Testimony of Christine Alberi, Child Welfare Ombudsman
Government Oversight Committee
Public Comment on OPEGA Report OCFS Case File Review: Maddox Williams
May 26, 2023

Good morning, Senator Hickman, Representative Fay, and members of the Government Oversight Committee. Thank you for having me here today. My name is Christine Alberi, and I am the Child Welfare Ombudsman for Maine.

I would like to take some time today to comment on the OPEGA report on Maddox Williams presented to this Committee last month. My office did complete a case specific review of this case, but due to confidentiality statutes I am unable to share any details of the cases preceding Maddox's death, other than what has been released by OPEGA in their review, or the Department in their public statements about the case.

OPEGA is correct in their report that it is not for any of us to determine whether actions taken by the Department could have prevented the death of Maddox Williams. OPEGA also concluded that the Department made no unsound safety decisions during involvements in the time before Maddox was killed. I would respectfully disagree with this characterization, but I think part of the issue is what we would consider a "safety decision." During the Department's involvement with Maddox Williams and his family, and in fact in all decisions made by the Department in the context of any child protective investigation or reunification case, most major decisions made by the Department are by definition safety decisions: Is the child safe now? Will the child be safe when he goes home? Is the child going to be safe in the future?

OPEGA is also correct as citing this case as an extreme example of the "range of complexities and complications" that child protective services encounters. But the case also follows some patterns that are familiar to the Ombudsman's office from our own case specific reviews.

Throughout OPEGA's report of the facts of the Department's involvement with Maddox's family, the parents are described as uncooperative. This is one of the issues that caseworkers encounter with many families and so when the Department has a chance to intervene, it is important that that chance is taken. In this case, the Department had their best chance back in March of 2018 when Maddox's siblings entered state custody after his two-year-old half sibling ingested methadone.

The OPEGA report's description of the protracted legal battle about the mother's mental health evaluation is central to this reunification case. Even though Maddox was not involved, other young children were, and even though it is clear from the OPEGA report of the reunification plan for their parents that physical abuse of the children was not one of the Department's concerns, the parents had a litany of other issues, primarily mental health and substance use disorder, that negatively affected the safety of their children.

The list of events provided on p. 8 of the OPEGA report, including the mother being discharged from her provider, the GAL recommending a CODE evaluation, the mother's minimal participation in the agreed upon compromise in place of the CODE evaluation, and the mother's

evaluation that was completed without the Department's input are all evidence of a parent who is unwilling or unable to acknowledge and work on her mental health issues. This is a common issue in reunification cases. A parent will see a provider without the Department's input, without a copy of court's jeopardy order for example, which renders the provider's opinion of the parent's mental health diagnoses and progress in treatment invalid. The OPEGA report is silent on whether or not the final evaluation in October of 2019 was with the full input of the Department, but the question for the Department to ask under these circumstances is why this evaluation was relied upon when other earlier ones were not.

The timing of the reunification case is also discussed in the OPEGA report. When Maddox's half sibling was born in June of 2019 his other siblings had been in state custody for a year and three months. Maddox's infant sibling entered state custody because the jeopardy in the parents' care to the older siblings had not been alleviated. OPEGA's recommendations that the statute is followed in regard to filing a TPR are very important. The timelines that exist in statute are there to ensure that children do not remain in uncertain and unstable situations for years on end. The OPEGA report also notes that the summer of 2019 was the most likely time that the TPR would succeed.

(In the Ombudsman's 2022 Annual Report, we noted that "…in six cases this year filing of petitions to terminate rights was delayed long after the required statutory timeframe…")

In August of 2019 the court determined that the infant would remain in state custody and that the mother "fails to appreciate the grave risk that her mental health and lack of treatment pose to her minor child." The father's underlying substance use issues and lack of following out-patient treatment recommendations were also listed as concerns.

At this point we know that Maddox's siblings had been in state custody since March of 2018. A court order entered 17 months later is clear that the mother's mental health and the father's substance use issues have not been adequately addressed. Then two months after this order, the mother had a mental health evaluation in October 2019 and by November 2019 the parents were cooperating with substance use and mental health evaluation and treatment expectations. One month later the parents were allowed unsupervised visits and then a month after that, trial placement began and Maddox's siblings went home to the parents. In most cases, even in the best-case scenario, three months of cooperation and progress with significant mental health and substance use issues would not be enough to determine that the parents were able to provide the children with long term safety and stability.

All the decisions during the reunification case, not asking the court to order that the mother have a CODE evaluation, not filing the TPR in accordance with statutory guidelines, and starting unsupervised visits and trial placement with such new and untested cooperation from the parents are all consequential safety decisions for the children in state custody, as well as for Maddox. The reunification case and decisions made during it set the stage for the next year of DHHS involvement with the family. The reunification of Maddox's half siblings with his mother and their father made the Department's intervention with the family much more difficult afterwards, for a number of reasons.

For example, the Department asked the court for and was granted a PPO for Maddox as to his mother based on her legal abandonment of him. The court agreed with the facts and legal argument in that preliminary petition, and those facts were not in dispute as far as we can tell. The Department then withdrew its petition and agreed to have Maddox return to the mother's custody. There is no doubt that the Department's argument to the court that Maddox would be unsafe with his mother was undermined by their decision weeks earlier to start a trial placement with the mother for Maddox's siblings. The Department's decision to withdraw the petition was another consequential safety decision.

From the Spring of 2020 when COVID began, and until Maddox's death, the Department's involvements with the family share the common theme of lack of cooperation with the Department. The OPEGA report notes that the parents were minimally engaged with the Department or not fully cooperative. This includes the investigation that occurred immediately before Maddox's death. The parents had learned that they did not have to cooperate with the Department.

OPEGA notes on p. 17 of the report that the Department did not contact the mother's oldest child's father during the last investigation before Maddox's death, and therefore may have missed an opportunity to learn what that older child knew about what life was like for the children in the mother's home. The Department's old and new policies on child protective investigation are consistent with the idea that whatever the initial report to the Department was about, in this case domestic violence, all areas of child abuse and neglect should be explored, especially during interviews with children.

