SEN. ROGER J. KATZ, SENATE CHAIR
REP. ANNE-MARIE MASTRACCIO, HOUSE CHAIR

MEMBERS:
SEN. NATHAN L. LIBBY
SEN. PAUL T. DAVIS, SR.
SEN. BILL DIAMOND
SEN. GEOFFREY M. GRATWICK
SEN. THOMAS B. SAVIELLO
REP. JEFFREY K. PIERCE
REP. JENNIFER L. DECHANT
REP. MATTHEW A. HARRINGTON
REP. DEANE RYKERSON
REP. PAULA G. SUTTON

MAINE STATE LEGISLATURE
GOVERNMENT OVERSIGHT COMMITTEE

MEETING SUMMARY
May 31, 2018
Accepted June 28, 2018

CALL TO ORDER

The Chair, Sen. Katz, called the Government Oversight Committee to order at 9:03 a.m. in the Burton Cross Building.

ATTENDANCE

Senators:	Sen. Katz, Sen. Libby, Sen. Diamond and Sen. Gratwick Absent: Sen. Davis and Sen. Saviello
Representatives:	Rep. Mastraccio, Rep. Pierce, Rep. DeChant, Rep. Rykerson and Rep. Sutton Absent: Rep. Harrington
Legislative Officers and Staff:	Beth Ashcroft, Director of OPEGA Ariel Ricci, Analyst, OPEGA Etta Connors, Adm. Secretary, OPEGA
Legislators:	Rep. Hymanson, Rep. Denno, Rep. Head and Sen. Bellows
Executive Branch Officers and Staff Providing Information to the Committee:	Governor Paul R. LePage

INTRODUCTION OF GOVERNMENT OVERSIGHT COMMITTEE MEMBERS

The members of the Government Oversight Committee introduced themselves.

NEW BUSINESS

- **OPEGA Report on the Child Protection System: A Study of How the System Functioned in Two Cases of Child Death by Abuse in the Home**

Sen. Katz said the GOC received the Report on the Child Protection System at their May 24th meeting and were hoping to learn, with respect to the two tragic deaths, who knew what, when they knew it and how the system failed these kids. This is a Rapid Response Review and a precursor to another review the Committee is going to task OPEGA with to review the Child Protection System deeper and suggesting some systemic changes to make sure tragedies like this do not happen again. OPEGA's ability to produce what the GOC requested, a transparent account of what happened and how the State collectively failed these two children was seriously constrained by two things. One was the need to not do anything that might interfere with the pending criminal trials in these cases and secondly the existence of confidentiality laws, both State and federal that have placed roadblocks to full public disclosure. He said the irony of the confidentiality part is that those laws are mostly designed to protect kids and here both of the kids are now dead. Also, those laws are designed to protect the privacy rights of the parents and caretakers, but those people are charged with the murders and arguably don't deserve that privacy shield that can lead to the public's right to know.

Sen. Katz said the Public Comment Period of the Child Protection System is scheduled for today. This is an opportunity for anyone and everyone to share their thoughts with the Committee about what the OPEGA Report has disclosed and what areas the GOC should concentrate on going forward. He said at the June 28th meeting the Committee will have a Work Session to decide what to task OPEGA with on a follow-up review of the Child Protection System process.

- **Public Comment Period**

Governor Paul LePage (A copy of his testimony is posted to the GOC/OPEGA website at http://legislature.maine.gov/doc/2325.)

Sen. Diamond said since last week's GOC meeting he has received a lot of information regarding specific things that are happening and noted that the Governor had made reference to them. He had a copy of the Child Protective Services Assignment Checklist from one of the Districts and said it is designed for two cases per week and the people who are trying to do this work are doing up to six or eight cases a week so none of the cases are getting addressed. The horror stories about kids currently being mistreated is because nobody can get to them. He asked the Governor if he will call the Legislature into a Special Session at the end of the summer, or whenever appropriate, to deal with some specific legislation that will address the immediate problems and not wait for a new Administration. Sen. Diamond is concerned that if the Legislature does act almost immediately, you are going to see more children dead.

Governor LePage agreed with Sen. Diamond and said he is currently preparing some legislation and budgets for a new system. He provided the Committee with the Child Welfare Overview Report saying the Committee will see that the State is moving ahead on everything that they can do in regulations and rules, legislation is being prepared and budgets are being developed so that we can move forward. If the Legislature wants to come back and deal with the matter this summer he would be more than happy to bring them back. The Governor said he would like to participate because he is very passionate about the issue.

Sen. Diamond said the mandatory reporting system is broken and the mandatory reporting legislation just passed was very weak. Governor LePage did not know if the GOC will be able to see all the details by the end of summer, but once the prosecutions are done in the two cases, there will be more information that will be available.

Rep. Rykerson thinks that reunification should not be the highest priority. Child removal from the families has definitely been abused in the past, but it should not be the highest priority. The safety of the child should be and he would sponsor or co-sponsor any legislation to that end. Governor LePage agreed with Rep. Rykerson that the system is broken and they need to do the right thing for the kids of the State. Reunification is happening too quickly. Yes you are saving a lot of money and yes the numbers look good, but there are some casualties that go unnoticed. Children don't die, but they have a life of trauma.

Sen. Katz said the Governor was doing the same thing as the GOC in not wanting to interfere with the criminal trials that are going on. He noted the Governor's report is looking ahead, however, to what the State ought to be doing. He asked if the Governor would be willing to make someone from the Department available at the GOC's work session to discuss the report the Governor had provided today. Governor LePage said if it is to discuss the report itself, he would be more than happy to, that is not the issue. The last thing he wants to do for the children who have passed is to interfere with the prosecution such that somebody gets off scot-free. Sen. Katz said the Committee will invite the Governor, or somebody from the Department, with the assurance that they will be discussing the Child Welfare Overview Report.

Rep. Pierce thinks the Governor hit the mark with his comments and would be willing to come in for a special session, and help with any legislation that is needed.

Rep. Sutton asked if there was any timeline on when the criminal trials will be coming up. Governor LePage said it is in the hands of the Courts. Sen. Katz did not believe the criminal proceedings would be done before this Legislature ends and the Governor agreed.

Rep. DeChant referred to replacing the outdated computer system and asked who was in charge of doing that. The Governor said the Executive Branch is in charge of operating the system, the Legislature is in charge in giving them the money to get an updated system. Rep. DeChant asked how long it has internally been understood that the system has been outdated and ineffective. Governor LePage said fifteen years.

