



Oregon

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

Reporting period: January 1, 2018 to March 31, 2018

Report date: May 14, 2018

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 first quarter of 2018, January 1 through March 31.

The data is separated by provider type for clarity.

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

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 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 January 1, 2018 through March 31, 2018

Summary: 13 Child Welfare/Office of Training, Investigations and Safety (OTIS)(formerly known as Office of Adult Abuse Prevention and Investigations (OAPPI)) investigations with 54 substantiated allegations

Note:

- *Reports beginning with ‘CCP’* were investigated using the pre-SB 1515 abuse definitions and standard of proof for substantiation (preponderance of the evidence).
- *Reports beginning with ‘CCA’* were investigated using the post-SB 1515 abuse definitions and standard of proof for substantiation (reasonable basis to believe abuse occurred).
- The outcome of the following reports could change upon appeal.

Child Caring Agency Report/Allegation	Provider	Approximate date abuse occurred	Nature of abuse and brief narrative	Did physical injury, sexual abuse or death result?	Corrective actions taken or ordered by the department, and outcome
CCP17015 Allegation A Allegation B Allegation E	Northwest Behavioral Healthcare Services	2016	Three allegations of maltreatment as defined in OAR 407-045-0820 (CCP) were substantiated against Northwest Behavioral Healthcare Services based on the use of: wrongful chemical restraints, wrongful physical restraints, involuntary seclusion, neglect of mental health needs and the failure to adequately evaluate and address self-harm and suicidal ideation.	No	This report was among many reports made during and after an unannounced visit to NW Behavioral Health in early November 2017. Interviews with current and former residents and program personnel revealed numerous instances of abuse and neglect and a failure on the part of NWBH and its employees to make mandatory reports of abuse or to report critical events as required by licensing rules. Following these discoveries DHS placed conditions on the program's child-caring agency license, including a restriction of new admissions.

					Shortly thereafter DHS issued a notice of intent to deny NWBH's application to renew its license. The program ceased operation in mid-November and subsequently relinquished its license as part of a legal settlement with DHS on February 2, 2018.
CCA170140 Allegation A Allegation D Allegation E Allegation F Allegation G	Northwest Behavioral Healthcare Services	2017	Five allegations of maltreatment as defined in OAR 407-045-0820 were substantiated against Northwest Behavioral Healthcare Services because they wrongfully chemically restrained multiple youth at the program through the involuntary injection of Geodon. Despite the Geodon being	No	This report was among many reports made during and after an unannounced visit to NW Behavioral Health in early November 2017. Interviews with current and former residents and program personnel revealed numerous instances of abuse and neglect and a failure on the part of NWBH and its employees to make mandatory reports of abuse or to report critical events as required by licensing

			prescribed by the program's physician, the medication was not an approved treatment activity in the youth's treatment plan or in connection with a court order.		rules. Following these discoveries DHS placed conditions on the program's child-caring agency license, including a restriction of new admissions. Shortly thereafter DHS issued a notice of intent to deny NWBH's application to renew its license. The program ceased operation in mid-November and subsequently relinquished its license as part of a legal settlement with DHS on February 2, 2018.
CCA170141 Allegation A Allegation C Allegation E	Northwest Behavioral Healthcare Services	2017	Three allegations of wrongful restraint as defined in OAR 407-045-0820 were substantiated against Northwest Behavioral Healthcare Services because they utilized a	Yes	This report was among many reports made during and after an unannounced visit to NW Behavioral Health in early November 2017. Interviews with current and former residents and program personnel revealed numerous instances of abuse and neglect and a

			restraint and seclusion program that is not nationally accredited as required by licensing rules and involved the use of a mechanical restraint on multiple youth.		failure on the part of NWBH and its employees to make mandatory reports of abuse or to report critical events as required by licensing rules. Following these discoveries DHS placed conditions on the program's child-caring agency license, including a restriction of new admissions. Shortly thereafter DHS issued a notice of intent to deny NWBH's application to renew its license. The program ceased operation in mid-November and subsequently relinquished its license as part of a legal settlement with DHS on February 2, 2018.
CCA170142 Allegation B Allegation C Allegation E Allegation F	Northwest Behavioral Healthcare Services	2017	Five allegations of neglect as defined in OAR 407-045-0820 were	No	This report was among many reports made during and after an unannounced visit to NW Behavioral Health

