# Oregon

Kate Brown, Governor

**Oregon Department of Human Services**
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## Oregon Department of Human Services Substantiated Investigation Quarterly Report to Legislative Committees on Child Welfare

## Period: Closed January 1, 2021 to March 31, 2021
## Report date: June 30, 2021

Senate Bill 1515 (2016) directs the Oregon Department of Human Services (ODHS) to submit a quarterly report to the interim legislative committees on Child Welfare regarding substantiated reports of abuse occurring in ODHS licensed Child Caring Agencies (CCAs).

Senate Bill 243 (2017) also directs ODHS to submit a quarterly report to the interim legislative committees on Child Welfare regarding substantiated reports of abuse occurring in ODHS certified foster homes (Child Welfare and Office of Developmental Disabilities Services) 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 ODHS to provide care or services to children in care.

The following report includes 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 first quarter of 2021, January 1 through March 31.

The data is separated by provider type for clarity.

**Related to Child Caring Agencies (CCAs)**

Information provided in this section contains:

- The name of any child-caring agency or proctor foster home where the department conducted an investigation that resulted in a finding that the report of abuse was substantiated during this 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 January 1, 2021 through March 31, 2021.

**Summary:** Eight (8) Office of Training, Investigations and Safety (OTIS) investigations with eleven (11) 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.
- The outcome of the following reports could change upon appeal.

<table>
<tr><th>Report/<br>Allegation</th><th>Provider</th><th>Approximate Date Abuse Occurred</th><th>Did physical injury, sexual abuse or death result?</th></tr>
<tr><td>CCA200105</td><td rowspan="2">Morrison Youth and Family Services-Proctor/Foster Care</td><td rowspan="2">06/18/2020-07/10/2020</td><td rowspan="2">No</td></tr>
<tr><td>1 allegation</td></tr>
<tr><th colspan="2">Nature of Abuse and Brief Narrative:</th><th colspan="2">Corrective Actions Taken or Ordered by the Department, and Outcome:</th></tr>
<tr><td colspan="2">One allegation of Neglect substantiated on a specific proctor parent after that proctor parent failed to properly store the youth's medication leading to several missing pills. Numerous concerns were identified including the medications not being stored or administered as required, leading to the youth snorting his medication. The youth was placed in this program to focus on his substance abuse issues so this incident was counterproductive to the youth's treatment. Additionally, to cover up his error, the proctor foster parent drove the youth to his parent's home two days in a row in an attempt to obtain more medication. Ultimately the youth ran on the second trip to his parent's home and was incarcerated.</td><td colspan="2">Morrison Youth and Family Services terminated the identified foster parent's foster certification. ODHS consulted with Morrison on ways to improve the program's medication administration training and oversight. The program made several improvements and is conducting an on-going analysis of more ways to improve in this area.</td></tr>
</table>

<table>
<tr><th>Report/<br>Allegation</th><th>Provider</th><th>Approximate Date Abuse Occurred</th><th>Did physical injury, sexual abuse or death result?</th></tr>
<tr><td>CCA200189</td><td rowspan="2">Rimrock Trails ATC</td><td rowspan="2">11/2020</td><td rowspan="2">No</td></tr>
<tr><td>2 Allegations</td></tr>
<tr><th colspan="2">Nature of Abuse and Brief Narrative:</th><th colspan="2">Corrective Actions Taken or Ordered by the Department, and Outcome:</th></tr>
<tr><td colspan="2">Two allegations of Neglect were substantiated on two different staff for two incidents in which hand sanitizer was left unsecured and unsupervised allowing a youth to access and consume. This is a drug and alcohol treatment facility with strict protocol on the storage of such items. The youth became intoxicated during the second incident, engaged in aggressive/assaultive behavior, and was arrested for this behavior.</td><td colspan="2">Rimrock terminated the employment of one of the staff who failed to properly secure the area where hand sanitizer was kept. The employee responsible for the other incident of youth gaining access to hand sanitizer was coached and placed on a formal work-plan. That employee is formally appealing the neglect finding, and the appeal is currently in process. Rimrock Trails changed how hand sanitizer is stored and secured to further reduce the possibility of youth accessing it.</td></tr>
</table>

