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Senator, District 9

THE MAINE SENATE
132nd Legislature

3 State House Station
Augusta, Maine 04333

Testimony of Sen. Joe Baldacci presenting

LD 770, "An Act to Establish the Office of the Inspector General of Child Protection,"

Before the Joint Standing Committee on Health and Human Services

Good morning Senator Ingwersen, Representative Meyer, and esteemed members of the Joint Standing Committee on Health and Human Services. My name is Joe Baldacci, and I represent Senate District 9, which includes Bangor and Hermon. I am here today to present LD 770, "An Act to Establish the Office of the Inspector General of Child Protection."

The problems with the Maine Department of Health and Human Services are going to require far more than the cosmetic surgery being suggested by some. Repeated Annual Ombudsman Reports have shown systemic problems in the child protection work of our state. Numerous state and federal reports have found Maine ranks very poorly nationwide on a variety of measures looking at child abuse and neglect.

In fact, the U.S. Department of Justice sued the State over the lack of services for disabled children and yet despite promises, very little progress has occurred. In The U.S. Department of Health and Human Services, their Office of Inspector General has identified abysmal results in its 2024 Report. The following is an excerpt from that report:

"Despite having an assurance in the form of a signed certification that Maine has in effect and is enforcing a State law or has in effect and is operating a statewide program that includes procedures for the immediate screening, risk and safety assessment, and investigation of reports of child abuse and neglect, OCFS did not comply with requirements associated with this assurance. Specifically, OCFS complied with all the requirements for just 6 of the 100 screened-in family reports in our sample but did not comply with all the requirements for the remaining 94 reports.

OCFS officials provided many reasons for not complying, such as not understanding requirements, training and staffing issues, and transition to and limitations of Katahdin. Failure to comply with requirements places the children's health and safety at risk. On the basis of our sample results, we estimated that 10,138 of the 10,762 (94 percent) screened-in family reports were not in compliance with one or more requirements related to the immediate screening, risk and safety assessment, and investigation of child abuse and neglect."

Maine's promises in this area are worthless and hollow, and endanger the health and welfare of thousands of Maine children. An Inspector General at the State level is a clear and articulate message that systems, procedures, accountability, and transparency need to be substantially altered.

The bill specifically requires the following:

1. The OIG would have the authority to conduct investigations in cases involving child protective services and the juvenile justice system.

2. Investigations would be conducted when there is a breach of duty, especially, to a child under the State's care, or to a child involved in a child protection or juvenile justice investigation.

3. The OIG would be appointed to a set term not coterminous with a Governor's term to promote some level of independence.

To be clear, Maine children deserve better. Maine families demand accountability, transparency, and action. I am asking each of you to think about doing something substantial — not cosmetic — to change the culture, if you will, and to demand the greater care, attention, and improved practices that we need to protect Maine children and Maine families. I thank you all for your time and consideration.

Department of Health and Human Services

Office of Inspector General

Office of Audit Services

November 2024 | A-01-23-02500

Maine Did Not Comply With Screening, Assessment, and Investigation Requirements for Responding to Reports of Child Abuse and Neglect

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REPORT HIGHLIGHTS

November 2024 | A-01-23-02500

Maine Did Not Comply With Screening, Assessment, and Investigation Requirements for Responding to Reports of Child Abuse and Neglect

Why OIG Did This Audit

- Abuse and neglect against a child by a parent, caregiver, or another person can have a long-term impact on the child's health, opportunity, and well-being. Abuse can be physical, sexual, or emotional in nature. Neglect is a failure to meet the child's basic needs, such as housing, food, clothing, education, and access to medical care.
- This audit is part of a series that examines States' compliance with the requirements of the Child Abuse Prevention and Treatment Act for the immediate screening, risk and safety assessment, and investigation of reports of child abuse and neglect. Based on our risk assessment and a report by Maine's Child Welfare Ombudsman that identified substantial issues where there was a deviation from best practices or adherence to policy or both that had a material effect on the safety and best interests of the children, or rights of the parents, we selected Maine for our first audit.

What OIG Found

On the basis of our sample results, we estimated that 94 percent of child abuse and neglect reports reviewed were not in compliance with 1 or more requirements related to immediate screening, risk and safety assessment, and investigation.

Number of Reports	Deviation from Requirements
92	A written notification letter was not sent to each parent/caregiver or person responsible for the child within 10 days of the investigation finding decision.
59	Safety assessments were not completed as required.
44	Investigations were not completed within 35 days of screening in a report.
17	Initial interviews with children and adult critical case members were not always completed as required.
9	Risk assessments were not completed within 35 days of completing the investigation.
8	A safety plan was not completed by OCFS as required.
7	A response time was not assigned.

What OIG Recommends

We made five recommendations, including that Maine provide additional training to caseworkers and supervisors to achieve compliance with requirements and develop additional written policies and procedures. The full recommendations are in the report.

Maine concurred with all of our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Abuse and neglect of a child under the age of 18 by a parent, caregiver, or another person in a custodial role can have a long-term impact on the child's health, opportunity, and well-being. Abuse can be physical, sexual, or emotional in nature. Neglect is a failure to meet the child's basic needs, such as housing, food, clothing, education, and access to medical care. Without effective State oversight to ensure that all reports of child abuse and neglect are responded to in accordance with policies and procedures, the safety of children cannot be assured.

The Child Abuse Prevention and Treatment Act (CAPTA) provides funds to assist States in child abuse and neglect prevention, assessment, investigation, prosecution, and treatment activities. In federal fiscal year 2022, the Administration for Children and Families (ACF) awarded $91.6 million in CAPTA State grant funding to 50 States, the District of Columbia, and Puerto Rico to improve their child protective services.

