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Testimony to Government Oversight Committee regarding the practices of Maines' Child Protective Services.

July 20, 2022

I would like to start by thanking you all for your continued efforts at improving the child protectives services of Maine, and for allowing public testimony today. As most of you know already, name is Melanie Blair. I am a licensed foster parent of going on 8 years, which had been a pleasant and rewarding experience until last year. I know that you probably all know the experience my family went through in December, so I won't take the time to repeat unless you have questions. I will however briefly give you some background information about where I am coming from aside from being a foster parent. I started my college experience with an associates degree in criminal justices and going through the reserve academy therefore, I am safety focused. After having a couple children, I changed gears and worked in banking for 7 years. At the collapse of the market, I went back to school and obtained my associates degree in Elementary Education. At this time I worked in behavior programs (etc.Spurwink), and did so for around 7 years until I was able to start working at a public school in special education and behavior. I did this for 15 years while completing my bachelor's degree in liberal studies with a focus in elementary education. The lense through which I look at all this data and experience is evaluative, and safety focused. Today I will focus on points of system failure that I have personally experienced.

department would truly listen to and work collaboratively with ALL parties, I believe will see true change in the number of child deaths that have had department involvement. This does not need to be about blame and punishment, rather- accountability and transparency. Meaning, that some policies are just not working and need to be changed, that poor decisions have been made, and a willingness to learn and grow from mistakes rather than deflect and cover them up.

Facts and research to support my position in addition to the OPEGA Report that outlined the shortcomings of OCFS:

CASEY FAMILY PROGRAM LETTER TO DR. LANDRY, dated October 2021

" TRANFORMING CULTURE/TOGETHER"

In a report to Dr. Landry, Casey keyed in on 7 recommendations that I have summarized in bullet points:

- Collaborations with others
- Communication
- Coordination
- Consistency
- Supporting engagement
- After hours policies, time frames and redundant work tasks

Most of these points I have addressed above as issues I have had person negative experience with. The department may argue that my case is not common, this kind of thing is rare, but according to OPEGA's report, as well as this one, these recommendations support my claims as NOT being unique, rather prevalent.

Importance of human factors in data collection:

According to Casey family report, human factors data is needed because people do not operate in a vacuum rather while constantly interacting within the system they work in. Therefore, hard factual information may serve little purpose in trying to understand WHY systems encounter difficulty if it is not understood from the

*In consideration of this, I would like to offer a solution to solve this problem, and accomplish goals in the Child Welfare Practice Model. I would like to committee to consider forming a sub-committee of some-sort that would comprise of foster parents, educators, childcare providers, child service providers etc. That the committee would be open to having periodic Town Hall sort of Forums that we could present issues and concerns to GOC. Despite the commissioners comment that there are already 4 groups that do this, none of them are independent of department influences. In doing this, I am simply asking for a way to have a collaborative seat at the table to voice our concerns free of the fear of department retaliation.

In addition, I would like to ask the committee to consider an Ombudsman branch that is just for f/p, c/c/w, educators, etc. The current system is not adequate to handle all that comes in, and whereas the governor has already approved to strengthen this program, I would request consideration to have a person there that focus solely on these issues. From a professional standpoint, complaints regarding upper management or in this case the department, should be handled with someone independent of the boss you are complaining of so to speak. It is not customary to file a complaint about your boss to your boss. Until there is an independent agent to hear and address these issues, you will not uncover and be able to resolve the difficulties in department culture as is evident in each report you have received. There is great dissatisfaction from caseworkers as well as foster parents etc., there is high turn over, perpetuating a re-training cycle rather than valuing and keeping the support staff you have. There is a consistent issue going on that needs to surface, and you will not get to the bottom of it until those of us on the front lines are able to share our stories free from the fear of retaliation or retribution. Perhaps then the department will be able to retain not only its caseworkers, but it's foster parents as well. We work with these children daily, interact with the families, and according to the 'model' should be valued as part of the team.

2007- May 2021 Maine Child Death Report Summary Analysis:

Melanie Blair

*please note that there are approximately 30 deaths not accounted for in this report.

58 "Accidents":

31 were classified as co-sleeping incidents, 30 of which had previous department involvement and the remaining 27 were unspecified. In summary:

- 39 out of 58 (67%) had previously received department SERVICES.
- 23 out of 58 (40%) - death occurred DURING an open case
- 14 out of 58 (25%) had a previous CUSTODY case

19 "Natural":

6 were labeled as "SUID", 1 occurring during an open case, 2 with previous services received, and 4 with alternative response.

The remaining 13 were "other natural of which 4 occurred during an open case, 3 had a previous custody case, 10 had previous services received and 1 with an alternative response. In summary:

- 12 out of 19 (63%) had previously received SERVICES
- 5 out of 19 (26%) occurred DURING an open case
- 3 out of 19 (16%) had a previous CUSTODY case
- 5 out of 19 (26%) had a previous alternative response

7 "Suicides" all occurring between July 2019 and May 2021:

- 6 out of 7 (86%) previously received services
- 1 out of 7 occurred during an open case

33 "Undetermined" :

20 of the 33 listed as undetermined, 10 out of 33 as SUID/undetermined, and 3 out of 33 C0-sleeping/undetermined.

In summary:

- 26 out of 33 (79%) had previously received SERVICES
- 8 out of 33 (25%) occurred DURING an open case
- 7 out of 33 (21%) had a previous CUSTODY case

CHILD WELFARE SERVICES PRACTICE MODEL

APRIL 2005

Child and Family Services joins with families and the community to promote long-term safety, well-being, and permanent families for children. This practice model guides our work with children and their families.

CHILD SAFETY, FIRST AND FOREMOST

- Making children and families safe is a collaborative effort. We create a team for each family, consisting of family, staff, and community members to find safe solutions for children.
- In our response to child safety concerns, we reach factually supported conclusions in a timely and thorough manner. Input from parents, children, extended family, and community stakeholders is a necessary component in assuring safety.
- We engage families with honesty and open minds. By exploring and listening, we help families use their strengths to meet safety needs of children.
- We value family perspectives, goals, and plans as critical to creating and maintaining child safety.
- We separate dangerous caregivers from children in need of protection. When court action is necessary to make a child safe, we will use our authority with sensitivity and respect.
- When children are placed in foster care, we ensure ongoing safety through frequent, meaningful contact with children and their caregivers. We welcome foster parents as a vital part of the family team.
- In our work to place children in adoption, safety is the first priority.

