A Compendium:

Oversight of Child Protection Services, 2018- Present

Conducted at the Direction of the Government Oversight Committee

by the Office of Program Evaluation and Government Accountability

Note: this document will be updated and expanded

Since 2018, at the direction of GOC, OPEGA has undertaken a number of reviews and reported on a broad range of matters in the field of child protection services in Maine. As the Committee looks ahead to future work sessions at the conclusion of OPEGA's most recent series of reviews—1.) OCFS case file reviews of four separate child fatalities in 2021; and 2.) a systemic review of the family reunification process—OPEGA seeks to further assist the Committee by summarizing and synthesizing our relevant body of work over the last five years along with GOC discussion and actions, and agency responses.

This Compendium of Oversight of Child Protective Services, which will expand in detail in the coming months, and also incorporate the results of pending OPEGA work, seeks to:

- facilitate the Committee's role in overseeing responsible agency official accountability;
- assist in the identification of potential commonalities as to risk factors, causes, and conditions of negative outcomes for children;
- inform Committee consideration of any relevant legislation the Committee may wish to propose; and
- provide notification to responsible agency officials that the Committee may wish to discuss further at the next work session(s) the status of matters previously reported.

As OPEGA continues to synthesize our work relevant to child protectives services, we suggest the Committee consider inviting OCFS officials to a work session to further understand:

- the status of implementation on the various recommendations OPEGA has provided to the agency;
- any matters previously reported that would benefit from additional legislation, even if not proposed at the time of the original reporting;
- conditions emerging or evolving since the original reporting that have required management attention and action;
- evolving or emerging conditions that show objective signs of demonstrable improvement; and
- any insights or other lessons learned from this overall body of work, and how and whether that has been communicated to frontline workers, with adequate corresponding supports.

The following pages currently present a list of OPEGA publications on child protectives services from 2018- 2023, and include OPEGA's findings, recommendations, and other considerations for OCFS and the GOC.

2018 | Report regarding the cases of Marissa Kennedy and Kendall Chick

Information Brief: Maine's Child Protection System – A Study of How the System Functioned in Two Cases of Child Death by Abuse in the Home

OPEGA reviewed and analyzed records of entities involved with the cases of Marissa Kennedy and Kendall Chick. We also reviewed statutes, rules, policies and procedures, and obtained additional information through interviews.

OPEGA identified a number of potential areas of concern or improvement in the child protection system with the expectation that these observations will help inform the GOC and OPEGA in consideration of potential areas of focus for a broader review of Maine's Child Protection System. The potential areas OPEGA identified in no particular order of priority include:

- guidance and training for mandated reporters, including expectations for what constitutes "reason for suspicion" for those in various roles;
- timeliness of answering phone calls regarding potential child abuse and neglect by OCFS Intake workers via the statewide, toll-free number;
- timeliness and comprehensiveness of OCFS and ARP assessments of risk for a child or family and junctures at which a comprehensive re-assessment of risk could be or should be conducted;
- appropriateness of caseloads and adequacy of supervision and training of OCFS and ARP staff;
- compliance with policies and procedures, and consistency and appropriateness of decisions made, by caseworkers and supervisors in OCFS Central Intake and District Offices;
- compliance with contractual obligations, and consistency and appropriateness of decisions made, by ARP caseworkers and supervisors;
- factors that impact OCFS or ARP decision-making on appropriate action to take in response to assessed risk levels, and information received or situations observed with a child or family;
- extent to which OCFS and ARP monitor whether families are participating in voluntary services intended to reduce the risk of child abuse and neglect and take action when they are not;
- extent to which mandated reporters, OCFS and ARP seek to verify, and can verify, information reported by a child's parents;
- effectiveness of the child protection system in identifying and responding to child abuse/neglect risks that are not considered to be imminent physical safety risk, i.e. emotional maltreatment, neglect, truancy; and
- extent and manner of communication and information exchange among the various key entities that are part of the child protection system including schools, law enforcement, health care providers, counselors and therapists, community service providers; OCFS Intake, OCFS Field Offices and ARP providers.

Discussion and GOC Actions:

- GOC Meeting 05-24-2018
  - GOC discussion of Information Brief Presented by OPEGA. https://legislature.maine.gov/doc/2335
- GOC Meeting 05-31-2018.

  - Public Comment on OPEGA Report: Gov LePage, Senators & Representatives from HHS Committee, various experts and members of the public. https://legislature.maine.gov/doc/2352
- GOC Meeting 06-14-2018.
  - Committee Discussion of Information Desired for June 28th Work Session https://legislature.maine.gov/doc/2364
- GOC Work Session 06-28-2018.
  - **GOC Passed motion to subpoena Commissioner of DHHS to appear before GOC. Passed motion to direct OPEGA to add a project to its workplan regarding perspectives of front-line CPS workers.** https://legislature.maine.gov/doc/2381
  - OPEGA's Areas of Concern & Potential Next Steps Document for 06-28-2018 GOC Work Session https://legislature.maine.gov/doc/2354
  - Additional Information Requested by GOC for their 6-28-2018 Work Session https://legislature.maine.gov/doc/2355
- GOC Meeting 07-10-2018.
  - Questioning of Commissioner Hamilton of DHHS appearing due to subpoena. https://legislature.maine.gov/doc/2382
- GOC Meeting 09-27-2018.
  - Review of Summary of legislation enacted during Second Special Session of the 128th Legislation related to child protective services. https://legislature.maine.gov/doc/2517

CPS-Related Legislation Enacted during the 2nd Special Session of the 128th Legislature:

- **LD 1920 – An Act to Modify the Expungement Requirements for Records under the Child and Family Services and Child Protection Act – P.L. 2017, c.472**
  - Current law governing records held by DHHS in connection with the department's child protective activities requires the department to maintain unsubstantiated child protective case records for no more than 18 months (except some unsubstantiated records related to certain persons eligible for Medicaid Services under the federal Social Security Act Title XIX which are retained for 5 years). Public Law 2017, chapter 472 increases that retention period to 5 years.
- **LD 1921 – An Act to Grant the Department of Health and Human Services Access to criminal History Information to Achieve the Purposes of the Child and Family Services and Child Protection Act – P.L. 2017, c.473**
  - Current law authorizes DHHS to take appropriate actions to help prevent child abuse and protect the health and safety of children (22 MRSA §§4003 and 4004). Public Law 2017, chapter 473 adds to the list of those appropriate actions, the authority to request and receive certain confidential criminal history record information (and public criminal history information) from the Department of Public Safety as defined under the Criminal History Record Information Act (17 MRSA c. 7).
- **LD 1922 – An Act to Amend the Child and Family Services and Child Protection Act – P.L. 2017 c. 470**
  - Current law lists as a purpose of the Child Protection Act making family rehabilitation and reunification a priority as a means for protecting the welfare of children. Public Law 2017, chapter 470 amends this purpose statement to require DHHS to make reasonable efforts to rehabilitate and reunify families.

