OPEGA Report

Our Approach

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

Separate Reports for Each Case

Resolution of any related criminal proceedings, through the sentencing stage, has also then permitted the DHHS Commissioner to release the kind of public account found at Appendix A of this report. Both of these milestones have now been reached concerning Hailey Goding. Hailey Goding's mother, Hillary Goding, has pleaded guilty to manslaughter in connection with Hailey Goding's death, and is expected to serve a prison sentence of 19 years, followed by a period of probation. Releasing an OPEGA report after these steps have occurred allows for a more detailed report.

Acknowledgments

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

February 2023
RR-CFRHG-22

OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Hailey Goding

Summary

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

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

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

We did not endeavor to determine—nor could we—that but for different or additional OCFS intervention, Hailey Goding would have certainly lived and otherwise remained safe. We examined the documented history of safety decisions concerning Hailey Goding to reach conclusions as to whether those decisions were sound in light of prevailing child protection policy and practice, the laws governing such matters, and the information known (or that should have reasonably been known) to authorities when the decisions were made. To the extent that it may be helpful in understanding how certain safety decisions were made or why certain actions were taken in response to various events and information, we have included descriptions of the conditions occurring at these points in the case (to the extent that the

information is publicly available via the Department's summary memo or court proceedings), as well as the legal and policy frameworks through which the Department must process that information.

Overall, OPEGA did not conclude that any OCFS safety decisions regarding Hailey Goding were unsound within the framework of the records we reviewed, interviews we conducted, agency policy and practice, and legal authority. We explain our conclusions in the following pages of this report to the extent permitted by the laws governing the confidentiality of these records. We also note two potential opportunities for improvement on Page 5.

In completing this work, OPEGA created our own timeline from the files received from the Department. After the criminal proceedings were complete, the Department released its November 18, 2022 Memorandum (Appendix A). OPEGA compared our timeline with the memo, and in all material aspects the Department's memo was consistent with what we found.

Child Welfare Philosophy and Law

Child welfare decisions made by OCFS are governed by federal and state law, guided by Department policy and rules, and resulting actions are often subject to judicial review and approval. Together, this framework largely emphasizes the rights of parents and family preservation, with exceptions for cases when there is evidence that a child is in serious risk of harm.

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

In making such determinations, OCFS must identify whether or not a child has been harmed and the degree of harm or threatened harm by a person responsible for the care of that child. If, after investigation, OCFS determines that a child is in immediate risk of serious harm or in jeopardy, OCFS must file a petition in court or, if a petition is not filed, assign a caseworker to provide services to the family to alleviate child abuse and neglect in the home. Two types of petitions are frequently used:

- A jeopardy petition, which is filed in *any* case where court intervention is necessary to alleviate the jeopardy associated with abuse or serious neglect such as deprivation of adequate food, clothing, shelter or necessary health care or abandonment.

- A preliminary protection order (PPO), which can be filed along with the jeopardy petition, when a child's *immediate* removal from a parent's custody is requested. This action requires a preponderance of evidence that there is an *immediate* risk of serious harm to the child. Examples of serious harm include serious physical harm, failure to protect a child from serious harm by others, domestic violence that is likely to cause emotional harm to the child, and inability to supervise, care for, or protect a child due to substance abuse or impaired mental health.

Caseworkers cannot remove a child from their parents without an order from the court; and the Department must also show they have provided specific, reasonable efforts to prevent the need to remove the child from the home or to resolve jeopardy prior to any action for child removal, unless there is an aggravating factor defined by statute.

If a child is removed from their parents' custody, rehabilitation and reunification efforts for parents must continue unless there is an aggravating factor or the court relieves the Department of this requirement. Aggravating factors include rape, gross sexual assault, sexual abuse, or previous conviction for assault or murder of a child in their own household. The Department may also be relieved of its obligation to provide reunification services to the family if the court finds that reunification is inconsistent with the child's permanency plan.

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

Exploring Why Certain Safety Decisions or Actions Were or Were Not Taken

Throughout the course of this case, there are two primary instances in which a reasonable observer may have questions about the decisions made and actions taken in response to various conditions, concerns, and suspicions. To the extent made possible by the Department's summary memo of involvement and details emerging from the court proceeding, we describe these incidents—as well as the legal and policy frameworks that the Department must view them through—to help readers better understand the context in which those decisions were made.

A lack of evidence ultimately limits OCFS actions in the wake of a May 2020 fentanyl ingestion by Hailey.

