MAINE STATE LEGISLATURE
GOVERNMENT OVERSIGHT COMMITTEE

MEETING SUMMARY
May 24, 2018
Accepted June 14, 2018

CALL TO ORDER

The Chair, Sen. Katz, called the Government Oversight Committee to order at 9:00 a.m. in the Burton Cross Building.

ATTENDANCE

Senators:	Sen. Katz, Sen. Libby, Sen. Davis, Sen. Diamond and Sen. Saviello Joining the meeting in progress: Sen. Gratwick
Representatives:	Rep. Mastraccio, Rep. Pierce, Rep. DeChant, Rep. Harrington, Rep. Rykerson and Rep. Sutton
Legislative Officers and Staff:	Beth Ashcroft, Director of OPEGA Matthew Kruk, Principal Analyst, OPEGA Scott Farwell, Senior Analyst, OPEGA Amy Gagne, Analyst, OPEGA Kari Hojara, Analyst, OPEGA Ariel Ricci, Analyst, OPEGA Etta Connors, Adm. Secretary, OPEGA

INTRODUCTION OF GOVERNMENT OVERSIGHT COMMITTEE MEMBERS

The members of the Government Oversight Committee introduced themselves.

SUMMARY OF THE MARCH 23, 2018 GOC MEETING

The March 23, 2018 Meeting Summary was accepted as written.

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NEW BUSINESS

- **Presentation of OPEGA Report on Child Protection System: A Study of How the System Functioned in Two Cases of Child Death by Abuse in the Home** (A copy of the Information Brief is attached to the Meeting Summary.)

Director Ashcroft noted that she did not feel OPEGA had been limited in any way in looking at the records needed to do the work for this review. What OPEGA is able to report has, to some degree, been impacted by what information is already in the public domain by virtue of media reports. In some ways, it has given them some latitude to talk about some things they may have otherwise had to hold confidential. On the other hand, they are not being able to share some details because it could identify a particular case. If OPEGA was reviewing more than two cases, or there had been amenity still around who these children and their families were, OPEGA may have been able to provide much more detail than what is being released today. Director Ashcroft knows the Information Brief being presented is going to be frustrating for the GOC, the public and OPEGA, but the laws under which we are functioning are important laws and they do not want to violate those laws. Consequently, OPEGA is being conservative in what is contained in the Brief because it is also that sharing some details without being able to share other would likely lead folks to incorrect conclusions. OPEGA did do what the GOC asked of them and understands the details of these two cases. The Committee will also be provided information that will help inform a broader review of the system.

The Director said, having said all that, there are some additional details that she may be able to share in response to questions. She will, however, be cautious in her responses. If she can answer, she will. If she knows she can't, she will say so. If it's a gray area, she will come back to the GOC with an answer once she's had a chance to get guidance on it.

Director Ashcroft presented the Information Brief on Child Protection System: A study of How the System Functioned in Two Cases of Child Death by Abuse in the Home. She thanked the OPEGA Analysts, and the many entities OPEGA had to reach out to for the records or to get additional information. She wanted to recognize, in particular, the Attorney General's Office, noting there has been a lot of time and effort on the part of several Assistant Attorney General's to assist OPEGA in an advisory capacity on confidential information and records.

Sen. Saviello asked if inadequate supervision mean the supervisor's position was unfilled, or does the supervisor have too many employees to supervisor properly. Director Ashcroft said there are some pieces of work OPEGA has not yet done because of time constraints. One is to understand the context for the actions and decisions that were being taken, or made, from the perspective of those entities. They do believe there are a number of factors, such as caseloads and the capabilities of the supervision, but OPEGA does not know all of what is impacting supervision. Supervision is one of the areas they have suggested might be appropriate to look into in the second phase of the review. Another thing OPEGA has not done is look at what occurred in these cases and match it up with policies and procedures require. They have done a high level, broad brush look at it, but not to the extent where she can opine on whether all entities involved complied with policy and procedure and is another area that OPEGA suggested ought to be looked at in phase two of the review.

The Judicial system is another part of the child protection system that OPEGA did not review at all. It is not DHHS that makes decisions about removing children from their homes. Those decisions are made by judges and she would find it likely that DHHS decisions and actions are impacted by how the Court system might deal with any particular case.

Sen. Saviello said he would like to see an organizational chart so he can better factor in some of these flows and would like to know which positions are open, and what is the turnover rate in those particular jobs. Director Ashcroft believes OPEGA has some organizational charts that DHHS has published on its website that can be provided for the work session or public comment period.

Rep. Sutton thought if the GOC was going to receive an organizational chart of DHHS it would be helpful to see some of the outside agencies and how they interact with DHHS.

Sen. Libby referred to the first bullet on page 2 "Poor job performance and inadequate supervision appear to have been factors." He asked if that is a conclusion or suggestion that OPEGA is proposing and if the Director could provide more detail about how they came to that conclusion. Director Ashcroft said that it was not only OPEGA's conclusion as there have been steps taken by the agency to address that particular issue. She was not aware of any public records associated with the finding matter as it would be a personnel issue.

Sen. Diamond is worried about the increase in child abuse that is currently going on. We are following all of our protection of information rules and as we sit here we know that kids are being abused. Child abuse has increased 52% from 2008 to 2016 and he asked how long they can follow the bureaucratic rules and protections of rights before being able to deal with child abuse. Director Ashcroft said, it is not from her observations from the cases, but from conversations OPEGA has had with, for example, the AG's Office staff, and one of the perspectives that was shared with OPEGA is the perspective on the rights that families have to operate in the way that they want to and the degree to which we have a society where we don't expect people to be necessarily meddling all the time in peoples' lives. Some of it is about does somebody who sees something feel they have enough information to be able to share with an agency who is charged with protecting a child. Some has to do with boundaries in which the agency itself has to operate because of the statutory charge and authority of the department. OPEGA has heard from a number of individuals who have perspectives on that from both ends of the spectrum.

Sen. Diamond knows all the difficulties OPEGA is dealing with, but as a Committee, he does not want another five or six months to go by before the GOC steps in and stops some of the abuse. The Committee knows enough to do something and he hopes they are not going to wait for the entire review to be done. Director Ashcroft said DHHS has already begun taking some actions that they identified themselves based on their own internal review of these two cases and possibly others. DHHS has a procedure they go through when there is a child death, or serious injury, and changes are resulting from that. The other thing OPEGA is doing is sharing with the entities involved their observations about these two cases so they can use that to change any practices or procedures that they might see fit to do within their entities. OPEGA is not holding onto everything they learned in terms of what we might offer for ideas for improvements, we are just not able to tell the GOC who the folks are and what specifically we are going to be sharing with them.

Rep. Rykerson asked if DHHS was reviewing other cases. Director Ashcroft said DHHS has a protocol they follow, but she is not sure of the different instances that might meet their criteria that they are currently reviewing.

Sen. Katz thinks OPEGA has done everything they can in this report, but as he read the Information Brief it was notable that there is not a single fact about either one of the cases in the review. He understands why, but said it was beyond frustrating for everyone. We have two child deaths and our confidentiality laws make it impossible to figure out why. The State has miserably failed these kids and the system we have created prevents us from bringing the facts into public for everybody to see and that has to be unacceptable. We can't make good policies when agencies are shielded from accountability because of laws the Legislature has passed. He hopes one of the first things the Committee will do in the next Legislature is to amend the laws so that in the event of a colossal failure of the system, like is seen here, the GOC will be able to use its subpoena power to shine light on what happened. He does not think that the Committee should be interested in the privacy rights of the relatives of these two kids who at least allegedly caused their deaths. In working with OPEGA, the GOC can do great work in phase two of the review to further explore system changes, but will be doing so with one hand tied behind their back until they review the confidentiality laws the Legislature has control of.

Rep. Mastraccio referred to a section of the statute – "Place children who are taken from the custody of their parents with an adult relative when possible" and asked if OPEGA found out if there is a process for establishing if that adult relative is an appropriate placement or is it assumed that just because they are a relative the placement is appropriate. Director Ashcroft thinks it is the same process as assessing the appropriateness of any

placement but relatives are the first option when looking for possible placement. Rep. Mastraccio said what is required here would be in DHHS' rules not statute. The statute says they will be placed so the rules that are written through DHHS would be that if the child has a relative then these are the next steps. Director Ashcroft agreed and said, if it is not in their rules, it would be in DHHS' policies.

