130th Legislature
Senate of Maine
Senate District 26

Senator Bill Diamond
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February 11, 2022

Senator Libby, Representative McDonald, and members of the Government Oversight Committee, my name is Bill Diamond and I represent district 26 in the Maine Senate, which includes the towns of Baldwin, Casco, Frye Island, Raymond, Standish and Windham. I appreciate the opportunity to share my thoughts pertaining to the "Oversight of Maine's Child Protective Services" report presented by the OPEGA staff to this committee on January 21, 2022. As a former member of this unique committee, I'm familiar with and thank you for the important work you and the OPEGA staff do.

I want to thank Director Lucia Nixon and Senior Analyst, Amy Gagne, for their time to meet with me and provide additional information pertaining to the CFSR – 3 and the OPEGA report.

Realizing this is the first in a series of investigative reports initiated by this committee, I would like to share some initial observations for your consideration. The structural and cultural problems that continue to exist within the Office of Child and Family Services (OCFS) will not be "fixed" until transparency within the OCFS is significantly increased. .

Substantiating that Problems Still Exist

Last week, DHHS released their annual report of child deaths tracked by their offices. The deaths included in the report are homicides, those occurring from neglect and abuse, and deaths that happened in families that have had prior involvement with Maine's CPS.

Tragically, they reported that 2021 had the highest number of child deaths in Maine since the department started keeping records in 2007 – a shocking 25 deaths! But their report wasn't accurate – it's even worse because the report didn't include the 5 child deaths last year, 4 of which resulted in murder charges. Also, another homicide with a murder charge was filed in September regarding a murder in 2020.

The child deaths not included in the DHHS report are:

June 2021

- Jaden Harding: 6-week-old infant boy from Brewer. (*Manslaughter)*
- Hailey Goding: 3-year-old little girl from Old Town. (*Manslaughter/Depraved Indifference Murder)*
- Maddox Williams: 3-year-old little boy from Stockton Springs. (*Depraved Indifference Murder)*

August 2021

- Sylus Melvin: 1-month-old infant from Milo. (*Depraved Indifference Murder)*

September 2021

- Harper Averill: 3-month-old infant from Turner. (Harper died in July 2020. *Manslaughter*/*Murder* charges issued Sept. '21)

November 2021

- Carson Malloy: 14-month-old infant from Oakland. (Drug trafficking)

(Note: Following the June deaths, Maine DHHS stated they would be evaluating child safety policies in the state in the wake of those murders.)

The Beginning of OCFS

The Adoption and Safe Families Act of 1997 authorized the US DHHS to review the state child and family service programs to monitor the federal conformity standards.

- The 1st Round FY 2001 – 2004, 2nd Round FY 2007 – 2010, 3rd Round 2015 – 2018.

The Recent OPEGA Report – CFSR (Round) 3

In the OPEGA report, specifically the page showing "Maine's Performance – CFSR 3," Maine is compared to other New England States in terms of meeting federal conformity standards. The report noted that the standards were high and difficult to meet. Nevertheless, the performance levels were based on preferred optimum outcomes. Of the 14 categories listed, Maine failed to meet the recommended outcomes in nine categories overall. They were:

Child and Family Outcomes

- Children are, first and foremost, protected from abuse and neglect.
- Children are safely maintained in their homes wherever possible & appropriate.
- Children have permanency and stability in their living situations.
- The continuity of family relationships and connections is preserved for children.
- Families have enhanced capacity to provide for their children's needs.
- Children receive adequate services to meet their physical and mental health needs.

Conforming with Systemic Factors

- Case review system.
- Staff and provider training.
- Service array and resource development.

It was noted that none of the other New England states met these thresholds, which is true, however, Maine's conformity failures, in many instances, are consistent with what our own Ombudsman has reported over the past years. I would urge caution about minimizing Maine's lack of conforming to the standards simply because the other New England states also failed to meet the preferred outcomes.

We only need to look to our neighbor, Massachusetts, where a 5-year-old girl has been missing for two years. The Chief Justice of Massachusetts Supreme Court ordered a review of their entire system including how and why a 5-year-old little girl had been lost for two years. There have also been reports about serious failures in other New England states, so being in that company should not be comforting to us.

