JURISDICTION ADVISORY COMMITTEE

HB4086

HB 4086 Scope of Jurisdiction Study

Findings and Recommendations

Produced by
Sylvia Deporto and Leslie Ann Hay
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Executive Summary

Background

Oregon House Bill 4086, which passed in the 2024 82nd Legislative Assembly, commissioned "a study on the scope of child abuse investigations in this state". Two consultants with extensive child welfare experience—Sylvia Deporto and Leslie Ann Hay—were asked by Aprille Flint-Gerner, former Oregon Department of Human Services- Child Welfare Director, to carry out the study, facilitate an advisory committee, and produce a report with facilitators' findings and recommendations designed to improve child abuse investigation practice and processes.

Jurisdiction Advisory Committee

The HB 4086 Steering Committee used a rigorous selection process to assemble an advisory group consisting of agency professionals, organization leadership, and individuals with lived experience, from every corner of Oregon. Called the Jurisdiction Advisory Committee, or JAC, this group advised the facilitators in the development of findings and recommendations about the numerous topics relevant to the HB 4086 Jurisdiction Study's scope of work. Guiding the work of the JAC were several core documents and principles that provided direction and maintained focus, including community agreements, mission, and values.

Focus of Study & Methodology

Four significant domains of investigation were studied: Definitions, Scope of Jurisdiction, Investigation Process, and Due Process. In order to manage such a wide span of study topics, the facilitators implemented a comprehensive approach that offered a sequential process of information gathering and refinement. This methodology ensured that each issue received adequate attention, and also that JAC members could contribute their support or concern about emerging content. With each topic, the facilitators followed this overall sequence:

1. Define the Issue
2. Get Informed About the Issue
3. Settle on Findings
4. Craft Recommendations

Throughout the study, a vast network of people, organizations, and information sources were tapped using a variety of approaches to gathering stakeholder input. This

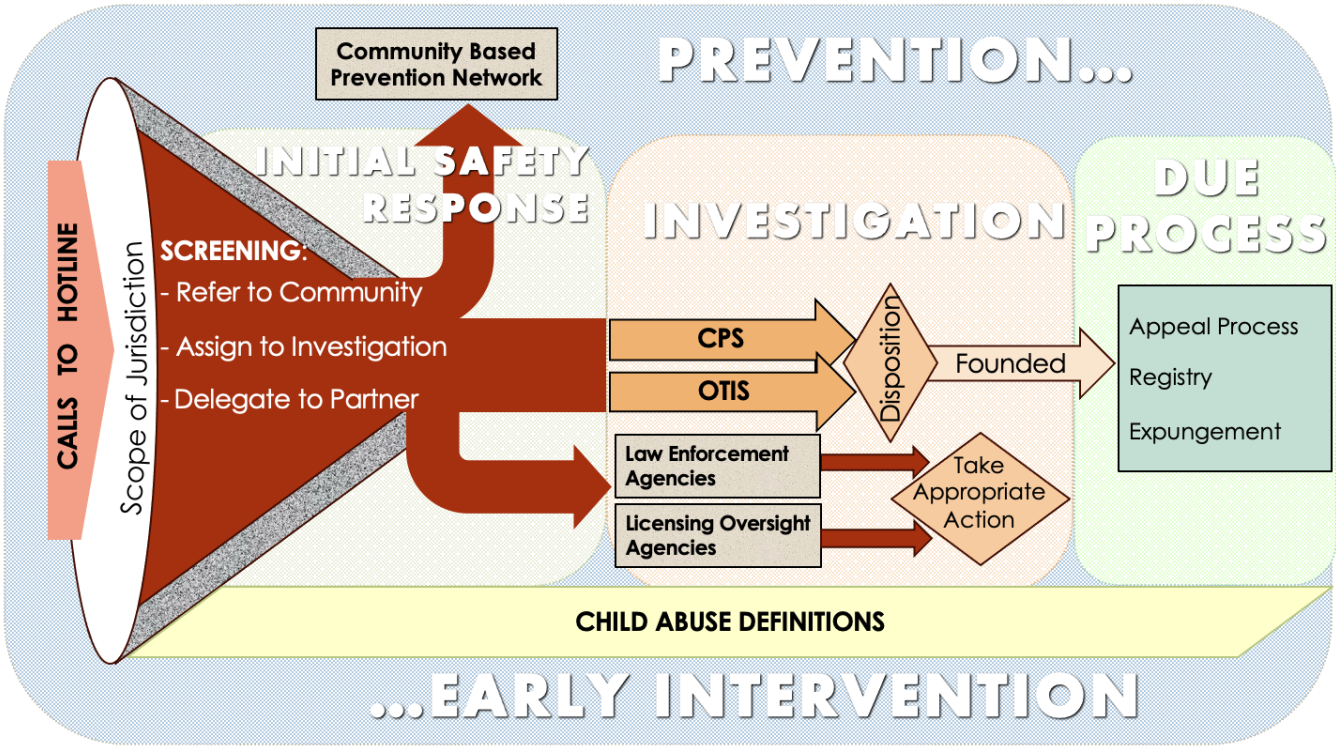
effort provided invaluable insight into a wide span of issues being studied. Out of this exploration and analysis, the facilitators charted a comprehensive, system-wide vision of a safety response system organized to more effectively address the needs of Oregon's children and families during child abuse investigations.

JAC members were given two opportunities to review and provide input regarding report contents. Facilitators utilized the input to revise and improve report narratives and recommendations. In addition, facilitators chose to move forward with viable recommendations without seeking unanimous agreement by all JAC members.

Child Abuse Investigation Landscape

Several critical findings emerged that required a modified context in which recommendations can be placed. Graphic 1 represents a possible future landscape for child abuse investigations:

Graphic 1: Child Abuse Investigation Landscape



In this environment, as with all Child Welfare child abuse investigations, the process begins with a call to the hotline, which starts the **initial safety response**. This marks the **scope of jurisdiction** which is filtered through a screening process that discerns the appropriate action. Four options are possible for reports where families may need assistance:

1. Close at screening and refer to community-based prevention organizations for services
2. Delegate to a relevant partner (as determined by case specifics) for appropriate action and either close at screening or assign/refer (if the allegations also constitute child abuse/neglect)
3. Assign to CPS for assessment, investigation, disposition and safety decision, or
4. Refer to OTIS (based on type of alleged perpetrator) for screening decision, investigation, and disposition

The **investigation** phase involves either CPS or OTIS determining a disposition (and safety decision in the CPS assessment process), and/or safety partners (i.e., law enforcement agencies or licensing oversight agencies) taking appropriate action. Finally, in the **due process** phase, persons exercise their right to file an appeal, while a balance between community safety and individual rights is maintained through registry and expungement considerations.

Recommendations

All of the recommendations resulting from the jurisdiction study have a home in this graphical representation of a possible child abuse investigation landscape. Recommendations are numbered and described below in Table 3.

Graphic 2: Child Abuse Investigation Landscape with Recommendations

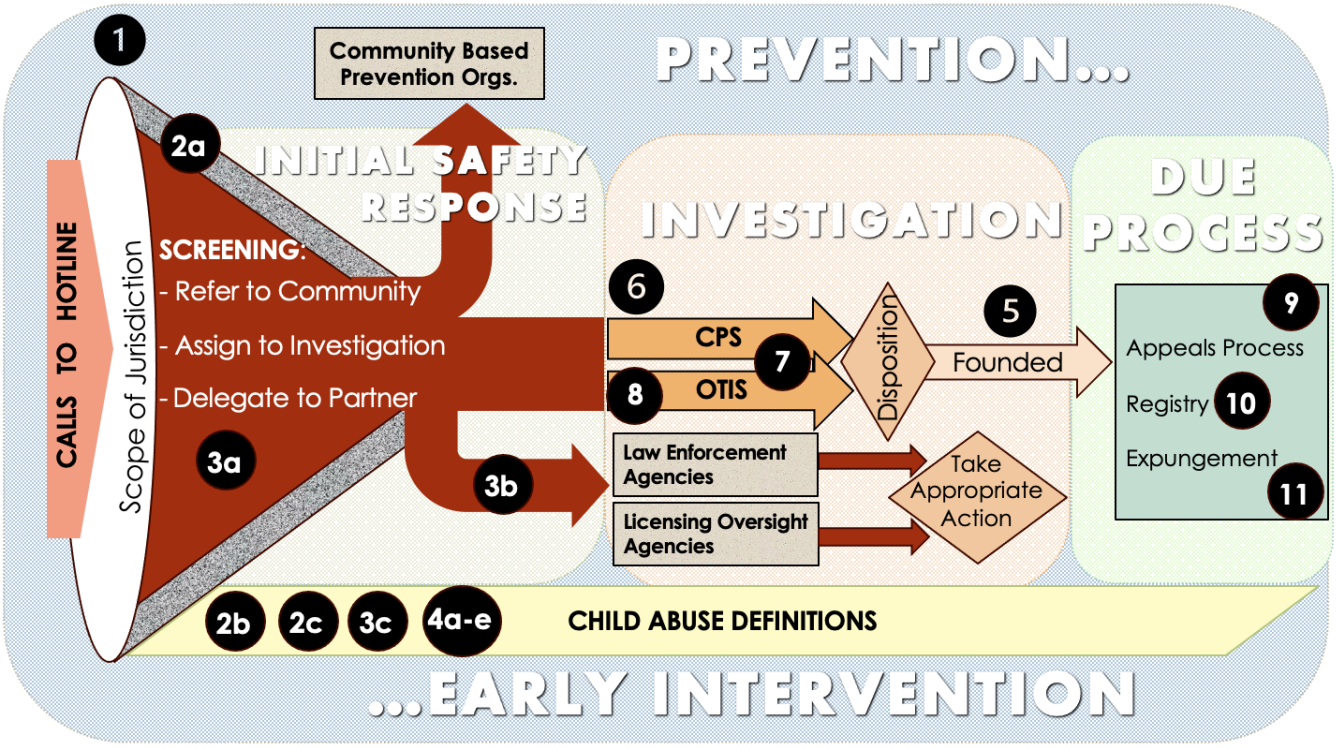


Table 3: Scope of Jurisdiction Recommendations

Recommendation	Description
1. Bring alternative pathways to scale	Expand community-based prevention network to formally respond to families in need of assistance.
2. Modify Scope of Jurisdiction for Child Welfare	
a. Narrow span of child welfare scope of jurisdiction	Allegations involving persons who do not have a caregiving role or any familiarity with the child would only be investigated by law enforcement.
b. Name perpetrators in statute	Clarify in statute who can be the subject of an allegation of child abuse to match the scope of jurisdiction.
c. Address child on child abuse	Children would no longer be alleged perpetrators of child abuse unless they are acting in a parental capacity, above a certain age acting in a caretaking role or under specific circumstances related to child trafficking.
3. Share Responsibility for Investigations	
a. Share responsibility for safety concerns	Lift statutory requirement that ODHS must issue dispositions on all screened in child abuse allegations
b. Allow certain investigations to be performed by other safety partners	Under specific conditions, ODHS has the discretion to defer investigations to LEA or appropriate licensing entities without completing a CPS investigation.
c. Use single terminology for dispositional findings	Both CPS and OTIS would use the terms “founded”, “unfounded”, and “unable to determine”.
4. Modify Child Abuse Definitions	
a. Account for 418 definitions in 419B	Streamline child abuse definitions into a single set.
b. Reclassify threat of harm definition	Include imminent risk language and distribute threat of harm content to standard child abuse categories.
c. Refine neglect definition	Amend neglect definition to include caregiver’s failure to provide adequate supervision and failure to provide adequate protection.
d. Add poverty exception to neglect definition	Add poverty exception language to the Neglect definition.
e. Remove seclusion & restraint as abuse types	Define wrongful restraint and involuntary seclusion as licensing violations, rather than child abuse in all settings.
5. Raise standard of proof for concluding child abuse investigations	Change the standard from reasonable cause to believe to preponderance of evidence.
6. Enhance client rights notification	Convene a work group to explore what rights should be provided to individuals at the beginning of a child welfare investigation.
7. Strengthen implementation of MDT best practices	Improve the consistency of MDT practice statewide by leveraging national best practices.
8. Extend SDM model to CPS & OTIS investigations	Promote more consistent and accurate investigation outcomes with the use of SDM tools. Explore possibility of SDM tools for OTIS.
9. Streamline appeal process	Simplify and consolidate the appeal process used for CPS and OTIS cases.
10. Establish child abuse registry	Create a more transparent and formalized repository of founded child abuse allegations.
11. Establish expungement protocol	Develop criteria and procedures for when expungement of founded allegations can occur.

Implementation Considerations

The recommendations on their own each point to a desired outcome: the route to achieving these outcomes is a well-crafted, strategically designed implementation plan. While it is beyond the scope of this report to create this plan, we've gleaned many insights about implementation through the course of the jurisdiction study and feel these fit well within a framework built on several principles of implementation science. This includes the following four distinct components of implementation planning:

1. Implementation Stages
2. Fidelity and Adaptation
3. Implementation Drivers
4. Continuous Improvement

Implementation considerations gathered throughout the scope of the jurisdiction study include those relevant to the overall implementation process as well as to individual recommendations. General implementation considerations that apply to the entirety of the jurisdiction recommendations include:

- Launching a work group to develop a comprehensive implementation plan to present at the 2027-29 long session.
- Involving JAC members and other committed partners and stakeholders in implementation work groups and committees.
- Incorporating timeframe (short, medium, or long-term efforts), cost, partnerships and efforts already underway when prioritizing implementation goals and timelines.

JAC members contributed many excellent suggestions when it comes to implementing specific recommendations. The broad range of perspectives among JAC members—from law enforcement to education, to behavioral health and community agency partners, and of course child welfare—led to a rich and insightful list of elements to keep front of mind when detailing out the steps to implement any of the recommendations. Among many specifics, there was a call for consistent and targeted training; coordination between law enforcement and child welfare; specific stipulations for licensing; and several areas needing robust exploration by collaborative effort before implementation can be planned.

Conclusion

The HB 4086 Jurisdiction Advisory Committee (JAC) has undertaken a comprehensive study to strengthen Oregon's child welfare/OTIS child abuse investigation processes, with a core focus on child safety. Through rigorous analysis and collaboration with a diverse group of stakeholders, the JAC has developed a set of recommendations aimed at improving the effectiveness and efficiency of child abuse investigations in Oregon.

Key recommendations include expanding community-based prevention networks, narrowing the scope of jurisdiction for child welfare, and sharing responsibility for safety concerns with law enforcement and other relevant agencies. The JAC also emphasizes the importance of using a single set of dispositional findings, modifying child abuse definitions to include imminent risk language, and enhancing client rights notification.

The implementation of these recommendations will require careful planning and collaboration among various agencies and community partners. By adopting these changes, Oregon can create a more responsive and effective child protection system that prioritizes the safety and well-being of children and families.

The JAC's work reflects a commitment to continuous improvement and a dedication to ensuring that all children in Oregon are protected from harm. The recommendations provided in this report offer a clear path forward for enhancing the state's child abuse investigation processes and ultimately achieving better outcomes for children and families.

Background

Oregon House Bill 4086

Oregon House Bill 4086, which passed in the 2024 82nd Legislative Assembly, commissioned "a study on the scope of child abuse investigations in this state". Two consultants with extensive child welfare experience—Sylvia Deporto and Leslie Ann Hay—were asked by Aprille Flint-Gerner, former Oregon Department of Human Services- Child Welfare Director, to carry out the study, facilitate an advisory committee, and produce a report with findings and recommendations about several key scope of investigation domains.

Legislative History

The Oregon Legislature has been increasing protections for children by expanding what is considered child abuse, particularly for children placed in homes licensed or certified by Oregon Department of Human Services (ODHS) and Child Welfare and clarifying the responsibilities of ODHS in responding to those reports of abuse. Changes range from expanded definitions, to broadening the scope of jurisdiction for ODHS child abuse investigations, to centralizing the Oregon Child Abuse Hotline (ORCAH).

This report refers to major legislation passed in Oregon related to child protection during this period, highlighting key themes, policy objectives, and the impact of these legal changes. Below is a summary of these key legislative actions.