This audit is part of a series that examines States' compliance with CAPTA requirements for the immediate screening, risk and safety assessment, and investigation of reports of child abuse and neglect. To identify high-risk States, we conducted a risk assessment and compared several factors including the percentage of population in poverty, rate of child fatalities, and percentage of reoccurrence of maltreatment. Based on our risk assessment and a report by Maine's Child Welfare Ombudsman that identified substantial issues where there was a deviation from best practices or adherence to policy or both that had a material effect on the safety and best interests of the children, or rights of the parents,[1] we selected Maine for our first audit. Our audit focused on the reports of child abuse and neglect that occurred within a family in which the suspect is the primary caregiver.

OBJECTIVE

Our objective was to determine whether the Maine Department of Health and Human Services, Office of Child and Family Services (OCFS), complied with requirements for the immediate screening, risk and safety assessment, and investigation of reports of child abuse and neglect.

BACKGROUND

CAPTA Grants to States

CAPTA was enacted in 1974 at a time of growing awareness and concern about abuse of children in their homes. The law has been reauthorized and amended several times, most

[1] Maine Child Welfare Services Ombudsman, *19th Annual Report* (2021). Accessed Mar. 3, 2023.

recently being reauthorized in December 2010, and amended in January 2019.[2] The American Rescue Plan Act of 2021 included $100 million in supplemental CAPTA State grant funding with a five-year project and expenditure period from October 1, 2020, to September 30, 2025.[3] Within ACF, the Children's Bureau administers CAPTA State grants. To apply for CAPTA grant funding, a State must submit a plan describing the activities that the State will carry out using this funding. This State plan must include an assurance signed by the Governor of the State certifying, among 30 other requirements, that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program, relating to child abuse and neglect that includes provisions and procedures requiring the immediate screening, risk and safety assessment, and prompt investigation of reports of child abuse and neglect.[4] Maine's CAPTA Plan included the required certification, signed by the Governor on September 18, 2011, certifying the that it has in effect and is enforcing a State law or has in effect and is operating a State program that includes had procedures for the immediate screening, risk and safety assessment, and prompt investigation of reports of child abuse and neglect.

Maine Department of Health and Human Services, Office of Child and Family Services Administration

Within the Maine Department of Health and Human Services (the Department), OCFS is the designated State entity for the CAPTA State Grant. Within the OCFS Child and Family Policy, Section IV outlines the requirements for Child Protective Services.[5] Specifically, OCFS must promptly investigate all abuse or neglect cases and suspicious child deaths coming to its attention. OCFS is responsible for the intake and investigation of reports of child abuse and neglect. OCFS is mandated to receive reports of suspected child maltreatment, assess allegations, and reach decisions, based on the preponderance of facts and evidence, about whether a child has been harmed and, if harmed, to what degree of severity. The OCFS Child Protective Intake Unit (CPIU) is staffed with trained caseworkers and receives reports of suspected child abuse and neglect statewide via a toll-free number 24 hours a day, 7 days a week. Reports can also be received via email, fax, or through the Maine OCFS Mandated

[2] CAPTA was originally enacted Jan. 31, 1974 (P.L. 93-247), and was last reauthorized on Dec. 20, 2010, by the CAPTA Reauthorization Act of 2010 (P.L. 111-320). It was amended in 2015, 2016, and 2018, and most recently certain provisions of the act were amended on Jan. 7, 2019, by the Victims of Child Abuse Act Reauthorization Act of 2018 (P.L. 115-424). CAPTA is codified at 42 U.S.C. §§ 5101–5115.

[3] P.L. 117-2 (Mar. 11, 2021), § 2205.

[4] 42 U.S.C. § 5106a(b)(2)(B)(iv). State Plans remain in effect for the duration of the State's participation in the CAPTA program. States are required to periodically review and revise the Plan as necessary to reflect changes in State strategies and programs. States are required to inform the Children's Bureau of any substantive changes to its laws or regulations related to child abuse and neglect that may affect their eligibility for CAPTA State funding (42 U.S.C. §§ 5106a(b)(1)(B) and (C)).

[5] The Child Protective Service policies are located in section IV, Subsection C: *Intake Screening and Assignment Policy*; Subsection D-1: *Child Abuse and Neglect Findings Policy*; and Subsection D: *Child Protection Investigation Policy*.

Reporter Portal.[6] Within OCFS, the Child Welfare unit investigates allegations of child abuse and neglect that occurred within a family in which the suspect is the primary caregiver,[7] either the parent or the custodian.[8]

Intake Screening of a Report

When the CPIU receives a report of suspected abuse or neglect, the intake caseworker is responsible for determining whether to accept a report as appropriate for assessment (screen a report)[9] for determining a response time, and which abuse types are alleged, including sexual abuse, physical abuse, neglect, emotional maltreatment, or other.[10, 11] The intake caseworker also determines whether a report includes the following initial criteria:

- a child under the age of 18,
- an allegation of abuse or neglect,
- a caregiver as the subject of the allegation, and
- a child residing in Maine or the abuse having occurred in Maine.

If the initial criteria are not met, the intake caseworker screens out the report and explains to the reporter why the report is not consistent with policy and may refer the reporter to other resources as appropriate. Screened-out reports are documented in the intake caseworker's daily call log and intake screens. The intake supervisor who reviews the screened-out report generates a form letter, with no names, that states the report does not rise to the level for assessment at this time, but the reporter should report back if they have additional concerns.

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[6] The OCFS Online Reporter Portal is designed to provide medical professionals, hospitals and hospital staff, school personnel, and law enforcement personnel the ability to report non-emergent information related to child abuse and neglect.

[7] *SDM Safety Assessment Tool Policy and Procedures Manual.*

[8] 22 MRS §4002 (5)(7).

[9] A screened-in report meets the statutory definition of child abuse and neglect and meets the criteria as appropriate for investigation as determined through use of the Structured Decision-Making tool. All other reports, except service requests, are screened-out (Child and Family Services Policy, Intake Screening and Assignment, § IV, subsection C, (VII)). Service requests are reports that do not contain allegations of abuse or neglect such as: requests by other States for courtesy interviews of family members, responses as required by court order, other requests from the Judiciary (Child and Family Services Policy, Child Welfare Glossary).