As a result of failing conformity standards Maine is required to develop the mandated Program Improvement Plan (PIP) meaning the Department must report how they will reach an acceptable performance level. Maine's PIP was approved by the Children's Bureau in February 2020. Interestingly, the information for the Review period was obtained from fiscal years 2015 – 2018 as required by CFSR, Round-3, a year and a half prior to the February 2020 approval date.

OCFS is not required to have the plan implemented until January 2024. So, we have data gathered between 2015 – 2018 that was the basis of the PIP approval in February 2020, and the completed goals of the PIP are not required until 2024. This only makes sense to bureaucracies.

DHHS has pending penalties from the US DHHS if the PIP goals are not met by 2024. However, OCFS reported to OPEGA that their improved strategies will enable the pending penalties to be waived. Maybe or maybe not. I would suggest progress reports should be monitored by this committee on a quarterly basis for obvious reasons. It's unclear the amount of the potential penalty.

The CFSR Aggregate Report is somewhat elusive and not user friendly and should be referenced with caution. I have reviewed the following documents (located by Director Nixon) which reveal important information about Maine's current policies for protecting children. The information is helpful in explaining the ongoing problems at the OCFS. The notable reports are:

- *Maine Child & Family Services Review 2017 Final Report*
- *Maine CFSR Statewide Assessment 2017*
- *Maine Program Improvement Plan Feb. 2020*
- *Maine Annual Services & Progress Report FY 2022*

One last note: There has always been a question about the definition of confidentiality relating to information of a child death. When a child death occurs it would be helpful to know if the Department had been involved with the child or family in any way prior to the death. There doesn't seem to be anything in the law currently that would prevent such disclosures. When I served on this committee, OPEGA reviewed the deaths of Marissa Kennedy and Kendall Chick in 2018, reporting the deficiencies of the Department's performance which was well in advance of the trials. Last June, the press reported that the Department had been involved with the Maddox Williams family including his placement. There is precedent for allowing public access to minimum information in these cases. I would ask this committee to review this issue.

Thank you again for the opportunity to share my comments, and for undertaking such important work on behalf of Maine's kids.

From: Betsey Grant <betseygrant1@icloud.com>
Sent: Wednesday, February 9, 2022 4:06 PM
To: Carey, Sabrina <Sabrina.Carey@legislature.maine.gov>
Subject: Re: [GOC] RE: Concerns/complaints regarding Child Protective Services

This message originates from outside the Maine Legislature.

Good afternoon

Thank you for such a quick response

These are a summary of what I see as a breakdown in the Child Protective Services but it is certainly not the only issues ….may I add :

There is no complaint process for individuals or mandated reporters to use when we see (investigators/case workers /subcontracted child abuse experts & AMHC supervisors) that act inappropriately, recklessly or intentionally intimidate their interrogated child , parent or caregiver.

To clarify ….my issues vary in five basic areas and encompasses several divisions with in the OCFS.
I'm asking if I am only to speak on CPS or May I elaborate on the communication break down in the fragmentation of the ChildWelfare System?
I can do either I just want to prepare.

Also the reunification plans and safety plans developed have no follow through, leading parents to know they can dismiss CPS because their safety plans for reunified child will not be enforced.

The ability to access danger is very low by CPS.

Betsey Grant
Tiny Tikes Daycare. Trenton Maine (Hancock County) #424615 betseygrant1@iCloud.com

-----Original Message-----
From: Betsey Grant <betseygrant1@icloud.com>
Sent: Wednesday, February 9, 2022 1:45 PM
To: GOC <GOC@legislature.maine.gov>
Subject: Concerns/complaints regarding Child Protective Services

This message originates from outside the Maine Legislature.

I have several concerns regarding Maines ChildWelfare System :

Investigation Impartiality (lack of)

Investigator Intimidation tactics

Incomplete questioning by Investigators

Caseworkers come to do A Child Check and must put “Eyes” on the child …however they do not. Sometimes do not even properly identify if the child they “ put eyes on “ is in fact the child on their caseload.

Caseworkers are slow to respond to concerns and return calls.

Caseworkers repeatedly (in my personal experiences) disregard valid concerns By Mandated Reporters… leading to serious injuries and crimes committed to infants

My concerns for the past four years are organized in a large file that I will overnight mail.