There is no telling what would have happened had Maddox's older sibling been interviewed in the father's home, but this is why it is ideal to use all information sources that might provide relevant information. Additionally, this family was not new to the Department. According to the OPEGA report, the Department had had almost constant involvement with the family since before Maddox's birth. The Department, as demonstrated by its actions over the years, was uneasy with Maddox in the mother's custody. When new investigations are opened with families with this much history, a more thorough investigation is warranted.

Thank you for your time, and I am happy to answer any questions.

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Maddox Matters

Good morning Senator Hickman, Senator Faye and honorable members of the Government Oversight Committee.

I first want to extend my deepest sympathy to the family members of Maddox Wiilliams.

On a very personal level, I would like to acknowledge the dedicated perseverance of Victoria Vose, who is the paternal grandmother of sweet Maddox. Her deep love for her grandson has brought him to life in my eyes, whereas I never knew of him until that day in June of 2021 when I heard of his death.

I have been a licensed childcare provider for decades which has led me to become a Child Welfare Reform Warrior.

It was a Monday morning when I sat in the infant room at our Daycare when our staff cried as we heard over the radio about a little three year old boy in Stockton Springs who had died from injuries all over his entire body.

As resilient protectors of children, it was horrifying to hear about a three year old's death in the care of his own home, most likely inflicted by his mother. As the days went by we all listened to the unfolding of the Maddox Williams tragedy. I must admit my staff and myself became outraged. At the time we had 24 staff members and 78 children enrolled, 19 of them being foster children (in State Care). I began writing to OCFS expressing deep concerns for the short-comings that were very noticeable to me. The tactics that are continuously used by OCFS/DHHS/CPS to cover up their reckless decision making is extremely apparent in the way they conduct their investigations. Investigation incompetence is an issue that includes incomplete questioning, incomplete documentation and an inability to notice major warning signs of obvious sleight of hand by an abusive adult (Bad Actor). The issue became even more clear at daycare when caseworkers would come "Put Eyes on the Child".

Everyday as we followed the tragic story of Maddox Williams the obvious and preventable danger kept leaping out to me. I could tell every new development that there was "No Eyes Put on the Child" from OCFS/DHHS/CPS.

Ways I could conclude this stems from 23 years of my own personal experiences with OCFS/DHHS/CPS. The lack of training (no matter what the caseworkers experience on the job) is abundantly dangerous. I have had experiences at my daycare when a caseworker has come into "Put Eyes on the Child" and they did not even come all the way into the playground. One time a caseworker even told me I don't want him to see me because then will tell his mom they (meaning the child's mom and new partner) will accuse me of something.

In March of 2022 I testified to the Government Oversight Committee over Zoom and I stated this issue. I spoke of an example that had just happened when a caseworker came to "Put Eyes on the Child" at the daycare. The case worker was accompanied by the 3 ½ year olds biological mother and when she put eyes on the child she did not ever identify her. It was at the end of

naptime there were nine other children sleeping, the daycare staff offered to wake this child up. The caseworker seemed extra resistant to not wanting to take a closer look at the child. The way she was sleeping it was not possible to make out whether she was a boy or a girl even. It was such a disturbing experience to see this child's mother ask to come back into the room so she herself could pull the blanket back and assure herself that this sleeping three year old was actually her daughter.

"Eyes of the Child" must be specifically written into policy for case workers. Documentation and pictures must be taken. A body chart must exist. Supervised and monitored visits must be safe and thoroughly documented. Reunified biological parents must be understanding of the fact that thorough collection of information and documentation by case workers is essential and protects the children foremost, but also protects them. All pictures can be viewed by parents and caregivers to promote accuracy. Photos of "No Injuries" are extremely important whereas it provides a time stamp.

In Maddox's case "Eyes on the Child" or lack thereof led to his death, whereas his cause of death was Battered Child Syndrome. The definition of Battered Child Syndrome is ***The set of symptoms, injuries, and signs of mistreatment seen on a severely or repeatedly abused child.***
I'm going to speak on what OPEGA may refer to as a missed opportunity but I am going to call it.
The Deadly Danger in the Detail that could have prevented Maddox's death.

On April 4, 2021 Maddox Williams was spending Easter weekend in a hotel with his mother, his half sister, and Mr Trefthron as well as the half Tefethron siblings. **On this weekend Maddox suffered a physical assault by being thrown out of a bathtub from the bathroom and landing on a slippery hard floor as well as hitting the wall.**

On April 8, 2021 Mr. Trefethron is known by the OCFS/DHHS/CPS to be arrested and charged with domestic violence. This led to an in person visit by DHHS to check on and ensure the children were not in jeopardy of endangerment in their home on April 9, 2021. On April 9, 2021 just five days after poor and defenseless Maddox was thrown wet, naked and coldly out of a bathroom DHHS observed no marks, bruises or injuries on the uncovered parts of this child.
In this instance the caseworker did not "Observe" because she wasn't allowed to look at the child who was sleeping and coverd up by his abuser. For the Department to allow a misleading word (Observed) to be used in their report to OPEGA is grossly negligent.

This is a major difference between observing a child and only glancing at a child.

The definition of observe is to regard with attention, especially so as to see and learn more about.
The definition of glance is to take a brief or hurried look.
What is clear in this OPEGA report is a discrepancy between the word "observe" and "glance". The major difference between these two words raises a level of suspicion in me and to how I have personally noticed weaponization of words by the OCFS/DHHS/CPS in order to cover up systematic failures that lead to children being left in harm's way.
This is not the first time OCFS/DHHS/CPS has weaponized words in an investigative report after a bad outcome has occurred to make themselves unaccountable.

“A darkened room”

When Ms. Trefetron “eventually allowed case workers (singular, one person) in her home.
This case worker has clearly been manipulated and intimidated by Ms Trefthron.
A case worker should be trained to include details in her visit. When dealing with people with a history of substance use disorder and mental health and trauma issues, the “Danger always Lies” in the Details. Meaning the “Lies” are able to be uncovered with proper training.

I can relate to this caseworker. She was scared. She should have never gone by herself and (I pray) she has been taken care of by her employer, OCFS/DHHS/CPS, and has received emotional and mental health support from a professional provider that can help her deal with emotional distress that will surely haunt her after her involvement in this tragedy. This is a question I must propose, was she allotted time to grieve and process her involvement in this case or was she expected to keep working?