- **LD 1923 – An Act to Improve the Child Welfare System – P.L. 2017, c.471**
  - Provides funding to increase the daily reimbursement rates for the various categories of foster homes; 2. Provides funding to create a new Child Welfare Investigator position; 16 Human Services Casework Supervisor positions;
  - Regional Associate Director for Child Welfare positions; 16 Human Services Caseworker positions; and 8 Customer Representative Associate II positions within the Department of Health and Human Services, Office of Child and Family Services;
  - Provides funding for a $5 per wage-hour stipend payment for Caseworkers, Caseworker Supervisors, Assistant Program Administrators and Program Administrator positions;
  - Provides funding for a $1 per wage-hour stipend payment for Caseworkers, Caseworker Supervisors, Services Assistant Program Administrators and Program Administrator positions for those holding or obtaining a relevant master's degree;
  - Provides funding for the procurement of a pilot program to provide supportive visitation, including supervision of court-ordered visitation with the child's relatives and evaluation of parental capacity;
  - Provides funding for the procurement of clinical support and guidance of caseworker practice, including direct consultation with a clinician, training, staff functioning and debriefing;
  - Provides one-time funding for the development of a new comprehensive child welfare information system and directs the Department of Health and Human Services to conduct a needs analysis for its comprehensive child welfare information system, review possible solutions to meet those needs and purchase or develop a new system;
  - Requires the Department of Health and Human Services to contract for a 3rdparty independent rate study to develop a separate rate for MaineCare reimbursement for trauma-focused cognitive behavioral therapy to be billed under rule Chapter 101: MaineCare Benefits Manual, Section 65; and
  - Requires the department to report on the progress of the department in implementing the provisions of the legislation to the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 31, 2019.

2019 | Report Regarding OCFS Frontline Worker Perspectives

Information Brief: Frontline Workers in the State Child Protective System – Perspectives on Factors That Impact Effectiveness and Efficiency of Child Protective Work

OPEGA was assigned a special project by the GOC which aimed to understand the perspectives of frontline workers in the Office of Child and Family Services (OCFS). OPEGA obtained workers' perspectives in two ways. An online survey was sent to all assessment, permanency and intake caseworkers and supervisors. OPEGA received a total of 191 responses from the survey. After reviewing the responses, OPEGA created follow-up interview questions and interviewed 44 child protective staff. Those interviewed represented each of the eight OCFS districts and involved caseworkers, supervisors, program administrators and assistant program administrators.

The information brief was not designed to contain conclusions or recommendations, but described the perspectives of frontline workers in the following areas:

- The Nature of the Job
  - Off-hours Demands;
  - Work/Life Balance;
  - Secondary Trauma and Health Effects;
  - Worker Safety;
  - Training & Preparedness;
  - Additional Work Components such as Documentation, MACWIS, Court Preparation, Travel, and Administrative Tasks.
- State of Workload for Intake and the Districts
  - External Factors Related to Increased Workload;
  - Internal Factors Related to Increased Workload;
    - Reports previously assigned to ARP
    - Automatic assessments after three inappropriate reports
    - Add-on Reports
    - Structured Decision-Making (SDM) Tools
  - Changes in Practice
    - Out-of-Home Safety Planning no longer permitted
    - Team Decision-Making
    - Changes in the Family Plan / Child Plan
    - Recently implemented Supervisory Tool Kit
    - Supervisors in the Field Requirement
  - Implementation of Changes by the Organization
- Systemic Barriers
  - Lack of Placements for Children
  - Lack of Services
  - The Role of the Courts
- Impacts on the Quality of Work
  - Impact of High Workloads
  - Ability to Do the Work
  - Places for Children in Care (including "hoteling")
  - Policy and Practice Changes
  - Confidence in Decision-making
- Impacts on Frontline Workers

- Workers Seeking Outside Employment
- Worker-Described Period of High Turnover in 2018
- What Could Help
- What Workers Want Legislators to Know

Discussion and GOC Actions:

- GOC Meeting 02-22-2019.
  - Discussion of Information Brief by OPEGA on Front-Line Worker Perspectives. https://legislature.maine.gov/doc/2870
- GOC Meeting 03-08-2019.
  - Public Comment on OPEGA Report 03-08-2019. Commissioner Lambrew, Charles Bicknell, Amy Cobb – OCFS Caseworker, Pamela Day, Brian Houston, Maine Children's Alliance, Jan Strout. https://legislature.maine.gov/doc/2909
- GOC Meeting 03-22-2019.
  - Potential Next Steps for CPS work: (Options included:
    1) Periodic updates from DHHS to GOC;
    2) Follow-up survey of OCFS Workers after implementation of changes described by DHHS;
    3) OPEGA's project on the workplan to Assess the status of current DHHS initiatives and their impact on previously noted areas of concern or improvement;
    4) OPEGA to review Out-of-Home Placements.)

    GOC passed a motion to put option 3 on hold.
    GOC passed a motion to put option 2 on OPEGA's workplan.
    GOC passed a motion to put option 4 on OPEGA's workplan.
    https://legislature.maine.gov/doc/2940
- GOC meeting 05-10-2019.
  - Minutes: https://legislature.maine.gov/doc/3098
  - Testimony from Commissioner Lambrew and Director Landry regarding OCFS' efforts to address concerns raised during system evaluations completed by OPEGA, the Ombudsman, and PCG's (Public Consulting Group) C.A.R.E. Project. https://legislature.maine.gov/doc/2954
  - C.A.R.E. Project recommendations: https://legislature.maine.gov/doc/2955
- GOC Meeting 08-14-2019.
  - Update on Child Protection Legislation from 129th Legislature:
    - **LD 192 – An Act to Require an Annual Report on the Activities of the Maine Child Welfare Advisory Panel – P.L. 2019, c.28**
      - The bill requires DHHS to submit an annual report to the HHS Committee on the activities of the Child Welfare Advisory Panel. The amendment removed a deadline for the annual report.
    - **LD 821 – An Act to Set Case Load Standards for the OCFS – P.L. 2019, c.34**
      - The bill requires DHHS to ensure caseworkers are not assigned cases exceeding a number established by department rule; the number must be recommended by a national organization with expertise in maximum caseloads; the number of caseworkers assigned to support staff must not exceed 8. The amendment replaces the bill and

requires DHHS to review case load standards and develop recommendations with input from caseworkers and PCG. Requires the department to submit a report by October 1, 2019 with findings and recommendations and submit an annual report on staffing in child welfare in relation to the case load recommendations; the reports are submitted to HHS Committee and GOC.