Senate Bill 1515 (2016): Child is defined as an unmarried person who is under 18 or is under 21 and residing in or receiving care or services from a CCA and created ORS 418 child abuse definitions.

Senate Bill 243 (2017): A Child in Care is defined as a person under 21 residing in or receiving services or care from a Child Caring Agency (CCA), certified foster home, or Developmental Disability (DD) home; to whom ORS 418 child abuse definitions apply.

Senate Bill 942 (2017): Requires Child Abuse Hotline Centralization and all allegations of abuse to conclude with a dispositional finding which ended Differential Response. It also established the Office of the Oregon Ombudsman for Foster Care to respond to complaints from children in care, foster parents, and advocates.

Senate Bill 804 (2019): Updated ORS for centralized reporting, includes "alleged" child abuse and changed cross reporting to law enforcement.

Senate Bill 155 (2019): Clarified and strengthened mandatory reporting requirements for school employees and volunteers and created new procedures for investigating and disclosing abuse allegations in public and private schools, as well as youth-serving organizations. It required ODHS to investigate abuse in educational settings and third-party abuse starting January 1, 2020.

Senate Bill 93 (2023): Resulted in the change to the mental injury definition in which "observable" was removed. It also provided clarifications as to the child in care definitions specific to application of both 418 and 419B definitions and when not to apply them. [Revised "child in care" to mean a person under 21 residing in or receiving care or services from: Child Caring Agency (CCA), certified foster home, Developmental Disability residential facility, unless care is provided by the child's parent.]

Jurisdiction Advisory Committee

The HB 4086 Steering Committee used a rigorous selection process to assemble an advisory group consisting of agency professionals, organization leadership, and individuals with lived experience, from every corner of Oregon. Called the Jurisdiction Advisory Committee, or JAC, this group first convened for an in-person orientation and kick-off meeting in October 2024. The committee continued to meet virtually twice monthly through January, then monthly through August 2025.

The role of the JAC was to advise the facilitators in the development of findings and recommendations about the numerous topics relevant to the HB 4086 Jurisdiction Study's scope of work. Members shared their expertise, joined subcommittees to dive into specific topics or questions, and informed recommendations as they were developed. The breadth of the committee's expertise as well as their commitment to the well-being of children and families brought passion, experience, and insight into the overall study.

JAC Membership

Table 1: Jurisdiction Advisory Committee Membership

Name/Role	Title	Agency/Affiliation
Adam Rodakowski	Director of Foster Care	Greater Oregon Behavioral Health Incorporated

Name/Role	Title	Agency/Affiliation
Alexis Amorelli	Foster Care Ombudsman	Governor's Advocacy Office
Amanda K. Barnhart	Family Services Program Administrator (former)	Confederated Tribes of Siletz Indians
Amber Barker	Parent Mentor	Morrison Child & Family Services
Amelia Kercher	Executive Director	Amani Center (Columbia County Child Advocacy Center/CAC)
Ana Day	Executive Director	Oregon Community Programs
Anneliese Sheahan	Childcare Provider	Child Care Providers Together Local 132 AFSCME
Arielle Hacker*	Strategic Initiatives Coordinator	Prevent Child Abuse Oregon
Ashley Cross	Parent Mentor	Morrison Child & Family Services
Buck Pearce	Police Captain	Albany Police Department, Oregon Association Chiefs of Police
Brendan Murphy	Chief Deputy District Attorney	Marion County; Oregon District Attorneys Association
Brian Flannery	Executive Director	Central School District 13J
Cassidy Kotter	Government Relations Specialist	Oregon School Employees Association
Chris Hinkel	Staff Attorney	Oregon CASA Network
Chris Peck	Children's Team Supervisor	Lane County Developmental Disabilities Services
Deborah A. Martin	Parent with Lived Experience	MA'DAM LLC
Diane Deleon	Parent with Lived Experience	District 6 Parent Advisory Council
Heber Bray	Senior Operations and Policy Analyst	Oregon Youth Authority
Heidi Moon*	Dependency Analyst	Oregon Judicial Department
Iris Hodge	Director of Government Relations (former)	Oregon School Employees Association
Jennifer Lieb	Child Welfare Certified Resource Parent	N/A
Kristin Ward	Attorney	Oregon Department of Justice, Child Advocacy & Protection Division
Lindsay Bigelow	Interim Chief Investigator	OR Department of Human Services (ODHS), Office of Training, Investigations & Safety (OTIS)
Lindsey Moore*	Senior Assistant Attorney General	Oregon Department of Justice
Lisa Bender**	Assistant Deputy Director	OR Dept. of Human Services, Child Welfare Division
Lisa Joy Bateman	Education Specialist	Oregon Department of Education
Nicole Cunningham	Executive Director	Prevent Child Abuse Oregon
Sam Elliott	Sheriff	Yamhill County; Oregon State Sheriff's Association
Samantha Fenner	Clinical Manager	Klamath-Lake CARES (CAC)

Name/Role	Title	Agency/Affiliation
Sarah Stewart	Executive Director	Kids FIRST (Lane County CAC)
Sarah Walker**	Assistant Program Manager Child Safety Program	OR Dept. of Human Services, Child Welfare Division
Scott Alto	Enforcement Officer	Oregon Department of Early Learning and Care (DELC)
ToiNae Gibson	Program Manager	Multnomah County Intellectual & Developmental Disabilities Children & Young Adult Program
Torri Lynn	Juvenile Director	Linn County Juvenile Dept; OR Juvenile Dept. Directors' Association (OJDDA)
Honorable Valeri Love	Circuit Court Judge	Lane County Juvenile Court

* Designated representatives identified by another member to cover in their absence.
** Sponsor and subject matter expert.

JAC Guiding Principles

Guiding the work of the JAC were several core documents and principles that provided direction and maintained focus. These were collectively developed by the JAC early in its work and agreed upon by the overall membership.

Committee members held the facilitators and each other accountable to the following set of commitments that served as guideposts for discussion, debate and conclusions. These Community Agreements set the tone for each committee meeting and ensured discourse was productive, respectful and goal oriented.

JAC COMMUNITY AGREEMENTS

- Bring our curiosity, reflections, vulnerability, skills, courage, and authenticity to the work of the committee
- Keep ourselves and each other focused on our mission in general, and on specific points in the moment
- Open ourselves to each other's perspectives, experiences, and suggestions
- Stay oriented toward solutions that move us toward our goal
- Seek out, engage and respect all voices of those impacted by our mission

The purpose of the JAC's task was embodied in the mission. This statement was frequently referenced to ensure intentionality in keeping the study inclusive of multiple voices, informed by research, and collaborative in both its process and resulting solutions.

JAC MISSION

The mission of the HB 4086 Jurisdiction Advisory Committee is to strengthen Oregon's child abuse investigation processes with a core focus on child safety. Our purpose is to collaboratively develop specific recommendations that prioritize the protection and well-being of children, while also:

- Reflecting the desires of the community, Tribes, child welfare staff, system partners and child and family serving providers
- Incorporating the latest trauma-informed research on safety, equity and family support to promote resilient children and families
- Ensuring Oregon's investigation system is aligned across systems, and is strength-based and culturally responsive to children, families, communities and Tribes

These recommendations will address child abuse and neglect definitions, scope of perpetrator jurisdiction, due process, and investigation process informed by best practices.

Finally, the set of values below served as touchstones throughout the study process. These core beliefs collectively agreed to by the JAC became foundational to key activities such as issue identification, stakeholder engagement, data collection and analysis, considering options and crafting solutions.

JAC VALUES

- Above all, strive to keep children safe from harm
- Equitably treat all individuals involved in safety determinations with honesty, integrity, dignity and respect
- Avoid re-traumatization of children in efforts to keep them safe from further harm, offer healing interventions and seek justice
- Reduce disproportionality of children and families in the child welfare system
- Share responsibility for child protection with the community
- Maximize the efficient and effective use of available resources

Focus of Study

As mentioned in the JAC mission, the goal of the study was to produce findings and recommendations for Oregon that would improve Child Welfare and OTIS child abuse investigation practice and processes. Domains of exploration included scope of jurisdiction, definitions, investigation process, and due process. A rigorous analytic process to arrive at recommendations has been pursued over nearly a one-year period of time.

The scope of the child abuse investigation study spanned four significant domains, each of which contained several specific issues to be addressed.

Table 2: Original Scope of Child Welfare/OTIS Child Abuse Investigation Issues

Definitions

- Reconcile dual definitions
- Clarify vague threat of harm definition
- Address poverty exception for neglect
- Address naming perpetrators in statute
- Clarify standard of proof
- Clarify dual terminology for disposition findings

Scope of Jurisdiction

- Refine scope & map shared responsibility
- Address child on child abuse

Investigation Process

- Identify alternative pathways gaps & best practices
- Identify Multidisciplinary Team (MDT) gaps & best practices

Due Process

- Clarify appeal process
- Address client rights notification
- Address registry expungement

Out of this exploration and analysis, the facilitators charted a comprehensive, system-wide vision of a safety response system organized to more effectively address the needs of Oregon's children and families during child abuse investigations. This will be described in detail in the sections that follow.

Methodology

Overview

In order to manage such a wide span of study topics, the facilitators implemented a comprehensive approach that offered a sequential process of information gathering and refinement. This methodology ensured that each issue received adequate attention, and also that JAC members could contribute their support or concern about emerging content. With each topic, the facilitators followed this overall sequence:

1. **Define the Issue**

Created an "issue statement" to clearly identify the nature of the issue: challenges and barriers the issue presented, who it involved and who it impacted, current efforts to address the issue, and other considerations to help delineate the boundaries of the topic.

2. **Get Informed About the Issue**

Surfaced and explored a range of resources to learn about the issue. In addition to the expertise of the JAC, several external sources contributed to deeper understanding by sharing relevant data, nationwide trends, current best practices, and the like.

3. **Settle on Findings**

Crafted a cogent picture of the topic that referenced key takeaways from research and consultations, conclusions from survey inquiries or other stakeholder input, and the influence of national trends and best practices. All topics were discussed with the JAC throughout the process.

4. **Craft Recommendations**

Based on the findings, drafted specific and practical recommendations that addressed each topic. Recommendations ranged from no change to clarification of intent to shifting in a new direction. The JAC members validated each final recommendation by registering their individual level of agreement expressed through a validation survey. These survey results are included in the Appendix of this report.

JAC members were given two opportunities to review and provide input regarding report contents. Facilitators utilized the input to revise and improve report narratives and recommendations. In addition, facilitators chose to move forward with viable recommendations even without unanimous agreement by all JAC members. The result

is a comprehensive set of recommendations crafted with substantial input representative of the people and professionals committed to the safety and well-being of the children and families in Oregon.

Sources of Information & Consultation

Throughout the study, a vast network of people, organizations, and information sources were tapped using a variety of approaches to gathering stakeholder input. This effort provided invaluable insight into a wide span of issues being studied. We extend considerable appreciation to the following contributors, all of whom presented their information clearly and shared their time generously.

Table 3: Key Informants

• Sarah Walker, Child Safety Program Assistant Manager • Steve Christian, Bipartisan Policy Center; author of Statutory Analysis Pursuant to Oregon HB 4086 Regarding OR Dept. of Human Services (ODHS) Jurisdiction • Anna Williams, Executive Director of System of Care Advisory Council • Michelle Pfeiffer, ODHS Child Welfare Legislative Coordinator • Roy Smith, Data Analyst, ODHS Child Welfare Strategy & Innovation • Leslie LaNier, ODHS Child Safety Program Coordinator • Mary Geelan, ODHS Family First & Integrated Policy Manager	• Jennifer Sorenson, OR Child Abuse Hotline Program Manager • Ronika Ferguson, ODHS Safety Program Assistant Manager • Kristen Khamnohack, ORCAH Manager • Yasmin Grewal-Kök, Policy Fellow, Chapin Hall • Leanne Heaton, Research Fellow, Chapin Hall • Denicia Carlay, Complex Sexual Behavior Committee Facilitator • Reesy Cormier, Complex Sexual Behavior Committee Facilitator • Tori Algee, Project Family First • Senator Sara Gelser Blouin • Senator Lisa Reynolds, MD

Table 4: Stakeholder Activities

• Interviews with child welfare administrators from Massachusetts, Minnesota, New Hampshire, Tennessee, Washington, Wyoming • Focus groups with the Oregon Parent Advisory Council, ODHS Child	• Survey data from 160 respondents representing all Oregon counties including CPS/OTIS staff, law enforcement, child abuse prosecuting attorneys, Child Advocacy Centers, and Multi-

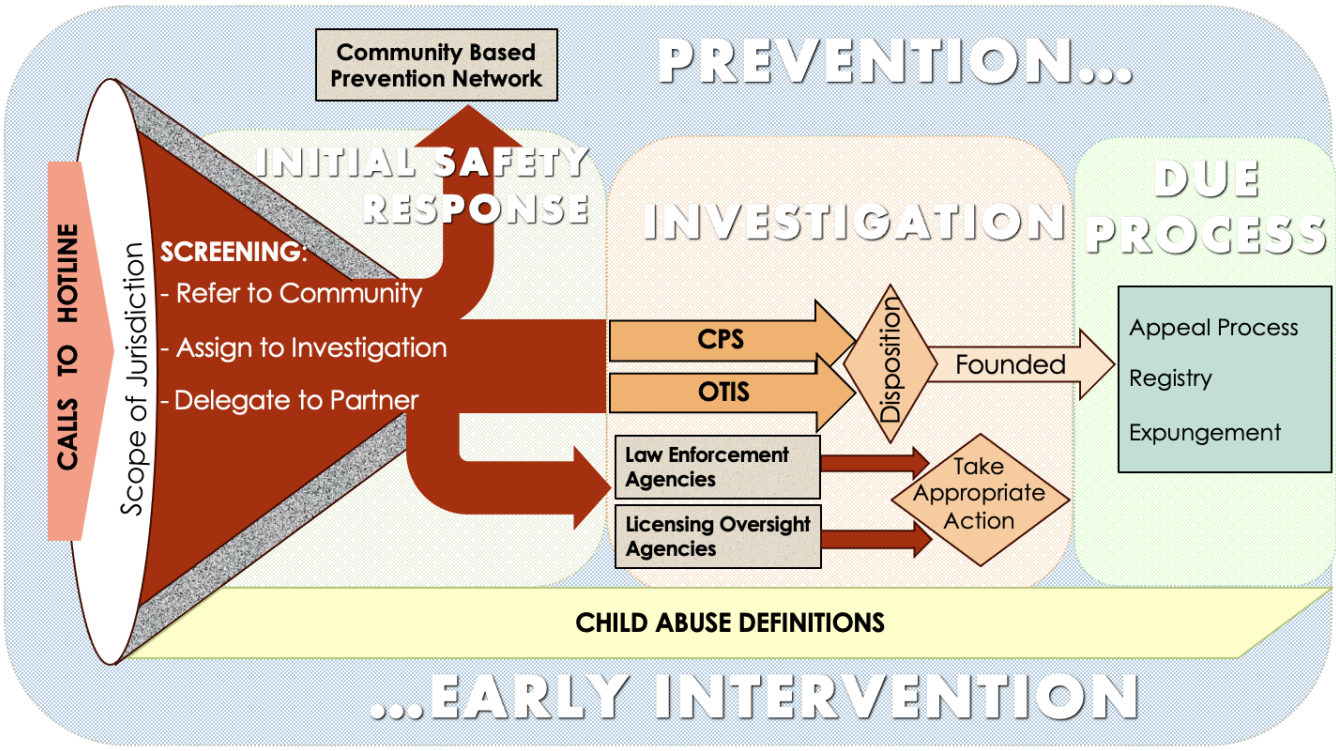
Protective Services (CPS) Program Managers	Disciplinary Team (MDT) partner agencies

Findings & Recommendations

Overview

Across the months of deep exploration, research, and consultation, several critical findings emerged that required a modified context in which recommendations can be placed. This represents a possible future landscape for child abuse investigations:

Figure 5: Child Abuse Investigation Landscape



This graphic depicts a flow of tasks and decisions across four distinct phases of activity. Influencing the entire process is the **prevention and early intervention** environment (blue background), which provides community-based services and efforts designed to bolster vulnerable families in ways that do not require child protective services (CPS) involvement.