Had this casework been properly trained by administration and leadership of OCFS then complete documentation would exist:

1. What time of day were the children sleeping? To my eye I’m speculating it was a nap and not a bed time sleep. Whereas the room had to be darkened and two other children were playing outside. A three year old can typically be evaluated by moving a blanket, shifting their pillow as you can check their back, stomach, face, arms and legs.
2. What color or pattern was Maddox’s blanket?
3. Where is Maddox’s bedroom located in the house?
4. How was Maddox positioned while sleeping?
5. How was he breathing? Example: was he snoring, was he stuffed up sounding, was he sweaty, was a pet sleeping with him, did he have a stuffed animal?
6. Were tattoos noticed on the uncovered parts of Maddox? What parts were uncovered on Maddox? Example: feet, hands, face, forehead. (It is well known that child abusers use tattoos and makeup to cover up bruising and other marks)

I can not emphasize enough how important documentation and information gathering is when determining the Safety of a Child.

OCFS must learn from other child death cases that a “Sleepy Child” has more clues to what is really happening,

Let’s not forget Marissa Kennedy “sleeping” during a case worker check. Ethan Henderson “sleeping” during a caseworker check and Gaberial Fernandez, across the nation the research I have seen shows that sleeping children can be the easiest target for an abuser or bad actor, to use as a deceptive cover up. Which has thrown entire cases in a different direction.
Now incompetent caseworkers have inaccurate words like “sleeping soundly” in their reports rather then the more likely realty of:

- Their bodies are weak due to repeated blows to the stomach

- Their bodies are malnourished

- They are suffering from a concussion or head trauma
- They are sleeping to much as a form of escapism from their abusive home

The combination of the inability to Identify Obvious Danger and Risk to Maddox Williams on April 9, 2021 is directly related to his cause of death was Battered Child Syndrome. "Eyes on the Child" and "Safe Sleep" both are OCFS responsibilities. I notice when the OCFS (Dr. Todd Landry) wants to Deflect they use data and New Developments that they are so proud of but underneath "Lies" a major shortcoming that results in child endangerment. In 2019 OCFS/DHHS updated its "Safe Sleep" practices to include D. which is a drug free home for babies. However, they did not add training to the caseworkers on the Number #1 way an abusive caregiver HIDES the injuries to a child which is under the disguise of "they are sleeping, I don't want them to be woken up"

Again I do not blame this caseworker. I empathize with her deeply whereas I have caskets on my conscience. I ask myself why didn't I call four times instead of three? Why didn't I keep calling?

The answer for me is this: I had blind faith and trust that DHHS was listening to my calls.
Call to Action: As I keep exposing the System Failures, I keep Proposing the Answers.

I could talk Endlessly on the Multiple things to change in OCFS and the ways to make those changes, like LD#785. I am just a Diaper Changer but I am ready to be the Game Changer for OCFS/DHHS/CPS. I can't change laws until I can change minds.

In Loving Memory of Maddox Williams
Betsey Grant

GOC TESTIMONY MAY 26, 2023

Presented by Bill Diamond
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Senator Hickman, Rep. Fay and members of the GOC, my name is Bill Diamond. Presenting my testimony today is something I've not looked forward to, but unfortunately it must be done.

I've been an adamant supporter of OPEGA/GOC from its inception in 2003 and its first meeting in 2004. This is the 20th anniversary of OPEGA/GOC and I'm extremely proud of their many accomplishments during that time. Having served on this committee for eight years I know firsthand the value and quality of OPEGA's professional research and investigations. OPEGA's well-deserved reputation has been earned based on their independent nature and willingness to seek the truth regardless of the agency/organization involved.

However, the most recent OPEGA report analyzing OCFS's handling of the Maddox Williams' case was not only inconsistent with the previous standards of presenting a thorough, reliable and factually based report, it was just the opposite, complete with carefully selected wording that softened and misrepresented the poor decisions by OCFS that unnecessarily put Maddox's life in jeopardy and finally resulting in his death.

The report's findings: *No unsound decisions* only *missed opportunities*. Such statements are mind boggling, vacant of any common sense, and mostly curious given the fact that the Maddox Williams case was the most egregious example of how seriously flawed OCFS's management and decision-making policies are as reported repeatedly by the Child Welfare Ombudsman. The report avoided any mention of OCFS's inappropriate decision-making, lack of procedural consistency, and ineffective communication.

Let me give you some specific examples. Maddox was living with his grandmother in a loving and caring home where he was protected and safe enjoying a happy life. Then OCFS decided that **Maddox must be taken from that loving home and placed with his biological mother.**

And lastly, one of the most cruel and uncaring occurrences by OCFS was how they allowed Jessica to take Maddox from his family one day while being cared for at his aunt's day care center without even telling his grandmother who was his full time care taker. OCFS allowed Jessica to literally walk into the day care grab Maddox – he was frightened and had no idea who she was – and take him away. The family pleaded with the department not to put Maddox in that dangerous mobile home explaining that Jessica was unstable and highly volatile and would surely hurt or even kill him. The begging and pleading by the family members, who knew Jessica better than anyone including OCFS, were ignored. Why didn't the OPEGA report include all of these instances and ask the obvious questions?

For those who know what really happened leading up to Maddox's tragic death, especially his family, and others who were working to improve the child protective system, this OPEGA report is seen as tragically flawed and very damaging because of its avoidance of declaring the need of accountability by DHHS. As Senator Ducson has said, GOC can't just wring our hands and feel bad, it's imperative to know what specifically needs to be fixed. This report carefully avoided that accountability question and delicately sidestepped focusing on the serious problems within the department.

This OPEGA report should have been exhibit A identifying specific system breakdowns with suggestions for the committee to consider to make meaningful changes, but instead it provided a flag of exoneration to be waved as needed.

In summary, it saddens me to say that this, but this report was a disservice to you as a committee, a misrepresentation to the public and a crushing insult to the family of Maddox Williams.

Testimony of Melissa Hackett
Maine Children's Alliance and Maine Child Welfare Action Network
Before the Government Oversight Committee
Public Comment, Maddox Williams Report
May 26, 2023

Senator Hickman, Representative Fay, 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, statewide public policy organization. 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. The loss of any child is a tragedy for their families, for our communities, and for our state. We appreciate the work of this committee and OPEGA, in coordination with the state, to ensure we are doing all we can to support the child welfare agency's effectiveness in providing safety for children and support for families in crisis.