- GOC Meeting 09-23-2019.
  - Minutes: https://legislature.maine.gov/doc/3335
  - Testimony for Director Landry: Includes discussion of OCFS turnover improvement between 2018 and 2019, but at the same time caseloads are not decreasing due to increases in cases. Also includes an update on children in hotels and emergency rooms due to lack of placements. https://legislature.maine.gov/doc/3228
  - Presentation Slides from Director Landry: https://legislature.maine.gov/doc/3229
- GOC Meeting 10-15-2019.
  - Minutes: GOC discussed OPEGA Tracking Document for use in handing off the Child Protection work to the next GOC. **GOC passed a motion to remove from the OPEGA workplan, the project they put on hold on 03-22-2019.** https://legislature.maine.gov/doc/3613
  - OPEGA developed a child protection system improvements - oversight coordination/tracking document. https://legislature.maine.gov/doc/3333
  - OCFS produced a Child Welfare Caseload and Workload Analysis. https://legislature.maine.gov/doc/3332
- GOC Meeting 03-13-2020.
  - Minutes: Committee questions regarding Director Landry's testimony. https://legislature.maine.gov/doc/4630
  - Director Landry Testimony 03-13-2020: Presented recent statistics for New Assessments, Children in Care, Percent Exiting to Some Form of Permanency, Hotel and Emergency Department Stays. https://legislature.maine.gov/doc/4018
  - Presentation Slides from Director Landry: https://legislature.maine.gov/doc/4019

The Committee did not meet until November 2020 due to COVID-19 pandemic.

- GOC Meeting 03-26-2021
  - Minutes: Discussion of OPEGA memo recommending avenues by which the GOC could continue its oversight of CPS should they decide to. https://legislature.maine.gov/doc/6535
    - **GOC passed a motion to direct OPEGA to perform a follow-up survey of frontline child protective service workers, with the understanding the results of that survey may trigger future work related to out-of-home placements or other matters.**
    - OPEGA memo to GOC detailing prior history of CPS work and recommendation of possible avenues to continue oversight. https://legislature.maine.gov/doc/6380
- GOC Meeting 04-23-2021
  - Minutes: Questions for Director Landry after his presentation regarding the status of initiatives and the effect of the pandemic. https://legislature.maine.gov/doc/6707
  - Presentation by Director Landry: https://legislature.maine.gov/doc/6663

Compendium of OPEGA's Work on Child Protection at the Direction of the GOC, including GOC Discussion and Actions

- GOC Meeting 07-14-2021
  - OPEGA Compendium of GOC and OPEGA Activities regarding the Child Protective System. https://legislature.maine.gov/doc/6918
  - OPEGA Summary of Media reports regarding recent child deaths. https://legislature.maine.gov/doc/6923
  - Minutes: https://legislature.maine.gov/doc/6958
    - Director Landry appeared before the Committee and answered questions regarding OCFS processes of assessment, the use of SDM tools, the workload analytic tool from PCG, and the upcoming Casey Family Programs methodology for case review. (Testimony attached to minutes)
    - Assistant Attorney General Lisa Marchese appeared before the Committee and discussed reasons associated with the confidentiality of case files during the adjudication and possible sentencing of prosecuted individuals.
    - Child Welfare Ombudsman Christine Alberi presented testimony to the Committee. (Testimony attached to minutes)
    - Both Senator Curry https://legislature.maine.gov/doc/6921 and Senator Diamond https://legislature.maine.gov/doc/6919 requested reviews of aspects of the Child Protection System. (Testimony attached to minutes)
    - **GOC passed a motion to add an immediate review to OPEGA's workplan for which OPEGA will provide a draft scope to be considered at their next meeting.**
- GOC Meeting 08-11-2021 Minutes: https://legislature.maine.gov/doc/7016
  - OPEGA presented a Proposed Scope of Work for evaluation of OCFS practices regarding investigations, reunification and an overview of the oversight of child protective services within the State. https://legislature.maine.gov/doc/6952
  - **The GOC passed a motion to approve OPEGA's scope with the following adjustments to Reporting items 3 and 4 (See page 3, Table 1,"Reporting):**
    - **3. Information Brief on Scope Area 3 by January 15, 2022,**
    - **4. Initial Evaluation Report on Scope Area 1 by March 15, 2022, and**
    - **5. Final Evaluation Report on, including Scope Area 2, by September 30, 2022.**
    - **The GOC directs OPEGA to prioritize the use of staff and adjust staff assignments to complete the work on the timeline the GOC has laid out.**
- GOC Meeting 09-08-2021 Minutes: https://legislature.maine.gov/doc/7421
  - Citizen Review Panels Bobbi Johnson https://legislature.maine.gov/doc/7024
  - MCWAP Presentation – Debra Dunlap https://legislature.maine.gov/doc/7025
  - CDSIRP Presentation – Mark Moran https://legislature.maine.gov/doc/7023
  - JCTF Presentation – Betsey Boardman (no copy)
- GOC Meeting 11-10-2021 Minutes: https://legislature.maine.gov/doc/7913
  - Presentation – Collaborative Safety, Casey Family Programs and the Office of Child and Family Services
    - Casey Family Programs / Collaborative Safety Report to OCFS https://legislature.maine.gov/doc/7420
    - Collaborative Safety Presentation to GOC https://legislature.maine.gov/doc/7429
    - Director Landry takes questions from the Committee

- Child Welfare Ombudsman testimony to Committee https://legislature.maine.gov/doc/7425

2022	Report Regarding the System of Oversight of Maine's Child Protective Services

Information Brief: Oversight of Maine's Child Protective Services

OPEGA presented facts and background information to describe state and federal oversight of child protective services. There were 10 key lessons and observations highlighted in 5 categories:

