

Investigations of California Group Homes Marked By Delays and Uncertainty

When California's Department of Social Services investigates reports of serious harm in its homes for troubled children, the results are often deemed "inconclusive."

by [Joaquin Sapien](#)

ProPublica, April 15, 2015, 2:57 p.m.



After months of chaos at FamiliesFirst, a group home for troubled children in Davis, California, it was closed. But records show the state's Department of Social Services struggles to quickly and effectively investigate reports of trouble at the state's dozens of other such homes. (Jessica Dimmock)

A ProPublica examination has found that the California Department of Social Services fails to swiftly or conclusively investigate hundreds of claims of misconduct and other problems in group homes that house the state's most troubled children.

ProPublica reviewed more than 450 complaint investigations undertaken by the agency between 2009 and 2014 from roughly 50 Level 14 group homes, the residential facilities for California's most acutely disturbed children. More than half the investigations produced "inconclusive" findings, meaning that no determination of facts was reached in cases that involved sexual abuse, physical assaults, drug use or inadequate care at the facilities.

In some instances, the agency didn't even begin its investigations in earnest until well after the alleged perpetrators and victims had moved on from the home. In other cases, the accused and the accusers lived side by side for months.

Additionally, in the investigations in which complaints were substantiated, the agency almost never imposed one of its toughest sanctions – civil penalties. Instead, even in cases where children were injured or sexually abused by their peers, the state was satisfied to order "retraining" for the staff that had failed to oversee the children.

Michael Weston, a Department of Social Services spokesman, defended the rigor of the investigations. He said the hundreds of "inconclusive" findings were the only fair determinations when the truth behind the allegations could not be established.

"Are you suggesting that they should substantiate things that they don't have preponderance of the evidence to substantiate?" Weston asked, referring to the department's investigators. "You want to investigate something thoroughly, but again, we're not encouraging people to substantiate things if they don't have a preponderance of the evidence to substantiate."

Weston added that all complaints are given "top priority," and are investigated "as soon as possible."

Advocates and experts in the field say the inconclusive reports reflect a deeper problem.

"The people conducting these investigations really aren't appropriately trained," said Bill Grimm, a lawyer with the National Center for Youth Law. "They don't look at it with a kind of rigid approach that someone in law enforcement would use in a criminal investigation. That really undercuts the legitimacy of these investigations."

In addition to acting on complaints filed by children, their families or workers at the facilities, the department is required to investigate what are known as "unusual incidents" – a range of episodes that can involve everything from missed medication to reports of criminal activity that come to involve the local police. The homes are required to file them electronically. The department must review each report within days and decide if it warrants further review. In those cases, inspectors typically visit the home, interview staff and children involved in the incident, and determine whether the home has violated its legal obligations.

ProPublica reviewed a sample of nearly 100 such investigations. The department appears to respond faster to incident reports than complaints and rarely makes "inconclusive" findings, but the investigations are sometimes left open indefinitely. Of the 100 investigations, DSS left about one-third of the cases open, found violations in another third, and deemed there were no violations in the final third.

In the cases involving complaints filed by the children or their families, the department is supposed to visit the home and initiate its investigation within 10 days. There are no legal requirements as to when the investigation must conclude. In dozens of instances, the records

reviewed by ProPublica fail to make clear whether inspectors visited the home within 10 days of the complaint. The records do make clear that investigations often drag on for months.

In some respects, it's understandable the department often struggles to reach a definitive conclusion. The complaints are often made by children with severe mental health issues, whose accounts may not be consistently reliable.

Still, close examination of these cases reveal disturbing outcomes and oversights.

At the Bayfront Youth and Family Services home in Long Beach, ProPublica looked at 43 complaints from 2009 to 2014. Thirty-two were deemed inconclusive. The allegations ranged in severity. Some were very serious: children claiming they'd been viciously attacked by their peers or counselors. Others were minor, such as when a child said the home's staff had abruptly ended a home phone call by hanging up the line.

Over this five-year period, the department substantiated 10 complaints that included allegations of sexual activity and the improper use of restraints, meaning instances in which children were physically calmed or controlled by staff. In 2012, the department determined that several children had been injured during the staff's use of restraints and that staff at the home had deployed the technique far too often.

Yet, in the two years prior, Marleana Reed, the home's director, had promised DSS on nine separate occasions that she would retrain her staff on the proper use of restraints and other supervisory issues.. The department accepted her "plans of correction," but the same problems went on for years.

Reed did not respond to repeated requests for comment.

On March 26, 2010, according to DSS files, two children had sex in one of the home's "day rooms." Reed told the department she retrained the staffers who were supposed to be supervising the children. That year, eight more complaints of serious abuses came in. Children said they'd been punched, kicked and bitten, sometimes by staff, sometimes by each other. The department substantiated three complaints. One involved a counselor who had allegedly grabbed a child by the neck. In another, a child was given an icepack after he broke his clavicle. The boy didn't receive medical treatment for several hours. In a third incident, a child stood accused of "inappropriately touching" another in a movie theater. In each instance, the department accepted Reed's promises to retrain her staff and imposed no other sanctions.

In 2011, the pattern continued. Children lodged 11 complaints that year and four were substantiated. Two involved allegations of assault by staff. The department also investigated 16 separate incident reports that year, formal notices filed by staff at Bayfront. In one, inspectors confirmed that a counselor punched a child. In another, a child was found slashing her arm in a bathroom and was later hospitalized after swallowing a piece of metal. Reed fired four employees involved in incidents that year and told the department she had retrained several others. In November of that year, the department issued a civil penalty after confirming that two children had sex on the campus — the second such incident in a year.

In March 2012, records show, a department inspector spoke to Reed at the home. Children had fought or left the campus on four consecutive days that month and the inspector was concerned about the volume of restraints on the campus. Reed was instructed to tell her staff to use the

technique only as a “last recourse.” But reports of violence between staff and clients continued that year.