Sen. Gratwick said the two children's deaths occurred on the Governor's watch, on his and other legislators watch and, as appropriate, we hold the generals accountable and not the foot soldiers who are actually on the frontlines. There has been a great deal of talk about money, not enough money available for this work the State does. He asked for the amount of money that has been devoted to this problem over the last six to ten years because much of what he has been reading and hearing relates to the fact that the employees are overloaded with work, their morale is poor, there is a great deal of turnover, etc. and we are not giving those workers the support they need. Governor LePage said the Executive and the Legislative Branches are culpable here. He put legislation out on two or three different occasions on mandatory reporting and it does not go anywhere. He has been trying for two years to get the Legislature to recognize that OIT is an important aspect of this State and that we have to give it priority. He tried to make it a cabinet level position so its importance would be elevated in the State and it keeps getting defeated, but he will try for the rest of his term to bring attention to it.

Governor LePage thinks the law itself is the problem because it tells us that when you take a child from a home, your top priority is to reunify that child with that family and he is saying that is counterproductive. In both these cases you will see that to be the fact. The Governor said he could put more resources there, or on a number of OIT situations, but OIT's budget is only 30% of what is needed. The system is very outdated and is a legacy system that has been patched for fifteen years. What is becoming more critical is the people who were patching the systems are now retiring and they found themselves having to go to Florida to get a retiree and bring him back to help patch the legacy system so they would keep it operating last year. He said the investments are huge and are multi-year.

Sen. Gratwick acknowledged what the Governor said is appropriate and true, but he is interested in resources devoted to personnel, people, the frontline folks that do the major work. Governor LePage said he will have DHHS get that information for the Committee. Over the last two years the Governor has been asking the Commissioners and OIT to set priorities on what programs and systems need to be addressed

next to make sure that the priorities are in the right places. DHHS is at the table for those discussions and decisions.

Sen. Katz said two things that come to the GOC anecdotally is the need for better coordination and information sharing and the Governor addressed that directly about the computer issues. The other issue is that the caseloads for the workers is too heavy and asked if the Governor knew if the need to increase the number of caseworkers is addressed in his report. Governor LePage said Sen. Katz was partially right. He does believe DHHS needs more caseworkers, but thinks the bigger issue is that they need better training and support for the staff. Staff is young and do not have seniors that they can go to for advice and they are having to make some tough decisions without being properly trained. DHHS needs more caseworkers, better training, and some ability to debrief them periodically. If the workers were debriefed and supported properly they can handle a lot more work and quicker.

Rep. Denno, a member of the Health and Human Services Committee. (A copy of his testimony is posted to the GOC/OPEGA website at http://legislature.maine.gov/doc/2325.)

Sen. Gratwick said he questioned the Governor about money given for front line workers and he always returned to technology. He acknowledged that technology is important, but is concerned about the larger priorities within the Department to give money toward training, the morale, and the retention of front line workers. He asked Rep. Denno in terms of other states if there is a standard amount of money that Maine needs to be spending to make sure departments, such as DHHS, work well per population. He asked if Rep. Denno is able to access the total budget amount that has been going into DHHS and Child and Family Services over the last ten years.

Rep. Denno said in response to the second part of Sen. Gratwick's question he did not have any information to add to what has been said regarding DHHS's budget. On the first part, and as stated in his testimony, he thinks the Legislature needs to engage with DHHS. Sen. Gratwick's two part question needs active engagement, not submission of written questions and answers, but active engagement of the GOC in conversation. The GOC needs to make sure the Legislature has some benchmarking that would provide means and averages for other states in terms of what are the staffing levels, salaries and what are turnaround times so we can measure where we are. Employees who do not feel supported, do not feel valued, do not feel trained or the network needed to succeed, are not going to be optimal employees. His suggestion is that there be an effort to go directly to employees and ask them what would it take for you to feel supported, and be able to do their very best in the job.

Sen. Katz said the Governor was pretty strong in what he said about his perception of over emphasis on family reunification. How aggressive are we, as a State government, in taking children away from their parents. Are we being aggressive enough because there are children we are leaving at risk or are we being too aggressive? He asked if Rep. Denno had any view on that subject.

Rep. Denno said he did not have any underlying information regarding that, but thought the Governor made an excellent point, as well as some of the GOC members, about the need to recalibrate a little, not to make a radical change, but to recalibrate so the interest of the child is put first and foremost.

Sen. Libby said the GOC was provided an organizational chart for OCFS. There are about 300 workers within the Office and about 30 vacant positions. Most of the vacant positions are the frontline positions and asked Rep. Denno, from information he received as a member of the HHS Committee, if that vacancy rate was consistent with other DHHS departments. Is it normal and is it a problem?

Rep. Denno said that is an excellent example of where the GOC needs to have engagement with the Department. There are times when there are very consciously established vacancies for whatever reason so reading a chart, in his experience, does not tell you a story. Thus, there needs to be an engaged conversation to say what is the reason for these vacancies. He said, not based on his direct experience but from talking with people he knows, these are very stressful and difficult jobs.

Sen. Diamond asked if the HHS Committee had been aware of the system breakdown in CPS. Has the Committee had indications of that, have they talked to the Department and has the HHS Committee tried to get involved in trying to fix the system?

Rep. Denno said it is not a secret that the HHS Committee had a lot of difficulty engaging with the Department over the last two years. Unfortunately, they did not have a good relationship in terms of having those open engagements. Sen. Diamond said he was not pointing fingers he was trying to find out if the HHS Committee had any indicators that the system was this badly broken. Rep. Denno said he should defer to Rep. Hymanson, Chair of the HHS Committee, but he did not recall seeing a direct indication that the system was in a state of collapse.

Rep. Hymanson, Chair, HHS Committee. (She did not provide a copy of her testimony.)

Rep. Hymanson brought the request for this review forward. As Chair of the HHS Committee, she is aware that the Committee has oversight of DHHS. The HHS Committee also has the Government Evaluation Act (GEA) review just as every Committee has a schedule of evaluations of the departments they have jurisdiction over. This year the HHS Committee had the review of DHHS's GEA Report. The GEA mandates questions and responses in a very particular way. Each Department will answer the sequential questions according to what the Act asks them to do. In most cases, the usual is to have the department come in front of the oversight committee, but as is the current practice, the HHS Committee was asked instead to submit questions about DHHS's GEA Report. The HHS Committee submitted their questions, but some of DHHS's answers to the Committee's questions needed a back and forth and that is the part that is not afforded to the Legislature. When she reviewed CPS's section in the GEA Report there were many questions that she would have liked to have had answered, including the CPS's staffing.