1. **Current structure of oversight of DHHS/OCFS and child protective services broadly:**
    a. Child protective services as administered by DHHS/OCFS are subject to in-depth regulatory oversight by the federal government as well as advisory oversight from a network of state-level entities.
    b. Federal oversight is comprehensive and outcomes-oriented with financial penalties for nonconformity.
    c. State-level advisory oversight engages all three branches of government and both public and private sector stakeholders.
2. **Roles and responsibilities of the entities involved in child protective services oversight:**
    a. The roles and responsibilities of the different entities address both macro-level oversight of the system and micro-level review and oversight of specific CPS cases, including cases of death and serious injury.
    b. The four state-level panels and the Ombudsman have distinct missions, but there is a degree of overlap as well as nuanced differences in the scope of their activities.
3. **Information sharing between entities, including barriers or gaps:**
    a. Information is routinely and regularly shared among the state-oversight entities and DHHS/OCFS. This routine information sharing among the panels is often the result of individual panel members and DHHS/OCFS staff being members of more than one oversight entity.
    b. Work is currently being done by several of the state oversight entities to formalize and institutionalize information sharing practices to ensure continuity in information sharing over time.
4. **Best practices and models of oversight of child protective services:**
    a. The state-oversight entities, including the four panels and the Ombudsman, are structured in a manner, and are practicing in a manner, that generally conform to published best practices for entities overseeing child protective services.
    b. Several of the entities have recently made or are in the process of implementing changes to improve alignment with published best practices.
5. **Effectiveness of the structure of child protective services oversight. Without the benefit of a full evaluation, we cannot draw evaluative conclusions about effectiveness. However, based on the limited research for the Information Brief, we can say:**
    a. The oversight structure includes many opportunities for DHHS/OCFS to obtain multiple points of view and draw on the expertise of several professional disciplines engaged in child protection across the private sector and multiple levels and branches of government.

Discussion and GOC Actions:

- GOC Meeting 01-21-2022
    - Presentation Slides – Oversight Info Brief https://legislature.maine.gov/doc/7925
    - Minutes – Questions from the Committee https://legislature.maine.gov/doc/8133

Compendium of OPEGA's Work on Child Protection at the Direction of the GOC, including GOC Discussion and Actions

- GOC Meeting 02-11-2022
  - Minutes – https://legislature.maine.gov/doc/8371
  - Public Comment on OPEGA Info Brief regarding CPS oversight – Betsey Grant, Bill Diamond, Victoria Vose, Christine Alberi, Molly Bogart https://legislature.maine.gov/doc/8139
  - OPEGA provided an update on CPS bills in the HHS Committee https://legislature.maine.gov/doc/8137
- GOC Meeting 03-11-2022
  - Minutes https://legislature.maine.gov/doc/8491
  - Memo provided to GOC regarding summary of OPEGA Info Brief and relevant public comment https://legislature.maine.gov/doc/8372
    - Additional CFSR information requested by the Committee https://legislature.maine.gov/doc/8388
    - GOC work session on confidentiality statutes among various CPS oversight organizations https://legislature.maine.gov/doc/8375
  - Update to GOC on HHS Committee timeline from Senator Claxton, Senate Chair https://legislature.maine.gov/doc/8376

2022 | Report Regarding Investigations in Child Protection Services

OPEGA Evaluation: Child Protective Services Investigations

OPEGA performed an evaluation of the processes for child welfare investigations at the Office of Child and Family Services with a focus of protecting child safety. Related below are the key takeaways followed by specific issues and recommendations for the agency and policy considerations for the Government Oversight Committee.

Common Misconceptions about Child Welfare

- There are a number of common misconceptions that limit individual and collective understanding of the realities of child welfare, which may lead to unreasonable expectations and missed opportunities for improvement. These misconceptions include the role and authority of OCFS and other key parties; the availability of timely, accurate, and complete information; and the causes and preventability of adverse outcomes. (See page 11.)

Child Welfare Philosophy and the "Pendulum Swing"

- There is a continuum of child welfare philosophies that emphasize child safety and family preservation to varying degrees. Child welfare practice at any given time may vary in response to the prevailing philosophy. Federal and state laws and policies have reflected both family-oriented and child safety principles, and have not substantially changed in several decades. In recent years, demands on the child welfare system have changed periodically as a result of elevated concerns caused by events like high-profile child deaths or unusually high numbers of children in state custody. Regardless of the prevailing child welfare philosophy at any one time, the initial investigation provides the basis for critical child safety decisions. (See page 14.)

Investigation Process Design

- Child abuse and neglect investigations are designed by OCFS to be comprehensive, employing structured tools to guide workers and supervisors to make decisions about child safety at several points throughout the course of the investigation. It is the goal of investigations that all threats to child safety be addressed, planned for, and/or resolved within a 35-day timeframe. The process, however, is lacking in guidance for sufficiency of investigation thoroughness and how to triage multiple cases and priorities. (See page 18.)

Training and Supervision of Caseworkers

- There is wide agreement that the training offered to new caseworkers has been insufficient to prepare them for investigations work. Over the past two years, OCFS has collaborated with the Cutler Institute of the Muskie School of Public Service to restructure the training, and a new course of training took effect in January 2022. (See page 28.)
- Supervisors have significant involvement in the training of new caseworkers, and they support a relatively inexperienced staff of caseworkers in the midst of relatively high turnover. (See page 33.)
- Supervisors are key to the investigations process. Supervisors assign investigations to caseworkers and monitor the whereabouts of caseworkers for safety purposes. They are involved in critical safety decisions at various points, and they provide support, mentoring, and oversight of investigations caseworkers throughout the investigations process. (See page 33.)

Quality Assurance Case Reviews

- OCFS's Quality Assurance Program performs ongoing case reviews. The reviews are conducted based on the federal Child and Family Services Review (CSFR) protocol. OCFS uses case reviews both during the federal CSFR period and on an ongoing basis as a tool for understanding and monitoring the quality of investigations of reported and alleged child abuse or neglect. The standards and expectations of the case review system are very high, and meeting them requires exceptionally thorough and comprehensive work to evaluate risks. (See page 34.)
- The QA case review results indicate a lack of overall thoroughness and completeness in investigations. However, we observed that caseworkers do generally appear to be thorough and complete in the assessment of the most critical and relevant risk and safety concerns, and the most critical and relevant individuals, with respect to the reported allegations. We attribute the lack of thorough and complete investigations to issues related to workload. (See page 36.)
- While infrequent, we observed several practice issues in the conduct of investigations that do not appear to be a function of workload challenges, but rather departures from expected practice. (See page 40.)

