IMPACT

---

which placed an individual receiving services at risk of physical or emotional injury or death. (c) In this chapter, when the alleged perpetrator is a direct provider to an individual receiving services from any other service provider, neglect is defined as a negligent act or omission which caused physical or emotional injury or death to an individual receiving services." 26 Tex. Admin. Code § 711.19.

Appendix B

ID: 48785934; allegations of Physical Abuse by Staff 3 of Individual 2), namely that Staff 3 allegedly hit Individual 2. Additionally, the reporter alleged that Individual 2 did not receive appropriate medical care for injuries allegedly caused by Staff 3. Child C was not named in any of the initial allegations; however, she was added to the investigation as an additional victim during the investigation.

Assigned Priority and Disposition:

Following receipt of the two intake reports, PI initiated a Priority Two Physical Abuse investigation related to Child C by Staff 3, which became its seventh concurrent open investigation into Physical Abuse and/or Neglect of Child C. Due to substantial investigative deficiencies, notably that it was not completed for 17 months after the intake, a disposition of the Physical Abuse allegation related to Child C cannot be determined. The investigator assigned the allegation a disposition of Inconclusive.

Monitors' Review:

Based upon the investigative record, it is unclear why the investigator added Child C as an alleged victim to this investigation. Because the investigator did not document her reason(s) for adding Child C as a victim, the monitoring team was unable to determine the specific allegation of Physical Abuse the investigator surfaced related to Child C. In the absence of this central information, the monitoring team identified this investigation as deficient. Next, the investigator used a separate interview of Child

C that occurred during a different investigation (IMPACT ID: 48801178, discussed below), similar to her approach in IMPACT ID: 48785934, to document her initial face-to-face contact with Child C for the instant investigation. As noted above, Child C was reportedly unwilling to speak to the investigator about allegations contained in the separate investigation and because the investigator did not interview Child C related to the instant allegation, the investigator did not gather any information about it. Next, when the investigator interviewed the alleged perpetrator 16 months after the investigation began, the investigator did not document whether she asked the alleged perpetrator any questions related to Child C. The investigator's interviews with other collateral staff members also did not discuss any allegations related to Child C. As such, the basis for the investigator's finding of Inconclusive for the allegation of Physical Abuse of Child C is unknown.

Notable Gaps in Investigation Timeframe:

The investigation took one year and five months to be completed. The intake was received on August 26, 2021. An extension was approved on October 7, 2021, with a documented reason of "Principal interviews are needed as well as documentary evidence." The investigation was delayed without activity from September 2021 to October 2022. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on February 7, 2023, approved on February 7, 2023, and closed on March 24, 2023.

Appendix B

14. IMPACT Case ID: 48801178

Summary of Key Allegations:

On September 1, 2021, a law enforcement officer reported that Individual 2 and Child C reported that at an unknown time during the night, a named staff member locked them in a bedroom and left the HCS Group Home. Individual 2 was allegedly able to break the bedroom door in half and exited the home with Child C. They then went to a neighbor's home and called 911. The officer reported that 911 received the call at 3:29 a.m. and law enforcement arrived at the home at approximately 4:00 a.m. At that time, according to law enforcement, no staff members were present in the home nor did they observe any posting or other information to inform law enforcement who to contact regarding Individual 2 and Child C's care. Also on September 1, 2021, a different law enforcement officer reported similar allegations about the staff member locking the residents in a bedroom before leaving them in the home. The reporter also stated that the staff member had to leave due to a family emergency and left the home at 3:00 a.m. The staff member allegedly notified another staff member that he needed to leave the premises. Approximately 30 minutes after the officer called in the second report, the officer called in a third report with allegations of Physical Abuse related to Child C and Individual 2. The officer reported that she observed that Child C had multiple bruises and cuts on the top of her eyelids and scratches on her face. Child C reported that Staff 3 punched her in the face and then reportedly stated that other residents "did it." The officer observed that

Individual 2 had a cut under her left eye and Individual 2 reported Staff 3 punched her.

Assigned Priority and Disposition:

Following receipt of the three intake reports from law enforcement officers, SWI referred them to PI for a Priority One investigation; PI initiated a Physical Abuse and Neglect investigation related to Child C by two named staff members, Staff 3 and Staff 4. This became its eighth pending investigation into abuse and neglect of Child C in 13 weeks. The investigation into these serious allegations was not completed for 17 months and in one of the more egregious examples of delay the Monitors found, the investigation sat without activity for a full year without explanation. The investigator requested and received an extension to conduct interviews but once granted, did not pursue any additional investigative activity. During that time and as discussed in the investigation below (IMPACT ID: 48846045), PI opened another investigation related to a separate allegation that Staff 3 hit Child C. The investigator assigned the Neglect and Physical Abuse allegations a disposition of Inconclusive. The monitoring team's review of the investigation determined that the allegation of Neglect should have been substantiated with a disposition of Confirmed as related to Staff 4. Regarding the Physical Abuse allegation, due to substantial investigative deficiencies, a disposition cannot be determined.

Appendix B

Monitors' Review:

According to Impact, C3 was a "3 bed person Group Home." The record contains a preponderance of evidence that Staff 4 locked Child C in a bedroom with another adult living at the home and then left the premises. The record showed that Child C was unattended for over two hours during the night, which placed C at risk of physical or emotional injury or death. The Monitors identified the following evidence in support of assigning the allegation of Neglect a disposition of Confirmed.

The police report confirmed Individual 2's allegation that Staff 4 locked Child C and Individual 2 in a bedroom and exited the premises and left them unattended for over two hours. As noted in the police report below, the residents did not have access to a telephone in the home and had to exit the home during the night to access a telephone in a neighbor's home, further exposing the residents to risk of physical or emotional injury. They also did not have access to a bathroom or any means of exit should there have been an emergency. Per the police report:

> Dated: 9/1/21 at 3:29 AM; [address removed] . . . Upon arrival Officer [name removed] located two females near the roadway at the intersection of S Center St and Motley St. The Females seemed to be in distress and were relieved to see Officers. The females were identified as [Ind. 2 and Child C]. [Ind. 2] stated she was low functioning but stated she was higher functioning than [Child C] who was

> non-verbal . . . [Ind. 2] stated she woke up in the middle and found the bedroom door to be locked from the outside. [Ind. 2] stated she yelled out for [Staff 4] who was the caretaker responsible for the overnight shift. [Ind. 2] stated when no one responded she and [Child C] broke the door open to exit the room so [Ind. 2] could use the bathroom. [Ind. 2] stated she and [Child C] searched through the residence and were not able to locate a responsible party or [Staff 4] in the residence. [Ind. 2] stated the front door was left unsecured so she and [Child C] checked the front drive and could not locate anyone outside. [Ind. 2] stated they do not have access to a phone in the house or the ability to call 911 so she went to the neighbor's house at [address removed] to ask them to call . . . Officers made a sweep of the location and did not locate anyone inside the residence . . . Officers located the bedroom of [Ind. 2 and Child C]. The door appeared to have been broken in half from the bottom of the door. Officers then attempted to contact numerous numbers associated with the group home's management, C3 Christian Academy. Officers were unable to reach anyone.

