OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Jaden Harding

Summary

The Government Oversight Committee of the 130th Maine State Legislature directed OPEGA to review certain records generated by the Maine Department of Health and Human Services (DHHS), Office of Child and Family Services (OCFS) to better understand the safety decisions and actions taken by the Department during its involvement in the lives of four Maine children who died in 2021. For reasons explained in the "Our Approach" section, this report concerns only Jaden Harding; separate OPEGA reports on Hailey Goding and Maddox Williams have been issued, and a report regarding Sylus Melvin will follow in turn.

At the outset, we, the Director and Analysts of OPEGA, wish to again convey our profound sympathy to the extended families of these children and to acknowledge that their lives were tragically cut short. In analyzing the records of OCFS performance, we sought to understand what their experiences may teach us about future efforts to protect Maine children. Our findings and conclusions have been reached after detailed and careful analysis of the facts and the law, and are the product of OPEGA's objective, professional judgment. OCFS cooperated promptly with our records requests, and answered any interview questions OPEGA deemed essential.

It is understandable that the death of a child with any degree of child protective services (CPS) involvement may prompt reasonable observers to question whether the services provided were adequate, and, more acutely, whether any safety decisions were sound. At the same time, OPEGA conducted our work mindful of the risks of so-called outcome bias, i.e., that a tragic outcome is itself somehow evidence of deficient performance by child protective services. In such situations, many people, conditions, and potential causes outside the control of OCFS can impact the course of events, and child protective services professionals reach safety decisions under often challenging circumstances.

During Jaden Harding's short life, there was no CPS involvement with his family. Prior to his birth, however, his family had a history of CPS involvement dating back to 2014, when his oldest half-sibling was born. As prior actions and safety decisions can potentially impact the safety of a child born later—and in the interest of identifying areas that may lead to improved outcomes for children—OPEGA reviewed this family's larger CPS history.

OPEGA Report

Our Approach

OPEGA has been conducting our file reviews while related criminal proceedings and some corollary child protection proceedings have been in differing stages of progress and completion. In performing our work, OPEGA has sought to avoid interfering with ongoing criminal prosecutions or child protective proceedings. Consequently, we have deferred for a time some interviews of certain persons we deem necessary to an adequate understanding of OCFS performance in all four cases.

Separate Reports for Each Case

Resolution of any related criminal proceedings, through the sentencing stage, has also then permitted the DHHS Commissioner to release the kind of public account found at Appendix A of this report. Both of these milestones have been reached concerning Jaden Harding. Jaden's father, Ronald Harding, was found guilty of manslaughter and sentenced to 15 years in prison with all but 8 ½ suspended, followed by 6 ½ years of probation. Releasing an OPEGA report after these steps have occurred allows for a more detailed report.

Acknowledgments

OPEGA appreciates the considerable and timely cooperation we received from all entities. We also greatly appreciate the substantial assistance provided by staff in the Attorney General's Office in their advisory capacity on confidential information.

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OPEGA endeavored to reach conclusions as to whether decisions made by OCFS were sound in light of prevailing child protection policy and practice, the laws governing such matters, and the information known (or that should have reasonably been known) to authorities when the decisions were made. To the extent that it may be helpful in understanding how certain safety decisions were made or why certain actions were or were not taken in response to various events and information, we have included descriptions of the conditions occurring at these points in the case, as well as the legal, policy, and practice frameworks through which the Department must process that information.

Overall, OPEGA identified two instances in which we concluded unsound safety decisions were made regarding the safety of children other than Jaden. Additionally, OPEGA identified two overarching practice issues, eight specific practice issues, one systems issue, and three potential opportunities for improvement—all of which are described beginning on page 5 of this report. At the same time, it is unclear how the actions taken (or not taken) in this case prior to Jaden's birth would have altered the arc of his life and tragic death. The man convicted by a jury of manslaughter, Jaden's father, Ronald Harding, did not appear, from our review, to have presented earlier actionable safety threats to Jaden.

Child Welfare Philosophy and Law

Child welfare decisions made by OCFS are governed by federal and state law, guided by DHHS policy and rules, and resulting actions are often subject to judicial review and approval. Together, this framework largely emphasizes the rights of parents and family preservation, with exceptions for cases when there is evidence that a child is in serious risk of harm. The OCFS practice model emphasizes child safety, first and foremost, and states, "we support caregivers in protecting children in their own homes whenever possible."

The Due Process Clause of the U.S. Constitution grants parents the fundamental rights of care, custody, and control of their children, and the U.S. Supreme Court has affirmed this right so long as a parent adequately cares for their children. Similarly, the Maine Child and Family Services and Child Protection Act (22 MRSA §§4001-4099) provides "that children will be removed from the custody of their parents only where failure to do so would jeopardize their health or welfare."

When allegations of child abuse and neglect meet the threshold for investigation, the Department must identify whether or not a child has been harmed and the degree of harm or threatened harm by a person responsible for the care of that child. If, after investigation, the Department determines that a child is in immediate risk of serious harm or in jeopardy, the Department must file a petition in court or assign a caseworker to provide services to the family to alleviate child abuse and neglect in the home. Two procedures are used to initiate a court case by the Department, if providing services is insufficient.

- *A Petition for Child Protection Order with a Request for a Preliminary Protection Order (PPO),* supported by a sworn statement, in which a child's immediate removal from a parent's custody is typically requested. This action requires that the Department prove by a preponderance of evidence (that it is more likely than not) that there is an immediate risk of serious harm to the child. Examples of serious harm include serious physical harm, failure to protect a child from serious harm by others, domestic

violence that is likely to cause emotional harm to the child, and inability to supervise, care for, or protect a child due to substance use or impaired mental health.

- *A Petition for Child Protection Order*, known as a "jeopardy petition" or "straight petition," in which there is no *immediate* risk of serious harm alleged, but there is evidence of serious abuse or neglect requiring court intervention. Examples of this include serious harm or threat of serious harm; deprivation of adequate food, clothing, shelter or necessary health care; or abandonment. Jeopardy may also be evidenced by truancy, in certain circumstances, or by the end of a voluntary placement where the return of the child to his/her custodian creates a threat of serious harm.

When OCFS files a jeopardy petition, the court determines by a preponderance of the evidence if the child is in circumstances of jeopardy to the child's health or welfare with respect to each parent/custodian. If the court finds that the child is in jeopardy, it must fashion a disposition. Only then, in determining the disposition, does statute provide for the court to consider the best interests of the child. This is detailed in 22 MRSA §4036; the judge should consider the following principles in order of priority:

1. protect children from jeopardy to their health or welfare;
2. give custody to a parent if appropriate conditions can be applied;
3. make the disposition in the best interests of the child; and
4. terminate Department custody at the earliest possible time.

It is clear in this section that the child's jeopardy must be proved against a parent prior to any other consideration being given weight regarding a child's disposition.

Caseworkers cannot remove a child from their parents without an order from the court. OCFS must also show they have provided specific, reasonable efforts to prevent the need to remove the child from the home or to resolve jeopardy prior to any action for child removal. The Department does not need to make reasonable efforts to prevent removal if it alleges an aggravating factor defined by statute and the court so orders. Aggravating factors include rape, gross sexual assault, sexual abuse, or previous conviction for assault or murder of a child in their own household. If a child is removed from their parents' custody, rehabilitation and reunification efforts for parents must continue unless the court agrees there is an aggravating factor or the court otherwise relieves the Department of this requirement.

The court can only terminate parental rights on the basis of parental unfitness if there is clear and convincing evidence that: 1) the parent is unwilling or unable to protect the child from jeopardy and these circumstances are unlikely to change within a time which is reasonably calculated to meet the child's needs; 2) the parent has been unwilling or unable to take responsibility for the child within a time which is reasonably calculated to meet the child's needs; 3) the child has been abandoned; or 4) if the parent has failed to make a good faith effort to rehabilitate and reunify with the child (22 MRSA §4055).

OCFS policy directs caseworkers to file a Petition for Termination of Parental Rights (TPR) at the earliest possible time that reunification is determined to be unsuccessful. The decision to file a TPR is made by the

caseworker and supervisor, in consultation with an Assistant Attorney General. Per statute, this is to occur when a child has been in foster care for 15 of the most recent 22 months. The department must file the petition before the end of the child's 15th month in foster care; however, the department is *not* required to file a termination petition if the department has chosen to have the child cared for by a relative or the department has documented to the court a compelling reason for determining that filing such a petition would not be in the best interests of the child. (22 MRSA §4052 2-A). Some other policy and practice issues relevant to this case include:

- **Substance exposed infant (SEI) reports**. The Maine Child and Family Services and Child Protection Act (22 MRSA §4004-B) says that "the department shall act to protect infants born identified as being affected by substance use or withdrawal symptoms resulting from prenatal drug exposure, whether the prenatal exposure was to legal or illegal drugs, or having a fetal alcohol spectrum disorder, regardless of whether the infant is abused or neglected." The Department must receive notification, investigate as determined necessary to protect the infant, determine if the infant is affected, determine if the infant is abused or neglected, and develop a plan for safe care[1]. In practice, the OCFS Child Protective Intake Unit receives notification of substance exposed infants at birth. In a subset of those cases, there is also a report of suspected child abuse or neglect. If an infant tests positive for only legal or prescribed drugs, the family is usually referred to services and the hospital puts together a plan of safe care. If there are concerns of abuse or neglect, OCFS investigates, identifies risk factors such as a history of illicit drug use, and looks for evidence of parental impairment and any negative effects on the child.

- **Families with significant cumulative history of CPS involvement**. When the Intake Unit screens in an allegation and it is assigned for investigation, the first step is for the caseworker and supervisor to complete the required assignment activities and identify potential safety factors, risk factors and safety threats, based on the reported information and review of prior history, alternative hypotheses, and the order of activities. Reviewing the family's prior CPS history is a key part of this first step. Risk factors considered include determining whether the caregiver has had previous CPS investigations of abuse and/or neglect; has caused an injury to a child through abuse or neglect; has had ongoing CPS involvement; and has a history of drug or alcohol use, mental health issues, or domestic violence. The CPS practice model states, however, "we believe that people can change. Their past does not necessarily define their potential."

- **Compelling parents to cooperate with CPS investigations**. The goal of OCFS is to work collaboratively with families to assess and address safety concerns. Parents have the right to refuse CPS caseworkers entry into their home, and parents can refuse to allow caseworkers to interview their children. The Department reports that most parents cooperate. Statute allows for an initial child interview without notification of parents under limited circumstances (22 MRSA §4021(3)(A)).

[1] A plan of safe care is a plan designed to ensure the safety and well-being of an infant with prenatal substance exposure following their release from the care of a healthcare provider by addressing the health and substance use treatment needs of the infant and affected family or caregiver.

Interviewing without prior notification is usually done in circumstances where the parents are not yet aware of the Department's investigation.

For more detail on statute, policy, practice, and roles of the various entities involved in the child protective services system, see OPEGA's March 2022 report Child Protective Services Investigations.

Overall OPEGA Conclusions

The timeline in this report (pages 29 – 53) illustrates how the life and tragic death of Jaden Harding, who lived only six weeks, comprised just a relatively tiny fraction of his mother and half-siblings' history of CPS involvement. That earlier CPS history was nevertheless relevant to our work, and is the subject of almost all of the findings or other observations reported here.

Indeed, prior actions and safety decisions regarding other children in a family can influence and impact later actions and decisions and potentially, the ultimate safety of a child born later. At the same time, it is unclear how the actions taken (or not taken) in this case (prior to Jaden's birth) would have altered the arc of his life and tragic death. The man convicted by a jury of manslaughter, Jaden's father, Ronald Harding, did not appear, from our review, to have presented earlier actionable safety threats to Jaden.

We conclude that our approach to reviewing and reporting the earlier history—the events involving the other children in the family—is consistent with seeking to understand how all Maine children might be better protected going forward, to the maximum extent possible.

Through our review of the larger history of CPS involvement, OPEGA identified:

- two unsound safety decisions in which we conclude that the facts of the case—as known at the time—warranted additional Departmental intervention to ensure the safety of the children in the home prior to Jaden's birth;
- two overarching practice issues that spanned multiple investigations and ultimately prevented the Department from making other necessary and appropriate safety decisions and taking related actions to ensure the safety of the children in the home prior to Jaden's birth;
- eight practice issues that occurred during specific investigations that were both prior to and following the announcement of Ms. Hartley's pregnancy with Jaden;
- one systems issue that contributed to the Department not fully understanding the risk that Ms. Hartley's relative/alleged abuser of her children posed to the children (other than Jaden) at a later point in the timeline; and,
- three potential opportunities for improvement.

These are all described in the following sections with recommendations, as appropriate. We also include our analysis related to the care and custody of Jaden.

Unsound Safety Decisions

At two points during this family's CPS involvement, we identified what we consider to be unsound safety decisions in which we conclude that the facts of the case—as known at the time—warranted additional Departmental intervention to ensure the safety of the children in the home.

Unsound Safety Decision 1: No Additional Interventions or Safety Planning to Ensure the Safety of the Children (Prior to Jaden's Birth) from the Man Living in Ms. Hartley's Home (February 2020)

Following the report that one of Ms. Hartley's children had sustained an ear injury that was allegedly inflicted by a man living in Ms. Hartley's home, the assigned caseworker performed several initial investigative tasks in advance of the preliminary safety decision being made with their supervisor. The record indicates that the caseworker interviewed the child at school, visited the home, observed the children in the home, interviewed the adults present during the home visit (Ms. Hartley and the man's partner), and performed background checks on Ms. Hartley, the man, and the man's partner. During the interviews, the caseworker learned that the man, the man's partner, and their 20-month-old child were living with Ms. Hartley and her children, and would continue to do so in the future. Those interviewed (the child, Ms. Hartley, and the man's partner) characterized the injury as having been the result of an accident that occurred while the children were playing a game with the man that involved pushing. Both adults attributed the injury to the child, who they alleged had slipped and fallen while playing the game. The child had initially stated in their first interview with the caseworker that the man had caused the injury, but, in the home and at the direction of their mother to tell the truth, the child claimed that they had injured themselves when they slipped, fell, and hit the wall while playing the game. These characterizations of the injury as accidental, self-inflicted, and as the result of roughhousing appear to have been given considerable weight when the preliminary safety decision was made, and the children were found to be safe in the care of Ms. Hartley without conditions.

On the contrary, OPEGA concludes that this safety decision was unsound as it did not adequately address the concerning information discovered during the caseworker's background check of the man. As summarized by the caseworker in the narrative log, that background check revealed the following:

- three domestic violence assaults from 2008 to 2015;
- one disorderly conduct from 2014;
- two violations of conditions of release in 2015; and
- one violation of a protection from abuse order (PFA) in November 2019.

While the majority of these were five or more years old, the violation of the PFA three months prior is especially relevant. At that point in time, the caseworker knew that the man and his partner shared a 20-month-old child of their own, that the man had a history of domestic violence, that a PFA had been filed against the man at some point, and that the man had recently violated that PFA. As the PFA was unable to be obtained in advance of the preliminary safety decision, the caseworker and their supervisor could not know whether the PFA had been filed on behalf of the man's partner (and child) or whether the PFA was still active

(which could potentially prohibit contact between the man and his partner if it were filed on the partner's behalf).

In light of the unknowns surrounding the PFA, the potential risks associated with the man's documented history of domestic violence, and the fact that the man was initially named as the alleged abuser of the child, we conclude that a safety plan that removed the man from the home pending a review of the PFA and an assessment of the man's safety was warranted to ensure the safety of the children residing there.

We note that this was not the only opportunity for the caseworker and supervisor to take this course of action. Hours later—but after the preliminary safety decision was made—the caseworker received records from the Bangor Police Department that indicated the PFA that the man violated in November 2019 had, indeed, been filed by his current partner. We conclude that this new information warranted—to an even greater extent—a safety plan that removed the man from the home while the caseworker fully assessed his safety and obtained a copy of the PFA to determine whether it was still active.

Unsound Safety Decision 2: No Additional Interventions or Safety Planning when Ms. Hartley's Out-of-State Relatives Leave Her Home (June 2020)

Following their response to the death of Ms. Hartley's adult family member in Ms. Hartley's home, law enforcement reported concerns to the Department for Ms. Hartley's mental health and her ability to care for her children in the wake of the death. The officer also noted that Ms. Hartley disclosed having mental health issues and being on medication. This report was screened in for investigation and assigned a 24-hour (i.e. immediate) response, and both the standby caseworker and the standby supervisor were notified.

Later, the caseworker arrived at the home unannounced to interview and observe Ms. Hartley and her children. Ms. Hartley was initially very angry that the caseworker was at her home, but soon participated in the investigation and interview after being calmed down by her out-of-state relatives, who had recently arrived and would be staying with Ms. Hartley for a few days while she dealt with the loss of her family member. From the record, it appears that the caseworker conducted a thorough interview with Ms. Hartley covering all of the expected topics: substance use, mental health, domestic violence, prior CPS involvement, Ms. Hartley's former partner, family supports, the children, the family's medical and service providers, and the allegations made in the report. The caseworker also interviewed Ms. Hartley's two older children and observed the third. The resulting information was relayed by the standby caseworker to the standby supervisor who entered the preliminary safety decision which found that the children were safe in the home. In our discussions with both the standby caseworker and the standby supervisor, the preliminary safety decision was based on several factors:

- Ms. Hartley did not appear to be actively experiencing a current mental health crisis during the caseworker's visit;
- Ms. Hartley was under the care of a physician and taking prescribed medications;
- Ms. Hartley's children appeared cared for and did not disclose any abuse;

- the family had service providers—none of whom had called in any concerns—who would continue to be involved with the family moving forward; and
- most importantly, the out-of-state relatives would be staying with Ms. Hartley for a few days, serving as familial supports, and would be able to ensure the safety of the children.

With the preliminary safety decision made, the investigation would continue with the same caseworker, but under the supervision of their usual supervisor moving forward. However—and as noted in the preliminary safety decision—Ms. Hartley's out-of-state relatives would be leaving in a few days and were reportedly the most significant factor in determining that the children were safe in the home. We conclude that upon the transfer of the investigation to the caseworker's regular supervisor, this information warranted additional interventions or a safety plan (such as additional supports, the required presence of a safe adult in the home or increased monitoring) to ensure the safety of the children while in the care of Ms. Hartley. However, we did not see any evidence that such actions occurred or were even considered.

Overarching Practice Issues That Hindered the Department in Making Additional Necessary and Appropriate Safety Decisions

Throughout our review of this family's CPS involvement, it became apparent that, over time, certain practice issues, mistakes, and missed details and connections all contributed to the Department not fully understanding some risk factors and safety threats that were present in the home. Consequently, as caseworkers and supervisors would not be able to act upon what they did not know, the safety of Ms. Hartley's children was compromised at some specific points in the timeline. We discussed these points with OCFS staff: what was known, what could have been known, and what caseworkers and supervisors would have done had they better understood the risk factors and safety threats. They indicated that with that additional knowledge at those points, different safety decisions and additional interventions would have been warranted. The two practice issues that contributed to much of what occurred are described below.

