OPEGA Report

Our Approach

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

Separate Reports for Each Case

Resolution of any related criminal proceedings, through the sentencing stage, has also then permitted the Commissioner of DHHS to release the kind of public account found at Appendix A of this report. Both milestones have been reached concerning Sylus Melvin's case. Sylus' father, Reginald Melvin, entered an "Alford" plea, in August of 2023, recognizing the State had enough evidence to convict him of domestic violence manslaughter. He was sentenced to 30 years in prison, five of which were suspended, followed by 6 years of probation. Releasing an OPEGA report after these steps have occurred allows for a more detailed report.

Acknowledgments

OPEGA appreciates the considerable and timely cooperation we received from all entities, including the substantial assistance provided by staff in the Office of the Attorney General in their advisory capacity on confidential information.

September 2024
RR-CFRSM-22

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

Summary

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

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

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

As prior actions and safety decisions can potentially impact the safety of a child born later—and in the interest of identifying areas that may lead to improved outcomes for children—OPEGA reviewed the Melvin family's larger CPS history which began in the summer of 2018, three years prior to Sylus' birth.

OPEGA endeavored to reach conclusions as to whether decisions made by OCFS staff were sound in light of prevailing child protection policy and practice, the laws governing such matters, and the information known (or that should have reasonably been known) to authorities when the decisions were made. To the extent that it may be helpful in understanding how certain safety decisions were made or why certain actions were or were not taken in response to various events and information, we have included descriptions of the conditions occurring at these points in the case, as well as the legal, policy, and practice frameworks through which the Department must process that information.

OPEGA Conclusion Regarding Sylus Melvin

With regard to the casework performed from the time of Sylus' birth on July 28, 2021, to his death on August 29, 2021, OPEGA concluded that it was sound within the parameters we have applied in our four case file reviews, and which are repeated at the top of this page. OPEGA concluded that the efforts of the CPS caseworker during this timeframe, and concerning Sylus, his mother, and his father, were thorough.[1] Given the information known to the Department at the time, casework practice and decision-making met OCFS policy standards. We note, however, that the reality that played out in the Newbert-Melvin home and with Sylus' family in the month before Sylus died, is one OPEGA cannot adequately resolve. OPEGA could find no evidence that the Department was made aware of specific safety threats to Ms. Newbert and the children by Mr. Melvin during that time frame. To the extent that there were complicated dynamics of a family in distress, related to mental health, substance use, and domestic violence, the Department should continue to examine and consider the risks to future families presented by the dynamics observed in this case.

OPEGA also reviewed Department interactions with the family that preceded Sylus' birth. Overall, OPEGA identified one instance in which we concluded that an unsound safety decision was made regarding the safety of Sylus' older full sibling.

Additionally, OPEGA identified an overarching practice issue which continued throughout the family's involvement with the Department, as well as a practice issue that was specific to one investigation. Three potential opportunities for improvement, and a practice observation, are also discussed in OPEGA's conclusions.

[1] The investigation was still open at the time of Sylus' death. See page 15 for a detailed list of investigative steps taken.

Child Welfare Philosophy and Law

Child welfare decisions made by OCFS are governed by federal and state law, guided by DHHS policy and rules, and resulting actions are often subject to judicial review and approval. Together, this framework largely emphasizes the rights of parents and family preservation, with exceptions for cases when there is evidence that a child is at risk of serious harm. The OCFS practice model emphasizes child safety, first and foremost, and states, "we support caregivers in protecting children in their own homes whenever possible."

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

When allegations of child abuse and neglect meet the threshold for investigation, the Department must identify whether a child has been harmed and the degree of harm or threatened harm by a person responsible for the care of that child. If, after investigation, the Department determines that a child is in immediate risk of serious harm or in jeopardy, the Department must file a petition in court or assign a caseworker to provide services to the family to alleviate child abuse and neglect in the home. Two procedures are used to initiate a court case by the Department if providing services is insufficient.

- *A Petition for Child Protection Order with a Request for a Preliminary Protection Order (PPO),* supported by a sworn statement, in which a child's immediate removal from a parent's custody is typically requested. This action requires that the Department prove by a preponderance of evidence (that it is more likely than not) that there is an immediate risk of serious harm to the child. Examples of serious harm include serious physical harm, failure to protect a child from serious harm by others, domestic violence that is likely to cause emotional harm to the child, and inability to supervise, care for, or protect a child due to substance use or impaired mental health.
- *A Petition for Child Protection Order*, known as a "jeopardy petition" or "straight petition," in which there is no *immediate* risk of serious harm alleged, but there is evidence of serious abuse or neglect requiring court intervention. Examples of this include serious harm or threat of serious harm; deprivation of adequate food, clothing, shelter or necessary health care; or abandonment. Jeopardy may also be evidenced by truancy, in certain circumstances, or by the end of a voluntary placement where the return of the child to his/her custodian creates a threat of serious harm.

When OCFS files a jeopardy petition, the court determines by a preponderance of the evidence if the child is in circumstances of jeopardy to the child's health or welfare with respect to each parent/custodian. If the court finds that the child is in jeopardy, it must fashion a disposition. Only then, in determining the disposition, does statute provide for the court to consider the best interests of the child. This is detailed in 22 MRSA §4036; the judge should consider the following principles in order of priority:

1. protect children from jeopardy to their health or welfare;
2. give custody to a parent if appropriate conditions can be applied;
3. make the disposition in the best interests of the child; and
4. terminate Department custody at the earliest possible time.