In May 2020, OCFS received a report from a medical provider that Ms. Goding had brought Hailey to the emergency department following what Ms. Goding believed to be a potential substance ingestion. According to Ms. Goding, Hailey had picked up a piece of tinfoil at a playground and put it in her mouth. Ms. Goding reported removing the tinfoil from Hailey's mouth, and, seeing what she suspected to be a substance on the tinfoil, immediately brought Hailey to the local emergency department, where she reported that Hailey had been falling asleep or unconscious while at the playground.
The emergency department could only test for seven substances; fentanyl was not one of these substances. Hailey's urine tested positive for cocaine. The mother, as reported to CPS Central Intake, appeared appropriate and not under the influence of any substances. Hailey was sitting up and awake at the emergency department and transferred to a second hospital for overnight observation. This report was screened in for investigation and a caseworker reported to the hospital in the morning to meet with and observe Ms. Goding and Hailey.

As the caseworker reviewed Ms. Goding's prior CPS history as part of a background check, the caseworker considered an alternative hypothesis that could account for the allegations: that the tinfoil story was false and that Ms. Goding could have been using substances, which prevented her from adequately supervising Hailey who got into the substances used by Ms. Goding.

This hypothesis was explored when the second hospital was asked by OCFS to drug screen both Hailey and Ms. Goding, which Ms. Goding agreed to. Both Hailey's and Ms. Goding's drug screens tested positive for fentanyl; Ms. Goding denied substance use and posited that her testing positive was the result of touching the tinfoil when removing it from Hailey's mouth.

While a reasonable person may question OCFS's actions in the wake of this first substance exposure, there were a variety of factors that led the child protective services investigation worker, supervisor, and program administrator (PA) to determine that they lacked sufficient evidence to establish a safety threat, make a finding, and to seek a court-ordered removal of Hailey from her mother's care.

One such factor in OCFS decision-making was the existence of a seemingly reliable eyewitness—an employee of a local school district, and, thus, a mandated reporter—who completely corroborated Ms. Goding's account of what occurred at the playground. Another factor was OCFS's inability to definitively rule out Ms. Goding's assertion that her positive test result was due to her own contact with the tinfoil. OPEGA has determined that at that time, there were well-established fears and beliefs within child protective services and other first responder communities of fentanyl exposure through only incidental skin contact, and Ms. Goding's assertion was accepted as possible. We note that these beliefs still exist and we cannot conclusively say whether or not Ms. Goding's assertion is scientifically possible given a range of variables (how the exposure occurred, whether mucous membranes were touched, the form and potency of the substance, and the testing methodology). An additional factor in decision-making was Ms. Goding's sober appearance at the hospital, her demonstrated protective capacity in taking Hailey to the hospital, and her willingness to participate in drug screens (which were negative for all substances in the days following Hailey's admission to the hospital) and services recommended by OCFS.

Ultimately, both the record and interviews with those directly involved in this case reflect that although the caseworker, supervisor, and PA all had their suspicions and concerns about Ms. Goding and her account of what occurred at the playground, they all felt that they did not have sufficient evidence to prove that Ms. Goding was actively using substances, that the fentanyl Hailey ingested was in fact Ms. Goding's, and that Ms. Goding had neglected to provide appropriate supervision to Hailey (thus allowing her to ingest the fentanyl). Without this evidence, OCFS was unable to establish a safety threat to file for a protection order removing Hailey from her mother's custody or to even make a finding of abuse and/or neglect.

At even the earliest moments in this particular investigation, OCFS was without clear evidence of an established safety threat. Lacking that threat, OCFS triaged the situation and endeavored to enter into a safety plan with Ms. Goding to manage child welfare concerns and a lack of evidence. With these goals in mind, OCFS worked with the mother and another caregiver in the household to develop a safety plan to ensure and monitor Ms. Goding's participation in services and drug screens, and to establish their expectations for Ms. Goding to maintain custody of Hailey. The plan included that Ms. Goding and Hailey would remain in the household with the second caregiver; Ms. Goding would participate in random, observed drug screens; Ms. Goding would not possess or use substances of any kind or expose Hailey to people who use illicit substances; and that Ms. Goding would participate in mental health and substance abuse counseling.