Allegation I			<p>substantiated against Northwest Behavioral Healthcare Services for inadequate and inconsistently applied self-harm and suicide protocols which resulted in multiple youth's mental health needs not being appropriately evaluated and addressed.</p>	<p>in early November 2017. Interviews with current and former residents and program personnel revealed numerous instances of abuse and neglect and a failure on the part of NWBH and its employees to make mandatory reports of abuse or to report critical events as required by licensing rules. Following these discoveries DHS placed conditions on the program's child-caring agency license, including a restriction of new admissions. Shortly thereafter DHS issued a notice of intent to deny NWBH's application to renew its license. The program ceased operation in mid-November and subsequently relinquished its license as part of a legal</p>
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					settlement with DHS on February 2, 2018.
CCA170144 Allegation A - Y	Northwest Behavioral Healthcare Services	2017	Allegations of involuntary seclusion as defined in OAR 407-045-0820 were substantiated against Northwest Behavioral Healthcare Services because they physically restricted numerous youth from leaving designated seclusion rooms for in for multiple days at a time.	No	This report was among many reports made during and after an unannounced visit to NW Behavioral Health in early November 2017. Interviews with current and former residents and program personnel revealed numerous instances of abuse and neglect and a failure on the part of NWBH and its employees to make mandatory reports of abuse or to report critical events as required by licensing rules. Following these discoveries DHS placed conditions on the program's child-caring agency license, including a restriction of new admissions. Shortly thereafter DHS issued a notice of intent to deny NWBH's

					application to renew its license. The program ceased operation in mid-November and subsequently relinquished its license as part of a legal settlement with DHS on February 2, 2018.
CCA170162 Allegation A-C	Trillium - Parry Center	12/06/2017	Three allegations of neglect as defined in OAR 407-045-0820 were substantiated against a Trillium Parry Center staff who failed to provide required line-of-sight supervision of three youth which resulted in the youth touching each other inappropriately.	No	Immediately following the reported incident Trillium Family Services restricted the identified employee from supervising children without other caregivers present. When the report was substantiated following DHS's investigation, Trillium terminated the caregiver's employment.
CCA180018C	Northwest Behavioral Healthcare Services	7/24/2017 and 7/25/2017	One allegation of involuntary seclusion as defined in OAR 407-045-0820 was	No	This report was among many reports made during and after an unannounced visit to NW Behavioral Health

			<p>substantiated against Northwest Behavioral Healthcare Services for involuntarily secluding a youth in a seclusion room for two consecutive days with no clear indication that it was necessary for the safety of the youth or others.</p>		<p>in early November 2017. Interviews with current and former residents and program personnel revealed numerous instances of abuse and neglect and a failure on the part of NWBH and its employees to make mandatory reports of abuse or to report critical events as required by licensing rules. Following these discoveries DHS placed conditions on the program's child-caring agency license, including a restriction of new admissions. Shortly thereafter DHS issued a notice of intent to deny NWBH's application to renew its license. The program ceased operation in mid-November and subsequently relinquished its license as part of a legal</p>
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					settlement with DHS on February 2, 2018.
CCA180024A	Trillium - Farm Home	01/25/2018	<p>One allegation of neglect as defined in OAR 407-045-0820 was substantiated against Trillium Children's Farm Home because a youth was left sleeping in a classroom on campus without supervision for over two hours. During these two hours Children's Farm Home staff never recognized that the youth was not accounted for. Due to the youth's vulnerabilities and self-harm behaviors they require constant supervision.</p>	No	<p>Trillium management thoroughly reviewed the circumstances of the incident with those present. Subsequently the procedures and best practices for handing off responsibility for supervising individual youth were reviewed with all personnel campus-wide. Trillium disagrees with the decision to substantiate the allegation of neglect and is formally appealing the finding.</p>