In this environment, as with all Child Welfare child abuse investigations, the process begins with a call to the hotline, which starts the **initial safety response**. This marks the **scope of jurisdiction** which is filtered through a **screening** process that discerns the appropriate action. Four options are possible for reports where families may need assistance:

1. Close at screening and refer to community-based prevention organizations for services.

2. Delegate to a relevant partner (as determined by case specifics) for appropriate action and either close at screening or assign/refer (if the allegations also constitute child abuse/neglect).
3. Assign to CPS for assessment, investigation, disposition and safety decision.
4. Refer to OTIS (based on type of alleged perpetrator) for screening decision, investigation, and disposition.

The **investigation** phase involves either CPS or OTIS determining a disposition (and safety decision in the CPS assessment process), and/or safety partners (i.e., law enforcement agencies or licensing oversight agencies) taking appropriate action. Finally, in the **due process** phase, persons exercise their right to file an appeal, while a balance between community safety and individual rights is maintained through registry and expungement considerations.

Limitations of the Study

Early Childhood Education & Educational Settings

Issues related to the Early Childhood Education settings and the Education system, for both certified and non-certified education personnel, were identified throughout the study. The number of challenges expressed by both early childhood education and educational representative members of the JAC around child abuse definitions, investigations, appeal processes, and expungement are worthy of further exploration and discussion. Unfortunately, the work of this committee did not allow for the breadth or depth of research and discussions necessary to address those concerns and challenges.

Some of the recommended changes in this report, specifically the investigations of third parties and the appeals process, if implemented could possibly reduce some of the challenges educators experience. However, further discussion, research, and exploration of how these issues are addressed in other states should be considered. In addition, there should be an in-depth exploration of how the abuse definitions apply to educational personnel and the appropriateness of some of them to this population of professionals.

Our recommendation is that Oregon implement a work group to study the issues in depth related to the early childhood education and education system and application of the current child abuse definitions and appeals processes as they relate to educators.

Case Law and Interpretation of Statute

This study was also limited in that there was no discussion of how statutes and the interpretation of those statutes create case law. The wording of a statute may seem clear; however, how courts interpret statute in any given circumstance creates case law that is based on that court's interpretation of the statute.

For example, a child abuse definitions statute names the potential perpetrators as parents, guardians and anyone having a familial caregiving relationship. The scenario is: A child is left for a half hour with a cousin, and the child is abused by the cousin. The court needs to determine if the statute covers the cousin as a family member with a caregiving relationship. The court's interpretation of the statute related to this issue results in newly created case law.

The study process did not include discussions of these types of issues and the impact they have or could have in the future on any of the recommendations contained in the report.

Presentation of Recommendations

All the recommendations resulting from the jurisdiction study have a home in the graphically represented child abuse investigation landscape shown in Figure 5. In the sections that follow, each area of findings will be represented in three ways:

- A table with relevant recommendations
- A graphic that places recommendations within the investigation landscape
- A comprehensive narrative overview of the context and considerations from which the recommendations were drawn.

Recommendations will be presented in the following order:

All Recommendations – Short Titles	
1. Bring alternative pathways to scale	5. Raise standard of proof for concluding child abuse investigations
2. Modify scope of jurisdiction for child welfare a. Narrow span of child welfare scope of jurisdiction b. Name perpetrators in statute c. Address child on child abuse	6. Enhance client rights notification
	7. Strengthen implementation of MDT best practices
	8. Extend SDM model to all of CPS & OTIS investigations
3. Share Responsibility for Investigations	9. Streamline appeal process

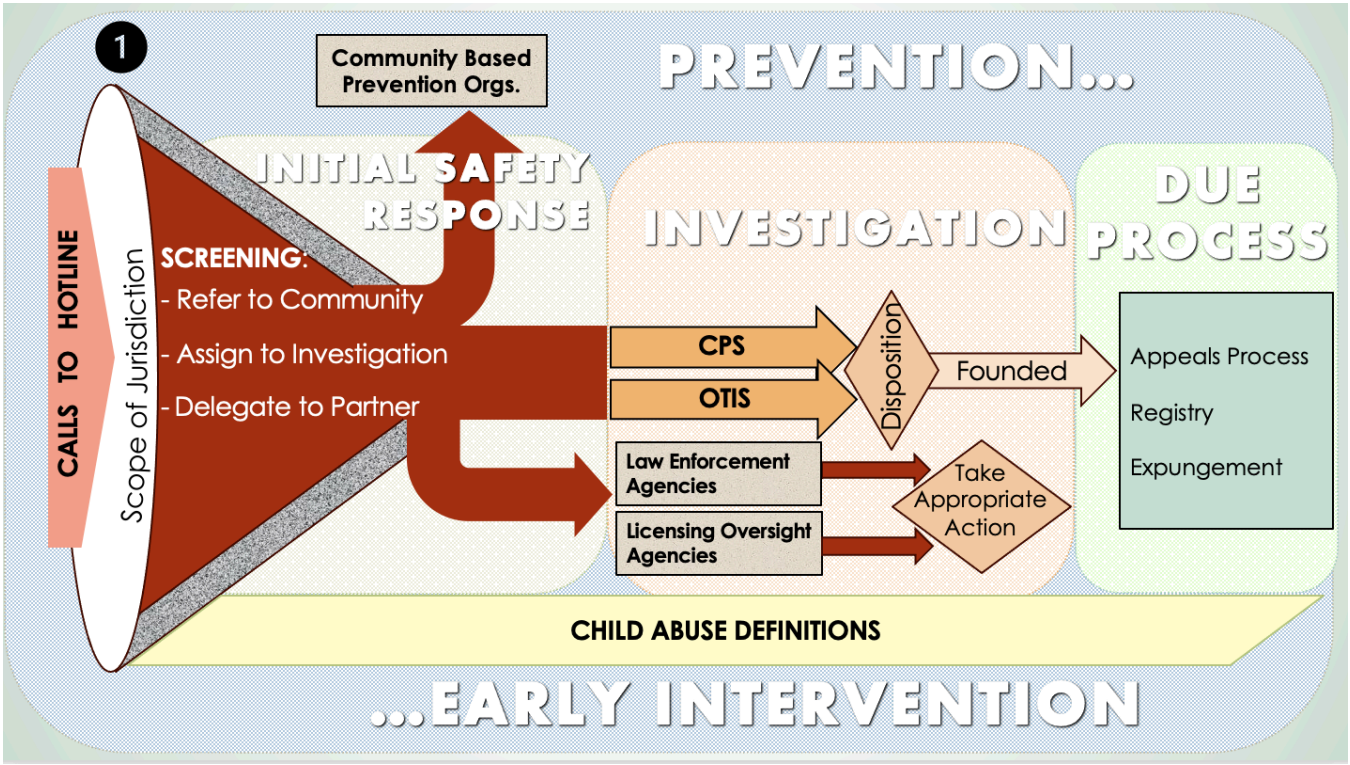
a. Share responsibility for safety concerns b. Allow certain investigations to be performed by other safety partners c. Use single terminology for dispositional findings	10. Establish child abuse registry 11. Establish expungement protocol
4. Modify Child Abuse Definitions a. Account for 418 definitions in 419B b. Reclassify threat of harm definition c. Refine neglect definition d. Add poverty exception to neglect definition e. Remove seclusion & restraint as abuse types	

Prevention, Early Intervention and Alternative Response System

Table 6a: Recommendation At A Glance

Recommendation	Description
1. Bring alternative pathways to scale	Expand community-based prevention network to formally respond to families in need of assistance.

Figure 6b: Prevention & Early Intervention Recommendations in Context



Alternative Pathways

Currently in Oregon family support services and resources are concentrated in the large and medium urban areas of the state and the rural areas of Oregon are less resourced. The lack of a robust statewide prevention system results in the absence of resources and access to services to help some families who are having trouble meeting their basic needs. This includes parents struggling to make ends meet financially, failing to be able to put food on the table for their children every day, or facing barriers to access appropriate medical care when needed. Parents or guardians may be unable to afford adequate childcare resources, stable housing, sufficient nutrition, etc. Their inability to cope with the stressors resulting from these issues becomes a major factor in their ability to safely parent their children emotionally and physically.

Communities that understand the challenges that families face and are aware of the impact of the stressors placed on families that are unable to meet their basic needs ensure that there are investments made to provide resources throughout their communities that assist families. This creates a safety net of resources focused on providing early intervention services that assist with gaining access to basic necessities such as food, housing, economic and employment assistance, subsidized childcare, and affordable medical care.

According to research by Chapin Hall, increased access to economic and concrete supports is associated with a decreased risk of child maltreatment and child welfare involvement.[1] Nationally over 60 percent of CPS responses involve neglect only and the provision of economic and concrete supports is associated with decreased risk for both neglect and physical abuse. Examples of economic and concrete supports include but are not limited to cash assistance, earned income tax credit, child tax credit, childcare, employment, in-kind benefits, housing supports, Medicaid, unemployment benefits, utility assistance, and food assistance. Many of these families are low risk for imminent safety concerns, but are in need of the connections, resources and interventions that can be more effectively provided by linkage to community-based organizations.

The National Child Abuse and Neglect Data System (NCANDS), defines alternative response as "the provision of a response other than an investigation that determines if a child or family needs services. A determination of maltreatment is not made, and a

[1] DeGuerre, K., Strolin-Goltzman, J., Briar-Lawson, K., & Gooley, B. (2021). Child neglect: Statutes, rates, and a neglect diversion model. Greenwich Social Work Review, 2(2), 208-218. https://doi.org/10.21100/gswr.v2i2.1269

perpetrator is not determined." (*Child Maltreatment 2022*, The Administration for Children and Families, n.d.)

Alternative Pathways such as Community Response, Alternative Response, or Differential Response are all a system's effort to work in collaboration with community agencies. In a community response these partnerships provide up front services for families that can be accessed by the family in their community prior to any referral to child welfare. In community response there is no child welfare intervention. A community response system can meet the needs of families who do not meet the definitions of abuse or neglect but still need some sort of help. This intervention can range from ensuring assistance with securing basic economic supports to short term interventions that include some level of home visiting and service provision. All of this occurs on a voluntary basis.

Alternative response, or differential response, allows child welfare to implement a different response other than investigating allegations and requiring a dispositional finding when an allegation of abuse is made. Assignment to an alternative pathway is typically completed by the screener at the child abuse call center This pathway assignment may be based on a number of factors which could include the type of abuse or neglect being reported, history of reports for the child, age of the child, or the level of risk. All these factors are consistently determined by the utilization of a standardized, evidence-based, decision-making process. This process is not clearly depicted in the graphic and if considered would need further discussion, exploration and statute change.

Child welfare is still the responsible entity to respond to these alternative or differential response cases through a less formal family assessment process to assess risk and safety. The key difference in alternative/differential response is that if the child(ren) are deemed "safe" at the end of the assessment, there is no dispositional finding and any referrals to services are typically voluntary and community-based, without oversight by child welfare or the juvenile court. If the child(ren) are not determined to be "safe", these cases would need to switch to a traditional CPS investigation, requiring a disposition and more formal oversight to ensure child safety.

Data presented by Chapin Hall from NCANDS from 2004-2017 showed that states with Alternative Response programs had approximately:

- 19% fewer substantiated reports

- 25% fewer children substantiated for neglect
- 17% reduction in foster care services utilization[2]

One example of a community response effort that would be beneficial in reducing the likelihood of child abuse referrals and investigations is to expand the use of Family Resource Centers (FRCs) that are available in communities to provide economic and concrete supports to families. Family Resource Centers are both a prevention resource for families and an early intervention or alternative pathway for families referred to child welfare that do not meet the definition of abuse or neglect. Chapin Hall research provides the following example:

> The Family Resource Center in Teller County, Colorado connects families who have been screened out of child welfare to community resources, family support services, and financial assistance.

After a formal partnership between child welfare and the FRC was established, Teller County saw a 63% reduction in its child maltreatment rate and saved an estimated $2.5 million (in 2018).[3]

Oregon's Opt-In Initiative

Oregon has begun to explore an early intervention program through the Opt-In Initiative. The Opt-In Initiative consists of four distinct phases which are Access, Engagement, Navigation and Support. This effort is being co-designed and created collaboratively with lived experts, community leaders and intergovernmental partners. The focus is to prevent unnecessary child protection system interactions and improve lives so that families and children thrive.

The program development will include a process for identifying families to be referred from ORCAH screened out reports and then referring to an identified partner site. These sites are community-based programs outside of the child welfare system. The site will then utilize various engagement strategies to reach out to those families.

Once the family is engaged, the site completes an assessment to identify the needed services and supports and assists the family in navigating the array of available services so that the search itself does not become a hardship for the family. The site

[2] Grewal-Kök, Y. & Heaton, L.; Chapin Hall; "Child Welfare System Involvement: Alternative/Differential Response Evidence"; Presentation to HB 4086 Jurisdiction Advisory Committee, March 12, 2025
[3] Grewal-Kök, Y. & Heaton, L.; Chapin Hall; "Economic & Concrete Supports and Community Response to Support Prevention"; Presentation to HB 4086 Jurisdiction Advisory Committee, March 12, 2025

continues to work with the family through provision of services and concrete material support. This supportive assistance will meet the priority needs with the goal of reducing future child welfare involvement.

Chapin Hall is conducting a formative evaluation of the Opt-In effort and includes the integration of implementation science and the stages of implementation from the National Implementation Research Network (https://nirn.fpg.unc.edu/). The formative evaluation is being conducted before a program or activity is fully implemented to ensure that it is feasible, appropriate, and acceptable. It includes all phases of exploration, design and installation.

An approach similar to the Opt-In initiative could also be applied to the development and implementation of a response for those sexual abuse allegations that involve child-on-child abuse. The Complex Sexual Behavior Committee, which was also a part of this HB 4086 legislation, provided several recommendations for implementation of programs, services, tools and resources to serve families and children in which these types of issues have surfaced. These recommendations can be found in the report "Toward a Coordinated Response to Complex Sexual Behavior in Children".

Washington State has implemented two evidence informed prevention programs that are demonstrating positive success. They are the Plan of Safe Care and Family Reconciliation Services, serving very different populations to prevent child welfare involvement. Below is a brief description of these programs:

Plan of Safe Care | Washington State Department of Children, Youth, and Families: https://dcyf.wa.gov/safety/plan-safe-care

> A Plan of Safe Care (POSC) is a family-centered prevention plan designed to promote the safety and well-being of birthing parents and their infants with prenatal substance exposure. A Plan of Safe Care can strengthen protective factors, promote healthy development, and prevent child welfare involvement or out-of-home placement through connections to parenting education, safety guidance, early intervention, and wraparound resources and services. The Plan of Safe Care implementation in Washington includes utilizing the evidence-based practice Help Me Grow.

Family Reconciliation Services (FRS) | Washington State Department of Children, Youth, and Families: https://dcyf.wa.gov/services/at-risk-youth/frs

Family Reconciliation Services (FRS) is a voluntary program serving runaway adolescents and youth who are in conflict with their families. The program targets adolescents between the ages of 12 through 17. FRS services are meant to resolve crisis situations and prevent unnecessary out-of-home placement. They are not long-term services. The services will assess and stabilize the family's situation. The goal is to return the family to a pre-crisis state and to work with the family to identify alternative methods of handling similar conflicts. If longer-term service needs are identified, FRS will help facilitate getting the youth and their family into ongoing services.

FRS services may include, but are not limited to:

- Short-term family counseling.
- Referrals for substance abuse treatment and counseling.
- Referrals for mental health services.
- Family Assessments in conjunction with juvenile court services for At-Risk Youth (ARY) and Child in Need of Services (CHINS) petitions.
- Crisis planning and help to respond to difficult situations, such as when a youth runs away.

Please note that the program no longer places the youth out of the home in most cases. Instead, FRS will work with the family to mend relationships via the services listed above.

It is recommended that Oregon more closely examine and consider expansion of community-based prevention networks across the state to formally respond to families in need of assistance.

