Oregon
Kate Brown, Governor

Department of Human Services
Office of the Director
500 Summer St. NE, E-15
Salem, OR 97301
Voice: 503-945-5600
Fax: 503-581-6198

Legislative Report
Department of Human Services

Substantiated Investigation Quarterly Report to Legislative Committees on Child Welfare Reporting

Period: April 1, 2019 to June 30, 2019

Report date: August 30, 2019

Senate Bill 1515, effective April 4, 2016 following the 2016 Regular Legislative Session, directs the Department of Human Services (DHS) to submit a quarterly report to the interim legislative committees on Child Welfare. Section 58 of the bill prescribes an effective date of July 1, 2016 for certain parts of the bill, including Section 38 which contains the quarterly reporting provision.

Senate Bill 243, effective August 15, 2017 following the 2017 Regular Legislative Session (the section of the bill pertaining to reports was operative January 1, 2018), directs DHS to also submit a quarterly report to the interim legislative committees on Child Welfare regarding substantiated reports of abuse regarding DHS certified foster homes (Child Welfare and Office of Developmental Disabilities Services certified foster homes) and developmental disabilities residential facilities (Office of Developmental Disabilities Services licensed group homes).

The quarterly reports are for the purposes of legislative and public review and oversight of the quality and safety of providers that are licensed or certified by DHS to provide care or services for children in care.

The following report represents data from Child Caring Agencies (CCAs), Child Welfare (CW) certified foster homes, Office of Developmental Disability Services (ODDS) certified foster homes and ODDS licensed group homes in the second quarter of 2019, April 1 through June 30.

The data is separated by provider type for clarity.

Related to Child Caring Agencies: information provided in this report contains:

- The name of any child-caring agency or proctor foster home where the department conducted an investigation pursuant to section 37, chapter 106, Oregon Laws 2016, that resulted in a finding that the report of abuse was substantiated during that quarter;
- The approximate date that the abuse occurred;
- The nature of the abuse and a brief narrative description of the abuse that occurred;
- Whether physical injury, sexual abuse or death resulted from the abuse; and
- Corrective actions taken or ordered by the department and the outcome of the corrective actions.

Time Period: Child Caring Agency (CCA)/Child Caring Provider (CCP) Abuse Reports Closed from April 1, 2019 through June 30, 2019.

Summary: Seventeen (17) Office of Training, Investigations and Safety (OTIS) (formerly known as Office of Adult Abuse Prevention and Investigations (OAPPI)) investigations with twenty-seven (27) substantiated allegations.

Note: The outcome of the following reports could change upon appeal.

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA180163 One Allegation	Janus Youth Programs – Annex 1	Unknown	No
Nature of Abuse and Brief Narrative: One allegation of Neglect was substantiated against a specific staff after that staff repeatedly allowed a youth to leave the program after curfew without supervision. This youth was not allowed unsupervised community time without his probation officer's approval and he later reported engaging in activities that violated his probation and damaged his progress in treatment.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** Janus Youth management placed the identified employee on administrative leave upon learning of the employee's failure to enforce the established curfew, and she ended her employment while the neglect investigation was in process.	
Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA190020 Two Allegations	Family Solutions-Cedar House	01/28/2019	No
Nature of Abuse and Brief Narrative: One allegation of Wrongful Restraint was substantiated on a specific staff after this staff responded to being bitten by one of the youth by shoving his head/neck rather than following his training. This staff did not document the incident, did not report an injury to his supervisor and did not follow the principles of CPI, rather his response was a forceful and immediate shove to the youth's head neck or face resulting in pain, shock and hyperventilating by the youth. One allegation of Physical Abuse was substantiated with a second youth after this staff forcefully took a water bottle from this youth, power struggled over the water bottle and pushed the youth backwards causing him to fall into a peer.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** Family Solutions implemented a safety plan when the allegations came to light. The plan included a requirement for the identified employee to be within line-of-sight of other staff on duty at all times when working in the facility. Due to a failure to effectively communicate this plan to everyone at the facility, the employee was not in line of sight of other staff when working on a shift he normally didn't work, and another allegation of abuse by the employee was made during this shift. The program then placed the employee on administrative leave. DHS inquired about the steps Family Solutions was taking to ensure safety when an employee is the subject of an abuse investigation. The program revised their policies and added a new requirement to communicate any safety plan involving a particular employee to every single employee of the program to avoid any possibility of	