Additionally, after law enforcement arrived on the scene, it took approximately two hours before a C3 Academy staff member was located and arrived at the home. Based upon the above evidence, the investigative record includes a preponderance of evidence that Staff 4 was negligent when he locked Child C and Individual 2 in a bedroom and

left them unattended with no access to an exit, bathroom or means to summon help for over two hours in the night, which placed Child C at risk of physical or emotional injury or death.

Moreover, in light of the allegations that a staff member locked two people living in the home in a room and departed in the middle of the night and that a staff member was deployed to the location only after law enforcement was able to make contact with a person at C3, it is confounding that the investigator failed to consider whether administrators at C3 Academy failed to "provide a safe environment for [the child], including the failure to maintain adequate numbers of appropriately trained staff" resulting in or creating risk of physical or emotional injury or death for this child.[67] Finally, the investigator did not consider highly relevant information about whether there were similar allegations suggesting a lack of appropriately trained staff at the facility;[68] as noted previously, a review of a site's referral history is not part of PI's practice unless it involves the same alleged perpetrator or victim.

Regarding the Physical Abuse allegation, the investigator did not adequately investigate whether Staff 3 hit Child C causing injury to her face. When interviewed by the investigator, Child C reported that she did not want to discuss the allegations. The investigator did not document

67. *See* 26 Tex. Admin. Code § 711.719(b)(3).

68. *See e.g.*, DFPS, *Preponderance of the Evidence*, 1, 5 (undated training manual) (on file with the Monitors).

any efforts to accommodate Child C's limited speech and comprehension during the face-to-face interview. Such efforts may have encouraged Child C's participation in the interview and, as discussed previously, two prior PI investigations, initiated on May 24, 2021 and July 19, 2021, indicated use of an ASL interpreter. The investigator also did not document whether she observed any injuries on Child C. During the investigator's interview with Individual 2, the investigator did not ask Individual 2 any questions related to whether Staff 3 hit her or Child C and did not document whether she observed any injuries on Individual 2. Next, the investigator did not interview Staff 3 (the alleged perpetrator for the Physical Abuse allegation) until 16 months after the investigation began. The investigator did not ask Staff 3 any questions related to the allegation of Physical Abuse and the injuries the officer observed on Individual 2 and Child C. Instead, the investigator asked Staff 3 questions related to the allegations that Staff 4 locked Child C in the room with an adult also living at the home. The investigator was unable to locate Staff 4 for an interview and at the time he attempted to do so 16 months after the investigation began, according to C3, he was no longer employed there.

Finally, one day after Staff 4 locked Child C and Individual 2 in a bedroom, law enforcement returned to the group home to conduct a welfare check. According to the police report, "While on scene, medics assessed [Child C] as she complained of not feeling well. [Child C's] heart rate and blood pressure vitals were elevated to the point that medics determined she needed to go to the hospital." The investigator did not question any administrators nor staff

members regarding Child C's admittance to a hospital for medical reasons nor did the investigator appear to consider whether Child C's medical issues were related to the serious allegations discussed above.

Notable Gaps in Investigation Timeframe:

The investigation took one year and five months to be completed. The intake was received on September 1, 2021. An extension was approved on November 1, 2021, with a documented reason of "Need more interviews." The investigation was delayed without activity from September 2021 to October 2022. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on February 7, 2023, approved on February 7, 2023, and closed on April 13, 2023.

15. IMPACT Case ID: 48846045

Summary of Key Allegations:

One month after it was alleged that Staff 4 locked Child C in a room at night with another adult living in the home and left the premises, on October 2, 2021, a law enforcement officer reported allegations of Physical Abuse and Neglect of Child C at her placement. The reporter stated that a staff member at the home contacted 911 to report Child C as a runaway. A law enforcement officer reportedly located Child C approximately a mile and a half from the home; she was walking down a busy street with her shirt off. According to the reporter, at the time Child C eloped,

a staff member was spoon feeding another resident who used a wheelchair. When law enforcement located the child, she was reportedly happy to see the officer. The reporter observed that Child C had "speech issues" and was unable enunciate her name or address well. As the reporter and Child C neared the placement, the reporter allegedly observed that Child C's "mood changed" and she became "sad" and was "whimpering." Child C told the officer that Staff 3 hit her; the child demonstrated the hit by making a fist and putting it on her chin. The officer did not observe any injuries on Child C.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority Two investigation, PI initiated a Neglect and Physical Abuse investigation of Child C by a named staff member, Staff 3. This was the ninth pending investigation of alleged abuse and neglect of Child C in four months, the third time that the child expressed to a reporter that someone was hitting her at the home, and the second time Child C specified that it was Staff 3 who hit her. And yet, one month after receiving the intake report, HHSC's PI did nothing to investigate these serious allegations and the investigation sat with no activity for over a year. In its investigative findings entered 16 months later, PI entered a disposition of Unconfirmed for the allegation of Neglect and a disposition of Inconclusive for the allegation of Physical Abuse. Due to substantial investigative deficiencies, the dispositions of the Neglect and Physical Abuse allegations related to Child C cannot be determined.

Appendix B

Monitors' Review:

The investigator failed to appropriately investigate the allegations of Neglect and Physical Abuse of Child C by Staff 3. First, despite Child C's outcry to the police officer that Staff 3 hit her in the face, the investigator did not interview her until five days after the receipt of the intake report.[69] During her face-to-face interview, Child C confirmed that at the time she ran away, Staff 3 was caring for another resident, and Child C decided to leave the placement. Child C also reported that Staff 3 hit her with a closed fist on the right side of her face. The investigator documented that Child C did not know when or why Staff 3 hit her, that it was first time Staff 3 hit her and that no one was present at the time. The investigator documented that she observed discoloration on Child C's face; however, she documented that it appeared to be dark skin pigmentation and not a bruise. HHSC provided the Monitors with photos, from which it is difficult to discern whether Child C had a bruise on her right temple or whether it was a spot of dark skin pigmentation. The investigator did not document any efforts to accommodate Child C's limited speech and comprehension during the interview.

---

69. The investigator made a first attempt to interview Child C three days after the receipt of the intake report at the location she attended for treatment services; however, the child was no longer present at that location when the investigator arrived. The investigator did not attempt to interview her at the group home later that day.

Following Child C's disclosure to the investigator that Staff 3 hit her in the face, inexplicably the investigator did not pursue any investigative activity for 16 months and the child remained in the placement. It is unclear from the investigative record whether Staff 3 had access to Child C during this extended timeframe prior to her removal from the placement in April 2022. After this substantial delay, the investigator attempted to contact Staff 3 for an interview. At that time, according to the administrator at C3 Academy, Staff 3 reportedly no longer worked at the home and did not return the investigator's call to schedule an interview.