For additional information on community readiness and steps for development of prevention services in communities see:

- Chapin-Hall_Community-Pathway-Policy-Brief_Sept-2024.pdf
  Chapin Hall Policy Report | Olivia Wilks & Krista Thomas | September 2024
- Establishing Community Pathways to Prevention Services In the Context of the Family First Prevention Services Act

Initial Safety Response

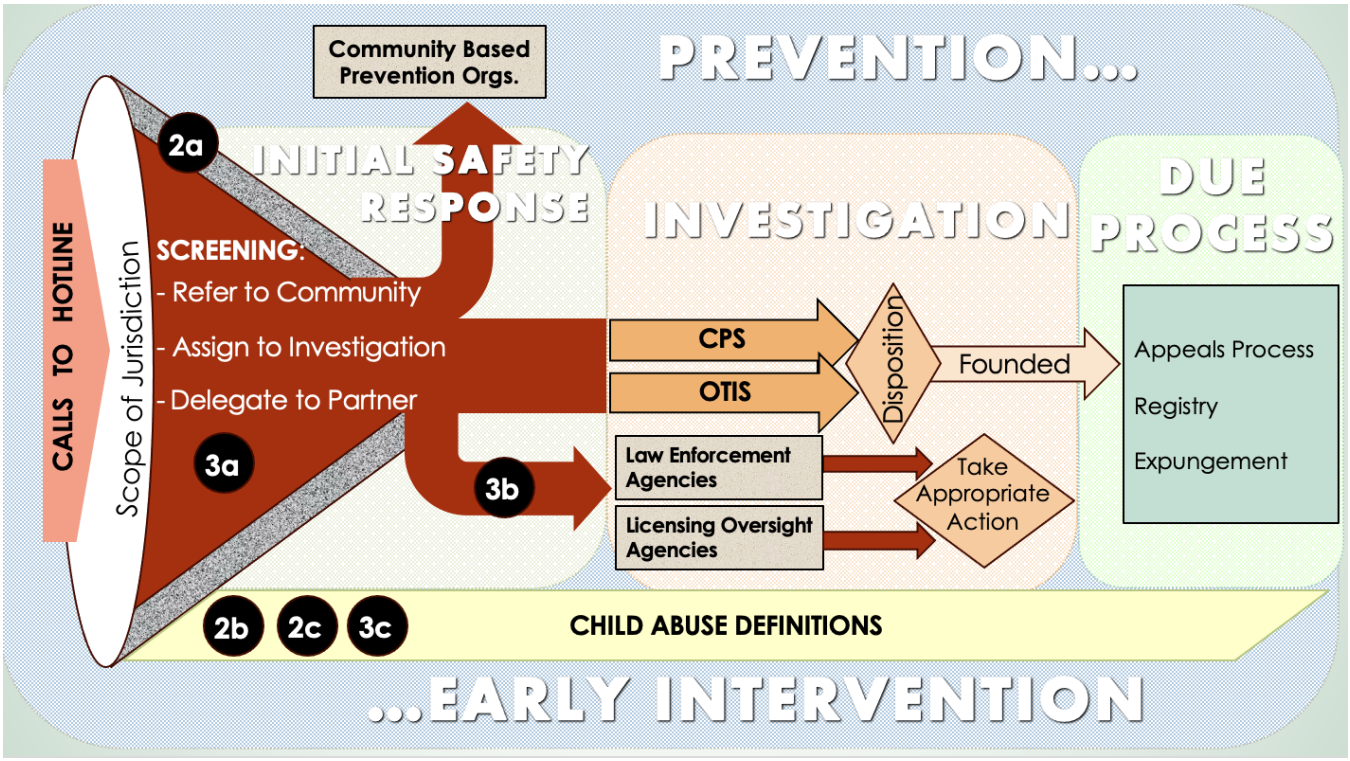
This section focuses on several categories of recommendations (#2a-c, #3a-c, and #4a-f) that address what comes into child welfare, the appropriate span of safety circumstances that fall within the purview of ODHS, and how collaboration with other safety partners within the community is a critical pathway of shared responsibility for child protection.

Safety Response in Partnership

Table 7a: Recommendations At A Glance

Recommendation	Description
2. Modify Scope of Jurisdiction for Child Welfare	
a. Narrow span of child welfare scope of jurisdiction	Allegations involving persons who do not have a caregiving role or any familiarity with the child would only be investigated by law enforcement.
b. Name perpetrators in statute	Clarify in statute who can be the subject of an allegation of child abuse to match the scope of jurisdiction.
c. Address child on child abuse	Children would no longer be alleged perpetrators of child abuse unless they are acting in a parental capacity, above a certain age acting in a caretaking role, or specific circumstance related to child trafficking.
3. Share Responsibility for Investigations	
a. Share responsibility for safety concerns	Lift statutory requirement that ODHS must issue dispositions on all screened in child abuse allegations
b. Allow certain investigations to be performed by other safety partners	Under specific conditions, ODHS has the discretion to defer investigations to LEA or appropriate licensing entities without completing a CPS investigation.
c. Use single terminology for dispositional findings	Both CPS and OTIS would use the terms “founded”, “unfounded”, and “unable to determine”.

Table 7b: Recommendations in Context



Scope of Jurisdiction

The scope of jurisdiction for child welfare in Oregon is currently very broad and requires the child welfare agency to investigate child abuse by third parties who have no caregiving role or who are unknown to the child. Oregon is currently the only state in the nation with this requirement. Additionally, the Child Abuse Prevention and Treatment Act (CAPTA) and most states name who the potential perpetrators are in their statutes with a focus on parents, caretakers or other persons responsible for the child's care. Oregon's statute (ORS 419B.005) does not name who the potential perpetrators of abuse can be.

The Oregon Department of Human Services, through Child Protective Services (CPS) or the Office of Training Investigations and Safety (OTIS), is also responsible for determining a disposition on any allegation of child abuse/neglect screened in. These strict conditions overlook the expertise of other safety partners, such as law enforcement agencies (LEAs). This unnecessarily increases the volume of investigations managed by ODHS alone and reduces the efficiency of the agency charged with the responsibility of ensuring the safety and permanency of children in the State of Oregon.

To ensure that children in any community are safe from abuse, it is not reasonable to place the sole responsibility of investigations in one agency alone. Child safety is a shared responsibility of public safety agencies, organizations serving children and families, and the community at large.

There are certain allegations of child abuse that are not appropriate for the child welfare agency to investigate. The key functions of the child welfare agency are to keep the child in their own home when it is safe to do so, to develop an alternative plan for the child when their safety is at risk, and to pursue separation of child and parents only when it is necessary. If a child is removed from their parents, then the agency must ensure the safety of the child in care, provide services and resources to parents to ensure reunification efforts are made to reunify the child with their parents or to pursue an alternative permanent plan if reunification is not possible. The child welfare agency is not only responsible for investigating instances of alleged child abuse/neglect but also to assist the families that come to their attention. At its core, this approach is a family-focused intervention.

A significant number of allegations of child abuse by third parties do not involve family members, placement resources or individuals known to the child. Therefore, these cases fall outside the scope of what child welfare should be investigating. The following data for 2024 from the ODHS-OTIS Digital Databook illustrate this point.

The specific categories of third parties who would fall outside of the proposed scope of jurisdiction are highlighted in the table below:

Table 8: Third Party Non-Familial Abuse by Allegation Type – 2024

	Abuse Type				
Simplified relationship	Neglect	Physical Abuse	Sexual Abuse	Threat of Harm	Total
Acquaintance	1	23	66	12	102
Employment			7		7
Family Friend		2	27	3	32
Friend's Relative	3	3	13	4	23
Neighbor		1	6	1	8
Online			59		59
Professional		1		1	2
Relative			2		2
Significant Other		1	2		3
Stranger/Unknown		25	61	13	99
TOTAL	**4**	**56**	**243**	**34**	**337**

The relationship types of acquaintance, online, and stranger/unknown are candidates for being investigated by more appropriate entities. Child welfare and OTIS should be relieved from the obligation to investigate such instances. Instead, these should be the responsibility of law enforcement to investigate. The circumstances in which the allegations involve a person who has no caregiving role for the child or has no relationship with the child in any other capacity (including no access to the child based on living situation or profession) and has no children of their own that may be at risk, should be the responsibility of law enforcement for investigation, intervention, or possible legal action. In these cases, there is no need for the child welfare agency to work with that individual in any capacity.

Figures 9 and 10 below show that while allegations of sexual abuse are by far the most common abuse type involving third party non-familial incidents, Figure 11 shows that less than 40% are substantiated and most of these represent the third parties who have a relationship to the child. All abuse types involving third party non-familial allegations are more likely to result in unfounded or unable to determine conclusions.

Figure 9: Third Party Non-Familial Total Allegations by Abuse Type and Finding – 2024

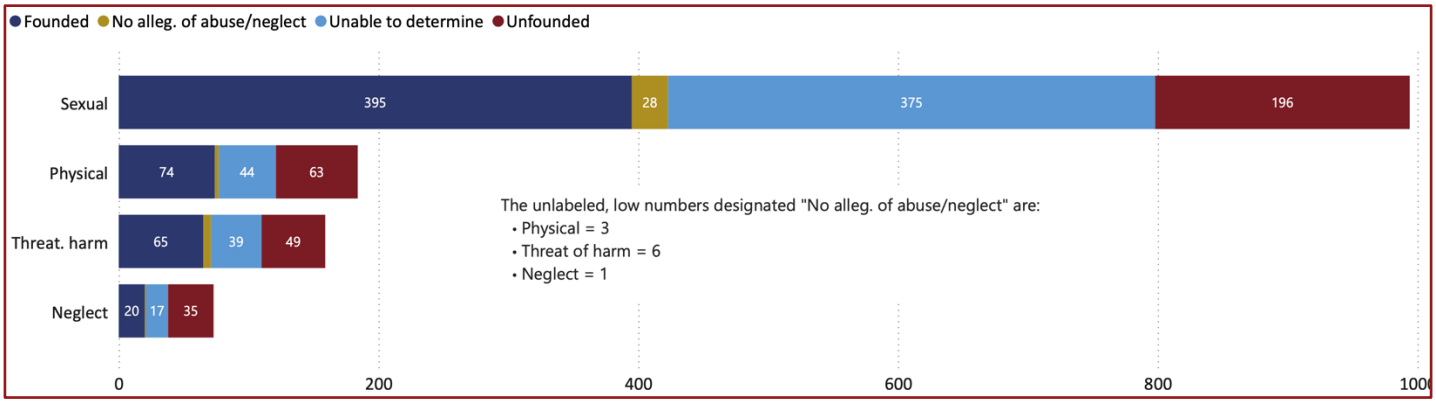


Figure 10: Third Party Non-Familial Abuse Type as a Percentage of Total Allegations – 2024

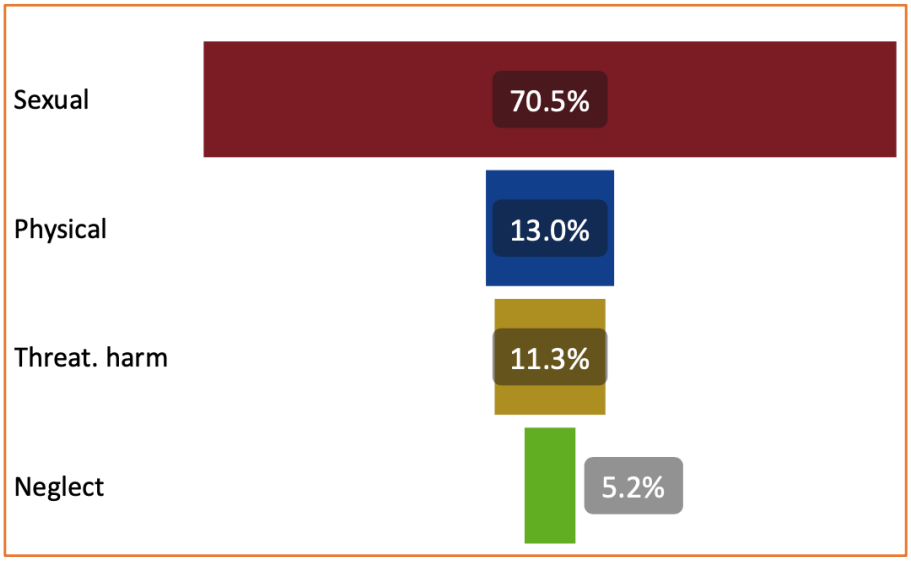


Figure 11: Substantiated Allegations – 2024

Substantiated allegations

Abuse Type	#Total allegations	#Founded	% Founded or substantiated
Sexual	994	395	39.7%
Physical	184	74	40.2%
Threat. harm	159	65	40.9%
Neglect	73	20	27.4%
Total	**1410**	**554**	**39.3%**

Even in cases involving stranger, online, and acquaintance alleged perpetrators, often a founded disposition is made against an "unknown" individual which does nothing to ensure the safety of the impacted child.

LEAs are more experienced and trained in criminal matters and are equipped to follow up on abuse to children involving strangers, online predators, and other individuals who have no caregiving role nor any ongoing relationship with or access to the child. By referring such incidents to the appropriate LEA, child welfare can reduce the volume of their investigations to concentrate on those they are best positioned to investigate, thus improving efficiency and effectiveness of Oregon's child protection system.

It is recommended that the statutory requirement [419B.020 (2)] for ODHS to be responsible for investigating and dispositioning all screened in allegations of child

abuse be modified to allow ODHS the discretion when the allegation involves acquaintance, online, and stranger/unknown person to have law enforcement to take appropriate investigatory action. Allegations that involve alleged perpetrators of child abuse who have no caregiving role to the child and have no relationship to the child in any other capacity should be the responsibility of law enforcement.

Wrongful Restraint/Involuntary Seclusion

Another instance in which there should not be a child abuse investigation is when the allegations are related to licensing, performance, or training, and do not involve any other type of abuse. These types of incidents include violations related to wrongful restraints, involuntary seclusion, violations of training expectations, staffing ratios or other technical standards and should be forwarded to the appropriate state regulatory agency for appropriate action.

If the allegation is a licensing violation and because of that violation includes an allegation of abuse, then it would be appropriate to have both agencies investigate with the regulatory agency focused on the potential violations and child welfare focused on the abuse allegations. If a child is harmed because of restraints being applied or seclusion, then the family or others can allege child abuse and refer it for an investigation of abuse by child welfare. There does not need to be separate definitions for restraint or seclusion for an abuse allegation to occur, as abuse is abuse.

It is recommended that wrongful restraint and involuntary seclusion be eliminated as abuse types and the following occur:

- K-12 incidents in violation of ORS 339.291 be reportable to ODE for action.
- Child in care incidents in violation of restraint and seclusion regulations be reportable to appropriate licensing and oversight entities for action.
- If another abuse type is present in any incident, it would require a report to ORCAH for action.

An example where a child abuse investigation is not appropriate:

Multiple school staff respond to support a dysregulated student. One teacher's training certificate is a week expired but performs a restraint properly and appropriately. Another staff member takes over the restraint and uses inappropriate level of force and pushes the student up against the wall causing an injury (concussion) to the student. The staff with the expired training would be followed up with by the school district and ODE. The second staff member would have a potential allegation of abuse followed up by OTIS.

Persons Responsible for Abuse

With a focus on those individuals who have a caregiving role or a relationship with the child there should be clarity provided in statute on who should be the focus of a CPS child abuse investigation.

Most states include in their statutes for definitions of abuse a statement about who is responsible for the care of the child and therefore can be accused of abuse. Included in the Appendix is a chart providing examples of how comparison states identify the person's responsible for care in their statutes on abuse definitions.

The state of Oregon has criminal statutes for offenses against persons in ORS Chapter 163. These are criminal statutes and not child abuse statutes; however, these can still result in a criminal conviction for the same incident of abuse that is investigated by child welfare.

It is recommended that the statute (419B.005) be amended to include a statement that child abuse/neglect investigations completed by ODHS/CPS are primarily focused on "person's responsible for the child's care". For further clarification the amendment may include a description that differentiates between those within the family unit and those outside of the family unit. Both of these sets of individuals would be considered responsible for the child's care.