Rep. Mastraccio asked if there was any central place where all the mandated reporters have training. Director Ashcroft said OPEGA has not heard that there is something like that where everybody is brought together, other than the law enforcement, but it could be because OPEGA has not asked that question yet.

Rep. DeChant asked when law enforcement is called multiple times to a situation, or same location, if there is a trigger that would require taking it to the next level. Director Ashcroft said there may be in some departments, but there is nothing in statute that requires it. Additionally, people who call in may be providing details to dispatch that don't necessarily end up in the final formal reports that any of the officers make and when DHHS gathers information when doing an assessment, there might have been details that do not necessarily get passed on through the law enforcement reporting process. There may be times where the information coming in is meaningful to DHHS but OPEGA does not know to what degree DHHS would have cared about those details in these cases. That is additional work OPEGA needs to do to understand whether any of the missed opportunities OPEGA noted would have made a difference in what steps DHHS was going to take based on information that might come from a law enforcement channel.

Rep. Pierce asked about mandatory reporting of truancy. Truancy seemed a factor in one of the two cases being discussed and he asked whether that issue didn't rise to the level to be reported or was it because nobody was sharing information. Director Ashcroft said OPEGA did learn about truancy and the truancy statutes in general. There are truancy statutes that specify the criteria for what is to be considered truant and the protocols that have to be followed by the school in addressing a truancy situation. If absences are excused for appropriate reasons, then excused absences don't count toward truancy. There is a possibility that a student being out of school is not necessarily seen as truant if there are reasonable explanations given for the excuse. But if they are identified as truant, truancy is one of the things that mandated reporting covers and school personnel are required to report truancy, in particular, if the child is at least seven years of age and has not completed sixth grade, that is seen as a criteria that meets the definition of child abuse and neglect as educational neglect. It is OPEGA's understanding that when those kinds of reports come into DHHS, one of the questions that DHHS asks about that report is whether or not the school has followed the truancy protocols that are laid out in statute. Until the school has followed their protocols it seems DHHS is likely to screen that out as an inappropriate report. She will have to check if that is one of the things DHHS has changed.

Rep. Pierce asked if the parent is the abuser and is excusing the child's absence from school, at what point does it rise to the school contacting DHHS or do all the different agencies, schools, law enforcement, etc., keep their own information because of confidentiality laws. Director Ashcroft said in OPEGA's conversations with the AG's Office, and other observations they have drawn, it appears that a school is not required to have any particular policy around when it would confirm, or not confirm, absences or seek to confirm the parent's explanation that has been given. It appears to vary by school system so that is another area OPEGA has picked out for consideration - when is it an appropriate situation to start questioning what the parents are providing for an explanation and when to seek additional information to try to confirm whether or not it is true. The risk rises if the parent has a known track record for lying, but how you put that in a policy for a school. OPEGA does not know yet totally what might be impacting the sharing of information. They did see that sharing of information did occur, so probably can occur, but there are some hoops that need to be jumped through to make that happen and sometimes that hinges on the parents giving consent for the release of particular information.

Sen. Libby said the State's truancy laws are severely antiquated and Lewiston has been trying to push modernization. In particular a child is not deemed truant until they are seven years old and in the 21st Century most of the school children are starting at age five and with pre-k programs at age four. If we have children in the school system who are habitually absent, but the school districts are unable to make reports to DHHS for four, five and six year olds, there is a disservice being done. In Lewiston, the policy is to take vigorous school attendance records. What the schools are finding though is that when school reports are made to DHHS on

children ages four, five and six who have missed two or three weeks of school DHHS says they cannot do anything about it. The parents are not making excused absences so he would ask the GOC to consider that piece, among the many, as they continue the review of the system.

Sen. Katz asked the Director if she could tell the GOC whether, in either of the two cases, reports were made of potential abuse based upon truancy. Director Ashcroft said there was a call to law enforcement from a mandated reporter seeking a welfare check on a child that indicated that there was truancy and other issues at play which was the reason they were asking for the welfare check. Law enforcement responded, saw the child and did not see signs of anything that caused them concern.

Sen. Diamond said the mandated reporting system in the State is very weak from the point of training all the way up to protecting the reporter. There was legislation in the last session to try to strengthen that, but for different reasons was watered down. A law enforcement officer, if not trained adequately, could leave a child in danger because they don't know the less than obvious things to look for. He said that also goes for teachers and others who are worried about their own security if they made a false report. He suggested that the GOC ask the Director to give this area a thorough review because until that is fixed the mandated reporters are unable to do the job and that child is still going to be left in that situation.

Rep. Mastraccio asked if somebody moves around a lot and there has been a report in one place they lived, is that information forwarded to where they moved to, is there a central place where information is held so if a report is made on someone, previously filed reports come up. Director Ashcroft said OPEGA does not yet know whether there are barriers to the transferring of information between entities. For example, information between schools. There are student records that follow a child from school to school, called the Student Cumulative Record, that can include a number of things, but it does not necessarily include all the concerns they had about a student's risk for child abuse/neglect. She does not know, under current law, whether there are legal barriers to doing sharing that ought to be examined.

Rep. Mastraccio said if concerns are raised about a child, the parent can now just say they are going to home school their child and asked what would happen in that case. Director Ashcroft found out in talking with the AG's Office what some of the challenges are with the home schooling from that perspective. Once the parent submits the paper work for home schooling to the school there is nothing more the school does, has to do or can do, for engagement and DHHS does not necessarily see home schooling as presenting a risk of child abuse. Home schooling does sound like an area we would want to understand better.

Sen. Katz asked if it was known what school records were transferred from the out-of-state school district to the first school district in Maine and from the first school in Maine to the second school district in Maine. Director Ashcroft said OPEGA does know that information and will have to consider whether that information can be shared with the Committee. Sen. Katz said, along with what Sen. Diamond suggested, if the law says that the only thing that needs to go from district-to-district is the report card, perhaps the Committee should be ensuring that the entire file on the child moves from one district to another. Director Ashcroft said the child's file includes more than just the report card. She did not know if it was for this particular case or by law, but will find out.

Rep. Mastraccio asked if, when the DHHS worker entered information, including the child's name, into MACWIS would all the information come up of what had been entered before, or how long would the information go back to and is the information available for that person right then. Director Ashcroft said the information is available, but she is not sure how far it goes back. It is not by the child's name, it would most typically be by the parent's name. The question of how user friendly and well MACWIS displays information that can be quickly processed is an open question that OPEGA has had for other reviews and would be another area to explore in these cases because it is in several ways the main conduit, or the main repository, for the body of information that is being captured in any of these situations.

Rep. DeChant asked if a script tool was used for the person doing intake, does the information from that tool transfer specifically and relevantly to MACWIS and does the intake worker take the information from the script and move it into MACWIS. She is concerned about where the information is not compatible. Director Ashcroft does not know what is captured in MACWIS from the tool and there was a lot of information OPEGA was not able to get to in the short timeframe for this review. She said the communications into the intake line are most often by phone, but also for certain mandated reporters there is a secure email or fax available by which they can make reports.

Rep. DeChant said the intake worker receives information and then they apply the script. Director Ashcroft said yes and as they are talking with the reporter they are trying to glean additional information they need for the script tool to work down through the decision-making process.

Sen. Katz understood in the two cases OPEGA reviewed that the intake worker and a supervisor decided whether to do nothing, whether to refer the matter to CPS for investigation or to refer it family or community services. He asked if it is known, for either of the cases, how many reports came into intake and what was done with respect to each one of them. Director Ashcroft said she could not answer from the perspective of any DHHS records, cannot say anything that may have occurred on the receiving end. She can say, however, from other records OPEGA has seen that the accounts in the media that reports were made to DHHS are valid. There were mandated reporters that made reports in at least one of the cases and OPEGA does know what actions DHHS took on any of the reports that came in.

Sen. Libby asked, in the two cases reviewed by OPEGA, were there reports made and was it deemed appropriate or inappropriate. Director Ashcroft confirmed again there were reports made. In regard to one case there were at least two reports made by law enforcement agencies to DHHS. There were also other reports from other mandated reporters. Sen. Libby asked if there were any reports made that were deemed inappropriate with respect to the two cases. Director Ashcroft will check on whether she can answer that question and get back to the GOC.

Sen. Katz asked if a referral was made to the District Attorney's Office in either of the counties. Director Ashcroft said in neither of the two cases does it appear that a referral to the DA's Office would have been appropriate prior to the children's deaths.