[10] For emergency reports, the response timeframe is 24 hours from receipt of the report, and for non-emergency reports the response timeframe is 72 hours from receipt of the report (Child and Family Services Policy, Child Protection Investigation Policy, § IV, subsection D, (VI)(A)(1) and (2)).

[11] Caregiver actions have led or are likely to lead to a child's sever anxiety, depression, withdrawal, or aggressive behavior toward self or others (Child and Family Services Policy, Intake Screening and Assignment, § IV, subsection C, (VII)(I)(1)).

If the initial criteria are met, the report of child abuse and neglect is assigned to an OCFS caseworker for investigation. If a suspected criminal act of abuse to a child is alleged, intake staff make a referral to the district attorney (DA) where the alleged crime occurred. This includes reports involving child death or serious injury, and domestic violence homicide. In addition, reports with allegations involving physical abuse, sexual abuse, sex trafficking, and child endangerment require a referral to the DA.

Investigation of Complaint

Once the report is determined to be screened-in, CPIU will assign either a 24-hour response time for emergency reports or a 72-hour response time for non-emergency reports. Caseworkers in collaboration with a supervisor will complete the Assignment Activity Tool prior to conducting interviews in the field that includes a review of the criminal history on each person responsible for the child.[12] These criminal history checks include the State Bureau of Investigation report, Bureau of Motor Vehicles report, and National Sex Offender Registry. All initial interviews with children and adults must be completed within the assigned response time (i.e., 24 or 72 hours). The caseworker and supervisor use the Structured Decision-Making (SDM) Safety Assessment Tool to assess whether the children are in immediate danger of serious harm that may require a protective intervention and determine which interventions should be maintained or initiated to provide appropriate protection.[13] The following determinations may be made:

Safety Assessment

"Safety" applies to the need for action based on an immediate threat of harm (i.e., present or impending danger) to the child.

- **Safe:** No safety threats were identified at this time. Based on the currently available information, the child is not likely to be in immediate danger of serious harm.
- **Safe With Plan:** One or more safety threats are present, and safety interventions have been planned or taken. The child will remain in the parent or caregiver's care and custody, but a Department Plan for Safety is required and must be signed by the parent or caregiver.
- **Unsafe:** One or more safety threats are present and a petition for a Preliminary Protection Order (PPO) is required. The filing of a PPO is the only safety intervention possible when one or more of the children are unsafe, and without a PPO one or more

[12] Person responsible for the child means a person with responsibility for a child's health or welfare, which as part of their function provides for care of the child (Child and Family Services Policy, Child Abuse and Neglect Findings, § IV, subsection D-1, (V)).

[13] The SDM Safety Assessment Tool is composed of a checklist of items that determines the level of safety for each child based on factors that influence child vulnerability, safety threats and safety planning capacities and interventions. This tool assists caseworkers in identifying whether children are safe, unsafe, or safe with a plan if they remain in the care of their parents/caregivers in order to match child welfare interventions to the needs of the child and their family (*SDM Safety Assessment Tool Policy and Procedures Manual).*

of the children will likely be in danger of immediate risk of serious harm. If any child remains in the home, a Department Plan for Safety is required.

The supervisor will complete the Safety Assessment Tool and document it in the system within 72 hours of initial contact with critical case members.

Risk Assessment

"Risk" refers to the likelihood of future maltreatment.

OCFS also uses the SDM Risk Assessment Tool to determine the risk level for families, including identifying the family's probability of future system involvement related to abuse or neglect. The tool assists caseworkers in identifying the family's risk level and matching the family with the appropriate level of intervention to achieve the goal of reducing the recurrence of maltreatment.[14] The Risk Assessment Tool must be completed by the caseworker at the end of the 35-day investigation period.

Finding Decision

Upon completion of an investigation, a decision is made by the investigator that an allegation of abuse or neglect was unsubstantiated, indicated, or substantiated based on the facts and evidence gathered during the investigation.[15] The investigation team will issue a written letter to each parent or caregiver to support the decision made.

HOW WE CONDUCTED THIS AUDIT

We obtained and reviewed data from Maine's Child Welfare Information System, known as Katahdin, for 10,762 screened-in family reports of child abuse and neglect for the period of October 1, 2021, through September 30, 2022 (audit period). We selected a stratified random sample of 100 screened-in family reports of child abuse and neglect received during our audit period and reviewed related case information from Katahdin. For each sample item, we determined whether OCFS complied with requirements for the immediate screening, risk and safety assessment, and investigation of reports of child abuse and neglect.

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[14] The SDM Risk Assessment Tool is composed of items that demonstrate a strong statistical relationship with subsequent system involvement related to child abuse and neglect and is completed at the end of the 35-day investigation period (*SDM Safety Assessment Tool Policy and Procedures Manual).*

[15] Unsubstantiated finding means that facts and evidence gathered during an assessment or investigation support a decision that a "person responsible for a child" has not, by preponderance of evidence, subjected that child to specific abuse or neglect. Indicated finding means that facts and evidence gathered during an assessment or investigation support a decision that a "person responsible for a child" has, by preponderance of evidence, subjected that child to low or moderate severity abuse or neglect. Substantiated finding means that facts and evidence gathered during an assessment or investigation support a decision that a "person responsible for a child" has, by preponderance of evidence, subjected that child to specific high severity abuse or neglect, thus causing the child to be in danger (Office of Child and Family Services, Glossary of Child Welfare Terms).

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

Despite having an assurance in the form of a signed certification that Maine has in effect and is enforcing a State law or has in effect and is operating a statewide program that includes procedures for the immediate screening, risk and safety assessment, and investigation of reports of child abuse and neglect, OCFS did not comply with requirements associated with this assurance. Specifically, OCFS complied with all the requirements for 6 of the 100 screened-in family reports in our sample but did not comply with all the requirements for the remaining 94 reports.