Perspectives on Elements Impacting Investigations

- OCFS staff reported that their workloads are unreasonable and that they do not have adequate time to understand risks to the child or the needs of the family. (See page 41.)
- Caseworkers reported that families are usually willing to engage with CPS during investigations, though they are sometimes unwilling to participate in services offered. (See page 45.)
- The sharing of medical and treatment information with OCFS appears to be a barrier to completing thorough and timely investigations. (See page 46.)

Family Perspectives and Service Needs

- Parents and children may experience a variety of reactions during a CPS investigation, including fear and confusion. Organizations that advocate for parents indicate that support for parents to assist in understanding and navigating a CPS investigation would be beneficial. (See page 49.)
- Access, availability, and engagement in services for families were concerns that emerged through interviews with OCFS management and other stakeholders, as well as in our surveys of caseworkers and supervisors, and in the results of the federal oversight of OCFS. (See page 51.)

Issues and Recommendations

OPEGA makes three recommendations for OCFS management's consideration. OPEGA recommends that OCFS:

1) Take steps to address the workload issue to ensure that caseworkers and supervisors have the time necessary to conduct thorough investigations and more effectively assess the safety risks to children and the needs of families; (Specifics on page 52.)
2) Evaluate the nature and extent of after-hours work requirements and expectations currently placed on caseworkers, and the risks to caseworker effectiveness and burnout; design and implement policy and program changes to address identified issues and risks; and consider restructuring the delivery of Children's Emergency Services to decreases or even eliminate required overnight shifts for caseworkers and supervisors; (Specifics on page 55.)

3) Build on the foundation of its existing QA system of case reviews to better identify specific practice concerns in a timely manner, within all OCFS districts, and link those concerns to opportunities for supervisor feedback, mentoring, and potentially additional training for individual caseworkers and other district staff. (Specifics on page 56.)

Policy Considerations

OPEGA recommends that OCFS, and the GOC as appropriate, consider the following additional areas noted, but not fully evaluated, in this review:

- **Training of new caseworkers and their transition into the field.** (See page 57.)
- **Caseworker access to medical records and treatment information.** Reluctance of parents' substance use and mental health providers to speak with caseworkers or share medical records can be a barrier to investigations. (See page 58.)
- **Services for children and families in the CPS system.** Mental health, substance use disorder treatment, in-home behavioral health services, and case management services appear to be inadequate in comparison to their need. (See page 59.)
- **Prevention of child abuse and neglect.** Child welfare practitioners describe three levels of prevention: (1) primary prevention, which is directed to the whole population, (2) secondary prevention, which is targeted to families experiencing risk factors, and (3) tertiary prevention, for families in which child abuse or neglect has already occurred. OCFS is primarily engaged at the level of tertiary prevention. Federal and state child welfare experts recommend that states invest in and coordinate efforts at all three levels of prevention. According to the U.S. Centers for Disease Control, the prevention of child abuse and neglect requires a comprehensive focus that crosscuts key sectors of society (for example, public health, education, social services, and the judicial system). (See page 59.)

Discussion and GOC Actions:

- GOC Meeting 03-25-2022
  - Minutes GOC questions regarding the report answered by OPEGA and additional questions to OCFS answered by Director Landry and Bobbi Johnson https://legislature.maine.gov/doc/8530
  - Investigations Report Slides – https://legislature.maine.gov/doc/8494
- GOC Meeting 04-08-2022
  - Public Comment CPS – Investigations: Senator Bill Diamond; Molly Bogart, DHHS; Laura Tomascik, resource parent; Melanie Blair, resource parent; Melissa Hackett Maine Children's Alliance & Maine Child Welfare Action Network; Richard Wexler, National Coalition for Child Protection Reform; Richard Hooks Wayman, resource parent and Volunteers of America Northern New England ; Tonya DiMillo. https://legislature.maine.gov/doc/8536
  - OPEGA summary of report recommendations and related legislation currently proposed. https://legislature.maine.gov/doc/8533
  - LD 960 130th 2nd Regular Session – An Act To Make Changes to the Laws Governing the Child Welfare Services Ombudsman Program P.L. 2021 c.550 https://legislature.maine.gov/doc/8532
  - DHHS/OCFS Responses to Questions posed by the GOC and HHS Committee on 03/25/22 https://legislature.maine.gov/doc/8535

Compendium of OPEGA's Work on Child Protection at the Direction of the GOC, including GOC Discussion and Actions

- GOC Meeting 04-13-2022
  - Minutes https://legislature.maine.gov/doc/8631
  - OPEGA summary of Actions Suggested at 04-08-2022 Public Hearing https://legislature.maine.gov/doc/8548
  - USM / OCFS Caseworker Foundations Training document https://legislature.maine.gov/doc/8547
  - DHHS/OCFS Responses to Questions posed by the GOC and HHS Committee on 04/08/22 https://legislature.maine.gov/doc/8546
  - OPEGA update of CPS bills in the 130th Legislature https://legislature.maine.gov/doc/8545
  - Letter from HHS Committee to Director Landry requesting updates to specific questions raised as a result of OPEGA's evaluation of Investigations. https://legislature.maine.gov/doc/8544
  - OPEGA memo to GOC restating report conclusions and providing options to the Committee to address or further define CPS issues. https://legislature.maine.gov/doc/8543
- GOC Meeting 05-18-2022
  - Minutes https://legislature.maine.gov/doc/8632 includes conversation with AAG Chris Taub regarding "what ability the GOC has to meet in executive session to discuss otherwise confidential matters or documents that are not presently available to the committee as public elected officials." The Joint rules and statutes referred to in this discussion are in: https://legislature.maine.gov/doc/8597 .
  - GOC letter to OCFS relaying questions for the Office https://legislature.maine.gov/doc/8595
  - OCFS Response to GOC regarding specific questions (discussion with Bobbi Johnsons and Molly Bogart - in minutes) https://legislature.maine.gov/doc/8598
  - OPEGA provided legislative update on CPS issues to GOC https://legislature.maine.gov/doc/8596
- GOC Meeting 06-15-2022
  - Minutes. The discussion involving CPS was a continuation of the conversation with Bobbi Johnson and Molly Bogart answering GOC questions for OCFS. https://legislature.maine.gov/doc/8679
- GOC Meeting 07-20-2022
  - Minutes https://legislature.maine.gov/doc/9049
  - Second Public Comment Period on OPEGA's CPS – Investigations Evaluation: Melanie Blair; Rachel Grubb; Arleen Sue Carter; Bill Diamond; Jennifer Pieces; Jessica Beck; John and Johnna Morton; Les Cook; Kristine; Mary-Gene Rumery; Stephanie Gaddar; Marcia Rogers; Sarah Sue Wood; Melissa Hackett. Others are recorded in minutes. https://legislature.maine.gov/doc/8689
  - Update to GOC on OPEGA's work regarding "Reunification" Phase 3 of the scope approved in August of 2021. https://legislature.maine.gov/doc/8685
  - After discussion with OCFS, OPEGA provided the GOC with the type of information available in the confidential casefiles from OCFS. https://legislature.maine.gov/doc/8684