<u>Overarching Practice Issue 1: Important Connections Missed by OCFS Across Multiple Investigations Regarding the Risks Posed by Ms. Hartley's Relative (And Alleged Abuser of Her Children)</u>

Throughout this family's history of CPS involvement, caseworkers were informed of the recent presence of one of Ms. Hartley's relatives, but were unable to recognize that this relative was the same relative who was the alleged sexual abuser of Ms. Hartley's children in March of 2019. We found that this inability was often the result of either a mistake, a systems issue, a lack of comprehensive review of the family's history, simply not seeing the connection or some combination (often compounding) of any of these factors. Ultimately, it resulted in the Department never fully understanding that Ms. Hartley was allowing the alleged sexual abuser of her children to reside in her home with those very same children on two later occasions that either overlapped or directly preceded CPS investigations. The timeline of how that came to be and the intersection of the various factors contributing to that are described below.

On March 21, 2019, the Department received a report from a medical provider that the paternal grandmother of Ms. Hartley's children had brought a child in for an examination as the child had disclosed that a relative

had touched them inappropriately. The relative was identified only by their familial relationship to Ms. Hartley (such as her sister, brother, uncle, etc.) as the referent did not know the relative's name. It appears that intake caseworkers then used that information in conjunction with Ms. Hartley's CPS history as a youth to determine the name and identity of the relative/alleged abuser, which was added to the report that would be assigned to the caseworker. However, the name that intake added was the relative's birth name rather than the relative's adoptive name that they were currently using—and had been using for quite some time. (This is noted as Practice Issue 3.)

On March 26, 2019, the caseworker interviewed Ms. Hartley. From the audio recording of this interview, we learned that the caseworker asked Ms. Hartley for the name of the relative and Ms. Hartley provided the relative's adoptive name. This name was not documented in the record, and, given what happens soon after, it does not appear that the caseworker noticed that the relative's name provided by Ms. Hartley did not match the relative's name in the report.

The caseworker later performed background checks for Ms. Hartley, the father of Ms. Hartley's children, the children's paternal grandmother, and Ms. Hartley's relative who was the alleged abuser. However, as evidenced by the records received by the caseworker, the background checks they ran on the relative were pulled using the relative's birth name—which was how intake screened the relative into the report—rather than the relative's adoptive name that Ms. Hartley had provided. As a result, the background checks for this individual did not return any records. A background check using the correct name would have returned the relative's true criminal history that, at that point in time, contained multiple domestic violence convictions (threatening, terrorizing, and assault), a history of violating conditions of release and/or probation violations, and a variety of other offenses.

We interviewed OCFS staff (including the caseworker assigned this investigation) regarding what would have occurred had the caseworker learned of Ms. Hartley's relative's criminal history. They explained that, with that information, further investigation and scrutiny of the relative would have been warranted—including a review of the relative's CPS history as an adult.

We requested that history from OCFS as only a small portion of it was ever seen and documented in the record by caseworkers. The relative's CPS history (again, as an adult) prior to 2019 (when the investigation of the relative's alleged sexual abuse of the children occurred) spanned nearly a decade. During that time, we observed that the relative could not have unsupervised contact with one of their children, had a PFA filed against them on behalf of one of their children and the child's other parent, had domestic violence issues and concerns with at least two different partners, and was alleged to have sexually abused another one of their children.

OCFS staff stated that had this been known during this investigation, there would have needed to be a conversation with Ms. Hartley to determine why the relative had been caring for her children and whether Ms. Hartley knew about the relative's past; if so, findings of neglect may have been made against Ms. Hartley, but other actions would probably not have been deemed appropriate at that time as Ms. Hartley was currently protecting her children and preventing their contact with the relative.

Instead—based on what was known at the time—the investigation was closed with no findings as the caseworker did not have any evidence indicating that Ms. Hartley had been abusive or neglectful towards any of her children while in her care and the fact that the Department could not make findings against a non-caregiver (which is how the caseworker and supervisor viewed Ms. Hartley's relative). In the closing summary for this investigation, the caseworker noted that if Ms. Hartley were to allow the children to have contact with the relative, a new report would need to be made to determine the level of safety. In that same documentation, we note that the caseworker identified the relative using their birth name and that the report and this investigation remained linked to the relative's birth name, as screened in by Intake, and not their adoptive name.

In February 2020, the same caseworker was assigned another investigation of this family after a school employee reported that one of the children had an ear injury, referenced earlier in this report, that was allegedly caused by a man staying at Ms. Hartley's home. While Ms. Hartley's relative was not a part of this incident or investigation, they were discussed on February 5th when the caseworker asked Ms. Hartley if there had been any contact with the relative/alleged abuser from the March 2019 investigation. Ms. Hartley indicated that there had been, but only because she did not believe that the relative had done anything to her children, and, instead, thought a different relative had abused them. The caseworker asked if the children were being monitored around the relative and Ms. Hartley stated yes.

As the children were reportedly having contact with the relative, we conclude that this would appear to be an appropriate time for the caseworker to follow-up on the results of Bangor PD's criminal investigation of the relative's alleged sexual abuse of the children (which had been underway when the prior CPS investigation had closed). We did not see any evidence that this occurred, which we note as Practice Issue 6[2].

In March 2020, the same caseworker was assigned their third investigation of this family after law enforcement reported that one of Ms. Hartley's children had been found unattended by the side of the road by a neighbor. The referent also reported that law enforcement had been called to the home the night before to remove a man—possibly Ms. Hartley's relative—from the home as there were concerns that this person had just been released from jail and had drugs in their possession.

On March 16th, the caseworker conducted interviews (which were recorded) with Ms. Hartley and the woman living in Ms. Hartley's home. In addition to asking about the child being unattended in the street, the caseworker also asked Ms. Hartley and the woman if there had been an incident involving Ms. Hartley's relative the night before. Ms. Hartley explained that her relative had been using drugs in the home and that

[2] On May 9th, Bangor PD attempted to serve the search warrant at the apartment where the relative was believed to be staying. The officers knocked on the door loudly, but no one answered. Outside the apartment, the officers saw movement through the windows of the apartment. They then forced the door to the apartment open and found the relative in the apartment. The officers explained why they were there and interviewed the relative. Two cell phones were seized from the relative. A forensic examination of the phones was conducted by Bangor PD and no images of sexually explicit material were found. On July 19th, the relative was involved in a domestic incident and was no longer residing at the apartment. Bangor PD did not know the man's whereabouts nor did the man contact the detective to retrieve their phones or take the polygraph that the relative had agreed to during the earlier interview. The detective noted that they did not have enough evidence at this point in time to charge the relative with a crime and recommended that the investigation be suspended pending locating the relative and/or the discovery of new evidence.

the woman had called law enforcement to have the relative removed from the home. The woman then provided additional context and disclosed that after Ms. Hartley's relative had been released from jail, Ms. Hartley allowed the relative to live in Ms. Hartley's home as long as the relative was sober. A little more than a week prior to the current incident, Ms. Hartley and the woman discovered that the relative was using substances in the home and kicked the relative out of the home. Days before the current incident, another relative of Ms. Hartley's was visiting the home and stayed overnight. The relative who had been kicked out of the home invited themselves over to see that other relative and spent the night as well. When the other relative left, the relative who had been kicked out of the home did not leave and remained in Ms. Hartley's home. Then, the night prior to the child being found unattended by the side of the road, the woman called law enforcement to have the relative removed from the home after the relative continued to use substances and leave bottles of ibuprofen where the children could access them. Ms. Hartley then noted that she had filed a PFA against her relative so that the relative could not be around her, her children, or the home.

Throughout the entirety of the recorded interviews, we did not hear Ms. Hartley or the woman refer to the relative by name, instead only using the relative's familial relationship to Ms. Hartley (such as her sister, brother, uncle, etc.). We also did not hear the caseworker ask for Ms. Hartley's relative's name. Based upon the subsequent actions taken by the caseworker in this investigation, it does not appear that the caseworker made the connection that the relative and alleged abuser of the children from the March 2019 investigation was the same relative as the one Ms. Hartley had allowed to live in her home until being kicked out for substance use. In our interviews with both the caseworker and their supervisor, they reported that, at that point, they were unclear that this was the same relative. Even though the caseworker and supervisor had questioned the credibility of the children's disclosures in March 2019, they still indicated that had they known that this was the same relative, they would have probably kept the family open as a service case with the Department (instead of referring them to ARP as was done) and possibly filed jeopardy, which would have allowed the Department to enlist more services for the family, compel Ms. Hartley's participation in those services, and conduct a more extensive evaluation of Ms. Hartley. Additionally, the Department could have made findings against Ms. Hartley for allowing the relative to reside in her home with her children.

On March 25th, the caseworker requested a copy of the PFA that Ms. Hartley said she had filed against her relative. Staff from the Bangor District Court[3] reported to the caseworker that no such PFA could be found in their system nor statewide. We did not see any evidence that this inconsistency was ever explored or discussed by the caseworker with Ms. Hartley, a fact we noted as a component of Practice Issue 5. Also, in the caseworker's documentation of their request for a copy of that PFA, we observed that the caseworker identified Ms. Hartley's relative using the relative's birth name—which was the same name the caseworker used for this individual in the March 2019 investigation. This was the first time in the record that there was any documented link between the relative appearing in the March 2019 investigation and the relative appearing in the current investigation. Although this link exists in the documentation, it does not appear that the caseworker actually made the connection that Ms. Hartley had allowed the previously alleged abuser of

3 Please note: the Director of OPEGA was the Clerk of the Bangor District Court, as well as for the other state courts in Penobscot County, at this time. Other professional staff in OPEGA reviewed and evaluated these facts, accordingly. This fact is shared here in the interests of full disclosure, and does not impact the substantive relevant analysis here.

her children to reside in her home with those same children as we did not see any documentation of this being explored with Ms. Hartley.

On March 27th, the Brewer Police Department provided a copy of the police report from the night Ms. Hartley's relative was asked to leave the home. The report indicated that the relative was issued a Criminal Trespass Notice, and referred to the relative using their adoptive name. We do not see any evidence that the caseworker noticed this or realized that they had conducted a prior investigation and background check using the incorrect name. However, both the caseworker and supervisor indicated to us that by this point, they had realized that the relative/alleged abuser from the March 2019 investigation was the same relative as in the current investigation. We would note that there are no references to the relative in the closing summary or findings letter sent to Ms. Hartley. On March 31st, the caseworker sent the findings letter to Ms. Hartley notifying her that the Department had made an indicated finding of low/moderate severity neglect against her and that a referral to ARP had been made.

As noted earlier, above, in June 2020, the Department received a report from a law enforcement officer expressing concerns for Ms. Hartley's mental health and her ability to care for her children following the death of a family member that had occurred in Ms. Hartley's home. The officer also added that two other individuals were residing in the home: Ms. Hartley's relative (the same relative named as the alleged abuser of her children in March 2019) who was now on probation for domestic violence, and the relative's partner who was on probation for drug-related criminal matters. We note that the officer referred to the relative using the relative's adoptive name.

On June 20th, the standby caseworker went to the home to interview Ms. Hartley and observe the children. When describing the family's CPS history during that interview, Ms. Hartley recounted the March 2019 investigation in which two of her children were alleged to have been abused by Ms. Hartley's relative. Ms. Hartley stated that her relative denied this, and that she now believed the relative because the relative was now sober. Ms. Hartley reported being unsure at the time when the allegations were made.

The standby caseworker observed the children and the home, and noted a third-floor bedroom where Ms. Hartley's relative and the relative's partner appeared to have been staying. The caseworker told Ms. Hartley that the relative's partner could not be at Ms. Hartley's home as the relative's partner was well-known to the Department and was not allowed unsupervised time with their own kids. The caseworker also told Ms. Hartley that given that her relative was partnered with this individual, the relative should also not be in the home with the exception of making arrangements for the deceased family member. Ms. Hartley stated that her relative and the relative's partner were currently staying in a hotel.

On June 22nd, the caseworker obtained SBI/DMV/SOR[4] background checks and CPS histories for Ms. Hartley, Ms. Hartley's former partner (and father of her children), and the two individuals who had been staying in Ms. Hartley's home just prior to the investigation—Ms. Hartley's relative and that relative's partner. The relative's partner's criminal history included charges for harassment, criminal trespassing, operating under the influence, and operating a meth laboratory; their CPS history included five investigations—two of which

[4] State Bureau of Identification/Motor Vehicle/Sex Offender Registry.

resulted in substantiated findings of neglect and the eventual termination of their parental rights. Ms. Hartley's relative's criminal history contained multiple domestic violence convictions (threatening, terrorizing, and assault), multiple violations of conditions of release and/or probation violations, and a variety of other offenses. Ms. Hartley's relative's CPS history only contained one unsubstantiated report from 2012—which we learned was the result of a systems issue (see fuller description in Systems Issue 1) in which multiple profiles could exist under a single individual with each profile containing elements of the individual's CPS history. The caseworker had apparently selected one of the relative's profiles—most likely one that contained other data fields that they recognized (such as an address)—and received only a small portion of the relative's CPS history.

On June 24th, the caseworker assigned the investigation called and interviewed the father of the children. The father reported having seen two of his children on June 18th and was unsure of their safety in their mother's care, but that Ms. Hartley was doing the best that she could. The father also reported being concerned that Ms. Hartley's relative was around his children, particularly given the prior allegations. This was the second time that these allegations had been mentioned to the caseworker, as Ms. Hartley had also discussed it in her initial interview with the caseworker. However, it does not appear that the caseworker realized that these allegations were not captured in the relative's CPS history that the caseworker had obtained. We conclude that this further contributed to the caseworker and supervisor not even considering any safety decisions or related actions to address the risk posed to Ms. Hartley's children by the relative's continued presence in the home. Had that history been known and the risk understood, OCFS staff indicated that instead of referring the case to ARP (which is what happened), a more likely course of action would have been for the Department to open their own service case with the family. Then, if Ms. Hartley failed to comply with the established service plan, file a jeopardy petition asking for court-ordered services for Ms. Hartley and custody of the children. If Ms. Hartley participated and complied with the court-ordered services, the Department could decide to no longer request custody of her children when the hearing on the petition was held.

Ultimately, across three different investigations in which Ms. Hartley's relative was either the alleged abuser of her children or had been recently allowed to live in Ms. Hartley's home, the Department was unable to assemble enough information to understand the risks posed by Ms. Hartley's relative to her children. At times, the missing or incomplete information included the relative's criminal history, the relative's CPS history, the children's disclosures made at the Children's Advocacy Center (CAC)[5] of the alleged sexual abuse by the relative, and the results of Bangor PD's criminal investigation of that alleged abuse. At other times, the information provided to caseworkers—such as the relative's name and CPS history—was wrong. And in the processing of that information, caseworkers failed to notice discrepancies in the information provided to them by various sources. We also note caseworkers' apparent focus on the specific allegations made in the reports, rather than a more holistic approach to assessing the safety of the family as another contributing factor. From our discussions with OCFS staff, it is apparent that these deficiencies had an impact on the investigations as other safety decisions and interventions would likely have been made to ensure the safety of the children.

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[5] The Children's Advocacy Center (CAC) is a child-focused, facility-based program where professionals from law enforcement, child protection, prosecution, mental health services, medical and victim advocacy, and child advocacy work together to interview children who have disclosed sexual abuse.

Overarching Practice Issue 2: No Comprehensive Review of the Family's Prior CPS Involvement That Would Have Shown a Pattern of Ms. Hartley Allowing Unsafe Individuals Around Her Children

At multiple points in the timeline, caseworkers appeared to only consider and respond to the specific incidents identified in their assigned reports, and did not have a full understanding of the family's prior CPS involvement, including previously identified safety risks and concerns that would continue to be relevant. We conclude that these incident-based responses also prevented caseworkers from identifying inconsistencies in information provided by critical case members over time, and hindered caseworkers' ability to identify patterns of concerning behavior that, cumulatively, may have warranted further CPS intervention.
One such pattern was Ms. Hartley continually allowing unsafe individuals to be around her children over a span of time:

- In March 2019, two of Ms. Hartley's children alleged that Ms. Hartley's relative had sexually abused them. For one of the children, the alleged abuse occurred when Ms. Hartley left the child in the care of her relative for almost three days. At that time, the relative's criminal history contained multiple domestic violence convictions (threatening, terrorizing, and assault), a history of violating conditions of release and/or probation violations, and a variety of other offenses. The relative's CPS history at that time indicated that the relative could not have unsupervised contact with one of their children, had a PFA filed against them on behalf of one of their children and the child's other parent, had domestic violence issues and concerns with at least two different partners, and was alleged to have sexually abused another one of their own children.
- From November 2019 to June 2020, Ms. Hartley allowed a man, a woman, and their young child to reside with her and her children in her home. The man had a history of domestic violence, violating conditions of release/probation violations, a violation of a PFA that his partner—the woman living in Ms. Hartley's home—had filed against him after she alleged he choked, hit, and punched her, and was the alleged physical abuser of one of Ms. Hartley's children in February 2020. At the end of that investigation, the caseworker wrote in the closing letter to Ms. Hartley that the man should not be a caregiver for her children.
- In March 2020, the caseworker learned that Ms. Hartley had allowed her relative (the alleged abuser of her children in March 2019) to stay in the home with her and her children until the relative was removed from the premises by law enforcement after allegedly using substances in the home.
- At some point, between March and June 2020, Ms. Hartley moves in a family member to help her care for the children; that family member previously had their parental rights terminated for their own children.
- In June 2020, the law enforcement officer making the report notes that Ms. Hartley's relative (the alleged abuser of her children in March 2019), who is now on probation for domestic violence, is living in Ms. Hartley's home along with the relative's partner, who is also on probation and not allowed unsupervised contact with their own child.
- Later in June 2020 (after Ms. Hartley's relative and their partner are no longer in the home), Ms. Hartley allows another relative to move into the home. This relative had their own CPS history (albeit

dated) and other factors that led to the Department recommending that this relative not be allowed to watch Ms. Hartley's children for more than an hour.

From a comprehensive review of this family's CPS history, it becomes apparent that Ms. Hartley continued to demonstrate a lack of protective capacity and an inability to keep unsafe people away from her children. OCFS staff indicated that this lack of protective capacity would warrant additional Departmental action; however, they also noted that caseworkers generally do not have the time available to perform the comprehensive review of a family's history that is necessary to identify such patterns.

We note that this was only one example of several patterns that emerged from a comprehensive review of the family's CPS history: Ms. Hartley's inconsistent descriptions of her substance use and mental health issues; the parents' inability to follow through with appointments, referrals, and recommended services; Ms. Hartley's lack of safe, familial supports; potential medical neglect; and how nearly everyone who interacted with Ms. Hartley (medical providers, service providers, friends, housemates) eventually reported her to CPS.