OCFS officials provided many reasons for not complying, such as not understanding requirements, training and staffing issues, and transition to and limitations of Katahdin. Failure to comply with requirements places the children's health and safety at risk.

On the basis of our sample results, we estimated that 10,138 of the 10,762 (94 percent) screened-in family reports were not in compliance with 1 or more requirements related to the immediate screening, risk and safety assessment, and investigation of child abuse and neglect.

OCFS DID NOT COMPLY WITH REQUIREMENTS FOR RESPONDING TO REPORTS OF CHILD ABUSE AND NEGLECT

OCFS did not comply with all requirements for the immediate screening, risk and safety assessments, and investigations of reports of child abuse and neglect for 94 of the 100 screened-in family reports.[16]

The different requirements with which Maine did not comply and the associated number of reports are shown in Figure 1 on the next page.

[16] A single report may be noncompliant with one or more requirements.

Figure 1: Number of Sampled Screened-in Family Reports That Did Not Comply With 1 or More Requirements

For **92 reports,** a written notification letter was not sent to each parent/caregiver or person responsible for the child within 10 days of the investigation finding decision.

For **59 reports,** safety assessments were not completed as required.

For **44 reports,** investigations were not completed within 35 days of screening in a report.

For **17 reports,** initial interviews with children and adult critical case members were not always completed as required.

For **9 reports,** risk assessments were not completed within 35 days of completing the investigation.

For **8 reports,** a safety plan was not completed by OCFS as required.

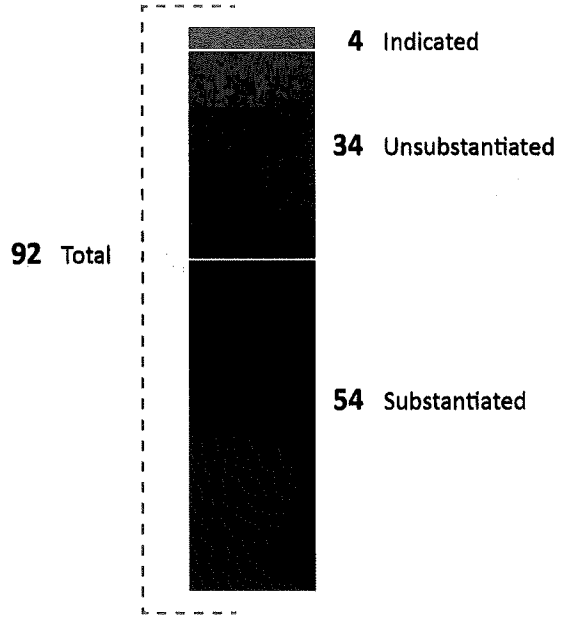
For **7 reports,** a response time was not assigned.

Notification Letters Were Not Sent to Each Parent or Caregiver

Upon completion of the investigation, the caseworker must provide both verbal and written notification to each parent or caregiver about whether findings of child abuse and neglect have been reached as a result of the investigation. The written notification must be sent to the individual by certified mail within 10 days regardless of whether there is a finding (Child and Family Services Policy, Child Protection Investigation Policy, § IV, subsection D, (VI)(F)(8)).

For 92 of the 100 screened-in family reports, we found that OCFS did not send a written notification letter to each parent or caregiver by certified mail within 10 days as required. (See Figure 2 on the next page.) Despite having a policy that required written notification letters be sent by certified mail to each parent or caregiver, regardless of the finding decision (unsubstantiated, indicated, substantiated), OCFS officials stated they were unaware that the policy indicated that written notification must be sent to each parent or caregiver regardless of the outcome.

Figure 2: Number of Reports by Finding Decision Without Notification Letters



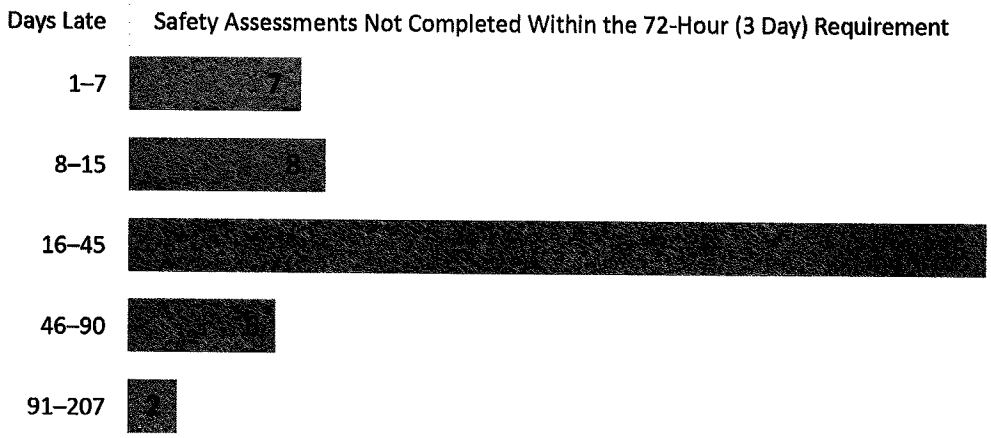
Failure to notify the parent or caregiver of investigation results could increase the risk or recurrence of abuse or neglect to children. For example, the risk could increase in circumstances where the parent or caregiver, who is not an alleged abuser, is living outside of the home and may be unaware of the reported incident or the results of a completed investigation and sends the child back to spend time with the abuser. In addition, in cases in which the parent or caregiver has a finding of indicated or substantiated, the individual would not be aware of their rights, such as the right to appeal.

Safety Assessments Were Not Completed Timely

The OCFS supervisor must complete the Safety Assessment Tool and document it in Katahdin within 72 hours of initial contact with Critical Case Members (Child and Family Services Policy, Child Protection Investigation Policy, § IV, subsection D, (VI)(D)(7)).