There are a few issues that appear in this case that are important to consider in context. Family reunification is recognized as best practice in child welfare, because research has shown that children generally do best when they are able to grow up with their families.[1] It is important to note that in many cases – around 50% of the time in Maine[2] – parents get the help they need to alleviate the issues that brought them into contact with child protection, and are able to safely reunify and raise their children. It is of course critical that this best practice always be applied within the context of each family situation, with the safety of children first and foremost in decision-making about placement and achieving timely permanency for the child.

This report also raises an issue identified in previous OPEGA reports. Caseworkers need significant time and support to conduct thorough investigations and to carefully assess complex family situations for child safety. Yet our state continues to struggle to attract and retain an adequate child welfare workforce to meet the current demand. This leaves caseworkers with unmanageable caseloads and insufficient time to conduct exhaustive investigations and to fully participate in the difficult work of crisis intervention with families. An overstressed child protective agency presents a challenge to ensuring child safety. We support in particular the recommendations outlined in this report regarding staff vacancies and encourage the Department and the Legislature to further consider how to reduce caseworker vacancies, and to reduce the pressure on the child welfare agency by preventing child maltreatment in the first place.

Preventing future tragedies starts with reducing child abuse and neglect, and that starts by investing in families with children. We encourage committee members to review the state's recently released Child Safety and Family Well-being Plan[3] for budget and policy initiatives we can support to keep kids safe by keeping families strong.

By helping families sooner, we can relieve some of the pressure on the state child welfare agency, so caseworkers have more capacity to work effectively to assess and respond in cases like this one, where there are significant issues with child safety and complicated family dynamics. It is essential that we have a robust and effective child protective agency, able to intervene when children are unsafe.

We all care deeply about the safety and well-being of children. Any efforts to respond to tragedy must consider, and then look beyond, any particular case to systemic issues and challenges. We encourage the committee to continue to explore and support ways to improve the broad child welfare system. This should include efforts to prevent child maltreatment, interventions to support families experiencing challenges, and ensuring the state child protective agency is working effectively to keep children safe.

Thank you.

REFERENCES

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2. Annie E. Casey Foundation. KIDS COUNT Data Center. Children Exiting Foster Care by Exit Reason. https://datacenter.aecf.org/data/tables/6277-children-exiting-foster-care-by-exit-reason?loc=21&loct=2#detailed/2/21/false/2048,574,1729,37,871,870,573,869,36,868/2631,2636,2632,2633,2630,2629,2635,2634/13050,13051

3. Department of Health and Human Services. Child Safety and Family Well-being Plan. https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/2023-05/Maine%20Child%20Safety%20and%20Family%20Wellbeing%20Plan.pdf

Senator Hinkman, Representative Faye, and Honorable members of the Government Oversight Committee,

My name is Melanie Blair from Lisbon. Thank you for listening to my testimony today. I am here to testify in regards to the disjustice, covering up and Justification of mistakes made in THE OPEGA report of the Maddox Williams death. I find it very difficult to understand where in this governmental system and process we have completely lost the ability to place sufficient value and importance on the life of a defenseless child within the Office of Child and Family Services and hold accountable those responsible for his neglect! This state system seems to have lost its focus on the safety first and foremost of the child, to the serious detriment of the children in this state. The rhetoric in this report is void of any human emotion, respectable character and trust, and is wrought with highly questionable logic! No amount of public policy will change the perspective of the people who can clearly see through this covering up of poor decisions and policy. The OPEGA report claims to look at the facts without outcome bias and concludes that "OCFS Safety decisions regarding Maddox Williams were not unsound..." YET, It also states that there are, "potential opportunities for improvement." How can both of these statements be true at the same time?

Policy mentions that the department needs to exercise due diligence in reunification. I would question how almost 10 years and 20,000 pages of department history is not a tad excessive. This is neglect, failing to keep a child safe. In my review, I find that the following policies were not followed, and were unsound:

***The department did not contact or interview a child's other custodial parent.**

*** Termination should be filed after 15 months, and it did not happen.**

***There was no documented reason for not filing TPR. This is unsound practice.**

*** The caseworker and AAG did not feel that termination would have been approved, so they didn't even try! Policy states that they are to attempt filing early on. This is also poor practice. There have been several caseworkers I have had. That have told me." When in doubt, file out, and let the judge decide."**

*** Termination by means of abandonment was not filed at six months. This is also in policy. Nor was termination filed due to a lack of parental cooperation, participation and substance and mental health treatment, or follow through earlier on.**

And how about common sense?

-Back in care, Maddox comes for repeat reasons. Yet because policy of termination was not filed, the department decided to drop the petition on Jessica stating they did not believe there was an immediate risk of serious harm to Maddox in his mother's custody. Even though she had abandoned him and not even cared for him in the past two years!

- The AAG and caseworker found that the condition in place (p.12), for the other children that were in care, "Were essentially the same conditions Jessica was already subject to as part of the existing trial home placement and concluded that Maddox would be similarly protected at that time in his mother's care." EVEN THOUGH the court had already indicated that it cannot, by law, impose such conditions unless there was an immediate risk of serious harm." Thus, the AAG and caseworker ultimately withdrew the PPO because they again did not think they would win in court. In other words, they played Russian roulette with this child's life, and they lost.

"A departure from policy leads to a missed opportunity" This is rhetorical doublespeak! Departure from policy, indicates that policy was not followed and therefore is unsound!

I would ask you to consider this, If the departments actions- failure to adhere to policy and protect a child who as a result, is beaten to death by his care giver, and this was a child neglect report being investigated by CPS, I am willing to bet that they would have substantiated abuse and neglect charges, yet the department has no fault or wrong doing in this case? This is a sad example of an over-reach of state power and authority.

I have pasted the policy statues I have reffered to below.

§4041. Departmental responsibilities

(6) Petition for termination of parental rights at the earliest possible time that it is determined that family reunification efforts will be discontinued pursuant to subsection 2 and that termination is in the best interests of the child. [PL 2001, c. 559, Pt. CC, §5 (NEW).]

§4002. Definitions

As used in this chapter, unless the context indicates otherwise, the following terms have the following meanings. [PL 1979, c. 733, §18 (NEW).]