- Memo to GOC from OPEGA providing more detailed information regarding media-reported child deaths where OCFS was involved. https://legislature.maine.gov/doc/8683
- Letter from AAG Gannon to Director Landry stating the opinion that confidential CPS records can be provided to OPEGA as the GOC's investigative arm, but not to the Committee directly. https://legislature.maine.gov/doc/8682
- Letter from OCFS – responses to questions from GOC at 06/15/2022 meeting https://legislature.maine.gov/doc/8681
- Presentation of SDM tools by Evident Change https://legislature.maine.gov/doc/8680
- **GOC passed a motion to have OPEGA continue it evaluation of phase 3 of the CPS scope: Reunification.**
- **GOC passed a motion to request casefiles to review in executive session**

- GOC Meeting 09-21-2022
  - Minutes. Discussion of Current Reunification work. Discussion of potential phase 4 projects. Discussion of OPEGA review of confidential casefiles. Discussion with counsel in executive session regarding response to DHHS refusal to provide confidential records directly to GOC. https://legislature.maine.gov/doc/9143
    - OPEGA future project recommendations in the realm of CPS https://legislature.maine.gov/doc/8940
    - Letter from DHHS Commissioner refusing request for confidential records https://legislature.maine.gov/doc/8939
  - **GOC passed a motion to direct OPEGA to do a "rapid review" of CPS casefiles with respect to 4 specific children's deaths. This put the Reunification work on hold.**
  - **GOC passed a motion to Subpoena the DHHS/CPS records – the casefiles (previously requested and denied) of the 4 children fatalities for the Government Oversight Committee to review in an Executive Session on October 19, 2022.**
  - Subpoena issued by GOC for confidential DHHS records to review in executive session https://legislature.maine.gov/doc/9121
  - DHHS subpoena response https://legislature.maine.gov/doc/9132
- GOC Meeting 01-13-2023
  - Minutes https://legislature.maine.gov/doc/9555
  - Superior Court denied GOC's motion to Compel https://legislature.maine.gov/doc/9464
  - GOC in executive session with counsel to discuss response.
  - **GOC passed a motion to move forward with an appeal of the Superior Court's decision.**
  - **GOC passed a motion to allow chairs and leads to be the liaison to Mr. Taub (counsel for GOC) for the appeal process.**

2023 | Report Regarding Case of Hailey Goding

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

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. This is the first of those four reports.

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:

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. We 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.

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. 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.

Discussion and GOC Actions:

- GOC Meeting 02-10-2023
  - Minutes – Questions regarding the report answered by OPEGA. Additional questions to Director Landry of OCFS. https://legislature.maine.gov/doc/9876
  - "Reunification" project is paused. https://legislature.maine.gov/doc/9714
  - 2022 Child Welfare Ombudsman's Report https://legislature.maine.gov/doc/9711
  - OCFS provided its published response letter to the most recent Ombudsman's Report https://legislature.maine.gov/doc/9712

Compendium of OPEGA's Work on Child Protection at the Direction of the GOC, including GOC Discussion and Actions

- GOC Meeting 03-10-2023
  - Minutes https://legislature.maine.gov/doc/9938
  - Public Testimony Regarding OPEGA Report: Michelle Ortega; Melanie Blair; Melissa Hackett; Letter from DHHS/OCFS in response to OPEGA report. https://legislature.maine.gov/doc/9929 Additional non-written testimony provided by Betsey Grant; Victoria Vose; Allison Porter; Brian Picciano; and Mark Moran (see minutes above).

2023 | Report Regarding Case of Maddox Williams

OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Maddox Williams

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. This is the second of those four reports.

OPEGA's Overall Conclusion on OCFS Safety Decisions for Maddox Williams
Overall, OPEGA concluded that OCFS safety decisions regarding Maddox Williams were not unsound within the legal, policy, and practice frameworks through which the Department must process its information.

OPEGA identified one Legal Issue, one Practice Issue, and one Resource Issue, all with corresponding recommendations; one Public Policy Consideration; and two Potential Opportunities for Improvement.

Legal Issue: Existing Process May Not Adequately Ensure Robust Documentation of Legal Justifications for Not Filing an Otherwise Statutorily Mandated TPR Petition
Recommendation:
OCFS should look to better formalize and more robustly document this specific decision in its process and system to prompt staff to make this decision according to the timeframe specified in statute in an effort to promote permanency for children in foster care.

Practice Issue: Custodial Arrangements Were Not Explored for All Children in the Home
Recommendation:
OCFS should provide guidance to supervisors and caseworkers on the practice of exploring custodial arrangements of the identified children in the household. Understanding the composition of the household, including any out of home parents and the corresponding custodial arrangements (such as when the child will be residing with the other parent), may be a means of obtaining information about the family and the potential risk and safety concerns. It also may be a means of gaining permission to interview or observe children during the course of an investigation, who are otherwise being prevented from being accessed by another parent. OCFS should reinforce this practice through communication and training of staff and amend the investigations policy and pursue any related forms, if necessary, to ensure this investigative task is always completed by caseworkers.