Rep. Hymanson said one of HHS Committee bills was about mandated reporters in the 127th Legislature. As a physician, she is a mandated reporter and is aware, as Rep. Denno said, the way to look at this is at the ground floor with caseworkers, and mandated reporters. She took the mandated reporters course and knows there are processes in place for mandated reporters. There is a $500 fine if you knowingly violate reporting and if you fail to report there is a possibility of a civil suit being filed against you from the family. Rep. Hymanson thinks people want to do the right thing and that was shown in these two cases. She thinks, after hearing Rep. Harrington's remarks at the last meeting, there needs to be better communication between mandatory reporters and DHHS.

Rep. DeChant asked if Rep. Hymanson knew if DHHS's vacant positions are just hard to fill or a matter of money. Rep. Hymanson said she did not know and thinks a direct conversation with DHHS would be the best way to get that information.

Rep. Sutton asked what problem Rep. Hymanson saw in criminalizing the failure to report. Rep. Hymanson said physicians have a mandate themselves and protocol for reporting so they will always do the right thing and report. She gave an example of a child brought in to the doctor's office with a broken arm. The physician goes through the usual and the parents say the child fell off a swing in the playground and broke their arm. The physician would examine the child for other bruises and see none so would assume the parents' story was right. Lets' say that story was not right and it came out that the child had been abused. Would you then go back to the physician and say you have committed a crime because you didn't report the broken arm. She thinks the better bang for the buck is educating people of their responsibility and to understand what and how they are looking for abuse. Criminalizing failure to report would be difficult to enforce.

Rep. Hymanson said the National Conference of State Legislatures is a very good resource for her and the Committee and she will be asking them about mandatory reporter laws in other states.

Rep. Mastraccio agreed that the technology issue is over all departments. She noted that as Chair of the HHS Committee, Rep. Hymanson will see DHHS's technology budget, but HHS is not the Committee that oversees technology. IT is overseen by the State and Local Government (SLG) Committee. Rep. Hymanson said the HHS Committee never talked about the IT needs of DHHS. It was in the budget as a budget item and was only talked about in general. The Committee was never given information to delve into DHHS's IT needs. Rep. Mastraccio asked if Rep. Hymanson would agree, as a Legislature, we have been negligent in addressing the issues around technology that affects every State department and maybe there is a better way for us to do that. She has been advocating for separate committee of oversight that can develop the needed expertise because she does not think there are enough people on any committee that have IT expertise. Rep. Hymanson said if DHHS's system has been breaking for fifteen years and dependent on one person in Florida who was called back to know how it worked, clearly we need a better process to move the State's IT needs along.

Rep. Head, a member of the HHS Committee. (She did not provide a copy of her testimony.)

Rep. Head wondered if what was happening in DHHS was overlooked. She understands DHHS hires a lot of outside contract workers and asked if more oversight was needed for those workers. She thinks there are vacancies in every department of the State, not just DHHS and, in this particular child welfare program, she was told there were thirty vacancies. Would it have saved the two little girls' lives had those positions been filled? She agreed with Rep. Denno's comments and thinks some of his suggestions could help improve the caseload.

Rep. Sutton asked if Rep. Head thought criminalizing failure to report sends a message that abuse is serious. Rep. Head said, for example a code enforcement officer, how much does he interact with the family. It would be a very limited scope of interaction with that child and she does not see how a code enforcement officer can be punished for not reporting. The mandatory reporters' list needs to be adequate if you are going to punish individuals for not reporting.

Sen. Bellows. (A copy of her testimony is posted to the GOC/OPEGA website at http://legislature.maine.gov/uploads/originals/public-comments-on-ptdz-report-as-of-9-26-17-1.pdf)

Rep. Rykerson knew that Sen. Bellows has advocated for privacy rights and asked what she thought of Rep. Denno's suggestion of closed executive sessions of committees so that confidential information can be shared and discussed. Sen. Bellows thinks when it rises to the level of child protection proceedings, and given the challenges the GOC and HHS Committee have had in having a frank and open discussion to fully understand what is going on, that may be appropriate and a suggestion worth serious consideration, particularly where discussions might infringe upon a court proceeding. You do not want to do anything to delay or deny justice from taking place, but at the same time there needs to be improvements in the system to help protect the children.

Rep. Pierce noted that Sen. Bellows referred extensively in her testimony about a whistleblower and asked if she would encourage that person to talk with Director Ashcroft, where their confidentiality would be protected, so the GOC could capture that information. Sen. Bellows said she has talked with the whistleblower about talking with OPEGA, but she will circle back with that person.

Sen. Gratwick said looking further into the reasons for the child abuse cases, makes one want to look further into the underlying causes in terms of drugs, alcohol, poverty, etc. and asked if Sen. Bellows had any insight in the larger demographics of this problem. Sen. Bellows said the Legislature has received data that has demonstrated explosion in the number of drug affected babies in Maine and that has increased the workload for DHHS. She is not familiar with the organizational chart for DHHS or CPS over the last decade, but if it has not changed significantly you cannot have the staff that was dealing with dozens of cases of drug affected babies ten years ago deal with hundreds of cases now and do an adequate job. She heard that work arounds have been developed internally to try to process more cases more quickly, but that

is when some of the critical cases fall through the cracks. The Legislature needs to increase the resources being devoted to this effort.

Sen. Katz followed up with what Sen. Bellows said and Rep. Pierce alluded to and hoped that people will feel comfortable in coming before the GOC and telling their stories. The Committee cannot offer complete protection from retaliation but said, on behalf of everybody on the Committee, that if anybody does come before them to tell their perspective and find they are retaliated against, the GOC would be interested in knowing that and would view it as interfering with their ability to do their job.