Sen. Gratwick said the GOC should ask if we are holding the Legislative Branch accountable in terms of the resources they have given to DHHS because he thinks that will be an important element. Does DHHS have enough caseworkers, are there enough people actually doing the work? He needs a better sense of the overall system as opposed to the failures of the rules, regulations and laws and the failure of those involved in these two cases. He is hoping that is something the GOC will look into because the Legislature and Executive Branch have made some allegations that resources may or may not be at appropriate levels.

Sen. Katz said the GOC will ask OPEGA to provide them with DHHS' organizational charts to see if there are vacant positions and if there are enough positions to do the work with which they are charged. Director Ashcroft noted that was a piece of context that OPEGA is lacking and that is an area they recommended being included in the next phase of the review.

Sen Katz asked, assuming DHHS is not dealing with a toddler, are there procedures in place regarding when, always or sometimes the child will be interviewed in private outside the presence of the parents or caretakers. Director Ashcroft said it is protocol for the DHHS worker to always attempt to interview the child. From what OPEGA understands of the policy, there are protocols around notifying the parents of the interview. It is supposed to be private, but it sometimes occurs in situations where the child may not be far enough away from their parents such that parents would not overhear. There are times when they will go to the school to interview the child, but in those cases, she believes the school is required to notify parents that the child is being interviewed at school and believes DHHS, as a matter of practice, notifies the parent that they are going to interview the child.

Sen. Katz's understanding is that the parent can refuse to have the child interviewed at that point and that is something the worker can take into account in assessing the risk. He asked if it was known if that took place in the two cases OPEGA reviewed. Director Ashcroft said OPEGA knows, but cannot share the information.

Rep. Mastraccio asked if it was possible that Intake would directly pass a report to the Alternative Response Program based on the Intake worker's assessment. Director Ashcroft said not as OPEGA understands it. If it is deemed an appropriate report, it would go to the District Office and it would be the District Office Supervisor who makes that determination on whether to assign the Child Protective Assessment to its own workers or whether to refer it to the Alternative Response Program for a similar assessment as to what CPS would do. She thinks the criteria are supposed to be that the only things that are referred to ARP are those deemed to be low to moderate severity in terms of the allegations that have been made. Anything that seems to be a high severity is assessed only by OCPS' own child protective workers. Rep. Mastraccio asked if ARP was primarily involved with either of the two cases. Director Ashcroft said OPEGA has that information, but cannot provide it to the GOC.

Rep. Mastraccio asked if it would be possible, in the next phase of the review, to give the GOC an idea if there have been changes in how things were parsed out over the last five or six years. Are we using more of the ARP workers than the State's own social workers and will the Committee be able to see that information? Director Ashcroft said DHHS does an annual report to the Legislature on this type of information. The most recent report does lay out how many reports they took in, how many cases they referred to ARP, etc. She cannot recall how many years' worth of statistics are shown in each annual report. Rep. Mastraccio would like to know how much the State is handling and how much is being parsed out and what the results are. Director Ashcroft said OPEGA can provide a cumulative picture if it does not already exists.

Rep. Sutton asked if there was a timeframe between the times of the deaths of the children and the last time there was an agency worker or person in the home. Director Ashcroft said OPEGA knows the specifics of this and has reported that in one case OPEGA observed there was no lack of individuals from various entities trying to assist the family right up until the child's death. That is the only response she is able to give.

Rep. Harrington said one thing that would be helpful to law enforcement would be a report back to the officer who submitted a report to DHHS. Over his eleven year career in law enforcement he has sent dozens of reports to DHHS and has never heard anything back. He thinks hearing back from DHHS would be a huge help to law enforcement. Director Ashcroft said that is one of the areas where it seemed information could be better shared amongst everybody in the network, but there seems to be some challenges in how to do that and there may be legal barriers as well. None the less, maybe there is an opportunity to at least let people know when a case is opened and closed. That is another area that OPEGA raised for possible further exploration.

Rep. Mastraccio asked if Director Ashcroft had said ARP did not automatically contact OCFS when appropriate and the fact that that did not happen is one of the places where things were breaking down. Director Ashcroft thinks it is one of the places DHHS identified was breaking down as a result of its internal reviews based on the actions they have reported they are taking..

Sen. Katz referred to the staffing levels within CPS and asked if OPEGA could get the information regarding staffing levels with the contractors, in particular, turnover with the contractors and the basis on which they are paid for the work they do.

Sen. Libby added to Sen. Katz's request the contractors' credential requirements for those involved.

Sen. Gratwick requested the budget lines for child protection over the last 10 to 12 years.

Sen. Libby asked if OPEGA could get information related to the phone logs, voice mails, transcripts, wait times, etc. regarding calls received by OCFS Intake workers regarding potential child abuse.

Sen. Saviello requested information on a typical weekly schedule for a case worker. Director Ashcroft said OPEGA has heard a number of concerns about time management, case load, what is expected and what they have for time for all the things they are supposed to do.

Rep. Rykerson said it is an overwhelming and tragic failure of the system. He thinks the whole thing needs to be looked at, including the basis of the Child and Family Protection Act. He is concerned that the purpose and priority of the Child and Family Protection Act is reunification and wondered if the pendulum has swung too far in the other direction so reunification may actually get in the way of child safety. The Committee has to look at the basis of reunification and decide if reunification or the child's safety is the priority.

Rep. Pierce asked if there should be recommendations for school policies because teachers, especially for the younger children, are the frontlines and if there are blockages or broken chain of commands that is a problem. He also thinks it is important for law enforcement to receive a report back on cases reported to DHHS from an officer.

Sen. Katz said the feedback of any mandated reporter gets after having made a complaint would be important.

Rep. Harrington said when law enforcement sends a complaint to DHHS they automatically assume that the Department will do their job. He said perhaps there should be more than just an assumption.

Sen. Katz referred Director Ashcroft to all the points on pages 8 and 9 listed under "Potential Areas for Concern or Improvement to Consider in Planning a Broader Review". He asked if the reason she put the concerns down was because each one of these might have been a concern in one or both of the cases OPEGA reviewed and, if not, which of them might have been an issue in one or both of the cases reviewed. Director Ashcroft said the first, third, fifth, and possibly the sixth, eighth, ninth, tenth and eleventh bullets were related to potential missed opportunities in one or both cases.

Sen. Katz noted in the bullet about compliance with policies and procedures and consistency and appropriateness of decisions made by case workers and supervisors in OCFS Central Intake and District Office. He asked if the Director could tell the GOC what policies and procedures were impacted in the two cases reviewed. Director Ashcroft could not because OPEGA did not get a chance to look at what happened in the cases compared to what was supposed to happen under policy and procedure. In one case OPEGA said they did recognize OCFS did not follow some of the particular policies and procedures and that was not only OPEGA's observation. While it is an area the Director thinks needs review, she cannot tell the Committee specifically at this time if there was a violation or policy involved beyond this one observation. In the Information Brief, OPEGA notes that the policies and procedures involved here were regarding assessment of the child's placement and staying engaged with child and family. Mostly, however, OPEGA is referring to policies and procedures that result in the assessment of the level of risk and that impact the decisions, actions and responses that are made based on that level of risk.

Sen. Katz asked what ARP contractual obligations were not complied with. Director Ashcroft said the Department is reaffirming with ARP certain junctures at which ARP is supposed to notify DHHS. There are some things in the contract that are about when ARP is supposed to notify OCFS of things they are observing in the case. Again, OPEGA has not looked specifically at what happened in comparison to those contractual obligations so she could not say for sure that there were violations, but it is an area where OPEGA has seen enough that they would want to explore it further.

Sen. Katz asked from what OPEGA has learned about the extent to which OCFS and ARP monitor whether the families are participating in voluntary services, is that a question in either one of the cases. Director Ashcroft said it was a concern in at least one of the cases. The services are voluntary so when a family is expected to benefit from services that keep risk in the family at low to moderate, but the family is refusing or not engaging in services, then there is not a chance for those services to be effective. That could be a trigger for should OCFS reassess what is going on with the family and how do we help them get services. Sen. Katz said so for at least one of the cases a family had agreed to participate in voluntary services, but there was not adequate follow-up to

see if those services were being received. Director Ashcroft was not sure whether follow-up to see whether the services were received was required by policy and procedure but it does seem to be an area to explore as to whether there should be some expectation that OCFS monitors the situation.