In addition to failing to interview Staff 3, the investigator also appeared to fail to identify that this was Child C's second allegation of Physical Abuse against Staff 3 and that Individual 2 had also recently made the same allegation. During this investigation, and at a significantly delayed time (January 27, 2023), the investigator documented that the prior case history of the "principals" was reviewed (presumably Staff 3);[70] however, the investigator reported that she did not use the case history because "it was deemed not relevant." The investigator erred when stating that Staff 3's prior case history was not relevant to her consideration of the allegations of Physical Abuse. This conclusion is unreasonable and inappropriate and raises

70. Due to its relevance, HHSC PI instructs its investigators to review the case history of the alleged victim and alleged perpetrator at the commencement of all investigations. HHSC, *Provider Investigations Handbook*, § 3310 Prior Case History, available at https://www.hhs.texas.gov/handbooks/provider-investigations-handbook/3000-investigation-process.

questions regarding whether the required case history review was performed.

Sixteen months after the alleged incident, the investigator interviewed a nurse who reported that she saw Child C daily and assessed her after any incidents, such as if the child ran away from the facility. The nurse reported that she no longer had access to her notes related to Child C, presumably due to the investigator's significant delay interviewing her. Based on her recollection 16 months later, she stated that she did not observe any injuries on Child C that were consistent with being hit or punched in the face during the time around October 2, 2021, when the child eloped from the placement. However, Child C did not provide a date or timeframe for when Staff 3 allegedly hit her and the delay and lack of access to her notes rendered the utility of the nurse's statement limited at best. The investigator also interviewed the law enforcement officer who was the reporter; the officer's account was consistent with the initial report of the allegations to SWI, and he again repeated his concern that Child C's demeanor changed in the presence of Staff 3 and that this concerned him.

Notable Gaps in Investigation Timeframe:

The investigation took one year and four months to be completed. The intake was received on October 2, 2021. An extension was approved on November 2, 2021, with a documented reason of "Need to request documentation and police report, talk to Ap." The investigation was delayed without activity from October 2021 to January

2023. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on January 27, 2023, approved on January 27, 2023, and closed on January 30, 2023.

16. IMPACT Case ID: 48896408

Summary of Key Allegations:

Approximately one month after the above investigation was initiated, on November 7, 2021, a clinical therapist at a hospital reported an allegation of Sexual Abuse of Child C. According to the reporter, Child C locked herself in her room at the C3 Academy group home on the date of the intake report. After an unknown period of time in her room alone, Child C used her hand to break a window and ran away from the home. Once Child C was located (presumably by law enforcement, although the intake report does not specify), she was taken to the hospital for "aggression and running away." While at the hospital, Child C made an outcry that an unnamed staff member forced her to have sex with him and attempted to force Child C to have sex with his girlfriend. Child C reported that the staff member was no longer employed at the home. The child reported that she did not want to return to the home.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority One investigation, PI initiated a Sexual

Appendix B

Abuse investigation of Child C by an unnamed staff member. This became the tenth pending investigation into allegations of abuse or neglect of Child C while placed at C3 Academy. This investigation evidenced one of the more egregious and confounding failures by PI to conduct its investigation in a manner consistent with the child's safety needs. Due to a dangerous delay and an utter disregard for child safety by the State, a disposition of the Sexual Abuse allegation related to Child C cannot be determined. The investigator assigned the allegation a disposition of Inconclusive.

Monitors' Review:

When the investigator attempted to conduct a timely, face-to-face interview of Child C at a hospital, a registered nurse requested that the investigator not speak with Child C due to difficult behaviors she had reportedly exhibited at the hospital; the investigator agreed to not speak with the child. It is unclear from the investigative record whether the investigator observed Child C at the hospital.

Ten days later, the investigator contacted a Children's Advocacy Center (CAC) to schedule a forensic interview of Child C in response to her allegation of Sexual Abuse. The CAC informed the investigator that only a law enforcement officer or detective who was assigned to Child C's case could request a forensic interview of a child. The investigator did not document any other efforts to secure a forensic interview. As a result, Child C did not participate in a forensic interview with a skilled interviewer who was competent in speaking with children who report allegations of Sexual Abuse.

Over the next 12 months, the investigator did not pursue any investigative activity into the Sexual Abuse allegations, despite the seriousness of Child C's allegation and the failure, up to this point, to interview the child. Notably, during that period of time, one staff member at the group home (Staff 2) was investigated by DFPS's CPI for Sexual Abuse of his stepdaughter and the allegation was substantiated on September 28, 2022. There is nothing in the record indicating that PI had any awareness of the DFPS investigation and substantiation. Nevertheless, finally on November 30, 2022, over a year after the initiation of the investigation while the investigation sat with no documented activity other than an extension, a different investigator attempted to interview Child C. When interviewed face-to-face, Child C allegedly responded to the investigator's questions by shrugging her shoulders or stating that she did not remember the incident. Approximately one month later, in late December 2022, a third investigator interviewed Child C; the interview was not conducted face-to-face, but through a Microsoft TEAMS video call. Child C confirmed over the computer that an unnamed individual sexually abused her. Child C additionally stated that the abuse occurred in a living room and she nodded affirmatively that the unnamed individual's girlfriend was present at the time, as she alleged in the original intake. Child C was reportedly unable or unwilling to provide the name of the alleged perpetrator to the investigator. At the conclusion of the interview, the investigator documented the following: "Investigator ended the interview due to [Child C's] limited speech and lack of response."

Not only did the investigators fail to interview the child for over one year, but when they finally did speak to her, the investigators did not facilitate Child C's participation in the interviews through appropriate accommodations for her limited speech and comprehension, which was fundamental to gathering information about the allegation to support Child C's safety and well-being even after she confirmed the abuse.

Over a year after the investigation began and for the first time, the investigator finally attempted to identify an alleged perpetrator through interviews with administrative staff members at C3 Academy. Both administrators reported to the investigator that Child C had a history of making false allegations of Sexual Abuse. The investigator documented that an administrator stated, "[Child C] would make the same allegations all of the time, against staff and other individuals." But the Monitors' review showed that Child C's investigative history at the placement does not include any prior investigations of Sexual Abuse; therefore, either that statement was untrue or staff members failed to report the prior allegations by the child. The lack of investigative history suggests that, if Child C did make those allegations in the past, staff members did not report Child C's prior allegations of Sexual Abuse to SWI. But the investigator did not question the administrator about this potential failure. (The monitoring team's review found that in many instances, law enforcement officers were the primary reporter of alleged abuse and neglect of Child C that led to the 12 investigations at C3 Academy).

