MAINE STATE LEGISLATURE
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September 3, 2025

Senator Craig Hickman, Chair
Representative Anne-Marie Mastraccio, Chair
Government Oversight Committee
c/o Office of Program Evaluation and Government Accountability
82 State House Station
Augusta, ME 04333-0082

Dear Senator Hickman, Representative Mastraccio, and members of the Government Oversight Committee,

We respectfully request an investigation by the Office of Program Evaluation and Government Accountability (OPEGA) into the issues outlined in the accompanying letter we have sent to Department Health and Human Services (DHHS) Commissioner Sara Gagné-Holmes. The recent series of articles in the Portland Press Herald that are linked in the letter regarding the murders of a father and his adopted son at the hands of a minor in the custody of DHHS has raised serious issues with the Department's Office of Child and Family Services (OCFS) division.

To summarize the series of articles, Christopher Hunnewell and Jessie Carter of Chelsea took in their relative as foster parents. Shortly after, Carter claimed they reached out to the Department regarding the minor's violence and declining mental state and sought to find another foster home for him. They were especially alarmed when a notebook detailing how he was going to murder the couple was found.

Further, Carter's charge that OCFS's caseworker was not truthful to her or her late husband about the extent of the minor's mental health issues showed a direct disregard for the safety of her family. This gross indifference toward resource parents and inaction by OCFS ultimately resulted in the death of Hunnewell and their son, Tyler Carter, both of whom were stabbed to death by the minor who also reportedly attempted to kill Tyler Carter's fiancée.

This request also comes amid the update to the child fatality dashboard indicating that OCFS recorded its third-highest year in child deaths when 31 children who had OCFS involvement died in 2024. As we mentioned in the letter to the Commissioner, more children with OCFS involvement have died in the last five years than the previous 13 years combined. It is an appalling record that is showing no sign of improvement despite the repeated promises that it would.

The murders raise significant questions surrounding how this case was handled by OCFS:

1. Why were the resource parents not notified of the minor's mental health history?
2. Why was the minor not given the proper mental health resources?
3. Why was OCFS unresponsive when the resource parents raised alarms of the minor's violence?
4. The settlement with the U.S. Department of Justice stipulated that the Department would conduct a comprehensive needs assessment on all minors in State custody and provide needed resources and support. According to sources the Press Herald spoke with, that "practice remains too rare for now." Is that the case here?

5. Why was the minor not removed immediately upon learning he was going to a new home? The murders reportedly occurred just after the caseworker left.

A thorough investigation by OPEGA will provide clarity to the facts surrounding this case, which interestingly is being kept quiet by the Executive and Judicial branches. If the review determines that critical errors were made by OCFS or the minor was, in fact, receiving mental health services, the investigation will be beneficial to the public. As it stands now, it appears there were materially significant shortcomings with this case, especially after the parents warned OCFS.

OPEGA is the proper venue for this review, given its mission and statutory authority to access confidential records as well as its exemption from the Freedom of Access Act. Its independence and expertise make it uniquely qualified to evaluate this sensitive matter.

The Maine Legislature has a fundamental duty to safeguard public safety and uphold the integrity of state processes. We look forward to further discussion of this request at the next meeting of the Government Oversight Committee, or perhaps hearing from the DHHS commissioner as we requested in the letter.

Respectfully,

Harold "Trey" Stewart III
Senate Republican Leader

Jeff Timberlake
State Senator, District 17

Brad Farrin
State Senator, District 3

Cc: Members, Government Oversight Committee
Peter Schleck, Director, Office of Program Evaluation and Government Accountability
Members, Joint Standing Committee on Health and Human Services