Resource Issue: Staff Vacancies May Impact Casework
Recommendation:
OCFS should conduct a comprehensive examination of CPS caseworker vacancies to identify and propose new strategies to recruit and retain staff. Resulting strategies should be specifically targeted and focused on child protective caseworker positions to address the staffing vacancies within this area of social work. This examination should include the following:

- continue to determine the underlying reasons for CPS caseworker vacancies through exit and stay interviews and how concerns of child protection caseworkers specifically may be alleviated;
- examine the fundamental structure of caseworker and supervisor jobs, and assess whether any restructuring would promote staff retention;

- explore changes to the retirement system and other incentives specific to child protective services casework to promote staff retention and longevity (The Department notes that the work of OCFS field staff is substantially analogous to that of other first responders, including law enforcement, but these staff do not benefit from the same treatment in statute and policies.);
- examine the Department's current requirement that caseworkers be licensed social workers;
- work with the State Board of Social Worker Licensure to develop a means of getting otherwise qualified applicants the requirements they need to become licensed; and
- report back to the Legislature on the status of these efforts and the current number of vacancies.

Potential Opportunities for Improvement:

1) **Continue OCFS Research into Identifying Risk Factors Related to Targeted Children**
2) **Increase Availability of CODE Resources**

Public Policy Consideration: Persistent Disconnect Between Public Expectations for the CPS System and the Current Legal and Policy Framework and Capabilities of OCFS

Discussion and GOC Actions:

- GOC Meeting 04-14-2023
  - Minutes including questions to OPEGA and to Director Landry of OCFS https://legislature.maine.gov/doc/10043
  - DHHS revised memo regarding the timeline of the Maddox Williams Case https://legislature.maine.gov/doc/10032 Original memo is Appendix A of OPEGA Report (linked above).
- GOC Meeting 05-26-2023
  - Minutes https://legislature.maine.gov/doc/10192
  - Caseworker Table associated with Maddox Williams case: https://legislature.maine.gov/doc/10138
  - Maddox Williams case Visual Timeline: https://legislature.maine.gov/doc/10137
  - Public Comment on OPEGA Report: https://legislature.maine.gov/doc/10132 Christine Alberi; Betsey Grant; Bill Diamond; Melissa Hackett; Melanie Blair. Additional unwritten testimony by Victoria Vose, Maddox Williams' grandmother; and Mark Moran noted in Minutes (above)
- GOC Meeting 07-07-2023
  - Minutes including questions regarding the report to OPEGA and to Director Landry of OCFS https://legislature.maine.gov/doc/10217.
- GOC Meeting 10-18-2023
  - Minutes including discussions with Molly Bogart and Todd Landry regarding Customer Wait Times in DHHS and OCFS (pages 4-8) and further discussion of a media news report regarding Maine's most recent Annual Service & Progress Report (ASPR) and the GOC's desire to intensify their meeting schedule to provide recommendations for the full legislature by January. (pages 8-9) https://legislature.maine.gov/doc/10407 .
- GOC Meeting 11-01-2023
  - Discussion of strategies for the Committee to accomplish its work. The discussion revolved around a goal for the GOC to provide recommendations to the full Legislature regarding how to make the system of child protection better. The

prevailing view was to hear from frontline workers of the system and use that information to inform further investigation. Prior work regarding frontline perspectives can be found in (Information Brief: Frontline Workers in the State Child Protective System – Perspectives on Factors That Impact Effectiveness and Efficiency of Child Protective Work and OPEGA Evaluation: Child Protective Services Investigations). (See 11-08-2023 GOC meeting, below, for testimony from frontline workers.) Viewpoints from the courts were also desired by members of the Committee. Discussion continued regarding how to obtain testimony from front-line workers while ensuring their job security and protecting confidential information.

Approaching the problem from two perspectives was suggested: aspects to prevent families from entering the system in the first place along with improving the performance of the system once in it.

There were questions regarding how mandated reporters are responded to by the department. (See OPEGA Evaluation: Child Protective Services Investigations page 43 for survey results of mandated reporters.)

Another topic of conversation included questions regarding how often caseworkers and AAGs disagree on or don't align their opinions in CPS court cases. [OPEGA note: OPEGA interviews with caseworkers and supervisors reveal that CPS cases have numerous decision points which may move the trajectory of the case in one direction or another. Disagreements are common in certain cases but typically move to consensus as the jeopardy petition or TPR is prepared.]

It was noted that drug use is common in the cases studied. Members expressed concerns about the variability and adequacy of testing in the State. Why can some facilities test for fentanyl and others cannot?

There were questions regarding whether parents should be able to keep a caseworker from coming into their home to inspect their children once a parent has been found to have children that are at risk.

The meeting continued with a discussion of the most recent Annual Progress and Services Report (APSR) highlighted in a recent media report. OPEGA produced a compilation of historical APSRs. https://legislature.maine.gov/doc/10377 .

The GOC passed a motion to allow OPEGA to interview CPS staff about their experiences in the department. Minutes: https://legislature.maine.gov/doc/10456

  - OPEGA staffing the Committee, provided a discussion power point: https://legislature.maine.gov/doc/10376 .
  - OPEGA staffing the Committee, provided an APSR trend report https://legislature.maine.gov/doc/10377 .
- GOC Meeting 11-08-2023
  - Testimony from front-line CPS workers: https://legislature.maine.gov/doc/10439

	Maureen Cote, Diane McGonagle, Mindy Bard, Sara Ament, Sen. Michael Carpenter, Rochelle Kadema plus written testimony from Dean Staffieri (including testimony to HHS Committee 01/25/2022.)

2023	Report Regarding Case of Jaden Harding

OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Jaden Harding

Through our review of the larger history of CPS involvement, OPEGA identified:

- two unsound safety decisions in which we conclude that the facts of the case—as known at the time—warranted additional Departmental intervention to ensure the safety of the children in the home prior to Jaden's birth;
    - **Unsound Safety Decision 1:** No Additional Interventions or Safety Planning to Ensure the Safety of the Children (Prior to Jaden's Birth) from the Man Living in Ms. Hartley's Home (February 2020)
    - **Unsound Safety Decision 2:** No Additional Interventions or Safety Planning when Ms. Hartley's Out-of-State Relatives Leave Her Home (June 2020)

- two overarching practice issues that spanned multiple investigations and ultimately prevented the Department from making other necessary and appropriate safety decisions and taking related actions to ensure the safety of the children in the home prior to Jaden's birth;
    - **Overarching Practice Issue 1:** Important Connections Missed by OCFS Across Multiple Investigations Regarding the Risks Posed by Ms. Hartley's Relative (And Alleged Abuser of Her Children)
        - **Recommendation:** OCFS should develop a process and standard for identifying which families' CPS histories should be subject to a more comprehensive review. Additionally, OCFS should ensure that any staff assigned this work have the time and resources needed to conduct them.
    - **Overarching Practice Issue 2:** No Comprehensive Review of the Family's Prior CPS Involvement That Would Have Shown a Pattern of Ms. Hartley Allowing Unsafe Individuals Around Her Children

