Oregon

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Legislative Report
Department of Human Services
Child-Caring Agency Licensing Investigation Quarterly Report to Legislative Committees on Child Welfare
Reporting period: January 1, 2017-March 31, 2017
Submitted May 1, 2017

Senate Bill 1515, Effective April 4, 2016 following enacted from the 2016 Regular Legislative Session, directs the Department of Human Services (DHS) to submit a quarterly report to the 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.

The quarterly reports are for the purposes of legislative and public review and oversight of the quality and safety of child-caring agencies that are licensed, certified or authorized by the department in this state and of proctor foster homes that are certified by the child-caring agencies.
Information provided in this report contains:

(a) The name of any child-caring agency or proctor foster home 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;
(b) The approximate date that the abuse occurred;
(c) The nature of the abuse and a brief narrative description of the abuse that occurred;
(d) Whether physical injury, sexual abuse or death resulted from the abuse; and
(e) Corrective actions taken or ordered by the department and the outcome of the corrective actions.

Reporting Period: CCA/CCP Abuse Reports Closed from January 1, 2017 through March 31, 2017

Summary: 17 OAAPI and Child Welfare investigations with 32 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).

Report # Allegation # (substantiated)	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
CCA160060 Allegation 1 Allegation 2 Allegation 3 Allegation 4	Trillium Family Services – Children's Farm Home	8/1/16	Four allegations of Neglect as defined in OAR 407-045-0820(14) were substantiated, because staff failed to provide supervision to four children receiving care from the program, resulting in the children accessing alcohol on the premises and becoming intoxicated.	No	The lapse in supervision that created an opportunity for the identified residents to obtain alcohol was not attributable to a particular Farm Home employee or group of employees. Upon becoming aware of the incident the program took steps to eliminate the possibility of a similar incident in the future. Since the time of the incident DHS and OHA have been working intensively and continuously with Trillium Family Services

					to assess, improve and monitor supervision of children at the Farm Home. The increased oversight includes but is not limited to multiple on-site visits to the program each month during which supervision documentation is reviewed, interviews are conducted and any concerns are addressed. These efforts are on-going, and the program has shown improvement.
CCA160132 Allegation 2	Trillium Family Services – Children's Farm Home	8/23/16	One allegation of Neglect as defined in OAR 407-045-0820(14) was substantiated, because program staff failed to provide supervision to a child	No	The investigation of this incident revealed that the neglect was the result of a collective failure on the part of the Trillium Family Services

			receiving care from the program, placing the child at significant risk of harm when she left the program and consumed medications unsupervised.		organization. The neglect was not attributable to a particular employee or group of employees. Since the time of the reported incident DHS and OHA have been working intensively and continuously with Trillium Family Services to assess, improve and monitor supervision of children at the Farm Home. The increased oversight includes but is not limited to multiple on-site visits to the program each month during which supervision documentation is reviewed, interviews are conducted and any concerns are addressed. These

					efforts are on-going, and the program has shown improvement.
CCA160160 Allegation 1 Allegation 2	Boys and Girls Aid Society of Oregon	August 2016	Two allegations of Neglect as defined in OAR 407-045-0820(14) was substantiated, because a proctor foster parent allowed two children receiving care from the program to share a room when their safety plans clearly indicated they should not have unsupervised contact with other children, placing them at risk.	No	Boys and Girls Aid moved the children from the home upon learning of the alleged neglect, and no other children have been placed in the home. When the neglect was substantiated the program submitted a new background check request to the DHS Background Check Unit (BCU). The BCU will take the substantiated report of neglect into account when assessing the fitness of the foster parent to continue in a care-giver role. The fitness determination is

					pending at this time. If the fitness determination results in approval, DHS will ensure BGAID provides training, oversight and direction to the foster parent to address the issues raised in the course of the investigation before placing children with the foster parent.
CCA160191 Allegation 1	Trillium Family Services – Parry Center	12/5/16	One allegation of Neglect as defined in OAR 407-045-0820(14) was substantiated, because a staff member failed to provide appropriate supervision to a child receiving care from the program, resulting in the child trying to commit suicide by	Yes	The employment of the staff member identified in the report was terminated by Trillium immediately after the incident was reported. Personnel from DHS and OHA subsequently visited the program to review supervision protocols, staff training records