Emily Douglas, Ph.D., Professor/Department Head, Social Science & Policy Studies, Worcester Polytechnic Institute. (A copy of her testimony is posted to the GOC/OPEGA website at http://legislature.maine.gov/uploads/originals/public-comments-on-ptdz-report-as-of-9-26-17-1.pdf)

Rep. Mastraccio asked if, when Dr. Douglas is training child welfare workers, does she talk to them about the fact that when in these positions they may not have the back-up that they need or are they totally unprepared for how poorly the State is doing that. Dr. Douglas thinks staff is unprepared and when sitting in front of a case they do not see the risk factors. When a child dies, the red flags jump out and seem so obvious to everybody. Yet when they are right there in front of it, it is not as obvious. The stakes and political climate are very high, they are either getting good supervision or they are not and she does not think they are always aware of what are the most important risk factors. It has been her experience that workers think that most kids die at the hands of their mom's boyfriend, physical abuse and that very young children are at risk. Dr. Douglas said the facts are that most kids die from neglect and actually die in the hands of their mother's care. Despite what is heard today moms are involved in sixty percent of children's death and dads are involved in forty percent. Moms' boyfriends are about fifteen percent in children's deaths. Workers are primarily getting their knowledge from the media and as she looks at child welfare training curricular, she has found only one state that has an entire section dedicated to deaths and that State is Florida. Florida put in a family preservation model and then cut funding, but you cannot do family preservation without funding. Family preservation is about services. She thinks what happens is we learn about what a risk is based on from what turns up in the papers. Child neglect cases don't end up in the newspapers and are not prosecuted for the most part.

Sen. Katz referred to giving workers research based training and risk factors for child maltreatment fatalities and then incorporate them. Dr. Douglas mentioned Florida and he asked if there were other States that are doing a particularly good job. Dr. Douglas said she has not reviewed all the states, maybe about twenty states' training curricular and Florida was the only one. Florida put together a profile of the families with deaths in their State. That is helpful, but she also thinks it is helpful to look at national trends as well because there are characteristics that are specific to states and it is important to take into account, but also thinks it is important to have a sense across the board of what are our risk factors.

Sen. Katz asked that as Maine tries to develop that training if Dr. Douglas was available to help. She said she was.

Sen. Libby said he was interested in Dr. Douglas' insight on training, but interested in her insight on appropriate caseload for caseworkers in this field and what has her experience been. Dr. Douglas said the best place to go for that information is the Child Welfare League of America. The League is the professional society for the child welfare workforce and sets national practice standards. For open, ongoing cases you should not have more that seventeen cases. Dr. Douglas said it can be problematic to be just counting cases because sometimes a case may be a parent and a child and another case might be three to four parents involved in this family system and five children and that is incredible complex. So sometimes the idea of workload is a better reference point than caseload because a single case can be a huge workload. She said the League sets the standards so we don't have to come up with the information. There is federal legislation pending requiring states to come up with their own caseload standard. At this point the federal government does not require caseload standards, does not offer any

kind of recommendations on it, but there is a bill that is pending that would ask each state to come up with workload guidelines that make sense for that state because some states are very rural so workers might share investigative work or case work.

Sen. Libby asked if Maine, with 1.3 million people and about three hundred working in the OFCS, 30 vacancies so a ten percent vacancy rate, was appropriately resourced in terms of case management. Dr. Douglas said she could not speak to that. What she could say is this is not a problem that is unique to the State of Maine. She realizes that this is an immediate problem, but it is a problem across the country. Anywhere between twenty-three to eighty-five percent of the child welfare workforce turns over every year. Imagine trying to put together a caseload or being a child in that system. Most workers burned out between eighteen months to two years. The historical knowledge that is required to keep an institution moving is very challenging so her guess would be that Maine is not very well resourced only because most states are not particularly well resourced. It is a very high risk profession. You are likely to get injured and to suffer vicarious trauma from working with so many traumatized children. The Governor spoke on the need for training and for adequate support for workers and she supports his sentiment. These are problems that are seen all over the country and that it is an opportunity to learn. Any state does not have to be in a silo. Every state has its own unique characteristics, but you do not have to be here in a silo because there are resources all over the country with people who are grappling with it everywhere. She said it is a time to look outside your own state to see what else is going on because there are a lot of other professional groups and societies that work on these issues that provide ongoing training, etc.

Sen. Diamond asked if there were priorities that jumped out at Dr. Douglas that they should look at sooner rather than later, that would warrant the Legislature coming back into Session. Are there priorities she could see that the Legislature should look long and hard at to try to make some changes. Dr. Douglas said she can speak to what happens in the field, not necessarily just what came out in the report because, as talked about, the report is general and does not point to specific things. In general, she guessed Maine's child welfare workforce is in crisis and going to work every day is not fun so they need help. What happens generally in the aftermath of deaths, the pendulum will swing. These two kids died with their birth parents so the pendulum will swing and kids will start coming into foster care. Nobody wants to be in the headlines and the Administration starts to crack down so they are adamant about making sure they are meeting all the federal and state mandates. So they need resources. They need resources, probably more workers, and people providing clinical consultation to debrief with the front line workers to make sure everybody is doing okay, to make sure they are making sound decisions. She noted that Massachusetts has just been through a horrendous series of child deaths that went on for a couple of years. Being out in the community is incredibly challenging, so people stopped wanting to call to make reports because they thought the state would not do anything anyway and felt they could do a better job keeping an eye on the situation themselves. When workers do engage with family members they get a lot of hostility, so what they need is to be stabilized. They need to know that somebody has their back even though things are really tough every day they go to work. The caseworkers are making decisions about the kids' well-being so you want a workforce that is stable and has the right skills, knowledge and background to be making decisions about being able to recognize when a kid is at risk.

Sen. Gratwick referred to the monies we spend at the state level, whether it be Maine or elsewhere, and the outcomes that you have and asked if there were benchmarks for the amount spent by the states and if there is a change in outcomes based on the monies spent. Dr. Douglas said she could not speak with any authority about that, but did know the League has done these kinds of analyses and that is a resource for them to look to.

Sen. Gratwick asked where are best practices if they don't exist in the US, where do you look abroad. Dr. Douglas said she could direct him within the US for that information and at Capitol Hill in Washington, DC those working on child welfare often look to the State of Tennessee who has done a lot of overhaul to their child welfare system and would be a model to look to.

Dr. Douglas said the home visiting programs are probably the best bet we have in terms of prevention of child abuse and neglect. That is on the prevention side, not necessarily all on the child welfare workforce side.