CCA180032B	NW Behavioral	January 2017	One allegation of involuntary seclusion as defined in OAR 407-045-0820 was substantiated against Northwest Behavioral Healthcare Services because a youth was involuntarily secluded multiple times for one or two days with no clear indication that it was necessary for the safety of the youth or others.	No	This report was among many reports made during and after an unannounced visit to NW Behavioral Health in early November 2017. Interviews with current and former residents and program personnel revealed numerous instances of abuse and neglect and a failure on the part of NWBH and its employees to make mandatory reports of abuse or to report critical events as required by licensing rules. Following these discoveries DHS placed conditions on the program's child-caring agency license, including a restriction of new admissions. Shortly thereafter DHS issued a notice of intent to deny NWBH's application to renew its license. The program
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					ceased operation in mid-November and subsequently relinquished its license as part of a legal settlement with DHS on February 2, 2018.
CCA170150 B and C	New Avenues for Youth	11/19/2017	One allegation of verbal abuse and one allegation of wrongful restraint as defined in OAR 407-045-0820 were substantiated against a New Avenues for Youth-Robinswood staff. The respondent made statements toward youth along the lines of "I'm gonna whoop your ass" and "If you were my kids you guys would get beat." The staff also placed a youth in a restraint despite not having	No	New Avenues for Youth (NAFY) initially restricted the identified employee's contact with the identified youth. Shortly thereafter, as the credibility of the allegations became clearer, the identified staff person's employment was terminated.

			justification to do so. In addition, the physical restraint that was used was not in accordance with the non-violent physical crisis intervention program (CPI) used by Robinswood.		
CCA170171B	Looking Glass (Stepping Stone)	Fall 2016	One allegation of neglect as defined in OAR 407-045-0820 was substantiated against a former Looking Glass Stepping Stone staff who developed an inappropriate relationship with a youth while working at the program. The inappropriate nature of the relationship was	Inconclusive-Sexual Abuse	The identified employee was no longer employed at Looking Glass Community Services (LGCS) at the time the initial report was made. The employee and the identified youth actively concealed the relationship both before and after the end of the employee's employment at LGCS, and LGCS wasn't aware of the relationship until the time of the report. LGCS has made efforts

			<p>detected after the staff quit their job. They continued secret phone contact with the youth until the youth ran from Stepping Stones directly to the respondent's home.</p>		<p>designed to better detect and thwart any possible inappropriate relationships and contact between youth and employees. These efforts include but are not limited to stricter controls on in-coming phone calls for youth and a heightened vigilance for even seemingly unintentional or insignificant boundary issues between youth and caregivers that may be indicative of an inappropriate relationship.</p>
CCA180037C	Maple Star Oregon	January 2018	<p>One allegation of physical abuse as defined in OAR 407-045-0820 was substantiated against a Maple Star foster parent because they spanked a foster youth with a</p>	No	<p>Immediately following the initial report, the identified youth was moved from the foster home, and Maple Star subsequently terminated the foster Home's certification.</p>

			<p>spatula which broke with the first strike. The foster parent then retrieved a second spatula and spanked the youth three more times on the buttocks. Other concerns about inappropriate discipline by this foster parent were also noted during this investigation.</p>		
<p>CCA180048 Allegation A Allegation C Allegation E</p>	<p>Youth Progress Association</p>	<p>3/12/2018</p>	<p>Three allegations of neglect as defined in OAR 407-045-0820 were substantiated against a Youth Progress Association staff who had marijuana edibles in his personal backpack in the staff office and confronted the</p>	<p>No</p>	<p>Youth Progress Administration (YPA) immediately placed the identified employee on leave at the time of the initial report. His employment was subsequently terminated as the basic facts surrounding the report we established. YPA has since strengthened and clarified its policies</p>

			<p>youth after they discovered the youth had taken them. The staff failed to take appropriate action or to notify other staff and program management after learning that the youth were in the possession of the edible marijuana.</p>		<p>concerning the types of employee belongings that restricted from YPA property.</p>
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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

- Corrective actions taken or ordered by the DHS and the outcome of the corrective actions

Time Period: Child Welfare certified foster home abuse reports substantiated from January 1, 2018 through March 31, 2018. Reports may have been received prior to the reporting period.

Summary: 19 reports were substantiated in Child Welfare certified foster homes (this includes certified relative caregivers).

Note: There were 5,183 Child Welfare certified foster care providers who held a Certificate of Approval in the time period 1/1/2018-3/31/2018.

Explanation of terms: Although every applicant who applies to become a certified family for Child Welfare must be assessed and approved under the same set of rules and procedures, there are different 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.

Report ID	Child Welfare Foster Home Allegations (Number of Children)	County	Approximate Date Abuse Occurred	Nature of abuse and brief narrative	Did physical injury, sexual abuse or death result?	Corrective actions taken or ordered by the department, and outcome
2957125	Neglect(1)	Jackson	1/29/2018	Substantiated for Neglect of the foster child by foster mother, due to unsafe individuals using controlled substances and displaying violent behavior in the home.	No	Child specific certification. Foster child was removed from the foster home. Foster home closed.