For 59 of the 100 screened-in family reports, we found that supervisors did not complete and document the safety assessments in Katahdin within 72 hours of initial contact with critical case members. Specifically, for 58 reports, supervisors did not complete and document the safety assessments within 72 hours (3 days) of initial contact with critical case members. (See Figure 3 on the next page.) For 1 report, there was no documentation to support that the supervisor ever completed the required safety assessment.

Figure 3: Number of Days Safety Assessments Were Completed After the Required Timeframe



According to OCFS officials, supervisors did not complete and document safety assessments within 72 hours of initial contact with critical case members because the preliminary safety decisions are completed in the field through consultation with the supervisors on the day of the interview. OCFS officials said supervisors take notes by hand and then document the results at a later date, resulting in the delay of a timely entry into the system. In addition, they said that during the transition to Katahdin, there was a steep learning curve as staff began to use the system. This contributed to supervisors documenting the preliminary safety decision after the fact.

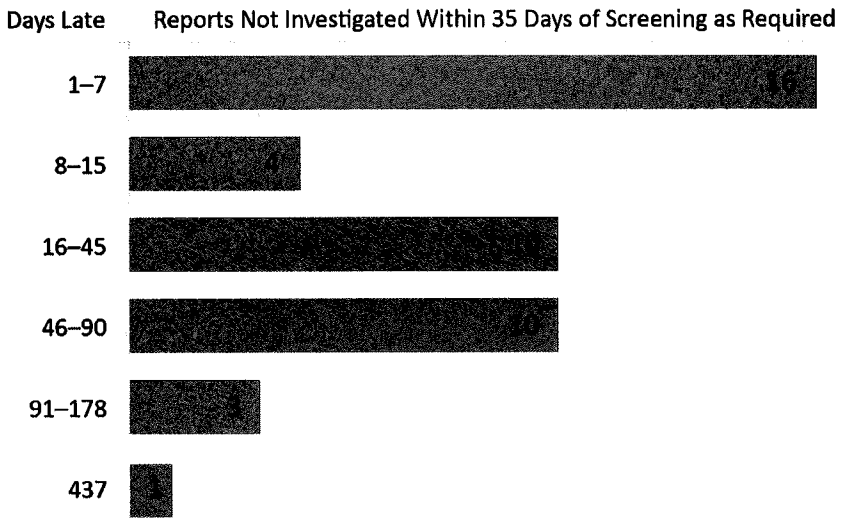
Failure to complete safety assessments within 72 hours of initial contact with critical case members reduces the caseworker's ability to fully assess factors that influence children's vulnerability, safety threats, safety planning capacities, and child welfare interventions. These delays could place children at risk.

Investigations Were Not Completed Timely

OCFS has established a 35-day timeframe for completing investigations and outlined a number of activities that must be completed within this timeframe (Child and Family Services Policy, Child Protection Investigation Policy, § IV, subsection D, (VI)(E)).

For 44 of the 100 screened-in family reports, we found that OCFS did not complete investigations within 35 days of screening in a report as required. (See Figure 4 on the next page.)

Figure 4: Number of Days Investigations Were Completed After the Required Timeframe



OCFS officials indicated that there was not enough documentation in the casefile to determine the cause of the delay in 43 of the 44 reports. For the remaining report, OCFS officials indicated that the caseworker was working on an older investigation and added a report for a different child in the same family to the old investigation but failed to close out this new report. As a result, the report remained open in the system for 437 days without anyone noticing until we brought it to OCFS's attention. Even though OCFS received monthly updates on the age of active reports, OCFS officials indicated that these monthly updates were not reviewed. In addition, OCFS caseworkers did not use the new dashboard features within Katahdin to monitor the aging status of their assigned reports. Failure to complete investigations within the 35-day required timeframe could place children at risk. Reports that take too long to investigate may result in continued child abuse or neglect of the victim.

Interviews With Children and Adult Critical Case Members Were Not Always Completed as Required

All initial interviews with children and adult critical case members must be done within the assigned response time (i.e., 24 or 72 hours). If a critical case member cannot be located, a caseworker must document the steps taken to try and locate the person (Child and Family Services Policy, Child Protection Investigation Policy, § IV, subsection D, (VI)(C)(1), (3) and (4)).

For 17 of the 100 screened-in family reports, we found that OCFS caseworkers did not: (1) conduct initial interviews with children and adult critical case members within the assigned response time and (2) maintain documentary evidence that the interviews with children and adult critical case members were conducted or document steps taken to locate the person to be interviewed. For seven reports, the initial interviews with children and adults were completed between 1 and 29 days late. For the remaining 10 reports, there was no

documentation provided showing the required interviews were ever conducted or documentation that demonstrated the steps taken to locate the person to be interviewed. The caseworkers did not follow OCFS policy to conduct interviews with children and adults within the assigned response time because of a lack of training. In addition, there is a lack of caseworker oversight as we found supervisors did not review and approve caseworker documentation to ensure the timely completion of the interviews conducted with children and adults. We also noted that the existing policy did not address supervisory oversight of caseworker documentation.

Failure to conduct initial interviews or to conduct timely initial interviews with children and adults reduces a caseworker's ability to accurately investigate the reported allegation, which could place children at risk.

Risk Assessments Were Not Always Completed as Required

The caseworker must complete the risk assessment at the conclusion of the 35-day investigation period (Child and Family Services Policy, Child Protection Investigation Policy, § IV, subsection D, (VI)(F)(3)).

For 9 of the 100 screened-in family reports, we found that OCFS did not complete the risk assessments at the conclusion of the 35-day investigation period as required. Also, OCFS caseworkers did not maintain documentary evidence that risk assessments were conducted. Specifically, for seven reports, three were completed 1 week late, three were completed more than 2 weeks late, and one was completed 426 days late. For the two remaining reports, there was no documentation to support that the required risk assessment was ever completed. OCFS officials stated that some risk assessments were not completed in a timely manner because in some situations the families would not engage with them. However, we reviewed the seven reports that were untimely and found no documented notes within the case file that stated the caseworker was unable to engage with the family.