PARENTS HAVE THE RIGHT AND RESPONSIBILITY TO RAISE THEIR OWN CHILDREN

- We recognize that family members know the most about their own families. It is our responsibility to understand children and families within the context of their own family rules, traditions, history, and culture.
- Parents' voices are valued and considered in decisions regarding the safety, permanency, and well-being of their children and family.
- We believe that people can change. Their past does not necessarily define their potential.
- Family teams develop and implement creative, individualized solutions that build on the strengths of families to meet their needs.

CHILDREN ARE ENTITLED TO LIVE IN A SAFE AND NURTURING FAMILY

- As family team leaders, we share responsibility with the family and community to help families protect and nurture their children.
- We support caregivers in protecting children in their own homes whenever possible.
- When children cannot live safely with their families, the first consideration for placement will be with kinship connections capable of providing a safe and nurturing home.
- We believe that children's needs are best served in a family that is committed to the child. We support placements that promote family, sibling and community connections, and encourage healthy social development.
- We listen to children. Their voices are heard, valued, and considered in decisions regarding their safety, well-being, and permanence.

ALL CHILDREN DESERVE A PERMANENT FAMILY

- Permanency planning for children begins at first contact with Child and Family Services. We proceed with a sense of urgency until permanency is achieved.
- All planning for children focuses on the goal of preserving their family, reunifying their family, or achieving permanent placement in another family.
- Permanency is best achieved through a legal relationship such as parental custody, guardianship, or adoption. 'Stability' is not permanency.
- Life-long family connections are critical for children. It is our responsibility to promote and preserve kinship, sibling, and community connections for each child. We value past, present, and future relationships that consider the child's hopes and wishes.

HOW WE DO OUR WORK IS AS IMPORTANT AS THE WORK WE DO

- Our organization is focused on providing high quality, timely, efficient, and effective services.
- As with families, we look for strengths in our organization. We are responsible for creating and maintaining a supportive working and learning environment and for open communication and accountability at all levels.
- As we work with children, families, and their teams, we clearly share our purpose, role, concerns, decisions, and responsibility.
- Relationships and communication among staff, children, families, foster parents, and community providers are conducted with genuineness, empathy, and respect.
- Our staff is our most important asset. Children and families deserve trained, skillful staff to engage and assist families.

130th Legislature
Senate of Maine
Senate District 25

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Appropriations & Financial Affairs
Committee, Chair

Rachel Grubb
208 Range Rd.
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My name is Rachel Grubb. I am a mother, a nurse, and recently completed my master of public health. My family has been a foster family since 2017. We have had four placements ranging from six months to one year. We recently got a little girl back after she had been with her mom for seven months. We originally had her with us from September 2020 to September 2021.

Since she was placed back with my family, we have noticed a marked lack of humanity from DHHS staff and a lack of regard for what the child, her bio family, and what my family deserve. For instance, when I requested a placement letter (standard operating procedure is to get a letter when you have a new placement) I was told by the case worker, "It's not my job." Several weeks later when I expressed concern that I still hadn't gotten a placement letter, I was told again that "It's not my job and this is low priority." A placement letter has the child's Maine Care number, giving them access to healthcare, and is the written proof from the state that the child is supposed to be with a specific family. Without that letter a foster family has no proof that a child is supposed to be in their house.

During this time the case worker requested that I supervise family visits for the mother and father of the child. I declined. I have three kids in my house, two jobs, and very little free time. I also have a relationship with our foster child's bio family that would not allow me to be impartial. Supervision should be done by a neutral third party and is not the responsibility of the foster family- although sometimes foster families do agree to supervise. When discussing the case with DHHS I was told, "They would have family visits by now, but you would not supervise them!" I pointed out that it is not my job or my responsibility to supervise visits and it most definitely is not my fault that DHHS has not met their obligations to the family.

Thank you Senator Diamond for inviting me to speak. My name is Arlene "Sue" Carter and I am currently the principal at Calais Elementary School and the Calais Alternative School. I started my professional career as a social worker in 1989 as a Child Protective Worker out of the Machias office. I worked for DHHS in that capacity, for 11 plus years. I loved my job and only left because I was given the opportunity to work a school schedule, and with 2 small children it was ideal.

I started work for the Calais School Department in 2000 to facilitate education for students who would be residing in a residential facility that was being open. In 2014 I became the principal of the elementary school in Calais, as well as the alternative school.

My concerns regarding DHHS/CPS have been ongoing and I have communicated these to the local supervisors, Bobbi Johnson, and the Ombudsman.

In 2019-2020, I had made a report to the Ombudsman office about an open child protective case. This past year, the alternative school made a referral on a family. They had made several referrals on this same family and they were getting pretty frustrated with the lack of response. Not long after the staff made this particular referral, I was advised that DHHS had made a referral on the school about the incident.
When I spoke to the institutional abuse investigator, several times she indicated that she was not sure why the referral was made and why it was assigned.

Most recently I made a referral on a family that a parent is employed by DHHS, in the same district, as is a very close family member.

I expressed my concern when I made the referral to the intake worker and later to the supervisor, about what I saw as the conflict of interest. When the local CPS caseworker called me, I expressed my concern again. He said that he was going to talk to his supervisor. When I reached back out to him as he did not call me back, he said that his supervisor did not see it as a conflict. I asked him if he did and he did not answer me.

In June I called the Machias office to pass on info about an open case to the caseworker. I reached child welfare back up who told me who the caseworker was and indicated that the caseworker was out. When I asked if she was "out out" or just out for the day, I was told that she did not know. When I asked about speaking to the supervisor, I was told that CPS caseworker was still working from home 3 days a week, and I was told that the other supervisor left for vacation the previous day. As a result, I had to call and make a whole new referral which as you know is time consuming for me and the person taking the info. This was alarming for two reasons, as it turns out, the caseworker was out and did not return to her job, (although the back up worker did not know this), and why is the CPS supervisor still working from home.

"

Sue Carter

When I was asked to come here today, I asked the school social worker about her concerns, this is what she wrote; Caseworkers rarely call us when we make a referral, (they are supposed to call the referent back is my understanding), and they rarely call the schools to talk to teachers, social workers, etc. to see if the school has any concerns.