		staff not knowing about a safety plan and the role of staff in implementing a safety plan. The staff person identified in this report was terminated shortly after being placed on leave.	
Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA190031 One Allegation	Family Solutions-Cascade House	02/11/2019	No
Nature of Abuse and Brief Narrative: One allegation of Verbal Abuse was substantiated against a specific staff after that staff stated in the youth's presence, "I can't be around her. I'm going to fucking hit her" while waving her fist in the air. The youth reported becoming emotionally triggered, physically ill and overcome with anxiety.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** Family Solutions placed the identified employee on administrative leave following the incident. The employee resigned while on leave and has had no further contact with children in care at the program.	
Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA190035 One Allegation	Klamath Basin Behavioral Health	02/13/2019	No
Nature of Abuse and Brief Narrative: One allegation of Verbal Abuse was substantiated against a specific staff after that staff engaged in a pattern of intimidating and threatening behavior over a period of hours. The entire event is captured on video and shows this youth visibly upset throughout, attempting to talk to a different staff however this staff stops the youth from accessing the second staff. This staff is seen on video invading the youth's space and pointing at the youth's face.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** Klamath Basin Behavioral Health (KBBH) placed the identified employee on administrative leave following the incident, and the employee was not permitted to work again. Her employment was terminated when the abuse investigation was complete. All KBBH care-giver personnel received additional training in collaborative problem-solving, trauma-informed care and conflict resolution.	
Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA190038 One Allegation	Klamath Basin Behavioral Health	02/26/2019	No

Nature of Abuse and Brief Narrative:	Corrective Actions Taken or Ordered by the Department, and Outcome:
One allegation of Wrongful Restraint was substantiated against a specific staff after that staff physically restrained a youth who was taunting the staff but was not being physically aggressive or a danger to self or others.	Klamath Basin Behavioral Health placed the identified employee on administrative leave following the incident, and the employee was not permitted to work again. Her employment was terminated when the abuse investigation was complete.

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA190039 Four Allegations	Boys and Girls Aid Society of Oregon (Foster Care Program)	Unknown	No

Nature of Abuse and Brief Narrative:	Corrective Actions Taken or Ordered by the Department, and Outcome:
Four allegations of Neglect, involving two youth and two proctor parents) were substantiated after both youth disclosed sexual contact occurring in the proctor home. Both youth are required line of sight supervision however the youth stated they were routinely left without supervision while in the home. Both proctor parents acknowledged being aware of the supervision expectations but not following them.	**Corrective Actions Taken or Ordered by the Department, and Outcome:** One of the two identified youth was moved from the foster home when the sexual contact was initially alleged, while the other identified youth remained as the sole foster child placed in the home. BGAID implemented a corrective plan for the foster parents which included retraining in supervision expectations. The foster parents are appealing the neglect substantiations. If the substantiations are upheld in the appeals process, DHS will ensure Boys and Girls Aid (BGAID) initiates a new background check and fitness determination via the DHS Background Check Unit (BCU) for both foster parents. There was a slight delay on the part of BGAID in making the abuse report, because the program spent some time confirming details. DHS clarified the expectation for mandatory reporters to make abuse reports without delay whenever abuse is alleged. BGAID subsequently reiterated reporting expectations with their staff and foster parents.

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA190051 Four Allegations	Homestead Youth and Family Services	03/10/2019	No

Nature of Abuse and Brief Narrative: Four allegations of Neglect, involving two youth and two staff) were substantiated after both youth eloped from the program undetected due to staff not performing room checks as required.	**Corrective Actions Taken or Ordered by the Department, and Outcome:** Homestead management met individually with the two identified employees, and both were retrained on supervision expectations. Homestead updated its room-check protocols and retrained all Homestead personnel. The two employees are appealing the neglect substantiations. If the substantiations are upheld in the appeals process, DHS will ensure Homestead initiates a new background check and fitness determination via the DHS Background Check Unit (BCU) for both employees.

Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA190054 Four Allegations	Family Solutions – Cedar House	04/02/2019	No

Nature of Abuse and Brief Narrative: Two allegations of Neglect against the program, as well as one allegation of Physical Abuse and one allegation of Verbal Abuse against a specific staff were substantiated after a specific staff responded to a youth being defiant by grabbing him by the throat. A second youth witnessed this incident and became upset, the staff responded by saying "I will be here when you're sleeping, you just wait." This was witnessed by a second staff. The program was substantiated due to this specific staff being under investigation for other concerns of wrongful restraint and physical abuse when this incident occurred.	**Corrective Actions Taken or Ordered by the Department, and Outcome:** The identified employee was placed on administrative leave following the incident and subsequently terminated. The abuse occurred during a time when the employee should have been within line-of-sight of other staff on duty, which was a component of a safety plan put in place following an earlier allegation of abuse involving the employee. The employee was working a shift he didn't normally work, and the staff on the shift were not made aware of the safety plan. Family Solutions updated its policies to require all program personnel, regardless of the shifts they work, to be informed of the details of any safety plan put in place for a particular employee.

Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA190056 One Allegation	Haag Home for Boys	03/30/2019	No

Nature of Abuse and Brief Narrative:	**Corrective Actions Taken or Ordered by the Department, and Outcome:**
One allegation of Neglect was substantiated against an unknown staff after a youth ingested an unknown amount of Coriciden and Mucinex, was exhibiting signs of being under the influence and staff did not seek medical attention for several hours. The youth was ultimately hospitalized and although none of the staff who were on shift over the time of the incident were medically trained, none felt the incident rose to the level of the youth needing medical intervention. Because the incident crossed over two shifts with multiple staff, all of which played a part in monitoring the youth, no single staff could be identified as the staff responsible.	Following the incident, Haag Home management created a new policy & protocol aimed at ensuring youth receive appropriate medical assessment and treatment by medically trained professionals whenever Haag employees become aware of a medication overdose or suspected overdose by a youth in their care. The policy was reviewed by DHS and determined be appropriate and complete. All Haag staff were educated on the policy.

Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA190061 One Allegation	Boys and Girls Aid Society of Oregon (Foster Care Program)	04/05/2019	Yes

Nature of Abuse and Brief Narrative:	**Corrective Actions Taken or Ordered by the Department, and Outcome:**
One allegation of Neglect was substantiated against a specific staff after the youth self-harmed at least twice on the graveyard shift and notified this staff; the staff failed to assess the wound, failed to sweep the youth's room, failed to increase supervision of the youth, failed to request additional staffing support, failed to notify a supervisor or seek medical attention for the youth. Ultimately the youth was taken to urgent care the next day and was not able to have the wound sutured as it had been longer than twelve hours since the injury occurred.	The identified employee was placed on administrative leave during the investigation and was later moved to "on-call" status. Boys and Girls Aid (BGAID) is not scheduling her to work pending the outcome of her appeal of the neglect substantiation. If the substantiation is upheld in the appeals process, DHS will ensure BGAID initiates a new background check and fitness determination by the DHS Background Check Unit (BCU) for the employee. In the meantime, BGAID has improved and enhanced its staff training and protocols for handling of self-harm by youth in care. The program removed written emergency protocols from the large binder kept on-site for staff reference and placed them in a separate smaller binder to make them more readily accessible when needed in the future.

Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA190063 One Allegation	Family Solutions-Cedar House	04/13/2019	No

Nature of Abuse and Brief Narrative: One allegation of Wrongful Restraint was substantiated against a specific staff after that staff pinned a youth to the ground by straddling the youth and using his forearm to keep him on the ground. Management indicated the youth should not have been placed in a physical restraint based on the incident itself.	**Corrective Actions Taken or Ordered by the Department, and Outcome:** Family Solutions placed the identified employee on administrative leave following the incident, and his employment was subsequently terminated.

Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA190064 One Allegation	St. Mary's Home for Boys	04/11/2019	Yes

Nature of Abuse and Brief Narrative: One allegation of Wrongful Restraint was substantiated against a specific staff who responded to an incident and determined a need to physically intervene without any cause to do so. The staff tackled the youth from behind causing them both to fall to the ground leaving the youth with abrasions.	**Corrective Actions Taken or Ordered by the Department, and Outcome:** The identified employee resigned shortly after the incident. DHS and OYA have been working with St. Mary's management on strategies to reduce physical interventions and the conflicts and power-struggles that lead to physical interventions. St. Mary's has increased its emphasis on collaborative problem-solving when addressing children's behaviors, and these efforts have contributed to a decrease in the frequency of physical restraints. DHS will continue to monitor and will continue to collaborate with OYA and St. Mary's on this.

Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA190068 One Allegation	Boys and Girls Aid Society of Oregon (Foster Care Program)	Unknown	No

Nature of Abuse and Brief Narrative:	Corrective Actions Taken or Ordered by the Department, and Outcome:
One allegation of Neglect was substantiated against a specific proctor parent after the proctor parent provided the youth with a full bottle of acetaminophen and the youth overdosed on the medication. The youth has a history of self-harm and suicidal ideation and requires sight and sound supervision. The youth was hospitalized for two days because of this suicide attempt. Consultation with the Oregon Poison Center revealed the approximated amount the youth ingested was five times the potentially fatal dosage, had the youth not received immediate medical care it could have resulted in liver failure or death.	Boys and Girls Aid (BGAID) retrained the identified foster parent immediately following the incident and placed the foster parent on a corrective action plan. The identified child was moved from his home and no other children were placed in the foster parent's care while the investigation was in process. The foster parent was terminated due to other performance issues that came to light.

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA190070 One Allegation	Family Solutions-Cedar House	04/26/2019	No

Nature of Abuse and Brief Narrative:	Corrective Actions Taken or Ordered by the Department, and Outcome:
One allegation of Wrongful Restraint was substantiated against a specific staff after that staff chased a youth to behind a shed and came out from behind the shed carrying the youth into the house. The restraint was not warranted and was not performed correctly.	The identified employee was directed to leave the facility immediately following the incident, and his employment was terminated. Following this and other incidents of wrongful restraint at the facility, all facility personnel were retrained over a 2-day period in non-physical behavior interventions the correct use of physical interventions. Family Solutions has doubled the amount of training time on this topic for new-hires as well as more than tripling the amount of training time provided annually to existing employees.

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA190071 One Allegation	Polk Youth Services	04/25/2019	Yes

Nature of Abuse and Brief Narrative: One allegation of Sexual Abuse was substantiated against a proctor provider's adult daughter was found having sexual intercourse with a youth placed in the home. The adult daughter resided in the home with the proctor providers and the youth placed in the home.	**Corrective Actions Taken or Ordered by the Department, and Outcome:** All foster youth were removed from the home following the incident, and no other youth were placed in the home. The home is no longer certified by Polk Youth Services.

Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA190081 One Allegation	Trillium-Farm Home	05/09/2019	No
Nature of Abuse and Brief Narrative: One allegation of Neglect was substantiated against an unknown staff after a highly vulnerable youth was unaccounted for over a period of at least an hour. Multiple staff were involved, and each appeared to have some level of responsibility however program policies and training were identified as lacking regarding school staff tracking youth on campus.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The investigation revealed issues with the process for transitioning Farm Home residents to the on-campus school. Following the incident Trillium improved its procedures and retrained staff. The improvements include a requirement for staff who bring youth to school to affirm that school personnel have acknowledged the arrival of each individual youth and taken responsibility for supervision of each individual youth.	

Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA190083 One Allegation	Trillium-Farm Home	05/14/2019	Yes
Nature of Abuse and Brief Narrative: One allegation of Neglect was substantiated against the program after a youth was able to access a box cutter while in the kitchen area and self-harmed with it. Multiple staff failures, a lack of training as well as a lack of policy lead to this being a program allegation.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** Following this incident Trillium ensured Farm Home personnel were aware of the prohibition against any Farm Home residents entering the campus kitchen. The door through which the identified youth entered the kitchen is now kept locked and can only be opened from the inside in order to ensure youth are not able to access the kitchen even if staff are unaware of the restriction.	

Related to Child Welfare certified foster care and relative caregiver providers: Information provided in this report contains:

- The number of allegations (children) for each report and type of allegation (Neglect, Physical Abuse, Sexual Abuse, and Threat of Harm);
- Name of the county (provided that there are five or more certified foster homes in the county) where DHS conducted an investigation pursuant to section 37, chapter 106, Oregon Laws 2016;
- The approximate date the abuse occurred;
- The nature of the abuse and a brief narrative description of the abuse that occurred;
- Whether physical injury, sexual abuse or death resulted from the abuse; and
- Actions the Department has taken following the substantiated findings.

