



Oregon

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Legislative Report Department of Human Services

Substantiated Investigation Quarterly Report to Legislative Committees on Child Welfare Reporting

Period: January 1, 2019 to March 31, 2019

Report date: June 5, 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 first quarter of 2019, January 1 through March 31.

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 January 1, 2019 through March 31, 2019.

Summary: Six (6) Office of Training, Investigations and Safety (OTIS) (formerly known as Office of Adult Abuse Prevention and Investigations (OAPPI)) investigations with sixteen (16) 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?
CCA180196 Six Allegations	Youth Progress Association-Proctor Care	Ongoing to 11/13/2018	No
Nature of Abuse and Brief Narrative: 6 allegations of Neglect were substantiated against two proctor parents after several youth disclosed an ongoing pattern by the proctor parents of restricting youth to their rooms, not allowing the youth in living areas of the home, intimidation by the proctor father, restriction of access to the restroom and failure to provide any kind of outings or community activities. The findings were substantiated after interviewing the therapist of the youth who spoke to the negative impact to the youth.		Corrective Actions Taken or Ordered by the Department, and Outcome: After more details came to light during the investigation, the 2 youth who were residing in the foster home were moved to a different home. The foster parents didn't serve any more children after that point and are no longer certified by Youth Progress Association (YPA). DHS Child Welfare, DHS Licensing and the Oregon Youth Authority issued a joint letter and action plan to YPA designed to address concerns with the agency's foster care program. DHS and OYA continue to coordinate in monitoring YPA's progress on its improvement plan and the overall functioning of its foster care program. DHS Licensing is working with DOJ to formulate formal licensing actions.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA180198 One Allegation	New Avenues for Youth- Robinswood	11/19/2018	No
Nature of Abuse and Brief Narrative: One allegation of wrongful restraint was substantiated on a specific staff who restrained a youth without justification. The incident was captured on video surveillance and the staff aggressively approached the youth after the youth was "being mouthy", knocked a basketball out of his hands and attempted to place the youth in a CPI hold from behind. Management saw the incident unfold and immediately placed the staff on administrative leave, ultimately terminating him.		Corrective Actions Taken or Ordered by the Department, and Outcome: The identified employee acted contrary to New Avenues for Youth policy and the training he received from New Avenues. He was put on administrative leave following the incident and subsequently terminated from employment.	

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA190005 Two Allegations	Trillium Family Services- Children's Farm Home	Unknown	Yes-Due to Neglect
Nature of Abuse and Brief Narrative: Two allegations of Neglect were substantiated on an unknown staff after a youth disclosed being sexually assaulted by a peer in a bathroom. The youth disclosed this went on for up to twenty minutes. Supervision guidelines for the bathroom include five-minute verbal checks and fifteen-minute visual checks, none of which were conducted per the victim.		Corrective Actions Taken or Ordered by the Department, and Outcome: All facility staff were extensively retrained in supervision protocols. Trillium also reviewed and modified the screening and intake process for the particular Farm Home cottage where this incident occurred in order to reduce the overall acuity of residents in the facility.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA190008 Two Allegations	Trillium Family Services- Children's Farm Home	Unknown	No
Nature of Abuse and Brief Narrative: Two allegations of Neglect were substantiated on a specific staff after a youth disclosed engaging in sexual contact with a peer in a common area of the unit. Youth stated this occurred with a staff present in the room, however that staff was using her cell phone and not providing supervision to the youth. The staff could not explain the policy regarding cell phone use on duty and stated she frequently used their cell phones while on shift.		Corrective Actions Taken or Ordered by the Department, and Outcome: The identified employee was terminated, and all facility staff were extensively retrained in supervision protocols and the limits on cell-phone usage. Trillium also reviewed and modified the screening and intake process for the Farm Home cottage where this incident occurred in order to reduce the overall acuity of residents in the facility.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA190026 One Allegation	Looking Glass	02/06/2019	No
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	

