**Sara A. Gelser Blouin**
**State Senator**
District 8

**Oregon State Senate**

March 24, 2023

Dear Chair Reynolds and Members of the Committee,

I apologize that I was not able to attend the hearing on HB 3333 to express my concerns in person and I thank you in advance for considering this written testimony.

I appreciate the caring intentions of the proponents of HB 3333. I also agree that we must increase wages and improve training for the fragile workforce serving Oregon children. However the good intentions of HB 3333 do not outweigh the unintended impact on child safety and dignity, agency accountability and continuous improvement.

The concerns raised by HB 3333 have largely been addressed over the last number of years. Investigations are now completed more quickly, screening decisions are more precise and OTIS now uses a process that includes identifying systemic vs. individually based issues. As a result, when appropriate, substantiated allegations are attributed to programs rather than individual people. The Legislature also responded to concerns about words like "abuser" and "perpetrator" in 2017. ***At no point in the process is an individual ever labeled as a "suspected abuser."*** Instead, even in cases of substantiated abuse, individuals are referred to as "the respondent."

This good work at OTIS is based on high quality screening followed by excellent investigations and a robust due process system. Until an investigation is complete, it is not possible to fully ascertain the context of the situation or what other information might be needed to determine whether abuse occurred. It also can be difficult to understand level of harm without understanding the background of the child and their specific care needs.

Each quarter, since 2016, ODHS releases a report describing every substantiated allegation of abuse involving a child in care in Oregon. These reports include all child serving entities covered by OTIS as well as certified foster homes investigated by CPS. As a result, we can separate fact from anecdote and legend, understand what types of allegations are substantiated and better understand the context behind each of those issues.

For instance, failing to provide appropriate supervision for youth in a DD facility to take a bathroom break for just a few minutes on its face seems like a lapse in judgement. However,

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In 2021 such a seemingly insignificant lapse led to the death of a child with intellectual and developmental disabilities. The lack of malintent did not mitigate the very real harm that came to the child. (The description of this incident is at the bottom of this testimony.)

This data in these reports also helps us sort out hypothetical situations from real ones. For instance, at the hearing on HB 3333 there was an example given in testimony about a substantiated abuse finding related to a simple medication error. To learn more about this situation, I read back through every substantiated allegation of abuse related to medication issues or inappropriate ingestion by youth since 2016. I could not find anything like the scenario described in testimony. I've updated the full list of medication/ingestion cases into OTIS, along with a similar list that includes every substantiated allegation of abuse related to inappropriate use of physical restraint.

In looking at these lists (and the full reports), I struggle to find any example of frivolous substantiations.

OTIS does excellent work to protect children, conduct trauma informed and respectful investigations and provide relevant and reliable information that helps us to improve the quality of programs serving Oregon's most vulnerable youth. This bill proposes to change that by short circuiting the investigation process, accepting some "minimum" level of harm that the state deems acceptable for children in its care to experience and exempts child caring agencies from meeting the same standard of accountability that must be met by developmental disabilities programs, programs serving seniors and adults with physical disabilities, nursing homes, memory care and other such setting.

HB 3333 would also have the effect of holding child caring agencies to a lesser standard than parents. When a parent is substantiated for abuse—regardless of whether they intended to harm their child—they face involvement from a state agency and potential loss of their child.

When we remove children and place them in the care of these programs, it would be inappropriate to hold those agencies that we pay to a lesser standard for safety and wellbeing for children than the parents from whom the state removed them. When the state removes a child from their family, or otherwise takes custodial care of a child, we owe it to that child and family to ensure they are in a better situation in terms of safety—not one that is less accountable.

It is essential that when there are allegations that meet the screening criteria for abuse, a complete and professional investigation is completed. HB 3333 would end that in some cases. That is not an appropriate outcome for youth and will take away essential tools for accountability and system improvement.

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Thank you for considering these significant concerns about this measure, and I do hope that you will look at the substantiated abuse reports that are posted in OLIS.

**Neglect finding: 2021**
Two staff were substantiated for allegations of neglect to the same child when they failed to provide appropriate supervision to the youth who subsequently ran away from the home. When she ran from the home, staff did not follow their runaway protocol and delayed law enforcement notification. One of the staff also left during their shift and was unable to immediately assist in searching for the youth which further delayed locating her. This resulted in the youth being struck by vehicle and killed.

Most sincerely,

Senator Sara Gelser Blouin

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