Sen. Katz referred to OPEGA's bulleted area for concern or improvement on extent to which mandated reporters, OCFS and ARP seek to verify and can verify information reported by a child's parents. He took it then that this was a concern in one or both of the cases in terms of whether there was an effort to verify information reported by one or both of these children's parents or caretakers. Director Ashcroft said OPEGA is not sure there is any requirement anywhere for anybody to try to confirm, but did note in both cases that parents were providing explanations that people took for a reasonable explanation and in one case there could have been reason to doubt the parent's truthfulness.

Rep. Mastraccio asked if parents refuse services at what point can DHHS say here is what we think needs to happen and if it doesn't happen, then your child is going to be removed from your home. Director Ashcroft said as OPEGA understands it, OCFS can move into that position, but it requires a filing with the court and a finding of jeopardy in order for the Department to have the clout to be more forceful with the family. OPEGA is interested in what are the barriers that are keeping OCFS workers from doing an effective job and what impacts their ability to do it well.

Sen. Gratwick asked if DHHS had an anonymous tip line for workers on one level to report issues like those seen by OPEGA up the chain of command or outside the chain to other groups. Director Ashcroft is not aware of any system like that but she will find out if one exists. Sen. Gratwick said a major focus is if the State is giving proper resources to OCFS to do their work.

Sen. Diamond is interested in making changes now that could make a difference. He asked if OPEGA can give the GOC some more immediate recommendations the Committee can address that fall within the GOC's purview. Director Ashcroft will give that some thought. She clarified that his question is what can OPEGA pick out that the Legislature can take action on right now as opposed to waiting for OPEGA to complete the next phase of the review. He agreed.

Sen. Katz said the GOC will hold a public comment period on OPEGA's Report on Child Protection System at their May 31, 2018 meeting. The Committee will have a work session on the report to discuss phase two of the review. Director Ashcroft noted that although it is phase two of the review, it will be a new full OPEGA project.

RECESS

Sen. Katz recessed the Government Oversight Committee at 11:27 a.m.

RECONVENED

Sen. Katz reconvened the GOC meeting at 12:08 p.m.

- **Presentation of OPEGA Report on Maine's Beverage Container Recycling Program**

Director Ashcroft presented OPEGA's Report on Maine's Beverage Container Recycling Program. (A copy of the Report can be found at http://legislature.maine.gov/opega/opega-reports/9149.)

Sen. Katz referred to page 9 of the Report and asked the reason for 3¢ handling fee for a brewer that produces no more than 50,000 gallons of product or a water bottler who sells no more than 250,000 containers of up to one gallon annually. Sen. Saviello said he thought the rationale was that the small distributors would mostly be handling the containers themselves.

Sen. Gratwick asked if a liquor bottle would go back to the manufacturer or are they going to just grind up the glass. Do the containers go back to the manufacturer to be reused or are they all being destroyed? Director Ashcroft said even in the cases of the beverage containers that are returned to the manufacturers they may choose to crush the glass and sell the glass as a community rather than actually reuse the same container. Sen. Gratwick wanted to confirm that the bottles are not used again. Director Ashcroft could not say in all cases they are never used. She will see if she can find out and get back to the Committee.

Sen. Katz bought a drink in the cafeteria and paid a 5¢ deposit and asked where that money goes from there. Director Ashcroft said when the cafeteria vendor bought the drink he paid 5¢ to the manufacturer or distributor he bought it from. That 5¢ is sitting with the manufacturer or distributor (initiator of deposit). The vendor gets reimbursed because Sen. Katz paid the 5¢ deposit. When Sen. Katz redeems the bottle, the redemption center will pay him 5¢ and whoever picks the bottle up from the redemption center will reimburse the redemption center the 5¢. Whoever picks the bottle up is going to get reimbursed the 5¢ from the manufacturer or distributor who held it in the first place. If you never redeem the bottle, the 5¢ never gets refunded back out. Those are what OPEGA is going to be referring to as unredeemed deposits.

Rep. Pierce asked who pays the handling charge. Director Ashcroft said the initiator of deposit ultimately pays the handling fee. Whoever picks up the bottle, if it is a contracting agent instead of the manufacturer themselves, they will pay the handling fee and then they will get reimbursed the handling fee by the manufacturer or IoD. The handling fee is different depending on whether the initiator of deposit is in a commingling group and there are certain smaller volume manufacturer who pay 3¢ per container as a handling fee.

Rep. Pierce asked why the registration labeling fees are $1 for wine labels and $4 for other beverages. Director Ashcroft said OPEGA was not clear on that.

Rep. Mastraccio wanted to clarify that the label registration fee is to register one particular label not each label put on a bottle. In other words, no matter how many millions of bottles that label is on, they pay just one fee for the label, but every time they change the design, they would have to pay a registration fee. Director Ashcroft agreed.

Sen. Saviello asked if BABLO pays handling fees. The Director said they do.

Rep. Mastraccio asked if the handling fee is the revenue for the businesses (i.e. redemption centers) that redeem the bottles. Director Ashcroft said yes and it is the only revenue they get from the redemption program.

Sen. Katz asked if OPEGA knew what the littering rate is, the percentage of bottles and cans that end up on the landscape in other states that don't have bottle redemption laws. Director Ashcroft referred to some information in the "Other States' Programs" section of the report and what those states were reporting as redemption rates. However, nobody seems to be having a good handle on what might be a statistic by which to gauge litter as a whole so OPEGA does not have that information either for the State of Maine or for any of the other states with recycling programs.

Rep. Mastraccio asked if OPEGA has figures on how many bottles are not redeemed but are just put in a recycling bin which goes to the recycler. Director Ashcroft did not have information on that and said it would be a question for the Department of Environmental Protection (DEP). Sen. Saviello's understanding is that materials are recycled for whatever the value is and if it has no value then it is landfilled. One of the arguments made for getting rid of the bottle bill is because aluminum has a greater value than the 5¢ deposit and would be better off staying in the single sort system.

Sen. Gratwick said aluminum has a good deal of value and glass has virtually no value at all, but he recalled glass is used for construction fill so basically the glass bottles are ending up as solid waste in landfills or construction, but nothing more creative than that. Director Ashcroft did not know to what extent glass is ending up in landfills. OPEGA heard and saw some evidence that glass is ending up in landfills because it does not

have any commodity value. There are recommendations in the Report about what could be done in the program that would help maintain some value for glass if it was color sorted, but there is nothing in statute that speaks to any prohibition that would make sure that materials that are going through the recycling process don't end up where the State did not intend for them to be in the first place.

Sen. Katz asked if, for example, you bought an exotic beer and take it to the redemption center how is that container being processed. Mr. Kruk said in talking with redemption centers these "little sorts" seemed to be a problem because they require multiple touches. Some of the products with volume would be put in a container and would not get picked up until they reach an established number for that beer container.

Sen. Saviello said in many cases the beer distributors are in commingling agreements so they have minimized, at least for the major producers, the number of sorts that are there. He thinks some of the micro craft breweries are getting into the commingling agreements. The redemption center's money is tied up until that bottle/can fills up to its critical number so they can call for the pick-up.

Sen. Katz asked what the State's interest is in limiting the number of redemption centers. Director Ashcroft thinks the idea is to make sure that there aren't so many redemption centers that the ones existing cannot remain viable. The centers' revenue is limited to just the handling fee they receive on each container. If there are too many redemption centers they will not individually get enough volume to make it a financially viable business. Sen. Saviello noted also that somebody has to pick up the containers and if you have a lot of centers then pick up can be inefficient.

Rep. Sutton thinks it is an example of government grossly overstepping in what should be private sector decision-making. Limiting redemption centers just adds to all the complicated things we are looking at.

Sen. Saviello said you have to be careful when using the term "being recycled". They may recycle it and pick it up, but the recycling commodity program is totally falling apart. For example China, which takes a lot of the recycling products, has now said if you send anything contaminated they will not take it. The Town of Jay just now sent an email to their citizens saying if they have contamination in their recyclables the handling costs for single sort goes from $30 a ton to $200 a ton because of contamination. Contamination might be that a non-recyclable item you put in your single sort gets through the single sort and packaged up. You have to be careful when you talk about things like that because it may get recycled and re-handled, but the ultimate final outcome is in the landfill.

Report Recommendation #1. Sen. Saviello commented there may be an argument about confidentiality of data collected, i.e. relevant to market share, so you would have to figure a way to protect the confidentiality.

Report Recommendation #2. Sen. Gratwick asked if it would not make sense that there be a requirement that all redemption centers, machines, Clynk, etc. read the UPC or bar codes because you would have a steady and dependable stream of information coming in. The small redemption centers may not like it, but you would have good data coming in and that is important as you figure out your larger picture. Director Ashcroft did not disagree with Sen. Gratwick and thinks that is something that DEP and Legislature will grapple with.