Failure to complete the risk assessment at the conclusion of the 35-day investigation period reduces the caseworker's ability to thoroughly assess the likelihood of future maltreatment and could place children at risk.

Safety Plans Were Not Always Completed as Required

If one or more safety threats are present, and safety interventions have been planned or taken, the preliminary safety decision is "safe with plan." Based on the interventions identified, the child will remain in the parent or caregiver's care and custody. A Department plan for safety (safety plan) signed by the parent is required (Child and Family Services Policy, Child Protection Investigation Policy, IV, subsection D, (VI)(D)(2)).

For 8 of the 100 screened-in family reports, we found that OCFS did not provide documentation to support that a safety plan was completed and signed by the parent as required. According to

OCFS officials, they do not have documentation to support that the safety plans were completed and signed by the parent or caregiver as required because district clerical staff shortages and turnover caused filings to be delayed or paperwork to be lost. OCFS began to see turnover numbers climb beginning in January 2021 and peaking in May 2021. As a result, some signed safety plan documents may have been lost or destroyed when caseworkers left employment with OCFS. Finally, some districts may have sent records to archives because of space limitations in the office, making it a challenge to locate records.

Failure to have these Department safety plan in place for the children who will remain in the care or custody of their parents may leave the child exposed to continued risk of abuse or neglect with no specific plan to address and protect the child from further danger.

Screened-In Reports Were Not Always Assigned a Response Time

For reports that are appropriate for referral, CPIU assigns a response time, and the intake supervisor reviews them. Intake workers consult the Structure Decision Making System Intake Screening and Response Priority (SDM SCRPT) Tool to determine response time, either 24 or 72 hours. Before making a recommendation to the intake supervisor, the intake workers consider factors that could either result in an increased or decreased response time. Factors that made responses faster include law enforcement requests immediate response, forensic considerations that could be compromised by slower response, a reason to believe the family may flee, or a prior child death in household from abuse or neglect. Factors that made responses slower include child safety requires strategically slower response, the child is in an alternative safe environment, and the alleged incident occurred more than 6 months ago (Child and Family Services Policy, Intake Screening and Assignment, § IV, subsection C, (VII)(J)(1) and (3)). The intake supervisors must review all reports and the screening decisions to verify they are consistent with policy and practice expectations (Child and Family Services Policy, Intake Screening and Assignment, § IV, subsection C, Appendix III, FAQ).

For 7 of the 100 screened-in family reports, we found that there was no response time assigned as required. A response time was not assigned because the SDM SCRPT Tool recommended to screen out the report, but the intake caseworker overrode the decision and screened in the report and did not manually enter the response time.[17] In addition, the intake supervisor also failed to ensure the response time was entered when the override occurred. According to OCFS officials, OCFS considered this to be a training issue related to when they transitioned to Katahdin because OCFS staff did not realize they had to manually input the response time when there was a system override; therefore, they left the response time blank. In addition, OCFS does not have written policies or procedures that outline the steps a caseworker must take to override a report from screened-out to screened-in and manually input a response time.

[17] An override allows the caseworker to change a screened-out report to a screened-in report based on unique circumstances that may not be captured by the SDM screening criteria.

The failure to ensure a response time is assigned can affect the caseworker's ability to respond within 24 hours to an emergency report of child abuse and neglect concerns. In non-emergency reports of child abuse and neglect, failure to enter a response time can affect the caseworker's ability to respond within 72 hours. These failures could place the safety of children at risk.

RECOMMENDATIONS

We recommend that the Maine Department of Health and Human Services, Office of Child and Family Services:

- provide additional training to caseworkers and supervisors as appropriate, to achieve compliance with requirements for the immediate screening, risk and safety assessment, and investigation of reports of child abuse and neglect; and

- develop written policies and procedures that:
    - require its supervisors to review and approve documentation of caseworker interviews with children and adults,
    - require its supervisors to monitor aging reports on a weekly basis to promptly identify delays in the investigation process,
    - outline the steps a caseworker must take to override a report from screened-out to screened-in and manually input a response time, and
    - requires supporting documentation to be maintained within Katahdin to demonstrate that written notification letters were sent.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, OCFS concurred with our recommendations and described the actions that it has taken or plans to take to address them. Specifically, OCFS stated the following:

- OCFS has implemented a "Supervision Framework" to guide supervisors in supporting caseworkers to ensure that statutory and policy requirements are met and added eight new training supervisors to support staff training.

- OCFS has incorporated the expectation that supervisors review and approve documentation of caseworker interviews with children and adults into its investigation practice and Katahdin.

- OCFS has a supervisory policy, effective November 8, 2023, that states that supervisors should use reports and quality assurance data to support caseworkers. OCFS also stated that the aging report is one of several tools that can be used to guide supervision.

- OCFS is in the process of creating a "desk-level procedure" for intake staff that will direct staff to enter a response time during the completion of an override and it will provide additional training in this area.

- OCFS is working to develop and implement an upgrade to Katahdin that ensures that notification letters are automatically created and maintained in the system, regardless of whether there are findings, and that the system will prompt staff to document sending the letters and receiving confirmation of receipt (when applicable).

OCFS's comments are included in their entirety as Appendix E.

We appreciate OCFS's cooperation throughout our audit and the actions it has taken and plans to take to address our recommendations. Although OCFS concurred with our recommendation that supervisors should monitor aging reports on a weekly basis, the written supervisory policy notes that supervisors should use reports and quality assurance data to guide caseworker supervision. The policy does not require supervisors to monitor aging reports on a weekly or other periodic basis. Therefore, we continue to recommend that OCFS require its supervisors to regularly monitor aging reports to promptly identify delays in the investigation process.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We obtained and reviewed data from Maine's Child Welfare Information System, known as Katahdin, for 10,762 screened-in family reports of abuse or neglect for the period October 1, 2021, through September 30, 2022. We assessed the reliability of the data and selected a stratified random sample of 100 screened-in family reports that were received during the audit period. For each sample item, we determined whether OCFS complied with requirements for the immediate screening, risk and safety assessment, and investigation of reports of child abuse and neglect.