When I spoke to Bobbi Johnson, I asked her to look at how long the supervisor's in Machias and the District Supervisor for Machias had been there and then to look at the caseworker turnover. I have spoken to the District supervisor about my concerns which she listens too, provides no feedback but is clear that she expects me to call her with concerns not up the ladder.

When I was a CPS caseworker (1989-2000) we met every single week to go over all of my cases. We may have missed a week occasionally but it was rare. Clearly if several months went by and kids were not seen, there is not a lot of supervision going on.

I just bumped into a caseworker who recently quit and she agreed with my statement that money is not the answer to keeping staff. The State keeps giving caseworkers more and more money. This is their attempt to solve a systematic problem. The problem is not money, and not the caseworkers, the problem in Washington and Hancock County is the lack of supervision and support and the fact that the caseworkers are held accountable and not the supervisors.

Recently, maybe within the last month there have been at least 2 caseworker's quit in Washington County and 2 in Hancock County. If I can see this so glaringly, why can't anyone else?

I am aware that Child Welfare workers recently got a significant salary increase. Even with the increase, caseworkers are quitting at an alarming rate in Washington and Hancock County. I have spoken to several of the caseworkers over the past couple of years, many who have left, they do not feel supported, they do not feel that their supervisors understand how difficult their jobs are, how difficult it is to carry a large caseload and feel confident that you are making the right decisions. Caseworkers feel 100% of the responsibility for the cases and God forbid something happened to a kid, they, and only they would be to blame. In my opinion, the caseworkers may need more money but more importantly they need to feel supported and heard. I have heard from many that they do not feel that they have a positive relationship with their supervisor's and don't feel that their opinions are valued.

In my opinion, many caseworkers are not equipped or trained to perform their job and this impacts their morale and confidence. Historically new caseworkers spent a lengthy period of time shadowing senior caseworkers and would go out on their own when the supervisor felt they were ready based on their assessment and feedback from the senior caseworkers. Now, the turnover is so vast that a caseworker does not have the luxury of feeling confident before taking on a whole caseload. And, if any of the foregoing is true, supervisors are not providing adequate and timely supervision for their staff. I know that all supervisors were once caseworkers, is it unfathomable that they train caseworkers out in the field? I know that I don't ask my staff to do anything that I am not willing to do myself.

Some cases over the last couple of years have had 7-8 caseworkers because of the turnover. Imagine you are a family that is being investigated by CPS, or even worse, a family that has had your children removed and you are working hard to get them back and you go from caseworker to caseworker over and over again. How are families supposed to build trust? How are families

130th Legislature
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Maine
Senate District 26

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Testimony of Sen. Bill Diamond regarding Maine child protection services before the Government Oversight Committee
July 20, 2022

As I sat through the GOC's meeting last month, and as I listened again to the recorded version a couple times since, I was struck by the lack of informative answers given by OCFS representatives to committee members' questions. The responses were often incomplete, vague and many times were simply deflected. The questions were probing and well thought out, and obviously designed to get a better understanding of how OCFS actually functions. However, the answers were frustratingly void of meaningful information to many, and maybe to the Committee members as well.

For example, and I paraphrase, the answers given to the Committee's questions: "Will have to get back to you." "Will have to go back to the data people." "Waiting for the work group to let us know." "Not sure." And the ever reliable: "The pandemic slowed us down."

Examples of OCFS Answers to Specific Questions

Sen. Libby: Sen. Libby was trying to quantify the caseloads for new caseworkers and had to ask his questions repeatedly and in different ways in an effort to get an answer. Still the ultimate answer was "will get back to you."

Rep. Arata: Rep. Arata noted that OCFS answers "sound reasonable," indicating all is going well. Yet, she added, the most recent OPEGA report tells us differently, revealing ongoing problems including failing to meet several federal standards. Rep. Arata's point: Answers don't match the facts.

Sen. Timberlake: The Senator asked why there was only a net of six positions from February to June. What's wrong with the system/process? Response: Answering with many excuses and deflections, totally avoiding the obvious – that there is a leadership problem.

Rep. Blier: "What is the base pay for the beginning case worker?" OCFS didn't know! The answer: "Will have to get back to you." NOTE: OCFS told of their extraordinary, all-out effort to

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Request for a Town Hall Forum

As I mentioned earlier, the frustrations you may be feeling with the lack of specific answers, and knowing that the clock is ticking, is shared many times over by those who are watching and work with the OCFS. The people who have the real answers to your questions are out there and you need to hear directly from them. Many are ready to help you expose the actual problems within OCFS and will tell you what's really going on and how to make positive changes. Their only purpose is to help improve the system for the children they care for.

If you want to pull back that curtain and see for the first time what's happening within OCFS, then I urge you schedule a "town hall" type forum specifically to hear from those who work directly with OCFS such as foster parents, child care professionals, educators, families of children who died while associated with OCFS and employees of OCFS. I receive a minimum of three or four frustrated emails a week from those are directly impacted by OCFS sharing their experiences that provide ground-level examples of what needs to change and how. This is the only way you're going to learn what really happens within the OCFS system. This is the only way you'll get real answers so you can make meaningful changes in a timely manner.

The answers you've been trying so hard to obtain will come to you if you ask the right people and provide the opportunity for those people to speak to you. Some will not dare to take the risk, but hopefully others will. Such a forum could be scheduled soon after Labor Day, thus giving you time to compile the information from their testimony and have OCFS respond to that information before you make any final recommendations.

DHHS and OCFS will strongly object to such a forum for obvious reasons, just as they have to every bill that I've sponsored that would increase transparency within their office. They will no doubt say that they already hold public forums around their districts to get feedback. Actually, the only reason they agreed to establish the public forums is because I sponsored LD 1554 in 2019, which would have established a commission to reform child protective services. When the Judiciary Committee felt there might be a need for such a commission, then and only then did OCFS offer to provide public input at district meetings if the bill was killed.

When checking on what's actually happening at these hearings, I found that in some cases the public is not always allowed to speak for whatever reason. Also, people are not confident that hearings conducted by OCFS would be productive and it would be way too risky to speak up.

You will be pressured from many political entities to NOT hold a public forum. But I sincerely hope you will reject that pressure – like you have already pertaining to this investigation. I urge you to reach out and let the people speak. This would be the first time in my memory that such a public forum would be offered, and maybe the first time something really meaningful will be done to save the lives of children in state care.