Recommendation:

OCFS should develop a process and standard for identifying which families' CPS histories should be subject to a more comprehensive review. Additionally, OCFS should ensure that any staff assigned this work have the time and resources needed to conduct them.

Specific Practice Issues Prior to the Announcement of Ms. Hartley's Pregnancy with Jaden

Over the course of our review, we identified several practice issues that occurred at specific points in this family's history of CPS involvement. The majority of those occurred prior to Ms. Hartley's announcement that she was pregnant with Jaden and are described in the following sections.

Practice Issue 1: Extremely Overdue Investigation with Periods of No Investigative Activity (April 2018)

On April 9th, the Department received a report from law enforcement following their response to a reported domestic violence incident at the home of Ms. Hartley and her partner. The referent explained that Ms. Hartley and her partner admitted to a verbal altercation which occurred in front of their children. While in the home, law enforcement determined that there was an active warrant for the arrest of Ms. Hartley's partner for unpaid fines and placed him under arrest. Ms. Hartley's partner was uncooperative and had to be forcibly handcuffed in front of the children. This report was screened in for investigation.

On April 12th, the assigned caseworker went to the home to interview Ms. Hartley and her partner, and to observe the children. During separate interviews, Ms. Hartley and her partner admitted that they had been arguing that night about the partner's substance use—which Ms. Hartley pointed out was never in front of the kids—and the partner staying out all night. Both denied domestic violence. The partner stated that he was waiting for his mother to come pick him up and take him to a hospital where he would seek substance use treatment; Ms. Hartley reported that her partner needed help in getting clean, and that she was willing to support him in any treatment he needed. Ms. Hartley expressed a great deal of anxiety about the Department

being involved and made it clear that the last thing she wanted was for her children to be taken from her and placed in foster care.

The caseworker observed the children, who appeared healthy, clean, and had no visible marks or bruises. The caseworker then consulted their supervisor who made and entered the preliminary safety decision that found the children were safe in the care and custody of their mother while the investigation continued. However, following that decision on April 12th, we did not observe any evidence that any subsequent steps of this investigation were conducted until June 28th when a new report is added on to this still open investigation.

On June 28th, the Department received an anonymous report that one of Ms. Hartley's young children had been left outside in a walker and fallen off a deck, which resulted in bruises to the child's head. The referent also noted that Ms. Hartley did not seek medical care for the child. Additionally, the referent expressed concerns about Ms. Hartley leaving her children alone with potentially unsafe people in unsafe environments outside of the family shelter where Ms. Hartley and her children had been staying. This report was screened in for investigation and added to the existing and still open April 2018 investigation.

On June 29th, the caseworker met with Ms. Hartley and her three children at the DHHS offices; Ms. Hartley was also accompanied by her adoptive mother and adoptive grandmother. Ms. Hartley reported that she and the children had been staying at a family shelter after she was evicted due to her former partner not paying the bills and taking all of their money. Ms. Hartley revealed that her former partner had "gotten physical" with her and that she had filed a protection from abuse order (PFA) against him that prevented the former partner from having contact with her or the children for two years.

Regarding the incident noted in the report, Ms. Hartley explained that while visiting on the deck of a close friend's home, one of the children left a gate open on the deck. One of her children was in a walker and made it to the stairs before Ms. Hartley could stop them. The child fell and had a bruise on their head, but Ms. Hartley did not think it was serious enough to take the child to the emergency room. Instead, the child was given ibuprofen and monitored by Ms. Hartley. Ms. Hartley provided the caseworker with the phone number of the close friend so that the caseworker could discuss the incident directly with them. Ms. Hartley was angry that another report had been made and stated that the last thing she wanted for children to be taken from her. Ms. Hartley did accept a referral for case management services. The caseworker observed each child and noted no marks or bruises on any of them, including the child who fell off the deck.

Later that day, a supervisor covering for the caseworker's regular supervisor entered the preliminary safety decision, which apparently found that the children were safe in the care of their mother as no safety plans or conditions were noted. Following the preliminary safety decision that is made on June 29th, only two events are documented in the narrative log over the next three months: the caseworker's receipt of a phone call from the children's paternal great-grandmother asking the caseworker to pass a message along to Ms. Hartley on July 9th, and the confirmation of Ms. Hartley's account of what occurred on the deck by Ms. Hartley's close friend who the caseworker was meeting with on another matter on July 9th. Other than the work documented on July 9th, we did not observe any evidence that any subsequent steps of this investigation were conducted until October 7th when yet another new report is added on to this still open investigation.

On October 7th, the Department received a report from a friend of Ms. Hartley that Ms. Hartley was struggling to care for her three children. The friend alleged that Ms. Hartley was not supervising her children and failing to get the children to their medical appointments. The referent was not going to allow Ms. Hartley at her home anymore because of Ms. Hartley's behavior and how Ms. Hartley treated her children and the referent's children. The referent also reported that Ms. Hartley was having contact with her former partner despite the active PFA and that Ms. Hartley had posted on Facebook that she and her children were moving to Bangor with her biological parents to "get away from DHHS." The referent added that Ms. Hartley had been removed from her parents' care as a child. This report was screened in for investigation and added to the existing and still open April 2018 investigation.

On October 9th, the caseworker left a message for the referent asking them to contact the caseworker so that the caseworker could get more information on the referent's report. That same day, the caseworker left messages for Ms. Hartley and the family shelter where Ms. Hartley had been staying asking Ms. Hartley to contact the caseworker. On October 23rd, the caseworker documented a conversation with a mental health professional regarding a mutual client in which the mental health professional informed the caseworker that they were also working with Ms. Hartley. The mental health professional reported that they did not have any current concerns regarding Ms. Hartley, and that Ms. Hartley had been working with a case manager. On November 6th, the caseworker again left messages for Ms. Hartley and the family shelter where Ms. Hartley had been staying asking Ms. Hartley to contact the caseworker. On December 3rd, the caseworker emailed the mental health professional to follow up on their work with Ms. Hartley; no response was documented. That same day, the caseworker wrote a letter to Ms. Hartley stating that the Department did not find that Ms. Hartley had abused or neglect her children, and that the Department would be closing the investigation. We noted two issues following the last report: the lack of efforts to locate/contact the family (Practice Issue 2) and that report's unexplored allegations (Practice Issue 4).

Lastly, the undated closing summary for this investigation noted that the Department was unable to substantiate findings against Ms. Hartley for neglect, but did make indicated findings of emotional maltreatment and substantiated findings of threat of physical abuse against the three children by their father (Ms. Hartley's former partner). On December 12, 2018—247 days after the initial report—the caseworker sent a letter to Ms. Hartley's former partner describing these findings.

During interviews with the caseworker and the caseworker's regular supervisor, they confirmed that the record accurately reflected what had occurred throughout this investigation, and that there were, in fact, extended periods of time where little to no work was performed. The caseworker and their supervisor further explained that this was the result of an overwhelming and unmanageable workload at that time caused by major OCFS policy changes[6] made in response to the 2018 fatalities of two children.

[6] In early 2018, the Department's then administration instituted two policy changes. The first policy change required automatic investigations whenever a family had been the subject of three or more inappropriate reports (i.e. those reports determined to have not met the established criteria for opening an investigation). The second policy change required OCFS to "take back" all cases that had been assigned to ARP from August 2017 forward that had not yet been completed by ARP. This could be due to ARP being unable to locate the family, the family refusing services or ARP being

With such high reported workloads, the caseworker and supervisor described being forced to triage their investigations in a manner that best ensured the safety of the children on their caseloads. New reports and investigative work for the most serious cases—including removals were prioritized. Investigative work and the closing of investigations for those children in the safest situations were not prioritized—and this is how Ms. Hartley's family was regarded at the time as Ms. Hartley had filed a PFA against her former partner and was now residing with her children in a family shelter that could monitor and support the family.

Recommendation:

Although we did not review data that would enable us to quantify the impact of the 2018 policy changes on workloads, we would still recommend that the Department take a thoughtful, measured approach to future policy changes with a focus on potential workload impacts to avoid similar risks—especially as the Department experiences difficulties in the recruitment and retention of caseworkers.

Practice Issue 2: Inadequate Efforts to Locate the Family (April 2018)

Following the October 7th report that was added to the still open, April 2018 investigation, the caseworker's attempts to contact Ms. Hartley consisted of only a pair of phone messages left with Ms. Hartley and the family shelter where she was last known to be staying (as the report alleged Ms. Hartley was moving to Bangor with her biological parents).

Caseworkers are to make every effort to locate all critical case members using the strategies contained within the Activities to Locate tool, and to document those efforts. Strategies referenced in this tool include searching OCFS records and other state agency records; contacting relatives, friends, providers, employers, landlords, etc.; and performing internet searches.

There were several actions that one would expect the caseworker to potentially take:

- make an in-person visit to the family shelter to see whether Ms. Hartley was still staying there, and, if so, possibly speak to her about the report;
- contact Ms. Hartley's biological parents, as the report alleged Ms. Hartley was moving there;
- contact Ms. Hartley's former partner, as the report alleged Ms. Hartley was seeing him; and

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otherwise unable to provide the services. These cases were referred back to the appropriate OCFS districts and investigated anew.
There were issues with these approaches. As some members of the public became aware of the "three inappropriate reports" policy, some in contentious situations (like a divorce) increased their reporting, which resulted in OCFS caseworkers investigating allegations that would typically be screened out. The "take back" of ARP cases resulted in OCFS caseworkers investigating reports that were up to six months old and had already been investigated.
We note that the automatic investigation after three inappropriate reports policy has been discontinued, all the applicable ARP cases have been referred back, and there are no more ARP cases to refer as the ARP contract was not renewed.

- contact Ms. Hartley's adoptive family members who accompanied her to the DHHS offices in June to meet with the caseworker.

However, we did not see any evidence that any of these actions were undertaken, which was confirmed by the caseworker and supervisor. They further explained that given the workload issues they were facing at the time, what they believed to be the relative safety of Ms. Hartley's children, the nature of the allegations made against Ms. Hartley (primarily neglect), the lack of contact from Ms. Hartley, and the length of time that the investigation had been open, that closing the case was a better choice than continuing to make efforts to contact Ms. Hartley.

Recommendation:

As the Department continues to update its investigations policy and any related documents, we recommend that the "Activities to Locate" tool continue to be used and caseworkers continue to be trained in its application.

Practice Issue 3: Incorrect Identification of Alleged Abuser by Intake (March 2019)

On March 21st, a report was made by a medical provider that the paternal grandmother had brought the child residing with them in for an examination as the child had disclosed that a relative had touched their genital area. The relative was identified only by their familial relationship to Ms. Hartley (such as her sister, brother, uncle, etc.) as the referent did not know the relative's name. This report was screened in for an investigation. From the documentation of the report, it appears as though intake caseworkers used the familial relationship between Ms. Hartley and the relative (which was provided by the referent) and Ms. Hartley's CPS history as a youth to determine the name and identity of the relative, which was then added to the report that would be assigned to a caseworker. However, the name that intake added ("screened in") to the report used the relative's birth name rather than the relative's adoptive name that they currently used[7].

This error soon made an impact as the caseworker performed background checks for Ms. Hartley, the father of Ms. Hartley's children, the children's paternal grandmother, and Ms. Hartley's relative who was the alleged abuser. However, as evidenced by the records received by the caseworker, the background checks they ran on the relative were pulled using the relative's birth name—which was how intake screened the relative into the report—rather than the relative's adoptive name that Ms. Hartley had provided during an interview with the caseworker. As a result, the background checks for Ms. Hartley's relative did not return any records—which did not accurately reflect the relative's actual criminal and motor vehicle histories. At that point in time, the relative's actual criminal history contained multiple domestic violence convictions (threatening, terrorizing, and assault), a history of violating conditions of release and/or probation violations, and a variety of other offenses—which would have warranted additional scrutiny and, possibly, eventual further action by OCFS according to those we interviewed.

[7] The relative's last name had changed upon adoption; their first name remained the same.

Recommendation:

While we do not know the extent to which intake screening errors such as this occur, we do recommend that OCFS consider implementing a mechanism into their existing process to denote instances in which intake—and not the referent—has identified a critical case member. In denoting these individuals, caseworkers may be more cognizant of the need to verify the accuracy of the identities provided solely by intake.

Practice Issue 4: Reported Allegations and Safety Threats Unexplored by Caseworkers (April 2018, March 2019, and March 2020)

While the April 2018 investigation continued to remain open, a new report was made on June 28th that was added to the existing investigation. This report contained two allegations: that Ms. Hartley's child had fallen from a deck and Ms. Hartley did not seek medical care for the child; and that Ms. Hartley was leaving her children alone with potentially unsafe people in unsafe environments. However, we did not find any evidence that the caseworker explored the latter allegation related to where and with whom Ms. Hartley was leaving her children.

On October 7th, 2018, yet another new report was added to the still open April 2018 investigation when a friend of Ms. Hartley reported that Ms. Hartley was struggling to care for her three children. The referent alleged that Ms. Hartley was not supervising her children and failing to get the children to their medical appointments. The referent also reported that Ms. Hartley was having contact with her former partner despite the still active PFA prohibiting that contact. They also noted that Ms. Hartley had posted on Facebook that she and her children were moving to Bangor with her biological parents to "get away from DHHS." The caseworker was unable to contact Ms. Hartley, leaving these allegations unexplored.

In the March 2019 investigation of Ms. Hartley's relative's alleged sexual abuse of two of her children, the investigation remained open while awaiting Spurwink's written evaluations of the children's physical examinations. During that period, a family service provider made a report on June 19th that Ms. Hartley had disclosed overhearing a relative—but not the relative/alleged abuser identified in that investigation—through the wall saying that they were going to abuse one of the children and blame it on Ms. Hartley so that the children would be taken away from Ms. Hartley. This report was screened out as there was no direct allegation of abuse or neglect occurring to a particular child, but added as an "FYI report" in the narrative log of the current investigation and emails were sent to the caseworker and their supervisor. We did not see any evidence that the caseworker explored this allegation with either Ms. Hartley or the relative; when interviewed, the caseworker did not believe that they had.

Recommendation:

OCFS should clarify and communicate its expectations for what caseworkers should do when an "FYI report" that would otherwise be screened out is added to an open investigation. For other

screened-in reports containing multiple allegations, supervisors should ensure that caseworkers, at a minimum, discuss all allegations with the parents/caregivers.

Practice Issue 5: Inconsistent and Sometimes False Information Unexplored by Caseworker (February 2020 and March 2020)

During the February 2020 investigation of one child's ear injury that was allegedly inflicted by a man living in Ms. Hartley's home, the caseworker obtained reports from Bangor PD involving the man. From the first of those reports, the caseworker would have known that the man's current partner had taken out a PFA against him, and had stated to law enforcement that she did not feel safe staying at her address so she went to stay with a relative. The caseworker also knew that he had violated that PFA a little over three months prior. Despite these facts and their inconsistency with his (and his partner's) current statements regarding domestic violence, we did not see any evidence that the caseworker explored these inconsistencies with either the man or the partner. In discussing this with the caseworker, we were told that they did not raise the issue in an effort to protect the man's partner in case the man assumed that his partner had told the caseworker. However, it appears that the caseworker could have simply shown the man the reports the caseworker had obtained, and, truthfully, indicated that those were the source of the caseworker's information—and not the partner.

Similarly, during the March 2020 investigation of one of Ms. Hartley's children being found unattended by the side of the road by a neighbor, it was learned that Ms. Hartley's relative (the alleged abuser of her children in the March 2019 investigation) had been staying at Ms. Hartley's home until the relative was removed from the premises by law enforcement. Ms. Hartley then claimed that she had filed a PFA so that the relative could not be around her, her children, or the home. However, on March 25th, the caseworker requested a copy of the PFA that Ms. Hartley said she had filed against her relative. Staff from the Bangor District Court reported that no such PFA could be found in their system nor statewide. We did not see any evidence that this inconsistency was ever explored or discussed by the caseworker with Ms. Hartley.

Recommendation:

OCFS should make efforts to communicate and reinforce its expectation that caseworkers identify and challenge inconsistencies in the information provided to them by families.

Practice Issue 6: Status of Bangor Police Department Investigation Unexplored by Caseworker (February 2020 and March 2020)

In the closing letter to Ms. Hartley following the March 2019 investigation of the alleged sexual abuse of two of her children by Ms. Hartley's relative, the caseworker stated that the Department closed its investigation as they did not have any evidence that Ms. Hartley had been neglectful towards any of the children in her care. The caseworker also noted that the Department cannot make findings against a non-caregiving adult, but a criminal case was opened and Bangor PD may still be working on their portion.

It is our understanding that CPS investigations and criminal investigations are distinctly different in both scope and process, and it is not uncommon for a CPS investigation (which has a focus on parents/caregivers and a different standard of evidence) to conclude well before a criminal investigation that also resulted from the same initial report. That is what occurred in this case when the March 2019 investigation closed, which was entirely appropriate. However, the caseworker assigned to the March 2019 investigation was also assigned to two more investigations of Ms. Hartley's family in February 2020 and March 2020, yet never followed up on the status of that prior Bangor PD investigation—even when Ms. Hartley's relative/alleged abuser of her children was learned to have been around the children.

During the February 2020 investigation, the caseworker asked Ms. Hartley if there had been any contact with her relative/alleged abuser of the children. Ms. Hartley stated yes, but only because she did not believe that the relative had abused her children (instead thinking a *different* relative had abused the children). The caseworker asked if the children were being monitored around Ms. Hartley's relative, and Ms. Hartley indicated that they were.

During the March 2020 investigation, the caseworker asked Ms. Hartley and the woman residing in Ms. Hartley's home if there had been an incident involving Ms. Hartley's relative/alleged abuser of her children the night before. Ms. Hartley explained that her relative had been using drugs in the home and that the woman had called law enforcement to have the relative removed from the home. The woman then provided additional context and disclosed that after Ms. Hartley's relative had been released from jail, Ms. Hartley allowed the relative to live in Ms. Hartley's home as long as the relative was sober. A little more than a week prior to the current incident, Ms. Hartley and the woman discovered that the relative was using substances in the home and kicked the relative out of the home. Days before the current incident, another relative of Ms. Hartley's was visiting the home and stayed overnight. The relative who had been kicked out of the home invited themselves over to see the other relative and spent the night as well. When the other relative left, the relative who had been kicked out of the home previously did not leave and remained in Ms. Hartley's home. Then, the night prior to the child being found unattended by the side of the road, the woman called law enforcement to have the relative removed from the home after the relative continued to use substances and leave bottles of ibuprofen where the children could access them. Ms. Hartley then noted that she had filed a PFA against her relative so that the relative could not be around her, her children, or the home.

In both of these later investigations, we believe the results and status of the relative's criminal investigation would have been relevant to the caseworker's assessment of the family's safety, and, more specifically, Ms. Hartley's protective capacity. Contacting Bangor PD may also have had other benefits: the caseworker may have realized that they had used the wrong name for the relative; the caseworker may have identified that their assessment of the credibility of the disclosures differed from that of Bangor PD, and potentially reconsidered their position; and the caseworker may have been able to provide Bangor PD with a location for the relative so that Bangor PD could continue its investigation.