			swallowing socks and paper towels during a period when she was unsupervised.		and other aspects of the program related to child safety. Based on information gathered it was evident that the staff person involved in the incident had been properly trained, coached and supervised, but failed to follow established supervision protocol. The program responded appropriately by terminating his employment.
CCA160200 Allegation 1	Kairos NW	12/26/16	One allegation of Verbal Abuse as defined in OAR 407-045-0820(1)(h)(A) and (B) was substantiated because a staff member yelled threats and obscenities at a	No	The staff member identified in the report terminated his employment with Kairos immediately following the incident. DHS conducted a comprehensive

			child receiving care from the program.		licensing review of Kairos facilities and programs in August and made an unannounced visit earlier this month. Neither visit revealed concerns about the safety and well-being of children served by Kairos. The incident described in the report appears to be an isolated event involving a staff member who is no longer employed at Kairos.
CCA170009 Allegation 3 Allegation 4	Looking Glass Pathways – Boys	1/20/17	Two allegations of Neglect as defined in OAR 407-045-0820(14) were substantiated because two staff members failed to ensure appropriate	Yes	One of the two staff members identified in the report was terminated from employment from Looking Glass Community and Family

			medical care after a child receiving care from the program strangled himself and lost consciousness.		Services following the incident. The other identified employee was re-trained and remains employed but is currently not permitted to be alone with Looking Glass residents unless/until the employee is approved by the DHS Background Check Unit following a fitness determination that takes into account the substantiated report of neglect. The fitness determination is pending at this time.
CCP16006 Allegation 1 Allegation 3 Allegation 4	Parrott Creek	Various 2015	Three allegations of Negligent Treatment as defined in OAR 407-045-0820(14) were substantiated, because a staff member	No	The identified employee acted contrary to established agency protocol and was placed on administrative leave

			provided three children receiving care from the program with cigarettes and lighters and alerted them to upcoming room searches. The staff person also allowed the children to use the staff's cell phone to call persons not on their approved contact list. These actions likely endangered the health and welfare of the three children by interfering with their treatment plan and placing them at risk.		when Parrott Creek became aware of the neglect allegations. The staff member remained on administrative leave during the investigation and terminated his employment with Parrot Creek prior to the investigation's conclusion.
CCP16094 Allegation 1 Allegation 2	Family Solutions	3/9/16	Two allegations of Negligent Treatment as defined in OAR 407-045-0820(14) were substantiated because program staff failed to	Undetermined	The report could not attribute the neglect to a particular employee. The Family Solutions Program where the incident occurred has

			ensure appropriate supervision of two children receiving care from the program, resulting in sexual aggression by one child against the other. Law enforcement conducted a concurrent investigation of the alleged sexual abuse between the children.		since closed.
CCP16121 Allegation 1 Allegation 2	Trillium Family Services – Children's Farm Home	4/1/16	Two allegations of Negligent Treatment as defined in OAR 407-045-0820(14) were substantiated because program staff failed to ensure appropriate supervision of two children receiving care at the program, resulting in inappropriate sexual	No	The identified employee was terminated before the conclusion of the investigation. Since before the time of the reported incident DHS and OHA have been working intensively and continuously with Trillium Family Services to assess, improve and

			contact between the two children.		monitor supervision of children at the Farm Home. The increased oversight includes but is not limited to multiple on-site visits to the program each month during which supervision documentation is reviewed, interviews are conducted and any concerns are addressed. These efforts are on-going, and the program has shown improvement.
CCP16146 Allegation 1	Chehalem Youth and Family Services	5/3/16	One allegation of Negligent Treatment as defined in OAR 407-045-0829 (14) was substantiated because program staff failed to provide appropriate supervision to a child	No	At the time of the incident DHS was working closely with Chehalem to support the program's efforts toward improvement, and a number of corrective actions had

			receiving care from the program by sending him to school without advising the school of the child's recent suicidal ideation and self-harm. While at school the child attempted to self-harm, including strangling himself with the cord from his jacket.		been issued following an unannounced visit to the program in January 2016. Ultimately the corrective actions and other measures employed by DHS did not result in significant improvements to the program. In June 2016 DHS issued a notice of intent to revoke Chehalem's license to operate as a child caring agency and began finding alternative placements for the children placed at Chehalem at the time of the notice. As of August 8, 2016, no children remained in care at Chehalem, and Chehalem has since voluntarily