| Report/ Allegation | Provider | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| CCA200154<br>1 Allegation | Milo Adventist Academy | Sept/Oct. 2020 | Yes |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
|---|---|
| One allegation of sexual abuse was substantiated against a known staff member. It was determined the staff member had touched the intimate parts of a male youth's body and developed an intimate relationship which began at the CCA facility. The staff allowed the youth to come over to her home and provide babysitting services. It was at her home where the sexual abuse occurred. They had social media contact which included sending photos of a sexual nature. The youth and staff made plans to continue their relationship following his exit from the program. | Milo Adventist Academy terminated the employment of the identified staff member when the situation that led to the abuse substantiation came to light. The program subsequently retrained all personnel in appropriate boundaries when interacting with students and provided additional instruction on the topic to its Residence Deans. |

| Report/ Allegation | Provider | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| CCA200171<br>2 Allegations | Trillium—Farm Home | 11/4/2020 | Yes |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
|---|---|
| Two allegations of Wrongful Restraint by two identified staff members to one youth. The use of a physical restraint was found to be justified based on the safety needs of the youth involved. However, after the restraint began, the youth dropped her weight to the floor. At this point, the youth should have been fully released from the restraint, but two of the involved staff members continued to hold the youth in a prone position. They then drug her across the floor of the facility for four seconds attempting to relocate her to another area of the facility. | One of the two identified employees was restricted from participating in physical interventions, and both employees were retrained in the Non-violent Crisis Intervention (NCI) techniques relevant to the situation that prompted the investigation. The employee who was restricted from participating in restraints was terminated prior to the investigation's conclusion. The other employee resigned shortly after the investigation's conclusion. |

| Report/ Allegation | Provider | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
| --- | --- | --- | --- |
| CCA200173<br>1 Allegation | Trillium—Farm Home | 11/5/2020 | No |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
| --- | --- |
| One allegation of Neglect by one identified staff member. The youth involved required a safety plan to manage his suicidal ideations and behaviors, which included no shoelaces/drawstrings allowed in the youth's bedroom. The staff failed to follow the safety plan and the youth attempted to self-harm by tying a shoelace around his neck. Other program staff intervened after conducting their required supervision checks and worked to remove the ligature item from the youth's neck. There was a secondary incident where staff followed the safety plan, however the youth then used an auxiliary cord around his neck which required staff to cut the ligature item to remove it from his neck. | Trillium management reviewed supervision expectations and safety protocols with the identified staff person following the incident and clarified expectations for all personnel in the facility. The staff person resigned from his position approximately 1 week after the report of neglect was substantiated. |

| Report/ Allegation | Provider | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
| --- | --- | --- | --- |
| CCA200174<br>1 Allegation | Trillium—Farm Home | 11/10/2020 | Yes |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
| --- | --- |
| One allegation of Neglect by an identified staff member. The youth involved required a safety plan to manage his suicidal ideations and behaviors, which included no shoelaces/drawstrings allowed in the youth's bedroom. The staff failed to follow the safety plan and the youth attempted to self-harm by tying a shoelace around his neck. Other program staff intervened after conducting their required supervision checks and worked to remove the ligature item from the youth's neck. The youth had a red line around his neck following the incident where the ligature item had been placed. The staff stated he was aware of the previous incidents involving the | The identified employee received a formal written warning and was placed on a work plan following the incident, and he subsequently resigned from his position shortly after the report of neglect was substantiated. |