My name is Jennifer Pieces my family and I live in Charleston Maine

“Our Written Testimony”

https://docs.google.com/document/d/1unmw6Wz_br1wz0o9Ae9x9oAhMIwuGo2A-emhJmZDDPc/edit

“Our Short Story”

https://docs.google.com/document/d/1XrORqWiUmF0Ihv6ucrEKADKt_rw5nFDEu2a1IKaXLlw/edit

“All those involved”

https://docs.google.com/document/d/17qTKlNU-ZMQZ_giL7Bv3pJljbwHFP9NiKZcali2UsDY/edit

“Table of Contents – Our Complete Story

https://drive.google.com/file/d/1E3BoUgT6PFoPRJ4O4sBAerC7aTUgpoQf/view

Jessica Beck
Via Email countlessdreams9@gmail.com

Good afternoon,

I am sending this email I'm hopes to voice what happened to my family over the last couple of months. A little background about us is that my husband and I have 3 biological children, we have been licensed since 2018, I worked for the State of Maine for 8 years and pursued my own children while taking foster kiddos. My husband works at Fisher Engineering and we reside in Knox County.
Our family has taking several children with extreme trauma and while we would love to help everyone in care, we had made a tough decision to be very firm with what we are and are not willing to expose our children to.

When screening for placements we have been very specific to not take children who have known sexual abuse trauma or violent behavior (we have a 2 year old, 8 & 12 boi children). With that being said we took in a 15 y/o boy and 11 y/o girl. Both the placement coordinator, supervisor and caseworker verified "no known abuse/behavior" was ever reported. They were desperate to place the children with someone who did not want to change their school. We took this placement as respite the week of February vacation and we all had a great time. The kiddos were placed with us on April 1st. Besides the normal child rivalry and fighting, everything had been going smoothly until 2 weeks ago when foster daughter made an accusation that our bio son was inappropriately touching her. She also told us the house before us it happened too with a cousin. It was reported immediately and the cw said "we will file a statement with the CAC just to have it recorded and as for the cousin it was a butt touch". Interviews were conducted Tuesday and FD told them not only was she touched but our daughter was also being abused by our son. The CAC advised all children to be removed from our home except our son until everyone was interviewed. We are now told from state investigators that FD has several reports from multiple people sexually assaulting her in different homes. It was explained that her abuse was more than a butt touch. We met with the investigators Monday and it has now been deemed that our son and possibly daughter have been sexually assaulted by the FD several times. Investigators also said that the dept did not take appropriate action an remove the alleged "victims" from the home the day the allegations were made. It's been 3 months with these kiddos and not ONCE did the dept tell us about FD exposure and abuse. We have never met a GAL for these kiddos and now our children and family are left devastated. When asked if this placement would be red flagged to not be in the home with other children we were told no due to the fact that there is not enough placement homes for kids in Maine. So basically, this child is going to more homes and other children will be her victims. How is this even okay? Since the children were removed, there has been no contact by the department. All of the childrens belongings still remain at our house. No follow up. Nothing. A social worker told us to get a lawyer and file a lawsuit against the SOM. We are heartbroken.

There is no incentive for families to foster in Maine when we are constantly held to a different standard. Before Covid, DHHS was understaffed and only checking the necessary boxes and nothing beyond that. Not only are foster families unsupported, we are emotionally dragged through all of this trauma with our own families and left to pick up the pieces.

There needs to be change.

From: John and Johnna Morton
To: Ranking House member...
Holly.Stover@legislature.maine.gov
CC: Secretary
Sabrina.Carey@legislature.maine.gov

Attached Video link
https://www.facebook.com/100005981131764/videos/443962530934022/

Dear Holly Stover Ranking house member of the Government Oversite Committee...

My Name is John Morton. Embedding videos don't work to well expecally one of this size so I made my video available to you publicly. I'm requesting my video be taken into consideration to the latest bill regarding the Department of Health and Human Services Child protection services for your hearing on the 20th of July 2022.
I'm sorry for the late notification of which will no doubt be Monday the 18th just 2 days before the hearing. The Video is quite long... kinda always is.

I embedded the link in the Email but if you do not trust the link you can find it on my Daughters Facebook Page Facebook dot com backslash Johnna dot Morton don 7. Its the video with your committee information in the title.

I have attached this E-mail to the secretary of the committee to share with the minority members I hope... cause honestly I suck at e-mail.

I wish I could come and testify in person but as it's last minute I am afraid I can not attend. Please let this video be entered into evidence as my statement in lieu of my appearance and thank you for taking on the issue.

John Morton...

my name is les cook. i have made numerous VALID complaints to cps on behalf of my son john homan over past 3 years. ranging from the rampant drug use my son is exposed to , to the violence my son is exposed to . in fact the homicide that occurred on pleasant point reservation recently is a very related issue.my sons mothers name is eunice homan. eunices closest friends on the reservation were kailee brackett, kim neptune amd qpiptes dana. kim neptune was the person stabbed 480 times. kailee brackett was the perpetrator along with donell dana brother of qpiptes. in other words my sons mothers best friend killed her other best friend with the help of the brother of another good friend. the homicide was over stolen drugs not stolen money. all of the people involved have the same very advanced heroine addiction that my sons mother suffers from. this is all documented. my son john homan who is now 6 has witnessed NUMEROUS fights between adults. he has had to fend for himself on many many occasions because of the consistent amount of time that eunice is dope sick. i have been threatened by eunices very violent friends in front of my son at our exchange spot. i have been assaulted by eunice in front of my son a few times. on july 29 2021 eunice came to my home while i was having breakfast with my son ,she kicked my door in , splintering the door frame. she entered ,assaulted me and tried to abduct my son. i shoved her out the door and called police. she was charged but not arrested. my son was interviewed by police and specifically left with me based on that interview. the next day tribe issued an ILLEGAL court order and removed my son and brought him right back to his violent drug addicted mother. i say ILLEGAL because no tribe has jurisdiction of my property . i have been assured of this by both the states and the nations leading tribal law attorneys , yet Washington county sheriff still served this illegal court order, effectively kidnapping my son. the tribe then held an illegal hearing and took my custody away. maines district court has supported the tribes illegal actions thouroughly . thereby also breaking the law themselves. in fact , the sheriff, the 3 judges involved, cps and my sons mother have ALL VIOLATED the law . the only 2 people involved who broke no law were the 2 who were punished . my son and myself.

