Testimony of Christine Alberi, Child Welfare Ombudsman
Government Oversight Committee
Public Comment on OPEGA Report OCFS Case File Review: Maddox Williams
May 26, 2023

Good morning, Senator Hickman, Representative Fay, 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.

I would like to take some time today to comment on the OPEGA report on Maddox Williams presented to this Committee last month. My office did complete a case specific review of this case, but due to confidentiality statutes I am unable to share any details of the cases preceding Maddox's death, other than what has been released by OPEGA in their review, or the Department in their public statements about the case.

OPEGA is correct in their report that it is not for any of us to determine whether actions taken by the Department could have prevented the death of Maddox Williams. OPEGA also concluded that the Department made no unsound safety decisions during involvements in the time before Maddox was killed. I would respectfully disagree with this characterization, but I think part of the issue is what we would consider a "safety decision." During the Department's involvement with Maddox Williams and his family, and in fact in all decisions made by the Department in the context of any child protective investigation or reunification case, most major decisions made by the Department are by definition safety decisions: Is the child safe now? Will the child be safe when he goes home? Is the child going to be safe in the future?

OPEGA is also correct as citing this case as an extreme example of the "range of complexities and complications" that child protective services encounters. But the case also follows some patterns that are familiar to the Ombudsman's office from our own case specific reviews.

Throughout OPEGA's report of the facts of the Department's involvement with Maddox's family, the parents are described as uncooperative. This is one of the issues that caseworkers encounter with many families and so when the Department has a chance to intervene, it is important that that chance is taken. In this case, the Department had their best chance back in March of 2018 when Maddox's siblings entered state custody after his two-year-old half sibling ingested methadone.

The OPEGA report's description of the protracted legal battle about the mother's mental health evaluation is central to this reunification case. Even though Maddox was not involved, other young children were, and even though it is clear from the OPEGA report of the reunification plan for their parents that physical abuse of the children was not one of the Department's concerns, the parents had a litany of other issues, primarily mental health and substance use disorder, that negatively affected the safety of their children.

The list of events provided on p. 8 of the OPEGA report, including the mother being discharged from her provider, the GAL recommending a CODE evaluation, the mother's minimal participation in the agreed upon compromise in place of the CODE evaluation, and the mother's

evaluation that was completed without the Department's input are all evidence of a parent who is unwilling or unable to acknowledge and work on her mental health issues. This is a common issue in reunification cases. A parent will see a provider without the Department's input, without a copy of court's jeopardy order for example, which renders the provider's opinion of the parent's mental health diagnoses and progress in treatment invalid. The OPEGA report is silent on whether or not the final evaluation in October of 2019 was with the full input of the Department, but the question for the Department to ask under these circumstances is why this evaluation was relied upon when other earlier ones were not.

The timing of the reunification case is also discussed in the OPEGA report. When Maddox's half sibling was born in June of 2019 his other siblings had been in state custody for a year and three months. Maddox's infant sibling entered state custody because the jeopardy in the parents' care to the older siblings had not been alleviated. OPEGA's recommendations that the statute is followed in regard to filing a TPR are very important. The timelines that exist in statute are there to ensure that children do not remain in uncertain and unstable situations for years on end. The OPEGA report also notes that the summer of 2019 was the most likely time that the TPR would succeed.

(In the Ombudsman's 2022 Annual Report, we noted that "…in six cases this year filing of petitions to terminate rights was delayed long after the required statutory timeframe…")

In August of 2019 the court determined that the infant would remain in state custody and that the mother "fails to appreciate the grave risk that her mental health and lack of treatment pose to her minor child." The father's underlying substance use issues and lack of following out-patient treatment recommendations were also listed as concerns.

At this point we know that Maddox's siblings had been in state custody since March of 2018. A court order entered 17 months later is clear that the mother's mental health and the father's substance use issues have not been adequately addressed. Then two months after this order, the mother had a mental health evaluation in October 2019 and by November 2019 the parents were cooperating with substance use and mental health evaluation and treatment expectations. One month later the parents were allowed unsupervised visits and then a month after that, trial placement began and Maddox's siblings went home to the parents. In most cases, even in the best-case scenario, three months of cooperation and progress with significant mental health and substance use issues would not be enough to determine that the parents were able to provide the children with long term safety and stability.

All the decisions during the reunification case, not asking the court to order that the mother have a CODE evaluation, not filing the TPR in accordance with statutory guidelines, and starting unsupervised visits and trial placement with such new and untested cooperation from the parents are all consequential safety decisions for the children in state custody, as well as for Maddox. The reunification case and decisions made during it set the stage for the next year of DHHS involvement with the family. The reunification of Maddox's half siblings with his mother and their father made the Department's intervention with the family much more difficult afterwards, for a number of reasons.