| youth's self-harming behaviors with the shoelaces. | |
|---|---|

| Report/ Allegation | Provider | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| CCA200176<br>1 Allegation | Trillium—Farm Home | 11/14/2020 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| One allegation of Neglect by an identified staff member. The youth involved required a safety plan to manage his suicidal ideations and behaviors, which included no shoelaces/drawstrings allowed in the youth's bedroom. The staff failed to follow the safety plan and the youth attempted to self-harm by tying a shoelace around his neck. Other program staff intervened after conducting their required supervision checks and worked to remove the ligature item from the youth's neck. The staff stated she was aware of the previous incidents involving the youth's self-harming behaviors with the shoelaces. | | Given the frequency of staff failing to ensure the identified youth did not have shoelaces when entering his room alone, Trillium replaced his laced shoes with shoes that don't have laces. Trillium management again reiterated supervision expectations to all facility personnel. The staff person identified as failing to ensure the youth did not enter his room with shoelaces in the context of this particular incident was required to undergo a new background check and fitness determination conducted by the ODHS Background Check Unit (BCU). The substantiated incident of neglect was considered, and the BCU determined the employee was fit to continue in her position. Part of the Department's follow-up on CCA2000176 and other substantiated reports of neglect at the program in November centered on improving pre-shift communication with staff as a means of ensuring the details of each youth's supervision plan are consistently reiterated. The program has shown improvement in this area. | |

| Report/ Allegation | Provider | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| CCA210018<br>2 Allegations | St. Mary's Home for Boys | 1/22/2021 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Two allegations of Neglect were substantiated on an unidentified staff after two youth were able to engage in sexual contact over an extended period of time due to a lapse in supervision. Although there were several staff on shift it is difficult to single out one staff that would have been more responsible than | | St Mary's management issued disciplinary memos to all staff present on the shift when the supervision lapse occurred. All staff were provided detailed re-training on supervision protocols and expectations. | |

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| another. All staff were performing their regular duties as assigned, but the two youth, who both have reported histories of self-harm, were unsupervised for a significant period without staff knowledge. | |

**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 ODHS 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 January 1, 2021 through March 31, 2021. Reports may have been received prior to the reporting period.

**Summary:** Twenty-five (25) current Child Welfare certified family foster and relative caregiver providers had a founded allegation against them during this reporting period.

**Note:** The number of certified families varies from month to month, there are approximately 3,500 Child Welfare certified family foster and relative care providers.

**Explanation of terms:** All applicants who apply to become a foster or relative caregiver family for Child Welfare must be assessed and to determine if they are appropriate to care for children/youth in community foster care or to care for a specific child.

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.

Field offices are required by Oregon Administrative Rule and Child Welfare Procedure to staff all concerns (allegations of abuse, closed at screenings, or other concerns). 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.

<table>
<tr><th>Report/ Allegation</th><th>County</th><th>Approximate Date Abuse Occurred</th><th>Did physical injury, sexual abuse or death result?</th></tr>
<tr><td>3345329</td><td rowspan="2">Lane</td><td rowspan="2">1/11/2021</td><td rowspan="2">No</td></tr>
<tr><td>Neglect in Care (1)</td></tr>
<tr><th colspan="2">Nature of Abuse and Brief Narrative:</th><th colspan="2">Corrective Actions Taken or Ordered by the Department, and Outcome:</th></tr>
<tr><td colspan="2">Relative foster father assaulted his wife while intoxicated and in front of his biological children as well as the foster child. The foster father was arrested.</td><td colspan="2">Foster father was arrested; there is a restraining order in place; certification remains open for foster mother as a single provider.</td></tr>
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<tr><th>Report/ Allegation</th><th>County</th><th>Approximate Date Abuse Occurred</th><th>Did physical injury, sexual abuse or death result?</th></tr>
<tr><td>3319047</td><td rowspan="2">Clackamas</td><td rowspan="2">10/7/2020</td><td rowspan="2">No</td></tr>
<tr><td>Neglect (1), Threat of Harm (1)</td></tr>
<tr><th colspan="2">Nature of Abuse and Brief Narrative:</th><th colspan="2">Corrective Actions Taken or Ordered by the Department, and Outcome:</th></tr>
<tr><td colspan="2">Foster father experienced a mental health crisis that required hospitalization. Prior to the hospitalization, the foster father's behavior was unsafe and frightening the children. The foster mother created safe words for the children in the event they had to leave the home or contact law enforcement, rather than reporting to ODHS.</td><td colspan="2">Certification is closed; no children in care remain in the home.</td></tr>
</table>