Recommendation:

Although we are unsure of the extent to which a scenario like this occurs, we believe that following up on the results and status of earlier criminal investigations can provide valuable information to caseworkers. As such, OCFS should consider developing guidance for closing summaries specifying how caseworkers are to document that there are ongoing criminal investigations at the time the investigation closes, and, also, establish expectations for what subsequent caseworkers are to do when they review that documentation in the future.

Practice Issue 7: Installation of Child Safety Locks Not Verified by Caseworker (March 2020)

After one of Ms. Hartley's children was found unattended by the side of the road, Ms. Hartley stated in her initial interview with the investigating caseworker that she would be installing child safety locks on the doors and windows of her home. That same day, the preliminary safety decision was made that Ms. Hartley's children were safe in her care and custody while the Department continued its investigation. That preliminary safety decision, as documented by the caseworker's supervisor, included the next steps to be taken by the caseworker to complete the investigation. One such step was to verify that Ms. Hartley either installed child safety locks[8] on the doors of the home or used the existing locks.

We did not see any evidence in the record that caseworker returned to the home or verified that child safety locks were installed (as Ms. Hartley had stated they would be) or that existing locks were being used appropriately. In an interview with the caseworker, the caseworker did not recall whether they went back to the home, but stated that they may have discussed the need for child safety locks with one of the family members' case manager. We were unable to find any documentation of such a discussion.

Recommendation:

OCFS should consider the development of a process to ensure that any tasks identified as next steps to complete the investigation as part of the preliminary safety decision are revisited by the caseworker and supervisor prior to the closure of the investigation. Any steps that are determined to still be relevant, but not yet performed should be performed before the investigation is closed.

Systems Issue

Systems Issue 1: Multiple Profiles for the Same Individual

During the review, we requested that OCFS provide us with separate CPS histories for the individual who was Ms. Hartley's relative and alleged abuser of her children in March 2019 using first the relative's birth name and then the relative's adoptive name. Neither set of results matched the CPS history that the caseworker documented in the June 2020 investigation, which was missing the majority of the relative's CPS

[8] We did not assess whether child safety locks were an appropriate intervention.

history as only one random record appeared. We asked OCFS to determine how the caseworker found only this piece of the relative's CPS history.

OCFS explained that OCFS's Comprehensive Child Welfare Information System (CCWIS) and the Office of Family Independence's Automated Eligibility System (ACES) use a common client repository to share client demographics across the two systems. ACES is the system of record for client demographic information, but duplicate clients can be created between ACES and CCWIS if staff fail to properly screen new individuals into the system (i.e. not determining that a person is already in the system).

In this particular case, Ms. Hartley's relative was first listed as two different individuals (one under the birth name and one under the adoptive name)—which was appropriate considering that the relative was adopted during a time in which children/youth were assigned different "A Numbers" (the unique id assigned to someone in ACES) when adopted.

However, there were also multiple profiles under each name resulting from the improper screening of this individual. When the caseworker selected one of these profiles, the caseworker saw only the CPS history that was attributed to that specific profile and not the entirety of the relative's CPS history that existed across multiple profiles. The selection of this specific profile was likely based on the caseworker's recognition of some data (address, birthdate, etc.) other than just the relative's name.

As in this case, multiple records for a single individual presents the risk that an individual's full and complete CPS history is not available to the caseworker. OCFS explained that multiple records may be produced through the use of multiple or different names, poor screening or when a child record is not properly connected to an adult record.

However, OCFS reports that this risk is better managed through its new CCWIS, Katahdin. Katahdin allows multiple search criteria to be used in searching for an individual and uses software tools that use algorithms to enhance search capabilities close sounding or spelled words. Katahdin also uses "verified client" status for clients that meet a required level of data. Katahdin further provides the ability to merge and replace clients when duplicates are found.

Recommendation:

Even with the improvements offered through the use of Katahdin, OCFS should establish appropriate search guidance to be used by caseworkers to mitigate the risks associated with multiple profiles. This guidance could include more thorough search criteria, such as adding a date of birth or social security number.

The Department should also review its current guidance related to screening people into the Department's various systems to ensure that guidance outlines a process that appropriately addresses the risks associated with entering multiple profiles for a single individual.

Specific Practice Issue Following the Announcement of Ms. Hartley's Pregnancy with Jaden

Of the several practice issues we identified, only one occurred after Ms. Hartley's announcement that she was pregnant with Jaden.

Practice Issue 8: Mr. Harding's Safety Never Assessed (June 2020)

After the closure of the June 2020 investigation related to Ms. Hartley's mental health and ability to care for her children following the death of a relative in Ms. Hartley's home, a family team meeting/transfer meeting was held on August 7th to officially transfer the family to ARP for additional services. Ms. Hartley, the OCFS caseworker, and the ARP worker were all present at this meeting when Ms. Hartley disclosed that she was pregnant and in a relationship with Ronald Harding.

We did not see any evidence that Mr. Harding's safety was ever assessed even though he met OCFS's definition of a household member; in fact, had Ms. Hartley's pregnancy and relationship with Mr. Harding been known before the closure of the investigation, the OCFS caseworker would have been expected to assess the safety of Mr. Harding.

Although the discovery of Ms. Hartley's pregnancy and Mr. Harding's existence occurred after the investigation closed and during the transfer to ARP for a particular set of services, we did not see any documentation that suggested the OCFS caseworker and the ARP worker discussed whether Mr. Harding should be assessed, and, if so, by whom. This was later confirmed in an interview with the former caseworker. In separate interviews with OCFS management and the Child Welfare Ombudsman, both parties indicated that any assessment of Mr. Harding—in particular a search of his criminal and CPS histories—would not have returned any results. While that is true for Mr. Harding's criminal history (which we were provided), our review of the internal briefing memo prepared in response to Jaden Harding's death by the Regional Associate Director (RAD) for that area of the state found a reference indicating the RAD had found something in the system that we would consider part of Mr. Harding's CPS history.

We asked the OCFS Associate Director to again search MACWIS for Ronald Harding, and, using a different approach, found Mr. Harding's name attached to an old screened-out report that was filed under the referent's name. We believe the contents of that report would have subjected Mr. Harding to further scrutiny, and specifically resulted in the caseworker contacting out-of-state CPS and law enforcement agencies for additional information. Through OCFS, we made those requests for the additional information, but no records could be found. Still, as indicated by OCFS staff, the information from the screened-out report would have at least warranted a psycho-social interview with Mr. Harding to discuss his past. Ultimately, it does not appear that the reference to Mr. Harding in the screened-out report would have been sufficient for the Department to intervene in any way with the family.

Recommendation:

OCFS should consider revising its investigations process and related checklists to require caseworkers to confirm a family's living arrangements and all household members have been identified when nearing the end of an investigation to ensure that the safety of all individuals residing in the home with access to the family's children is assessed before the investigation is closed. This is particularly relevant as it appears the living arrangements and household compositions of the families that the Department works with can change often and sporadically.

Questions Related to the Care and Custody of Jaden Harding

Given the practice issues, unidentified risks, and unsound safety decisions we identified that occurred prior to Jaden Harding's birth, a reasonable person may wonder whether the absence of those deficiencies would have prevented him from being in the care of his father—the person a jury found responsible for his death.

As such, we explored various hypothetical scenarios—particularly one in which Ms. Hartley had lost custody of her three children prior to the birth of Jaden—with both OCFS management and staff. As described to us, the Department was never close to filing a PPO for the immediate removal of Ms. Hartley's children, and, even with the absence of the identified issues and unsound safety decisions, at most, the Department's most likely course of action would be the filing of a jeopardy petition. That petition would have sought court-ordered services for Ms. Hartley, and asked for the custody of the children—but even that would depend on the Department's assessment of Ms. Hartley's participation and progress in those services. If the Department sought custody, the courts would ultimately make that determination. As Ms. Hartley had a history of complying with Department-recommended services when it was advantageous or necessary to ensure her custody of the children, it seemed unlikely to everyone we spoke with that Ms. Hartley would not have participated in such services, and, ultimately, lost custody of her children.

However, even if the children were removed from Ms. Hartley's custody, the Department would then be required[9] to immediately begin efforts to rehabilitate and reunify Ms. Hartley with her children. Ms. Hartley's custody of Jaden at the time of his birth would have then been impacted by the trajectory and timing of those reunification efforts. According to OCFS, if the progress of the reunification was positive, the issues that led to the removal had been resolved or were moving towards resolution, and there were no identifiable immediate risks to Jaden, it is likely that Ms. Hartley would not have lost custody of Jaden at birth. Even if reunification efforts had stalled, there was still the presence of Mr. Harding to be considered. At the time, Mr. Harding's background checks were clean, and, he would have been viewed as a positive and safe support to mitigate any risks posed by Ms. Hartley. From what we understand, the nature of the reference to him in an

[9] If a child is removed from their parents' custody, rehabilitation and reunification efforts for parents must continue unless there is an aggravating factor and/or the court otherwise relieves the Department of this requirement. Aggravating factors include rape, gross sexual assault, sexual abuse, or previous conviction for assault or murder of a child in their own household. The Department may also be relieved of its obligation to provide reunification services to the family if the court finds that reunification is inconsistent with the child's permanency plan. It does not appear that this would have applied to Ms. Hartley in any hypothetical scenario.

old CPS report would not be sufficient to remove Jaden from his parents' custody. In yet another scenario, had Jaden been removed from Ms. Hartley's custody, he could have remained in the custody of his father, if the father had separated from Ms. Hartley.

In reality, there were no reports made to CPS regarding Ms. Hartley and/or Mr. Harding following ARP's involvement with the family that ended in November 2020, nor were there any reports or accusations of abuse or neglect towards Jaden by either parent.

Potential Opportunities for Improvement

During the course of this review, we identified three potential opportunities for improvement that may warrant further consideration by OCFS or the GOC, but have not been thoroughly evaluated by OPEGA. These opportunities include areas in which OCFS is currently making substantial changes as well as some areas that were beyond the scope of this portion of the review. We recommend that OCFS, the Health and Human Services Committee, and the GOC, where appropriate, consider these opportunities as they continue to oversee and improve child protection services.

Identifying and Providing Appropriate Levels of Services for Families

Ms. Hartley's family—like many of the families in our similar reviews—consistently exhibited a number of risk factors that generally hovered near the threshold for Departmental intervention. In those instances when the family's risk level was at or exceeded that threshold, various services would be provided to the family to mitigate some of those risks and to help the family in its day-to-day functioning. To some extent, the family would experience success in services—often just enough to end CPS's involvement with the family; however, when those services ended (or the family otherwise stopped participating), the family would regress. Conditions would eventually worsen until another report would be made to CPS—and the process would start over again.

In discussing this cycle with OCFS staff, they expressed the need for a better means of conducting individual, parent, and family function analyses to be in a better position to recommend the most appropriate types and levels of services needed. Identifying those services would only be one component of that challenge; services would need to actually be available, which is beyond the complete control of OCFS.

While we do not know exactly what those analyses would look like or even which services are most needed, we were able to observe that the services provided to Ms. Hartley's family were never enough to improve the family's overall level of functioning over the long-term and, ultimately, prevent the need for future CPS reports.

Information Sharing Between OCFS, Law Enforcement, and the Courts

Over the six-year period in which this family had various, intermittent CPS involvement, we noted times in which law enforcement had information that would be valuable to OCFS considering the family's history—even though that information alone may not have warranted a report to be made.

One such time was when Ms. Hartley's relative and alleged abuser of her children in March 2019 was later removed from Ms. Hartley's home in March 2020 by law enforcement following the relative's alleged substance use in the home. Although this was reported the following day as part of the report related to one of Ms. Hartley's children being found unattended by the side of a road by a neighbor, it appears that the relative's removal from the home would have remained unknown to OCFS had the child been supervised and not left the home. Similarly, in the February 2020 investigation of one child's ear injury that was allegedly inflicted by a man living in Ms. Hartley's home, information related to the status of a potential PFA filed against the man appears particularly relevant when making the preliminary safety decision. However, this information was in the possession of the courts and unavailable/inaccessible to the caseworker and supervisor when the preliminary safety decision was made.

As our work related to these information gaps is quite limited, we have no specific recommendations. However, we encourage the parties involved to consider how information might be better shared or accessed so that OCFS and caseworkers can identify and appropriately respond to concerns as they emerge—particularly when those concerns involve families with high levels of risk and frequent CPS involvement. Reviewing the extent and manner of communication and information exchange among these parties represents a potential opportunity for improvement.

Feedback and Management Expectations

Throughout these reviews, we have spoken to members of OCFS management who had also performed comprehensive reviews of the CPS histories in these cases. During these discussions, it was apparent that management had certain practice expectations for caseworkers (and supervisors) when given the facts of this case, such as the analyses of information, investigative actions taken (or not taken), and the conditions that would warrant further investigation or even Departmental intervention.

We also interviewed multiple caseworkers and supervisors who worked with the family at specific points during the family's CPS history. As we explored their analyses of the facts, decision-making, and actions taken, we noted that caseworkers and supervisors' practice expectations sometimes varied from that of higher management. As a result, we began asking whether caseworkers and supervisors had received any feedback from higher management related to the specific investigations that they had conducted. We were told that this had not occurred.

We believe this represents a potential opportunity for improvement as management should share their perspectives on what occurred in these investigations, as well as their expectations, directly with the caseworkers and supervisors who performed the work.

Timeline of Key Events and Exploration of Certain Decisions and Actions

February 2014: Investigation of Substance Exposed Infant

On February 13th, the Department received a report from a medical professional that Ms. Hartley's newborn child may have been exposed to substances prenatally. The referent noted that Ms. Hartley reported that she did not use drugs during her pregnancy except for marijuana and a drug screen at the hospital tested negative for all substances. The referent also reported that Ms. Hartley may need guidance in appropriately caring for the child. This report was screened in as appropriate and an investigation was opened.

The caseworker visited Ms. Hartley in the home and discussed options for services. Ultimately, the family was referred to the Alternative Response Program (ARP) and Public Health Nursing (PHN) and engaged with both services. On March 27, 2014, ARP closed their involvements with the family. The closing summary for the investigation recommended that the parents continue to keep all scheduled appointments, to continue services with PHN and Maine Families (in particular, attending parenting classes through Maine Families), and refrain from using substances while caring for the child.

May 2015: Report of Substance Exposed Infant Referred to Public Health Nursing

On May 28th, the Department received a report from a medical professional that Ms. Hartley's newborn (her second child) may have been exposed to substances prenatally as Ms. Hartley had tested positive for marijuana upon admission to the hospital. Ms. Hartley was reportedly surprised by the result and denied marijuana use. The referent also reported that PHN services were offered, but the family declined.
As there were no allegations of child abuse and/or neglect, no investigation was necessary, but intake did make a referral for PHN (even though the family had just declined those services at the hospital). On August 20th, intake was notified that the family had not accepted the referred services, which were voluntary.

September 2015: Screened Out Report of Alleged Domestic Violence Incident

On September 21st, the Department received a report from law enforcement of an alleged domestic abuse incident at the home of Ms. Hartley and her partner. The referent reported that both parents denied to law enforcement that there had been any physical altercation, but only a verbal argument. Both children were present in the home at the time. This report was reviewed by an intake supervisor who determined it did not meet the criteria for investigation.

December 2015: Investigation of Parents Not Bringing Their Child to Scheduled Appointments for a Potentially Serious Health Issue

On December 4th, the Department received a report from a medical professional regarding one of Ms. Hartley and her partner's children as the father had called the emergency pediatric phone line the previous evening to report that the child had been having white diarrhea for two days. The referent reported that the child had not been seen since they were one week old, that white stool was a cause for concern, and that they

had advised the father that the child should be seen as soon as possible. The parents could not attend an appointment to have the child examined that evening, so one was scheduled for the next morning. The referent noted that the family did not show up for that appointment nor did they call the office. This report was screened in for an investigation, and, that same day, a caseworker went to the home where they met Ms. Hartley and the child, arranged for a medical appointment that same day, and then drove Ms. Hartley and the child to the appointment (where the child was found to be fine) and home again. Ms. Hartley's partner was angry at the Department being involved and there was little cooperation moving forward.

On December 12th, another medical professional contacted the Department reporting that the parents were not following through with a necessary medical evaluation and interventions to address one of the children's medical issues. On January 5th, the caseworker was able to speak with Ms. Hartley and her partner who explained that the medical professional had been very pushy about the children's vaccinations (which the parents wanted to wait on) and that they were looking for a different provider for the children. Ms. Hartley and her partner reported that the child referenced in the most recent report was receiving services from other providers to address their medical issues. Ms. Hartley stated that they were uncomfortable with the caseworker continuing to be involved and felt it wasn't necessary any longer. The caseworker stressed the importance of yearly doctor visits for the children. On January 8th, the Department closed its investigation with no finding of abuse and/or neglect.

March 2017: Report of Substance Exposed Infant Referred to Public Health Nursing and Maine Families

On March 7th, the Department received a report from a medical professional that Ms. Hartley's newborn (her third child) may have been exposed to substances prenatally as Ms. Hartley had tested positive for marijuana upon admission to the hospital.

As there were no allegations of child abuse and/or neglect, no investigation was necessary, but an intake supervisor did write a letter to the parents referring them to services with PHN and Maine Families. The family declined PHN, but did consent to services from Maine Families.

June 2017: Investigation of Ms. Hartley Feeling Overwhelmed by the Children and Spanking Them

On June 9th, the Department received a report from a home visit provider that Ms. Hartley had disclosed that she felt overwhelmed in caring for her three children and admitted to spanking her two older children hard enough to leave red marks. Ms. Hartley had an infant in the home and there were signs of post-partum depression. This report was screened in for an investigation.

On June 12th, the assigned caseworker interviewed Ms. Hartley at the family's home. They discussed the services currently being provided in the home, the stress and challenges of caring for the three young children alone during the day, additional services that might help alleviate some of that stress, post-partum depression and Ms. Hartley's mental health, resources to help with post-partum depression, and the discipline used in the home.

Regarding the discipline used, Ms. Hartley described talking to the children, sending them to their room for five minutes, and having them sit on the couch. Ms. Hartley described spanking the children on the butt over diapers or clothes and noted that sometimes it didn't even phase the children.

For part of this interview, Ms. Hartley's partner was present, and, during that time, was agitated that Ms. Hartley was engaging with the caseworker. The caseworker was only able to speak to the partner briefly as the partner needed to leave for work.

While at the home, the caseworker observed all of the children and completed a safe sleep assessment for the youngest. That same day, an SBI check for Ms. Hartley was documented along with a note from the caseworker that there had been some mention of an eviction notice.