During an interview, one of the administrators provided the investigator with the name of a male staff member (Staff 2) who worked in the HCS home at the time of Child C's allegation one year prior; the investigator added this individual as the alleged perpetrator.[71] Another administrator reported that Staff 2 no longer worked for the home and was presently in jail and "will not be released anytime soon." Five months prior, on June 22, 2022, while this investigation sat without activity, DFPS had received an intake report that Staff 2 sexually abused his stepdaughter and substantiated the allegations on September 28, 2022. When the investigator resumed in November 2022 and Staff 2 had already been substantiated by DFPS for the Sexual Abuse of his stepdaughter, the investigator appeared entirely unaware of these developments. Moreover, in part due to the failure of the investigator to timely identify an alleged perpetrator and conduct this investigation, it appears that Staff 2 had access to all of the residents at the HCS home, including Child C for some period of time.[72]

---

71. The investigator did not document whether she asked the administrator whether there were any other males who worked at the home at the time of the allegation. The monitoring team's reviews showed that multiple males worked in the HCS home while Child C was a resident; it is unknown why these individuals were not considered by the investigator. Lastly, while the investigator documented that Staff 2 was the alleged perpetrator in the investigative record, the investigator did not formally assign Staff 2 as the alleged perpetrator in IMPACT. As such, the alleged perpetrator for this case is documented as unknown in IMPACT.

72. Child C was discharged from C3 Academy in May 2022.

Appendix B

In addition to the substantiation of Sexual Abuse, Staff 2's investigative history includes one other investigation with allegations of Sexual Abuse from November 2018 while employed by C3 Academy. In that investigation, a young woman resident at the home alleged that Staff 2 masturbated while she was showering. PI assigned a finding of Unconfirmed to the allegation. But the investigator failed to review or discuss both the substantiation for Sexual Abuse by DFPS and the alleged Sexual Abuse allegation investigated by PI during Staff 2's employment at C3 Academy. When the investigator finally interviewed Staff 2 at a county jail 13 months after the investigation began, the alleged perpetrator denied the allegation that he sexually abused Child C. The investigator documented that Staff 2 was in jail due to alleged sexual abuse of his stepdaughter.

The investigator did not interview any other staff members or residents who may have had information related to Child C's allegation. When the investigator asked one of the administrators to provide the names of other residents who lived in the home at the same time as Child C one year prior, the administrator reported that she did not remember their names and when the investigator followed up for records of their names, there is no documentation indicating that she ever received it from the administrator. The administrator also did not appear to respond to the investigator's requests for documents one year after the investigation began, such as timesheets, Staff 2's employment application, names and numbers of other residents, and Child C's incident reports and hospital

records.[73] The investigator did not appear to ask Child C the names of other staff members or residents. More critically, the investigator did not review any of Child C's nine prior investigations, all of which occurred in close proximity to these allegations and included names and contact information of other residents and staff members who lived or worked in the home during that time period.

Due to these critical deficiencies and the neglectful manner with which this investigation was conducted, the monitoring team was unable to determine an appropriate disposition for the allegation of Sexual Abuse of Child C.

Notable Gaps in Investigation Timeframe:

The investigation took one year and one month to be completed. The intake was received on November 7, 2021. An extension was approved on December 10, 2021, with a documented reason of "Extraordinary Circumstances." The investigation was delayed without activity from November 2021 to November 2022. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on December 21, 2022, approved on December 21, 2022, and closed on December 23, 2022.

---

73. The monitoring team was unable to locate any documentation in NeuDocs for this investigation.

Appendix B

17. IMPACT Case ID: 49096014

Summary of Key Allegations:

On April 6, 2022, five months after PI opened the above investigation involving allegations of Sexual Abuse of Child C, an OCOK caseworker reported an allegation of Physical Abuse of Child C at C3 Academy. The reporter alleged that a staff member (Staff 5) hit Child C on the leg with a cord because she was allegedly behaving "bad." The caseworker reported that Child C had a thin bruise on her left thigh that was about two inches long. Seven days later, on April 13, 2022, school personnel reported that Child C stated that she did not want to return to C3 Academy because she was being abused there. The reporter stated that a school nurse observed Child C with circular bruises on the front of her thigh, noting that one bruise was approximately two inches in length. The reporter stated that Child C said the injury occurred in the group home, but Child C did not provide the name of the individual who allegedly hit her.

Assigned Priority and Disposition:

Following receipt of the two intake reports, which SWI referred for a Priority Two investigation, PI initiated a Physical Abuse investigation of Child C by a named staff member (Staff 5). This became the eleventh pending investigation into allegations of abuse or neglect of Child C while placed with C3 Academy and the sixth allegation of Physical Abuse. In a failure to prioritize Child C's safety, the investigation had a nine-month delay in investigative

activity, despite Child C's confirmation of her allegation of Physical Abuse. Due to substantial investigative deficiencies, a disposition of the allegation cannot be determined, despite the investigator's assignment of a disposition of Inconclusive.

Monitors' Review:

Due to significantly delayed and missing interviews, the investigator failed to gather sufficient information to determine whether Staff 5 physically abused Child C. Nine days after SWI received the first intake report, the investigator interviewed Child C, who maintained her original allegation.[74] She stated to the investigator that on an unknown date, she went in the bathroom at C3 Academy and hit her head on the wall; after Staff 5 heard Child C hit her head, Child C stated that Staff 5 entered the bathroom and hit her with a white cord on her leg. Child C stated that no one observed the incident. According to the investigator, Child C did not allow her to observe whether she had any bruising nor photograph her.

Despite Child C's confirmation of her allegation of Physical Abuse by Staff 5, the investigator did not conduct any investigative activity for nine months, a clear disregard for the child's safety. Based on the investigative record, it is unclear whether Staff 5 continued to work and have

74. The investigator attempted a timely face-to-face interview with Child C; however, the attempt was unsuccessful because no one at the group home allegedly opened the door to the investigator. The investigator did not attempt to interview Child C again until nine days after the date of the first intake report.

access to residents at C3 Academy during this significant lapse in investigative activity. Nine months after Child C's interview and when Child C was no longer placed at the group home, the investigator first attempted to contact Staff 5. At that point, Staff 5 reportedly no longer worked at C3 Academy and did not respond to the investigator's late attempt for an interview. In the absence of this key interview with Staff 5, the investigator did not attempt to interview collateral staff members nor residents to gather information about the allegation. When the investigator interviewed the reporters (school personnel and caseworker), they consistently reported that Child C disclosed to them nine months prior that a staff member hit her with a cord and they observed a bruise on Child C's leg, though it was unclear to the reporters whether the bruise was new or old when they observed it. Despite Child C's consistent outcry to both reporters and the investigator that Staff 5 hit her with a cord, the investigator assigned a disposition of Inconclusive to the allegation of Physical Abuse by Staff 5.