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<tr><th>Report/ Allegation</th><th>County</th><th>Approximate Date Abuse Occurred</th><th>Did physical injury, sexual abuse or death result?</th></tr>
<tr><td>3346664</td><td rowspan="2">Marion</td><td rowspan="2">1/14/2021</td><td rowspan="2">No</td></tr>
<tr><td>Threat of Harm (2), Sexual Abuse (1), Threat of Harm (4)</td></tr>
<tr><th colspan="2">Nature of Abuse and Brief Narrative:</th><th colspan="2">Corrective Actions Taken or Ordered by the Department, and Outcome:</th></tr>
<tr><td colspan="2">Foster parent sexually abused a foster child when the child was previously placed in his home. Foster children voiced concerns that the foster father was demonstrating grooming</td><td colspan="2">Certification in process of being closed; no children in care remain in the home.</td></tr>
</table>

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| behavior, showing them videos of women dancing in only underwear. The children indicate they ran away from the home due to comments the foster father made that made them uncomfortable. | |

| **Report/ Allegation** | **County** | **Approximate Date Abuse Occurred** | **Did physical injury, sexual abuse or death result?** |
|---|---|---|---|
| 3363818<br>Threat of Harm (1), Neglect in Care (2) | Klamath | 3/12/2021 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Foster father grabbed child by the shirt, dragged him and threw him on a different chair before striking him in the head several times with a closed fist. Both foster parents allowed the foster home to fall below minimally adequate standards with animal urine and feces, no access to laundry facilities, as well as having every surface cluttered. Because of this, one of the foster children does her own laundry at the laundromat and buys her own food. | | Certification is closed; no children in care remain in the home. | |

| **Report/ Allegation** | **County** | **Approximate Date Abuse Occurred** | **Did physical injury, sexual abuse or death result?** |
|---|---|---|---|
| 3359413<br>Physical Abuse in Care (1) | Washington | 2/26/2021 | Yes |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Foster child was bit by a Pitbull that was visiting the home. The bite punctured the child's skin and marks were visible weeks later. The foster mother knew the child was bit, however, did not realize how serious it was and as a result did not provide medical attention. The foster parent also threatened to put soap in the child's mouth and put her finger in the child's mouth, who then bit down. The foster mother instinctively slapped the child. | | Approval to maintain certification obtained; Child remains in the home; foster parent completed KEEP; 30 visits from certifier, placement support plan, and a specific training plan put in place. | |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3356765<br>Verbal Abuse in Care (1) | Polk | 2/18/2021 | No |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
|---|---|
| Foster father verbally abused the foster child by intimidating and threatening him with firearm related violence. | Certification is closed; no children in care remain in the home. |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3308684<br>Physical Abuse (1) | Douglas | 1/31/2021 | Yes |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
|---|---|
| Foster father engaged in a physical altercation with foster child while under the influence of alcohol. This resulted in the foster father biting the child numerous times, one of the bites drawing blood and becoming infected. | Certification in process of being closed; no children in care remain in the home. |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3346787<br>Physical Abuse (2) | Douglas | 1/15/2021 | No |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
|---|---|
| Relative foster parent was spanking both children with his hand. | Certification closed; no children in care remain in the home. |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3342184<br>Neglect (1), Threat of Harm (1) | Deschutes | 12/29/2020 | No |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
|---|---|
| Foster parent allowed the foster child's biological mother to move into the home and stay for several months while hiding this from ODHS caseworkers. The mother has a history of significant mental health and safety issues. Also founded against biological mother. | Certification closed; no children in care remain in the home. |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3336390 | Lane | 12/7/2020 | No |
| Neglect in Care (1) | | | |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Relative foster mother failed to attempt to prevent foster child from leaving Oregon to reunite with her biological mother and adult brother out of state. Foster mother did not notify the agency | | Certification closed; no children in care remain in the home. | |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3331744 | Washington | 11/19/2020 | No |
| Neglect (1), Threat of Harm (1) | | | |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Foster mother was aware that her friend had a prior conviction for sexually abusing a child, however allowed him to take the foster child on long, isolated walks as well as shopping. The foster mother also failed to provide adequate food and nurturing to the foster child. Also founded against friend of foster mother for threat of harm. | | Certification closed; no children in care remain in the home. | |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3327175<br>Neglect (1), Neglect in Care (1) | Clackamas | 11/4/2020 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Foster parents denied food to foster child who refused to eat what was presented at a meal. They continued to offer the meal that the child would not eat, refusing to provide any other foods. | | Certification closed; no children in care remain in the home. | |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3312729<br>Threat of Harm (2) | Marion | 9/16/2020 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Foster parent reportedly pushed and punched a youth at his place of employment and was founded for Physical Abuse by OTIS. There were no concerns with the children placed in this foster home, rather a threat of harm due to the foster father's behavior. | | Certification closed; no children in care remain in the home. | |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3336637<br>Neglect (4), Neglect (4), Physical Abuse in Care (2) | Union | 12/8/2020 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Foster parents failed to ensure foster children were attending school and failed to ensure one of the children was attending mental health appointments. Foster children also disclosed the foster mother was physically abusing them, | | Certification in process of being closed; no children in care remain in the home. | |