every serious infraction has been reported to cps for over 3 years and all ignored. i have been told repeatedly by cps workers , including their highest supervisors that the state has no jurisdiction and that they are sorry but there is nothing they can do . jeanne lambrew, scott perkins, kate imbruno and an endless list of employees all LIED and all BROKE THE LAW when they told me there was nothing that could be done. i have been in touch with the heed of east coast bureau of indian affairs office , evangeline campbell who assured me that state can open a case. i asked her why would cps workers deny the ability to open a case . her answer was that is was easier for a maine state cps worker to tell me there was nothing they could do than it would be for them to actually do their job. this is what bia says about maines cps. she stated maine was now also a 280 state and that 280 states have the jurisdiction to intervene on a childs behalf on reservations. kate imbruno and every other cps worker challenged that statement but REFUSED to speak to mrs campbell after the invitation to discuss the matter was extended. additionally if anyone in maine had bothered to actually read the indian child welfare act, the law that is being touted as the reason this is all legal, they would find that they are all actually in violation of the indian child welfare act. there is a section called TIPS TO PRACTICIONERS, by practitioner they mean CPS , LAW ENFORCEMENT AND JUDGES. it clearly state in the state of maine , the state has jurisdiction over both the passamaquoddy and penobscot tribes. so any agreement this state has made with this tribe is NOT legally binding and when a cps worker

or JUDGE defers jurisdiction to the tribe , they are in actuality ,BREAKING THE LAW! which brings me to my next point.

im sure that in most of the cases of the unfortunate 21 children who died after reports to cps were ignored that cps was not the only entities that ILLEGALLY shirked thier responsibility. i would wager that both law enforcement and family court judges played a major role and violated law. that is absolutely the case in my circumstance. i feel this investigation is an absolute necessity however to do this right you must now continue to open this can of worms. i would guarantee that in many of the cases that there is nothing cps is guilty of that law enforcement and judges are not also guilty of and if this committee wants to truly make for better environments for this states children that you broaden the spectrum and investigate both law enforcement and judges. these entities cannot remain immune if they are shirking responsibility resulting in the death of a child. in my case i can irrefutably demonstrate how washington county sheriff, judge locke, judge david mitchel and judge charles budd all broke the law. maines judicial conduct committee has done all it could to protect these judges instead of rightfully punishing them . i reiterate, this investigation is of the utmost importance and i would advise a close look be taken at this states family court judges and their position that they can just make up law that suits them. it is known nationwide that it is the COLLUSION between family court AND cps that lays the foundation for all of this neglect

L.L.

When I first started into foster care. At the meeting, they made everything sound so good for the most part. They said in 6-8 months TPR are filled with children being adopted in 12-18 months. SO not true. I have had my FS for 2 years.

I was told at the meeting before I became a foster that DHS will repay for anything the child needs NOT true still waiting on money for car seat glasses as he needed scratch resistant glasses Maine care will not pay for. When I called to check on the payment the women who looked, it up was nasty and said you are getting your monthly payment so deal. Ya ok $25 a day does not pay for all the gas to all his appointment time off work and all his needs it is a joke. Yet people like to say foster do this for money.

When my FS came to me he was a mess. FS had lice, bite marks on his face I later learned could have been from rats. My FS had huge food issues I later learned bio mom was putting hot sauce in his mouth. FS was under weight and had dark circles under his eyes. He was given to me with cloths way to small and a few sets of sweats I believe the first foster home got him. Along with a nasty car seat that was out dated.

The family this child comes from is known to be very dangerous and into dealing drugs. My FS was left home alone a lot. He screamed all night every night for about 7 months. He has many behavior issues. With the help of his DR I have gotten him into so much. NO one ever offered help through DHS. When I asked the middle CW Trent he had no idea what to do and never got back to me.

My FS came into care after many calls DHS never investigated after a WIC worker reported Bio saying she hated him wanted him dead and wish she got rid of him, Then the Bio dad called in after 8 months of family members calling him saying bio mom was leaving FS home alone all the time and abusing him so bio dad was "sick of them calling him" so he called DHS. My FS came into care at 14 months old

He has PTSD, sensory, and Attachment disorder I also see drug affects and FASD.

First court hearing on Jeopardy was interesting. The bio showed just how unstable she was. Yet Judge Martin wrote his order to send my FS back to a mom that had no job no housing and failed all drug test along with many mental health issues. Judge Martin put that my FS could go back while bio mom worked on many things listed out in the order. My CW Anna at that time was incredible and put in for an amended order asap to keep the child safe. I strongly feel if I had one of the other, works I have had this child would be dead if it was not for Anna protecting him fast. This was a very dangerous order for a judge to do. This is why these kids are dying This Judge has no right to risk a child's life.

As my case went on the bio has done 0 on her order and has not made it through any of the evaluation as she is that unstable. In 2 years. Bio mom has failed 4 out 7 drug test no showed to the others. She was positive for Meth, coke, Bath salts, Mollies, and more. Yet in court for TPR told the judge it wasn't her pee all times.

The lawyer on my case was so new and did not know what he was doing he missed many things that should have been entered as well as never asking me for any of my notes. The lawyer messed up so bad the Judge entered into evidence the criminal record of the bios witness, that our lawyer should have done. The lawyer would not talk to me so I could tell him more on the case he was not told.

Court new CW said on stand that this is all small town drama and that is what she told bio mom at a meeting with her. So she is saying that this child wasn't abused by that comment. Let's just say I was more than angry.

On to new CW first home visit, she was rough around the edges to say the least

2nd home visit new CW was blunt and rude she downed my old CW Anna for 45 min bad, Let's say I have never felt so uncountable in my own home in my life and I will never again. She is cocky and rude.

With things I have brought up about t this case, I do not believe new CW has ever read the whole case.

New CW called the daycare asking them things about bio and not about the child. They know nothing about bio. They are there for this child. Daycare pulled me aside asking why they were asked these things and they felt as though the new CW was fishing for things. They said she was not very nice at all she was bossy.

New CW called OT Seth and demanded info. Seth said he would like to reach out to me, as he had no idea at that point of a new CW or who that maybe he does have HIPPA

CW was rude and said I have the custody not the foster you will answer my questions. I apologized to him.