1-A. Abandonment. "Abandonment" means any conduct on the part of the parent showing an intent to forego parental duties or relinquish parental claims. The intent may be evidenced by:

A. Failure, for a period of at least 6 months, to communicate meaningfully with th. child; [PL 1995, c. 481, §1 (AMD).]

B. Failure, for a period of at least 6 months, to maintain regular visitation with the child; [PL 1995, c. 481, §1 (AMD).]

C. Failure to participate in any plan or program designed to reunite the parent with the child; [PL 1983, c. 184, §1 (NEW).]

D. Deserting the child without affording means of identifying the child and the child's parent or custodian; [RR 2021, c. 2, Pt. B, §177 (COR).]

CPS safety investigations analysis

Public Comment Testimony in regards to the OPEGA report given to GOC on March 25, 2022.

Thank you for the opportunity to testify before you all today. My name is Melanie Blair, and I live in Lisbon. I testify in front of you with twenty-five years as a mother, fifteen+ years as an educator in special education, ten+ years working in behavior programs, and 7+ years as a foster parent.

According to the OPEGA Report given to the GOC on March 25th, The scope of OCFS goes beyond child protection as reflected in the mission of the Office which is: "***joining with families and the community to promote long-term safety, wellbeing, and permanent families for children."*** As is evidenced by this report, as well as my personal experience as a foster parent, this is just not happening consistently, and the children continue to pay the price. When will we stop accepting minimal progress, a lack of communication and transparency, the same excuses year after year, focusing solely on the lower-level workers as the problem, and address the upper-level management structural and procedural problems that are failing these children? When will we REALLY put the safety and well-being of the children as top priority?

Cases briefly in point:

Case 1-

This child we had twice. The first time was when the child was 8 years old and removed from an unsafe primary caretaker. The child was very hyper, had challenges in school, and was in a special behavior program. However, was happy, healthy, and making progress during the approximately two months at our home. This child was then sent to live with the other biological parent that had D.V. history. Approximately two years later, this child came back into care at 10 years old. The child that returned to my home, was sadly not the same child that left. This child was sickly thin, beaten and bruised in the face to the effect that the mouth on one side drooped and speech was significantly affected.

Case 2-

This next family of four children was a local family that I made two reports on. The second report was the most disturbing and concerning. The parent involved, who has had open and closed cases previously, was involved in a D.V. incident in front of the children in which an ax was used as a threat. I was told by the investigator that my report was screened out.

Just a few months later, another baby was born to this parent testing positive for substances, and all children were taken. Three of them went to their other biological parent who also has history of DV and abuse of a minor. Also at this time, the oldest child was not able to be located, so the department reached out to me since we knew this child personally and I was able to locate the child, who had resourcefully found their own safe place to be.

Case 3-

This next case is my own personal experience. I share this in extreme brevity, as this is very difficult to share. At the end of 2021 all 7 of my fosters were traumatically removed from my home as we were sitting down to eat dinner. All stemming from a dissociative report by a young child that was subsequently and intentionally aggravated by a false report made by a disgruntled community member. Rather than sticking to the original plan as discussed on the phone with the investigating caseworker, the department disregarded all other caseworker feedback and investigative work that had been already done, ignoring the fact that we were a vested foster family with many department worker relationships, even though on a monthly basis I had between 5 and 10 workers visiting my home with these children. The event that took place at my home that night by the department traumatized every child and adult in my house. The amount of resource, time, and money that were used on this is astonishing.

But perhaps even worse, was 'the process' that occurred over the next two months. The lack of communication, misinformation, or no information, and the covering up and passing the buck that occurred was unbelievable. The people that we have spent so much time working directly with over the past few years, including attorneys, had little to no input in my case. As a matter of fact, they were actually excluded from the meetings that were occurring because my case was being handled by central office. Despite my regular email requests for a meeting with said workers from central office (who remained anonymous), I was not once answered. During this process, I also realized how little information the investigators have access to that they should have. Our investigator did not have critical information about my family that would have changed the direction of this case prior to the trauma that our household of 13 suffered at the time of the removal. All of this information the department actually had in their computer system, but the investigative worker claimed she did not have access to it. During this process two of our five caseworkers left the department, I had attorneys in disbelief questioning the department regularly as to why they would not resolve this issue and return the children to my family, I had workers, and community members reaching out in support, including a daycare I had been using for six years, and worst of all, I had kids placed all over, some in homes that were previously not approved by the department. The amount of fight we had to put into resolving this was unbelievable. All the while, cases of real concern were being mishandled and shuffled around.

I share this story in fear. Fear of not only retaliation, but in serious concern that the department's ability to assess reports of suspected abuse or neglect safely and appropriately is compromised at a much higher and greater level than any of us are really seeing. These kinds of issues do not change with more money and more case worker positions, as FY 2018/2019 should evidence, as approximately 30 positions were added to alleviate workloads and training concerns. We are no better now with child deaths than we were then. During all of this, I have done my own research, read several of your reports and legislative proposals, have spoken to many foster parents, kinship relatives, and other frontline caretakers, and can assure you, that these concerns and experiences are not just mine. I have heard horror story after horror story, and most of them will not come forward in fear of department retaliation and the desire to continue fostering.

I strongly believe that if the committee would provide some kind of whistle blower assurance for other families to come forward without retaliation, you would see a clear pattern of not only poor choices and decision making, but deceptive practices that can only change at higher levels. My experience showed me firsthand that the lower-level workers are primarily doing what they are told to do, even if they disagree. Consequently, no matter how many positions you add, how much more training you provide, if the culture of the department and the communication and procedural practices do not change, you will not see the changes needed to keep children safe, and you will continue to see caseworker and foster parent burnout as you have for years because nobody is really listening to those of us that are in

the field every day. For significant change to occur, legislative changes need to happen from the top down.

The OPEGA report that was presented to the GOC in essence reaffirmed what we have all known for at least five years, so I ask those of you charged with ensuring the children are ' first and foremost safe from abuse and neglect', pass meaningful legislation to make changes from the top down-rather than solely focusing on this as merely a caseworker caseload and training issue. I ask you instead to scaffold the issues of WHY safety assessments and investigations are still not being properly completed. The problem ultimately falls on leadership and the department culture. Questions do not get answered, the buck gets passed, the fault lies on the frontline workers and the children pay the ultimate price. Legislation needs to delegate and hold accountable central office to make major policy changes otherwise we will continue to get the same results we have been. As my personal experience has shown me, central office is far too removed from the real, day to day ongoing and interpersonal relationships that these children are involved in and are far too often making bad decisions.