Time Period: Child Welfare certified foster home abuse reports substantiated from April 1, 2019 through June 30, 2019. Reports may have been received prior to the reporting period.

Summary: 19 reports were substantiated in Child Welfare certified foster homes, including certified relative caregivers.

Note: There were approximately 4,094 Child Welfare certified family foster and relative care providers on June 30 2019.

Explanation of terms: All applicants who apply to become a foster or relative caregiver family for Child Welfare must be assessed and certified under the same set of rules and procedures.

There are 2 types of certificates:

- *General Certificate of Approval:* Issued to individuals who do not have a previous relationship with a child in care and are applying to become foster parents for the general foster child/young adult population.
- *Child Specific Certificate of Approval:* Issued to individuals to provide care for a specific child/young adult, including relatives of the child/young adult or others who know the child or family of the child needing placement.

- *ICPC (Inter State Compact for the Placement of Children):* A case where a state requests Child Welfare

assess and certify a home for placement of a specific child from their state.

- *Inactive referral status:* A designation given to a foster home or relative caregiver home where no additional children may be placed in the home.

Review process when there is an allegation of abuse in a child welfare certified foster or relative caregiver home:

Field offices are required to submit a "Sensitive Issue Memo" each time there is an allegation of abuse in a Child Welfare certified home. The memo is sent electronically to management/leadership of the Department as well as program staff.

Field office are required Oregon Administrative Rule and Child Welfare Procedure which requires for all concerns (allegations of abuse, closed at screenings, or other concerns) a staffing occur. This staffing involves certification staff, CPS staff, and casework staff for each child placed in the home. Concerns/allegations are discussed and a plan is developed.

When there is an assessment of abuse in a foster home, the home is placed on "inactive referral status" and no additional children may be placed in the home.

1. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3125928/ Neglect (2)	Lane	2/7/2019	No
Nature of Abuse and Brief Narrative: Relative provider (maternal aunt and uncle) were allowing the maternal grandmother to provide care for the children, despite concerns regarding excessive alcohol consumption, impulsive behavior and an unsafe living environment. The grandmother's alcohol consumption resulted in her becoming verbally abusive to the children. The foster parents were aware of the grandmother's alcohol use and continued to allow her to care for the children.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** Initially a plan was put in place to have the children remain in the home, an approval for the founded was obtained. The foster children were very clear they wanted to remain with this family. The home is now closed, as the foster children returned home.	

2. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3101011/ Neglect (2)	Marion	11/27/2018	No
Nature of Abuse and Brief Narrative: Foster parent and his significant other failed to take measures to prevent foster child from engaging in sexual activity with biological son, despite observing multiple incidents of inappropriate physical contact between the children.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The foster children were moved from the home. The certification is closed.	

3. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3096681/ Neglect (1)	Douglas	11/13/2018	No
Nature of Abuse and Brief Narrative: Relative foster parent admitted to locking the foster child in her room after the child would wake in middle of the night due to having nightmares. Foster parent admitted to having locked the child in her room on two separate occasions. The child described being unable to get out of the room, and being scared and crying.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The foster children were moved from the home. The certification is closed.	

4. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3136753/ Neglect (1)	Douglas	3/5/2019	No

Nature of Abuse and Brief Narrative:	**Corrective Actions Taken or Ordered by the Department, and Outcome:**
Foster parent was advised by the Department on multiple occasions to not allow the foster child to have contact with her friend, due to the friend's child welfare history. The child disclosed smoking marijuana with the friend of the foster parent, despite the multiple warnings.	The foster children were moved from the home. The certification is closed.

5. Report/ Allegation (Number of Children)	**County**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
3134561/ Neglect (1)	Lane	2/27/2019	No
Nature of Abuse and Brief Narrative:		**Corrective Actions Taken or Ordered by the Department, and Outcome:**	
Foster parents were leaving the child unsupervised in the bathtub. While they were checking on the child regularly, there were many times the child was unsupervised, leading to a potentially dangerous situation.		Caseworker required the foster parents to sign an updated supervision plan. The importance and requirement always supervising young children in the bathtub was discussed with the foster parents. The home remains open.	

