



Oregon

Kate Brown, Governor

Department of Human Services

Office of the Director

500 Summer St. NE, E-15

Salem, OR 97301

Voice: 503-945-5600

Fax: 503-581-6198

Legislative Report

Department of Human Services

Child-Caring Agency Licensing Investigation Quarterly Report

to Interim Legislative Committees on Child Welfare

Reporting period: July 1, 2017-September 30, 2017
October 20, 2017

Senate Bill 1515, Effective April 4, 2016 following enacted from the 2016 Regular Legislative Session, directs the Department of Human Services (DHS) to submit a quarterly report to the interim legislative committees on child welfare. Section 58 of the bill prescribes an effective date of July 1, 2016 for certain parts of the bill, including Section 38 which contains the quarterly reporting provision.

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

Information provided in this report contains:

- (a) The name of any child-caring agency or proctor foster home where the department conducted an investigation pursuant to section 37 of this 2016 Act that resulted in a finding that the report of abuse was substantiated during that quarter;
- (b) The approximate date that the abuse occurred;
- (c) The nature of the abuse and a brief narrative description of the abuse that occurred;
- (d) Whether physical injury, sexual abuse or death resulted from the abuse; and
- (e) Corrective actions taken or ordered by the department and the outcome of the corrective actions.

Time Period: CCA/CCP Abuse Reports Closed from July 1, 2017 through September 30, 2017

Summary: 6 CW/OAAPI investigations with 14 substantiated allegations

Note:

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

Report # Allegation # (substantiated)	Provider	Approximate date abuse occurred	Nature of abuse and brief narrative	Did physical injury, sexual abuse or death result?	Corrective actions taken or ordered by the department, and outcome
CCA170030 Allegation 2	Janus Youth Programs	Between June 2016 and	One allegation of Neglect as defined in OAR 407-045-	No.	Upon learning of the allegations Janus Youth Programs management

		December 2016	0820(1)(b) and (14)(a) was substantiated because a program staff engaged in an inappropriate emotional relationship with a child receiving care from the program which interfered with the child in care's treatment and contributed to risk of negative outcomes to the child.		coached the employee with regard to appropriate boundaries and later moved the identified employee to another worksite where the employee would not be in contact with the identified youth while the investigation continued. The employee left employment with Janus Youth Programs prior to the conclusion of the investigation.
CCA170055 Allegation 1 Allegation 3 Allegation 6	Janus Youth Programs	June 2017	Three allegations of Neglect as defined in OAR 407-045-0820(1)(b) and (14)(a) were substantiated, because on two instances a program staff failed to provide adequate	No.	Upon learning of the identified employee's failure to supervise, Janus management met with the employee to re-train the employee on the subject of supervision protocols and to reinforce the overall importance of strict and constant

			<p>supervision to three children receiving care from the program, resulting in the children engaging in sexual contact with each other which was detrimental to their treatment goals.</p>		<p>supervision of the population served by the facility. Similar re-training was provided to all staff at the facility a short time later. The youth involved in the incidents were terminated from the program and moved within 2 days of management becoming aware of the incidents. The report of alleged neglect was recently substantiated following the investigation, in light of the substantiation, Janus management is consulting internally with the Janus human resources office to determine an appropriate course of action. Janus is aware that they must initiate a new background check and fitness determination by the</p>
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					DHS Background Check Unit (BCU). This incident of substantiated neglect will be considered by the BCU in the course of a fitness determination.
CCA170056 Allegation 1 Allegation 2 Allegation 3	On Track – Teens Program	03/23/2017	Three allegations of Neglect as defined in OAR 407-045-0820(1)(b) and (14)(a) were substantiated, because a program staff allowed three children receiving care from a drug and alcohol oriented treatment program to skip a therapeutic meeting and, instead, go to the staff's private home, where the staff pretended to smoke marijuana using a pipe in the home and offered	No.	The identified care-giver's employment was terminated immediately following the incident described in the report. At the time the report was initially screened, DHS was moving toward revoking On-Track's Child Caring Agency license due to a pattern of non-compliance and the program's failure to adequately address numerous on-going concerns. DHS issued a notice of intent to revoke the license on April 8 th , 2017. Subsequent to DHS issuing the notice, the Oregon Health Authority issued a formal restriction on new