Notable Gaps in Investigation Timeframe:

The investigation took nearly ten months to be completed. The intake was received on April 6, 2022. An extension was approved on May 11, 2022 with a documented reason of "Extraordinary Circumstances." A second extension was approved on August 16, 2022, again with a documented reason of "Extraordinary Circumstances." The investigation was delayed without activity from April 2022 to January 2023. The record did not include any explanation for the lack of investigative activity and

substantial delay in completing the investigation. The investigation was completed on January 27, 2023, approved on January 27, 2023, and closed on January 30, 2023.

18. IMPACT Case ID: 49131249

Summary of Key Allegations:

On April 28, 2022, Child C's caseworker reported an allegation of Physical Abuse of Child C at C3 Academy. The caseworker reported that on the date of the intake report hospital staff notified her that an unnamed staff member dropped Child C off at the hospital. The unnamed staff member reported to the hospital that Child C had been restrained at the group home; the staff member reportedly did not provide any other information to the hospital before departing and no one stayed with the child at the hospital. While at the hospital, medical personnel determined that Child C had a fractured jaw, which required surgery. The reporter stated that it was unclear how or when Child C was injured. One day later, on April 29, 2022, medical personnel from the hospital reported that Child C had a fractured mandible (lower jaw) in two places and Child C was unable to explain how she was injured.

Assigned Priority and Disposition:

Following receipt of the two intake reports, which SWI referred for a Priority One investigation, PI initiated a Physical Abuse investigation of Child C by a named staff member, Staff 6. This investigation became the twelfth

pending concurrent investigation of abuse and neglect of Child C at C3 and the seventh allegation of Physical Abuse. The allegation of Physical Abuse should have been substantiated with a disposition of Confirmed. The disposition of Inconclusive assigned by PI nine months after the investigation was initiated is inappropriate, and the investigation was conducted with an utter disregard for child safety.

Monitors' Review:

Despite a delayed and deficient investigation, the Monitors found that the record contains a preponderance of evidence that Staff 6 hit Child C, causing substantial injury to the child by fracturing her jaw. The Monitors identified the following evidence in support of assigning the allegation of Physical Abuse with a disposition of Confirmed:

- Medical personnel reported that Child C was diagnosed with a fractured jaw in two places after a C3 staff member dropped the child off at the hospital;

- When the investigator asked Child C what Staff 6 "did to her," Child C "clearly stated" that Staff 6 hit her; and,

- An administrator of C3 Academy, who was interviewed six months after the intake, reported that another resident[75] informed her that she

75. Because C3 Academy did not comply with the investigator's request for the witness's contact information, the investigator did

> observed Staff 6 hit Child C in the face with his fist multiple times the day before the child was taken to the hospital. According to the administrator, after the child was physically abused by Staff 6, presumably the only staff member on-duty for that evening's shift, Child C reportedly went to bed with untreated and substantial injuries. The following day, a different staff member and the administrator observed blood and bruising on Child C's face. At this time, the administrator instructed a staff member to transport the child to a hospital and the administrator reportedly notified law enforcement. The Monitors were not able to locate any documentation confirming that anyone at C3 notified SWI of the critical incident of abuse and the investigator did not attempt to corroborate the administrator's claim that the group home notified law enforcement. The administrator reported that Staff 6 was immediately terminated.

Based upon the above evidence, the investigative record contains a preponderance of evidence that Staff 6 used inappropriate and excessive force when he hit Child C and fractured her jaw in two places. At the time of this incident, PI's investigation of the Physical Abuse of Child C with a taser remained open for four more months until it was finally Confirmed in October 2022.

---

not interview the witness. It is unclear whether the investigator could have obtained the witness's contact information independent of C3 Academy. C3 Academy also failed to comply with the investigator's request for other documentation related to Child C and the allegations.

The monitoring team's review identified that on February 24, 2022, two months prior to Staff 6 hitting and significantly injuring Child C, PI initiated a separate investigation (IMPACT ID: 49038369) involving allegations that Staff 6 physically abused an adult resident at the group home.[76] Because PI did not conduct a timely or adequate investigation of the Physical Abuse allegation related to the adult resident, Staff 6 continued to work at the group home and two months later was able to physically assault Child C.

As noted above, the monitoring team found that the investigation of Staff 6's Physical Abuse of Child C was again significantly delayed and deficient, which is particularly egregious given the severity of the incident of Physical Abuse suffered by Child C. In addition to conducting delayed interviews with key individuals six

76. The investigation (IMPACT ID: 49038369) of Staff 6 was initiated on February 24, 2022 in response to, among other allegations, a law enforcement officer's report to SWI that he observed that an adult resident of C3 Academy had a bruise under his left eye. During the adult resident's interview with a PI investigator on February 25, 2022, the individual reported that he thought Staff 6 tried to hit him, that Staff 6 was mean to him "over little stuff," and that Staff 6 told the individual to "Get your ass to bed." The investigator's photograph of the adult showed bruising under his eye. Following this interview and clear indication of risk related to Staff 6, the investigator did not pursue any investigative activity for 14 months. At this delayed time, the investigator attempted to interview, among other individuals, Staff 6. Staff 6 did not respond to the investigator's attempts for an interview. Shortly thereafter, the investigator closed the deficient investigation with a finding of Inconclusive for the allegation of Physical Abuse.

months after the investigation began, the investigator did not investigate the following allegations of Neglect made by the child's caseworker during the investigation. These allegations raised significant concern for the safety and well-being of the residents placed at C3 Academy.

- The OCOK caseworker reported that when law enforcement arrived at the group home a few hours after Child C arrived at the hospital, "C3 Academy had completely cleaned out the house." The investigator did not appear to ask the caseworker to provide any clarifying detail to explain her statement that the group home had "completely cleaned house." The investigator also did not attempt to contact the responding police station for eight months after the investigation began to request information, such as a police report, which may have provided additional information regarding the caseworker's statement. The investigative record did not include a police report.

- The OCOK caseworker reported that when law enforcement arrived at the group home they observed that one on-duty staff member had an ankle monitor and was reportedly "out on bond for felony stalking" and another on-duty staff member was a registered sex offender.[77]

77. Due to investigative failures, it is unclear whether the staff member that the OCOK caseworker stated was a registered sex offender was Staff 2, who was reportedly incarcerated for sexually assaulting a minor, as discussed in investigation IMPACT ID: 48896408.

The investigator made no attempts to identify the names of these staff members, to determine whether they continued to be employed at C3 Academy and had access to residents, nor to corroborate or explore the information about the staff members' alleged criminal charges. The investigator only documented in her findings that "It is a concern that the agency is employing registered sex offenders." The investigator did not appear to take any action regarding this serious safety concern, another egregious failure to conduct the investigation in a manner consistent with child safety at all times that reflected a shocking disregard of children's safety.