Sen. Saviello said legislators who are dealing with the recycling issue in the future have three things to deal with regarding redemption centers: the concept of litter, jobs and donations. If you end up tinkering with one of those things, the line of people testifying will be out the door.

Rep. Pierce said you have to remember that these people make 3¢ on a bottle and you have to ask how minimum wage affected their profitability. We might want to look at some of those aspects and ask how many do you want to put out business. Rep. Mastraccio agreed and added that it is more being able to get the necessary data and thinks there is a way to do that with today's technology. Rep. Pierce did not want to put the data collection requirement on the redemption centers. Director Ashcroft said OPEGA's recommendation is for the pick-up agents to be reporting redemptions by IoDs and whatever pieces of data you can get from that.

Report Recommendation #4. Rep. Pierce asked if this would be where you would put in that spirits be 5¢ to be equal with other deposits so for those not being remitted would cut the amount down by two-thirds.

Sen. Diamond asked if the size of the recycling container mattered for the amount of the deposit. Director Ashcroft said OPEGA observed we do not know how much of a deposit value is needed to incent somebody to return the container. She does not know if there is any research that says somebody is more likely to only return a big container if it is 15¢ as opposed to a small container at 5¢. What is observed is that the bottles that are bigger, the wine bottles that have a 15¢ deposit, are probably less likely to be littered than some of the other containers with a 5¢ deposit.

Sen. Katz said the two main purposes is to avoid litter and to keep these things out of solid waste landfills. The program was established at a time when the State did not have much recycling. He asked what percentage of other glass or other metal is being recycled now. He was not suggesting anything, but said if we are already recycling a significant percentage, for example 85% of glass and recycling 85% of beer bottles, what is the continued reason for the existence of the law. Director Ashcroft said this is an area that OPEGA does not have a lot of data available that would inform that kind of discussion. When OPEGA looked at the PEW Center for the States report on states that had recycling programs, the recycling rate nationwide was a little over 34% so there could be discussion of how do you get an effective result either way.

Report Recommendation 7. Rep. Pierce referred to the possibilities for the fraud in the redemption program, the out-of-state containers, shorted bags, returning money to MRS, etc. He asked if OPEGA has been able to quantify a number of how much fraud, monetarily, exists in the program. Director Ashcroft said no and part of what OPEGA was looking to do, if the GOC tasks them with the additional analysis, is to pick out situations where they see the escheat problem. There is not good data captured around how the out-of-state redemption might be an issue. Clynk and the reverse vending machines kick those out so out-of-state redemption is not an issue with those particular redemption avenues. OPEGA does not feel they currently have a way to quantify all of the costs of program abuse.

Rep. Pierce mentioned the Legislature possibly addressing the shorted bags problem with penalties. At some point you have to address the fraud because the fraud is costing tax payers money. Director Ashcroft agreed and said that is why OPEGA is suggesting that DEP come up with a proposal for that and put forward whatever statutory and rules changes are needed to implement it.

Rep. Sutton did not understand why people cannot already be held accountable for bag shortage. Director Ashcroft said there is no mechanism for it currently unless the bags are counted on site. If they take the bag away from the site, then there is not a mechanism. She said DEP is working with program participants to figure out how to address this issue and are going to be putting something forward as a proposal.

At the conclusion of presenting OPEGA's Report on Maine's Beverage Container Recycling Program Director Ashcroft reported the Public Comment Period on the Report will be held at the June 14th GOC meeting.

- **Request for OPEGA Review of the Small Business Advocate Program -** Request Withdrawn by Sponsors

No action required by the Government Oversight Committee.

- **Legislative Joint Standing Committees' Reviews Under 5 M.R.S.A. § 12023 sub§ 3**

- **Education and Cultural Affairs Committee on Review of**:
  -- Child Development Services System
  -- Maine Community College System
  -- Maine Health and Higher Education Facilities Authority
  -- Maine Maritime Academy
  -- University of Maine System

- **Energy, Utilities and Technology Committee Review of:**
  -- Maine Municipal and Rural Electrification Cooperative
  -- ConnectME Authority
  -- Efficiency Maine Trust

No action required by the Government Oversight Committee.

UNFINISHED BUSINESS

- **Review Status of Legislation of Interest to GOC**
  - LD 1796 (P.L. 2018, ch. 339)
  - LD 1654
  - LD 1338
  - LD 1781 (P.L. 2018, ch. 361)

Director Ashcroft gave an updated on the status of legislation of interest to the Committee.

REPORT FROM DIRECTOR

• Status of Projects in Progress

Director Ashcroft said OPEGA is in the final stages and has begun drafting the report for the **Temporary Assistance for Needy Families** review and will be reporting the review out to the GOC at their meeting on June 28th. They are also drafting the **Employment Tax Increment Financing** report and are looking to present it to the GOC either July 26th or sometime the first of August. OPEGA is working on the **Special Project for Information they have to give to the Taxation Committee for the Expedited Tax Expenditure Reviews** and that is due by July 1st. OPEGA has begun the review of **Timber Sales From Public Lands** and her goal is to get something to the Committee in August. OPEGA is working on **BETR and BETE** as a lower priority tax expenditure review. The **Citizen Initiative Process** review is still mid-stream and technically still in process awaiting planning for the fieldwork stage that was approved by the GOC. OPEGA also has on their planned list the **Unemployment Claims System** that the Committee assigned in late March. It had been her intention to try to get something started on that review once the Maine's Beverage Container Recycling Program was complete. The Director didn't know if the Committee had any guidance about the priority they would like to see that review get versus the Citizen Initiative Process review, but she is going to try to get both reviews started before she leaves. She does not see OPEGA getting to the **Substance Abuse Programs in the Correction System** and **DHHS Audit Functions** in the near future**.**

• Status of Director Recruitment

Director Ashcroft said the recruitment is still in process and the position will be reopened for an additional limited recruitment.

ANNOUNCEMENTS AND REMARKS

Sen. Katz said the GOC is holding the public comment period on OPEGA's Report on Child Protection System at the May 31st meeting. The Committee will also be meeting June 14th and June 28th (presentation of TANF Report). He noted the Chairs talked earlier about meetings for July and August and said the GOC will be meeting July 26th , (presentation of the ETIF Report and the public comment period on the TANF Report) and August 9th (ETIF Public Comment Period and, if ready, the presentation of Report on the Sale of Timber From Public Lands).

Sen. Gratwick noted that the Senate will be in session for confirmation on May 31, 2018 at 3:00 p.m.

NEXT GOC MEETING

The next Government Oversight Committee meeting is scheduled for May 31, 2018 at 9:00 a.m.

ADJOURNMENT

The Chair, Rep. Mastraccio adjourned the Government Oversight Committee meeting at 2:37 p.m. on the motion of Sen. Gratwick, second by Sen. Diamond, unanimous.

OPEGA

Information Brief

Purpose

On March 9, 2018, the Government Oversight Committee (GOC) directed OPEGA to determine the facts surrounding the handling and response to potential child abuse and neglect reports received by DHHS in the cases of Marissa Kennedy and Kendall Chick. This fact finding is the initial phase of a broader review of Maine's child protection system. The request for review of the system and these cases was submitted by the House Chair for the Joint Standing Committee on Health and Human Services.

OPEGA reviewed and analyzed records of entities involved with the two children. We also reviewed statutes, rules, policies and procedures, and obtained additional information through interviews.

Federal and State confidentiality laws prevent OPEGA from reporting detailed information on these two children. Consequently, this Brief includes only a high level summary of OPEGA's observations from the two cases, the role of DHHS and mandated reporters in protecting children, and potential areas for concern or improvement. Results of this review will inform the scope of the broader review.

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.

May 2018

RR-CPS-18

Maine's Child Protection System:

A Study of How the System Functioned in Two Cases of Child Death by Abuse in the Home

Summary

Maine's child protection system relies on a network of parties that interact with children and families to communicate information to the Department of Health and Human Services' Office of Child and Family Services (OCFS). This information serves to help identify child abuse/neglect risks that warrant the agency's involvement and inform the assessments, decisions and actions that occur in response to those risks.

Through our review of the cases of Kendall Chick and Marissa Kennedy, we were able to observe the important role those who may interact with children and families have in the system. In general, any number of parties may interact with children and/or families and be in a position to observe and report risks. These parties may include schools, local police departments, hospitals, medical providers, and other social service providers. The statutory responsibility for the protection of children, however, rests with DHHS, and, as such, this information brief focuses on DHHS' role and its contracted agents.