On June 29th, the caseworker was finally able to interview Ms. Hartley's partner over the phone. As is common in all interviews of this nature, the caseworker explored the partner's mental health, substance use, and medications; any incidents of domestic violence; and the partner's criminal and CPS histories. They also discussed the discipline used in the home with Ms. Hartley's partner stating that they had changed their approach to disciplining the children away from spanking or yelling that was ineffective and just scared the children.

On June 30th, the caseworker documented a series of efforts: they had attempted to contact the children's paternal grandmother, had contacted the family's home visitor (who reported continuing to work with the family), and attempted to reach one of the children's service providers. The caseworker also contacted the children's medical provider, who reported seeing two of the children recently, but that the family often no-showed appointments.

On July 10th, the caseworker sent a letter to Ms. Hartley stating that the Department did not find evidence that rose to the level of a physical abuse finding against her and that the investigation was now closed.

<u>January 2018: Screened Out Report of Alleged Medical Neglect</u>

On January 1st, the Department received a report from a medical professional that Ms. Hartley and her partner's three children were not receiving proper medical treatment as they were not being brought in for well-child appointments or vaccines. This report was determined by Intake to be inappropriate for investigation.

<u>April 2018: Investigation of Multiple Reports</u>

On April 9th, the Department received a report from law enforcement following their response to a reported domestic violence incident at the home of Ms. Hartley and her partner. The referent explained that Ms. Hartley and her partner admitted to a verbal altercation which occurred in front of their children. While in the home, law enforcement determined that there was an active warrant for the arrest of Ms. Hartley's partner for

unpaid fines and placed him under arrest. Ms. Hartley's partner was uncooperative and had to be forcibly handcuffed in front of the children. This report was screened in for investigation.

On April 12th, the assigned caseworker went to the home to interview Ms. Hartley and her partner, and to observe the children. During her interview, Ms. Hartley admitted that they had been arguing that night about her partner's substance use—which she pointed out was never in front of the kids—and him staying out all night, but denied any domestic violence. Ms. Hartley reported that her partner needed help in getting clean, and that she was willing to support him in any treatment he needed. Ms. Hartley expressed a great deal of anxiety about the Department being involved and made it clear that the last thing she wanted for her children was for them to be removed from her and placed in foster care.

During his interview, Ms. Hartley's partner admitted that they had been arguing about him staying out all night and disclosed that he had been using suboxone off the street after being kicked out of a suboxone program for noncompliance with services. The partner stated that he was waiting for his mother to come pick him up and take him to a hospital where he would seek substance use treatment. The partner also denied any physical fighting between him and Ms. Hartley.

The caseworker observed the children, who appeared healthy, clean, and had no visible marks or bruises. The caseworker then consulted their supervisor who made and entered the preliminary safety decision that found the children were safe in the care and custody of their mother while the investigation continued.

Practice Issue 1: Extremely Overdue Investigation with Periods of No Investigative Activity

Following the preliminary safety decision on April 12th, we did not observe any evidence that any subsequent steps of this investigation were conducted until June 28th when a new report is added on to this still open investigation. During interviews with the caseworker and the caseworker's supervisor, they indicated that it was likely that no work was performed on this case during that period as they were triaging an overwhelming workload caused by major policy changes made in response to the 2018 fatalities of two children. This is not the only instance in which a period of inactivity prolonged this investigation, as described under Practice Issue 1 on page 15.

On June 28th, the Department received an anonymous report that one of Ms. Hartley's young children had been left outside in a walker and fallen off a deck, which resulted in bruises to the child's head. The referent also noted that Ms. Hartley did not seek medical care for the child. Additionally, the referent expressed concerns about Ms. Hartley leaving her children alone with potentially unsafe people in unsafe environments outside of the family shelter where Ms. Hartley and her children had been staying. This report was screened in for investigation and added to the existing and still open April 2018 investigation.

On June 29th, the caseworker met with Ms. Hartley and her three children at the DHHS offices accompanied by her adoptive mother and adoptive grandmother. Ms. Hartley reported that she and the children had been staying at a family shelter after she was evicted due to her former partner not paying the bills and taking all of their money. Ms. Hartley revealed that her former partner had "gotten physical" with her and that she had

filed a protection from abuse order (PFA) against him that prevented the former partner from having contact with her or the children for two years.

Ms. Hartley then explained that while visiting on the deck of a close friend's home, one of the children left a gate open on the deck. One of her children was in a walker and made it to the stairs before Ms. Hartley could stop them. The child fell and had a bruise on their head, but Ms. Hartley did not think it was serious enough to take the child to the emergency room. Instead, the child was given ibuprofen and monitored by Ms. Hartley. Ms. Hartley provided the caseworker with the phone number of the close friend so that the caseworker could discuss the incident directly with them. Ms. Hartley was angry that another report had been made and stated that the last thing she wanted was for children to be taken from her. Ms. Hartley did accept a referral for case management services. The caseworker observed each child and noted no marks or bruises on any of them, including the child who fell off the deck.

Later that day, a supervisor covering for the caseworker's supervisor entered the preliminary safety decision, which apparently found that the children were safe in the care of their mother as no safety plans or conditions were noted.

Following the preliminary safety decision that is made on June 29th, only two events are documented in the narrative log over the next three months: the caseworker's receipt of a phone call from the children's paternal great-grandmother asking the caseworker to pass a message along to Ms. Hartley on July 9th, and the confirmation of Ms. Hartley's account of what occurred on the deck by Ms. Hartley's close friend who the caseworker was meeting with on another matter on July 9th. We again note the duration of this period (June 29th to October 7th), the lack of investigative activity, and the fact that the investigation continued to remain open as part of Practice Issue 1 and note another practice issue:

> <u>Practice Issue 4: Reported Allegations and Safety Threats Unexplored by Caseworker</u>
>
> In the June 28th report, two allegations were made: that Ms. Hartley's child had fallen from a deck and she did not seek medical care for the child and that Ms. Hartley was leaving her children alone with potentially unsafe people in unsafe environments. We did not find any evidence that the caseworker explored the allegation related to where and with whom Ms. Hartley was leaving her children. As this is not the only instance in which reported allegation were unexplored, fuller details are available under Practice Issue 4 on page 20.

On October 7th, the Department received a report from a friend of Ms. Hartley that Ms. Hartley was struggling to care for her three children. The friend alleged that Ms. Hartley was not supervising her children and failing to get the children to their medical appointments. The referent was not going to allow Ms. Hartley at her home anymore because of Ms. Hartley's behavior and how Ms. Hartley treated her children and the referent's children. The referent also reported that Ms. Hartley was having contact with her former partner despite the active PFA and that Ms. Hartley had posted on Facebook that she and her children were moving to Bangor with her biological parents to "get away from DHHS." The referent added that Ms. Hartley had

been removed from her parents' care as a child. This report was screened in for investigation and added to the existing and still open April 2018 investigation.

On October 9th, the caseworker left a message for the referent asking them to contact the caseworker so that the caseworker could get more information on the referent's report. That same day, the caseworker left messages for Ms. Hartley and the family shelter where Ms. Hartley had been staying asking Ms. Hartley to contact the caseworker. On October 23rd, the caseworker documented a conversation with a mental health professional regarding a mutual client in which the mental health professional informed the caseworker that they were also working with Ms. Hartley. The mental health professional reported that they did not have any current concerns regarding Ms. Hartley, and that Ms. Hartley had been working with a case manager. On November 6th, the caseworker again left messages for Ms. Hartley and the family shelter where Ms. Hartley had been staying asking Ms. Hartley to contact the caseworker. On December 3rd, the caseworker emailed the mental health professional to follow up on their work with Ms. Hartley; no response was documented. That same day, the caseworker wrote a letter to Ms. Hartley stating that the Department did not find that Ms. Hartley had abused or neglected her children, and that the Department would be closing the investigation. We again note the duration of this period (October 7th to December 3rd) and the lack of investigative activity as part of Practice Issue 1 and note another practice issue:

> Practice Issue 2: Inadequate Efforts to Locate the Family
>
> Following the most recent report, the caseworker's attempts to contact Ms. Hartley consisted of only a pair of phone messages left with Ms. Hartley and the family shelter where she was last known to be staying (as the report alleged Ms. Hartley was moving to Bangor with her biological parents). Caseworkers are to make every effort to locate all critical case members using the strategies contained within the Activities to Locate tool, and to document those efforts. Strategies referenced in this tool include searching OCFS records and other state agency records; contacting relatives, friends, providers, employers, landlords, etc.; and performing internet searches.
>
> There were several actions that one would expect the caseworker to potentially take:
>
> - make an in-person visit to the family shelter to see whether Ms. Hartley was still staying there, and, if so, possibly speak to her about the report;
> - contact Ms. Hartley's biological parents, as the report alleged Ms. Hartley was moving there;
> - contact Ms. Hartley's former partner, as the report alleged Ms. Hartley was seeing him; and
> - contact Ms. Hartley's adoptive family members who accompanied her to the DHHS offices in June to meet with the caseworker.
>
> However, we did not see any evidence that any of these actions were undertaken, which was confirmed by the caseworker.

Lastly, the undated closing summary for this investigation noted that the Department was unable to substantiate findings against Ms. Hartley for neglect, but did make indicated findings of emotional

maltreatment and substantiated findings of threat of physical abuse against the three children by their father (Ms. Hartley's former partner). On December 12, 2018—247 days after the initial report—the caseworker sent a letter to Ms. Hartley's former partner describing these findings.

March 2019: Screened Out Report of Alleged Sexual Abuse by a Relative

On March 19th, a report was made by shelter staff that Ms. Hartley had disclosed that she believed one of her children may have been sexually abused by a family member while at the family member's home in Bangor. Ms. Hartley had explained that they would no longer be having contact with that family member, and that the child in question was now residing with the child's paternal grandmother in Presque Isle for a while as Ms. Hartley had been feeling overwhelmed with all of her children at that point in time. As the alleged abuser was neither a household member nor a caregiver to the children and Ms. Hartley was not allowing contact between her children and the family member, this report was determined not to meet the criteria for investigation when the SDM Intake Assessment Tool was used and, ultimately, screened out. However, a referral to the District Attorney was made.

March 2019: Investigation of Alleged Sexual Abuse by a Relative

On March 21st, a report was made by a medical provider that the paternal grandmother had brought the child residing with them in for an examination as the child had disclosed that a relative had touched their genital area. The relative—who was not the same relative as in the prior report—was identified only by their familial relationship to Ms. Hartley (such as her sister, brother, uncle, etc.) as the referent did not know the relative's name. In addition to the report, the medical provider made a referral for the child to Spurwink's Center for Safe and Healthy Families (CSHF) for a forensic medical exam. Although this report contained largely the same information as the prior screened out report, the intake supervisor entered a screening override—likely due to the now two consecutive reports that were received—to open an investigation, and a referral to the District Attorney was also made.

> Practice Issue 3: Incorrect Identification of Alleged Abuser by Intake
>
> From the documentation of the report, it appears as though intake caseworkers used the familial relationship between Ms. Hartley and the relative (which was provided by the referent) and Ms. Hartley's CPS history as a youth to determine the name and identity of the relative, which was then added to the report that would be assigned to a caseworker. However, the name that intake added ("screened in") to the report used the relative's birth name rather than the relative's adoptive name that they currently used[10]. We note this as a practice issue, and the impacts of this error are noted as a component of Overarching Practice Issue 1: Important Connections Missed by OCFS Across Multiple Investigations.

On March 25th, a caseworker who was not assigned this investigation interviewed the child. The child disclosed that the relative named in this report had touched them inappropriately. That same caseworker also

[10] The birth and adoptive names both shared the same first name.

interviewed the paternal grandmother who stated that the child had made the same disclosure to them, which is why the paternal grandmother brought the child to the medical provider.

On March 26th, the caseworker that was assigned the investigation met with and interviewed Ms. Hartley at the family shelter where she and her children were staying; this interview was recorded. Ms. Hartley explained that she initially thought her child may have been abused by a different relative based on an interaction the child had with that relative. Ms. Hartley was so concerned by this that she asked the child's paternal grandmother to have the child checked out at a hospital. Ms. Hartley noted that the child had not disclosed any abuse to her.

Ms. Hartley then explained her understanding of what the child had disclosed to the other OCFS caseworker the day before. After learning of those disclosures, Ms. Hartley asked one of her other children if anything had happened between the child and the relative as the child had recently stayed at the relative's home for a few days. Ms. Hartley claimed that without coaching, the child indicated something inappropriate had happened.

When the caseworker learned of this child's disclosures, they let Ms. Hartley know that they would not be interviewing the child today, and, instead, would schedule an interview for the child (as well as their sibling who had also made disclosures) at a Children's Advocacy Center (CAC). Those interviews would be recorded as a District Attorney referral had been made at the time of the report, but an officer was not available to participate in the interviews that day. The caseworker then explained to Ms. Hartley the differences between a CPS investigation and a law enforcement investigation.

The caseworker and Ms. Hartley discussed Ms. Hartley's plans for keeping her children safe. Ms. Hartley stated she did not plan on seeing or speaking to the relative and that she was considering taking out a PFA against the relative.

A review of the audio recording of this interview found that the caseworker also asked Ms. Hartley the name of her relative who was the alleged abuser in this report. Ms. Hartley identified the relative by using the relative's adoptive name, which we note as a component in Overarching Practice Issue 1: Important Connections Missed by OCFS Across Multiple Investigations.

Following the interview with Ms. Hartley and observations of the two children in Ms. Hartley's care, the caseworker's supervisor entered the preliminary safety decision that same day which found that the children were safe in the care of their mother and paternal grandmother, respectively.

Shortly after the preliminary safety decision was made, the caseworker performed background checks for Ms. Hartley, the father of Ms. Hartley's children, the children's paternal grandmother, and Ms. Hartley's relative who was the alleged abuser.

However, as evidenced by the records received by the caseworker, the background checks they ran on the relative were pulled using the relative's birth name—which was how intake screened the relative into the

report—rather than the relative's adoptive name that Ms. Hartley had provided. As a result, the background checks for this individual did not return any records, which did not accurately reflect the relative's actual criminal and motor vehicle histories; we note this as another component of Overarching Practice Issue 1: Important Connections Missed by OCFS Across Multiple Investigations as a background check using the correct name would have returned the relative's true criminal history. The relative's actual criminal history, at that point in time, contained multiple domestic violence convictions (threatening, terrorizing, and assault), a history of violating conditions of release and/or probation violations, and a variety of other offenses—which would have warranted additional scrutiny and, possibly, further action by OCFS, according to those we interviewed.

On March 27th, the two children were interviewed at the CAC. The caseworker was present and observed both interviews, although the narrative log only contains the caseworker's notes and impressions from one child's interview. These notes reflect that the child was very active (at one point, throwing playdough), needed to be redirected several times, had a hard time listening to the interviewer, and was "all over the place" with their story of what had occurred.

That story generally aligned with the child's earlier disclosures that the relative had touched them inappropriately. However, based on the caseworker's notes, those details were interspersed with non-sequiturs, factual inaccuracies, other details that did not make sense, and statements that gave the appearance that the child had possibly been coached in making the disclosures (such as "DHHS is going to kill [the relative].")

In our interviews with the caseworker, they explained that while the CAC interviewer does not make official determinations of whether a child is credible or not, law enforcement officers, district attorneys, caseworkers, and the CAC interviewers often discuss the interview immediately after it is conducted. According to the caseworker, the CAC interviewer in this case stated that they were unsure whether these were credible reports. The caseworker themselves noted that the children appeared unable to establish a timeline of events. The caseworker then brought the recorded CAC interviews to their supervisor and they discussed the credibility of the disclosures. Even accounting for the ages of the children, the caseworker and supervisor determined that—based on their experience—these children were not credible.

While we have not requested, obtained, nor reviewed the recorded CAC interview and, consequently, are not in a position to determine the credibility of the disclosures, we do note that the caseworker and supervisor's determination stands in stark contrast to the actions taken by the Bangor Police Department (Bangor PD) that were based on the very same interviews and disclosures. The Bangor PD was provided recordings of the CAC interviews to potentially use in pursuing a criminal case against the relative, which is distinctly separate in both scope and process from a CPS investigation. In the weeks following the CAC interviews, Bangor PD tried locating the relative/alleged abuser who was listed as a transient until May 2nd. That night, the relative was briefly arrested (and quickly bailed out) for operating without a license, but did provide the arresting officer with an address of where they were staying. With the relative's location now known, Bangor PD requested and obtained a search warrant on May 8th to search the relative's residence and person for any

computers, cellular phones, and/or other digital devices capable of recording or storing images of the juvenile victims in this case. These actions reflect a belief in the credibility of the disclosures.

Similarly, in our interviews with multiple individuals at OCFS, we were told that despite the issues with the children's disclosures, the disclosures would still be sufficient to make findings against the relative had the relative been established as a household member or a caregiver to the children. It was also noted that law enforcement investigations generally require a higher standard for evidence than that of CPS investigations; however, we did not attempt to determine why OCFS and the Bangor PD had such different analyses of the CAC interviews as part of this review.

On April 25th, both of the children were finally able to be seen for forensic medical exams at Spurwink's Center for Safe and Healthy Families (CSHF) in Bangor. The caseworker met the family at this location and observed the children prior to their examinations, which the physician reported were normal (which we understand is not uncommon in these types of cases).

While awaiting Spurwink's written evaluations, a family service provider made a report on June 19th that Ms. Hartley had disclosed overhearing a relative—but not the relative/alleged abuser identified in the current investigation—through the wall saying that they were going to abuse one of the children and blame it on Ms. Hartley so that the children would be taken away from Ms. Hartley. This report was screened out as there was no direct allegation of abuse or neglect occurring to a particular child, but added as an "FYI report" in the narrative log of the current investigation and emails were sent to the caseworker and their supervisor. We did not see any evidence that the caseworker explored this allegation with either Ms. Hartley or the relative; when interviewed, the caseworker did not believe that they had. We note this as another instance of Practice Issue 4: Reported Allegations and Safety Threats Unexplored by Caseworkers.

On July 8th, the caseworker received the written evaluations from Spurwink, which reiterated that the children's examinations were normal. That same day, the SDM Risk Assessment Tool was run and the tool recommended not opening a case with the family. The Department closed its investigation as they did not have any evidence that Ms. Hartley had been neglectful towards any of the children in her care, and the Department cannot make findings against a non-caregiving adult (such as Ms. Hartley's relative/alleged abuser of her children).

In the closing summary for this investigation, the caseworker documented that the children "appeared to be very active and struggled to be interviewed at the CAC. They had to be redirected several times, and, at this point, it is unclear as to whether the abuse has occurred."

July 2019: Screened Out Report of Alleged Physical Discipline

On July 10th, the Department received a report from a service provider that Ms. Hartley had disclosed having issues managing her children and had slapped one of her children across the face. The referent noted that they did not observe any marks on the child, and had no information related to the impact of the incident on the child. The referent reported that Ms. Hartley was open to discussing alternative methods of discipline and

that the referent would be exploring case management services for the child. The referent had no other concerns for the family. This report was determined by Intake to be inappropriate for investigation.