Sen. Katz said the Governor and Dr. Douglas mentioned how when something happens to a child in foster care there is a swing away from foster care and if it happens in the home of natural families there is a swing away from that. In terms of evidence about where children are more at risk, does there seem to be more problems in a state that emphasizes kinship care, reunification or foster care. Dr. Douglas said it really is not that simple. She can say that most children do not die as a result of their foster parent and knows that a lot of people think if you put kids into foster care then they wind up dead. On occasion that happens, but if you look at the national statistic on who are the perpetrators of fatal child maltreatment, you are under five percent for foster parent. What is best to focus on is keeping children safe and each state is going to decide what that looks like by bringing in best practices and research to be informed on what happens. The child welfare profession has a history of getting a new idea and just running with it without a lot of evidence behind it. Dr. Douglas thinks that tide is turning and now there is a lot of good research being conducted.

Lawrence Ricci, MD, Medical Director of Spurwink Child Abuse Program, South Portland, ME. (A copy of his testimony is posted to the GOC/OPEGA website at http://legislature.maine.gov/uploads/originals/public-comments-on-ptdz-report-as-of-9-26-17-1.pdf)

Sen. Libby referred to frustration on the part of hospital workers in making reports to CPS and asked if Dr. Ricci could elaborate on that. Dr. Ricci said he was most familiar with Portland. There are meetings monthly with all the social workers and the Spurwink staff and some other medical providers get together to review all the prior child protective reports from the hospital over the preceding month. So, he has a lot of discussions about cases. He hears often from hospital social workers that they have high risk families and call DHHS, but the case is not opened or is not assigned to a worker. They will call again and the same case may not yet be assigned to a worker. He did not want to bad mouth that too much, but at first it was really a problem and making it more difficult to get cases assigned. His own experience recently was a case of a baby who, by report, fell in the arms of the mother and sustained a life threatening head injury. It was a mandatory report for them to report to CPS because it was a child under the age of six months with a life threatening injury, yet a decision was made to not open the case because a Physician Assistant in another hospital said it was probably an accident. Dr. Ricci said it could well have been an accident, and he was not saying it wasn't, but this was a baby who almost died while in the care of a sixteen year old mother and it took significant efforts on his part to get CPS to open that case, which ultimately happened. He believes that policy is changing and that these babies that sustain those kinds of injuries are getting opened for investigation. It is another point of check for the families.

Dr. Ricci said in another case the hospital staff was very concerned about the welfare of the baby and child welfare services did not seem to be responding. He said there is always two sides to any of these questions. The baby had a small bleed on the surface of the eye and there was a CPS worker assigned to the case. The child was sent to the primary care provider who opined that this could have been due to constipation which, in his experience, is impossible. An eighty year old with constipation could have hemorrhaging in their eyes, but not a three week old. Spurwink was not called and the child went home and died. In that case, and other cases, if Spurwink had simply been called, they could have admitted the baby and found the baby had other multiple injuries and could have been saved. He said there is a lot of frustration on the part hospital staff, particularly hospital social workers who work with these families on a regular basis, about trying to convince intake workers to assign the cases.

Sen. Katz referred to the structured decision-making which is an intake tool and asked if there was a problem with the tool itself or how it is being used. There must be a best practices intake model. Dr.

Ricci said these tools are well developed tools and are good tools theoretically. It is always in practice where the tool has to be tweaked, particularly for each individual state. His problem with structured decision-making is that it was never vetted by community providers or had an opportunity to see the tool. They have had discussion with the Department about it and they have been responsive to those discussions, but he still thinks with any tool like that, which standardizes practice it needs to be appropriately reviewed by the experts in the field who are making the reports.

Rep. Rykerson said since Dr. Ricci's testimony has to do with reporting and lack of response to reporting, he asked if he had an opinion on the criminalization for lack of reporting. Dr. Ricci said he does not know what the right answer is for criminalization and does not have a strong opinion either way. If criminalization would lead to better reporting practices he would say let's do it. Maine has a decent mandatory reporting law and the law was changed to say that anytime you have a baby under the age of six months with a serious injury, it is mandatory that you make a report. As far as mandatory reporters, he thinks that many of them are not getting trained. He referred to what was mentioned earlier of an infant falling on a playground and getting an arm fracture. If the baby was six months old and did not fall on the playground, the baby was abused. If it was a four year old who had fallen and got a broken arm, those are likely accidental injuries. Dr. Ricci said one of the things they emphasize in their training is if you have any doubts to call Spurwink if you are not sure what to do they will help you think through the decision about reporting. That does not mean you don't have to report, the obligation is still there, but he said he was on the fence about criminalization.

Sen. Gratwick asked if Spurwink, who is an independent group with its own independent funding, professional staff, etc. was mandated to look at the DHHS cases. Is Dr. Ricci's organization potentially one that could look at the way the Department functions and give appropriate feedback so it functions better? Dr. Ricci said in some cases Spurwink might be in a position to look at departmental function, but in most cases that is a bit beyond their expertise. Spurwink's expertise is in diagnosing individual abuse cases and to say whether or not a child has been abused. At least a third of the kids they see have not been abused where somewhere else said they had been. Spurwink has a good relationship with DHHS and makes comments to individual caseworkers, supervisors, regional program administrators and leadership about how to improve practice with regard to individual case decision-making. Spurwink staff are experts at training folks on how to avoid biases and thinking errors. It is an independent mental health agency and Spurwink Child Abuse Program is under the umbrella of Spurwink.

Sen. Katz asked Dr. Ricci if he could tell the Committee what the Maine Child Death and Service Injury Review Panel (CDSIRP) is and how it relates to these cases. Dr. Ricci said he would defer to Mark Moran to answer that question.

Mark Moran, Licensed Clinical Social Worker, Eastern Maine Medical Center. (A copy of his testimony is posted to the GOC/OPEGA website at http://legislature.maine.gov/uploads/originals/public-comments-on-ptdz-report-as-of-9-26-17-1.pdf)

In addition to his written testimony, Mr. Moran said he agreed with the Governor in terms of his position on better supporting the work staff including providing better training, debriefing, etc. Safe or unsafe is not the question trying to be answered. It is safe enough or unsafe enough. The art of being able to engage a family in difficult circumstances comes with time and when caseworkers are turning over every eighteen to twenty-four months after being hired, that expertise is lacking.

In response to the comment about whether we are being too aggressive or not aggressive enough in terms of removing children from families, he reminded everyone that removing a child from a family is not in itself a benign intervention. They can be traumatic interventions for the child, for the family and for the people doing the removals.