OPEGA's specific charge for this review was to examine how the child protection system functioned in the cases of these two children. We observed that these cases are nearly on opposite ends of the spectrum in terms of interactions with mandated reporters and other individuals that had opportunities to observe what was going on in their young lives. The two cases also differ substantially with regard to specific areas within the child protection system where there may have been missed opportunities to better protect them from harm.

There are two things, however, that both cases have in common. First, both children died from physical abuse believed to be occurring over some period of time in the two-adult home where they resided. Second, it seems that on the few occasions when individuals from outside the household observed actual physical marks that might indicate physical child abuse, one or both of the adults explained them as injuries the children themselves were responsible for causing. Observers appear to have found these explanations reasonable at those times given what they knew of the child and family.

To date, OPEGA's examination of these two cases has consisted primarily of reviewing and analyzing detailed information from numerous records obtained from multiple entities involved with these children or their families. Entities we sought records from included DHHS, Maine State Police, relevant municipal and county law enforcement, relevant local school districts and the Department of Education inclusive of Child Development Services. Information we received included records from health care and other service providers. We also reviewed at a high level the relevant statutes and rules, as well as policies and procedures we requested from several entities. Lastly, we gathered as much additional information through follow-up questions and interviews as the timeframe for our review allowed.

OPEGA cannot publicly share many details about these two cases at this time. This is primarily due to the federal and Maine State laws that govern the confidentiality of health, education and child protective records. The ongoing criminal investigations, related court proceedings and protecting rights of individuals to a fair trial are also considerations. Some details we are unable to share at this time may come out

through those proceedings. We note, however, that knowing some but not all of details could easily lead to inaccurate perspectives and conclusions about what worked, and what did not, in the child protection system.

OPEGA's overall observations about how the system functioned in these two cases and missed opportunities that may have better protected these children are as follows:

- In one case, we observed OCFS failed to follow policies and procedures in fully assessing the appropriateness of the placement and staying engaged with the child and family to ensure needed services and supports were provided. Poor job performance and inadequate supervision appear to have been factors.

- In one case, we observed that the risk of child abuse/neglect, particularly risk of physical abuse, was not necessarily evident without continually putting together many pieces of information held by various parties interacting with the child and/or her parents over time. We noted there was much information sharing occurring within the child protection system initiated primarily by certain mandated reporters. We also noted several junctures, particularly in the last two months of this child's life, where greater information sharing among several parties might have prompted further action or reassessment of the risk level for the family. Periodic reassessments of the whole body of information known about the family might also have prompted different approaches to addressing the risks identified. There are, however, no guarantees that further actions or different approaches would definitely have been taken. We observed overall that there was no lack of individuals from various entities persistently trying to assist the family and make a difference in their lives.

We believe we have gleaned a decent understanding of what occurred, and what did not, with regard to roles various entities played in these children's cases. We are, however, still lacking a full understanding of the context from their various perspectives, particularly around what factors impacted their decisions and actions. Additionally, we have not yet completed assessing whether the responses, decisions and actions by OCFS or any other entity were consistent with statute and rules, and the policies, procedures and training specific to those entities.

Consequently, we are unable to say yet, with any certainty, whether potential areas for concern or improvement we have noted might have changed the outcomes for these children. In reality, we may never know that for sure. Nonetheless, we have identified potential areas of concern or improvement in the child protective system that seem worth exploring further toward the goal of better protecting children in the future.

Relevant Statutes and Rules

The Child and Family Protection Act in Title 22 Chapter 1071 is the principal statute that governs child protection activities of the Department of Health and Human Services (DHHS or the Department). It directs the Department to establish rules regarding child protection. Department Rules Chapter 201 covers procedures for the receipt, investigation, and management of child protection cases.

DHHS Authority

Statute authorizes DHHS to protect and assist abused and neglected children, children in circumstances that present a substantial risk of abuse and neglect, and their families. Statute provides that children will be taken from the custody of their parents only where failure to do so would jeopardize their health or welfare. Family rehabilitation and reunification is statutorily established as a priority when it does not needlessly delay permanent plans for children. Children who are taken from the custody of their parents are to be placed with an adult relative when possible. Those children who cannot be returned to their families are to have established permanency plans early on. The legislative intent is to reduce the number of children in foster care.

Title 22 § 4003. Purposes (excerpted)

Recognizing that the health and safety of children must be of paramount concern and that the right to family integrity is limited by the right of children to be protected from abuse and neglect and recognizing also that uncertainty and instability are possible in extended foster home or institutional living, it is the intent of the Legislature that this chapter:

1. Authorization. Authorize the department to protect and assist abused and neglected children, children in circumstances which present a substantial risk of abuse and neglect, and their families;

2. Removal from parental custody. Provide that children will be taken from the custody of their parents only where failure to do so would jeopardize their health or welfare;

3. Reunification as a priority. Give family rehabilitation and reunification priority as a means for protecting the welfare of children, but prevent needless delay for permanent plans for children when rehabilitation and reunification is not possible;

3-A. Kinship placement. Place children who are taken from the custody of their parents with an adult relative when possible;

4. Permanent plans for care and custody. Promote the early establishment of permanent plans for the care and custody of children who cannot be returned to their family. It is the intent of the Legislature that the department reduce the number of children receiving assistance under the United States Social Security Act, Title IV-E, who have been in foster care more than 24 months, by 10% each year beginning with the federal fiscal year that starts on October 1, 1983; .....

Mandated Reporting

The Child and Family Protection Act statute also establishes roles and responsibilities for reporting suspected or known child abuse, neglect, or suspicious death. Specified professionals are directed to immediately report to the Department when they know, or have reasonable cause to suspect, that a child has been or is likely to be abused or neglected. The mandated reporters specified in statute include, but are not limited to, certain medical professionals, certain school personnel, social service workers, law enforcement officials, and mental health professionals. Mandated reporters must complete training approved by the Department at least once every four years.

"Abuse or neglect" means a threat to a child's health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these or failure to ensure compliance with school attendance requirements."
Source: –22 M.R.S. § 4002, sub-§ 1.

DHHS' Mandated Reporting training materials defines the types of abuse/neglect as:

Physical abuse	Abusive treatment to a child that caused or is likely to cause physical injury.
Sexual abuse	A person who engaged in sexual contact with a child, or forces a child to have sexual contact with others; a sexual offender of children who has uncontrolled access to children; a person intentionally subjecting a child to purposefully suggestive remarks and behaviors, creating a sexualized environment that is likely to result in sexual abuse or exploitation.
Emotional abuse	Abusive treatment by a person that has resulted in emotional impairment or distress in a child.
Neglect	Failure to provide adequate food, clothing, shelter, supervision, or medical care when that failure causes or is likely to cause injury including accidental injury or illness.

Mandated reporting includes truancy, which is considered educational neglect. The statutory definition of child abuse/neglect includes truancy if the student is at least 7 years of age and has not completed grade 6. School personnel, as mandated reporters, would be required to report truancy to the Department.

Reports must be made immediately, by telephone to DHHS, and must be followed by a written report within 48 hours if the Department requests. Hospitals, medical personnel, and law enforcement may submit emergency reports via secure email or fax. Law enforcement officials and hospital staff are directed to make reasonable efforts to take photographs of any areas of trauma visible on a child, and make the photographs available to the Department as soon as possible.

Office of Child and Family Services

The OCFS performs a variety of professional social work services through specialized caseworker roles. Intake workers, child protective workers, permanency workers, and adoption workers all work with families and the community to promote long-term safety, well-being, and permanent families for children. Each type of caseworker performs a distinct role. The work of caseworkers also varies depending on the circumstances and needs of particular families.

The Child Welfare Services practice model guides the work with children and their families, and is based on five principles:

1. Child safety, first and foremost.
2. Parents have the right and responsibility to raise their own children.
3. Children are entitled to live in a safe and nurturing family.
4. All children deserve a permanent family.
5. How we do our work is as important as the work we do.

OCFS' child protective work has several parts: (1) the intake of reports of suspected child abuse and neglect; (2) the investigation (assessment) of reports that are deemed to be appropriate for a child protective response; and (3) the continuation of services to children and families that have been found to need departmental services as the result of an assessment. The work is divided between OCFS Central Intake and OCFS District Offices.