The statute (419B.005) could also be amended to specify that investigations of child abuse by third parties with no familial or caregiving relationship to the child are the responsibility of law enforcement.

Possible wording as follows:

1. An individual functioning **within the family unit** and having responsibility for the care of the child such as the parent, guardian or other person having similar care responsibility is the responsibility of child welfare.
2. An individual functioning **outside the family unit** and having responsibility for the care of the child such as a teacher, school administrator, or other school employees or agents, or other lawful custodian of a child having either full-time or short-term care responsibility including, but not limited to, daycare, child care providers, babysitting, counseling, teaching, coaching, foster care, group home care and residential treatment is the responsibility of OTIS.
3. A third party with no family relationship or caregiving responsibility for the child is the responsibility of law enforcement.

With the child welfare agency's focus on serving families there should be opportunities available for the ORCAH screeners to redirect families to community services and interventions, when the issues do not rise to the level of abuse/neglect; and when the circumstances are appropriate, for CW investigators to redirect to community services and interventions without having to determine a disposition (i.e., differential or alternative response). This would allow families who are experiencing difficulties to receive information and assistance from resources, services, and organizations in their communities with reduced child welfare involvement. (See Recommendation #1 above in Prevention/Early Intervention)

It is recommended that the statute (419B.026) be amended to eliminate the requirement that ODHS is required to make a finding/determination on all assigned reports of child abuse to allow the agency the discretion to refer to law enforcement or community resources and services.

Child on Child Abuse

As previously stated, Oregon's current statute fails to identify who can be a person responsible for child abuse. As a result, in Oregon children can be reported and investigated as perpetrators of child abuse.

As was so eloquently stated by a member of the JAC, "we must consider what is the purpose of labeling a child a child abuser". Child welfare's focus is on ensuring the safety of children and the question is, does labeling them a child abuser make other children any safer? If the answer to that question is "no", then it is concerning that a child is labeled in such a way. This label can negatively impact them in the future, and they may not have the ability or resources to challenge this. In no instance should a child be labeled as a child abuser unless they are themselves a parent accused of abuse of their own child, or under limited circumstances that should be defined (i.e., above a certain age), when acting in a caretaker role, or specific circumstances related to child trafficking.

Senate Bill 155 (2019), clarified and strengthened mandatory reporting requirements for school employees and volunteers, and created new procedures for investigating and disclosing abuse allegations in public and private schools, as well as youth-serving organizations. It required ODHS to investigate abuse in educational settings and third-party abuse starting January 1, 2020. It also required ODHS to expand the scope of child abuse investigations and a dispositional finding be made on all referrals screened in for investigation.

The lack of clarity on who can be a person responsible for child abuse and the requirement for a dispositional finding on all referrals screened in by ORCAH creates a situation in which, if the agency strictly adheres to statute, children are being labeled as child abusers.

Currently abuse allegations that involve child-on-child abuse are received and reviewed by ORCAH to obtain information about the actual description of what occurred. This includes consideration of the child's developmental age, any special needs of the child, what parental knowledge and response is to the abuse allegations, what actions the parents are taking to address the issue and if there is negligence on the part of the parent.

Given this information ORCAH considers the family safety issues and if appropriate assigns for investigation and concurrently cross reports the screening report to law enforcement for possible investigation.

It is our recommendation that children who are reported for abuse be screened as part of a family system in which there needs to be an assessment regarding the parents' ability to supervise and protect the other children in the home, as well as secure appropriate services to address the issues.

When the allegations involve sexual abuse and the alleged perpetrator is a child/youth, and if the requirement for all ODHS referrals screened in for investigation to have a disposition is removed, then the agency can triage the referral and refer to appropriate community resources to provide intervention and treatment, complete an investigation or refer to law enforcement as appropriate.

As previously mentioned, the Complex Sexual Behavior Committee has provided several recommendations for programs, services, tools and resources that can be implemented to serve children and families experiencing these issues. This would allow for appropriate intervention and treatment opportunities instead of a disposition for a child as an abuser.

Dual Terminology

There is one additional element that needs to be addressed and that is the dual terminology for determining a dispositional finding that is found in Chapters 418.259 and 419B.026 of the Oregon Revised Statutes (ORS). CPS currently utilizes founded, unfounded and unable to determine as their dispositional findings per ORS 419B.026 while ORS 418.259 requires the use of the dispositional findings substantiated, unsubstantiated and inconclusive which is utilized by OTIS.

The dual definitions and the dual dispositional findings have led to much confusion and misunderstanding from those who are being investigated as they can possibly have two different dispositional findings for the same allegation. This has not only created confusion but also a great deal of frustration for those individuals who are challenging the disposition through the established appeal process.

It is recommended statute ORS 418.259 be amended to require use of the same dispositional findings used by CPS and have one set of dispositional findings used for

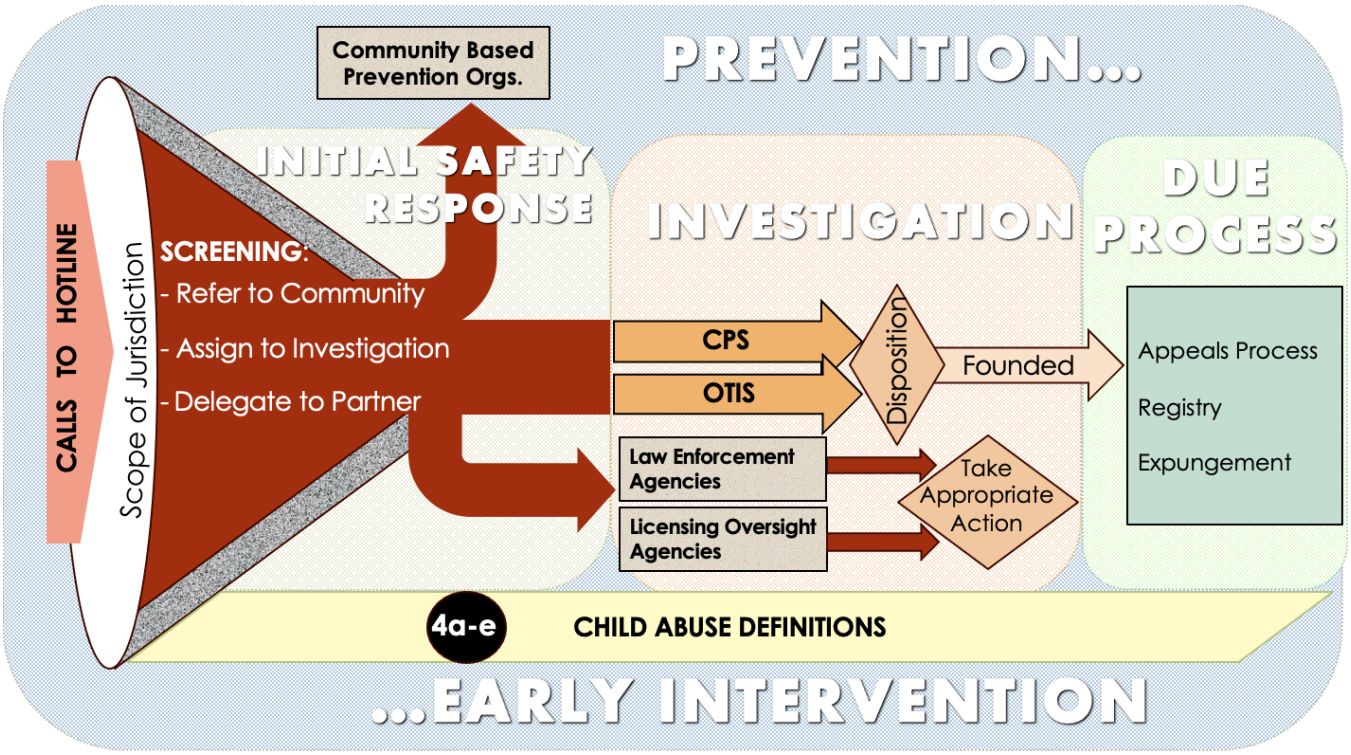
all investigations completed by both CPS and OTIS. The three dispositional findings are Unfounded, Founded and Unable to Determine.

Child Abuse Definitions

Table 12a: Recommendations At A Glance

Recommendation	Description
4. Modify Child Abuse Definitions	
a. Account for 418 definitions in 419B	Streamline child abuse definitions into a single set
b. Reclassify threat of harm definition	Include imminent risk language and distribute threat of harm content to standard child abuse categories.
c. Refine neglect definition	Amend neglect definition to include caregiver's failure to provide adequate supervision and failure to provide adequate protection.
d. Add poverty exception to neglect definition	Add poverty exception language to the Neglect definition.
e. Remove seclusion & restraint as abuse types *(addressed in previous section)*	Define wrongful restraint and involuntary seclusion as licensing violations, rather than child abuse in all settings.

Figure 12b: Definitions Recommendations In Context



With the naming of potential perpetrators in statute and allowing ODHS to have the discretion to move certain third party investigations to the appropriate agency, eliminating the licensing violations from the child abuse definitions in statute and using one set of dispositional findings for all investigations conducted by ODHS there

is no longer a need for a dual set of child abuse definitions as is currently in Chapters 418 and 419B of the Oregon Revised Statutes. It is recommended that ORS 418 and 419B definitions be reviewed for duplication and consolidated into one set of abuse definitions.

Threat of Harm & Imminent vs. Substantial Risk

Oregon has a more prevalent use of the "threat of harm" abuse type than most states and the definition is relatively vague compared to the detailed provisions in some states. The statute definition of Threat of Harm states the following:

> *Threatened harm to a child, which means subjecting a child to a substantial risk of harm to the child's health or welfare.*

In contrast, other states typically include threatened harm as part of their neglect or other abuse types rather than considering it a completely stand-alone abuse type. In addition, Oregon defines threatened harm as subjecting a child to a "substantial risk of harm" to their health or welfare which is a lower standard than what CAPTA requires which is "imminent risk of serious harm".

It is understood that children may be "at risk" of some harm because of various circumstances that are present. A couple of common examples include past abuse of other children by a caretaker or increased vulnerability of the child due to developmental delays. However, the standard of "substantial risk of harm" is quite subjective and could lead to inconsistent decision making because of varying interpretations of the term "substantial."

Oregon utilizes a tool called Structured Decision Making (SDM) only at ORCAH to assist with screening of referrals. SDM is an evidence-based decision-making tool that can also be implemented during the CPS process and identifies the issues that are most highly correlated with abuse and neglect. SDM is used in case decision making and can assist in reducing the subjectivity and inconsistencies of decisions. These tools are focused on identifying those children that are at "imminent risk" versus "substantial risk" reducing the subjectivity and inconsistency in decisions so that families with the highest risk and need levels are the ones that the agency is focused on serving. There is further discussion of the value of the SDM suite of tools later in this report.

Parents have rights and due process protections. Government intervention in a family should be reserved for those circumstances in which a child's safety is compromised.

Additionally, one needs to consider the implications of CPS intervention in a child's life for reasons that do not present any clear immediate safety issues for the child.

When looking at Oregon's data for founded allegations of abuse reviewed by the central office based on a request for review, over a five-year period the largest percentage of founded dispositions reviewed are for neglect and threat of harm. Combined they represent approximately 66% of all the reviews completed.

Table 13: Number & Percentage of Allegation Abuse Types Reviewed Statewide, Jan. 2020 – Sept. 2024

Count of allegations reviewed **Statewide**	
Mental Injury	76
Neglect	528
Physical abuse	282
Sexual abuse	185
Threat of harm	674
Involuntary Seclusion CIC	2
Neglect CIC	34
Physical abuse CIC	26
Sexual Abuse CIC	1
Verbal abuse CIC	5
Wrongful Restraint CIC	6
Grand Total	**1819**

Percentage of allegations reviewed **Statewide**	
Mental Injury	4.2%
Neglect	29.0%
Physical abuse	15.5%
Sexual abuse	10.1%
Threat of harm	37.1%
Involuntary Seclusion CIC	0.1%
Neglect CIC	1.9%
Physical abuse CIC	14.3%
Sexual Abuse CIC	<0.1%
Verbal abuse CIC	0.3%
Wrongful Restraint CIC	0.3%
Grand Total	**1819**

Source: Central Office Founded Disposition Review Results Data, Statewide, Jan. 2020 – Sept. 2024

Oregon Administrative Rule (OAR) allows founded allegations to be overturned for the following reasons:

- The information gathered does not support reasonable cause to believe
- What occurred does not meet the definition of abuse
- The identified perpetrator was not the individual responsible for the abuse
- The identified victim was not the victim of abuse

We then look at the percentage of abuse types reviewed by central office over that same five-year period that were overturned or changed upon review, and we see that the largest percentage of those are neglect and threat of harm. Combined they represent approximately 75% of all overturned or changed dispositions.

Table 14: Number & Percentage of Abuse Types of the Dispositions Overturned or Changed by Central Office, by Year

Abuse type	2020	2021	2022	2023	2024	Total
Mental Injury	7	5	3	6	11	32
Neglect	91	32	37	24	21	205
Physical Abuse	11	7	6	6	6	36
Sexual Abuse	7	8	15	7	8	45
Threat of Harm	43	44	33	38	31	189
Involuntary Seclusion CIC					1	1
Neglect CIC			3	1	1	5
Physical Abuse CIC			7		2	9
Verbal Abuse CIC			1	1	1	3
Total	**159**	**96**	**105**	**83**	**82**	**525**

Abuse type	2020	2021	2022	2023	2024	Total
Mental Injury	4%	5%	3%	7%	13%	6%
Neglect	57%	33%	35%	29%	26%	39%
Physical Abuse	7%	7%	6%	7%	7%	7%
Sexual Abuse	4%	8%	14%	8%	10%	9%
Threat of Harm	27%	46%	31%	46%	38%	36%
Involuntary Seclusion CIC	0%	0%	0%	0%	1%	0.2%
Neglect CIC	0%	0%	3%	1%	1%	1%
Physical Abuse CIC	0%	0%	7%	0%	2%	2%
Verbal Abuse CIC	0%	0%	1%	1%	1%	1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Central Office Founded Disposition Review Results Data, Statewide, Jan. 2020 – Sept. 2024

It is recommended that the current abuse type Threat of Harm be eliminated and the threat of harm language be included in the respective definitions of abuse as an "at risk of" element. For example, if a child is at risk of physical abuse due to physical abuse of a sibling, then this should be included in the definition of physical abuse as an "at risk of physical abuse."

In addition to including an 'at risk of abuse' phrase in each appropriate definition it should include 'imminent risk of serious harm' as the standard versus 'substantial risk'. This modification increasing from substantial risk to imminent risk indicates that there are some immediate safety issues that need to be addressed for the child to remain safe. By increasing the standard to imminent versus substantial risk the founded dispositions will more accurately reflect those instances in which the safety of a child was truly compromised; therefore, leading to more accurate dispositions which should result in a reduction of overturned dispositions on appeal.

By unbundling and reclassifying the existing Threat of Harm abuse category elements that are in the SDM screener guidance into more descriptive categories of abuse—whether the child is at imminent risk of such abuse or has experienced the abuse type—reporting data on these categories will measure the actual safety of the children in Oregon more accurately. This will also help Oregon compare itself more effectively to other state and national child abuse trends.

Table 15: Unbundling & Reclassifying Threat of Harm Categories

Currently Included in TOH	Relabel to:	Captured in Data as:
TOH-Physical abuse	Physical abuse as "at risk of physical abuse"	Physical abuse
TOH-Sexual abuse/exploitation	Sexual abuse as "at risk of sexual abuse or exploitation"	Sexual abuse
TOH-Neglect	Neglect as "at risk of neglect"	Neglect
TOH-Domestic Violence	Neglect as "at risk of DV or IPV"	Neglect

Domestic Violence/Intimate Partner Violence

In Oregon the Threat of Harm definition has typically been used to capture Domestic Violence (DV) or Intimate Partner Violence (IPV) issues. As previously stated, this definition is broad and vague. Generally, threats of harm are included in the neglect or appropriate abuse definition. There are different ways in which states capture the issues of DV and IPV as issues that impact children. Some states utilize the neglect definition to include acts of domestic violence witnessed by children and some states include it in their emotional abuse/mental injury definition. However, in our research we could not find any state that currently has a definition of abuse specific to domestic or intimate partner violence.