- The OCOK caseworker reported that C3 Academy terminates staff members after allegations of abuse or neglect are made against them; however, the group home will then hire these same staff back after an investigation has closed. The investigator did not investigate this allegation and did not appear to discover evidence that, in this instance, it was not accurate.

- The OCOK caseworker reported that C3 Academy did not provide her with any of Child C's paperwork, medications, or belongings after Child C left the placement. The caseworker reported that she threatened to call law enforcement in order for the group home to provide Child C's medications, which she ultimately received. The

group home never provided Child C's belongings or paperwork.

- The OCOK caseworker reported in her intake report that according to hospital personnel, a staff member from C3 Academy dropped the child off at the hospital and departed without providing additional information on behalf of the child, leaving the child alone. She also indicated that she learned of the child's status through hospital personnel, as opposed to notification from anyone at the placement. The investigative record failed to clarify or confirm the duration of time C3 Academy left the child alone at the hospital with a fractured jaw nor whether anyone attempted to notify the caseworker or law guardian.

Due to serious and ongoing safety concerns that appeared to have gone unaddressed by HHSC and PI, a detective for the local police department reported to the investigator that the department was presently attempting to "shut down" C3 Academy. Following the detective's statement to the investigator, the investigator did not document that she took any additional action to safeguard the children and adults still placed at C3 Academy.

This egregious incident of Physical Abuse occurred nearly one year after a different staff member tasered Child C, seven months after another staff member locked Child C in a bedroom and left the group home location, and five months after her outcry of sexual abuse, among other

serious allegations; and yet, once again, the investigator failed to consider or discuss whether administrators at C3 were neglectful, particularly for a failure to "provide a safe environment for [Child C], including the failure to maintain adequate numbers of appropriately trained staff, if such failure results in physical or emotional injury or death to [Child C] or which placed [Child C] at risk of physical or emotional injury or death."[78]

Child C did not return to C3 Academy after she was hospitalized for a fractured jaw.

Notable Gaps in Investigation Timeframe:

The investigation took nine months to be completed. The intake was received on April 28, 2022. An extension was approved on June 8, 2022, with a documented reason of "Extraordinary Circumstances." The investigation was delayed without activity from May 2022 to November 2022. The record did not include any explanation for the lack of investigative activity and substantial delay in completing the investigation. The investigation was completed on February 7, 2023, approved on February 7, 2023, and closed on April 13, 2023.

Child D, age 15, IQ of 47

The monitoring team reviewed three PI abuse or neglect investigations with a disposition of Unconfirmed that involved a child (Child D, age 15) while he was placed

78. *See* 26 Tex. Admin. Code § 711.719(b)(3).

at Exceptional Employment Service, an HCS Group Home. Child D is diagnosed with the following: autism spectrum disorder; Moderate Intellectual Disabilities; Speech Impairment; Attention-Deficit/Hyperactivity Disorder; Urinary Incontinence; and Mitochondrial Metabolic disease, which causes gastrointestinal and respiratory problems. Due to Child D's low IQ of 47 and behavioral and mental health needs, he was eligible for and enrolled in the HCS waiver program and was placed at the HCS Group Home from April 23, 2018 until present. As discussed below, the monitoring team's review found that PI inadequately conducted the following three abuse or neglect investigations involving Child D while he was placed at Exceptional Employment Service.

19. IMPACT Case ID: 48870997

Summary of Key Allegations:

On October 20, 2021, a law enforcement officer reported an allegation of Neglect of a child (age 13 and not in DFPS care) at Exceptional Employment Service. The reporter stated that the child was located by a member of the community after running away from the facility. The reporter alleged that "[t]his [was] not the first or second time a special needs child ran away or escaped" from the group home.

Assigned Priority and Disposition:

Following receipt of the intake report, which SWI referred for a Priority Two investigation, PI initiated a Neglect

investigation related to the child who was not in DFPS care. During the investigation and nearly four months after receiving the intake, the investigator added two PMC children (Child D, age 15 and Child E, age 15) to the investigative record as alleged victims due to the nature of the allegations; Child D and Child E lived in the home at the time of the incident. Due to substantial investigative deficiencies, most notably that it took 15 months to complete the investigation, a disposition regarding the Neglect allegation cannot be determined, despite the investigator's assignment of a disposition of Unconfirmed for both Child D and Child E.

Monitors' Review:

This investigation is deficient due to significant investigative delays, including a four-month delay in speaking to the alleged victims, a failure to conduct face-to-face interviews with the alleged victims, and a missing interview with the alleged perpetrator. Approximately four months after the investigation was initiated, the investigator interviewed a collateral staff member who reported that Child D and Child E lived in the home at the time of the alleged incident. The investigator had not previously identified the other residents who lived in the home at the time the primary victim ran away. At this delayed time, the investigator attempted to conduct telephone interviews with both Child D and Child E, despite the HCS Group Home's house manager reporting to the

* * * *

APPENDIX C — Order of the United States Court of Appeals for the Fifth Circuit Denying Petition for Rehearing En Banc and Dissenting Opinion of Judge Stephen A. Higginson (Feb. 11, 2025)

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 24-40248

M. D., BY NEXT FRIEND SARAH R. STUKENBERG; D. I., BY NEXT FRIEND NANCY G. POFAHL; Z. H., BY NEXT FRIEND CARLA B. MORRISON; S. A., BY NEXT FRIEND JAVIER SOLIS; A. M., BY NEXT FRIEND JENNIFER TALLEY; J. S., BY NEXT FRIEND ANNA J. RICKER; K. E., AS NEXT FRIEND JOHN W. CLIFF, JR.; M. R., AS NEXT FRIEND BOBBIE M. YOUNG; J. R., AS NEXT FRIEND BOBBIE M. YOUNG; H. V., BY NEXT FRIEND ANNA J. RICKER; P. O., AS NEXT FRIEND ANNA J. RICKER; L. H., AS NEXT FRIEND ESTELA C. VASQUEZ; C. H., BY NEXT FRIEND ESTELA C. VASQUEZ; S. R., AS NEXT FRIEND BOBBIE M. YOUNG; S. S., AS NEXT FRIEND ESTELA C. VASQUEZ; A. R., AS NEXT FRIEND TOM MCKENZIE, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

Plaintiffs-Appellees,

versus

Appendix C

GREG ABBOTT, IN HIS OFFICIAL CAPACITY AS GOVERNOR OF THE STATE OF TEXAS; CECILE ERWIN YOUNG, IN HER OFFICIAL CAPACITY AS EXECUTIVE COMMISSIONER OF THE HEALTH AND HUMAN SERVICES COMMISSION OF THE STATE OF TEXAS; STEPHANIE MUTH, IN HER OFFICIAL CAPACITY AS COMMISSIONER OF TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES,

Defendants-Appellants.