In my plea to you, I will highlight the following from the report: "the tool", staffing and training issues, the pendulum swing and department culture. During the OPEGA report to GOC, Senator Bailey asked a critical question that honestly was answered with a non- answer, as I have grown accustomed to hearing. She asked, 'how can we fix the investigation process if we do not have access to the tool in which you are using to make your assessments?' Mathematically speaking, this would be like being asked to solve an advanced mathematics problem without knowing the formula. This question, as well as many others, was referred to Dr. Landry to answer. Which in answering, I'm not sure I could tell you what he said the answer was. How can anyone, or any agency solve a problem without having all relevant information available to them? After all, this is what the department claims hinders CPS investigations, correct? Not having access to the critical information such as mental health records, medical information, etc.. Is it fair to expect this committee to complete such an important task such as monitoring OCFS' ability to adequately assess childrens' safety without access to such critical information from OCFS?

To answer Senator Bailey's question regarding the tool from my personal experience, the answer is that the answers to the questions the tool asks can be changed until a certain point. In essence, it is much like online tax software. You input the data you have and can go back to say, 'adjust' some information to perhaps get more of the result you were hoping for. But once you've gone so far as to "submit to the IRS", for example, you cannot change the results. You, committee members, need to have this information in order to see where the problems are occurring. In other words, transparency from the department.

Secondly, the frontline workers- foster parents, caseworkers, kinship providers, child care workers etc., are given the least amount of incomplete information, yet are held more visibly responsible and accountable but are not included or listened to regarding safety issues. For example, the OPEGA report claims to have surveyed 109 stakeholders, none of which were categorized to be foster, kinship parents or daycare providers who spend the majority of their day with these children. We are with them all day, have built important relationships, yet we are not considered to be part of this survey, or the solution? Because I was curious, and wanted these frontline workers to be included, over the last approximately 10 days I completed my own survey which was very similar to the surveys used in the OPEGA report. The results are included in this report at the end, and not only show that most foster parents do not feel the department is safely and adequately assessing the safety of children, but in doing so, I discovered that most people do not reach out, question, or complain due to fear of department retaliation. There has become, in the foster parent world, a culture of silent intimidation

well known amongst seasoned foster parents. We have no rights and they know it. If we question too much or advocate too hard there is a price to be paid. If there wasn't, I can assure you, you would have people lined up to tell you their stories. But they are fearful of department blacklisting and retaliation and speak quietly amongst themselves instead for support. All frontline workers should have a voice and be valued, not just be a rest stop for children and a scapegoat for mistakes made.

Next, I will take a trip down the staffing and training issue, as well as the pendulum swing. In the two decades of educational experience and behavior program training I have completed in crisis management and response programs, I have completed TCI, MANDT, and SAFETY CARE more times than I can remember. One thing that has always stuck out to me as crucial in keeping the children safe was to appropriately manage the environment and evaluate and adapt to the ABC's of the childrens' behavior. In theory, if the childs' environment is managed appropriately, negative behavior is minimized and the childs' safety and well-being is intact. When something happens to trigger an event, the ABC model is used as a group to discover the antecedent to the behavior, the behavior, and the consequence of the behavior. If, in the case of safety assessments the department cannot determine- due to a lack of transparency, information, and collaboration, the cause or antecedent of the behavior, then the behavior and the consequences of the behavior will not change. In other words, if they can't determine why the safety assessments are not made correctly then they will continue to be made incorrectly and the children will continue to pay the price.

We cannot continue to be reactive, firefighting a problem, and expect meaningful and significant change. We cannot, again say as was done in 2018/ 2019 that the solution to the problem is just better training and adding another 30 plus positions. This was done in 2018/ 2019, and the results did not change. The turnover has been and continues to be an issue for case workers as well as foster care providers. Yes, the job is stressful and needs some improvements. But it is so much more than that. It is a culture of fight or flight, reactive responses, where lower level people who are doing the day to day field work are not listened to, valued, and are often excluded. They are not given the information that they need to be successful. Therefore, it is no wonder that retention continues to be a serious problem. Many people are just giving up, foster parents especially. They have no voice, no advocate, or consistent equitable training themselves. They are left on their own to find supports and do the best they can while hopefully not saying too much as to upset the applecart and get blacklisted. Much like my local McDonald's, the department expects to solve their staffing problems with a sign on bonus and more positions. Unfortunately, money does not change the work environment and culture. It is a vicious cycle of hiring, training, and quitting that never seems to end. Vested workers have invaluable experience, and should be valued in the decision making process. Another personal example I can share is that of a short season I spent working at a particular behavior program in an elementary school that was seriously struggling with out of control student behaviors. After about a month, it was blatantly apparent to me that it was not a staffing issue at all. Rather, a scheduling and mismanagement issue. The program needed to be changed and restructured in how it was run in order to best utilize the resources they had, and be run in a more efficient way which in turn was safer and more pleasant for everyone. More money and more positions did not solve the problem in 2018-2019, and it won't completely solve them now either.

In conclusion, if child safety is really first and foremost the number one priority of OCFS, then all of the goals from the OCFS website concerning child safety should come before anything else. Therefore, from the goals chart on the website, children deserve a safe and nurturing environment and children deserve permanency should be second and third on the list and parents rights and responsibility to raise their own children should be subsequent, if not last. If these children were for

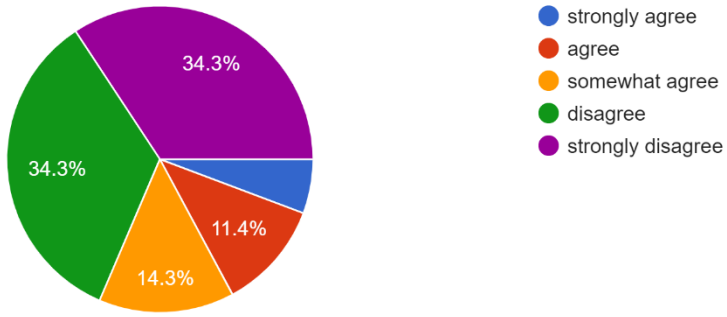
good reason removed from their parents' care due to safety issues, then why would the parents' rights supersede the childrens' rights to a safe and nurturing environment and for permanency?