I have been on long wait list to get this child into a good daycare and into OT. I did not do this for a rude CW to out this at risk. Again, I was upset. I have reached out to the GAL and my liaison Molly. I have not called the supervisor yet as when I reached out 2 time to Trent's supervisor I was never called back so I gave up. Where they find these workers I do not know but out of my 3 I drew the short straw on 2 bad ones for sure. This does not help these poor kids or us as fosters and I am sorry but good fosters are putting much more than anyone on these teams. We as fosters deal with ALL the child's needs on our own with our hearts blood sweat and many tears. It is very painful to see these kids do not matter to anyone but us fosters. The system should NOT be all about reunifying for every child as numbers show it is much higher that the kids come back into care more abused than the first time or die. The number of success with reunification is low. There for this should only be for parents working hard and succeeding to reunify.

My name is Kristine and my husband & I were licensed foster care parents and the OCFS system is broken, CPS needs to do a better job when fielding issues or reports, and take the time to investigate reports, as most children in care will make up stories if they are not happy in their current situation, as that is what happened to us back in 2018 when we lost our license, a child made outlandish accusations against us and we even told the state to pull the cameras from there issues occurred, and they never did. They always take the words of the child, while some children will be honest, but those in care will lie to get their way.

Kristine

Good morning and Thank you Senator Libby, Representative Stover, and all other members of the committee for the opportunity to speak to you today. My name is Mary-Gene Rumery and I am a licensed foster parent from Norridgewock, district 5 however both my cases have been out of Ellsworth, district 7.

On June 28th, 2018, we were called to the DHHS office in Ellsworth as my husband's nephews and niece were being taken into care. We had no experience with DHHS previously, we had no idea what we could expect, what we should ask for etc. We had no idea we could have taken all three; the youngest a girl could have slept in our room; we could have made an agreement with the department to look for a larger home or give her our room when she turned 1. We had no idea the boys could have visits with her until several months after coming into care without her. We were told we would receive paperwork to become licensed and did not for almost a year, we were told we would receive a stipend and did not for four months. We left the department with two children and two, 250.00 vouchers and a promise of day care reimbursement as our only means of starting them out. I drained my saving to be able to give them the things they needed.

18 months in we were headed for termination when we were told by the sisters foster family when they adopted her our boys would need to be known as her cousins or they would stop visits as they did not want her to know she was adopted. I went to the case worker and his supervisor, they arranged a meeting where they basically asked the other foster family and us to fight it out and figure out how we could make it work, they also made the other family start letting the boys and us see her every two weeks. After several months and no resolution as to how we could keep the siblings together under our roof, a larger home we rented to be able to comply with DHHS regulations I wrote a 14-page letter to Governor Janet Mills. Not asking her to fix our situation but asking to have someone investigate district 7 and their practices, so that our situation did not happen to another family. In November 2019 our niece was moved to our home with only a weeks' notice. Termination happened in December and the biological father appealed. The children were forced to continue to see him, confusing them and causing fear in them. I know you hear all the talk of "what's in the best interest of the children" however that is false. It really is what "won't violate the rights of the biological parents", as the children and the foster families that care for them have no rights. The appeal was denied, and we started the preparations for adoption. Our Case manager asked for childcare expense assistance as we were adopting three and the department denied us, we fought back, and they agreed to help with the child that needed help with speech and after care for the oldest. I was forced to remain home with the three-year-old girl and not return to the work force. May 5th, 2021, we adopted the sibling set of three after 1043 days of them being in care.

Our second case is now 873 days old. January 30th, 2020, I moved into the hospital with the drug effected ½ sister of the sibling set and we started this rollercoaster all over only this time thru covid. The biggest issue this time around in my opinion was the biological mother had just had rights termed a month before and then gave birth to a drug effected baby and was given every opportunity after opportunity with little to no progress for a year and the presumptive father was offered DNA testing 17 times, arranged once out of state and every time he did not show. It has been one issue after another.

We are now waiting for legal clearance for her to be open for adoption, we were told she would be cleared this week and that has not happened yet. When it will take a minimum of six to nine months to complete her adoption putting her time in care some place around 1000 days. I would wager if you asked any of the other foster parents in this room today how long their kiddos have been in care, they can tell you to the day and then ask they case managers and they will have to look in a file. We know the numbers and details because we the foster parents live it every day. The timing for most cases in Maine is unbelievable unfair to the children and the families who want to give them permanency. While I understand much of that is due to the department doing their due diligence it remains unfair. One more thing I would like for you to be aware of is things are not done the same district to district and I understand that not all cases are the same however the bio mother in my cases had a termination and one month later a baby that came into care and districts 7 allowed her every opportunity to reunify but a case I am aware of in district 5 same circumstances the baby was fast tracked, no opportunities given, and he will be adopted in under 400 days. This is not good practice.

Again, I thank you and will be available if you should want to speak further. Mary-Gene Rumery, 207-692-3485, mareinmaine@gmail.com

Good Morning –
Thank you for the time on Wednesday to be heard. Due to the time restriction of 5 minutes my wife Stephanie and I wanted to make sure you all received our full written Testimony. Please see below for your use:

I worked for district 1 as a child protective caseworker for 5 years. I took the position because my values and morals aligned with the mission of OCFS.

While I was working at DHHS I was taught best practice and policy through weekly supervision with my supervisor. The expectation with her was always best practice. However, That wasn't the same throughout the units. There were some supervisors I was scared to be supervised by due to their own practice, lack of support and lack of knowledge about policy. For instance, while I was out in the middle of the night on an emergency called, the supervisor on duty asked me if I was going to call her again because she wanted to get back to sleep. I have waited outside of a clients house for 45 minutes waiting for my supervisor to call me back to complete a final review before I could leave and I never got a call back. I have been physically assaulted by a child in crisis due to being told I had to stay in the child's crisis room. After I told one of my supervisors that the children in the home didn't want to be adopted by the foster home, her response was "well they don't have a say in the court until they are 12." There were times when I worked more than I could clock in my time sheets, where My supervisors were aware of this. I received cases that had been open for over a year within the court system and there were no reunification plans or child case plans. The work was hard, at times I didn't feel supported by my superiors, but it was the support of my peers that got my through the tough times.