Every time a child dies in Maine you cannot have OPEGA review every death case. If there is a mechanism, a statutory protection that allows the OPEGA staff to get into the meat of these cases and be able to offer some recommendations for improvement then there must be another way for another body to be able to do it. The MCDSIRP has a level of expertise in the child welfare system that other bodies often times do not have. Rep. Hymanson commented on the letters that get sent to reporters indicating whether a report has been assigned or not for investigation and in his experience those letters are completely unhelpful. They contain approximately two lines of text, they identify the case by a number that is assigned in the MACWIS system and he has no knowledge what name that number translates to. For his staff, who make about thirty to fifty reports a month at Eastern Maine Medical Center, they have no idea what that number refers to.

Sen. Bellows commented on the whistleblower's opinion about cases now being assigned for investigation after receiving three inappropriate reports and echoed the concerns about that practice though there are times when a series of inappropriate reports that don't quite rise to the level of requiring an investigation should be assigned.

Mr. Moran said the question about criminalization of failure to report has been commented upon and asked about multiple times over the years. He thinks it is a tricky issue in large part because it is hard to operationalize. It would require, as he understands the legislation that was proposed previously, knowingly failing to report. Dr. Ricci referenced the newer section of the mandated reporting law that deals with babies under the age of six months. He said those are hard and fast things, they are not cases in which the reporter, whether it be a doctor, nurse or law enforcement officer, has discretion about reporting, it is clearly stated in the law. The remainder of the mandatory reporting statute is based upon a statement that says we have to report as mandated reporters when we have reasonable cause to suspect. Who knows what reasonable cause to suspect means. He cannot define it, and if you cannot define it, he thinks it is inappropriate then to criminalize failure to report. He thinks there could be room for discussion in terms of the potential for criminalizing failure to report on the absolute mandated pieces.

Sen. Gratwick asked earlier about the upstream interventions and Mr. Moran said the Legislature has had many days of public hearings talking about mental health, substance abuse services, Medicaid expansion and access to a livable wage, etc. and there are things that we know, generally speaking, will alter and influence risk factors for child maltreatment. He thinks there is room for examination of how we can minimize the risk factors and prevent the bad outcomes by looking more upstream than whether just child protective services knocks on a door or not.

Rep. DeChant understands there is no standardized approach to training people to reporting and asked who is in charge? Mr. Moran said in the last couple of years the statute changed to require training every four years for mandatory reporters in Maine. There is not specific language in the law that he is aware of that says what that training ought to include or in what form it ought to be provided or obtained. DHHS has online training and he said there is value to that, but he does not know if that statutory requirement on training is widely known about. There is no reference to consequence if a social worker doesn't get the training or a question on the license renewal form for the Social Worker Licensing Board that says did you complete your mandated reporting training. Not all mandatory reporters are licensed by the State so there are difficulties there. Dr. Ricci mentioned the Bangor Police Department has recently requested training, and Mr. Moran has been providing training to their officers. Many of Bangor's police officers are young, they don't have children of their own yet so they do not know what they are looking for when they get a call for a welfare check. They see the toddler running and should know what they should be looking for, what kind of marks or injuries should alert the officer that something is wrong or should be reported or further investigated.

Sen. Katz said it was disturbing to hear Mr. Moran say and to read that OCFS staff have been directed not to speak about the OPEGA report or the ongoing review process. As we work collaboratively with the Administration on this matter hopefully that is going to change because, as everybody has pointed

out, these are the folks who know most about what is going on. He asked if Mr. Moran could forward to OPEGA the three studies he referred to regarding the difficulties of trying to define a standard when somebody is reasonably at risk and that impacts our decision on whether to criminalize failure to report.

Christine Alberi, Maine Child Welfare Services Ombudsman. (A copy of her testimony is posted to the GOC/OPEGA website at http://legislature.maine.gov/uploads/originals/public-comments-on-ptdz-report-as-of-9-26-17-1.pdf)

Rep. DeChant asked how the Ombudsman's position co-exists with DHHS because if Ms. Alberi is opening cases, where is the communication and connectivity with DHHS. Ms. Alberi said when she opens a case for review the primary communication is with the program administrator of a District Office. They are her direct point of contact in the cases. Rep. DeChant asked if Ms. Alberi is operating as a consultant, a supervisor, caseworker or fact finder, etc. Ms. Alberi said she has no enforcement authority over DHHS. The Department's cooperation with the Ombudsman is entirely voluntary. An Ombudsman by definition is someone who investigates the government, so essentially that is what she is doing. A fact finder is a good word for it, but just in individual cases, and a consultant because the Department will sometimes ask what they should do in a situation. The first and foremost is to improve what is happening in a particular case and then also to improve policies and procedures. Primarily the goal is to keep the children safe and everything they do, the findings and recommendations made in a case, have to do with that.

Rep. DeChant asked if Ms. Alberi's is talking to the kids, parents, or working with the case manager. Ms. Alberi said the Ombudsman's reviews are based entirely on records.

Rep. Pierce asked what should happen when the caseworker is refused entry to a home. DHHS employees have no authority to enter a home unless they are allowed or permitted in. Ms. Alberi said it is very difficult and thinks one practice issue if a family refuses to cooperate that she has seen is, for example, to get a medical evaluation, the Department can go to court and ask the child to be evaluated at the Spurwink Clinic and the court can order that. She said Rep. Pierce is right, the parents can refuse and when she gets calls from parents asking if they have to let the caseworker in, the answer is no, but if you don't it is probably not the best idea. In Maine, caseworkers do not have a right to just enter a home and there are a host of constitutional issues that go with that. Generally speaking parents are cooperative and she thinks it would be interesting to know how many times that actually occurred when a caseworker is not allowed to enter. What comes up more often is, and with a change in law could improve, is where a family will move out of a district and the caseworkers cannot find the family. They will close the case without doing the activities to locate that family like the Department is supposed to do in order to find the family that fled.

Rep. Pierce said what if it is a Friday afternoon and it takes until the following week to get the paperwork from the Court, a lot can go on within that time. He was asking people to think how this piece of the policy could be strengthened.

Rep. Sutton asked if the Ombudsman offered any training programs for child protection or on mandatory reporting. Ms. Alberi said the Ombudsman Office does not offer training and said the Office is a nonprofit office and she is the one full-time employee. They have an Associate Ombudsman who helps her review cases, but no other staff. Ms. Alberi does refer people to other resources when she cannot help them.