For example, the Department asked the court for and was granted a PPO for Maddox as to his mother based on her legal abandonment of him. The court agreed with the facts and legal argument in that preliminary petition, and those facts were not in dispute as far as we can tell. The Department then withdrew its petition and agreed to have Maddox return to the mother's custody. There is no doubt that the Department's argument to the court that Maddox would be unsafe with his mother was undermined by their decision weeks earlier to start a trial placement with the mother for Maddox's siblings. The Department's decision to withdraw the petition was another consequential safety decision.

From the Spring of 2020 when COVID began, and until Maddox's death, the Department's involvements with the family share the common theme of lack of cooperation with the Department. The OPEGA report notes that the parents were minimally engaged with the Department or not fully cooperative. This includes the investigation that occurred immediately before Maddox's death. The parents had learned that they did not have to cooperate with the Department.

OPEGA notes on p. 17 of the report that the Department did not contact the mother's oldest child's father during the last investigation before Maddox's death, and therefore may have missed an opportunity to learn what that older child knew about what life was like for the children in the mother's home. The Department's old and new policies on child protective investigation are consistent with the idea that whatever the initial report to the Department was about, in this case domestic violence, all areas of child abuse and neglect should be explored, especially during interviews with children.

There is no telling what would have happened had Maddox's older sibling been interviewed in the father's home, but this is why it is ideal to use all information sources that might provide relevant information. Additionally, this family was not new to the Department. According to the OPEGA report, the Department had had almost constant involvement with the family since before Maddox's birth. The Department, as demonstrated by its actions over the years, was uneasy with Maddox in the mother's custody. When new investigations are opened with families with this much history, a more thorough investigation is warranted.

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

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Maddox Matters

Good morning Senator Hickman, Senator Faye and honorable members of the Government Oversight Committee.

I first want to extend my deepest sympathy to the family members of Maddox Wiilliams.

On a very personal level, I would like to acknowledge the dedicated perseverance of Victoria Vose, who is the paternal grandmother of sweet Maddox. Her deep love for her grandson has brought him to life in my eyes, whereas I never knew of him until that day in June of 2021 when I heard of his death.

I have been a licensed childcare provider for decades which has led me to become a Child Welfare Reform Warrior.

It was a Monday morning when I sat in the infant room at our Daycare when our staff cried as we heard over the radio about a little three year old boy in Stockton Springs who had died from injuries all over his entire body.

As resilient protectors of children, it was horrifying to hear about a three year old's death in the care of his own home, most likely inflicted by his mother. As the days went by we all listened to the unfolding of the Maddox Williams tragedy. I must admit my staff and myself became outraged. At the time we had 24 staff members and 78 children enrolled, 19 of them being foster children (in State Care). I began writing to OCFS expressing deep concerns for the short-comings that were very noticeable to me. The tactics that are continuously used by OCFS/DHHS/CPS to cover up their reckless decision making is extremely apparent in the way they conduct their investigations. Investigation incompetence is an issue that includes incomplete questioning, incomplete documentation and an inability to notice major warning signs of obvious sleight of hand by an abusive adult (Bad Actor). The issue became even more clear at daycare when caseworkers would come "Put Eyes on the Child".

Everyday as we followed the tragic story of Maddox Williams the obvious and preventable danger kept leaping out to me. I could tell every new development that there was "No Eyes Put on the Child" from OCFS/DHHS/CPS.

Ways I could conclude this stems from 23 years of my own personal experiences with OCFS/DHHS/CPS. The lack of training (no matter what the caseworkers experience on the job) is abundantly dangerous. I have had experiences at my daycare when a caseworker has come into "Put Eyes on the Child" and they did not even come all the way into the playground. One time a caseworker even told me I don't want him to see me because then will tell his mom they (meaning the child's mom and new partner) will accuse me of something.

In March of 2022 I testified to the Government Oversight Committee over Zoom and I stated this issue. I spoke of an example that had just happened when a caseworker came to "Put Eyes on the Child" at the daycare. The case worker was accompanied by the 3 ½ year olds biological mother and when she put eyes on the child she did not ever identify her. It was at the end of

naptime there were nine other children sleeping, the daycare staff offered to wake this child up. The caseworker seemed extra resistant to not wanting to take a closer look at the child. The way she was sleeping it was not possible to make out whether she was a boy or a girl even. It was such a disturbing experience to see this child's mother ask to come back into the room so she herself could pull the blanket back and assure herself that this sleeping three year old was actually her daughter.