February 2020: Investigation of One Child's Ear Injury

On February 4th, a report was made by a school employee that one of the children had an ear injury allegedly caused by a man staying at Ms. Hartley's house. That same day, an investigation was opened and the caseworker completed a forensic interview of the child at the school. During the interview, the child described having fun and playing the "pushing game" with the man when the injury occurred. The child stated the man, the man's partner, and their young child were living at Ms. Hartley's home.

That same day, the assigned caseworker attempted unsuccessfully to locate Ms. Hartley at the family's home. The caseworker was, however, able to reach Ms. Hartley by phone, and they set up an appointment for the following morning at the home.

On February 5th, the caseworker went to the home to conduct interviews and observe the children. As the caseworker began the interview with Ms. Hartley, Ms. Hartley had the child (the alleged victim) come into the room where—at the direction of Ms. Hartley to tell the caseworker what really happened—the child claimed that they had injured themselves—not the man. As confirmed by the audio recording of this interaction, the caseworker explored this new account with the child asking a series of questions related to why the child had previously told the caseworker that the man had done it and what exactly had happened. Woven together, the child's various responses indicate that the child was playing some type of "game" that involved pushing between two rooms of the house, someone (possibly the man) had missed, and the child slipped, fell, and hit their ear on the wall. The child stated that they had thought the man had done it because he was looking when they slipped, but they didn't really know. The child was then excused from the conversation and the interview with Ms. Hartley continued, covering all of the standard questions. As for the incident itself, Ms. Hartley had been outside when it occurred, but recounted what she was told occurred. Ms. Hartley also confirmed that the man, his partner, and their young child had been living in the home and that was the plan moving forward.

While in the home, the caseworker was also able to interview the man's partner, covering the same topics as they had with Ms. Hartley. Notably, the man's partner denied ever being in a domestically violent relationship. Regarding the "push game," the man's partner stated that the children would try to push the man and he would dodge them. As for the child's injured ear, all of the children had been running around the kitchen and living room at dinnertime while the man was at the stove, but she did not see what exactly happened. The man's partner did not have any concerns or worries for those in the home.

Later that same day (February 5th), the caseworker received SBI/DMV/SOR background checks for Ms. Hartley, Ms. Hartley's former partner (the father of her children), and the man now living in her home. (A background check for the man's partner was pulled at a later time.)

Notably, the man's SBI check showed the following:

- three domestic violence assaults from 2008 to 2015;
- one disorderly conduct charge from 2014;
- two violations of conditions of release in 2015; and
- one violation of a protection from abuse order (PFA) in November 2019.

At 11:00 am on February 5th, the caseworker's supervisor entered the preliminary safety decision which found that the children were safe in the care of their mother in the home.

> Unsound Safety Decision 1: No Additional Intervention or Safety Planning to Ensure the Safety of the Children from the Man Residing in Ms. Hartley's Home
>
> We note the preliminary safety decision as an unsound safety decision as it ignored the concerning and relevant information that was available to the caseworker following the caseworker's background check of the man residing in Ms. Hartley's home. The man had a documented history of domestic violence (although most of the charges were five or more years old), but, most concerning, a violation of a PFA within the last three months. With the man and his partner sharing a 20-month-old, it was possible—or even likely—that the man's current partner had filed the PFA. Although it was unlikely that a copy of the PFA could have been obtained from the courts prior to the preliminary safety decision being made, we also did not see any evidence the caseworker explored the man's history of domestic violence and/or any treatment that the man may have received with his partner (as the man was at work and unavailable to be interviewed).
>
> In light of the fact that the man was the alleged abuser in this report, had a history of domestic violence, and may have been the subject of an active PFA, we conclude that additional Departmental intervention—specifically, a safety plan that removed the man from the home pending a review of the PFA and an assessment of the man's safety—was warranted to ensure the safety of the children.

Instead, the children would remain in the home with their mother and the mother's housemates. Later that same day following the preliminary safety decision, the caseworker requested and received past reports from the Bangor Police Department that involved the man. The first of those reports referenced the November 2019 protection order violation and confirmed that the man's current partner had filed the PFA against him. Although the status of that PFA was still unknown, this new information presented another opportunity for Departmental intervention, which we again note as part of Unsound Safety Decision 1, as we believe this new information warranted a safety plan in place that would remove the man from the home while his history was more fully reviewed and a copy of the PFA was obtained to determine whether it was still in effect; however, that did not occur.

The caseworker continued the investigation, obtaining the children's medical records, requesting that Ms. Hartley to have the man contact the caseworker, speaking with one of the children's service providers, and attempting to locate the man at Ms. Hartley's home.

The caseworker also contacted a detective from the Brewer Police Department and explained the bruising that the caseworker had observed on the child's ear, described the family's prior CPS involvement, and provided the detective with pictures of the bruising and the recorded interviews of Ms. Hartley and the man's partner.

On February 24th, the caseworker interviewed Ms. Hartley's other school-aged child at the child's school. The child stated that there was nothing she disliked about the man and denied having any worries or concerns. Later that day, the caseworker was able to locate the man at Ms. Hartley's home. Regarding the incident, the man explained that the children had been playing in the living room and kitchen while he was trying to finish cooking dinner. The man stated that he told the children to go sit down because one of them was going to get hurt, and after he said that, the child spun around, lost their footing, and hit the baseboard with the left side of their head. The man denied hurting the child and was unsure why the child would have said he did it. During the interview, the man also reported that he did not have any current legal issues and that there have been no domestic violence issues between him and his current partner.

<u>Practice Issue 5: Inconsistent and Sometimes False Information Not Explored by Caseworker</u>

At that point in time, the caseworker had obtained reports from Bangor PD involving the man. From the first of those reports, the caseworker would have known that the man's current partner had taken out a PFA against him, and had stated to law enforcement that she did not feel safe staying at her address so she went to stay with a relative. The caseworker also knew that he had violated that PFA a little over three months prior. Despite these facts and their inconsistency with his (and his partner's) current statements regarding domestic violence, we did not see any evidence that the caseworker explored these inconsistencies with the man.

In discussing this with the caseworker, we were told that they did not raise the issue in an effort to protect the man's partner in case the man assumed that his partner had told the caseworker.

Later that day, the caseworker obtained a copy of the temporary PFA between the man and his current partner. The record indicates that there was no final order as the PFA was dismissed at the hearing. The contents of the PFA described multiple incidents of domestic violence, including in September 2019 when the man allegedly choked his partner in front of their child, took the woman's phone and shattered it, and hit and punched the woman.

The next day (February 25th), the caseworker spoke with Ms. Hartley and the man's partner regarding the man's history of violent behavior to assess Ms. Hartley's protective capacity, which would be a consideration in the outcome of the investigation. The man's partner explained that the man was aware that should anything happen (as it did in the past) that he would be kicked out of the home. The caseworker explained to Ms. Hartley and the man's partner that they were responsible for providing a safe environment for the children, which meant providing for all of their basic needs and protecting them from unsafe people. The caseworker also explained to Ms. Hartley that the man should not be a primary caregiver for her children. Ms. Hartley

and the man's partner both stated that they understood and would not allow the man to remain in the home should he become violent.

With this agreement, the caseworker was confident in the ability of Ms. Hartley and the man's partner to protect the children, particularly as the man's partner had demonstrated this previously when she called the police and taken out a PFA. The caseworker also considered the fact that Ms. Hartley and one of the children both received case management services and their respective case managers would, to some extent, have opportunities to interact with the family and notify the Department of any concerns. While the caseworker's supervisor was less confident in Ms. Hartley's protective capacity, they similarly felt that this did not rise to level of any further interventions by the Department.

Later that day (February 25th), the SDM Risk Assessment Tool was run and it recommended not opening a case; the Department did not open a case with the family and the investigation was closed with no findings. In the closing letter, the caseworker again made it clear that the man should not be providing care for Ms. Hartley's children (as he was not a biological parent and had a history of being domestically violent) and that if the man were to become violent or aggressive in the home, Ms. Hartley would have the protective capacity to ask him to leave the home.

Although the Department cannot necessarily remove someone from a home based only on their history of domestic violence, the fact that the caseworker determined that the man should not be a caregiver for Ms. Hartley's children raises the question of whether the man was a safe caregiver for his own child, and whether enough was done to assess his safety. We note this as a potential component of Unsound Safety Decision 1 as other potential interventions may have been appropriate pending the results of further investigation.

March 2020: Investigation of Child Found Unattended in Street

On March 14th, a report was made by a law enforcement officer after one of Ms. Hartley's children was found unattended on the side of the road by a neighbor. The officer reported that during their response to the unattended child, Ms. Hartley and a woman residing in Ms. Hartley's home (who was the partner of the man with the history of domestic violence from the previous investigation) returned to the home after having walked to a nearby redemption center. Ms. Hartley explained to the officer that her children had been left under the supervision of a friend's 11-year-old who was visiting the home. The 11-year-old reported not knowing that Ms. Hartley and the woman had left, and said that they did not know that they were supposed to be caring for the children. The woman's partner—the man with the history of domestic violence from the previous investigation—was also residing at the home and was home when this incident occurred, but upstairs on the third floor of the home caring for his own child. The officer reported not being aware of any of the children getting out of the home unattended before, but did note that that law enforcement was called to the home the previous night to remove a person—possibly Ms. Hartley's relative—from the home after there were concerns that this person had just been released from jail and allegedly had drugs in their backpack. This report was screened in for an investigation.

On March 16th, the caseworker completed background checks for all of the parents of the children in home and then went to the home to conduct interviews and observe the children. At the home, Ms. Hartley explained to the caseworker that she had forgotten to tell her friend's 11-year-old or the man residing in the home who was upstairs with his own child that she and the woman were leaving. As the caseworker explained how the child could have been seriously injured, Ms. Hartley claimed that this was an honest mistake and that they would be installing child safety locks for the doors and windows to ensure this could not happen again.

During the interviews—which were recorded—the caseworker also asked Ms. Hartley and the woman if there had been an incident involving Ms. Hartley's relative the night before. Ms. Hartley explained that her relative had been using drugs in the home and that the woman had called law enforcement to have the relative removed from the home. The woman then provided additional context and disclosed that after Ms. Hartley's relative had been released from jail, Ms. Hartley allowed the relative to live in Ms. Hartley's home as long as the relative was sober. A little more than a week prior to the current incident, Ms. Hartley and the woman discovered that the relative was using substances in the home and kicked the relative out of the home. Days before the current incident, another relative of Ms. Hartley's was visiting the home and stayed overnight. The relative who had been kicked out of the home invited themselves over to see the other relative and spent the night as well. When the other relative left, the relative who had been kicked out of the home did not leave and remained in Ms. Hartley's home. Then, the night prior to the child being found unattended by the side of the road, the woman called law enforcement to have the relative removed from the home after the relative continued to use substances and leave bottles of ibuprofen where the children could access them. Ms. Hartley then claimed that she had filed a PFA against her relative so that the relative could not be around her, her children, or the home.

Throughout the entirety of the recorded interviews, we did not hear Ms. Hartley or the woman refer to the relative by name, instead only using the relative's familial relationship to Ms. Hartley (such as her sister, brother, uncle, etc.). We also did not hear the caseworker ask for Ms. Hartley's relative's name (which we have noted as a component of Overarching Practice Issue 1: Important Connections Missed by OCFS Across Multiple Investigations).

> <u>Practice Issue 6: Results and Status of Bangor Police Department Investigation Unexplored by Caseworker</u>
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> Additionally—despite having been assigned to the March 2019, February 2020, and March 2020 investigations—we did not see any evidence that the caseworker contacted the Bangor PD to ask about the results and status of their criminal investigation stemming from the reported sexual abuse of Ms. Hartley's children by Ms. Hartley's relative in March 2019. We believe that this was a potentially valuable source of information, and, given the reappearance of the relative in Ms. Hartley's home just prior to this investigation, warranted the caseworker following up with law enforcement.

On March 17th, the caseworker returned to the home to interview the woman and to try to set up a time to meet with the woman's partner. The caseworker also observed all the children in the home. Later that day, the

caseworker's supervisor entered the preliminary safety decision, which found that the children were safe in the care and custody of Ms. Hartley in the home.

On March 18th, the caseworker called and spoke with the man and woman residing in Ms. Hartley's home. The man stated he did not have much to say to DHHS because his child had been safe in his care upstairs in their room. The man also added that he did not have any concerns or worries for any of the children in the home. The caseworker attempted to speak with him about the dangers of a child leaving the home, but the man stated that he didn't have anything else to say at this time.

On March 25th, the caseworker requested a copy of the PFA that Ms. Hartley said she had filed against her relative. Staff from the Bangor District Court reported that no such PFA could be found in their system nor statewide. We did not see any evidence that this inconsistency was ever explored or discussed by the caseworker with Ms. Hartley, and we note this as a component of Practice Issue 5: Inconsistent and Sometimes False Information Not Explored by Caseworker.

In the caseworker's documentation of their request for a copy of that PFA, we observed that the caseworker identified Ms. Hartley's relative using the relative's birth name—which was the same name the caseworker used for this individual in the March 2019 investigation in which the relative was the alleged sexual abuser of Ms. Hartley's children. This was the first time in the record that there was any documented link between the relative appearing in the March 2019 investigation and the relative appearing in the current investigation.

Although this link exists in the documentation, it does not appear that the caseworker actually made the connection that Ms. Hartley had allowed the previously alleged abuser of her children to reside in her home with those same children. We note this as another component of Overarching Practice Issue 1: Important Connections Missed by OCFS Across Multiple Investigations, which is more fully described on page 8 along with the implications of those missed connections.

On March 27th, the Brewer Police Department provided a copy of the police report from the night Ms. Hartley's relative was asked to leave the home. The report indicated that the relative was issued a Criminal Trespass Notice, and referred to the relative using their adoptive name.

On March 31st, the Department closed their investigation and indicated Ms. Hartley for neglect due to a lack of supervision of her children. The SDM Risk Assessment Tool was run and recommended opening a case. A referral was made for the family to work with ARP. The record indicates that the caseworker discussed this with Ms. Hartley who agreed it would be helpful. However, ARP never provided services to the family as, reportedly, the agency received an email from the caseworker's supervisor indicating that the family wasn't returning calls from the caseworker and to disregard the referral (thus freeing up space for another family to receive those services).

Practice Issue 7: Installation of Child Safety Locks Not Verified by Caseworker

As part of the preliminary safety decision, the next steps to complete the investigation were documented by the supervisor. Among the steps listed, was to verify that Ms. Hartley installed child safety locks (as she had indicated she would) or used existing locks appropriately.

At the time of the decision to close the investigation, we did not see any evidence in the record that caseworker returned to the home or verified that child safety locks were installed (as Ms. Hartley had stated they would be) or that existing locks were being used appropriately. In an interview with the caseworker, the caseworker did not recall whether they went back to the home, but stated that they may have discussed the need for child safety locks with one of the family members' case manager. We were unable to find any documentation of such a discussion.

April 2020: Screened Out Report Containing Multiple Concerns

On April 7th, the Department received a report from a counselor who recounted the concerns that a client—who was not a member of Ms. Hartley's family, but had stayed for a week at Ms. Hartley's home—had told the counselor regarding Ms. Hartley. The caseworker explained that they had been told that Ms. Hartley was abusing drugs and alcohol, was acting paranoid even when not using drugs, and allegedly hearing people talk about her in the walls of the home. The client also disclosed that Ms. Hartley had told the client that Ms. Hartley had touched one of her children in a sexual way. Additionally, the client described Ms. Hartley's children as dirty and the house as very dirty.

The counselor, however, was unable to provide further details, such as the types of drugs used by Ms. Hartley, whether the drug use happened in the home or while caring for the children, how Ms. Hartley had touched the child, the extent of the uncleanliness of the home, and the impact of any of these things on the children.

This report was determined by Intake to be inappropriate for investigation. According to OCFS, the intake caseworker used the SDM Intake Assessment Tool to guide them in determining the final disposition of the report. For this report, the disposition was due to either there being not enough information to deem the report appropriate for investigation or that the information that was provided didn't meet the definitions for suspected child abuse and/or neglect and was therefore screened out.

June 2020: Screened Out Report of Ms. Hartley Experiencing a Mental Health Episode

On June 9th, the Department received an anonymous report from someone who had been recently kicked out of Ms. Hartley's home after Ms. Hartley had what the referent alleged to be a mental health episode. The referent also reported that Ms. Hartley's children were present for this, but did not appear to be bothered by it. The intake caseworker noted that the anonymous referent could not provide specific details regarding how Ms. Hartley's behavior and possible mental health issues were impacting the children. With no established

impact to the children and no reported abuse or neglect, this report was determined not to meet the criteria for investigation when the SDM Intake Assessment Tool was used, and was therefore screened out.

June 2020: Investigation of Ms. Hartley's Alleged Mental Health Issues and Ability to Care for her Children

On June 20th, the Department received a report from a law enforcement officer expressing concerns for Ms. Hartley's mental health following the death of a family member that occurred at Ms. Hartley's home. The family member had recently moved in to assist Ms. Hartley in caring for Ms. Hartley's children. Immediately following the death, Ms. Hartley was reportedly distraught and unable to care for her children in that moment. The referent explained that Ms. Hartley had reported mental health issues and being on medication. The referent also stated that two other individuals were residing in the home: Ms. Hartley's relative (the same relative named as the alleged abuser of her children in March of 2019, who the officer identified using the relative's adoptive name) who was now on probation for domestic violence, and that relative's partner who was on probation for drug charges. This report was screened in for investigation and assigned a 24-hour response, and both the standby supervisor and standby caseworker were notified.

Later that day (June 20th), the caseworker arrived at the home unannounced to interview and observe Ms. Hartley and her children. Ms. Hartley was initially very angry that the caseworker was at her home, but soon participated in the investigation after being calmed down by her out-of-state relatives, who had recently arrived and would be staying with Ms. Hartley for a few days while she dealt with the loss of her family member. Ms. Hartley provided relevant medical, mental health, criminal, substance use, domestic violence, and CPS histories for the members of her household, and shared the names of the family's various service providers.

When describing the family's CPS history, Ms. Hartley recounted the March 2019 investigation in which two of her children were alleged to have been abused by Ms. Hartley's relative. Ms. Hartley stated that her relative denied this, and that she now believed the relative because the relative was now sober. Ms. Hartley reported being unsure at the time when the allegations were made.

The caseworker observed the children and the home, and noted a third-floor bedroom where Ms. Hartley's relative and the relative's partner appeared to have been staying. The caseworker told Ms. Hartley that the relative's partner could not be at Ms. Hartley's home as the relative's partner was well-known to the Department and was not allowed unsupervised time with their own children. The caseworker also told Ms. Hartley that given that her relative was partnered with this individual, the relative should also not be in the home with the exception of making arrangements for the deceased family member. Ms. Hartley stated that her relative and the relative's partner were currently staying in a hotel.