As a foster parent for district 2 I have experienced gaslighting in the most horrifying form. I have seen where lack of knowledge of practice and policy is not only at the supervisor level, but supported by the PA,APA and Bobbi Johnson herself. I emailed the PA,APA, Bobbi Johnson and the regional director multiple times stating how i didn't feel safe with the caseworker and supervisor due to the way they spoke to me and the things they were saying about social work practice. On multiple occasions I made the PA and APA aware of the following policy violations completed by one worker.
Referring a child that has just entered state care for a PREP and CDS evaluation is best practice, policy and part of the law. The child on my care was never referred to a CDS evaluation until 13 months after he entered care and he never received a PREP evaluation.
Family team meeting policy: when DHHS was going to begin a trial home placement without having a family team meeting to discuss plans, transition and making the child aware of the transition.
Visitation policy: when the caseworker allowed visits and reunification to continue despite the parent no call/no showing 4 weekend overnight visits and canceling 1 weekend visits 2 months before a trial home placement start date. This policy was also violated when the caseworker changed the visits in anyway without talk to the child or his primary caregivers about how the child is before and after visits.
Confidentiality: the caseworker and the supervisor violated my confidentiality when they added a bio parent to my email chain. The caseworker also engaged in slanderous communication with the child's therapist about me in multiple occasions.
Levels of care policy: the child never had a levels of care completed the second time he entered care, when he was in care for 25 months at that time.
Standard of practice policy states that the caseworker should act in a child focused way. I have multiple emails from the caseworker and the supervisor dismissing the child's voice and not even acknowledging the child's behaviors/ or therapist recommendations when the parents did not show, or did show for a visit.
This same policy outlines that the parents are to engage in some sort of service in order to rectify jeopardy. However, a parent in my case did not and DHHS continued to allow him to reunify.
Permanency and concurrent planning policy: concurrent planning is supposed to begin on day one of the child entered care. Concurrent planning was never discussed until a year after the child entered care. State law and policy identifies a timeline I which a child should obtain permanency. The child in my care exceeded the 24 month policy by 12 months. The state pulled the TPR from the court system before beginning a trial home placement. This is a dangerous avenue to use because by doing this all the eggs are in the basic of the child returning home and their concurrent plan is essentially taken off the table and prolonged should the trial home placement not be effective.
Trial home placement policy: The supervisor on the case reported that DHHS will check in with the child and parent once a month. It is policy that the caseworker check in with the child, parent and school biweekly. The supervisor sent

an email acknowledging that DHHS was going to move forward with a trial home placement despite the father never contacting the child therapist, never attending a child therapy appointment and having no plans to continue therapy for the child.
Child case plans are due every 6 months. This is when the caseworker gives an update and summary on how the child is doing and needs to put in collateral contacts outlining providers report of how the child is doing. The caseworker on my case never asked his daycare directly how the child was doing, but in a family team meeting the caseworker reported that daycare said the child was fine and “normal”. Once I was made aware of this I spoke to daycare, had them write a letter stating they never had this conversation with the caseworker and I shared this with Bobbi Johnson and the caseworkers direct supervisor. Nothing was done.
The worker did not come to my house to see the child for a home visit for 6 months and did not see his room the first year he was placed with us.

Honestly, there are more policy violations and I have emails to the PA, Bobbi Johnson and Ellen Nelson about them, but it’s really painful reliving it.

It’s terrifying that DHHS supervisors and caseworkers get away with treating foster parents how I was treated. Even at a level as high as Bobbi Johnson. It is unjust when reunification at all cost becomes the practice versus. It’s unjust and equally terrifying that caseworkers are practicing/ assessing child safety out of the scope of policy and best practice and it is not only being allowed, but supported. When lying by omission is allowed by caseworkers, it’s no wonder why children are being hurt, so many kids re-enter care multiple times.

I am an advocate, social worker and a therapist because of the amazing supervisor i had when I was first hired. It is a shame that the standard of care and practice is not the same across different units and across the state. If we are going to protect the children in the state of Maine, best practice needs to be the standard and we need OCFS to abide by the laws and policies that have been made. We need to listen to those closest to the children.

Stephanie Gaddar
207-660-1235

Marcia Rogers
Testimony OCFS Government Oversight Committee
July 20, 2022

Thank you Senator Bill Diamond for your passion and commitment to fixing this broken system. It takes courage to stand up to something so big. Thank you to the committee for your time and energy for an issue that is top priority, our children.
I have been a Head Start Center Coordinator working in the school department for over 30 years. I work with low income disadvantaged children and their families. They bring me such joy in their resiliency and hope for the future.
My husband and I are proud parents of 7 adopted children, all through OCFS. We were also foster parents when child protective needed a home in a pinch.
I have been a CASA GAL for the court for over 20 years. Needless to say, I've had a variety of experiences with OCFS!

I can give you a few examples of children that did not receive the care and support that I felt they were owed from OCFS.

Several years ago I was assigned as a CASA GAL a teenager that was removed from his home. He had a tough time of this and ran away time after time. He was involved with law enforcement on several occasions and quit school. This young man was lost. I asked the supervisor for some support maybe a tutor and/or a mentor. Someone that could help this young man head down a more positive path. I was told by a supervisor, that she would not waste money on a kid that didn't give a shit. This was exactly what she said. I was shocked but not surprised.

A more recent case concerning a pre k child that has been an ongoing issue with OCFS. This child was in foster care. He was placed back into his home with his bio mother during the height of covid almost two years ago. The mother had no support because no one could go into the home. She had no visiting health nurse, no case management, no services at all. I repeatedly asked the caseworker to slow the process down because we knew there would be no support for this mom. This is a recipe for failure in my opinion. His attendance was poor. He needed services for a diagnosed disability but received none. Frequent calls to the OCFS did little. A plumber called the school to report that he went into the home to repair a pipe in the bathroom. He reported that there was a dead cat on the porch and used needles on the floor in the bathroom. The principal Sue Carter reported to OCFS and I made a report. I called a caseworker to ask why they would not investigate. He told me that it was the plumber's word against the mother and she denied it. He said that the plumber should have taken pictures. I've never known a service provider to go into someone's home and take pictures! I informed the caseworker that there was a pattern here that should concern him. Another call from us regarding the child crying, don't make me go home, I don't want mommy to come pick me up. The child was

coming in smelling like cat urine. Another call was from a neighbor to the local police department. She reported that mother was staggering down the street in the middle of the road. She also called the school because she knew the child. I called the police because we did not want to release the child to the mother in her condition. They informed me that the mother was walking not driving a car, it would be child endangerment and that OCFS should handle it. The police called child protective. I also called the department to make the same report because when the mother got to us she was staggering. Her words were slurred. We let her child go with her with great concern.