Rep. Mastraccio's understanding is that the Ombudsman reviews cases that already have come before DHHS and is not the person receiving the calls. For example, a parent would call Ms. Alberi if they do not like the results of what DHHS did so the Ombudsman is coming in after the fact and reviewing those records to see if what happened was appropriate, inappropriate or open the case for review. Ms. Alberi said Rep. Mastraccio was essentially right except she makes the decision of whether or not to

open a case based on the complaint phone call she gets. Only then does she have the ability to look at the records.

Rep. Mastraccio asked if the Ombudsman's Office has fulfilled what the people had created it for in statute or has it always been one person. Ms. Alberi said the Ombudsman Office has not always been one person. She took the position in 2013 and said before 2012 the Ombudsman was housed in the Maine Children's Alliance which is a child advocacy and lobbying organization. She can tell by looking at their data base that there used to be a lot more people who were working on these cases so they had the ability to have different staff review cases, field phone calls and do other work as well. She could not say how many resources were devoted to each part of the work. In 2012, the Ombudsman left the Maine Children's Alliance and there was a reduction in their budget. It essentially became one person at that point with a part-time Associate who works about one week a month. Her view is that the Ombudsman has worked well over the years. She thinks there are many things over the last several years that have increased the strain on child welfare services and she did not know why assessments and investigations have been more difficult, but it has been. Things have not changed for the better based on her recommendations in recent years.

Rep. DeChant asked if Ms. Alberi's recommendations and assessments or observations in her Annual Report that goes to the legislative committee of jurisdiction, have any action taken on them by the Legislature. Ms. Alberi said she cannot speak to what the Legislature has done with the report, but DHHS has not disagreed with her. They acknowledged their issues on many occasions and had made commitments to, for example, implement structured decision-making in assessments, increase training, and have new policies on safety planning.

Rep. DeChant asked if these tragedies had not happened and the investigation brought before the GOC, what would have happened to Ms. Alberi's recommendations in her Annual Report. Ms. Alberi said she did not know the answer to that question. Historically DHHS has been good about following her recommendations, but she does not know what would have happened.

Rep. DeChant noted that the Ombudsman also has access to all the information in MACWIS and asked if she found MACWIS to be a problem. Ms. Alberi said MACWIS is not user friendly and can be frustrating to work in. She thinks that caseworkers have a lot of documentation that they have to do that is time consuming, but important to be documented, and having the system be easier to use for caseworkers would be a huge improvement. Changing MACWIS is not going to have an appreciable effect on a caseworker's or supervisor's workload or their ability to recognize risk. There are many amazing caseworkers in the Department, and for immediate changes, she thinks training for people to recognize risk and investigation into the caseloads are the most important things.

Sen. Libby referred to Ms. Alberi's testimony on the supervision of staff and asked for her observations of worker caseload, frontline caseworker caseload in terms of numbers. Are the number of current vacancies normal or abnormal? Ms. Alberi could not comment on caseload because that is not something she has researched or has access to any information on. She is not sure about the last year, but historically, there has been about a third of caseworkers turning over every year in Maine. If that is what is happening, that is what has been happening for a long time. It is a consistent problem and is why she can't emphasize enough how important the supervisors are and that they have the time they need. It is a complicated issue because the number of cases that a caseworker in Portland has can have a different impact then the number of cases for a caseworker that has to drive a long distance in rural Maine to get to all their cases.

Sen. Katz followed up on Sen. Libby's question and noted there were vacancies in all departments of Maine Government because sometimes they cannot find the people to fill the position and sometimes it is because they are not trying to fill them. He asked if Ms. Alberi had any sense to what the case is here. She thinks sometimes it is hard to fill those vacancies, it is a difficult job to do and there are people who apply for the job and in the interview process are not right for the job. She suspects it is different in

Portland than it is in Aroostook County or Skowhegan where there might not be as dense a population to draw from for caseworkers. She does not know what has been done lately in terms of recruitment efforts.

Sen. Katz said for the work session and to the extent that the people from DHHS are listening in on the meeting, the GOC is going to want to talk with them about the staffing issues and, in particular, what are the reasons for the vacancies.

Sen. Gratwick referred to an earlier statement of "the OCF staff has been directed not to speak about the OPEGA report on the ongoing review process" and is probably in response to the ongoing legal aspects of the cases. He asked Ms. Alberi if she found the OCF staff to be forthcoming in all instances when she needed data. Ms. Alberi said she can get into MACWIS herself, but said she has not had any resistance in her regular case reviews from any of the Districts in getting data and they are usually very willing to provide her with information. She has not asked the District Office any questions about these reports, but in terms of her regular work, it has never been an issue.

Sen. Diamond said it seems Ms. Alberi thinks the system is not protecting kids the way it should. She agreed. And kids are being abused and as a system, as a State, or Department, they are not being taken care of and it is getting worse. Ms. Alberi agreed. He asked if she also agreed that there are things that can be done sooner, rather than later, to address some of the issues. Ms. Alberi agreed and said the Department has made some changes in response to the two cases being talked about and those changes are excellent for the most part. For example, that now if there are three inappropriate reports called in, that case will automatically be opened for an assessment. On the whole she thinks that is a wise decision and actually used to be the policy years back. Her concern is that now the assessment workers are going to, by definition, have more cases to open and how are they going to do those assessments. If there is any way the caseworkers can get more help as soon as possible she thinks that would be helpful and is her immediate concern. Sen. Diamond thinks change can be done if you can get everybody together and the money needed to do it.

James Breslin, Winslow, Maine. (A copy of his testimony is posted to the GOC/OPEGA website at http://legislature.maine.gov/uploads/originals/public-comments-on-ptdz-report-as-of-9-26-17-1.pdf)

Mr. Breslin's testimony was read by Sue Wood because he had to leave the meeting.

Mr. Breslin is a retired LCSW and Child Advocate for DHHS, Division of Mental Health. His testimony is in regard to his helping Sue Wood maintain custody of her children because of the most egregious case of misplaced attention by Child Protection he had ever encountered.

Sue Wood. (A copy of her testimony is posted to the GOC/OPEGA website at http://legislature.maine.gov/uploads/originals/public-comments-on-ptdz-report-as-of-9-26-17-1.pdf)

Ms. Wood's testimony is regarding her own experiences with DHHS and CPS.