Within three days of the incident, OCFS made a referral for counseling services. Within the next month, Ms. Goding attended three counseling sessions for assessment and was referred to trauma therapy. She was assigned a case manager and received a referral for the therapy. The OCFS investigation closed in July with no findings of abuse or neglect, and the family was transferred to an Alternative Response Program (ARP) to continue services. In August, ARP noted that Ms. Goding continued to seek counseling but had not heard back from any service providers. She was actively working with her case manager to apply for housing and other benefits. A scheduled ARP meeting in September did not occur because the case manager was ill. In October, ARP learned that there had still been no response from the therapy referral, and Ms. Goding and the case manager were looking into other therapy options. The ARP service case was closed.

Activities to locate Ms. Goding were thorough and exhausted the Department's options prior to closing the January 2021 investigation.

During the January 2021 investigation of an anonymous report that Ms. Goding had threatened a family member with a gun, the caseworker:

- Performed background checks on Ms. Goding and the other adult household member.
- Interviewed the alleged victim of the threat, who denied that the incident happened.
- Spoke with Ms. Goding on the phone one time. She refused to meet, to answer questions, or to cooperate with the investigation despite subsequent attempts to reach her by telephone.
- Checked with two law enforcements agencies for recent involvements with Ms. Goding and two friends she was believed to be with.
- Called eight hotels to check for guest registered as Ms. Goding or either of her friends.
- Called two other friends of Ms. Goding, who reported that they did not know where she was and had not been in touch with her recently.
- Checked with Hailey's health care provider regarding preventative care history and any recent visits.
- Called another relative to inquire about Ms. Goding's whereabouts and explore any concerns about Hailey.

OCFS was unable to locate Ms. Goding or Hailey, and, thus, could not assess Hailey's safety at that time in her mother's care. Based on the limited information that the caseworker was able to learn during the investigation—primarily, that the alleged victim/family member denied the incident with the firearm—the Department did not feel that there was sufficient grounds or evidence to make findings against Ms. Goding.

Similarly, OCFS did not believe that there was sufficient grounds or evidence to pursue court intervention to compel Ms. Goding's engagement with child protective services—although the practicality and effectiveness of any such court action is very limited when the Department cannot locate the family.

As a result, and, in accordance with OCFS policy, this investigation was closed. There is no record of further contact with the Department until the events of June 2021 leading to Hailey's death that are described in the Department's public account reprinted in Appendix A.

OPEGA's Overall Conclusion on OCFS Safety Decisions for Hailey Goding

OPEGA did not conclude that any OCFS safety decisions regarding Hailey Goding were unsound within the framework of the records we reviewed, interviews we conducted, agency policy and practice, and legal authority.

Potential Opportunities for Improvement

OPEGA identified two potential opportunities for improvement in the child protection system during our review of this case. The potential areas OPEGA identified, in no particular order of priority, include:

1. Establish a Central Resource for Substance-related Questions

   During our review, we noted a lack of clarity regarding the resources, if any, child protective services workers might consult in an effort to validate or refute the likelihood that exposure to fentanyl in the manners asserted by Ms. Goding in May 2020 on behalf of herself and Hailey were scientifically possible. While poison control and individual caseworker contacts within the law enforcement and treatment communities were described to us as potential resources, we remain unsure whether these sources would be able to provide the specific information needed in this case. At the same time, and in light of the other steps child protective services undertook at the time, we do not intend to suggest that the failure to identify and consult a substance exposure expert resulted in an unsound safety decision.

However, we do believe that establishing such a resource would be beneficial to caseworkers in the future as they encounter various drug-related scenarios and may have questions about certain exposures, interactions, and presentations that may ultimately impact safety decisions.

2. Improve Service Availability and Enhance OCFS's Ability to Ensure Recommended Services Are Provided

   In the wake of Hailey's May 2020 substance ingestion, the Department worked to improve Hailey's safety in the custody of her mother by making a series of initial referrals for mental health and substance use treatment and drug screens for Ms. Goding. Later, additional referrals were made for trauma counseling and case management services.

   Despite the efforts of the Department, ARP, a case manager, and even Ms. Goding herself, who had demonstrated a willingness to participate in such services, we observed that trauma counseling services were never established nor provided. While we do not intend to suggest that had these services been provided, Hailey would have surely remained safe in the home, we do recognize that part of OCFS's larger charge is the preservation and rehabilitation of families—the success of which may depend heavily on a family's participation in services to improve family functioning and mitigate risks to children.