6. Report/ Allegation (Number of Children)	**County**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
3160495/ Threat of Harm (1)	Deschutes	5/3/2019	No
Nature of Abuse and Brief Narrative:		**Corrective Actions Taken or Ordered by the Department, and Outcome:**	
Foster mother passed out as a result of strangulation by the foster father on two occasions. The child did not witness the interactions, rather was sleeping in another room.		The perpetrator of the substantiated disposition was the foster father. This individual is no longer part of the certified home, and the foster mother is seeking a divorce.	

7. Report/ Allegation (Number of Children)	**County**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
3149623/ Neglect (3)	Washington	4/9/2019	No
Nature of Abuse and Brief Narrative:		**Corrective Actions Taken or Ordered by the Department, and Outcome:**	
Each of the children suffer from acute asthma that can be life threatening if their needs are not provided for. The conditions of the foster home were unclean, including clutter to the ceiling as well as pet feces and urine, dander and odor throughout the home and in the children's medical equipment.		The foster children were moved from the home. The foster parent is contesting the disposition. The office will staff the certification options after the Founded Review Committee.	

8. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3154743/ Neglect and Mental Injury (2)	Jackson	4/22/2019	No
Nature of Abuse and Brief Narrative: Foster parent was shouting at the children when angry, throwing objects, calling them names and raised her fist at them in a threatening manner. The children were also not taken to doctors, dentists and mental health providers, despite repeated prompting from the agency to address the children's previous trauma and medical/dental needs.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The foster children were moved from the home. The certification is closed.	

9. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3111933/ Neglect (1)	Polk	1/2/2019	No
Nature of Abuse and Brief Narrative: Foster parents failed to lock medication and firearms in their bedroom, resulting in one of the firearms going missing. The foster parents later located another, different firearm under the mattress of one of the children.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The foster children were moved from the home. The certification is closed.	

10. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3121362/ Mental Injury (2)	Multnomah	1/28/2019	No
Nature of Abuse and Brief Narrative: Foster parents were found to have rigid/controlling parenting, focusing on the child's behavior as not normal and dark. Foster parents also failed to support the children in engagement in services, were inconsistent with sibling visitation, and spoke negatively of the children.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The foster children were moved from the home. The foster parent is contesting the founded disposition. The department is working with DOJ on the revocation process.	

11. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3132225/ Physical Abuse (1)	Jackson	2/21/2019	No
Nature of Abuse and Brief Narrative:		**Corrective Actions Taken or Ordered by the Department, and Outcome:**	

Foster mother was using physically discipline including the use of a spatula on the foster child in home.	The foster child was moved from the home. The foster parents are appealing the disposition. Certification staff is working with DOJ and revocation process.

12. Report/ Allegation (Number of Children)	**County**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
3102855/ Neglect (2)	Marion	12/3/2018	No
Nature of Abuse and Brief Narrative: Siblings were placed in foster home with a safety plan including having the children sleep in separate bedrooms due to previous concerns of inappropriate touching. The foster parent allowed the children to sleep in the same room and at times the provider's niece would sleep in the room despite knowledge of the children's need for high level supervision.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The foster children moved from home. The certification is closed.	

13. Report/ Allegation (Number of Children)	**County**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
3144963/ Physical Abuse (1) and Neglect (1)	Marion	3/26/2019	No
Nature of Abuse and Brief Narrative: Foster father hit one of the foster children on the forehead with a closed fist. The child provided a detailed disclosure and expressed fear when speaking of the incident.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The foster children were moved from home. The certification is closed.	

14. Report/ Allegation (Number of Children)	**County**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
3133481/ Sexual Abuse (1)	Crook	2/25/2019	Yes
Nature of Abuse and Brief Narrative: Foster child was sexually abused by the foster parent's biological son. The foster parent was appropriate in response to the disclosures.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The perpetrator (the biological son) is not in the home, is under the supervision of the juvenile department, and is living with his grandparents, with a likely plan of residential treatment. The foster parent was cooperative and appropriate during the assessment, and the home remains open with children placed.	

15. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3134091/ Physical Abuse (1)	Coos	2/26/2019	No
Nature of Abuse and Brief Narrative: Foster parent used a belt to discipline foster child, despite knowledge of department policy on physical discipline.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** A management approval to maintain certification and the placement of the foster parent's nephew was obtained. A placement support plan regarding discipline was developed. The court granted guardianship to the foster parents and the certification is closed.	

16. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3115304/ Physical Abuse (1)	Josephine	1/11/2019	No
Nature of Abuse and Brief Narrative: Foster parents were spanking the foster child as a form of discipline that resulted in pain. The foster parents were utilizing this form of discipline in order to manage the child's unwanted behaviors despite the historical trauma the child endured.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The foster children were moved from the home. The certification is closed.	

17. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3131792/ Neglect (1)	Multnomah	2/20/2019	No
Nature of Abuse and Brief Narrative: Relative foster parent and her fiancé were using physical discipline and spanking the foster child. The foster parent had also left the child in the care of unauthorized adults, including a convicted felon.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The foster children were moved from the home. The certification is closed.	

18. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3136428/ Physical Abuse and Neglect (1)	Lane	3/4/2019	No
Nature of Abuse and Brief Narrative: Relative foster parent (Grandmother) was using a wooden back scratcher to threaten, as well as discipline, the foster child, by striking the child on the hand and arm. Relative foster parent admitted to		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The foster children were moved from the home. The certification is closed.	

providing foster child with prescription sleep medicine on 2 to 3 occasions, indicating she did not believe the child's own medication was effective. Foster parent was giving child sleep medications to manage the child's behavior when her husband was working and not able to assist with caring for the child.	

Related to Developmental Disabilities certified foster care:

During this reporting period, there was one substantiated report in ODDS certified foster care.

1. Report/ Allegation (Number of Children)	**County**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
3086553/ Neglect (1)	Jackson	10/21/2018	No
Nature of Abuse and Brief Narrative: Founded for neglect against foster parent for failing to intervene after foster child reported physical aggression by another child in the home. The foster parent also refused to take the foster youth to the hospital after she reported suicidal ideation. Foster child has history of significant abuse/neglect and has ongoing struggles with suicidal ideation.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** Issued an Intent to Revoke CFH license. Provider appealed and later withdrew appeal due to moving and appealing the Child Welfare findings. Issued a final order by default; the home is closed.	

Related to developmental disabilities (Office of Developmental Disabilities Services (ODDS) licensed group homes). Information provided in this report contains:

- The name of any child-caring agency or proctor foster home, certified foster home or developmental disabilities residential facility where the department conducted an investigation pursuant to section 37 of this 2016 Act that resulted in a finding that the report of abuse was substantiated during that quarter;
- The approximate date the abuse occurred;
- The nature of the abuse and a brief narrative description of the abuse that occurred;
- Whether physical injury, sexual abuse or death resulted from the abuse; and
- Corrective actions taken or ordered by the DHS and the outcome of the corrective actions

Time Period: CDD/SC Abuse Reports Closed from April 1, 2019 through June 30, 2019

Summary: 1 Office of Training, Investigations and Safety (OTIS) (formerly known as the Office of Adult Abuse Prevention and Investigations (OAPPI) investigations with 2 substantiated allegations.

Explanation of terms:

- OTIS is responsible for investigating allegations of abuse or neglect in a child-caring agency, proctor foster home, or developmental disabilities residential facility. Child Welfare is responsible for investigating allegations of abuse or neglect in certified foster homes.
- Reports beginning with 'CDD' were investigations conducted in a developmental disabilities residential facility.
- Reports beginning with 'SC' were investigations conducted in a Stabilization and Crisis Unit home licensed for children.
- The outcome of the following reports could change upon appeal.

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD19027 Two Allegation	Albertina Kerr Centers	04/26/2019	Yes
Nature of Abuse and Brief Narrative: Two allegations of Neglect were substantiated against an unknown staff after a staff (unable to identify responsible staff) left cleaning supplies unsecured. One of the youth sprayed his housemate in the eyes with said chemicals which required immediate medical attention to ensure there was no long-term damage		**Corrective Actions Taken or Ordered by the Department, and Outcome:** Staff on duty during the incident were immediately retrained on locking chemicals up. All staff were retrained at the following staff meeting. Two follow up visits were completed by the Residential Specialist following the incident/retraining; they observed that all chemicals were locked up. Issued a civil penalty of $1,000	