| including hair pulling, spanking, kicking and pushing. | |
|---|---|

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3295901<br>Physical Abuse in Care (1) | Morrow | 7/15/2020 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Relative foster parent grabbed the foster child's face, scratching it. Foster parent also pushed the child, leaving a scratch. | | Victim moved to a different placement; approval to allow other 2 grandchildren to remain in home; grandmother expressed interest in appealing disposition. | |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3335174<br>Neglect (1) | Lane | 12/3/2020 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Foster parent failed to meet the foster child's medical needs by failing to keep a medication log of the child's psychotropic medications and inappropriately administered them. The foster parent also failed to address the child's medical issue with vaginal discharge. The child later was diagnosed with Bacterial Vaginosis. | | Approval to maintain certification obtained; placement support plan put in placement, provided training related to medications, medical logs, psychotropic medication form. Foster parent indicated would be appealing founded disposition. | |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3344184<br>Neglect (1), Neglect (1) | Morrow | 1/6/2021 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Foster parents failed to secure Tylenol, after having been informed that the foster child had previously attempted suicide using Tylenol | | Certification is on Inactive Referral Status; no child in care remain in the home; foster parents have submitted letter that they are appealing the founded disposition. | |

| along with the supervision plan which detailed this information. | |
|---|---|

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3327633<br>Physical Abuse (1) | Lane | 11/5/2020 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Foster child disclosed that the foster mother grabbed her by the hair and shoved her face onto the hood of the foster mother's car. | | Certification is closed; no children in care remain in the home. | |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3350776<br>Neglect (1) | Clackamas | 1/28/2021 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Foster parent lost his temper and yelled and cursed at the foster child, scaring him. | | Providers were general applicant providers; upon this founded an approval was granted to allow their grandchild to be placed in their home with the certification numbers reduced to one. A placement support plan was put in place with training and skill development around trauma responses in children, trauma informed parenting skills, dealing with obstinate behaviors, not engaging in power struggles and maintaining emotional control. | |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3345329<br>Neglect in Care (1) | Lane | 1/11/2021 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Relative foster father assaulted his wife while intoxicated and in front of his biological children as well as the foster child. The foster father was arrested. | | Foster father was arrested; there is a restraining order in place; certification remains open for foster mother as a single provider. | |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3319047<br>Neglect (1), Threat of Harm (1) | Clackamas | 10/7/2020 | No |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
|---|---|
| Foster father experienced a mental health crisis that required hospitalization. Prior to the hospitalization, the foster father's behavior was unsafe and frightening the children. The foster mother created safe words for the children in the event they had to leave the home or contact law enforcement, rather than reporting to ODHS | Certification is closed; no children in care remain in the home. |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3346664<br>Threat of Harm (2), Sexual Abuse (1), Threat of Harm (4) | Marion | 1/14/2021 | No |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