<p>One allegation of Neglect on a specific staff after the staff allowed free access to hygiene items without supervision. A youth took aerosol cans from the basket without the staff's knowledge and self-harmed with the items. The staff was not aware of youth accessing these items, did not follow the procedure in place for such items and did not ensure all items were accounted for.</p>		<p>The identified employee was terminated prior to the investigation. Looking Glass eliminated aerosol cans from the hygiene products available to residents and made improvements to the system for checking out and tracking hygiene products.</p>	
<p>Report/ Allegation</p>		<p>Provider</p>	
<p>CCP18013 Four Allegations</p>		<p>Windell's Academy/Wy'East Mountain Academy</p>	
<p>Nature of Abuse and Brief Narrative:</p> <p>Two allegations of Physical Abuse and two allegations of Neglect were substantiated against two specific staff after the staff burned a youth by placing hot metal on the youth's bare skin and failed to seek medical attention for approximately three weeks when the injury appeared to be infected. This was a historical incident that was not reported at the time it occurred, rather it was discovered after the parent of this victim filed a lawsuit against the program.</p>		<p>Corrective Actions Taken or Ordered by the Department, and Outcome:</p> <p>The two identified employees were terminated prior to the investigation. DHS is working with the Dept. of Justice to formulate and impose formal conditions on the program's license.</p>	

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 January 1, 2019 through March 31, 2019. Reports may have been received prior to the reporting period.

Summary: 24 reports were substantiated in Child Welfare certified foster homes (this includes certified relative caregivers).

Note: There were approximately 4,100 Child Welfare certified family foster and relative care providers in this quarter.

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.

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 to follow a protocol at the local level 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?
3112698/ Neglect (1)	Douglas	1/4/19	YES
Nature of Abuse and Brief Narrative: Foster child was burned with a stick, by another child, from a burn pile the foster parent thought had been put out. The supervising foster parent was in the home during the incident, despite knowing the needed level of supervision due to the child's behaviors, while the other children were outside playing alone.		Corrective Actions Taken or Ordered by the Department, and Outcome: Foster parents disputed founded report; contacted GAO and recorded meeting with DHS for their attorney. The foster parents voluntarily closed their certificate. Children were moved from the home, the certification is closed. .	
2. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
2955507/ Physical Abuse (2)	Columbia	1/26/18	YES
Nature of Abuse and Brief Narrative: Relative foster parent (Grandfather) was using a paddle to the body and hot sauce in the mouth for disciplinary methods. The children would feel a burning sensation in their mouths and would not be allowed to get water, as pain was the reason for the method. Grandmother did not intervene and would threaten the children with these methods to instill fear.		Corrective Actions Taken or Ordered by the Department, and Outcome: Children moved from the home, certification is closed.	
3. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3093388/ Neglect (1)	Baker	11/5/18	NO
Nature of Abuse and Brief Narrative: Foster parent was aware of foster child's need for high level supervision, due to her sexual reactivity and behavioral concerns. Foster parent allowed child to be unsupervised with another child for extended periods of time, allowing for the foster child to sexually abuse the other child.		Corrective Actions Taken or Ordered by the Department, and Outcome: Management approval for the founded obtained. Child remains in the certified home with a placement support plan put in place.	
4. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3032634/ Neglect (2)	Douglas	6/7/18	NO
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome: Children moved from the home and the certification closed.	

Foster mother was berating and calling the foster children derogatory terms. Children expressed feeling afraid of being in the home.			
5. Report/ Allegation (Number of Children)			
County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?	
3114250/ Physical Abuse (2)	Multnomah	1/9/19	NO
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	
Relative Foster parent was spanking both foster children in her care. Both children report that the spankings have caused them pain but there have been no lasting injuries.		Management approval for the founded obtained. Placement Support Plan put in place, discussion regarding spanking with foster parents. Children remain in home.	
6. Report/ Allegation (Number of Children)			
County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?	
3097890/ Neglect (2)	Wallowa	11/15/18	NO
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	
Relative foster father consumed alcohol in excess creating an unsafe living situation for all the children in the home. His drinking has caused him to engage in domestic violence episodes, threatening the foster children to return them to DHS and verbal aggression toward all the members of the home.		Relative foster father moved from home, relative foster mother continues to be certified.	
7. Report/ Allegation (Number of Children)			
County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?	
3109785/ Physical Abuse (1)	Josephine	12/20/18	NO
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	
Foster parent was spanking foster child causing pain. The biological children in the home report hearing foster parent spank the foster child as a form of punishment.		Management approval for the founded obtained. Placement Support Plan put into place, child remains in home.	
8. Report/ Allegation (Number of Children)			
County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?	
3099653/ Neglect and Mental Injury (1)	Jefferson	11/22/18	NO

Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	
Foster parent was threatening foster child by saying they would restrict visits or a return home if he does not listen or if he tells people what is occurring in the home. Foster parent is also not fulfilling the child's medical needs by not having him seen by a physician nor filling his prescriptions regularly. Foster child has been without consistent meds for 4 months.		Foster parent dispute findings in CPS assessment, stated she would appeal the decision. The children were moved from the home, and the certification is in the process of being closed.	
9. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3052249/ Physical Abuse (2)	Jackson	7/31/18	NO
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	
Foster parent was using physical discipline on both foster children in the home. On one instance the foster parent "smacked" the foster child "upside the head" and the child's nose started to bleed. Foster parent is reported to have used her hand for spanking and on one occasion used a plaster hanger.		Children were moved from the home and the certification has been closed.	
10. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3111896/ Neglect (1)	Yamhill	1/1/19	NO
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	
Foster child was found by a neighbor, face down in the pond. Foster parents were notified and were already distraught as they noticed foster child was missing. Foster child is on 24/7 sight and sound due to her high-level needs. The home was set with alarms to alert the foster parents if the child was leaving the home. Foster parents had turned off the alarms as they had company over and did not assure that these protective measures were reestablished as part of their daily routine. Child fully recovered and was found to of not been in the water for a long period of time.		Child was initially moved from home pending the assessment. At the conclusion, branch management approved the exception to continue certification and have the child placed back in the home. A placement support plan was put in place.	
11. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3093151/ Neglect (1)	Lane	11/5/18	NO
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	

Relative foster parent was intoxicated while caring for the foster child. Child was having a hard time getting foster parent to wake up and due to the significant level of intoxication, the foster parent was admitted to the hospital. During this time, it was found that foster parent's BAC was two times over the legal limit.		Child was moved from the home and the certification of the home was closed.	
12. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3053569/ Neglect (3)	Douglas	8/2/18	NO
Nature of Abuse and Brief Narrative: Foster parent was allowing foster child to drink and smoke marijuana. Foster mother also moved, with the foster children, to a new home where non-certified individuals moved into the home. Since the living situation had changed, the foster children no longer had the required space per certification standards.		Corrective Actions Taken or Ordered by the Department, and Outcome: Children were moved from the home, certification closed.	
13. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3121904/ Neglect (1)	Malheur	1/29/19	NO
Nature of Abuse and Brief Narrative: Foster parent was over administering a Controlled PRN of Clonidine, to help control the foster child's behaviors.		Corrective Actions Taken or Ordered by the Department, and Outcome: Management approval for the founded obtained. Placement support plan put in place.	
14. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3079145/ Neglect (1)	Malheur	10/3/18	NO
Nature of Abuse and Brief Narrative: Foster child was not being supervised when he was attempting to get on the house via a ladder. Foster parent was inside and not providing adequate supervision for foster child.		Corrective Actions Taken or Ordered by the Department, and Outcome: Management approval for the founded obtained. Child remains in home.	
15. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3088730/ Neglect and Physical Abuse (1)	Lincoln	10/25/18	YES

Nature of Abuse and Brief Narrative: Foster parents were hitting foster child with belt leaving marks and bruises. Foster child was also left to sit or sleep in the garage as a form of discipline. The garage was not set up with adequate sleeping arrangements.		Corrective Actions Taken or Ordered by the Department, and Outcome: Children moved from home, home in process of being closed.	
16. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3078287/Neglect (1)	Polk	10/2/18	NO
Nature of Abuse and Brief Narrative: Foster parent allowed their adult relative to stay in the home after receiving methamphetamine possession charges. Foster child reports finding drug paraphernalia in another adult's belongings in the home. Foster parent failed to notify DHS of the possession charges and the other adults moving into the home.		Corrective Actions Taken or Ordered by the Department, and Outcome: Child moved from home, certification closed.	
17. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3092561/ Neglect and Sex Abuse (1)	Washington	11/3/18	YES
Nature of Abuse and Brief Narrative: Foster child was sexually abused by the foster parent's adoptive son. There was information provided to the agency that noted their son should not have unsupervised contact with other children, due to his sexualized behaviors. The foster parents did not set up protective measures to assure their son did not victimize the other children in the home.		Corrective Actions Taken or Ordered by the Department, and Outcome: Child moved from home, certification closed.	
18. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3101121/Neglect (1)	Deschutes	11/28/18	NO
Nature of Abuse and Brief Narrative: Relative foster parent was allowing unrestricted/unsupervised access to parent who had their parental rights terminated for various instances of abuse and to parents' partner who is a convicted sex offender.		Corrective Actions Taken or Ordered by the Department, and Outcome: Child moved from home, certification closed.	

19. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3073930/ Neglect (2)	Washington	9/21/18	NO
Nature of Abuse and Brief Narrative: Foster parent was engaging in sexual grooming type behavior with the two foster children in their care. The foster parent had pictures of them sleeping with the foster children with a blanket covering them. The children would sleep on the foster parent's chest. Texts were sent to the children stating he loved them and to not tell DHS about their relationship. It is believed the foster parent had contact with the foster children after he was explicitly directed not to.		Corrective Actions Taken or Ordered by the Department, and Outcome: Children moved from home. Certification in revocation process.	
20. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3114091/ Neglect and Physical Abuse (4)	Umatilla	1/8/19	NO
Nature of Abuse and Brief Narrative: Foster parents were allowing their adult children to spank the foster children. On one instance a foster child was shaken by one of the adult children and the foster child was afraid to return home. Foster parents were using involuntary seclusion by mandating the children to their rooms for days or even weeks at a time, as a form of discipline.		Corrective Actions Taken or Ordered by the Department, and Outcome: Children were moved from the home. The home is on inactive referral status (no children may be placed in the home) and is being staffed regarding closure.	
21. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3095494/ Neglect (2)	Lane	11/9/18	NO
Nature of Abuse and Brief Narrative: Relative foster parents allowed unapproved individuals in the home with unrestricted access to the children. These unapproved individuals engaged in several incidents of domestic violence and one of them is a registered sex offender. The foster parents did not notify DHS or implement a proper safety plan to assure the safety and supervision of the children in the home.		Corrective Actions Taken or Ordered by the Department, and Outcome: Children were moved from the home, certification is closed.	
22. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3103694/ Neglect (1)	Deschutes	12/4/18	NO

Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	
Relative foster parent was providing marijuana to foster child. Foster child was also encouraged to not share their self-harming ideation and behavior with DHS and their attorney. Child reports that foster parent ignores her when she is not doing well and will not address the self-harm behaviors.		Child moved from home, certification is closed.	
23. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3089986/ Physical Abuse (1)	Josephine	10/29/18	YES
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	
Foster parent was spanking foster child and child reported there would be pain associated with the spankings.		Management approval signed by branch management for certification to remain open and the child to remain in the home. Placement support plan put into place. The foster parents indicate they are appealing the Founded disposition.	
24. Report/ Allegation (Number of Children)	County	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
3088738/ Threat of Harm (1)	Marion	10/25/18	NO
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	
Foster parent had sexually abused his step daughter. Foster parent initially denied allegations but later confessed to the acts. He was determined to be a threat of harm to the other children as he had access to them and he showed a pattern of impulsive and dangerous behaviors.		Foster father moved out of the home. Certification remains with the foster mother. The foster mother was protective and is seeking divorce. The child remains with the foster mother.	

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 January 1, 2019 through March 31, 2019

Summary: 33 Office of Training, Investigations and Safety (OTIS) (formerly known as the Office of Adult Abuse Prevention and Investigations (OAPPI) investigations with 19 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?
CDD18144 One Allegation	Partnerships in Community Living, Inc.	09/11/18-10/28/18	No
Nature of Abuse and Brief Narrative: One allegation of verbal abuse was substantiated on a specific staff after the staff repeatedly called the youth names such as “fucking idiot” “retarded” “useless”, had the youth repeat terms such as “black people” and “I like men” while in the community, and taught the youth to make animal noises.		Corrective Actions Taken or Ordered by the Department, and Outcome: The employee was immediately suspended and later terminated by the agency. Issued Civil Penalty of \$500.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD18156 One Allegation	Renew Consulting	12/2018	No
Nature of Abuse and Brief Narrative: One allegation of neglect was substantiated on the program after staff cleaned out a youth’s room due to the smell and bugs found in the room. The youth’s plan stated the room was to be cleaned weekly by staff if the youth refused to do so due to hoarding and self-harm. During this deep clean staff removed four bags of garbage and located a lock box containing a box knife and a razor blade. This allegation was substantiated on the program as a similar allegation was substantiated in November 2018 and the program failed to take action or conduct training for staff to keep future incidences from occurring.		Corrective Actions Taken or Ordered by the Department, and Outcome: ODDS increased oversight of the group home and worked with the agency to develop a Positive Behavior Support Plan to ensure a similar occurrence does not happen again. ODDS staff attended the employee training on the plan and increased their visits to the home to ensure the plan was being implemented. All employees received training regarding keeping the office and kitchen locked and not allowing the children to have access to employee’s house keys. Issued Civil Penalty of \$500.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD18160 Four Allegations	Albertina Kerr Centers	Unknown	No
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	