In their report, OPEGA recommends designing and implementing policy and program changes. In order to do so, you need to change the structure and culture of the department from the top down, not the bottom up. You need to improve transparency, communication and collaboration across different levels. Then you will not only be able to maintain current staff, but fill additional needs, and ultimately keep kids safer, which is the goal after all. I also believe that the information that goes into the tool needs GOC oversight. Without accountability and transparency, we will never know where the problem lies in safety assessments. Oversight should also be done on a minimum number of cases regularly and by district utilizing all frontline workers with the opportunity at some level to share ideas for means of improvement. I believe you will find, in time, that public misconceptions and negative perspective of the department can be countered by not only educating, but including the public in your surveys and feedback, by taking accountability and giving all frontline workers a voice free from fear and retaliation, as well as consistent and equitable training and opportunities for all.

Thank you for your time and consideration in reading this report. Please see the following two stakeholder survey results create on google forms:

Do you feel your concerns regarding children adequately addressed?

35 responses



If you did not "strongly agree" or "agree" to the above question, what topics are a primary concern for you?27 responses

-Child safety

-Issues concerning reunification, concerns about visits and issues that occur at visits, medical care etc

-Lack of followup! accountability..and the push for reunification

-placement, honesty, timely communication

-Children need more say in their lives. FP need to be able to speak up without retaliation.

-Caseworkers close assessments without truly understanding that children are at risk

-Timelines, excuses, best interest of the child

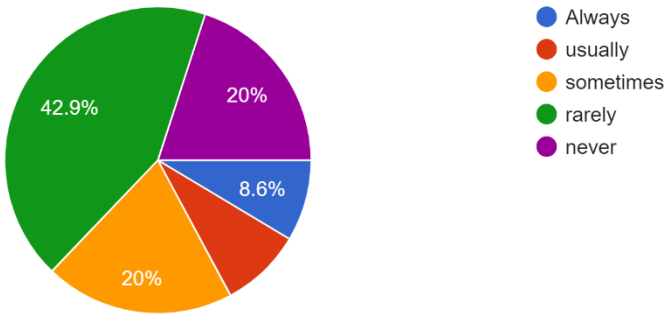
-Communication, ability to speak with anyone at all, how investigations are completed

-Communication

-I feel like the workers hands were tied many times in our case. Where she didn't really want to move the child back but didn't have any choice.
-I believe I have the dream team when it comes to case worker/GAL combos.
-As a foster parent I spend 24/7 with our placements. There needs to be more value in what I see and the concerns I voice.
-I don't want to be told what I want to hear or what the department thinks I want to hear. I want facts.
-Team cmunication
-I've been made to do things that I know are questionably unsafe with my fosters. I've questioned and pushed back and never received an answer.
-This list is very very long. They system is critically broken.
-Safety, putting the child first, considering the foster families needs and boundaries.
-Lack of communication is the biggest problem with DHHS.
-Our gal was completely absent and no way to request a new one. She started telling lies and never met fs in almost 22 months. As well as bioparents missing/late for a lot of visits and lying and getting rewarded for it.
-Missed visits. Return to bios when they are clearly not cooperating and misinformation provided by caseworkers to make parents look like they are.
-Child safety w/regard to bio parents
-Lack of resources and follow through. I've had CW tell me they can't possibly review full files, it would be a disservice to other kids on their roster, we've had GALS who never once set foot in our home to check on kids, the list goes on
-They generally tell us what we have to say is not important no matter how the kids are doing
-Our words are considered bias and we are not taken seriously. Even when we have personal support saying the same as us.
-Child safety, manipulative communication, incestuous nature of the players
-Neglect, child abuse, domestic violence, and substance abuse.
-The dept doesn't consider the child's well being at all. Things move way too fast for a child that has never had any contact with bio parent at all

Do you feel that your feedback and input is BOTH valued AND used in decisions regarding the safety and well-being of children?

35 responses



What are your primary areas of concerns in regard to the safety and well-being of children that you would like to have more voice in decision-making?28 responses

-Mental health screening of the parent
-The state rushing reunification when families are not ready. Putting more emphasis on the parental desires rather than the well being of the children.
-Total overhaul
-placement
-What is in the child's best interest.
-Resource parents should be treated like our voice matters and not as a glorified babysitter.
-timelines
-The efficacy of investigations. Each worker seems to go by their own guidelines so there is no uniformity among the department. Lack of actually protecting children even with overwhelming evidence of abuse or neglect.
-Parents needs and interests being out before the childrens
-In our case mom had extensive history spanning 15+ years with the department and they were still moving forward with trial home placement. They didn't listen to me when I told them I knew mom was using again.
-I felt like our first caseworker did not take our concerns seriously.
-The length of time that kids are in care. There has to be an across the board time frame, not just a suggested amount if time. --We need to stop playing with their lives.
-Permanency
-Placement back to bios
-It's not that I don't have a voice- I do. But case workers either don't have time to help you or don't have resources and Families don't have access to get them for the kids. If we did, and dcfs would pay for it, we could take a lot off dcfss plate. Instead, kids don't get resources and homes disrupt because the kids go into crisis. It's not the kid's fault.
-I just want to be heard and validated. I know I don't know what all is going on with cases but I'm living the day to day with the children.
-If I had to pick one place to start make case loads much smaller. Much. Then maybe the currently broken system can limp along.
-Shortening the time children are in the system, giving parents a set amount of time to reunify so kids can get to permanmcy quicker with less transitions, forcing children to visit with their abusers.
-Reunification
-We were told to right down everything the child was going through behaviors health issues and never once were asked to hear how is day to day was, especially at the beginning when he was withdrawing from drugs
-Return to bios, drug screens, follow up by dept for med appts and evals set up while in care. If missed it should be grounds for immediate removal.
-I don't feel the foster parents are taken into consideration at all. We're there to serve a purpose, yes. But we also observe a lot more interactions with bios, behaviors following visits, real-time conversations with bios as they become more comfortable with us. I don't feel any of that is truly taken into consideration when it comes time for the big decisions.
-I think foster parents should be included in all parts of team meetings, not just to report, so they can help support parents in their journey to reunification (if that's an option). I believe every child that enters care should be assigned a therapist and visits should be mandatory. I believe there should be accountability when GALS, case workers or supervisors don't respond or fail to --follow up on issues
-Where they go for medical and emotional help, whether their parents are safe
-The lack of guidelines or rules around what "in the children's best interest" looks like in practice. The continued "repeat offenders ", and how this seems to be the only "system" in America where you can commit the same wrong doing and your consequences never worsen with each time your children are returned to care. How all of this happens on the back of our most

vulnerable citizens and they are the ones “punished” for the wrong doings of their parents. Also there are no consequences for the department if they do not meet deadlines or timelines placed before them, but we as recourse parents have consequences for every move we make. Their is no body that governs the department and checks their regulations, that doesn’t have their paychecks signed by the state.
-"best interest of the child"