|---|---|
| Foster parent sexually abused a foster child when the child was previously placed in his home. Foster children voiced concerns that the foster father was demonstrating grooming behavior, showing them videos of women dancing in only underwear. The children indicate they ran away from the home due to comments the foster father made that made them uncomfortable. | Certification in process of being closed; no children in care remain in the home. |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| 3293311<br>Threat of Harm (1) | Clackamas | 7/6/2020 | No |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
| --- | --- |
| Registered sex offender allowed foster parent and foster child to move into his home. The sex offender spent ten years in prison for sexually abusing his stepdaughter and is restricted from contact with minors of any age. | Certification closed; no children in care remain in the home. |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
| --- | --- | --- | --- |
| 3293311<br>Neglect (1), Threat of Harm (1) | Clackamas | 7/6/2020 | No |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
| --- | --- |
| Relative foster parent moved the foster child into a home with a sex offender, fully aware of his restrictions surrounding contact with minors. Also founded against the registered sex offender who allowed foster parent and foster child to move into his home. The sex offender spent ten years in prison for sexually abusing his stepdaughter and is restricted from contact with minors of any age. | Certification closed; no children in care remain in the home. |

| Report/ Allegation | County | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
| --- | --- | --- | --- |
| 3311896<br>Neglect (1), Mental Injury (1) | Columbia | 9/14/2020 | No |

| Nature of Abuse and Brief Narrative: | Corrective Actions Taken or Ordered by the Department, and Outcome: |
| --- | --- |
| Foster parent subjected the foster child to her relationship with a teenage boy who worked at the home. The foster mother attempted to enlist the foster child in lying to the foster father and other children in the home and threatened that they would not adopt the child if she told anyone. The foster mother's behaviors resulted in observable and substantial impairment of the child's psychological and emotional wellbeing. | Certification closed; no children in care remain in the home. |

<table>
<tr><th>Report/<br>Allegation</th><th>County</th><th>Approximate Date Abuse Occurred</th><th>Did physical injury, sexual abuse or death result?</th></tr>
<tr><td>3346426</td><td rowspan="2">Klamath</td><td rowspan="2">1/14/2021</td><td rowspan="2">No</td></tr>
<tr><td>Neglect (1)</td></tr>
<tr><td colspan="2">Nature of Abuse and Brief Narrative:</td><td colspan="2">Corrective Actions Taken or Ordered by the Department, and Outcome:</td></tr>
<tr><td colspan="2">Foster child found a gun, alongside ammunition, next to the foster parent's bed. The foster parent had multiple conversations with the caseworker regarding the foster child's supervision needs prior to this incident.</td><td colspan="2">Certification closed; no children in care remain in the home.</td></tr>
</table>

**Related to ODDS Certified Foster Care**

During this reporting period, there were no substantiated reports in ODDS certified foster care.

**Related to ODDS Licensed Group Homes**

Information provided in this section contains:

- The name of any developmental disabilities residential facility where the department conducted an investigation that resulted in a finding that the report of abuse was substantiated during this 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 ODHS and the outcome of the corrective actions