					relinquished its child-caring agency license.
CCP16163 Allegation 1	Trillium Family Services – Children's Farm Home	5/2/16	One allegation of Negligent Treatment as defined in OAR 407-045-0820 (14) was substantiated because a staff member failed to provide appropriate supervision to a child receiving care from the program, resulting in the child gaining access to and ingesting medication and leading to hospitalization.	Yes	The identified employee ended his employment at Trillium immediately following the reported incident. Since the time of the incident DHS and OHA have been working intensively and continuously with Trillium Family Services to assess, improve and monitor supervision of children at the Farm Home. The increased oversight includes but is not limited to multiple on-site visits to the program each month during which supervision documentation is

					reviewed, interviews are conducted and any concerns are addressed. These efforts are on-going, and the program has shown improvement.
CCP16218 Allegation 1	Chehalem Youth and Family Services	6/19/16	One allegation of Negligent Treatment as defined in OAR 407-045-0820 (14) was substantiated because program staff failed to provide appropriate supervision to a child receiving care from the program, resulting in the child engaging in uncontrolled violent and dangerous behavior.	No	At the time of the incident DHS was working closely with Chehalem to support the program's efforts toward improvement, and a number of corrective actions had been issued following an unannounced visit to the program in January 2016. Ultimately the corrective actions and other measures employed by DHS did not result in significant improvements to the

					program. In June 2016 DHS issued a notice of intent to revoke Chehalem's license to operate as a child caring agency and began finding alternative placements for the children placed at Chehalem at the time of the notice. As of August 8, 2016, no children remained in care at Chehalem, and Chehalem has since voluntarily relinquished its child-caring agency license.
CCA16267 Allegation 1	Eastern Oregon Academy (EOA)	March 2016	One allegation of Negligent Treatment as defined in OAR 407-045-0820 (14) was substantiated because a staff member failed to provide appropriate	No	The identified staff member's employment at Eastern Oregon Academy was terminated sometime in the weeks following the incident. DHS

			supervision to children receiving care from the program, allowing the children to hike unsupervised in a wilderness area and leaving the site before the children had returned, causing them to have to walk back to the program along the highway.		worked extensively with EOA toward improving EOA's recruitment, hiring, training and supervision of qualified and appropriate care-givers, including but not limited to the issuance of a licensing condition wherein EOA was required to seek outside consultation on the topic and report to DHS on the outcome of the consultation and planned improvements. These efforts were not entirely unsuccessful, but due to on-going concerns about the program and other incidents of substantiated abuse, DHS issued a notice of

					intent to revoke EOA's license in December of 2016. The program subsequently ceased operation and voluntarily relinquished their license.
CW# 899741	BGAID, Safe Place	Sep-16	The report is substantiated/founded for sexual abuse of a youth and the neglect of three youth by a staff member at the CCA. The staff member provided alcohol to and had sexual intercourse with a youth in the facility. This staff member also allowed boys into the girls' rooms and an older male to enter the facility after hours.	Yes	The CCA terminated the employee when the allegations were made. CCLU assigned for follow up to ensure that the program has made changes since the incident to better ensure safety of residents during night time hours. CCLU will take steps to further verify that the BGAID appropriately screened and checked the identified employee

					and will verify that safety measures the program indicates they've put in place are continuing. CCLU will also conduct a follow-up on-site visit to the program.
CW# 890119	A Family for Every Child	Nov-16	The report is substantiated/founded for two allegations of neglect against each of the pre-adoptive foster parents for the use of corporal punishment with the children despite their trauma history and information that had been provided to them by professionals advising that the use of corporal discipline with these children would likely impact	No	CCLU participated in multiple staffings on this case along with AFFEC personnel and Child Welfare personnel from the branch and the central Permanency Unit. AFFEC acted appropriately to ensure the safety of the children and cooperated with CW in formulating a plan for the children. The children were ultimately moved from

			their mental and emotional development.		the adoptive home and remain out of the home at this time. CCLU will communicate with AFFEC or central office Permanency staff to determine if there is any plan to maintain the approval of the identified family to adopt, and if so, OLRO will coordinate with AFFEC and central office personnel to ensure new BCU background checks and fitness determinations are completed for both adoptive parents.
CW# 906603	Hearts with a Mission	Dec-16	This report is substantiated/founded for neglect by a staff person regarding two youth. The staff	Yes	The CCA placed the perpetrator on leave immediately upon learning of the incident and subsequently fired

			member was present and did not intervene while one youth sexually abused another. The staff member was not in compliance with and disregarded established safety policies and procedures. He failed to maintain a safe and supportive environment for youth staying in the facility.		him. Furthermore, CCLU reviewed the perpetrator's personnel file and verified that the program had appropriately screened and background checked him and provided him required training. No other Hearts with a Mission employees were implicated in connection with the incident.