Sent from my iPhone

To: Government Oversight & Health and Human Services Committees

From: Maine Citizen Review Panels

February 10, 2022

Dear Members of the Government Oversight and Health and Human Services Committees,

We are writing today as the three CAPTA/CJA ("the panels") panel chairs and designees with regard to the information briefing that was provided to this committee on Friday, January 21, 2022. At the conclusion of the information briefing, members of both committees were given the opportunity to ask questions of the OPEGA staff. Many of the questions were related to how the panels communicate as well as how panel information is communicated to the public. We are providing this letter to clarify and inform both committees of current cross-panel communication and public access to panel information.

Cross-Panel Communication

(1) All three panel chairs or designees meet on a quarterly basis. This practice was established in August 2021.
(2) On a quarterly basis beginning in 2022, all three panels will provide an update at the other two panel meetings. For 2022, cross-panel updates will occur in March, June, September, and December.
(3) If a report is issued by one panel in between designated cross-panel meeting updates, any panel may request that the author of the report present the report at an upcoming meeting for discussion. All reports will be shared with the other panels upon release.

Public Availability of Panel Information

The joint citizen review panel website (https://www.mecitizenreviewpanels.com/) contains information about all three citizen review panels. While the information for the Child Death and Serious Injury Review Panel is limited due to confidentiality constraints, all agendas, minutes, organizational documents, meeting schedules, and annual reports for the other two panels are available to the public. In addition, the meetings for the Maine Child Welfare Advisory Panel and the Maine Justice for Children Task Force are open to the public. Individuals who wish to attend have the opportunity to contact panel staff for attendance information.

We hope this information provides clarity around cross-panel information sharing as well as panel information that is available to the public. If you have any additional questions, please feel free to reach out to one of the panel chairs or designees listed below.

Sincerely,

Debra Dunlap, Co-Chair, Maine Child Welfare Advisory Panel
Ahmen Cabral, Co-Chair, Senior Policy Associate, Cutler Institute for Health & Social Policy, USM
Mark Moran, LCSW, Chair, Maine Child Death and Serious Injury Review Panel
Betsy Boardman, Maine Justice for Children Task Force, Designee

Testimony of Christine Alberi, Child Welfare Ombudsman
Government Oversight Committee
Public Comment on OPEGA Information Brief: Oversight of Maine's Child Protective Services
February 11, 2022

Good morning, Senator Libby, Representative McDonald, and members of the Government Oversight Committee. Thank you for having me here today. My name is Christine Alberi, and I am the Child Welfare Ombudsman for Maine.

The OPEGA Information Brief on Oversight of Maine's Child Protective Services details the roles and responsibilities of six oversight bodies. Of those six, four review cases, including the confidential records, involving child abuse and neglect, although that may not be their sole function.

The Child Welfare Ombudsman and the federal reviews performed by the Quality Assurance department within the Office of Child and Family Services exclusively review cases involving child protection investigations and cases that are the responsibility of Child Welfare Services. Quality Assurance reviews cases based on a random sample and proportionally to the distinct types of child welfare involvement. The Child Welfare Ombudsman reviews cases based on complaints received from the public.

As I have said to you previously, I agree with OPEGA that the Office of Child and Family Services' Quality Assurance department has a thorough and objective process. The federal progress reports, which are available on the Office of Child and Family Services website, are detailed and reflect a consistent process to review cases that are not easy to quantify.

The Serious Injury and Death Review Panel and the Domestic Violence Homicide Panel review cases involving serious injuries and deaths of children or children killed by interfamilial violence or who are bystanders to domestic violence homicide. Each panel also reviews cases that either do not involve child welfare, or do not involve children, but both have unique insight into why children who are the victims of the most serious abuse and neglect experience what they do. Unlike the Ombudsman's office and the Quality Assurance Department, both of these panels have the benefit of extensive medical expertise.

The Maine Child Welfare Advisory Panel and the Justice for Children Task Force do not review confidential case records but provide expertise in child welfare and make recommendations and provide trainings and surveys that are invaluable. The Ombudsman's office has membership in both the Maine Child Welfare Advisory Panel and the Justice for Children Task Force.