   Mental health, trauma, and substance abuse treatment counseling; parenting and daily living skills classes; and batterer's intervention programs all appear to be commonly recommended services. However, from our work on this case and other child protective services reviews, we understand that there is a pronounced lack of available services that may vary based on the geographic location or the specific type of service sought.

   Relatedly, as Departmental (and, at the time of this case, ARP) involvement with a family stemming from a single report is not designed to be never-ending, many cases may close without families receiving recommended services for which they were referred. To the extent that these services may improve family functioning and reduce future risk to children, increasing the availability of needed services and developing a means for the Department to ensure that families follow through with recommended services presents a potential opportunity for improvement in the broader child protective system.

Appendix A. DHHS Memorandum

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services Commissioner's
Office 11 State House Station 109 Capitol Street
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-3005 TTY: Dial 711 (Maine Relay)

MEMORANDUM

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

SUBJECT: Hailey Goding

DATE: November 18, 2022

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

Child's Name: Hailey Goding

Child's Age at Time of Death: 3 years

Child's Caregiver(s) at time of death: Mother, Hillary Goding

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

- January 2018 – The Department received a report from a health care provider when Hailey Goding was born on January 29, 2018. Her mother, Hillary Goding, tested positive for marijuana and oxycodone when she was admitted for Hailey's birth. Ms. Goding reported she had used one Percocet from an old prescription but denied any other use. Ms. Goding was residing with her mother and stepfather at the time and reported that she did not know who Hailey's father was. This report was referred to the CradleMe Program which provides support to birthing families. Ms. Goding accepted Public Health Nursing Services.

- September 2018 – The Department received a report regarding Ms. Goding babysitting a 5-year- old whom she left alone on the beach while she went to the parking lot to change Hailey. Ms. Goding reported the car was parked 6 feet away from the 5-year-old child. During the investigation, Ms. Goding reported that when she was 15 years old, she used Percocet and that she had gone to rehab and not used illicit drugs ever since. This investigation was unsubstantiated.

  January 2020 – The Department received a report that an anonymous tip had been made to the Maine Drug Enforcement Agency (MDEA) that Ms. Goding was using drugs in her car with

Hailey in the back seat. Law enforcement followed up on the tip and found no grounds for additional investigation. This report was screened out.

- May 2020 – The Department received a report regarding Hailey Goding from a medical provider that Ms. Goding brought Hailey to the emergency department stating Hailey had put a piece of aluminum foil she found on the playground in her mouth. The Department assigned the report for investigation.
  - Hailey's drug screen was positive for cocaine in the emergency department and later a more comprehensive drug screen found both Hailey and Ms. Goding were positive for fentanyl.
  - Another individual corroborated Ms. Goding's story of the tinfoil being found at the playground. The police could not locate the tinfoil. A relative reported the following:
    - There was a tin can downstairs in the home where Ms. Goding put her extinguished cigarettes that had white pieces of tin foil in it. Ms. Goding's relative had taken a picture of the tin can but thrown the can itself away.
    - Ms. Goding had been to rehab two times and right now she "looks horrible."
    - Ms. Goding was being vague, avoiding questions, and was very secretive.
    - Ms. Goding had stolen checks from the checkbook of a family member as recently as February.
    - Ms. Goding told a family member within the previous week that she was detoxing and using Suboxone to help.
  - The Department worked with Ms. Goding to develop a short-term safety plan to ensure Hailey's safety while the Department completed its investigation.
  - The Department made referrals for mental health and substance use treatment and drug screens for Ms. Goding,
  - Ms. Goding engaged in treatment and completed three drug screens which were negative for all substances. Ms. Goding's provider reported she was making positive progress in her treatment.
  - The Department made additional referrals for trauma counseling and case management for Ms. Goding.
  - At the completion of the investigation in June of 2020, the Department made no findings of abuse or neglect against Ms. Goding. The Department opened a month-long "service case," in which the Department supported services to Ms. Goding to improve Hailey's safety without taking custody.
  - The Department referred the family to the Alternative Response Program (ARP) for ongoing monitoring. ARP closed the case with the family in October 2020 with ARP noting that Ms. Goding had engaged in services, applied for public benefits, and was continuing to ensure Hailey's basic needs were met. Hailey was reported to have gained weight after being below normal weight since birth.
  - On the date that the ARP involvement ended, the Department received a new report regarding an incident in which Hailey had stuck a pea up her nose and Ms. Goding waited a few days until a scheduled appointment to address this issue. This report did not contain allegations of child abuse or neglect and was not assigned for investigation.