"Eyes of the Child" must be specifically written into policy for case workers. Documentation and pictures must be taken. A body chart must exist. Supervised and monitored visits must be safe and thoroughly documented. Reunified biological parents must be understanding of the fact that thorough collection of information and documentation by case workers is essential and protects the children foremost, but also protects them. All pictures can be viewed by parents and caregivers to promote accuracy. Photos of "No Injuries" are extremely important whereas it provides a time stamp.

In Maddox's case "Eyes on the Child" or lack thereof led to his death, whereas his cause of death was Battered Child Syndrome. The definition of Battered Child Syndrome is ***The set of symptoms, injuries, and signs of mistreatment seen on a severely or repeatedly abused child.***
I'm going to speak on what OPEGA may refer to as a missed opportunity but I am going to call it.
The Deadly Danger in the Detail that could have prevented Maddox's death.

On April 4, 2021 Maddox Williams was spending Easter weekend in a hotel with his mother, his half sister, and Mr Trefthron as well as the half Tefethron siblings. **On this weekend Maddox suffered a physical assault by being thrown out of a bathtub from the bathroom and landing on a slippery hard floor as well as hitting the wall.**

On April 8, 2021 Mr. Trefethron is known by the OCFS/DHHS/CPS to be arrested and charged with domestic violence. This led to an in person visit by DHHS to check on and ensure the children were not in jeopardy of endangerment in their home on April 9, 2021. On April 9, 2021 just five days after poor and defenseless Maddox was thrown wet, naked and coldly out of a bathroom DHHS observed no marks, bruises or injuries on the uncovered parts of this child.
In this instance the caseworker did not "Observe" because she wasn't allowed to look at the child who was sleeping and coverd up by his abuser. For the Department to allow a misleading word (Observed) to be used in their report to OPEGA is grossly negligent.

This is a major difference between observing a child and only glancing at a child.

The definition of observe is to regard with attention, especially so as to see and learn more about.
The definition of glance is to take a brief or hurried look.
What is clear in this OPEGA report is a discrepancy between the word "observe" and "glance". The major difference between these two words raises a level of suspicion in me and to how I have personally noticed weaponization of words by the OCFS/DHHS/CPS in order to cover up systematic failures that lead to children being left in harm's way.
This is not the first time OCFS/DHHS/CPS has weaponized words in an investigative report after a bad outcome has occurred to make themselves unaccountable.

“A darkened room”

When Ms. Trefetron “eventually allowed case workers (singular, one person) in her home.
This case worker has clearly been manipulated and intimidated by Ms Trefthron.
A case worker should be trained to include details in her visit. When dealing with people with a history of substance use disorder and mental health and trauma issues, the “Danger always Lies” in the Details. Meaning the “Lies” are able to be uncovered with proper training.

I can relate to this caseworker. She was scared. She should have never gone by herself and (I pray) she has been taken care of by her employer, OCFS/DHHS/CPS, and has received emotional and mental health support from a professional provider that can help her deal with emotional distress that will surely haunt her after her involvement in this tragedy. This is a question I must propose, was she allotted time to grieve and process her involvement in this case or was she expected to keep working?

Had this casework been properly trained by administration and leadership of OCFS then complete documentation would exist:

1. What time of day were the children sleeping? To my eye I’m speculating it was a nap and not a bed time sleep. Whereas the room had to be darkened and two other children were playing outside. A three year old can typically be evaluated by moving a blanket, shifting their pillow as you can check their back, stomach, face, arms and legs.
2. What color or pattern was Maddox’s blanket?
3. Where is Maddox’s bedroom located in the house?
4. How was Maddox positioned while sleeping?
5. How was he breathing? Example: was he snoring, was he stuffed up sounding, was he sweaty, was a pet sleeping with him, did he have a stuffed animal?
6. Were tattoos noticed on the uncovered parts of Maddox? What parts were uncovered on Maddox? Example: feet, hands, face, forehead. (It is well known that child abusers use tattoos and makeup to cover up bruising and other marks)

I can not emphasize enough how important documentation and information gathering is when determining the Safety of a Child.