One of the current difficulties in sharing information between the oversight bodies that review cases are the restrictions on sharing confidential information. Also, unlike the Ombudsman's office and the Quality Assurance department, the Serious Injury and Death Review Panel and the Domestic Violence Homicide Panel wait until criminal prosecutions or investigations are complete to review cases.

Except for cases of overlapping membership, the oversight bodies detailed in the Information Brief do not have a formal process of regularly communicating with each other, and in the cases of the bodies that review confidential case information, there is no consistent sharing of information or collaboration outside of our standard public reporting.

I have found the public reports of Quality Assurance, the Serious Injury and Death Review Panel, and the Domestic Violence Homicide Panel to be an important check on my own work at the Ombudsman's office both in the past and currently. If communication barriers are broken down, and some of the oversight bodies are given the ability to share confidential information not publicly, but between oversight bodies, we may be able identify consensus on issues where it exists. Then, we can more quickly advocate with child welfare to draw attention to trends and concerns, before public reports that lack detailed case information are released.

Thank you, and I am happy to answer any questions.

Christine Alberi
Child Welfare Ombudsman
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207-215-9591

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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Comments from the Department of Health and Human Services
Before the Joint Standing Committee on Government Oversight

Regarding the OPEGA Information Brief on Oversight of Maine's Child Protective Services, January 2022

Hearing Date: February 11, 2022

Good Morning Senator Libby, Representative Stover, and Members of the Joint Standing Committee on Government Oversight:

I am Molly Bogart, Director of Government Relations for the Department of Health and Human Services and I am here today to provide the Department's comments on the Office of Program Evaluation and Government Accountability's Information Brief on Oversight of Maine's Child Protective Services and some additional information in response to questions during the presentation of this report to the Committee.

The Department appreciates the work of OPEGA in developing this brief and concurs that child protective services is subject to "in-depth regulatory oversight" that is "comprehensive and outcomes-oriented," and "engages all three branches of government and both public and private sector stakeholders." The Department has continued its ongoing commitment to system improvement in conjunction with the entities cited in the report, as well as the Legislature. The Department believes the system is designed in such a way that ensures appropriate overlap and connection among the entities and their members. OCFS' Associate Director of Child Welfare Services attends and participates in all CAPTA panel meetings, as well as the Domestic Abuse Homicide Review Panel, and works collaboratively with the Child Welfare Ombudsman and the Children's Bureau. This is just one example of the overlap and child welfare staff involvement that OCFS benefits from in relation to these entities.

Following the meeting where the OPEGA Information Brief was presented, OCFS provided OPEGA with information in response to questions that were raised in that meeting. Specifically in this forum, I want to offer some additional information on the three Citizen Review Panels: Maine Child Welfare Advisory Panel, Child Death and Serious Injury Review Panel, and Maine Justice for Children Task Force.

Citizen Review Panels (CRPs)

- The Chairs of the citizen review panels meet with one another quarterly to share information on priorities and the work of each Panel.
- Beginning in March 2022, a representative from each Panel will present an update quarterly at each of the other Panel meetings. There is also cross-representation on the panels.

- Panels do not share confidential, case-specific information. However, it is important to note that the Justice for Children Taskforce and Maine Child Welfare Advisory Panel meetings are open to the public and this information has recently been added to the website.
- The OCFS provides staff support for the MCWAP and CDSIRP but does not staff the Justice for Children Taskforce – that panel is staffed by the Maine Judicial Branch.
- While OCFS provides support and staff serve on the Child Death and Serious Injury Review Panel and the Maine Child Welfare Advisory Panel, it is as non-voting members. OCFS has worked intentionally over the last few years to bolster the citizen leadership of these panels to support their independence.
- All 3 Panels collaborated to develop the Citizen Review Panel website, which can be found at https://www.mecitizenreviewpanels.com/. Agendas, minutes, and annual reports for each Panel are located on this website, as well as a mechanism for public input.

Thank you for the opportunity to provide these comments before you today. The Office of Child and Family Services and Department of Health and Human Services continue to be committed to engaging with Government Oversight, OPEGA, the Health and Human Services and Judiciary Committees, and the Legislature as we work toward our shared goal of ensuring every child and family in Maine can be safe, stable, happy, and healthy. I'm happy to answer any questions you may have.