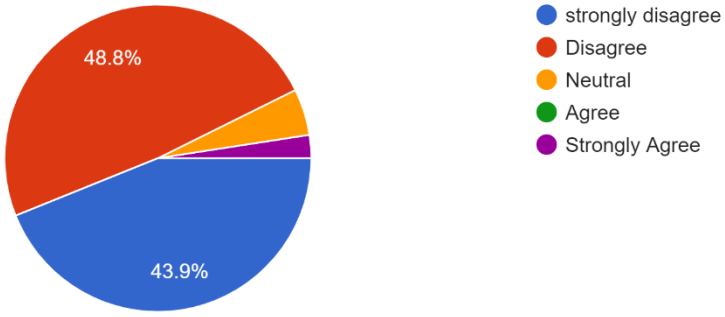
-Reunification, following through on things dhhs outlines for parents to complete before reunification, other forms of drug testing.

Do you wish to remain anonymous? If so, why?27 responses

No
Yes. Fear of being “black listed”.
yes-retaliation
Yes, I do still have guardianship kiddos
No
Yes, I have active foster kiddos that we are waiting for the adoption process on
Yes. I currently utilize DHHS low income help and that has been an impossible task enough.
Yes
Yes. So I don’t have retaliation from dhhs
I don’t care either way.
Yes,I don’t want any retaliation.
Yes. Very worried about department reprisal and being blacklisted. I speak out to my CWs all the time, but even THEY acknowledge there is vindictive decision making happening that impacts foster families and our kids
I am in the process of adopting one and have a foster. I don’t want to jeopardize their place with me. I’ve had both since birth. I have no trust that they wouldn’t be taken from me in retaliation. When I am done fostering I’m planning on speaking out but keeping them as safe as possible is worth holding my tongue for now.
Yes - I don’t trust the system :(
Yes.
no
Yes. Fs is in trail placement and would not like to ruin anything
No, I closed my license for a reason. The red tape and lack of communication was just too much to keep going with foster care. If my honest feedback can help fix things for resource families in the future, I’ll happily provide it.
I’d prefer to remain anonymous because there always seems to be backlash if not
Because what you say can and will be used against you
Yes because we are in the process of adopting and The department can make your life hell if they do choose.
Yes, retaliation
Yes, because things are used against you

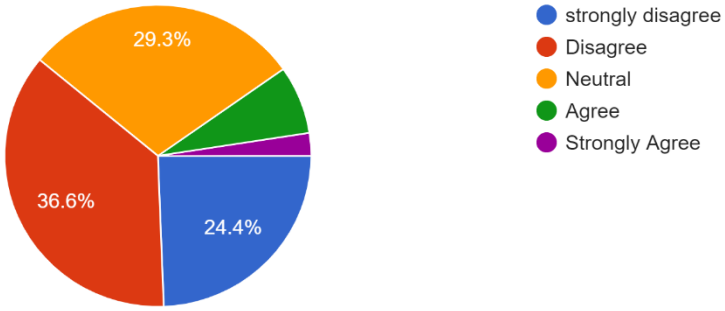
I am confident in the decisions the department makes.

41 responses



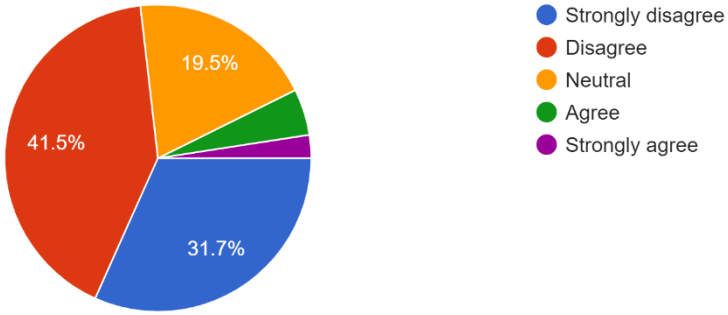
Department child safety investigations are thorough.

41 responses



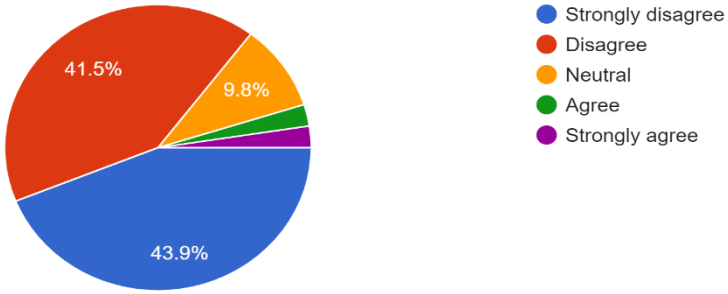
Department workers are able to accurately access risk.

41 responses



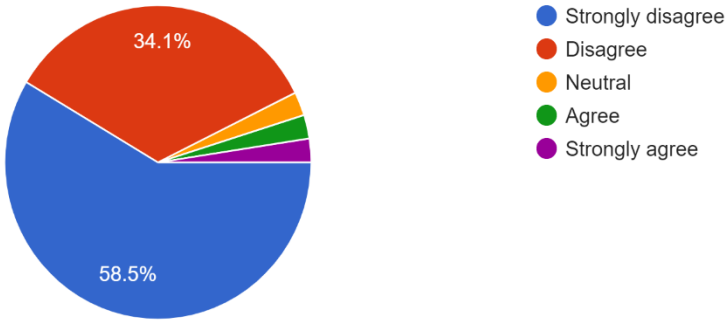
I believe DHHS appropriately balances child safety and and family preservation.

41 responses



Department decisions appear to be in the best interest of the child.

41 responses



I am a :

41 responses