- eight practice issues that occurred during specific investigations that were both prior to and following the announcement of Ms. Hartley's pregnancy with Jaden;
    - **Practice Issue 1:** Extremely Overdue Investigation with Periods of No Investigative Activity (April 2018)
        - **Recommendation:** Although we did not review data that would enable us to quantify the impact of the 2018 policy changes on workloads, we would still recommend that the Department take a thoughtful, measured approach to future policy changes with a focus on potential workload impacts to avoid

similar risks—especially as the Department experiences difficulties in the recruitment and retention of caseworkers

- **Practice Issue 2:** Inadequate Efforts to Locate the Family (April 2018)
  - **Recommendation:** As the Department continues to update its investigations policy and any related documents, we recommend that the "Activities to Locate" tool continue to be used and caseworkers continue to be trained in its application.
- **Practice Issue 3:** Incorrect Identification of Alleged Abuser by Intake (March 2019)
  - **Recommendation:** While we do not know the extent to which intake screening errors such as this occur, we do recommend that OCFS consider implementing a mechanism into their existing process to denote instances in which intake—and not the referent—has identified a critical case member. In denoting these individuals, caseworkers may be more cognizant of the need to verify the accuracy of the identities provided solely by intake.
- **Practice Issue 4:** Reported Allegations and Safety Threats Unexplored by Caseworkers (April 2018, March 2019, and March 2020)
  - **Recommendation:** OCFS should clarify and communicate its expectations for what caseworkers should do when an "FYI report" that would otherwise be screened out is added to an open investigation. For other screened-in reports containing multiple allegations, supervisors should ensure that caseworkers, at a minimum, discuss all allegations with the parents/caregivers.
- **Practice Issue 5:** Inconsistent and Sometimes False Information Unexplored by Caseworker (February 2020 and March 2020)
  - **Recommendation:** OCFS should make efforts to communicate and reinforce its expectation that caseworkers identify and challenge inconsistencies in the information provided to them by families.
- **Practice Issue 6:** Status of Bangor Police Department Investigation Unexplored by Caseworker (February 2020 and March 2020)
  - **Recommendation:** Although we are unsure of the extent to which a scenario like this occurs, we believe that following up on the results and status of earlier criminal investigations can provide valuable information to caseworkers. As such, OCFS should consider developing guidance for closing summaries specifying how caseworkers are to document that there are ongoing criminal investigations at the time the investigation closes, and, also, establish expectations for what subsequent caseworkers are to do when they review that documentation in the future.
- **Practice Issue 7:** Installation of Child Safety Locks Not Verified by Caseworker (March 2020)
  - **Recommendation:** OCFS should consider the development of a process to ensure that any tasks identified as next steps to complete the investigation as part of the preliminary safety decision are revisited by the caseworker and supervisor prior to the closure of the investigation. Any steps that are determined to still be relevant, but not yet performed should be performed before the investigation is closed.
- **Practice Issue 8:** Mr. Harding's Safety Never Assessed (June 2020)

        - Recommendation: OCFS should consider revising its investigations process and related checklists to require caseworkers to confirm a family's living arrangements and all household members have been identified when nearing the end of an investigation to ensure that the safety of all individuals residing in the home with access to the family's children is assessed before the investigation is closed. This is particularly relevant as it appears the living arrangements and household compositions of the families that the Department works with can change often and sporadically.
- one systems issue that contributed to the Department not fully understanding the risk that Ms. Hartley's relative/alleged abuser of her children posed to the children (other than Jaden) at a later point in the timeline;
    - **Systems Issue 1:** Multiple Profiles for the Same Individual
        - **Recommendation:** Even with the improvements offered through the use of Katahdin, OCFS should establish appropriate search guidance to be used by caseworkers to mitigate the risks associated with multiple profiles. This guidance could include more thorough search criteria, such as adding a date of birth or social security number. The Department should also review its current guidance related to screening people into the Department's various systems to ensure that guidance outlines a process that appropriately addresses the risks associated with entering multiple profiles for a single individual.
- three potential opportunities for improvement.
    - Identify and Provide Appropriate Levels of Services for Families
    - Improve Information Sharing Between OCFS, Law Enforcement, and the Courts
    - Improve Feedback and Management Expectations

- GOC Meeting 11/15/2023
    - Presentation of OPEGA Report on the Case of Jaden Harding followed by continued testimony from Bobbi Johnson and Molly Bogart and then select front-line workers: Bethany Fournier – Resource Parent, Occupational Therapist and Executive Director of the Nonprofit Nanna's House; Masha Rogers – Retired CASA Guardian Ad Litem, District 7 + Foster Parent; Sandra Hodge – Founding member of the Child Death and Serious Injury Review Panel, past Program Specialist for the Child Protective Services central office; Kerry Hewson – CASA Guardian Ad Litem + School Nurse; MaryAnne Spearin – Superintendent of Schools, Washington County; Stacey Henson-Drake – Investigations Caseworker, District 3 OCFS; Priscilla Girard – Guardian Ad Litem + LCSW; https://legislature.maine.gov/doc/10479.
- GOC Meeting 11/29/2023
    - Public Testimony regarding OPEGA's report on Jaden Harding: Melanie Blair, Shawn Yardley, Mark Moran, Christine Alberi, Melissa Hackett https://legislature.maine.gov/doc/10462 .
    - OPEGA Document: House Composition over time – Mother of Jaden Harding https://legislature.maine.gov/doc/10452 .
      (minutes unavailable as yet).

Compendium of OPEGA's Work on Child Protection at the Direction of the GOC, including GOC Discussion and Actions

- GOC Meeting 12/06/2023
  - DHHS Commissioner's Response to Questions from the Government Oversight Committee: https://legislature.maine.gov/doc/10481 .
  - Discussion with Commissioner Lambrew and Acting Director Bobbi Johnson.
  -
- GOC Meeting 12/13/2023
  -

Future CPS Reports on OPEGA's Work Plan

2024 OPEGA Evaluation: Child Protective Services - Reunification

2024 OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Sylus Melvin