Appeal from the United States District Court
for the Southern District of Texas
USDC No. 2:11-CV-84

Filed February 11, 2025

ON PETITION FOR REHEARING EN BANC

Before JONES, CLEMENT, and WILSON, *Circuit Judges*.

PER CURIAM:*

The petition for rehearing en banc is DENIED. At the request of one of its members, the court was polled, and a majority did not vote in favor of rehearing (FED. R. APP. P. 40 and 5TH CIR. R. 40).

---

* CHIEF JUDGE ELROD, and JUDGES HO and OLDHAM did not participate in the consideration of the rehearing en banc.

Appendix C

In the en banc poll, five judges voted in favor of rehearing (Judges Stewart, Graves, Higginson, Douglas, and Ramirez), and nine judges voted against rehearing (Judges Jones, Smith, Richman, Southwick, Haynes, Willett, Duncan, Engelhardt, and Wilson).

Stephen A. Higginson, *Circuit Judge*, joined by Stewart, Graves, and Douglas, *Circuit Judges*, dissenting from denial of rehearing en banc:

I would grant the petition for rehearing. The panel opinion conflicts with prior decisions from the Supreme Court and this court, and the questions raised are of substantial public importance. This case warrants a second look.

The case concerns the Texas foster care system. The district court found, and this court agreed, that deficiencies in that system violated Texas's constitutional obligations to children in its care. *M.D. ex rel. Stukenberg v. Abbott*, 907 F.3d 237, 264–68 (5th Cir. 2018). To remedy those violations, the district court ordered Texas's Department of Family and Protective Services (DFPS), formerly under the state's Health and Human Services Commission (HHSC), to timely and adequately investigate certain allegations of child abuse and neglect. *See M.D. ex rel. Stukenberg v. Abbott*, 730 F. Supp. 3d 354, 363 (S.D. Tex. 2024). DFPS is now a standalone agency, but HHSC retains the responsibility to investigate allegations of abuse and neglect of children supported by certain programs for individuals with intellectual and developmental disabilities. The state failed to be

transparent with the district court about shortcomings in those investigations. *Id.* at 512. On April 15, 2024, the court imposed a daily fine until HHSC certified that it was substantially complying with the court's decree in investigations closed after December 4, 2023, as well as in investigations that remained open. *Id.* at 626–27. The panel opinion, *M.D. ex rel. Stukenberg v. Abbott*, 119 F.4th 373 (5th Cir. 2024), concluded that these sanctions were barred by sovereign immunity, amounted to criminal contempt without due process, and assessed compliance with the decree too stringently. The case was reassigned.

I respectfully disagree with the panel opinion's analysis, starting with the question of sovereign immunity. The panel opinion concluded that the district court's fines "punish[ed]" HHSC's "past malfeasance in violation of the Eleventh Amendment." *Id.* at 383. The opinion relied on the distinction between "an injunction that governs the official's future conduct" and an award of "retroactive monetary relief," putting the district court's order in the second category. *Id.* at 382 (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 103, 104 S. Ct. 900, 79 L. Ed. 2d 67 (1984)).

Were we to grant rehearing, I do not think that reasoning would withstand scrutiny. It cannot be deduced that relief is "retroactive" merely because it is predicated on events in the past. The district court attempted to coerce *future* compliance by imposing sanctions informed by HHSC's *ongoing* contempt for its decree. The reasoning for the court's decision should not be conflated with the effect of its judgment. A contempt sanction

is not retrospective in effect simply because the court considers—as it must any time contempt is in issue—a party's past failures to comply with the decree.

Neither can it be maintained that the district court ordered "retroactive monetary relief" solely because fines are monetary. That would be incorrect as a matter of first principles, and it is directly contradicted by Supreme Court precedent. Even when monetary exactions in aid of an injunction are "'compensatory' in nature," that "does not change the fact that" the underlying relief "operates prospectively" as permitted by the Eleventh Amendment. *Milliken v. Bradley*, 433 U.S. 267, 290, 97 S. Ct. 2749, 53 L. Ed. 2d 745 (1977).

Accordingly, it is completely consistent with the Eleventh Amendment for federal courts to assess fines against state officials in civil or even criminal contempt proceedings, as was explained in *Hutto v. Finney*, 437 U.S. 678, 690–91, 98 S. Ct. 2565, 57 L. Ed. 2d 522 (1978). "The principles of federalism that inform Eleventh Amendment doctrine surely do not require federal courts to enforce their decrees only by sending high state officials to jail." *Id.* at 691. "If a state agency refuses to adhere to a court order, a financial penalty may be the most effective means of insuring compliance." *Id.* That is just what happened here. HHSC refused to adhere to the district court's order, so the district court imposed a financial penalty as a means of ensuring compliance with that order in the future. That was not retroactive relief, and it was not barred by the Eleventh Amendment.

One explanation for these missteps is that the panel opinion thought it was proper to treat the contempt sanctions at issue as a unified punitive and thus retrospective whole. From this, the opinion concluded not only that the sanctions offended the Eleventh Amendment, but also that they lacked the process required in proceedings of a criminal nature. Even setting aside *Hutto*, however, there are substantial problems with that approach.

The first problem—a matter of interpretation, but given the public importance, one that warrants our consideration en banc—is that the sanctions do not appear to have been punitive at all. Had HHSC certified to the district court that investigations closed prior to the order were not in substantial compliance and could not be effectively reopened to remedy their defects, it is far from clear that the district court's order would have imposed fines upon HHSC in perpetuity for a failure of compliance that could never be cured. Rather, the point of the order was for HHSC to rectify its failures of transparency by certifying to the court that any deficiencies that could be remedied had been addressed. If it was felt that the district court's phrasing needed clarification, the order could have simply been modified for that purpose.

The second and more substantial problem is that, even if the sanctions were criminal as applied to past conduct, it takes an additional and unsteady step to infer that the sanctions were thereby also criminal as applied to HHSC's future compliance. Even assuming the district court intended to punish HHSC for its past failures,

other parts of the sanctions were clearly meant to coerce HHSC into conforming to the decree going forward. The panel opinion strained against precedent and logic, and perhaps even committed the sort of error of which it accused the district court, in concluding that the district court's attention to the past disqualified it from ensuring HHSC's compliance in the future.

The panel opinion relied on the rule that when a contempt sanction with both criminal and civil aspects is appealed before final judgment, "the criminal feature of the order . . . fixes its character for purposes of review" because "jurisdiction to review that part which was civil" accompanies interlocutory review of the criminal portion. *See Union Tool Co. v. Wilson*, 259 U.S. 107, 110–11, 42 S. Ct. 427, 66 L. Ed. 848, 1922 Dec. Comm'r Pat. 264 (1922). According substantive weight to this procedural detail, the panel opinion reasoned that any punishment for past noncompliance made the entire contempt order criminal in nature and thus rendered it void for lack of due process. 119 F.4th at 378–82.