2951773	Neglect(1)	Multnomah	1/19/2018	Substantiated for Neglect of the foster child by foster parents. Foster parents failed to provide adequate shelter free from environmental hazards.	No	ICPC home. Foster child returned to sending state. Foster home closed.
2929825	Physical Abuse(1)	Columbia	11/28/2017	Substantiated for Physical Abuse of the foster child by foster mother. Child reports getting hit, hair pulled - no physical injury.	No	Child specific certification. Foster child removed from foster home. Foster home closed.
2937311	Neglect(1)	Deschutes	12/18/2017	Substantiated for Neglect of the foster child by foster parents. Foster parents allowed the child to be cared for by an unsafe individual.	No	Foster child initially placed in home with a temporary child specific certificate. Child removed from foster home. Home closed.

2904468	Physical Abuse(1)	Clackamas	9/12/2017	Substantiated for Physical Abuse of the foster child by foster mother. Foster mother has demonstrated violent behavior towards the foster child. No physical injury.	No	General certificate. Foster children moved from home, and after substantiated disposition, DHS moved toward revocation, however the family moved with no forwarding information, certificate automatically terminated when family moved. Foster home closed.
2915658	Neglect(1), Sexual Abuse(1)	Clackamas	10/16/2017	Substantiated for Neglect of the foster child by foster parents. Foster parents failed to protect the foster child from being sexually abused in their home. Also substantiated for Sexual Abuse of the	Yes	General certificate. Foster children removed from foster home. Foster home on inactive referrals status. Certification action pending

				foster child by the teenage son of the foster parents.		while there is an appeal of substantiated disposition.
2894255	Physical Abuse(1), Mental Injury(3)	Yamhill	8/4/2017	Substantiated for Physical Abuse and Mental Injury of the foster children by foster father. Foster father physically assaulted one child and engaged in unreasonable discipline and intimidation of three children.	No	General certificate. Foster children removed from foster home. Foster home closed.
2913282	Sexual Abuse(1)	Lane	10/9/2017	Substantiated for Sexual Abuse of one foster child by foster father. Foster child disclosed sexual abuse by the foster father.	Yes	General certificate. Foster children removed from foster home. Foster home closed.
2914461	Threat Of Harm(3)	Lane	10/11/2017	Substantiated for Threat of Harm of one foster child by foster father. The other foster child in the home disclosed sexual	No	General certificate. Foster children removed from foster home.

				abuse by the foster father, this poses a risk of harm to the other foster child.		Foster home closed.
2895604	Threat Of Harm(3)	Washington	8/5/2017	Substantiated for Threat of Harm of the foster child by the foster father. The child was exposed to domestic violence in the home.	No	Child specific certification. Foster child removed from foster home. Foster home closed.
2904460	Physical Abuse(1)	Yamhill	9/12/2017	Substantiated for Physical Abuse of the foster child by foster mother. Foster mother pinched the child during discipline, causing a bruise.	Yes	Pre-adoptive placement (adoptive assessment by private agency). Children removed from foster home. Foster home closed.
2866910	Threat Of Harm(1)	Marion	5/4/2017	Substantiated for Threat of Harm of the foster child by foster father. Foster father has a criminal history of sex offenses, placing the child at risk.	No	Child specific certification. Foster child removed from foster home. Foster home closed.

2916964	Neglect(1)	Clackamas	10/19/2017	Substantiated for Neglect of the foster child by foster parents. Foster parents failed to provide the child adequate nutrition, resulting in hospitalization.	No	General certificate. Foster children removed from foster home. Foster home on inactive referral status, pending action for revocation.
2895620	Neglect(2), Physical Abuse(3)	Malheur	8/9/2017	Substantiated for Physical Abuse of two foster children and Neglect of two foster children by foster mother. Foster mother has hit and spanked the foster children and failed to provide them with adequate support and protection.	No	Child specific temporary certificate. Foster children removed from foster home. Foster home closed.
2903099	Neglect(1)	Lane	9/7/2017	Substantiated for Neglect of the foster child by foster mother. Foster mother allowed an unsafe individual in the home, around the child.	No	Child specific certification. Foster children removed from foster home. Foster home closed.