Four allegations of neglect were substantiated against a specific staff after youth and coworkers disclosed an ongoing pattern of foul language and intimidation of the youth placed in the home. The youth described feeling scared, crying, upset and making efforts to avoid this staff due to feeling unsafe in her presence. This staff's coworkers supported the youth's statements and witnessing the youth being fearful.		The agency terminated the employee. Issued Civil Penalty of \$2000.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD19001 Two Allegations	Albertina Kerr Centers	12/31/2018	No
Nature of Abuse and Brief Narrative: Two allegations of neglect were substantiated on a specific staff after staff fell asleep thus allowing two youth opportunity to leave the home unnoticed. Police located the two youth at a convenience store at 3:40 AM and when the officer returned the youth to the home, it took the staff several minutes to answer the door as he was sleeping. The youth stated his bedroom window alarm did go off, but the staff did not respond as he was asleep. Both youth who eloped are extremely vulnerable due to their developmental delays.		Corrective Actions Taken or Ordered by the Department, and Outcome: The agency terminated the employee. The ODDS Residential Specialist conducted a walk through at the group home to assess window and door alarms were working properly. All alarms were working correctly following the visit. All employees were retrained on supervision levels and expectations on graveyard shift. Issued Civil Penalty of \$1000.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD19002 One Allegation	Partnerships in Community Living	01/03/2019	No
Nature of Abuse and Brief Narrative: One allegation of neglect was substantiated against a specific graveyard staff after the staff turned down the door alarm and fell asleep at which time a youth eloped from the home wearing only a thin dress and did not have on shoes or a coat. The youth got lost and was located by law enforcement approximately two miles away. The youth has a myriad of risks and diagnoses, including a developmental disorder, making her very vulnerable in this situation.		Corrective Actions Taken or Ordered by the Department, and Outcome: The employee was immediately suspended pending the investigation. Once the investigation was completed it was determined that the employee would no longer work at the home. The alarm has been covered with a lockbox and all employees have been trained to not tamper with the alarm system. Additional 1:1 staffing was added to increase supervision. Issued Civil Penalty of \$500.	

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD19003 One Allegation	Albertina Kerr Centers	01/05/2019	No
Nature of Abuse and Brief Narrative: One allegation of wrongful restraint was substantiated against a specific staff after that staff was witnessed to be holding the youth on the floor in a manner inconsistent with OIS. Although this was witnessed by other staff members, the accused staff stated the incident did not occur and he never put his hands on this youth.		Corrective Actions Taken or Ordered by the Department, and Outcome: The agency terminated the employee that implemented the wrongful restraint. The other employee was retrained on the Oregon Intervention System (OIS) and mandatory abuse reporting. No Civil Penalty issued.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD19005 One Allegation	Work Unlimited	Unknown	No
Nature of Abuse and Brief Narrative: One allegation of neglect was substantiated on a specific graveyard staff after that staff fell asleep and one of the youths was able to move freely about the home unsupervised, including restricted areas with safety hazards. The youth also reported finding a pipe (believed to be a marijuana pipe) with a substance in it that smelled like “a skunk”. The youth drew a picture of the pipe and stated he attempted several times to wake the staff up however the staff did not react until he attempted to take the staff’s keys.		Corrective Actions Taken or Ordered by the Department, and Outcome: The agency removed the employee from working the graveyard shift and only allowed them to work during shifts other employees were present. The program closed on May 2019. Issued \$500 Civil Penalty.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD19011 Six Allegations	Albertina Kerr Centers	01/21/2019	No
Nature of Abuse and Brief Narrative: Six allegations of neglect were substantiated on two specific staff after the two staff took an unapproved adult on an outing to Seattle with three youth. The youth reported staff asked them to keep this a secret and wrote documentation indicating the youth		Corrective Actions Taken or Ordered by the Department, and Outcome: The agency terminated both employees. Issued Civil Penalty of \$3000.	

<p>were upset and making up allegations. Additionally, the youth reported one of the staff and this unapproved adult kissing. All three youth are reported to have significant trauma history and this incident was said to have caused them fear and distrust of their caregivers. All three youth were initially believed to be lying based on the staff's documentation.</p>			
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD19015 One Allegation	Albertina Kerr Centers	Unknown	No
<p>Nature of Abuse and Brief Narrative:</p> <p>One allegation of verbal abuse was substantiated on a specific staff after that staff went to a home he does not work at and confronted one of the youth about an incident that occurred between that youth and this staff's significant other. The staff cornered the youth in her room and the conversation became "heated". A coworker expressed concern about this staff's pattern of verbal aggression with youth in the program.</p>		<p>Corrective Actions Taken or Ordered by the Department, and Outcome:</p> <p>The agency terminated the employee.</p> <p>Issued Civil Penalty of \$500.</p>	