We did not assess OCFS's overall internal control structure. Rather, we limited our review to OCFS's internal controls related to the immediate screening, risk and safety assessment, and investigation of reports of child abuse and neglect.

We conducted our fieldwork at OCFS's office located in Augusta, Maine, from June 2023, through September 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable requirements related to the immediate screening, risk and safety assessment, and investigation of reports of child abuse and neglect;
- interviewed State officials to gain an understanding of the OCFS process for intake and investigation of reports of child abuse and neglect;
- obtained data from the State's system representing 10,762 screened-in family reports of child abuse and neglect received during our audit period;
- selected for review a stratified random sample of 100 screened-in family reports (Appendix B);
- evaluated and tested procedures for the immediate screening, risk and safety assessment and investigation of reports by reviewing case files for the selected screened-in family reports;
- estimated the number and percentage of screened-in family reports in the sampling frame not reported in accordance with requirements; and

- discussed the results of our audit with OCFS officials.

See Appendix B for the details of our statistical sampling methodology, Appendix C for our sample results and estimates, and Appendix D for a summary of sample results and deficiencies for each sampled screened-in family report.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 10,762 screened-in family reports of alleged child abuse and neglect received during the audit period.

SAMPLE UNIT

The sample unit was a screened-in family report.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample as follows:

Table 1: Sample Design and Sample Sizes

Stratum	Preliminary Safety Assessment Decision	Number of Frame Units	Sample Size
1	None Specified	3024	10
2	Safe	6572	25
3	Safe with Plan	817	25
4	Unsafe	349	40
	Total	**10,762**	**100**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical software.

METHOD OF SELECTING SAMPLE UNITS

We sorted the items in each stratum by the intake identification number in ascending order and then consecutively numbered the items in each stratum in the sampling frame. After generating the 100 random numbers in accordance with our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the number and percentage of screened-in family reports within the sampling frame that were not in compliance with requirements. We calculated the point estimate and the corresponding two-sided 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size	Sample Size	OCFS Did Not Comply With One Or More Screening Requirements	OCFS Did Not Comply With One Or More Safety Assessment Requirements	OCFS Did Not Comply With One Or More Risk Assessment Requirements	OCFS Did Not Comply With One or More Investigation Requirements	OCFS Did Not Comply With One Or More Requirements
1	3,024	10	0	4	2	9	9
2	6,572	25	1	13	0	23	24
3	817	25	2	18	3	23	24
4	349	40	4	27	4	37	37
Total	**10,762**	**100**	**7**	**62**	**9**	**92**	**94**

Table 3: Estimated Number and Percentage of Reports in the Sampling Frame Not in Compliance with Requirements
(Limits Calculated at the 90-Percent Confidence Level)

	Number of Reports Not in Compliance with Requirements	Percentage of Reports Not in Compliance With Requirements
Point estimate	10,138	94
Lower limit	9,477	88
Upper limit	10,762*	100

* The computed upper limit of the 90-percent confidence interval for the number of reports not in compliance with requirements is greater than the total number of reports in the sampling frame. Therefore, the upper limit is being reported as the sampling frame total.

APPENDIX D: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED SCREENED-IN FAMILY REPORT

Table 4: Deficiencies Identified for Each Sampled Screened-in Family Report

Sample Number	Stratum	OCFS Did Not Comply With One Or More Screening Requirements	OCFS Did Not Comply With One Or More Safety Assessment Requirements	OCFS Did Not Comply With One Or More Risk Assessment Requirements	OCFS Did Not Comply With One Or More Investigation Requirements	OCFS Did Not Comply With One Or More Requirements
1	1		X		X	X
2	1			X	X	X
3	1		X		X	X
4	1		X		X	X
5	1		X		X	X
6	1			X	X	X
7	1				X	X
8	1				X	X
9	1				X	X
10	1					
11	2		X		X	X
12	2		X		X	X
13	2		X		X	X
14	2				X	X
15	2		X		X	X
16	2				X	X
17	2		X			X
18	2		X		X	X
19	2				X	X
20	2				X	X
21	2				X	X
22	2	X			X	X
23	2		X		X	X
24	2					
25	2		X		X	X
26	2		X		X	X
27	2				X	X
28	2				X	X
29	2				X	X
30	2		X		X	X
31	2				X	X
32	2		X		X	X
33	2				X	X
34	2		X		X	X
35	2		X		X	X
36	3		X		X	X
37	3		X		X	X

Sample Number	Stratum	OCFS Did Not Comply With One Or More Screening Requirements	OCFS Did Not Comply With One Or More Safety Assessment Requirements	OCFS Did Not Comply With One Or More Risk Assessment Requirements	OCFS Did Not Comply With One Or More Investigation Requirements	OCFS Did Not Comply With One Or More Requirements
38	3		X		X	X
39	3				X	X
40	3		X	X	X	X
41	3		X		X	X
42	3				X	X
43	3				X	X
44	3		X	X	X	X
45	3	X	X		X	X
46	3				X	X
47	3		X		X	X
48	3		X		X	X
49	3		X		X	X
50	3		X		X	X
51	3				X	X
52	3		X		X	X
53	3		X			X
54	3					
55	3		X		X	X
56	3	X	X		X	X
57	3				X	X
58	3		X		X	X
59	3		X		X	X
60	3		X	X	X	X
61	4		X		X	X
62	4	X			X	X
63	4		X		X	X
64	4				X	X
65	4					
66	4		X		X	X
67	4		X		X	X
68	4		X		X	X
69	4		X		X	X
70	4		X		X	X
71	4		X		X	X
72	4				X	X
73	4				X	X
74	4				X	X
75	4		X		X	X
76	4			X	X	X
77	4	X			X	X