- January 2021 – The Department received an anonymous referral alleging that, in November of 2020, Ms. Goding had threatened her mother with a firearm while Hailey was present in the home. The report alleged that Ms. Goding was using substances and had mental health issues and that Hailey was significantly underweight. The Department assigned the report for investigation. o The Department spoke with Ms. Goding's mother, who denied that the incident with the firearm occurred.
  - The caseworker made several attempts to meet with Ms. Goding. The caseworker made phone contact with Ms. Goding once and she refused to meet with the caseworker and would not provide information regarding where she was staying. Ms. Goding did not respond to further attempts by the Department to contact her.

  - The Department contacted family members who reported that Ms. Goding was staying in a hotel room somewhere in the Bangor area.
  - The caseworker contacted eight hotels in the Bangor area looking for guests registered under Ms. Goding's name and the name of two friends she was believed to be staying with, without success.
  - The caseworker contacted friends of Ms. Goding who reported they had not recently had contact with her.
  - The caseworker reached out to law enforcement who had no record of the alleged incident with the firearm, nor any recent involvement with Ms. Goding. Law enforcement indicated they had information that Ms. Goding had sometimes spent time with individuals using substances.
  - The Department contacted Hailey's Primary Care Provider (PCP). The PCP reported Hailey was last seen in August of 2020 for her annual well child checkup (WCC) and was scheduled for her next WCC in August of 2021. At the time the PCP was contacted, Hailey was not due for any other appointments, and she was up to date on all immunizations. The PCP indicated they were monitoring Hailey's growth.
  - Based on the information the Department was able to gather, there were insufficient grounds to make findings against Ms. Goding regarding Hailey's safety and well-being and pursue court intervention to compel Ms. Goding's engagement with the Department.

- June 2021 – The Department received a report on June 5, 2021, from a Detective with the Old Town Police Department who reported that Ms. Goding had called 911 at 10:48pm on June 4, 2022, due to Hailey being unresponsive. When the police arrived, Hailey had no pulse. CPR was performed for 15-20 minutes, and Hailey regained a pulse. Law enforcement noted that Ms. Goding appeared to be impaired and nodding in and out. She reported that Hailey had been lethargic, sneezing, and coughing the day prior. A subsequent call to the Department from a nurse at Northern Light Healthcare (NLH) confirmed that the child's toxicology screen was positive for fentanyl. Hailey's medical condition was such that doctors did not believe that Hailey had been unconscious for only 25 minutes, as Ms. Goding had stated. Upon further questioning by medical staff, Ms. Goding stated that Hailey had accessed her drugs in the bathroom and immediately started acting strangely. Ms. Goding claimed that Hailey accessed a straw that Ms. Goding had used to ingest drugs. Medical staff informed the caseworker that Hailey was brain dead due to extended oxygen deprivation. Hailey was pronounced dead at 10:04 a.m. on June 6, 2021.

The caseworker worked with law enforcement to conduct interviews and gather information. Ms. Goding reported that she did not call 911 immediately due to fear of the repercussions, including child welfare involvement.

The Department substantiated allegations against Ms. Goding for neglect, which resulted in Hailey's death. The findings were based on Hailey's ability to access drugs and Ms. Goding's failure to immediately seek medical care for Hailey.

Appendix B. OPEGA's Methodology

To complete this evaluation of the Goding case, OPEGA staff collected and analyzed information from multiple sources. We reviewed the OCFS case files, related OCFS memos, a draft report from the Maine Child Welfare Ombudsman, consulted with the Maine Attorney General's Office regarding the criminal case proceedings, created a timeline of case events, interviewed OCFS staff and others involved in the case, and applied Maine statute, agency rules and policies to the actions taken by OCFS.

The OCFS Goding case files included CPS investigative files and reports, medical records, and drug screening results records. OPEGA also listened to approximately 90 minutes of recorded interviews between CPS and participants in the investigations, which were also included in the files. In addition, OPEGA conducted interviews with multiple CPS staff involved in the case.

OPEGA staff reviewed a June 14, 2021 internal Briefing Memo from the CPS Regional Associate Director to the CPS Associate Director of Child Welfare Service regarding the death, and the November 18, 2022 Memorandum publicly released by DHHS Commissioner Jeanne M. Lambrew after the criminal case and sentencing was complete. OPEGA staff also reviewed a draft report from the Maine Child Welfare Ombudsman of the Goding case, based on an Ombudsman review of the case as requested by a Legislator.