On October 22, the home incurred another civil penalty after a child’s face was injured during a restraint. A week later, the “day room” again was the site of sexual activity among children, according to an incident report.

In the first six months of 2013, department inspectors investigated six more complaints and responded to three incident reports at Bayfront. They substantiated just one complaint, finding that a child’s thighs, torso and arms had been bruised during several restraints.

In spite of the home’s record, the department allowed the facility to expand.

In the summer of 2013, the home added one more child to each of 11 rooms that originally housed two. It now has a capacity of 40 boys and girls, making it one of the largest Level 14 facilities in the state.

Since then, state inspectors have been back to the facility at least a dozen times to investigate claims of beatings and harassment perpetrated by staff. Again and again, the investigations have ended with a finding of “inconclusive.”

Department of Social Services spokesman Weston would not answer questions about the home and the state’s oversight of it.

Other homes had their share of problems, too, the records show.

In March of 2009, the Department of Social Services received a complaint that a staff member at a 28-bed group home called Casa Pacifica in Camarillo was having sex with a minor resident.

The home’s chief executive, Steven Elson, had hired the worker in 2008, and Elson said the man passed a background check performed by DSS. Elson said he had submitted the man’s fingerprints and work history information to the department. The department, Elson said, reviewed the material and cleared him to work in the home in early 2008.

Six months later, Elson said he started receiving emails from staff about the worker. The man was supposed to be working exclusively with boys, but he kept showing up in the girls’ cottage. Elson said he reprimanded the man, but decided to keep him on the staff.

In early 2009, a female resident of the home complained about the man’s conduct. She said the man had been having sex with another girl on the campus. Elson’s staff filed an unusual incident report with DSS. Elson said he also began an internal investigation. He couldn’t substantiate the girl’s claim. The alleged victim said she never had sex with the man and the accuser recanted her allegation. Elson said he fired the worker anyway.

DSS didn’t begin its investigation until five weeks after the man had been fired. The investigation then took nine months. In that time, DSS wasn’t able to substantiate the allegation of sex abuse.

But the inspectors did unearth one troubling, incontrovertible fact: It turned out the worker had impregnated an under-age child eight years earlier in 2001, state records show. The child was not a resident of a group home, and the man had yet to begin working for a home. Still, both the department and Elson missed that troubling episode during their background check.

No action was taken against the facility. “There are no deficiencies cited,” the report concludes.

Elson, in an interview, said that his facility had acted responsibly. He said he was disappointed, but not altogether surprised by the department’s conduct in the investigation.

“It’s a big bureaucracy. They regulate thousands of facilities: senior care, day care centers, group homes. Thousands of fingerprints and other information go to them. I know they probably aren’t going to catch everything,” Elson said. “But here’s the thing. Child serving businesses — day care centers, schools, places that work with children — they are a magnet for pedophile types. So you’ve got to be super careful and have policies that will highlight activity that might be concerning.”

In February 2010, DSS banned the former worker from working at any facility overseen by the department. Weston, the DSS spokesman, would not elaborate on how the department missed the earlier instance of child abuse.

“There was no information provided to the Department during the background check process that would have allowed the Department to deny the application for clearance,” he said.

In San Diego, the list of complaints made against the San Diego Center for Children in February of 2013 were lengthy and serious: too many children; not enough staff; staff members were driving residents of the facility around the city despite having been drinking and taking drugs; the facility’s medical technicians were underqualified. State investigators took nine months to investigate the charges. Ultimately, they declared they could neither prove nor disprove any of the allegations. “Therefore, the above allegations are found to be inconclusive at this time,” the DSS report reads.

Representatives of the group home declined to address the specific allegations, saying only that they try to maintain a transparent and open relationship with the department and are sometimes frustrated themselves by DSS’s inconclusive reports.

“As an organization we would like the opportunity to be cleared of allegations such as these and have the reports reflect the department’s actual findings,” said Cheryl Rode, the home’s senior clinical director.

In December of 2012, a staffer at the Fred Finch Youth Center in Lemon Grove had allegedly broken a child’s collar bone. After nine months, investigators confirmed that the child had indeed suffered a fracture. But, their report said, “there is insufficient evidence to determine how the injury occurred.” There is no indication that the child or the alleged assailant had been relocated.

In an interview, Fred Finch Youth Center President and CEO Tom Alexander said the boy broke his collar bone when counselors were trying to prevent him from attacking them and other children.

“It was an accident,” Alexander said. “The staff did what they could. He was a big kid, probably 240 pounds or something like that.”

Alexander said that, in general, it’s not unusual for a DSS investigation to culminate in an “inconclusive” finding. He said reports often sit on the desks of investigators for months after an initial questioning. Alexander attributes the delays to underfunding and understaffing in the department.

“They don’t have the staff to get out to the facilities and investigate as quickly as they should,” Alexander said. “People’s memories change. A kid might feel strongly about a complaint three weeks ago and now they can’t remember it. That leads to more inconclusive reports than they’d have if they had adequate staff to make rapid and comprehensive review of allegations.”

Weston told ProPublica the agency is sufficiently funded to “meet its mandates.”

Maria Ramiu, an attorney for the Youth Law Center in San Francisco, said the inconclusive reports suggest a lack of training and expertise on the part of DSS investigators.

“You can move from being a DMV clerk to working as a [Licensing Program Analyst] if you meet the state’s basic requirements,” Ramiu said, referring to the DSS employees who respond to complaints. “It goes to the core of whether we have an oversight system that is structured to keep kids safe. These children are very vulnerable. This is a population that is likely to be preyed upon because of their history of abuse. They are isolated. But we don’t have a good system of protection for them.”