2904366	Neglect(1)	Curry	9/12/2017	Substantiated for Neglect of the foster child by foster mother. Foster mother failed to provide the child with adequate supervision needed due to her mental health needs.	No	Child specific certification. Children removed from home. Foster home closed.
2913238	Neglect(3), Sexual Abuse(1), Threat Of Harm(2)	Benton	10/9/2017	Substantiated for Neglect of the foster child by foster mother and Threat of Harm of the foster child by the foster father. Foster father sexually abused his own child, creating a threat of harm to the foster child. Foster mother failed to protect the foster child.	No	General certificate. Foster children removed from foster home. Foster home closed.
2920549	Threat Of Harm(6)	Hood River	10/30/2017	Substantiated for Threat of Harm of two foster children by foster father. Foster father was involved in sexually explicit communication with children over the internet - placing the	No	Child specific certification. Foster children removed from foster home. Foster home closed.

				foster children at threat of harm.		
2953157	Neglect(1)	Clackamas	1/22/2018	Substantiated for Neglect of the foster child by foster parents. Foster parents allowed people actively using controlled substances in the home, around the child.	No	Child specific certification. Foster child removed from foster home. Foster home closed.

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

- The name of any ODDS licensed group home 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
- Corrective actions taken or ordered by the DHS and the outcome of the corrective actions

Time Period: ODDS licensed group home abuse reports substantiated from January 1, 2018 through March 31, 2018. Reports may have been received prior to the reporting period.

Summary: 3 Office of Training, Investigations and Safety (OTIS) (formerly known as the Office of Adult Abuse Prevention and Investigations (OAPPI)) investigations with 3 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.
- The outcome of the following reports could change upon appeal.

Report/Allegation	Provider	Approximate date abuse occurred	Nature of abuse and brief narrative	Did physical injury, sexual abuse or death result?	Corrective actions taken or ordered by the department, and outcome
CDD18007 Allegation A	Renew Consulting, Inc.	01/08/2018	One allegation of neglect as defined in OAR 407-045-0820 was substantiated against a specific staff as that staff did not follow program procedure, administered a double dose of a medication and did not follow protocol after recognizing the error. Staff then sent youth to school without notifying school staff and did not seek out medical care. The investigator was advised by the medical provider	No	ODDS met with Renew administration and recommended retraining all staff on medication administration procedures as well as implementation of additional procedures including, assigning one staff per shift who is responsible for medication administration and not allowing graveyard shift to pass medications. ODDS attended the staff meeting where staff were trained on the new medication administration procedure. Since implementation of the new medication administration protocol

Report/Allegation	Provider	Approximate date abuse occurred	Nature of abuse and brief narrative	Did physical injury, sexual abuse or death result?	Corrective actions taken or ordered by the department, and outcome
			that a double dose could cause high blood pressure, stroke, and cardiac issues and could potentially be fatal.		there have been no further medication errors (as of 4/12/18). ODDS issued a civil penalty \$500.00
CDD18018 Allegation A	Partnerships in Community Living (PCL)	02/05/2018	One allegation of neglect as defined in OAR 407-045-0820 was substantiated against a specific staff after staff failed to provide appropriate medical treatment to the youth after youth engaged in self-harm behaviors. Staff used duct tape to secure gauze over youth's thigh and	No	The employee was reassigned following the outcome of the investigation. ODDS recommended that all staff be retrained on first aid. The training occurred on 2/9/18.

Report/Allegation	Provider	Approximate date abuse occurred	Nature of abuse and brief narrative	Did physical injury, sexual abuse or death result?	Corrective actions taken or ordered by the department, and outcome
			calf. The next day the school nurse saw the excessive duct tape used, had difficulty removing the tape, and the youth stated she was in pain and had difficulty walking due to the tape.		
SC18002 Allegation A	Stabilization and Crisis Unit (SACU)	02/23/2018	One allegation of neglect as defined in OAR 407-045-0820 was substantiated against a specific staff after the staff ignored youth's supervision (1:1 constant visual due to seizure activity) for a period of hours	No	The employee was placed on administrative leave since this incident was reported. A new background check will be run on this employee. Human Resource will conduct investigatory interviews with this employee and will determine the appropriate personnel action.

Report/Allegation	Provider	Approximate date abuse occurred	Nature of abuse and brief narrative	Did physical injury, sexual abuse or death result?	Corrective actions taken or ordered by the department, and outcome
			<p>stating it was not her responsibility. Staff articulated her understanding of the need for supervision, did not provide said supervision, and did not notify other staff or management that the youth was not being provided this supervision.</p>		<p>SACU management staff are conducting rotating drop-ins during graveyard shift to monitor staff compliance with children's supervision protocols.</p>