For our earlier report on CPS Investigations, OPEGA examined relevant state statutes, agency rules, and OCFS policies in order to develop an overview of the framework under which OCFS delivers child protective services. In particular, OPEGA examined written OCFS policies governing the process for intake and investigations from the initial report of suspected child abuse or neglect to the determination of findings and the decision to close an investigation or open a services case.

From these reviews, OPEGA created a timeline of each significant event and decision-making point in the case. Once the review of the file and compilation of the timeline was complete, OPEGA staff discussed each significant decision-making point, and compared each to Maine statute, agency rules and CPS policy to determine if we understood and agreed with the decision made and whether we could identify any potential opportunities for improvement of the process.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services Child and Family Services 11 State House Station 2 Anthony Avenue
Augusta, Maine 04333-0011
Tel.: (207) 624-7900; Toll Free: (877) 680-5866 TTY: Dial 711 (Maine Relay); Fax: (207) 287-5282

January 25, 2023

Office of Program Evaluation and Government Accountability
82 State House Station
Room 104, Cross State Office Building
Augusta, ME 04333-082

Dear Director Schleck,

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

DHHS and OCFS appreciate the opportunity to respond to the section "Potential Opportunities for Improvement" in the report. The number of overdoses and prevalence of substance use, particularly opioids, has a significant impact on children and families. In response, OCFS is providing additional training for staff regarding the impact of substance use on families and strategies to address the concerns that substance use disorder often creates related to child safety and well-being. OCFS has developed and implemented the first of three planned mandatory child welfare staff trainings on these topics. OCFS plans to complete implementation of the remaining two trainings in 2023 in partnership with the Maine Drug Enforcement Agency and the Northern New England Poison Center. OCFS has also partnered with the Maine CDC to ensure lock boxes for safe storage of substances and other items that may be dangerous to children are available to staff in each District office for distribution to families.

OCFS agrees with OPEGA's recommendation to improve the resources available to staff for substance-use related questions. As such, OCFS is considering how best to establish resources in the District Offices to aid field staff in understanding and addressing both the nuances of substance use disorder and the treatment options available in different geographic regions of the state.

In cases of child fatalities due to child abuse or neglect, OCFS has specific procedures in place to review past history with the family and develop opportunities to improve practice, training, etc. In this case, part of that work included outreach to the Northern New England Poison Center regarding the likelihood that dermal exposure to fentanyl could result in testing positive on a drug screen. The Center informed OCFS that, in general, an individual would not test positive due to dermal exposure only. However, a positive test is possible

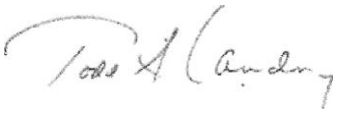
if the substance was transferred (for example, if an individual touched the substance and then put their fingers in their mouth). This information will be incorporated into future training for staff.

OCFS also agrees with OPEGA's recommendation regarding services. Service availability is a common challenge across multiple human services systems in both Maine and nationally, which is why the Department has advanced multiple funding initiatives to address the state's behavioral health needs in the Governor's proposed budget. These initiatives include $213 million to continue increased MaineCare reimbursement rates based on rate studies conducted in 2022 and payments to behavioral health providers for cost-of-living adjustments due to higher-than- expected inflation, as well as $17 million to expand the range of behavioral health services available to children and families, and $7 million dedicated to addressing substance use (in addition to Maine's $28 million in opioid litigation settlement funds). These funding initiatives build upon MaineCare's new rate system reform process developed and implemented in 2022.

Any fatality involving a child is a tragedy. OCFS has dedicated significant resources to learning from cases, like this one, where abuse or neglect by a parent is a primary cause of the child's death. These cases present an opportunity to look holistically at the child welfare system and identify areas for improvement, both within OCFS and the larger child welfare system in Maine. OCFS' ongoing efforts include policy and training improvements (part of the Cooperative Agreement with USM), implementation of the Safety Science approach to critical incident reviews which seeks to identify opportunities for system improvement while avoiding hindsight bias, and reviews by the Child Death and Serious Injury Review Panel (CDSIRP) and Domestic Violence Homicide Review Panel (where appropriate).

Regards,

Jeanne M. Lambrew, Ph.D.
Commissioner



Todd A. Landry, Ed.D.
Director, Office of Child and Family Services