The Jurisdictional Advisory Committee (JAC) members felt strongly that DV and IPV were issues that needed to be clearly included in an abuse definition. It is recommended that consideration be given to amending the neglect definition to include the issues of DV and IPV as elements of abuse that cause harm to children that should be specifically addressed.

Neglect/Negligent Treatment

In reviewing Oregon's statutory definition of neglect and the Oregon Administrative Rules (OAR), it was found that Oregon does not include the issues of lack of supervision, failure to protect or any exceptions for poverty, spiritual treatment or age-appropriate independent activities for children/youth. Of importance to note is that poverty is not a crime nor is it negligence. To ensure that CPS and OTIS caseworkers include in their investigations a review of both supervision and protection issues by the parent or caregiver these have been included in the training guidance provided to staff and in the ODHS written rules. The issue of addressing poverty as a circumstance that contributes to neglect is also something that is discussed in the training of child welfare staff and is part of the case consultation discussions that occur as part of an investigation focused on neglect.

According to Chapin Hall, when adding a poverty exception to the neglect definition it is important that communities have strategic practices in place. These include economic and concrete supports, alternative pathways such as alternative response, differential response or community response, a higher standard of proof (from "reasonable cause to believe" to a "preponderance of the evidence") and a higher threshold of harm (from

substantial risk to imminent risk)[4]. As previously stated, CPS intervention should be based on immediate safety issues for the child.

It is recommended that a modification be made to the neglect definition to include language that addresses the caregiver's failure to provide adequate supervision, failure to provide adequate protection, and include language that addresses the need to consider poverty in the assessment and the caretakers ability and willingness to accept financial resources to address the concerns.

Some examples of how other states have included a poverty exception in their statutes are:

- The inability of a parent or caregiver to provide for a child due to inadequate financial resources shall not, for that reason alone, be considered neglect. (Louisiana, Citation: Ch. Code art. 603)
- It is not considered neglect when the failure to provide a child with necessary care, food, clothing, shelter, medical, or dental care is due to poverty. (Wisconsin, Citation: Ann. Stat. § 48.981)
- It is not considered neglect when the parent's failure to provide for the child's needs is due to financial inability, and no services or relief have been offered. (Arkansas, Citation: Ann. Code § 12-18-103)
- Negligent treatment or maltreatment means failure to provide adequate food, clothing, shelter, or medical care that includes medical neglect, and the deprivation is not due to the lack of financial means of his or her parent, guardian, or other custodian. (District of Columbia, Citation: Ann. Code § 16-2301)
- It shall not be considered neglect if failure to provide for the child is caused primarily by financial inability unless actual services for relief have been offered to and rejected by the parent. (Florida, Citation: Ann. Stat. § 39.01)[5]

[4] Cahalane, H., DeGuerre, K., Perry, M. A., &
Briar-Lawson, K. (2023). Case study of child neglect cases in Pennsylvania: A
positive outlier? In K. Briar-Lawson, P. Day, & L. Azzi-Lessing (Eds.), Child neglect, inequity, and poverty: Contextual issues and implications (pp. 377-416). Child Welfare League of America.
https://community.cwla.org/store/viewproduct.aspx?id=21971007

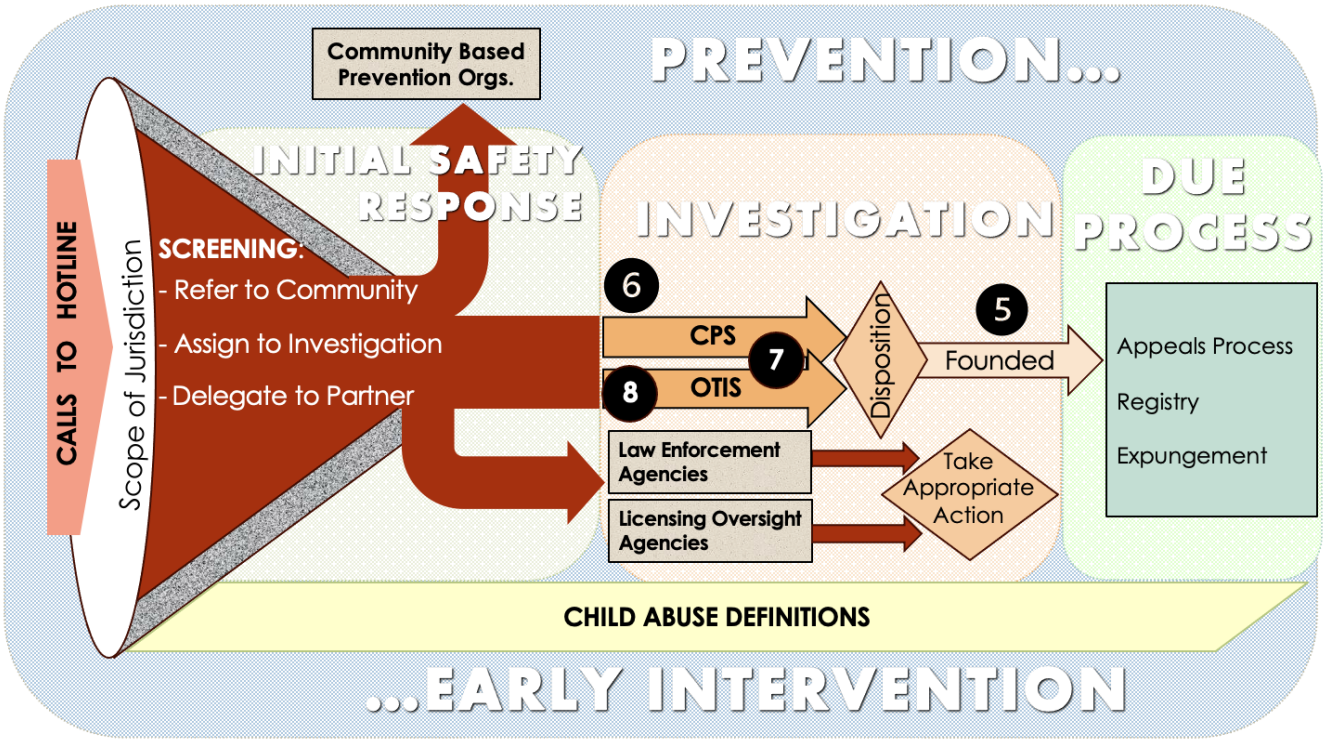
[5] Child Welfare Information Gateway: Definitions of Child Abuse and Neglect: Summary of State Laws
www.childwelfare.gov

Investigation

Table 16a: Investigation Recommendation At A Glance

Recommendation	Description
5. Raise standard of proof for concluding child abuse investigations	Change the standard from reasonable cause to believe to preponderance of evidence.
6. Enhance client rights notification	Convene a work group to explore what rights should be provided to individuals at the beginning of a child welfare investigation.
7. Strengthen implementation of MDT best practices	Improve the consistency of MDT practice statewide by leveraging national best practices
8. Extend SDM model to CPS & explore for OTIS investigations	Promote more consistent and accurate investigation outcomes with the use of SDM tools. Explore possibility of SDM tools for OTIS.

Figure 16b: Investigation Recommendations in Context



Oregon is one of seven states that utilizes "reasonable cause to believe" as the standard to found reports of abuse and neglect.[6] This is considered the lowest standard that can be used in abuse determinations. Most states use "preponderance of evidence" as the standard which is considered a higher standard of evidence than reasonable cause to believe. Reasonable cause to believe is typically used when there is a need for a reasonable basis to act, but not necessarily a fully proven fact. A mandatory reporter may have a reasonable cause to believe abuse has occurred to report it. Preponderance of the evidence requires that the evidence presented demonstrates that something is more likely than not to be true. The evidence shows that a greater than 50% chance or more likelihood that what happened is true.

As was previously stated Chapin Hall research demonstrated that when there are prevention, early intervention and alternative pathways present and effective, modifying the standard of proof and raising the threshold of harm can assist in decreasing the number of children coming into the child welfare system for neglect alone. These families can more appropriately be served through community-based programs offering these interventions and support.

Community-based organizations have begun the work to clarify the resources and support available in Oregon's Prevention Ecosystem. The state should collaborate with these entities to inform of opportunities for public/private partnership in support of child and family well-being.

Currently if a worker makes a founded disposition on an allegation of abuse it does not necessarily mean that the family or the child will be safer or will receive services. The lower threshold of reasonable cause to believe leads to more individuals having founded dispositions but not necessarily an open CPS case, removal from the perpetrator or receipt of services.

The ODHS child welfare also needs to consider full implementation of the use of an evidence-based risk and safety set of tools such as SDM. These tools are

[6] Statutory Analysis Pursuant to Oregon HB 4086 Regarding ODHS Jurisdiction, Bipartisan Policy Center, September 2023

research-based and provide detailed definitions for abuse categories that help the worker to maintain a fair and unbiased perspective about the circumstances. The tools are designed to reduce an individual's biases in their decision making by adhering to the definitions provided. Utilization of these tools to fidelity focuses the efforts of the agency on those children and families most in need of intervention.

The evidence-based decision-making tools in conjunction with a higher threshold of harm assists the agency in identifying those whose immediate safety is compromised and most at risk of future harm if the situation is not remedied. The agency can then focus its efforts on those children and families with higher safety and risk concerns. As stated earlier, government intervention should be reserved for those instances in which a child's safety is compromised.

It is important to state that raising the standard of proof for founding a disposition should have no impact on the threshold for mandated reporting of suspected child abuse. The mandated reporter is not expected to make any determination if suspected abuse meets a specific threshold to report. If abuse is suspected, then it should be reported, and the agency will make a determination based on the information the reporting party provides and utilize the screening tools already in use at ORCAH.

It is recommended that the standard of proof for founding dispositions in Oregon be modified and raised from reasonable cause to believe to preponderance of the evidence once the state has invested in robust prevention, early intervention and alternative pathway programs and services in communities throughout Oregon.

Structured Decision-Making

Oregon child welfare currently utilizes "Structured Decision Making" (SDM), an evidence-based tool developed by Evident Change, at ORCAH for screening child abuse referrals. This tool is the "Intake Assessment". ODHS is currently

working with Evident Change to develop a screening tool that can be used by OTIS as well for the populations on which they complete investigations.

The Structured Decision-Making model for child protection is a suite of decision-support tools that promote safety and well-being for children. The SDM model combines research with best practices, offering workers a framework for consistent decision making and offering agencies a way to target in-demand resources toward those who can benefit most. This evidence-and research-based system identifies the key points in a child welfare case and uses structured assessments to improve the consistency and validity of each decision. The SDM model additionally includes clearly defined service standards, mechanisms for timely reassessments, methods for measuring workload, and mechanisms for ensuring accountability and quality controls. The model consists of several assessments that help agencies work to reduce future system involvement and to safely expedite permanency. (https://evidentchange.org/child-welfare/).

These tools are specifically designed for working with families in a child welfare system. In most jurisdictions all the assessment tools available in SDM are utilized by child welfare as they are a suite of assessments that build off each other throughout the life of a case. In addition to the Intake Assessment the following tools are available: Safety Assessment, Risk Assessment, Family Strengths and Needs Assessment, Risk Reassessment and Reunification Assessment. These set of assessments assist the workers in determining which cases should be investigated, which children should be placed due to safety concerns, and which families require the most intensive services. These assessments are used as benchmarks for the progress, or lack thereof, that the family is making towards addressing the issues that have brought them to the attention of the child welfare agency.

These tools are designed to assist in reducing individual biases and personal experiences from the decision making in that they utilize sets of prescribed definitions for which to apply to the family situation. Then the worker uses the SDM results, clinical expertise and supervisory guidance to determine the course

of action with the family. When used with fidelity these tools narrow the differences in decision making as each worker utilizes the same discreet set of definitions to guide their assessment.

Given that ORCAH is already utilizing SDM for screening of reports to the centralized hotline it is recommended that ODHS child welfare pursue full utilization of all the assessment tools available with Structured Decision Making. This will assist in increasing consistency in decision making on referrals and cases across the state of Oregon. Staff across the state of Oregon should also receive training in the intake assessment tool so that they understand the rationale for the referrals that are assigned for investigation by ORCAH. This would help to improve consistency across the state in what referrals are investigated. A continuous quality improvement (CQI) process is recommended to assess the accuracy and consistency of statewide implementation.

It is recommended that ODHS continue working with Evident Change to explore the possibility of the development of tools for both screening and investigations of allegations of abuse against the populations that OTIS investigates.

Accused Individuals Rights Notification

Currently in Oregon during the initial investigation stage individuals accused of child abuse/neglect are informed about the investigative process that includes but is not limited to what to expect in the investigative process, what information they are allowed to have access to, what a disposition is and if they can challenge the results. The current ODHS rules relate to the internal agency guidelines as opposed to the rights of individuals accused of child abuse. There are currently three different pamphlets that are used by ODHS (CPS and/or OTIS), one for parents, one for third parties, and one for ODHS personnel.

Some states more explicitly convey to accused individuals rights they are entitled to in a child welfare investigation which include but are not limited to their right to have an attorney present, their right to deny access to their children, their right to deny entrance into their home and their right to record their interactions with

CPS at their discretion. Below is a chart that shows some states, (California, Connecticut, Texas) and the rights for accused individuals that are communicated to them prior to an investigative interview. Oregon is included for comparison purposes.

Table 17: State Comparison of Accused Individuals Rights

Information Provided	CA	CT	TX	OR
Right to ask for more information	X			
Right to deny entry	X	X	X	
Right to not speak to investigator		X		
Right to an attorney & to be present for interviews (or home entry)	X	X	X	
Right to deny interview of child in home	X			
Inform that any statement (or failure to cooperate) can be used against them in proceedings (including removal)	X	X		
Inform that investigator cannot provide legal advice		X		
Right to not consent to a drug test	X		X	
Right to refuse medical exam for child	X			
Right to translation services	X			X
Right to reasonable accommodations for disability	X			X
Right to understand what is happening if unable to read	X			
Right to not sign any documents		X		
Right to record any interaction or interview			X	
Right to consult attorney before consenting to voluntary safety plan			X	

There are of course circumstances in which the provision of these rights may compromise any criminal investigation that may need to occur if the allegations are of a criminal nature. In those instances, CPS generally coordinates their investigations with law enforcement so as not to compromise the criminal investigation.

Informing them of their rights may assist in de-escalating an individual that is angry, it may assist in enhancing the individual's engagement with the case

worker, and it may assist in leveling the playing field some by giving the individual some of their power back in a situation in which they may feel powerless. These are all beneficial to the investigation as a whole and to the welfare of the child(ren) who are the subject of the investigation.

It is recommended that the agency convene a work group to discuss and identify what rights should be provided to individuals involved in a child welfare investigation in Oregon under Oregon law. This workgroup should include representation from clients' rights attorneys and attorneys familiar with the child welfare system. Some potential issues that the workgroup may want to consider are the following:

- Should accused individuals be informed that there will be a dispositional finding from the investigation, the potential of their name on a registry and what potential impact it could have on them?
- Should accused individuals be provided with information about support available in the community that they may reach out to for assistance through the investigative process?
- Should accused individuals be provided with written information that is understandable, in their primary language and should it be verbally reviewed with them to ensure their understanding?
- Should accused individuals be informed that information they share can be used in a court proceeding?
- Should accused individuals be informed of their right to appeal a founded disposition?

Multidisciplinary Teams

Oregon currently utilizes The National Children's Alliance (NCA) standards for their Multidisciplinary Teams (MDT). This is another area that can be strengthened in the investigative process of child abuse cases in Oregon. The NCA provides accreditation standards for Children Advocacy Centers (CAC) that require a multidisciplinary approach to child abuse response, including representation from law enforcement, CPS, prosecution, medical, mental health,

victim advocacy and the CAC itself. These standards ensure a coordinated, culturally competent and trauma-informed response to child abuse allegations. The MDT coordinates efforts to avoid duplication of interviews and ensures that services like forensic interviews, medical evaluations, and mental health services are provided in a coordinated manner. The MDT also ensures that all services are culturally competent and accessible to all CAC clients. Currently, Oregon has an MDT in each county of the state that is by statute to be organized and led by the district attorney's office.