As for the condition of the home, the caseworker noted that the living room was tidy and that the kitchen was well picked up; Ms. Hartley explained that the downstairs of the home had just been cleaned. Upstairs, the caseworker noted clothes and smooshed crackers on the floor, but nothing dangerous.

At 8:35 pm, the standby supervisor entered the preliminary safety decision which found that the children were safe in the home. In discussions with both the caseworker and the standby supervisor, the preliminary safety decision was based on several factors:

- Ms. Hartley did not appear to be actively experiencing a mental health crisis;
- she was under the care of a physician and taking prescribed medications;
- the children appeared cared for and did not disclose any abuse;
- the family had service providers—none of whom had called in any concerns—who would continue to be involved with the family moving forward; and
- most importantly, the out-of-state relatives would be staying with Ms. Hartley for a few days, serving as familial supports, and would be able to ensure the safety of the children.

With the preliminary safety decision made, the investigation would continue with the same caseworker, but under the supervision of their usual supervisor moving forward.

Unsound Safety Decision 2: No Additional Interventions or Safety Planning when Ms. Hartley's Out-of-State Relatives Leave Her Home

As noted in the preliminary safety decision, Ms. Hartley's out-of-state relatives would be leaving in a few days and were reportedly the most significant factor in determining that the children were safe in the home. We believe that upon the transfer of the investigation to the caseworker's usual supervisor, the conditions surrounding this report warranted additional interventions or a safety plan (such as additional supports or monitoring) to ensure the safety of the children while in the sole care of Ms. Hartley. However, we did not see any evidence that such actions occurred or were even considered.

The children remained in the care of Ms. Hartley while the caseworker continued the investigation. On June 22nd, the caseworker obtained SBI/DMV/SOR background checks and CPS histories for Ms. Hartley, Ms. Hartley's former partner (and father of her children), and the two individuals who had been staying in Ms. Hartley's home just prior to the investigation—Ms. Hartley's relative and that relative's partner. The partner's criminal history included charges for harassment, criminal trespassing, operating under the influence, and operating a meth laboratory; their CPS history included five investigations—two of which resulted in substantiated findings of neglect and the eventual termination of their parental rights. Ms. Hartley's relative's criminal history contained multiple domestic violence convictions (threatening, terrorizing, and assault), multiple violations of conditions of release and/or probation violations, and a variety of other offenses. Strangely, Ms. Hartley's relative's CPS history only contained one unsubstantiated report from 2012.

Systems Issue 1: Multiple Profiles for the Same Individual

During the review, we requested that OCFS provide us with separate CPS histories for this individual using first the relative's birth name and then the relative's adoptive name. Neither set of results matched the CPS history that the caseworker documented in this investigation, which was missing the

majority of the relative's CPS history with only one record that appeared to be random. We asked OCFS to determine how the caseworker found only this piece of the relative's CPS history. OCFS explained that OCFS's Comprehensive Child Welfare Information System (CCWIS) and the Office of Family Independence's Automated Eligibility System (ACES) use a common client repository to share client demographics across the two systems. ACES is the system of record for client demographic information, but duplicate clients can be created between ACES and CCWIS if staff fail to properly screen new individuals into the system (i.e. not determining that a person is already in the system).

In this particular case, Ms. Hartley's relative was first listed as two different individuals (one under the birth name and one under the adoptive name)—which was appropriate considering that the relative was adopted during a time in which children/youth were assigned different "A Numbers" (the unique id assigned to someone in ACES) when adopted.

However, there were also multiple profiles under each name resulting from the improper screening of this individual. When the caseworker selected one of these profiles, the caseworker saw only the CPS history that was attributed to that specific profile and not the entirety of the relative's CPS history that existed across multiple profiles. The selection of this specific profile was likely based on the caseworker's recognition of some data (address, birthdate, etc.) other than just the relative's name that could be shared with many others in the state.

We note this as Systems Issue 1; a further description of this issue—in particular its impact on this investigation—and our related recommendation can be found on Page 24.

That same day, the caseworker's supervisor received a message from Ms. Hartley's former partner/the children's father asking that he be contacted. On June 24th, another caseworker—one located geographically closer to the father—met with and interviewed the father and his current girlfriend at their apartment. The caseworker learned that they were doing well with their substance use treatment, were working, and had a strong system of supports in place (for which the father signed releases of information). The caseworker also learned that Ms. Hartley and the children's PFA against the father would expire on June 28th.

On June 24th, the caseworker assigned the investigation called and interviewed the father of the children. The father reported having seen two of his children on June 18th and was unsure of their safety in their mother's care, but that Ms. Hartley was doing the best that she could. The father explained that his girlfriend had supervised visits with her child, but thought that unsupervised visits would be happening soon. The father also reported being concerned that Ms. Hartley's relative was around his children, particularly given the prior allegations.

This was the second time that these allegations had been mentioned to the caseworker, as Ms. Hartley had also discussed it in her initial interview with the caseworker. However, it does not appear that the caseworker realized that these allegations were not captured in the relative's CPS history that the caseworker had obtained and that that history was incomplete. We conclude that this contributed to the caseworker and supervisor not

even considering any safety decisions related to the relative as they did not fully understand the risk that the relative's presence in the home had posed to Ms. Hartley's children. We note this as a component of Overarching Practice Issue 1: Important Connections Missed Across Multiple OCFS Investigations.

Over the next several days, the caseworker continued to assess the safety of both the children's father and Ms. Hartley. Ms. Hartley was drug screened and tested negative for all substances. The caseworker contacted and spoke with Ms. Hartley's identified relative resources and providers, learning that Ms. Hartley had a mental health evaluation scheduled for July 1st—which she did not show up for—and a medication management appointment scheduled for July 6th. Bangor PD were contacted and indicated that no new reports concerning the household had been made. The children's father and paternal grandmother were both interviewed to discuss the father's substance use, mental health, domestic violence, criminal and CPS histories, his progress and current status. They both reported that the father was doing well. On July 10th, the caseworker spoke with one of Ms. Hartley's out-of-state relatives who had been in the home to support Ms. Hartley immediately following the death of Ms. Hartley's family member. This individual reported encouraging Ms. Hartley to work with the caseworker as the Department may be able to offer some services to help her. The out-of-state relative did not think that the children were unsafe, and the caseworker encouraged the out-of-state relative to call Ms. Hartley more often and to let the caseworker know if there were any concerns.

On July 13th, another caseworker—along with the caseworker assigned this investigation—went to Ms. Hartley's home to find and interview Ms. Hartley's relative and the relative's partner as the partner had their own open CPS involvement. Ms. Hartley reported that they were not at the home, which the caseworkers confirmed by touring the home with Ms. Hartley. With those individuals not at the home, the other caseworker left, while Ms. Hartley's caseworker remained to interview Ms. Hartley. They discussed the state of the home, which was in worse condition from the caseworker's prior visit to the home. Ms. Hartley agreed to work on tidying up the home with a relative (but not the relative who was previously alleged to have sexually abused Ms. Hartley's children) who had recently moved into the home. Ms. Hartley discussed her mental health and the mental health evaluation that was missed—Ms. Hartley stated that she forgot about it. The caseworker asked Ms. Hartley to do three things before the end of the week: get the home cleaned up, call and reschedule the mental health evaluation, and call about adding the relative to her housing voucher application. The caseworker then interviewed the relative and discussed Ms. Hartley's children, discipline, the relative's own diagnoses and providers, as well as any substance use, domestic violence and criminal or CPS histories that they may have had. During this interview, the relative disclosed some CPS involvement in their past.

Throughout the rest of the investigation, the caseworker and the caseworker's supervisor contacted or attempted to contact the father's various providers and supports, as well as Ms. Hartley's relative who was previously alleged to have abused the children and that relative's partner. One of the father's providers had yet to meet with him, but was scheduled to later in the week. Another provider commented on the strength of the father's support system at that time. Ms. Hartley's relative and the relative's partner never showed up for their interview with the caseworker.

On July 16th, the caseworker returned to the home to check on Ms. Hartley's progress. Ms. Hartley's relative who was residing at the home was there and the caseworker observed that the house looked better. The relative explained that Ms. Hartley was not at home as she was reportedly attempting to retrieve her other relative (the previously alleged abuser) as that relative had been arrested. The caseworker reiterated to the relative residing in the home that the other relative and that relative's partner were not allowed at the home.

On July 22nd, the supervisor ran the SDM Risk Assessment Tool which determined that the family was at a high risk for neglect and recommended opening a case with the family. Instead, the family was referred to ARP, which, given that there were only indicated findings of low/moderate severity neglect by Ms. Hartley, was an appropriate option per OCFS policy.

August 2020: Transferring the Family to ARP and First Appearance of Ronald Harding

On August 7th, the caseworker met with Ms. Hartley and Ms. Hartley's new ARP worker at Ms. Hartley's home for a transfer/family team meeting. The caseworker explained that the Department had chosen to not open a service case with the family and instead transfer the case to ARP; if Ms. Hartley chose to not sign on with ARP, the Department might instead open a case with the family. Ms. Hartley then stated that she would like to work with ARP.

The OCFS caseworker explained that the Department was worried about Ms. Hartley's mental health and the recent passing of a family member in Ms. Hartley's home. A mental health evaluation had been previously scheduled, but Ms. Hartley did not show up.

The OCFS caseworker also listed the Department's recommendations for Ms. Hartley as she worked with ARP:

- follow the recommendations of her providers;
- not let the relative currently staying in Ms. Hartley's home babysit the children for more than an hour;
- choose appropriate caregivers for the children;
- engage in parenting/daily living skills classes; and
- continue communicating with the children's father.

As these recommendations were discussed, Ms. Hartley disclosed that she was pregnant and unsure what medications she would be allowed to take during her pregnancy, but would be scheduling an appointment with an OB-GYN. Ms. Hartley explained that she was very happy about the pregnancy and that the baby would be the first child for her boyfriend, Ronald Harding. Ms. Hartley additionally stated that she did not think that she needed parenting/daily living skills classes, and, even if she felt that she did, did not have a babysitter to be able to attend classes or a Zoom meeting. Ms. Hartley also noted that her relative and the relative's girlfriend were not living at her home as initially found, but would continue to use her address as their mailing address.

After this discussion, the OCFS caseworker left the meeting while the ARP worker reviewed the recommendations again with Ms. Hartley and finalized a family plan in which ARP would continue to monitor and support Ms. Hartley as she worked to follow the Department's recommendations—with the exception of participating in parenting/daily living skills classes, which Ms. Hartley declined. ARP would work with Ms. Hartley for a period of 120 days; if safety concerns increased during that time, ARP would notify the Department.

Practice Issue 8: No Safety Assessment of Ronald Harding

We did not see any evidence that Mr. Harding's safety was ever assessed even though he met OCFS's definition of a household member; in fact, had Ms. Hartley's pregnancy and relationship with Mr. Harding been known before the closure of the investigation, the OCFS caseworker would have been expected to assess the safety of Mr. Harding.

Although the discovery of Ms. Hartley's pregnancy and Mr. Harding's existence occurred after the investigation closed and during the transfer to ARP for a particular set of services, we did not see any documentation that suggested the OCFS caseworker and the ARP worker discussed whether Mr. Harding should be assessed, and, if so, by whom. This was later confirmed in an interview with the former caseworker.

In separate interviews with OCFS management and the Child Welfare Ombudsman, both parties indicated that any assessment of Mr. Harding—in particular a search of his criminal and CPS histories—would not have returned any results. While that is true for Mr. Harding's criminal history (which we were provided), our review of the internal briefing memo prepared in response to Jaden Harding's death by the Regional Associate Director (RAD) for that area found a reference that indicated the RAD had found something in the system that we would consider part of Mr. Harding's CPS history.

We asked the OCFS Associate Director to again search MACWIS for Ronald Harding, and, using a different approach, they found Mr. Harding's name attached to an old screened-out report that was filed under the referent's name. We believe the contents of that report would have subjected Mr. Harding to further scrutiny, and specifically resulted in the caseworker contacting out-of-state CPS and law enforcement agencies for additional information. Through OCFS, we made those requests for the additional information, but no records were available. Still, as indicated by OCFS staff, the information from the screened-out report would have at least warranted a psycho-social interview with Mr. Harding to discuss his past. Ultimately, it does not appear that the reference to Mr. Harding in the screened-out report would have been sufficient for the Department to intervene in any way with the family.

August 2020 – November 2020: Period of ARP Involvement

On August 13th, the ARP worker contacted one of the children's case managers. The case manager reported that they hadn't done a home visit since February and that their organization was currently only doing Zoom meetings. The case manager did not have any concerns, but did state that Ms. Hartley needed help with organizational skills and being reminded of appointments. On August 17th, the ARP worker contacted Ms. Hartley's case manager who stated that they had not seen Ms. Hartley since June and if they did not hear from Ms. Hartley, her case would be closed. The ARP worker then called and relayed that information to Ms. Hartley who indicated that she did not want that to happen and would contact her case manager.

On September 2nd, Ms. Hartley texted the ARP worker that she wasn't feeling well and asked to reschedule the ARP worker's planned home visit. Due to scheduling difficulties, they rescheduled for September 25th. Ms. Hartley also noted that she had an appointment with a mental health provider the next day. On September 24th, the ARP worker contacted Ms. Hartley's case manager who stated that Ms. Hartley had missed their scheduled appointment because Ms. Hartley allegedly did not have a ride to the office. The case manager indicated that they were unsure what Ms. Hartley wanted to actually work on and the ARP worker responded that Ms. Hartley had expressed an interest in finding a new apartment.

Later that day, the ARP worker conducted an announced home visit with Ms. Hartley and all three children. Ms. Hartley reported that she had been in contact with the mental health provider per the Department's recommendations, but that because she was pregnant she was not on any medications. Ms. Hartley noted that she had been seen by an OB-GYN and that the relative who had been living at Ms. Hartley's was no longer there. Ms. Hartley expressed that she did not want to find a new apartment at that moment, preferring to do so after her pregnancy. The ARP worker instructed Ms. Hartley to inform her case manager of that decision. All three children were observed by the ARP worker. At the end of the visit, Mr. Harding came home from work. The ARP worker and Mr. Harding greeted one another and then the ARP worker left.

On October 16th, the ARP worker obtained Ms. Hartley's drug screen results from her appointment at the OB-GYN, which came back negative for all substances. Four days later, the ARP worker made their second announced home visit. Ms. Hartley reported that she and her case manager were playing phone tag. Ms. Hartley stated that she and Mr. Harding had purchased a van and were going to remain in their current apartment. Ms. Hartley noted that her relationship with the children's father was going well and her mental health issues weren't as bad. On October 27th, the ARP worker contacted the children's medical provider and learned that they all had appointments scheduled for November and that there were no concerns noted in their files.

On November 10th, the ARP worker made their third and final announced home visit. Ms. Hartley reported that the youngest of her children had an infected tooth that required a trip to the emergency room. Ms. Hartley's uncle gave her and the child a ride to the hospital while Ms. Hartley's aunt watched the other two children at the home. The ARP worker noted that the child did not appear to be in pain and all the children appeared well-groomed. Ms. Hartley and the ARP worker reviewed the original family team meeting goals and discussed Ms. Hartley's compliance with each. The ARP worker suggested that Ms. Hartley reach out to her

mental health provider after the birth of the baby and Ms. Hartley indicated that she would. Later that day, the ARP worker completed the closing summary for the case, thus ending ARP's involvement with the family.

Jaden Harding was born to Ms. Hartley in April 2021.

June 2021: Death of Jaden Harding

There was no further CPS involvement with the family until May 31st, 2021 when the Department received a report from a hospital that Jaden Harding had been brought to the emergency by ambulance and was unresponsive. Ms. Hartley had explained to medical providers that she had been cooking dinner, left the room while Jaden was in a chair, and when she returned to the room Jaden appeared to be choking. The family called 911 when Jaden became unresponsive. The hospital determined that Jaden's prognosis was not positive, that the timeline as described by Ms. Hartley did not match the injuries, and that non-accidental trauma could not be excluded.

Jaden Harding was pronounced dead at 3:50 pm on June 1st, 2021.

Appendix A. DHHS Memorandum

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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MEMORANDUM

FROM: Jeanne M. Lambrew, Ph.D., Commissioner

SUBJECT: Jaden Harding

DATE: September 19, 2023

Pursuant to State and Federal law, in consultation with the Office of the Attorney General, the Department may disclose certain categories of child protective information when child abuse results in a child fatality. This memo provides information regarding the involvement of Maine's child protective services in the life of Jaden Harding, in line with Department practice in previous cases. Now that this criminal case has concluded with Ronald Harding's conviction and sentencing, there is no longer a risk that disclosure will jeopardize the criminal investigation or proceeding.

Child's Name: Jaden Harding

Child's Age at Time of Death: 1 month

Child's Caregiver(s) at Time of Death: Mother, Kayla Hartley and Father, Ronald Harding

Others Previously Involved: Ms. Hartley's former partner and her older children (Jaden's half-siblings)

History of Reports to Child Protective Services and Actions Taken in Response:

Mr. Harding had no history with the Department prior to May 31, 2021.

The Department's involvement with Mr. Harding, Ms. Hartley, and Jaden:

- May 31, 2021 – Medical personnel made a report to the Department that Jaden had presented at the ER and was unresponsive. The report indicated that Ms. Hartley was cooking dinner, left the room while Jaden was playing in a chair, and when she returned to the room, he was choking on an unknown substance.

- Medical personnel determined that Jaden had several brain bleeds, hernias, and pneumonia. Medical personnel were concerned that Ms. Hartley's timeline did not match the injuries and believed non-accidental trauma could not be excluded.

- Jaden was pronounced dead at 3:50 p.m. on June 1, 2021. On autopsy it was determined that Jaden's injuries were inflicted.
- The Department observed the mother's other children the night of May 31, 2021, in the home Ms. Hartley shared with Mr. Harding. The children were interviewed the next day at the Children's Advocacy Center.
- The Department also interviewed the father of these children and the father's girlfriend. The children's father agreed to take placement of the children and the Department filed a Petition for Child Protection Order and a Request for Preliminary Protection Order (PPO), to place the older children in the custody of their father. The Court granted the father custody pursuant to this request.
- The Maine State Police arrested Ronald Harding and charged him with manslaughter for Jaden's death. The report from the Office of the Chief Medical Examiner indicated that Jaden had been shaken.
- Both Mr. Harding and Ms. Hartley continued to deny causing Jaden's death or knowing how it occurred.
- Mr. Harding was substantiated for physical abuse to Jaden as well as threat of physical abuse to Ms. Hartley's three older children.
- Ms. Hartley was substantiated for neglect to all four children.
-

Ms. Hartley was not charged in the death of Jaden Harding nor were there abuse findings against her. In the interest of transparency, the appendix below describes Ms. Hartley's history with Child Protective Services prior to Jaden's birth.