OCFS Central Intake is in Augusta and there are OCFS offices throughout eight Districts. Some districts have multiple offices. The District offices currently have caseworkers and supervisors for three separate functions: child protective, permanency, and adoption.

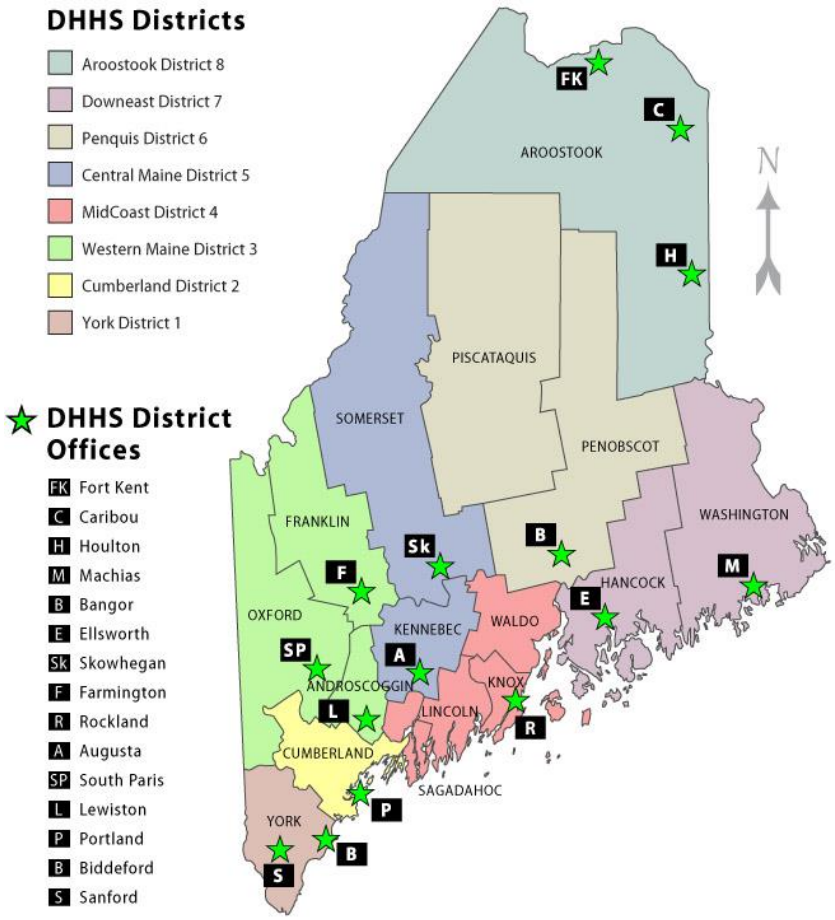
Summary of Intake Processes and Decisions

The child protective process in Maine generally begins when a reporter makes a call to the 24-hour Child Protective Intake Unit in Augusta via a statewide toll-free number. If district offices receive reports of child abuse or neglect, they also route this information to Central Intake.

Intake workers receive the reports of suspected child abuse and neglect and, along with their supervisors:

- screen the reports;
- determine whether they are appropriate for child protective response;
- determine the urgency needed for a response; and
- assign the reports to the responsible District office.

Intake is also responsible for identifying families that may benefit from prevention services even if they do not rise to the level of risk requiring a child protective assessment. Since May 2017, Intake has been using a Structured Decision Making Intake Screening and Response Priority Tool (SDM SCRPT Tool) to assist in the screening of reports and decision-making with regards to report appropriateness, assignment, and urgency.



Intake workers document call information into a report in MACWIS, the agency's electronic record-keeping system. Sometimes the reporter's information is not sufficient to determine if a report is appropriate for child protective response. In these cases, the intake caseworker may, with supervisory approval, contact at least one professional person who may have direct knowledge of the child's current condition prior to creating a report in MACWIS. Intake workers may also access additional information including previous MACWIS reports or entries, and relevant information from other systems including:

- Automated Client Eligibility System (eligibility for assistance programs);
- Bureau of Motor Vehicles (10-year driver history report, includes all driving violations);
- State Bureau of Identification (criminal history, based on arrests in Maine); and
- Sex Offender Registry.

Intake is responsible for making a decision on the disposition of all reports within 24-hours of receipt. The intake caseworker reviews the information, including additional sources as needed, and determines whether the report(s) are:

- appropriate - meets the definition of abuse or neglect;
- inappropriate - does not meet the definition of abuse and neglect;
- involves a substance-exposed newborn or drug-affected baby with no allegations; or
- other.

An intake supervisor reviews all intake worker decisions, even reports that are screened out because they do not involve children or allegations of abuse. When the intake worker, with the supervisor, determines that a report requires an immediate response, the worker calls the report into the assigned District Office to alert them. All other appropriate reports are completed by the intake worker and submitted to the intake supervisor for approval by the end of the intake worker's shift. Once approved by the intake supervisor, reports are sent to the appropriate district supervisor for assignment for Child Protective Assessment or referred to a Community Intervention Program.

If a suspected criminal act of abuse to a child is alleged, Intake staff make a referral to the District Attorney (DA) responsible for the area where the alleged crime occurred. This includes reports involving child death and/or serious injury, ingestion, and domestic violence homicide. In addition, reports with allegations involving physical abuse, sexual abuse, sex trafficking, and child endangerment require a referral to the DA.

Summary of Child Protective Assessments

Once a report is sent to a OCFS District Office, the family must be seen within the response time specified by Central Intake as either 24 or 72 hours, dependent on the result of Intake Screening Tool. A Child Protective Assessment is the first stage of departmental involvement with a family to determine whether or not child abuse or neglect is present in a family, whether children are safe, and whether or not there is a need for OCFS to play a continuing role with the family beyond the assessment period.

Assessments are conducted by child protective workers or contracted Alternative Response Program (ARP) workers. The worker will make contact with a family and gather and analyze information within the framework of child abuse and neglect to assess signs of safety, risk, and danger for children in the family. Child protective workers begin making contact with a family and conducting a face-to-face contact with each alleged child victim within 24 or 72 hours, depending on the severity of the alleged abuse and other factors. Immediately following the first face-to-face contact with each alleged child victim, the child protective worker consults with her/his supervisor and makes an initial safety decision. If the child protective worker determines that children are safe, the worker will continue with assessment activities.

OPEGA understands that assessment activities may include speaking with family, school officials, medical professionals, and involved professionals, along with gathering records. The steps a child protective worker will take are individual to each assessment. Overall objectives of the assessment are to determine:

- if a child has been abused or neglected and how severely;
- the impact of the abuse and neglect on the child(ren);
- signs of safety, signs of risk, and signs of danger;

- how likely it is for a child to experience abuse and neglect within the next six months;
- caregiver strengths and needs related to child safety;
- if this is a family in need of Child Protective services; and
- whether a plan should be developed to assist the family in keeping the children safe.

At the end of the assessment period, the child protective worker makes a finding on whether the initial allegations of abuse or neglect were indicated, substantiated, or not found. Indicated abuse is of a low/moderate severity, while substantiated abuse is of a high severity.

Child protective workers, with their supervisors, are also responsible for determining whether families are in need of continuing OCFS services. At any point during an assessment, a child protective worker might identify signs of danger for children that require immediate intervention or court action to remove the child from the home. OCFS would continue services with this family. An assessment may also find that signs of danger are not as emergent, but it is determined that a family needs continued OCFS services. In these cases, the department might file a court action that alleges that the children are at risk in their home if no changes are made in that environment. OCFS would also be continuing services with a family in this situation.

Summary of Prevention Role

Until October 2017, some OCFS District offices had a role for prevention social workers in addition to child protective, permanency, and adoption workers. In four districts, prevention workers were assigned cases in high-risk neighborhoods that did not rise to the level of needing a Child Protective Assessment, but were still identified as having family risks that could benefit from caseworker support. The prevention worker would offer to work with the family to mitigate the identified risks and to connect the family with services. Family participation with the prevention worker was voluntary.

Prevention workers were required to make a new report to Intake if they encountered information during their work with a family that caused them to have reasonable suspicion that a child had been, or was likely to be, abuse or neglected. In this case, the District's Child Protective unit would conduct an assessment with the family and the prevention worker would close their case. According to DHHS, prevention workers documented their work in a system other than MACWIS. If a case was transferred from one OCFS service to the next, information was shared through staff to staff interactions, typically through a family team meeting.