Sandra Hodge, Brunswick Maine. (A copy of her testimony is posted to the GOC/OPEGA website at http://legislature.maine.gov/uploads/originals/public-comments-on-ptdz-report-as-of-9-26-17-1.pdf)

Sen. Libby asked for examples of what the risk factors for child abuse and neglect are. Ms. Hodge said risk factors include a very young child, a child who is identified as being difficult to care for, parents who have experienced child abuse or neglect in their background, and there is some evidence of domestic violence, but that research is not as strong. There are mobility issues, parents who move around. In a lot of the child death cases you might find a recent change in living arrangements, a lack of knowledge of child development, often an acute lack of empathy for others, including their own children, and lack of problem solving skills.

Rep. Sutton said the GOC has heard a lot today about burnout and difficulty in keeping folks on the job in these difficult positions. She asked to what accounts for Ms. Hodge's longevity in the profession and how might the State get more of it. Ms. Hodge said it is a very difficult job and having held jobs in the field at various levels, there was nothing as stressful as being the child protective caseworker and going into the field, confronting clients, then having to go to court and doing all the documentation. You have the responsibility of protecting all of the children in your community and you care a lot. What you have to do and what you are benefitted by most is having a good, supportive, knowledgeable supervisor and the resources needed to do your job. On a personal level you must have ways that you get rejuvenated and ways to take care of yourself and your family.

Sen. Gratwick asked Ms. Hodge if Maine's system has improved at all over the years. Ms. Hodge said she does not have inside knowledge so did not know. She said new information comes along and new programs are tested and brought on board. For her, the crux is to use the most researched, evidence based information to inform what the Department does in their job in protecting children. That is going to change over time as new information and knowledge becomes available. There is always room for improvement and to take a good hard look against what we know and against what we don't know and use that information because the information will change over time.

Lucie Stewart. (Ms. Stewart provided the GOC with miscellaneous information. A copy of the information is on file in OPEGA.)

Ms. Stewart testified about her experiences with DHHS.

Peggy Rice. (A copy of her testimony is posted to the GOC/OPEGA website at http://legislature.maine.gov/uploads/originals/public-comments-on-ptdz-report-as-of-9-26-17-1.pdf)

In addition to Ms. Rice's written testimony she offered personal testimony regarding her sixteen years of being on the frontline in CPS.

Ms. Rice said one piece that has not been talked about at the meeting, but adds to DHHS' turnover rate because it did for her, is that her family had gotten threatened. The local sheriff's office started patrolling her daughter's school and her husband bought a gun to protect the family. Child protective workers are constantly under pressure and the stress is both professional and personal.

Ms. Rice thought smaller caseloads would help and perhaps sending two caseworkers out together, especially on the initial visit or involving the police more in terms of going out with the worker.

Sen. Gratwick referred to the statement of "a workforce fractured between public workers and private contractors, can make it difficult" and asked if she could give him a perspective of how that could be better handled. Ms. Rice said she would like to get back to him with a written response or have the MSEA get back to him. He was curious of which was serving the larger cause better.

Secondly, it was said that the voices of her group have not been heard by management in the decision-making process and asked how the workers can make their voices heard. Ms. Rice was hoping the Committee would listen to the workers, although she said in their defense, she thinks some are concerned about speaking up too much if they are currently employed with DHHS. She has not talked with any of the staff who said they are concerned about that, but it would not surprise her because it would not have surprised her back when she was in the field. Sen. Gratwick asked if that related to a particular individual or a culture. Ms. Rice thought it was a culture in State government. State workers, in general, are nervous in saying anything negative about the department they work for, especially with legislators.

Ruth Lyons, PhD, Education Psychologist, but testifying as a foster parent.

Ms. Lyons answered the GOC's questions regarding her experiences with CPS as a foster parent.

Claire Berkowitz, Executive Director of the Maine Children's Alliance. (A copy of her testimony is posted to the GOC/OPEGA website at http://legislature.maine.gov/uploads/originals/public-comments-on-ptdz-report-as-of-9-26-17-1.pdf)

Rep. Mastraccio asked if Ms. Berkowitz could describe the Ombudsman program when it was part of the Maine Children's Alliance (MCA). Ms. Berkowitz said when MCA had the Ombudsman program she was the Kids Count Director so she was involved in producing the reports of data. MCA had an Ombudsman, Assistant Ombudsman and support staff who took calls so there were more personnel on the job. She thinks because of the MCA organization they were able to highlight the issues a little more when the Ombudsman presented the Annual Report to the Legislature in January. A press release was put out.

Carol Ford, Cumberland, Maine. (She did not provide a copy of her testimony.)

Ms. Ford testified on her experiences as a former Court Appointed Special Advocate (CASA) and adoptive parent of a child who was formerly in Maine foster care.

Heather Kilgore (She did not provide a copy of her testimony.)

Ms. Kilgore's testimony was in regard to her experiences as a parent with children in DHHS custody.

The GOC members thanked all those who presented testimony and for answering questions.

Rep. Mastraccio closed the public comment period on OPEGA's Information Brief on Child Protection System.

- **Committee Work Session**

Director Ashcroft said the GOC planned to have a work session on OPEGA's Information Brief at the June 28, 2018 GOC meeting.

Sen. Gratwick requested that the GOC receive some of the larger economic figures including DHHS's budgets, etc. Director Ashcroft said notes were taken at the last meeting of information the GOC members wanted to receive, but she did not have the opportunity to get it all together for this meeting. She thinks DHHS is pulling some of the statistics together and she will coordinate with them. Rep. Mastraccio asked that if any Committee member had specific requests for information they email them to Director Ashcroft or Etta prior to the meeting.

Rep. Sutton said the allocations and appropriations are two different mechanisms so when looking at the budget to see what kind of funding has been provided to DHHS over a period of time, she asked that a distinction between the two be made. Director Ashcroft confirmed OPEGA was not reviewing all of DHHS's budget, but just the budget of the Office Child and Family Services and, in particular, the child protective functions. Committee members agreed.

- **Committee Vote**

The GOC did not vote on OPEGA's Information Brief at this meeting.

UNFINISHED BUSINESS

None.

ANNOUNCEMENTS AND REMARKS

None.

NEXT GOC MEETING DATE

The next Government Oversight Committee meeting is scheduled for June 14, 2018 at 9:00 a.m.

ADJOURNMENT

The Chair, Rep. Mastraccio, adjourned the Government Oversight Committee meeting at 2:23 p.m. on the motion of Sen. Gratwick, second by Sen. Diamond, unanimous.