Sample Number	Stratum	OCFS Did Not Comply With One Or More Screening Requirements	OCFS Did Not Comply With One Or More Safety Assessment Requirements	OCFS Did Not Comply With One Or More Risk Assessment Requirements	OCFS Did Not Comply With One Or More Investigation Requirements	OCFS Did Not Comply With One Or More Requirements
78	4	X	X	X	X	X
79	4		X		X	X
80	4	X	X		X	X
81	4			X	X	X
82	4					
83	4		X		X	X
84	4		X		X	X
85	4		X		X	X
86	4		X		X	X
87	4				X	X
88	4		X		X	X
89	4		X		X	X
90	4		X	X	X	X
91	4				X	X
92	4		X		X	X
93	4		X		X	X
94	4		X		X	X
95	4					
96	4		X		X	X
97	4		X		X	X
98	4		X		X	X
99	4		X		X	X
100	4		X		X	X
	Total	**7**	**62**	**9**	**92**	**94**

APPENDIX E: AUDITEE COMMENTS

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner

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October 18, 2024

Office of Audit Services, Region I
JFK Federal Building
15 New Sudbury Street, Room 2300
Boston, MA 02203

RE: Report Number A-01-23-02500

Dear Mr. Roy,

Thank you for the opportunity to review and respond to the Office of the Inspector General's Audit of Maine's system for screening, investigating, and responding to reports of alleged abuse and/or neglect of Maine children.

Maine has policies and procedures in place designed to ensure thorough screening, investigation, and response to allegations of abuse and neglect, yet agrees that in some circumstances the practice of Office of Child and Family Services (OCFS) has either deviated from policy or staff have not sufficiently documented work done in compliance with policy. While this audit was conducted over the last year, it was reviewing cases for the period of October 1, 2021, through September 30, 2022. Two to three years have elapsed since the completion of these investigations and significant work was undertaken in that time to improve staffing, address workload concerns, implement and enhance the child welfare information system (Katahdin), comprehensively update policies and procedures, and address issues identified through internal and external reviews of OCFS' operations.

The feedback provided by this audit has allowed us to further identify opportunities to strengthen casework practice, policy, and technology to ensure staff understand expectations, supervisors can ensure these expectations are being met, and staff at all levels document their work.

OIG Recommendations

1. Provide additional training to caseworkers and supervisors as appropriate, to achieve compliance with requirements for the immediate screening, risk and safety assessment, and investigation of reports of child abuse and neglect

   OCFS concurs with this recommendation. Over the last year, OCFS has implemented a Supervision Framework to guide supervisors in supporting caseworkers to ensure that statutory and policy requirements are met. In addition, OCFS recently added eight new Training Supervisor positions, co-located in each of OCFS' eight Districts to provide support for training new and existing staff and tailoring those trainings to identified District-specific needs.

2. Develop written policies and procedures that require its supervisors to review and approve documentation of caseworker interviews with children and adults.

   OCFS concurs with this recommendation and has incorporated this expectation into both investigation practice and the Katahdin information system. These expectations are reinforced by the newly implemented Supervision Framework.

3. Develop written policies and procedures that require its supervisors to monitor aging reports on a weekly basis to promptly identify delays in the investigation process.

   OCFS concurs with the recommendation. Presently the Supervisory Policy, effective November 8, 2023, states, "Individual supervision allows a supervisor to develop a collaborative relationship with their worker and conduct a comprehensive assessment of the worker to understand their strengths, capabilities, areas of growth and address challenges. This includes holding staff accountable for their assigned workload." Additionally, the policy further states, "Individual supervision is used to review progress in investigations, cases, and resource licensing and to outline steps necessary to build engagement with the family and ensure child safety, permanency, and well-being." The policy also references the tools that can be used to support caseworker supervision. "Data. Reports and Quality Assurance (QA) data should be utilized in supervision to assist workers in understanding the agency's performance measures, how their work impacts the outcomes, and how they can improve their outcomes as outlined in their performance evaluation." The aging report, readily available in Katahdin, is one of several tools that can be used to guide supervision.

4. Develop written policies and procedures that outline the steps a caseworker must take to override a report from screened-out to screened-in and manually input a response time.

   OCFS concurs with this recommendation. OCFS is in the process of creating a desk-level procedure for Intake staff that will address this issue by directing staff to enter a response time when they are completing an override. In addition, the Information Services Team and the Training Unit have worked with Intake to provide additional training and support in this area. Missing timeframes can now be monitored through Katahdin, allowing for real-time identification of any situations where a response time is not assigned as expected.

5. Develop written policies and procedures that require supporting documentation to be maintained within Katahdin to demonstrate that written notification letters were sent.

   OCFS concurs with this recommendation. The latest revision of the Child Protection Investigation policy, effective date April 29, 2024, reads "The findings letter will serve as legal notification to the parent(s)/caregiver(s) regarding the Department's findings decision. The letter outlines who caused the abuse, the victim(s) of the abuse, the abuse type and severity, and the behaviors by the parent(s)/caregiver(s) that resulted in the child abuse and/or neglect. The letter will be sent to the parent(s)/caregiver(s) by certified mail

within ten (10) days of the findings decision and uploaded into the child welfare information system along with the receipt of notification when received. This is an important part of an appeal process as it demonstrates that timely notification was provided to the parent(s)/caregiver(s)." OCFS is currently working to develop and implement an upgrade to Katahdin to ensure notification letters are automatically created and maintained in the system, regardless of whether or not there are findings, and staff are prompted to document sending the letters and (when applicable) receiving confirmation of receipt.

OCFS appreciates the opportunity to respond to this audit. The recommendations reflect many of the important steps OCFS has already taken, or is in the process of implementing, to improve our system of screening, investigating, and responding to reports alleged abuse and/or neglect and reinforce our focus on strengthening policy, training, and supervisory support for staff to ensure quality and consistency of practice statewide. Through this work alongside system partners, OCFS will continue to improve outcomes for Maine children and families.

Regards,

Sara Gagné-Holmes
Commissioner

Bobbi L. Johnson, LMSW
Director, Office of Child and Family Services

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