During the study process a survey was conducted to determine the utilization and quality of MDTs throughout the state. Participants who responded to the survey included staff from the following agencies: ODHS, CPS, DA, Child Advocacy Center, ODHS OTIS, Education, Law Enforcement, Victim Services, and Public Health.

The results of the survey showed that most counties in the state are conducting MDTs, some more regularly than others. The survey results revealed that there is a lack of standardization and adherence to the NCA standards across the state. These are some themes that emerged from the survey:

- There is a lack of clarity around the purpose of the MDT – this ranged from being a forum to critique the child abuse investigation, to a focus on prosecutorial outcomes, to a planning venue for family-centered and child-focused interventions.
- There is a wide span in how the MDTs are structured – from formalized forensically focused trauma-informed MDT's, to referral driven ad hoc MDT's, to informal staffing.
- There is a significant variation in the quality of collaboration – from tense conflict filled sessions marked by mistrust, to smooth proactive interactions around a shared purpose.
- There is inconsistent participation from key partners – from regular tightly honed teams to partners lacking capacity to meet the demand, to a diminished sense of urgency to come together.

ODHS is currently convening work groups to address these issues. We recommend that the statewide MDT framework that mirrors the NCA standards be adopted by all MDT's. This will guide consistency and quality for MDTs across counties. This framework should establish a shared purpose for conducting an MDT, and in which all participants' contributions are valued and assist in ensuring child-focused interventions.

Partnership roles should be clarified, and clear responsibilities be identified for leading, facilitating, sharing power and participating in the MDT. The MDT should be child and family focused and avoid shaming and blaming of agency participants. Processes need to be established or clarified, and standards identified for sharing of information, partner expectations, timelines and confidentiality.

In addition, case referral criteria should be defined to ensure that the most appropriate cases are identified and referred for an MDT. These criteria should be shared widely with all agencies that participate in the MDT. Tribal partners should be included in all instances involving an Indian child. Lastly there should be the development of standard processes for conflict resolution.

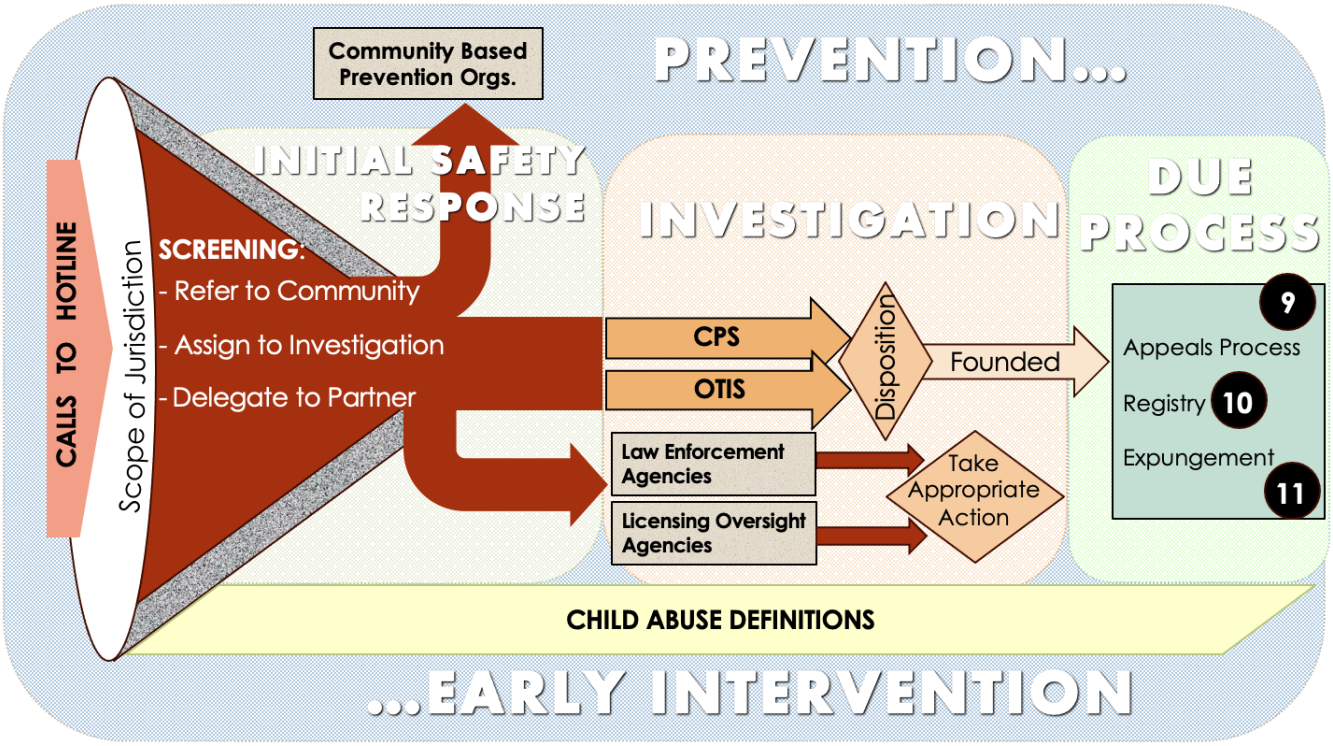
Once these recommendations are in place, utilizing the principles of implementation science, quarterly check-in meetings should occur to see if the MDT process is improving, what needs to be worked on, what needs to be modified or changed, what is working well, leading to the development of a plan to address the identified areas of need. Once the MDTs across the state are working well the establishment of an annual self-assessment of the statewide MDT processes and protocols should be conducted and informed from the perspectives of all MDT partners.

Due Process

Table 18a: Due Process Recommendation At A Glance

Recommendation	Description
9. Streamline appeal process	Simplify and consolidate the appeal process used for CPS and OTIS cases.
10. Establish child abuse registry	Create a more transparent and formalized repository of founded child abuse allegations.
11. Establish expungement protocol	Convene a work group to develop criteria and procedures for when expungement of founded allegations can occur.

Figure 18b: Due Process Recommendations in Context



Due Process Rights Post Investigation

As was discussed earlier in this report, Oregon should consider improving the due process rights for individuals accused of child abuse/neglect. The following are all areas of recommended improvement.

Appeals Process

Currently in Oregon an individual with a founded or substantiated abuse finding is supposed to receive notice of their rights to appeal at the completion of an investigation

by CPS or OTIS. This notice provides the individual with their appeal rights and the timeframe in which they must submit their request to appeal.

Currently there are two separate appeal processes, one for CPS founded dispositions and one for OTIS founded/substantiated dispositions. CPS investigations generally focus on familial allegations of abuse whereas OTIS investigations generally focus on third party allegations of abuse. Both CPS and OTIS are housed in the ODHS agency; however, OTIS is not a part of child welfare and has its own rules, guidance and structure. As a result, it is entirely possible that an individual could have a founded disposition in both CPS and OTIS and may need to pursue two different appeal processes to challenge the founded or substantiated dispositions. The following are some examples of when this can occur:

- A CW certified resource parent has youth placed with them and an unrelated child is visiting the home, and an incident occurs. OTIS will investigate the unrelated child, and CPS will do an assessment on any youth placed with the resource parent.
- An in-home daycare provider with their own children is investigated by OTIS for the daycare children and assessed by CPS for biological children.
- A parent is driving impaired with their own children and their children's friend is in the car, there is a car accident and one of the biological children are killed. OTIS investigates the children's friend CPS assesses the biological children.

The current appeals process for both CPS and OTIS consists of approximately five steps. Due to the length of this process individuals can be negatively impacted especially in their employment while in the appeal process. Additionally, there is currently no assistance available to individuals who want to pursue an appeal for a founded or substantiated disposition other than their own resources if they can afford such assistance.

It was previously recommended that the use of Substantiated, Unsubstantiated and Inconclusive terminology be eliminated and that both CPS and OTIS utilize Founded, Unfounded, and Unable to Determine terminology for all investigations. The consistent use of terminology for founded dispositions can help in reducing the confusion for individuals' appealing dispositions along with clear explanations of the two separate investigation processes and the context for those investigations.

It is also recommended that ODHS create a single standard appeal process for all founded dispositions. The appeal process for CPS should be streamlined to a three-step process that involves a local office review, appeals that move beyond the local review should then be heard by an administrative hearing officer with prior CPS experience, and then if upheld move to circuit court if the individual wants to continue to appeal. These changes could be beneficial to family members who have been separated from their family, may have an interruption in their employment or have been removed from participating in a volunteer capacity as a result of the founded disposition.

For OTIS since they are centralized, founded dispositions should be reviewed by a manager outside of the chain of command, appeals that move beyond the manager should be heard by an administrative hearing officer with prior CPS experience, and then if upheld move on to circuit court if the individual wants to continue the appeal. This would allow for a timelier and expedited process for both CPS and OTIS appeals. These changes could be beneficial to professionals who are pursuing an appeal and have been temporarily removed from their work environment because of the founded disposition.

It is also recommended that the appeal process contains strict timelines once the appeal request is received that are adhered to by the agency. The burden of timely resolution on an appeal should be on the agency and not on the individual appealing the disposition. Due to the potential adverse effects on the livelihood of decisions should be as expeditious as possible. Oregon may also want to consider possible consequences for the agency's failure to meet appeal timelines.

Consideration for extending timeframes for which an individual may appeal a founded disposition is also recommended. Many individuals going through an abuse investigation are traumatized and may not have the emotional or psychological strength to go through an appeal process at that time. Circumstances change in a person's life and having an ability to appeal at a later point in time may be beneficial to the individual.

It is also recommended that the investigative dispositional burden of proof and the appeals process burden of proof be consistent. The utilization of the 'preponderance of evidence' standard would be consistent with the courts.

Lastly, it is recommended that information be provided to individuals upon receipt of their dispositional finding that informs them of their right to appeal, the timeframes for appealing, their right to have representation legal or otherwise, and resources that are available to them that can assist in navigating the appeal process to ensure equity for all individuals appealing a founded disposition.

Child Abuse Registry

Oregon's current child abuse registry is located within the ODHS information system for CPS (OR-KIDS) and ODHS allows identified ODHS and Oregon Health Agency (OHA) personnel to access this information under specific circumstances. This information is generally accessed for the purposes of background checks for potential employees, providers, volunteers, or contractors seeking employment or participation in specific agencies or settings, working with or in proximity to children as defined in ORS 409.025(3). This information is also used by CPS and OTIS in their investigations to review prior history on an individual prior to starting an investigation. Additionally other agencies such as education and early childhood education have their own systems for completing background reviews.

The Washington and Lee Law Review, Volume 77; Issue 2; Article 7 published an article in April of 2020 titled "Inadequate Protection: Examining the Due Process Rights of Individuals in Child Abuse and Neglect Registries". In this article they explore due process protections for individuals accused of child abuse, and the processes that exist to be placed on or removed from a registry.

The authors cited two main areas of registry impacts on individuals regardless of where these are housed or how they are constructed. These impacts are:

- Child abuse and neglect registries are used for employment screening in fields involving childcare and protective investigations, and
- Errors in registry inclusion can lead to significant reputational harm and employment restrictions without adequate procedural safeguards.

In Oregon, there is a 30-year record retention policy; however, other than the appeals process there is no other mechanism for an individual to be removed from the central registry. There is no expungement process or protocol in place. This means that an

individual remains on the registry in perpetuity regardless of their circumstances in the future.

Maintaining the registry in ODHS/CPS creates a challenge for expungement in that CPS agencies should and do maintain their records for the purposes of preserving the history for future investigations. However, there cannot be an expungement process if the registry is maintained by CPS.

Therefore, it is recommended that Oregon consider the development and implementation of a registry that is separate from the CPS registry and would allow for access and use by state licensing agencies and other specific agencies for the purpose of completing background checks for professionals working in fields with access to vulnerable populations and children. In some states these registries are maintained separately in the human services agency and in others with the department of justice. These registries are still not public facing, are confidential and allow very specific limited access for background check purposes.

It was recommended earlier in this report that Oregon raise the standard of proof for a founded case from 'reasonable cause to believe' to 'preponderance of the evidence'. According to the Washington and Lee Law Review article, over 29 states require a higher burden of proof to place an individual's name on the child abuse registry. Oregon should follow suit and raise their standard of proof for child abuse findings and for placement on their registry. Raising the standard of proof for both dispositional findings and appeals findings can assist in ensuring individuals who are placed on the registry present a clear safety threat to children.

Expungement

The current ODHS CPS information system (OR-KIDS), which is the centralized registry, maintains the data on founded/substantiated dispositions in perpetuity. Other than the appeals process there is not a protocol or any criteria for expungement from the records. An individual who has a founded/substantiated dispositional finding will remain in the OR-KIDS database up to 30 years which is the current record retention policy. This is appropriate for a CPS agency as they want to preserve the history of individuals investigated and the dispositions to reference future investigations.

The lack of a separate registry and protocol for expungement is concerning overall but especially for minors who are currently labeled as child abusers and will remain even

after they have reached the age of majority and may not even know that they are included in this database.

Oregon should consider the long-term implications of individuals whose names are maintained on a registry forever. This does not allow for an individual's growth and development throughout their life and the possible change that can come with that.

- CAPTA requires states to have "provisions…[for]…prompt expungement of any records that are accessible to the general public or are used for purposes of employment or other background checks in cases determined to be unsubstantiated or false…(except to keep such files for State CPS use in future risk and safety assessments)".

Below is a chart that shows the registry and expungement practice from the comparison states of California, Connecticut, Iowa and Vermont.

Table 19: Comparison States Registry & Expungement Practices

Registry & Expungement Practices	CA	CT	IA	VT
PLACEMENT OF FINDINGS ON REGISTRY				
Only substantiated reports	X	X	X	X
Substantiated findings where abuser poses a risk to children		X		
All administrative appeals have been exhausted		X		
Minor perpetrators of physical abuse/neglect likely to reoccur			X	
Minor perpetrators of sexual abuse (<13 y/o name withheld; 14-17 y/o name withheld if court finds good cause)			X	
REGISTRY EXPUNGEMENT				
No expungement policy		X		
Expungement of founded reports after a specified number of years	X		X	
Expungement timeframe is 5-30 years based on abuse severity			X	
Automatic expungement based on perpetrators age at time of incident & no subsequent report	X			X

Source: Child Welfare Information Gateway

It is recommended that Oregon consider a work group that can further explore expungement practices and develop criteria for possible registry expungement. These criteria should include but not be limited to consideration of the type of abuse, subsequent reports, age of perpetrator at time of incident and the existence of any subsequent reports for that individual (specifically for minors).

Implementation Considerations

The recommendations on their own each point to a desired outcome: the route to achieving these outcomes is a well-crafted, strategically designed implementation plan. While it is beyond the scope of this report to create this plan, we've gleaned many insights about implementation through the course of the jurisdiction study and feel these fit well within a framework built on several principles of implementation science.

Implementation Science Framework

Successful implementation processes are comprised of four distinct components:

1. **Implementation Stages**: Implementation processes occur across four distinct stages, each requiring strategic planning.
   - Exploration: Assessing readiness for change and identifying the best interventions for the target population.
   - Installation: Preparing the necessary infrastructure, training, and resources for implementation.
   - Initial Implementation: Piloting practices and addressing early challenges.
   - Full Implementation: Ensuring interventions are consistently applied across the system.
2. **Fidelity and Adaptation**: Fidelity refers to implementing an intervention as intended by its developers, while adaptation reflects the necessary changes to fit local contexts.
3. **Implementation Drivers**: The core infrastructure elements that support successful implementation. These drivers relate to:
   - Competency: Training, coaching, and ongoing support for staff
   - Organization: Policies, practices, and data systems to sustain practices
   - Leadership: Guidance and advocacy from leaders to champion new interventions
4. **Continuous Improvement**: Using data to guide decision-making, monitor progress and refine interventions. Continuous improvement loops involve collecting feedback, analyzing outcomes, and making necessary adjustments.