This mother loves this child. She wants to be a good mom. She is an addict and her addiction is her greatest need. This mother needs support and this child needs a safe nurturing environment until his mother can get clean and healthy. What is happening right now is not working for the mother or her child. We are likely raising another generation of children with mental health issues, addiction and physical health concerns. Just look at the ACES scores on any of these children raised in an unsafe environment with an absent parent.

I have many experiences that highlight the incompetence of this department.
This is just two. The last one I deal with daily and continue to do so. If we don't change the leadership in Washington and Hancock Counties it is my opinion that you will not change the culture. This toxicity comes from the top down. There are many great caseworkers that want to do a good job but they are not allowed. They fear any challenge to the system and they fear standing out doing a good job will bring negative attention. This leadership has been in control for many years. Isn't it interesting that the caseworker turnover is through the roof but the supervisors have been there forever? I am not sure what the state wide issues are but I can tell you in Downeast Maine it's the culture stemmed from poor leadership.

In closing, after my testimony the next day I met a caseworker at the ice cream shop. She pulled me aside and asked me if Sue and I went to Augusta to speak. I told her that we did. She had excitement in her voice. She said do you think that there will be changes? Do you think that anyone really listened? When do you think that we will know? The questions kept flying. What I took from that conversation was that for once, this caseworker had some hope that change was coming and that our Senators were listening to the voices that represent the children of Maine.

Thank you all for the hard work that you are tasked with. It is no easy job! A special thank you to Senator Bill Diamond for your countless hours and endless energy to this cause.

Sincerely,
Marcia Rogers

Investigative Hearing DHS Child Protective Services

My name is Sarah Sue Wood. I am here today to share my story of what happened to me, 25 years ago. Child Protective services tore my family apart and never reunited us. Instead of following the full letter of the law, the state took it upon themselves including the Judge who signed the order of terminating my rights, to violate federal statutes of reunification. A petition by my lawyer for an expedited hearing was supposed to be held on 8/24/2000. Obviously it was not.

For the past 25 years not only has this gross error of justice destroyed my life forever, it has also affected my ability to financially improve my life. This followed me and prevented me from gainful employment. I have an associate degree in mental health and human services. Eight jobs that I applied for turned me away, due to the past irrevocable harm that the state of Maine did to me. In 2019, I was able to appeal the substantiations against me and my name was cleared in 2019; allowing me to apply for work in the mental health field without fear of denial of employment. I also received a Bachelor degree in Justice Studies in 2019.

I want my story to be told so that no other Mother would ever go through what I went through. Logan Marr was a young child, that was killed at the hands of a former social worker for CPS. She was a foster child, that died in 1998; when my children were in the foster care system. I was a victim of severe domestic violence in my marriage and even my attorney at that time, informed the CPS worker, Ms. Dix that he felt she was on a "fishing expedition". He informed her that I was going through enough from he tumultuous marriage where I had been abused in every way as well as terrorized and had my life threatened when I tried to leave the marriage.

My daughters were sexually abused by their father. I have it recorded by an art therapist, Susan Marshall, that yes, indeed, they were abused! Because I left the marriage, the state of Maine did not even attempt to prosecute him to prevent him from harming any more children.

On three separate occasions when an appointment with a Forensic Specialist, Dr Ritchie was made; the CPS worker, Kathryn Dix, had

Thank you for your time.

Sincerely,

Sarah Sue Wood

Sarah Sue Wood, AKA Becky Sue Wood

(a legal name change took place on 7/23/2019)

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Testimony of Melissa Hackett
Maine Children's Alliance and Maine Child Welfare Action Network
Before the Government Oversight Committee
Public Comment, Child Protective Services Investigations
July 20, 2022

Senator Libby, Representative Stover, and esteemed members of the Government Oversight Committee. My name is Melissa Hackett. I am a policy associate with the Maine Children's Alliance, a nonprofit, public policy organization whose mission is to advocate for sound public policies and best practices that improve the lives of all Maine children, youth, and families. I also serve as the coordinator for the Maine Child Welfare Action Network, a group of organizations and individuals in Maine working together to align, strengthen, and sustain efforts to ensure the safety and well-being of all Maine families.

We all want children in our state to grow up in safe and supportive environments. Our Network stands with the families who have experienced the trauma of child abuse and neglect. Their voices should be central in our discussions.

As this committee considers future scope of work as it relates to OPEGA and the child welfare system, we would encourage a focus on surveys to gather input from a wide range of those with experience of this system. This should include, but not be limited to caregivers – birth, foster, grand, and kinship families; and providers working directly with families, particularly through supportive visitation and mental health and substance use treatment providers.

We recommend the committee further investigate supportive services for families. While survey responses from the most recent OPEGA report strongly indicated a lack of available services for families as a concern, we do not have an established understanding of where and what the specific service gaps are. Yet we know issues with availability of family supportive services are not new.[1] The committee should consider assessment of service availability, mapping, and barriers to access across the state.

The scope and effectiveness of current prevention of child abuse and neglect efforts is another important consideration for committee follow-up action. As our Network has noted previously,[2] there is currently no statewide plan for prevention, and a lack of clarity regarding coordination and effectiveness of efforts within state government and outside entities. The importance of prevention was also recently emphasized by the Ombudsman. A focus on prevention efforts should reduce instances of abuse and neglect and the resulting trauma to children and families and reduce the current strain on child protective services.

We encourage the committee to continue to explore and support ways to improve the way our child welfare system supports the Maine children, youth, and families it is meant to serve. This should include efforts to gather input from families and providers with experience in the child welfare system, as well as assessment of primary and secondary prevention efforts both in and outside state government. We believe this would be informative and valuable to the work of this committee and the legislature. Thank you.

1. *In the 2017 CFSR, the State's array of services available to children and families in the CPS system was rated as an area that needs improvement. Stakeholders interviewed at the time of the CFSR statewide assessment reported waiting lists for core services and major gaps in services available, particularly in rural areas.*

2. Maine Child Welfare Action Network, A Framework for Child Welfare Reform, https://mainechildrensalliance.org/site/assets/files/1901/framework_for_maine_child_welfare_reform_1_13_22.pdf