DHHS describes these prevention services as having been a pilot program aimed at offering additional services in areas of the State identified as high risk for child abuse and neglect. The Department decided to end the prevention services due to a lack of consistency between District offices and lack of data to show success. The Department also notes that they decided to focus OCFS caseworkers on the child welfare work that falls within the statutory mandate of the office.

Summary of ARP Role and Assessments/Services

In addition to the internal caseworker roles, OCFS has contract-based prevention services throughout the State intended to focus on early family intervention and the prevention of child abuse and neglect. OCFS describes the purpose of these services as reducing the risks associated with maltreatment of children and addressing family needs. These services, referred to as Alternative Response Program (ARP), occur after an OCFS District supervisor has determined that a case is appropriate for this type of intervention.

Supervisors make two distinct types of ARP referrals:

(1) Supervisors receive cases from Intake that have been determined appropriate for a child protective assessment but have low to moderate severity allegations. They may refer these cases to ARP to conduct the child protective assessments. This type of referral requires ARP to complete an assessment of allegations of abuse and neglect, a family plan, and referrals to appropriate community services.

(2) Supervisors may also refer cases to ARP after an OCFS child protective worker has completed an assessment with the family. These post-assessment referrals occur when OCFS has determined that a family may benefit from additional support in connecting with community services.

The OCFS Intake Screening and Assignment policy refers to situations where reports may be screened out as inappropriate, but intake workers still identify risk factors for families such that the families would benefit from Community Intervention Program or Prevention Services. In these cases, the policy directs Intake staff to make referrals directly to Prevention Services or send reports to the District Office. ARP may receive these referrals as well.

ARP staff are mandated reporters. Additionally, ARP contracts require the ARP caseworker to make a decision whether or not a sign of danger is present following the initial parent/caregiver and child interviews. Very serious parental behaviors, conditions and child or family circumstances that either have caused, or very soon could cause, high severity child abuse/neglect are considered signs of danger. If any sign of danger is present, the assessment is to be immediately returned to the Department. The contract also requires ARP to notify the Department by telephone or voice mail by the next business day when a family refuses services, and also to notify the Department when a family cannot be located within 35 days.

If ARP workers encounter information in a case that rises to the level of a new report of abuse or neglect, they are required to report this information to OCFS Intake. Within this reporting, they disclose information that they learned during their work with a family that caused them to have reasonable suspicion that a child has been, or is likely to be, abused or neglected. The case would then be re-assigned to OCFS Child Protective for assessment.

ARP workers document their work and interactions with a family in MACWIS, including their activities to locate a family. OCFS has access to the information ARP has entered to MACWIS. In addition, information could be shared through direct conversations between the ARP staff and OCFS Child Protective staff.

Summary of Permanency Unit Role

Once the child protective worker and supervisor determine that a family needs continuing services and the assessment is closed, the child protective worker will transfer the case to a permanency worker who continues the next stage of OCFS involvement. Permanency work involves working with a family to establish safety, working with families towards reunification in cases where children have been removed from their homes, or working towards other forms of permanency for children.

Permanency workers are responsible for:

- facilitating family team meetings and developing individualized solutions for families;
- arranging services for children and parents working toward reunification, including setting up visitations;
- working with foster families, if applicable; and
- assuring ongoing safety for children through frequent contact with children and their caregivers.

As necessary, permanency workers may take court action and/or work towards permanency outside of the child's birth family through adoption or other placement. At all times, permanency workers are responsible for meeting federal and state mandates and timeframes and keeping written case records.

Permanency work moves past assessment of safety and danger, though this is an ongoing process for all social workers, to the work of making plans and arranging services to best meet the safety, well-being, and permanency needs of children.

Recent Changes to OCFS processes and procedures

In certain instances of child death or serious injury, DHHS conducts a Child Death/Serious Injury (CDSI) Internal Case Review using the CDSI Review Tool. The review consists of a record review, interviews with staff, analysis, conclusions and implementation of practice or policy changes if applicable.

CDSI Internal Case Reviews were conducted following the deaths of both children whose cases OPEGA reviewed. During a May 15, 2018 meeting, OCFS staff described processes that they have modified as a result of the internal reviews.

- Intake will automatically consider a case appropriate for assessment after three reports of child abuse that individually would have been deemed inappropriate. Previously, the first factor considered in the Child Protective Intake process was the severity of the individual child abuse/neglect report, and then the entire record and the context of the case was to be considered.
- Beginning September 2018, OCFS will implementation the Structured Decision Making (SDM) model for child protective assessments. DHHS has been using the SDM tool for Intake decision-making since May, 2017.

- Any case open with ARP that receives a new appropriate report of abuse/neglect will be automatically closed with ARP and opened with OCFS Child Protective. Previously in these situations, the ARP caseworker would contact the OCFS District Office to discuss and evaluate whether to turn the case back over to OCFS Child Protective or have it remain with ARP.
- OCFS is re-emphasizing with ARP their responsibility to notify DHHS if the family refuses services or if the ARP worker cannot make contact with the family.
- Any case open with ARP that receives a new report of child abuse/neglect that is deemed inappropriate becomes a separate child abuse/neglect report in MACWIS. Previously, the information obtained from the reporter was entered into the narrative log and no new report of abuse/neglect was created in MACWIS.

DHHS has since provided additional information on practice and process changes. These include:

- Increased real-time quality review of casework practice statewide through implementation of the Quality Improvement Program to increase oversight of casework practice through continuous, real-time review of Child Welfare caseworker documentation.
- Implementation of the case review toolkit for supervision by caseworker supervisors to utilize with caseworkers in order to strengthen high quality, consistent casework practice and increase oversight and organization of supervisor practice related to caseworker supervision.
- Discontinuing Out of Home Safety Plans to mitigate risk related to the practice of agreeing to place a child outside of their parents' home(s) and place them with another caretaker without the court's oversight.
- Increasing high quality statewide practice through continued implementation of Family Teaming Practice to increase engagement of the caregivers and their informal supports to create a plan to meet the safety needs of the children who are involved with Child Welfare interventions.
- Increasing Child Welfare oversight and review of cases by adding a clinical psychologist to increase the level of clinical supervision and Child Welfare case reviews available to the District staff therefore increasing high quality casework practice.
- Increasing ability to holistically review reports of abuse by updating the Intake process to make all Reports of Abuse separate reports to increase high quality practice in the review of reports of abuse and ensure that the gravity of repeat reports is easily noticed and assessed within the decision making for dispositions of reports of abuse.

Potential Areas for Concern or Improvement to Consider in Planning a Broader Review

OPEGA identified a number of potential areas for concern or improvement in the child protection system from our review of these two cases and relevant statutes, rules, policies and procedures. We expect these observations will help inform GOC and OPEGA consideration of potential areas of focus for a broader review of Maine's Child Protection System, as will information gleaned from the Public Comment period the GOC has scheduled on this report. The potential areas OPEGA identified, in no particular order of priority, include:

- guidance and training for mandated reporters, including expectations for what constitutes "reason for suspicion" for those in various roles;
- timeliness of answering phone calls regarding potential child abuse and neglect by OCFS Intake workers via the statewide, toll-free number;
- timeliness and comprehensiveness of OCFS and ARP assessments of risk for a child or family and junctures at which a comprehensive re-assessment of risk could be or should be conducted;
- appropriateness of caseloads and adequacy of supervision and training of OCFS and ARP staff;
- compliance with policies and procedures, and consistency and appropriateness of decisions made, by caseworkers and supervisors in OCFS Central Intake and District Offices;
- compliance with contractual obligations, and consistency and appropriateness of decisions made, by ARP caseworkers and supervisors;

- factors that impact OCFS or ARP decision-making on appropriate action to take in response to assessed risk levels, and information received or situations observed with a child or family;
- extent to which OCFS and ARP monitor whether families are participating in voluntary services intended to reduce the risk of child abuse and neglect and take action when they are not;
- extent to which mandated reporters, OCFS and ARP seek to verify, and can verify, information reported by a child's parents;
- effectiveness of the child protection system in identifying and responding to child abuse/neglect risks that are not considered to be imminent physical safety risk, i.e. emotional maltreatment, neglect, truancy; and
- extent and manner of communication and information exchange among the various key entities that are part of the child protection system including schools, law enforcement, health care providers, counselors and therapists, community service providers; OCFS Intake, OCFS Field Offices and ARP providers.

There were also many individuals who contacted OPEGA wanting to share their concerns regarding the child protection system. We did not have time to gather information from them all, but we are prepared to share the perspectives we did get when working with the GOC on areas of focus for the broader child protection system review.