OCFS must learn from other child death cases that a “Sleepy Child” has more clues to what is really happening,

Let’s not forget Marissa Kennedy “sleeping” during a case worker check. Ethan Henderson “sleeping” during a caseworker check and Gaberial Fernandez, across the nation the research I have seen shows that sleeping children can be the easiest target for an abuser or bad actor, to use as a deceptive cover up. Which has thrown entire cases in a different direction.
Now incompetent caseworkers have inaccurate words like “sleeping soundly” in their reports rather then the more likely realty of:

- Their bodies are weak due to repeated blows to the stomach

- Their bodies are malnourished

- They are suffering from a concussion or head trauma
- They are sleeping to much as a form of escapism from their abusive home

The combination of the inability to Identify Obvious Danger and Risk to Maddox Williams on April 9, 2021 is directly related to his cause of death was Battered Child Syndrome. "Eyes on the Child" and "Safe Sleep" both are OCFS responsibilities. I notice when the OCFS (Dr. Todd Landry) wants to Deflect they use data and New Developments that they are so proud of but underneath "Lies" a major shortcoming that results in child endangerment. In 2019 OCFS/DHHS updated its "Safe Sleep" practices to include D. which is a drug free home for babies. However, they did not add training to the caseworkers on the Number #1 way an abusive caregiver HIDES the injuries to a child which is under the disguise of "they are sleeping, I don't want them to be woken up"

Again I do not blame this caseworker. I empathize with her deeply whereas I have caskets on my conscience. I ask myself why didn't I call four times instead of three? Why didn't I keep calling?

The answer for me is this: I had blind faith and trust that DHHS was listening to my calls.
Call to Action: As I keep exposing the System Failures, I keep Proposing the Answers.

I could talk Endlessly on the Multiple things to change in OCFS and the ways to make those changes, like LD#785. I am just a Diaper Changer but I am ready to be the Game Changer for OCFS/DHHS/CPS. I can't change laws until I can change minds.

In Loving Memory of Maddox Williams
Betsey Grant

GOC TESTIMONY MAY 26, 2023

Presented by Bill Diamond
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Senator Hickman, Rep. Fay and members of the GOC, my name is Bill Diamond. Presenting my testimony today is something I've not looked forward to, but unfortunately it must be done.

I've been an adamant supporter of OPEGA/GOC from its inception in 2003 and its first meeting in 2004. This is the 20th anniversary of OPEGA/GOC and I'm extremely proud of their many accomplishments during that time. Having served on this committee for eight years I know firsthand the value and quality of OPEGA's professional research and investigations. OPEGA's well-deserved reputation has been earned based on their independent nature and willingness to seek the truth regardless of the agency/organization involved.

However, the most recent OPEGA report analyzing OCFS's handling of the Maddox Williams' case was not only inconsistent with the previous standards of presenting a thorough, reliable and factually based report, it was just the opposite, complete with carefully selected wording that softened and misrepresented the poor decisions by OCFS that unnecessarily put Maddox's life in jeopardy and finally resulting in his death.

The report's findings: *No unsound decisions* only *missed opportunities*. Such statements are mind boggling, vacant of any common sense, and mostly curious given the fact that the Maddox Williams case was the most egregious example of how seriously flawed OCFS's management and decision-making policies are as reported repeatedly by the Child Welfare Ombudsman. The report avoided any mention of OCFS's inappropriate decision-making, lack of procedural consistency, and ineffective communication.

Let me give you some specific examples. Maddox was living with his grandmother in a loving and caring home where he was protected and safe enjoying a happy life. Then OCFS decided that **Maddox must be taken from that loving home and placed with his biological mother.**

And lastly, one of the most cruel and uncaring occurrences by OCFS was how they allowed Jessica to take Maddox from his family one day while being cared for at his aunt's day care center without even telling his grandmother who was his full time care taker. OCFS allowed Jessica to literally walk into the day care grab Maddox – he was frightened and had no idea who she was – and take him away. The family pleaded with the department not to put Maddox in that dangerous mobile home explaining that Jessica was unstable and highly volatile and would surely hurt or even kill him. The begging and pleading by the family members, who knew Jessica better than anyone including OCFS, were ignored. Why didn't the OPEGA report include all of these instances and ask the obvious questions?

For those who know what really happened leading up to Maddox's tragic death, especially his family, and others who were working to improve the child protective system, this OPEGA report is seen as tragically flawed and very damaging because of its avoidance of declaring the need of accountability by DHHS. As Senator Ducson has said, GOC can't just wring our hands and feel bad, it's imperative to know what specifically needs to be fixed. This report carefully avoided that accountability question and delicately sidestepped focusing on the serious problems within the department.

This OPEGA report should have been exhibit A identifying specific system breakdowns with suggestions for the committee to consider to make meaningful changes, but instead it provided a flag of exoneration to be waved as needed.

In summary, it saddens me to say that this, but this report was a disservice to you as a committee, a misrepresentation to the public and a crushing insult to the family of Maddox Williams.