APPENDIX:

Ms. Hartley's history involving her former partner and three older children:

- February 2014 – The Department received a report that Ms. Hartley's newborn may have been exposed to substances prenatally. She denied using substances except for marijuana during pregnancy and her drug screens were negative for all substances. The family was referred to the Alternative Response Program (ARP) and Public Health Nursing (PHN). The family engaged with both services. PHN reported no concerns regarding Ms. Hartley's ability to care for the child. The parents ensured the child attended all scheduled appointments. They also planned to attend parenting education, and the family engaged in home visiting services.

- May 2015 – The Department received a report that Ms. Hartley's newborn may have been exposed to substances prenatally. Ms. Hartley tested positive for marijuana. The family was referred to ARP and PHN, but they declined PHN services.

- September 2015 – The Department received a report from law enforcement about a possible domestic violence incident between Ms. Hartley and her then-partner. When law enforcement responded, both denied any physical contact but admitted to verbal arguments that occurred while the children were present in the home. This report was determined not to meet the criteria for investigation.

- December 2015 – The Department received a report that Ms. Hartley's child had not been seen for medical care in several months. This report was determined to meet the criteria for investigation.
  - During the open investigation:
    - An additional report was received regarding lack of follow-up for medical issues.
    - The parents subsequently followed up as directed by the child's providers and the child was receiving services from Child Development Services (CDS).
    - The parents did not agree to sign releases to provide information to the Department.
  - Based on the information the Department was able to gather, there were insufficient grounds to make findings against either parent regarding the safety and well-being of their children, or to pursue court intervention to compel their engagement with the Department.

- March 2017 – The Department received a report that Ms. Hartley's newborn may have been exposed to substances prenatally. Ms. Hartley tested positive for marijuana and acknowledged

using marijuana for pain. The parents were initially receptive to both PHN and home visiting, but ultimately declined PHN services. They did engage with home visiting. This report was determined not to meet the criteria for investigation.

- June 2017 – The home visitor assigned to the family made a report to the Department due to Ms. Hartley's admission that she felt overwhelmed caring for three young children. Ms. Hartley had admitted to spanking two of the children. This report was opened for investigation.
    - The investigation identified concerns regarding Ms. Hartley's mental health, but the Department determined she was engaged in mental health treatment and following provider recommendations.
    - Based on the information the Department was able to gather, there were insufficient grounds to make findings against either parent regarding the safety and well-being of their children.

- January 2018 – The Department received a report that Ms. Hartley and then her-partner were not adequately addressing the medical needs of one of the children. This report was determined not to meet the criteria for investigation.

- April 2018 – The Department received a report from law enforcement due to a domestic violence incident reported by neighbors. Ms. Hartley and her then-partner admitted to a verbal fight related to the partner's substance use. Law enforcement determined there was an active warrant for the partner's arrest. He resisted arrest in the presence of the children. This report was opened for investigation.
    - During the open investigation:
        - Ms. Hartley obtained a Protection from Abuse (PFA) order on behalf of herself and the children and Ms. Hartley left her relationship and moved to a shelter with the children.
        - The Department received an additional report regarding an injury one of the children had sustained. The Department determined this injury was accidental.
    - The Department received an additional report that Ms. Hartley was struggling to care for all three children and may have allowed contact between the children and their father (who had been her partner during previous Department involvements). The Department attempted to follow-up with Ms. Hartley following receipt of this report but was unable to reach her.
    - Based on the information the Department was able to gather, there were insufficient grounds to make findings against Ms. Hartley regarding the safety and well-being of

her children, or to pursue court intervention to compel her engagement with the Department.
    - The Department made indicated findings of emotional maltreatment and substantiated findings of threat of physical abuse against Ms. Hartley's partner/the father of the children.

- March 2019 – The Department received a report that one of the children may have been sexually abused by a family member, but that Ms. Hartley was not allowing contact between her children and this family member. This report was determined not to meet the criteria for investigation.

- March 2019 – A new report was received regarding possible sexual abuse by a family member. An investigation was opened.
    - During the open investigation:
        - Interviews of the children were conducted at the Children's Advocacy Center (CAC) and two of the children reported sexual abuse.
        - Ms. Hartley demonstrated protective capacity and ensured her children were not allowed alone with the family member.
        - Law enforcement was involved and investigated the allegations.
        - The children's father was not contacted during the investigation due to the PFA that was still in place.
        - Two additional reports were received by the Department during the open investigation regarding concerns of possible sexual abuse by a relative.
    - The Department did not make findings of abuse or neglect as the family member did not meet the definition of a "person responsible for the child" which is required in order to make a finding.

- July 2019 – The Department received a report that Ms. Hartley had used physical discipline with one of the children. The provider who made the report indicated that Ms. Hartley was open to discussing discipline techniques and the Department made a referral for case management services for the child. This report was determined not to meet the criteria for investigation.

- February 2020 – A report was received that one of the children had bruising on their face. An investigation was opened.
    - During the open investigation:
        - The child reported she and another person were playing a game and that is how the child was injured.

        - Ms. Hartley admitted to allowing an individual with a history of domestic violence to reside in the home but denied the individual was providing care for the children.
        - Ms. Hartley agreed she would not allow this individual to remain in the home if they became violent.
        - The caseworker attempted to contact the father of the children but was unsuccessful.
    - Based on the information the Department was able to gather, there were insufficient grounds to make findings against the parents regarding the safety and well-being of their children, or to pursue court intervention to compel engagement with the Department.

- March 2020 – The Department received a report after one of the children was found unattended on the side of the road. When law enforcement responded, it was determined that the children had been left at home under the supervision an 11-year-old. An investigation was opened.
    - During the open investigation:
        - The 11-year-old reported not knowing that Ms. Hartley had left the home and the Department discovered that the same individual with the history of domestic violence was present in the home but on a different floor and not aware of the situation.
        - Ms. Hartley reported to the caseworker she had forgotten to tell the 11-year-old she was leaving to walk up the street.
        - No attempts were made to contact the father of the children.
    - The Department indicated Ms. Hartley for neglect due to lack of supervision and the Department referred the family for ARP services.

- April 2020 – The Department received a report from a provider who indicated that an individual who had been staying with Ms. Hartley had decided to move out of the home due to Ms. Hartley's use of substances. The provider reported it was unknown what substances Ms. Hartley was using and whether she was using them while caring for the children. There were also concerns regarding a sexualized environment around the children. This report was determined not to meet the criteria for investigation.

- June 2020 – The Department received an anonymous report from someone who indicated they had recently lived in the home. The person reported being kicked out of the home after Ms. Hartley had a mental health episode. Upon further questioning by intake, the referent indicated that Ms. Hartley had yelled upstairs to say that the referent and her boyfriend needed to leave

the home. There was no information in the report about impact to the children. This report was determined not to meet the criteria for investigation.

- June 2020 – The Department received a report from law enforcement with concerns for Ms. Hartley's mental health. The officer reported that Ms. Hartley was distraught over the death of a family member and was unable to provide care for the children. The Department determined that two relatives were residing in the home, one of whom was on probation for domestic violence and the other who was on probation for drug charges. An investigation was opened.
  - During the investigation:
    - The Department interviewed the children's father and his providers and determined that he had ameliorated the safety issues he had posed to the children in the past. During his interview with the Department, the father reported concerns for Ms. Hartley's mental health and said her demeanor would change rapidly.
    - Ms. Hartley was receptive to services and engaged with case management and a medication provider to ensure she took her medication as prescribed.
    - Ms. Hartley engaged in drug screens requested by the Department and was found to be negative for all substances.
    - The children were engaged with appropriate mental, behavioral, and physical health services to meet their needs.
  - The Department indicated Ms. Hartley for neglect and the family was referred to ARP. ARP remained engaged with the family from August of 2020 to November of 2020. The ARP record reflects that Ms. Hartley was pregnant and following the recommendations of her doctor and mental health providers. Mr. Harding is mentioned in the record as "Ron" and it appears he moved into the home around July or August of 2020. No follow-up regarding Mr. Harding, his relationship with Ms. Hartley, or his history is noted in the ARP record. Per policy ARP would have referred any new concerns to the Department for possible investigation had they arisen during their involvement.

- January 2021 – The Department received a report from the father of the older children that the children may have been sexually abused by a relative. These allegations were previously assessed and as a result the report was determined not to meet the criteria for investigation.

Appendix B. OPEGA's Methodology

To complete this review of the Jaden Harding case, OPEGA staff collected and analyzed information from multiple sources. The Attorney General's office provided OCFS case files to OPEGA that contained CPS reports, investigations, narrative logs, medical records, and background check results. After a first review, OPEGA requested some related documentation, as well as three recorded interviews between caseworkers and those subject to investigation. The Attorney General's office and OCFS researched and fulfilled our requests.

Records Reviewed in the Jaden Harding Case File Review		
Record type	**Number of documents**	**Pages**
OCFS records	47	366
Medical records	16	418
Court documents	2	19
Background checks	14	67
Total	**79**	**870**

For our earlier work on CPS, OPEGA has collected and examined relevant state statutes, agency rules, and OCFS policies in order to document the framework within which OCFS delivers child protective services. We drew on this documentation to interpret the CPS casework and court decisions in this case.

Additionally, OPEGA staff reviewed the Department's June 14, 2021 Internal Briefing Memo regarding the death of Jaden Harding, and the September 19, 2023 Memorandum publicly released by DHHS Commissioner Jeanne M. Lambrew after the criminal case and sentencing was complete (see Appendix A). We also reviewed a draft report from the Maine Child Welfare Ombudsman based on that office's review of the Harding case, and we interviewed the Ombudsman about her findings.

OPEGA then created a timeline of each CPS contact with this family. The staff team identified and discussed each significant decision-making point, and compared them to Maine statute, agency rules, and CPS policy to determine whether we understood the rationale for each decision made. OPEGA then conducted interviews with the various CPS caseworkers and supervisors, as well as other members of CPS management with firsthand knowledge of the case. These individuals provided more insight into the reasons for their decisions and actions. After completing all the initial discussion, we conducted follow-up interviews with several individuals for further clarification. Finally, the OPEGA team made conclusions on safety decisions and identified practice issues, systems issues, and potential opportunities for improvement.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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November 13, 2023

Office of Program Evaluation and Government Accountability
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Augusta, ME 04333-0082

Dear Director Schleck,

Thank you for the opportunity to review and respond to OPEGA's Case File Review on the Jaden Harding case. The Department of Health and Human Services (DHHS) and the Office of Child and Family Services (OCFS) thanks the staff of OPEGA for their thorough review and analysis of the records in this case. We have confidence in the objective nature of OPEGA's work and as such will not be responding to any of the factual information in this review and upcoming case file reviews unless there is disagreement with the characterization or representation of any of the facts of the case. In this case, we have no concerns with the factual information.

OPEGA's report noted practice concerns that OCFS believes can primarily be categorized into one or more of the following overarching categories:

- Availability and assessment of information (ongoing issue #1, specific issues #2, 3, 5, system issue #1)
- Safety planning and decision making (ongoing issue #2, specific issues #4, 6, 7, 8)
- Implications of policy/practice changes (specific issue #1)

Before OCFS responds to each of these categories, we note that the practice concerns identified by OPEGA revolve primarily around the Department's involvement with Jaden's mother and his older siblings. As OPEGA did in this review, the Department's approach to reviewing these cases includes a thorough review of all history while avoiding speculation on how different actions, decisions, policies, or practices would have changed the trajectory of a child's life. Jaden's case illustrates why this type of speculation or, as OPEGA describes it "outcome bias," should be avoided. Despite the Department's past involvement with Jaden's mother and his siblings, the reality remains that the person who killed Jaden had no direct history with OCFS and no concerns about the family were reported to the Department during Jaden's life. Furthermore, as OPEGA's report notes, even if Jaden's mother's history had warranted a safety plan or removal at the time of Jaden's birth, the Department would have had no reason to prevent his father from being his primary caregiver based on available information.

OCFS also notes that this case is one of the cases that was reviewed as part of the Department's collaboration with Casey Family Services and Collaborative Safety, LLC. Those reviews resulted in several recommendations in October of 2021, some of which mirror or align with those of OPEGA. OCFS has worked to systematically address each of those recommendations, completing that work earlier this year. OCFS has acted and will continue to do so on all three of OPEGA's "Potential Opportunities for Improvement:" identifying and providing appropriate levels of services for families; information sharing between OCFS, law enforcement, and the courts; and feedback and management expectations.

The alignment of OPEGA's recommendations with those from the independent Safety Science-driven review reinforces the ongoing value of OCFS' implementation of Maine's Safety Science Model. Under this Model, which is now established within OCFS, a Multidisciplinary Team conducts reviews of cases involving critical incidents. The Safety Science process gets feedback from staff involved in these cases about how and why decisions were made as part of a comprehensive examination of the system, with the goal of identifying and making changes to improve the outcomes for children and families rather than casting blame.

OCFS staff have a deep commitment to improving the lives of children and families. To describe the work of child protection as challenging would be an understatement, and we know our staff devote their lives to this work because they have a passion for serving children and families to both provide protection and improve their lives. To that end, we also know our staff strive each day to make the best possible decisions and recognize that those decisions are made within the context of federal and state statute, policies, practices, and community resources.

Availability and assessment of information

OCFS agrees that it can sometimes be challenging for staff to gather all the relevant information regarding a family. This can be due to many factors including, but not limited to, reluctance of a family to engage with child protective services and/or provide information, difficulty obtaining information from the source, the volume of information available regarding some families, and the difficulty synthesizing that information to use it effectively when working with the family.

Improving the ability of staff to gather and evaluate information in a comprehensive and holistic manner has been a driving force behind some of the Department's system improvement efforts in the past few years. OCFS has continued to refine the Structured Decision Making (SDM) tools staff use when evaluating risk and safety and determining what next steps may be warranted in an investigation or case.

Recognizing that the output of the SDM tools is based on the information available, OCFS has worked to improve information sharing with law enforcement and health care providers through an ongoing workgroup that includes representatives of OCFS, the Office of the Attorney General, law enforcement, and medical providers. OCFS has also continued its work with the University of Southern Maine to review and update all of OCFS' policies, including building-in opportunities to look more holistically at a family's current and past circumstances in making decisions.

OCFS has also implemented a new Comprehensive Child Welfare Information System (CCWIS) known as Katahdin. This system has expanded the way in which an individual's history can be reviewed. In the old system (known as MACWIS), a person's history was broken down only by their past involvements (including reports, investigations, and cases). In Katahdin, each individual has a person-level profile that brings together information across all involvements the individual has had with child protective services. This allows staff to comprehensively view the prior history an individual has had with OCFS. As with any new system, there is a learning curve. With input from staff, OCFS' Information Services team is continuing to work towards system enhancements that improve the ability of staff to organize and analyze information about an individual or family.

While positive efforts have been made toward improving the information available to staff, OCFS has also been experiencing an increase in vacancies that affect continuity of caseworkers for children and families. OCFS leadership met with staff from across the State over the past few months and have frequently heard that staff vacancies pose challenges such as limiting the time needed to thoroughly review and synthesize a family's entire history. OCFS remains committed to its ongoing and intensive recruitment efforts spearheaded by the Office's dedicated recruitment specialist, as well as to innovative solutions. Such solutions include shifting some work from Districts with the highest vacancies to those that are better staffed and addressing afterhours and weekend coverage concerns from staff, including by establishing a dedicated Children's Emergency Services (CES) unit with support from the Legislature.

Safety planning and decision making

The issues identified regarding safety planning and decision making are closely linked to those related to gathering and assessing relevant information.

The need to further improve safety planning practice has been identified through Safety Science reviews and other case-level reviews over the last few years. As a result, OCFS has convened a workgroup of key stakeholders to look at safety planning practice, how it is currently implemented, what best practices might exist related to the concept of safety planning, how other states utilize safety planning, etc. This work is currently ongoing and any resulting changes to policy or practice will be documented in future reports from OCFS, including our annual report and quarterly reports to the Health and Human Services Committee.

OCFS has also been careful to review the Harding case and others through the lens of the circumstances at the time of the Department's involvement. Ms. Hartley's history dates back to 2014, long before prevention for families demonstrating a high risk for child abuse and/or neglect became a primary area of focus for OCFS. In October of 2021, OCFS implemented the federal Family First Prevention Services Act (FFPSA). Under FFPSA the Department receives federal funding to provide evidence-based services to children and families where the children are at imminent risk of removal. These services were not available at the time of the Department's past involvement with Ms. Hartley and her children. Upon reviewing the information in the records and the Department's guidelines for prevention services that currently exist, it is possible that the family could have benefitted from prevention services had they been available at the time. There is no way to know what impact these services may have had for the

children or Ms. Hartley, but this example demonstrates a change OCFS has made (with the help of federal guidance and funding) to work with families to prevent abuse and neglect instead of addressing it after the fact.

Implications of policy/practice changes

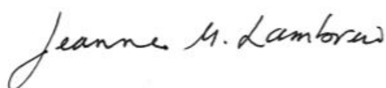
One of the specific issues identified by OPEGA in its review was a policy/practice decision made in April of 2018 that significantly increased workload across child protection. This decision was made in an attempt to ensure the safety and wellbeing of children due to concern that safety had not been fully assessed after receiving reports that were appropriate for investigation. The benefit of hindsight is that it provides a comprehensive understanding which, in this situation, indicates that while trying to ensure the safety and wellbeing of children in one area, additional risk may have been created in another. This is an issue that the current Administration is aware of and was a driving force behind OCFS' current commitment to involving staff and other stakeholders in decisions regarding changes to policy and/or practice.

One of OCFS' most recent changes to policy and practice demonstrates this commitment and resulted in part from the reviews of the Harding case. Earlier this year, OCFS updated its investigation timeframe to extend from 35 to 40 days the period in which a child protective investigation must be completed. This change was made after extensive work with a stakeholder group comprised of field staff from across the State. OCFS is committed to taking this same approach that relies heavily on the input of those with first-hand, recent experience doing the work, with all significant policy and practice changes. Staff have the opportunity to provide feedback on every new or revised policy developed by OCFS' Policy and Training Team in conjunction with the Catherine Cutler Center at the University of Southern Maine.

Final note

No amount of retrospective review will change the grief, loss, and anger that results from a caregiver murdering a child. Nonetheless, we are committed to utilizing these cases to learn and take every possible step to prevent future harm as well as improve the overall well-being of children and families. OCFS is grateful for the work of the Child Welfare Ombudsman, the Child Death and Serious Injury Review Panel (CDSIRP), the Domestic Abuse Homicide Review Panel, Collaborative Safety, other partners and the Legislature in reviewing cases involving child fatalities. The insight provided to the Department through this multidisciplinary approach is valued and speaks not just to possible improvements within OCFS but also to potential improvement opportunities across the child welfare system. OCFS is committed to continuing to work to prevent tragedies through system improvements and upstream preventative measures that avoid the need for child protective involvement altogether.

Regards,



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