Following this roadmap for successful implementation ensures that the shift from focusing on the "what" of a policy or practice change to the "how" goes smoothly and considers the critical success factors that help put an initiative on the ground. In

addition, well-crafted implementation plans account for complex environments, uneven resources, and urgent needs for improved outcomes. Finally, bringing recommendations to life with a solid implementation plan helps evidence-based practices be more effective by addressing each component of implementation.

General Implementation Considerations for All Recommendations

The following are considerations that apply to the entirety of the jurisdiction recommendations, in whatever way they are clustered or timed in an implementation plan.

- Consider launching an ongoing work group to develop an implementation plan to share with the legislature during the 2027-29 long session. Include interested members of the Jurisdiction Advisory Committee and other stakeholders with vested interest or hands-on involvement.
- Design the milestones and timelines of the overall implementation plan according to priorities determined by weighing several critical and interdependent factors related to the recommendations, including:
    - Short-, medium-, or long-term timeframe to reach full implementation
    - Pre-existing work toward efforts or initiatives already underway
    - Estimated cost to reach full implementation
    - Array of partners or stakeholders needed and willing to be involved in implementation
- In short order, organize around implementing the recommendations (or portions of recommendations) that ODHS can implement without legislative change.
- Several recommendations cluster into similar or overlapping topic areas. For instance, six recommendations all pertain to narrowing the scope of jurisdiction for child abuse investigations (1, 2a 2b, 3a, 3b, 4e: see chart on page 5 or 62 for details). Consider exploring additional approaches to organizing implementation by groups of related recommendations.
- Because child abuse investigations involve multiple partners across various agencies, it's critical to involve consistent representation from these agencies in the development of implementation work groups.
- Because child abuse investigations involve an array of partners across different agencies, maintaining an active communications plan is critical to a smooth implementation phase. Developing this communication plan early (e.g. Oct 2025-Feb 2026) enables communication materials to be created for various stakeholder audiences to share change initiatives underway.

- Almost without exception, implementation of any of these recommendations will require a robust and ongoing training component. This should include both people directly involved with practice changes and stakeholders or community partners who can benefit from a deep understanding of new policies and procedures.

Implementation Considerations for Specific Recommendations

The following implementation considerations were gleaned from discussions with the Jurisdiction Advisory Committee, consultations with stakeholders and content experts, and themes the facilitators gathered over the course of the entire study. Recommendations are identified by number and short title: to see more complete descriptions, refer to Table 3 on page 5.

1. Bring Alternative Pathways to Scale
    - Pay close attention to deliberate planning around key stages of implementation for any future alternative response pathway such as:
        - Explore readiness for change, define target populations, and clearly specify alternative response protocols.
        - Install necessary infrastructure, accessible training and coaching supports, and sufficient resources for consistent implementation statewide.
        - Pilot test new practices to address early challenges, adjust implementation components, and learn from small scale installation.
        - Bring new practices to scale in ways that maintain fidelity and are consistently applied and supported across urban and rural areas alike.
    - Use neutral language to name the new alternative pathway initiative to avoid triggering negative assumptions from the past about Differential Response (DR).

2a. Narrow span of child welfare scope of jurisdiction; 3a. Share responsibility for safety concerns; 3b. Allow certain investigations to be performed by other safety partners

- Add specifics of what law enforcement agencies (LEA) would be required to do when a report is referred to them from ODHS: accept referral, conduct investigation, document action taken.
- Create MOUs between ODHS and LEAs across Oregon to delineate how the narrow set of non-familial third party "other" investigations (acquaintance, online, and stranger/unknown) will be handled; LEA conducts criminal investigations under ORS 163.
- Utilize MDTs as forum locally for confirming follow-through and appropriate action taken by LEAs.

- Training will be needed for all parties involved in investigations to reinforce the narrower scope of jurisdiction for ODHS and how these incidents will now be investigated.
- Identify and raise awareness across the span of licensing entities who will receive request for investigation of licensing violations from ODHS.

3c. Use Single Terminology for Disposition Findings

- Training will be needed for anyone involved in investigations to understand the use of single terminology for dispositions made by OTIS or CPS.
- In educational settings, the Dept of Education would like to see more deliberation, specialized units, or other refinements to handle abuse allegations in school settings, especially against teachers.

4a. Account for 418 Definitions in 419B

- Conduct a deliberate transition plan that carefully determines which elements of 418 are subsumed under 419B and which elements of 418 statute remain. Create a workgroup to analyze both sets of child abuse and neglect definitions to determine exactly how to consolidate into one combined set.

4b. Reclassify Threat of Harm Definition (specifically, changing substantial risk to imminent risk)

- Ensure sufficient licensing oversight and caseworker/child regular contact provisions are being practiced when children are placed in out of home care. If a concern arises that does not rise to level of imminent risk of serious harm, but still indicates a performance issue, the appropriate oversight authority can take action. It shouldn't take a disposition of abuse to trigger corrective action on the part of oversight agencies. This will help ensure safety proactively, rather than reactively.
- Examine how OTIS currently investigates safety concerns in out of home placements to ensure children are protected from future harm (e.g., putting home on hold, banning further placements until investigation concluded, possible removal of children currently placed in home in question).
- Ensure adequate information sharing so that licensing entities can view history, patterns, and other factors to put sanctions or other interventions in place without relying on a dispositional outcome by OTIS for their actions.

4c. Refine Neglect Definition

- The State of Oregon will need to explore how to include the exception for poverty in its neglect definition.

4e. Remove Seclusion & Restraint as Abuse Types

- Further development and design of the specific protocol for handling seclusion & restraint incidents needs to be fleshed out.

- This is a practice issue that should be addressed through ODHS policy & procedure regarding communication protocols for responding to a critical incident for a child who is a ward.

5. Raise Standard of Proof for Child Abuse Investigations
    - Conduct a more thorough study of the implications of raising the standard of proof for determining allegation dispositions; relate to CPS & OTIS decisions as well as mandatory reporter standards.
6. Enhance Client Rights Notification
    - Convene a workgroup to more thoroughly identify which rights under state and federal law are afforded individuals who are the subject of a child abuse investigation and when in the investigation process the individual should be made aware of those rights.

8. Extend SDM Model to CPS and Explore for OTIS Investigations
    - Design SDM training so that child welfare staff can identify issues of clear neglect, versus issues solely related to poverty.
    - Consider integrating a Continuous Quality Improvement process as part of implementing the SDM model.
    - ODHS should continue exploring with Evident Change the possibility of developing SDM tools for the populations OTIS investigates.

11. Establish Expungement Protocol
    - The work group should explore how to address past cases (e.g. minors as perpetrators, or restraint/seclusion) and cases going forward in the development of an expungement process.

Conclusion

Reflections on the Scope of Jurisdiction Study

The HB 4086 Jurisdiction Advisory Committee (JAC) has undertaken a comprehensive study to strengthen Oregon's child welfare/OTIS child abuse investigation processes, with a core focus on child safety. Through rigorous analysis and collaboration with a diverse group of stakeholders, the JAC has developed a set of recommendations aimed at improving the effectiveness and efficiency of child abuse investigations in Oregon.

Key recommendations include expanding community-based prevention networks, narrowing the scope of jurisdiction for child welfare, and sharing responsibility for safety concerns with law enforcement and other relevant agencies. The JAC also emphasizes the importance of using a single set of dispositional findings, modifying child abuse definitions to include imminent risk language, and enhancing client rights notification.

The implementation of these recommendations will require careful planning and collaboration among various agencies and community partners. By adopting these changes, Oregon can create a more responsive and effective child protection system that prioritizes the safety and well-being of children and families.

The JAC's work reflects a commitment to continuous improvement and a dedication to ensuring that all children in Oregon are protected from harm. The recommendations provided in this report offer a clear path forward for enhancing the state's child abuse investigation processes and ultimately achieving better outcomes for children and families.

Table 20: Complete List of Scope of Jurisdiction Recommendations

Recommendation	Description
1. Bring alternative pathways to scale	Expand community-based prevention network to formally respond to families in need of assistance.
2. Modify Scope of Jurisdiction for Child Welfare	
a. Narrow span of child welfare scope of jurisdiction	Allegations involving persons who do not have a caregiving role or any familiarity with the child would only be investigated by law enforcement.
b. Name perpetrators in statute	Clarify in statute who can be the subject of an allegation of child abuse to match the scope of jurisdiction.
c. Address child on child abuse	Children would no longer be alleged perpetrators of child abuse unless they are acting in a parental capacity, above a certain age acting in a caretaking role or under specific circumstances related to child trafficking.

Recommendation	Description
3. Share Responsibility for Investigations	
a. Share responsibility for safety concerns	Lift statutory requirement that ODHS must issue dispositions on all screened in child abuse allegations
b. Allow certain investigations to be performed by other safety partners	Under specific conditions, ODHS has the discretion to defer investigations to LEA or appropriate licensing entities without completing a CPS investigation.
c. Use single terminology for dispositional findings	Both CPS and OTIS would use the terms "founded", "unfounded", and "unable to determine".
4. Modify Child Abuse Definitions	
a. Account for 418 definitions in 419B	Streamline child abuse definitions into a single set
b. Reclassify threat of harm definition	Include imminent risk language and distribute threat of harm content to standard child abuse categories.
c. Refine neglect definition	Amend neglect definition to include caregiver's failure to provide adequate supervision and failure to provide adequate protection.
d. Add poverty exception to neglect definition	Add poverty exception language to the Neglect definition.
e. Remove seclusion & restraint as abuse types	Define wrongful restraint and involuntary seclusion as licensing violations, rather than child abuse in all settings.
5. Raise standard of proof for concluding child abuse investigations	Change the standard from reasonable cause to believe to preponderance of evidence.
6. Enhance client rights notification	Convene a work group to explore what rights should be provided to individuals at the beginning of a child welfare investigation.
7. Strengthen implementation of MDT best practices	Improve the consistency of MDT practice statewide by leveraging national best practices
8. Extend SDM model to CPS & OTIS investigations	Promote more consistent and accurate investigation outcomes with the use of SDM tools. Explore possibility of SDM tools for OTIS.
9. Streamline appeal process	Simplify and consolidate the appeal process used for CPS and OTIS cases.
10. Establish child abuse registry	Create a more transparent and formalized repository of founded child abuse allegations separate from the CPS registry.
11. Establish expungement protocol	Convene a workgroup to develop criteria and procedures for when expungement of founded allegations can occur.

Appendix

Recommendation Validation Findings – Jurisdiction Advisory Committee

Using an online survey tool in two parts (First Half; Second Half), JAC members submitted their recommendation validation choices (Accept As Is, Accept with Conditions, Oppose) along with details about suggested edits or counter-proposals. JAC members had the opportunity to update their initial validation choices based on subsequent revisions of the report. Some members chose to abstain from specific questions or the survey altogether.

Recommendation	Accept As Is	Accept with Conditions	Oppose
1. Bring alternative pathways to scale	9	9	0
2a. Narrow span of child welfare scope of jurisdiction	10	7	1
2b. Name perpetrators in statute	11	5	1
2c. Address child on child abuse	9	5	0
3a. Share responsibility for safety concerns	11	6	1
3b. Allow certain investigations to be performed by other safety partners	11	6	0
3c. Use single terminology for dispositional findings	11	6	0
4a. Account for 418 definitions in 419B	12	5	1
4b. Reclassify threat of harm definition	11	4	1
4c. Refine neglect definition	10	6	0
4d. Add poverty exception to neglect definition	12	4	1
4e. Remove seclusion & restraint as abuse types	10	5	1
5. Raise standard of proof for concluding child abuse investigations	7	7	1
6. Enhance client rights notification	8	7	0
7. Strengthen implementation of MDT best practices	11	3	0
8. Extend SDM model to CPS & OTIS investigations	9	5	0
9. Streamline appeal process	12	3	1
10. Establish child abuse registry	9	6	0
11. Establish expungement criteria	8	6	0

HB 4086 MDT & Due Process Survey

This survey was distributed statewide through networks to which the JAC members had access. A total of 160 respondents from around the state completed the survey. A discussion of the survey results occurred during the May 2025 JAC meeting and can be viewed on the state website.

HB4086 - Children and Adolescents Exhibiting Complex Sexual Behavior: A review of services, interventions, and system responses

The HB 4086 Complex Sexual Behavior committee was a parallel group to the JAC. They produced a significant report, which can be found here:
https://www.oregon.gov/odhs/agency/Pages/hb4086-cecsb.aspx

Comparison of Other State's Definitions of Persons Responsible for Care

State & Citation	Definition of Persons Responsible for the Child
State**: New Hampshire** Citation**: Rev. Stat. § 169-C:3**	'A person responsible for a child's welfare' includes the child's parent, guardian, or custodian, as well as the person providing out-of-home care of the child, if that person is not the parent, guardian, or custodian. For purposes of this definition, 'out-of-home care' includes child daycare and any other settings in which children are given care outside of their homes. The term 'parent' means mother, father, adoptive parent, or stepparent, but the term shall not include a parent whose parent-child relationship has been terminated by judicial decree or voluntary relinquishment. 'Household member' means any person living with the parent, guardian, or custodian of the child from time to time or on a regular basis who is involved occasionally or regularly with the care of the child.
State: **Massachusetts** Citation: **Ann. Laws Ch. 119, § 51A; Code of Mass. Regs. Tit. 110, § 2.00**	Responsible persons include the parent and any other person responsible for the child's care. *In regulation:* The term 'caretaker' (caregiver) means: • A child's parent, stepparent, or guardian • Any household member entrusted with the responsibility for a child's health or welfare • Any other person entrusted with the responsibility for a child's health or welfare, whether in the child's home, a relative's home, a school setting, a daycare setting (including babysitting), a foster home, a group care facility, or any other comparable setting The term 'caretaker' includes, but is not limited to, teachers, babysitters, school bus drivers, camp counselors, etc. The 'caretaker' definition is meant to be construed broadly and inclusively to encompass any person who is, at the time in question, entrusted with a degree of responsibility for the child. This specifically includes a caregiver who is a child (e.g., a babysitter who is under age 18).
State: **Minnesota** Citation: **Ann. Stat. §§ 260E.03; 260C.007, Subd. 17**	'Person responsible for the child's care' means the following: • An individual functioning within the family unit and having responsibilities for the care of the child, such as a parent, guardian, or other person having similar care responsibilities • An individual functioning outside the family unit and having responsibilities for the care of the child, such as a teacher, school administrator, other school employees or agents, or other lawful custodian of a child having either full-time or short-term care responsibilities including, but not limited to, daycare, babysitting (paid or unpaid), counseling, teaching, and coaching

	'Family or household members' means spouses, former spouses, parents and children, persons related by blood, persons who are presently residing together or who have resided together in the past, and persons who have a child in common regardless of whether they have been married or have lived together at any time.

State: **Tennessee**
 	
Citation**: Ann. Code §§ 37-1-102; 37-1-602**
	'Caregiver' means any relative or other person living, visiting, or working in the child's home who supervises or otherwise provides care or assistance for the child, such as a babysitter, or who is an employee or volunteer with the responsibility for any child at an educational, recreational, medical, religious, therapeutic, or other setting where children are present. 'Caregiver' also may include a person who has allegedly used the child for the purpose of commercial sexual exploitation of a minor or trafficking a minor for a commercial sex act, including, but not limited to, as a trafficker. For purposes of this chapter, 'caregiver' and 'caretaker' shall have the same meaning.
	A related caregiver shall include the child's birth, step, or legal grandparent; great grandparent; sibling; aunt; uncle; or any other person who is legally or biologically related to the child.
	Responsible persons include any of the following:
	• The child's parent, relative, guardian, or caregiver
	• A person with whom the child lives
	• Any 'other person responsible for a child's care or welfare' that includes, but is not limited to, the following:
	  • A legal custodian or foster parent
	  • An employee of a public or private child care agency or public or private school
	  • Any other person legally responsible for the child's welfare in a residential setting