			the children chocolate candies containing alcohol, all of which was detrimental to the children's treatment goals.		admissions to the program where the incident described in the report occurred. Ultimately On-Track voluntarily closed the program as part of a legal settlement with DHS.
CCA170081 Allegation 1 Allegation 2 Allegation 5 Allegation 6 Allegation 7	Morrison Center	Various 2017	Two allegations of Involuntary Seclusion as defined in OAR 407-045-0820(1)(i) and OAR 407-045-0820(22) were substantiated, because a proctor foster parent locked two foster children in their rooms repeatedly for discipline and the convenience of the foster parent. In addition, two allegations of Physical Abuse as	No.	When Morrison Child & Family Services was made aware of the reported involuntary seclusion of children in the identified foster home, Morrison ensured the practice ceased and increased oversight of the home. When Morrison was subsequently made aware of the alleged physical abuse that came to light in the course of the investigation, Morrison moved the children to a different foster home and did not place other children in

			<p>defined in OAR 407-045-0820(1)(d) were substantiated, because the proctor foster parent willfully inflicted pain on the two foster children by showering them with cold water. One more allegation of Physical Abuse as defined in OAR 407-045-0820(1)(d) was substantiated, because the proctor foster parent willfully inflicted pain on one of the foster children by covering the child's face with the foster parent's hand and with a pillow.</p>		<p>the home. Morrison ultimately terminated the certification of the identified foster parent. In addition Morrison has enhanced its procedures for monitoring and ensuring safety in its certified foster homes and has improved the direction and training provided to foster parents on the topic of appropriate discipline. The program is also exploring other options for improvements and changes aimed at ensuring recruitment of safe and appropriate care-givers.</p>
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<p>CCA170089</p> <p>Allegation 1</p>	<p>Maple Star Oregon</p>	<p>June/July 2017</p>	<p>One allegation of Neglect as defined in OAR 407-045-0820(1)(b) and (14)(a) was substantiated, because a proctor foster parent failed to provide the required social media and internet supervision to a child receiving care from the program, resulting in the child using social media to connect with others on-line for sexual activity and drug use, both inside and outside the foster home.</p>	<p>No</p>	<p>At the time the allegations came to light Maple Star took steps to ensure that the youth's access to the internet and social media was terminated. When Maple Star was informed that the alleged neglect had been substantiated they terminated the identified foster parents' certification. The foster parents no longer care for children.</p>
<p>Child Welfare Case # 303847</p> <p>Allegation 1</p>	<p>Maple Star Oregon</p>	<p>04/08/2017</p>	<p>One allegation of Neglect was substantiated, because the 18-yr-old foster sibling of a child receiving</p>	<p>No</p>	<p>The child's foster sibling is the subject of the substantiated report of neglect. There is no allegation of neglect by the child's foster parents</p>

			<p>care caused a car accident while driving a car stolen from the foster parents while the child was a passenger in the car. On a separate occasion the same 18-yr-old foster sibling drove while smoking marijuana with the child in the car.</p>		<p>or anyone else employed by Maple Star. The foster youth were being supervised in accordance with Maple Star policy and the youth's individual plans. The youth eloped from the program in the middle of the night in the foster family's vehicle. After this occurred, the foster parents hid their keys. The 18-yr-old foster youth had obtained a duplicate key to the vehicle while on the run which the foster parents didn't know about. The duplicate key was used to steal the vehicle during the 2nd nighttime elopement from the foster home. After the 2nd incident, the 18-yr-old foster youth was moved to a different foster home, and a no-contact order was put in</p>
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					place with regard to the 18-yr-old having any contact with the identified child.
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