**Time Period:** CDD/SC Abuse Reports Closed from January 1, 2021 through March 31, 2021.

**Summary:** Six (6) OTIS investigations with a total of seven (7) 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 disability residential facility
- Reports beginning with 'SC' were investigations conducted in a Stabilization and Crisis Unit home licensed for children (or in certain cases when children are placed in adult SACU homes).
- With the implementation of the CAM system in October 2019 the case numbers for this population have changed.
- 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? |
|---|---|---|---|
| CDD 00113091<br>1 Allegation | Partnerships in Community Living, Ruth House | 11/20/2020 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| One allegation of Wrongful Restraint was substantiated a specific staff member. It was initially alleged the staff member physically abused the child-in-care while placing the child in a physical restraint and pulling the child's hair. After gathering more information regarding the incident, an allegation of Wrongful Restraint was identified as it was found the staff member did not properly utilize the physical restraint of the child. The child was placed into a restraint when alternative measures could have been taken to prevent the physical intervention, and the restraint was not used to prevent harm to the child or others. | | Issued civil penalty of $500.<br><br>The staff no longer works for the agency. | |

| Report/ Allegation | Provider | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| CDD 00110659<br>1 Allegation | Advocates for Life Skills (ALSO)- Glacier Home | 11/4/2020 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| One allegation of Neglect was substantiated against the program after multiple failures in supervision and equipment allowed an incredibly vulnerable youth to exit the home undetected, remaining unsupervised in a dangerous area of the community. This youth eloped from this program several times and was frequently found near a transient camp, on one occasion disrobed. | | Issued civil penalty of $500.<br><br>The 24-hour home is closed. | |

| Report/ Allegation | Provider | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| CDD 00095642<br>1 Allegation | Albertina Kerr Centers-165 Ave | 7/30/2020 | 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 because it was unclear which staff was responsible for ensuring the youth's supervision. Multiple staff errors led to the lack of supervision as multiple staff were required to provide supervision of this youth, who requires sight and sound supervision when he is in the backyard, in addition to regular checks while in his bedroom. This lapse led to the youth being locked out of the home and sleeping in the backyard overnight, being found the next morning. | | Issued civil penalty of $500.<br><br>The supervision protocol was revised, and staff trained. | |

| Report/ Allegation | Provider | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| CDD 00122612/ 00122617<br>2 Allegations | Albertina Kerr Centers-196th Ave | 1/27/2021 | No |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| Two allegations of Neglect were substantiated against a specific staff after that staff left the program van running while entering a store with two youth. The youth asked to return to the vehicle, which the staff allowed. The youth then locked the staff out of the vehicle and began to drive away. Although they did not drive out of the parking lot, the youth then eloped and remained unsupervised in the community for several hours. | | Issued civil penalty of $1,000.<br><br>The staff was terminated on the same date of the incident. | |

| Report/ Allegation | Provider | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| CDD 00106119<br>1 Allegation | Youth Unlimited, Inc. | 10/1/2020 | Yes |
| **Nature of Abuse and Brief Narrative:** | | **Corrective Actions Taken or Ordered by the Department, and Outcome:** | |
| One allegation of Wrongful Restraint was substantiated against an unidentified staff after a youth was found with marks to his neck, believed to be a result of a physical restraint. The youth refused to identify the staff who placed him in the restraint because he "does not want them to get in trouble." He stated the injury to his neck, bruises to his arms, bruise to his knee and bruise/bump on his forehead were all from restraints. | | No civil penalty issued, 24-hour home and Medicaid agency closed. | |

| Report/ Allegation | Provider | Approximate Date Abuse Occurred | Did physical injury, sexual abuse or death result? |
|---|---|---|---|
| CDD 00102847<br>1 Allegation | Youth Unlimited, Inc. | 9/14/2020 | Yes |
| **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 a youth disclosed staff twisted and pulled his shirt, causing injury to his neck. It appears the staff was either attempting to intervene between the youth and his peer or deflect his aggression toward her. Either way it is apparent she had ahold of his shirt collar which is what caused the marks to the youth's neck. Although CARES Northwest describes this as concerning for physical abuse due to the physical injury, it falls within the definition as wrongful restraint due to her explanation that she was attempting to intervene in his behavior. OIS does not allow for grabbing of the shirt in this manner. Although she states she was falling backwards off the chair, she should not have under any circumstances had ahold of the collar of his shirt during this time. | | No civil penalty issued, 24-hour home and Medicaid agency closed. | |

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