In my view, that analysis was incorrect and so was the conclusion. "[I]t does not necessarily follow" from "the review of civil contempt orders which would otherwise not be final and appealable" that in a "'mixed relief' case, a Court must vacate and remand the whole proceeding for failure to comply with criminal procedure." *FDIC v. LeGrand*, 43 F.3d 163, 170 (5th Cir. 1995). Instead, this court "need only vacate the criminal element of the order." *Id.* This has been apparent since *Union Tool*, which treated the reviewability rule as procedural, *see* 259 U.S.

at 110–11, and on the merits sustained the "remedial, as distinguished from punitive" portion of the contempt sanction, going so far as to say that the district court abused its discretion in purging the defendant's contempt, *id.* at 114.

We addressed a situation like the one here in *Lamar Financial Corp. v. Adams*, 918 F.2d 564 (5th Cir. 1990). There, we were also reviewing a fine which accrued daily for deficient compliance. *Id.* at 566. The fines were found to be punitive as assessed on failures of compliance preceding a hearing, since such failures could not be cured, but coercive as assessed on conduct following the hearing, since the contemnors had the option to cure the contempt. *Id.* We noted that the contempt order "contain[ed] both a punitive and a coercive dimension" so would be "characterized as a criminal contempt order" for "purposes of appellate review"—but rather than invalidating the whole sanction for lack of due process, we vacated only the punitive "portion of the sanction." *Id.* at 567.

I read the panel opinion primarily to say that we took a different approach in *Lamar* by treating the civil and criminal parts of the single sanction at issue as severable. *See* 119 F.4th at 382 n.1. I agree, and I think the same approach was required here. Trimming any reference to the past from the order could have been accomplished by taking out the days from December 4 to April 15. That would have settled any doubts on this score.

Appendix C

The issue of substantial compliance presents no less pressing concerns. Over 427 pages of analysis, the district court described how HHSC's procedures led to ineffective and delayed investigations that left children in harm's way, in contrast to the procedures implemented by DFPS under the court's orders. The district court focused on this noncompliance within HHSC in view of the agency's responsibility to protect disabled children from abuse and neglect, and determined that HHSC was out of compliance in a majority of this especially vulnerable subset of cases. The panel opinion rejected this analysis, stating that the district court should have instead compared noncompliance with the overall rate of compliance across the state. *Id.* at 384–85.

But the panel opinion did not remand for factfinding according to that standard. Instead, the panel presented a series of calculations and then affirmatively concluded that the defendants, assessed together, were in substantial compliance. *Id.* at 385. No legal justification for that conclusion appears anywhere in the opinion. At no point is set forth any "judicially manageable standard," *cf. Vieth v. Jubelirer*, 541 U.S. 267, 291, 124 S. Ct. 1769, 158 L. Ed. 2d 546 (2004) (opinion of Scalia, J.), indicating that compliance, in whatever way measured, was *substantial*.

I doubt that relegating disabled children, who are most at risk of abuse and neglect in the foster system, to a separate and inferior system of investigations pencils out to substantial compliance under even the most austerely mathematical of standards. Were we to remand, the district court might well reason that HHSC's systematic

failure to protect those most vulnerable to mistreatment was not consistent with substantial compliance. The district court might take the view that it is inappropriate to treat disabled children, simply because they are fewer in number than other children, as "just a drop in the bucket." *See* 119 F.4th at 385. Such a view would be in line with what we "expect[]" in "a civilized and decent society," and I see no reason to doubt that this is among those "vast majority of situations" in which consideration of the special needs of the most vulnerable among us "is not only legitimate but also desirable." *See City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 444, 105 S. Ct. 3249, 87 L. Ed. 2d 313 (1985).

This all brings us to the removal of Judge Jack from this case that she has been shepherding for over a decade. I question whether the foregoing errors may have helped to support the decision to reassign the case and would submit accordingly that this part of the panel's decision warrants our reconsideration as well.

As a court of review rather than first view, we should exercise the utmost restraint in removing district court judges from cases, especially based on sharp and sarcastic statements to counsel of a kind that we have been known to deploy ourselves. The panel thought that Judge Jack was inappropriately "telegraph[ing]" her "leanings." 119 F.4th at 393. But district court judges, sitting alone in yearslong dialogue with counsel (unlike us), often have justifications and excuses for these kinds of statements.

Appendix C

We typically allow district court judges to make statements that reflect familiarity with the litigation. *See Liteky v. United States*, 510 U.S. 540, 551, 114 S. Ct. 1147, 127 L. Ed. 2d 474 (1994). "If the judge did not form judgments of the actors in those courthouse dramas called trials, he could never render decisions." *Id.* (quoting *In re J.P. Linahan, Inc.*, 138 F.2d 650, 654 (2d Cir. 1943) (Frank, J.)). And here, we are dealing with administration of managerial devices at the remedies stage, not prejudgment of a case that has just been filed on the docket. *See* Samuel L. Bray, *The System of Equitable Remedies*, 63 UCLA L. Rev. 530, 564–67 (2016). We should be cautious about generalizing indicia of partiality from our pretrial precedents to the setting where a veteran judge is steadily administering a remedy for a constitutional violation that has already been adjudged (and upheld on appeal).

I am particularly untroubled by Judge Jack's diligent attention to the interests of the children in the Texas foster care system. *See* 119 F.4th at 388, 389, 392, 393. Equity moderates the rigors of the law, and therefore demands appropriate consideration for those who are least able to mount a vigorous offense by legal right alone. To extend the chancellor's protection over those children who have too little else to shelter them from the perils of the world is not partiality but traditional equity practice. *See, e.g.*, *Clitherall v. Ogilvie*, 1 S.C. Eq. (1 Des. Eq.) 250, 261 (S.C. Ch. 1792).

I respect the panel's assessment of the considerable record compiled by Judge Jack during her decade-plus involvement with this crisis. But our decision today as a full court to leave things as they are strikes me as resting on miscalculations. I worry that we have concluded, from Judge Jack's assiduous effort in the face of structural friction and intense factual complexity, from remarks based in at best a desire to expeditiously give effect to the Constitution and at worst human error of a nature with regard to which we have perhaps not always set the best example, that Judge Jack is not suited to preside over this case for precisely the reasons that she is suited to preside over this case. I fear that we have inadvertently decided that we cannot leave the case with a district court judge who is deeply familiar with the parties and their conduct and with the substantial public interests at stake. At the very least, I question whether we have met the exceedingly high threshold for removing an Article III colleague.

It is fundamental in our historic liberties that the state may not set aside due process of law in the care of its wards. But today, we turn away the children protected by those guarantees and shut the doors of this court. On the other side, with them, is Supreme Court precedent and our own case law and the familiarity built by a fellow inferior court judge over many long years. On the other side is abuse and neglect, put out of sight of the law once more. We should rehear this case. I respectfully dissent.