It is clear in this section that the child's jeopardy must be proved against a parent prior to any other consideration being given weight regarding a child's disposition.

Caseworkers cannot remove a child from their parents without an order from the court. OCFS must also show they have provided specific, reasonable efforts to prevent the need to remove the child from the home or to resolve jeopardy prior to any action for child removal. The Department does not need to make reasonable efforts to prevent removal if it alleges an aggravating factor defined by statute and the court so orders. Aggravating factors include rape, gross sexual assault, sexual abuse, or previous conviction for assault or murder of a child in their own household. If a child is removed from their parents' custody, rehabilitation and reunification efforts for parents must continue unless the court agrees there is an aggravating factor, or the court otherwise relieves the Department of this requirement.

Some other policy and practice issues relevant to this case include:

- **Substance exposed infant (SEI) reports**. The Maine Child and Family Services and Child Protection Act (22 MRSA §4004-B) says that "the department shall act to protect infants born identified as being affected by substance use or withdrawal symptoms resulting from prenatal drug exposure, whether the prenatal exposure was to legal or illegal drugs, or having a fetal alcohol spectrum disorder, regardless of whether the infant is abused or neglected." The Department must receive notification, investigate as determined necessary to protect the infant, determine if the infant is affected, determine if the infant is abused or neglected, and develop a plan for safe care. In practice, the OCFS Child Protective Intake Unit receives notification of substance-exposed infants at birth. In a subset of those cases, there is also a report of suspected child abuse or neglect. If an infant tests positive for only legal or prescribed drugs, the family is usually referred to services and the hospital puts together a plan of safe care. If there are concerns of abuse or neglect, OCFS investigates, identifies risk factors such as a history of illicit drug use, and looks for evidence of parental impairment and any negative effects on the child.
- **Families with significant cumulative history of CPS involvement**. When the Intake Unit screens in an allegation and it is assigned for investigation, the first step is for the caseworker and supervisor to complete the required assignment activities and identify potential safety factors, risk factors and safety threats, based on the reported information and review of prior history, alternative hypotheses, and the order of activities. Reviewing the family's prior CPS history is a key part of this first step. Risk factors considered include determining whether the caregiver has had previous CPS investigations of abuse and/or neglect, has caused an injury to a child through abuse or neglect, has had ongoing CPS involvement, has a history of drug or alcohol use, mental health issues, or domestic violence. The CPS

practice model states, however, "we believe that people can change. Their past does not necessarily define their potential."

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

Overview of Family's CPS Involvement

As OPEGA staff has observed in other cases, past CPS actions and safety decisions regarding a family's earlier children may later impact the actions taken, decisions made, and overall safety of that same family's subsequent children. As such, we reviewed the CPS history of Sylus Melvin's family that spanned from the birth of Sylus' older full sibling in June 2018 through Sylus' death in August 2021.[2]

Over the course of that CPS history, there were four distinct investigations—the first three of which occurred in succession following the birth of Ms. Newbert and Mr. Melvin's first child together. These first three investigations all resulted in either a service case being opened, or the family being served by the Department's contracted Alternative Response Program (ARP). Including investigations and the related service cases, the Department was either directly or indirectly (in the case of ARP) involved with the family from June 2018 through February 2020 with only a five-month period of non-involvement (December 2018 – April 2019) that coincided with Mr. Melvin's incarceration.

From March 2020 to June 2021, the Department was not involved with the family other than receiving three reports that were ultimately "screened out" by intake as inappropriate for investigation.

Following Sylus' birth in July 2021, the hospital reported a substance-exposed infant due to Sylus' exposure to his mother's prescribed medication for her substance use disorder treatment. The report also referenced Ms. Newbert and Mr. Melvin having had prior CPS involvement that resulted in Ms. Newbert having the authority to determine the circumstances and conditions of Mr. Melvin's visitation with Sylus' older full sibling. The referent noted that although Ms. Newbert had reported domestic violence issues with Mr. Melvin in the past, Ms. Newbert also stated that they were now getting along much better and had been living together for a year. This report was "screened in" for investigation, and the investigation was still open at the time of Sylus' death in August 2021.

A complete and detailed timeline of the CPS reports, investigations, and service cases can be found on pages 26 - 49 of this report.

[2] The family's CPS involvement continued after Sylus' death as Sylus' older full sibling was brought into state custody. Our scope was limited to the time up to and including Sylus' death.

Overall OPEGA Conclusions

Through our review of the family's history of CPS involvement, OPEGA identified:

- one overarching practice issue that began during the family's first investigation in 2018 and continued throughout the rest of the family's CPS involvement;
- one specific practice issue that occurred during the family's first investigation in 2018;
- one unsound safety decision that was made during the family's first investigation in 2018;
- three potential opportunities for improvement related to the investigation following Sylus' birth in 2021 and what transpired after; and
- one practice observation.

Additionally, in the years following Sylus' death, Ms. Newbert has made a number of statements (both publicly and to OPEGA directly) indicating that she and others had contacted the Department and law enforcement prior to Sylus' death to inform them that Mr. Melvin was using illicit substances, had been physically violent with Ms. Newbert, and/or threatened the physical safety of Ms. Newbert and their children—and that this information was not acted upon by any agency. As this allegation would suggest a major failure of the broader child protective system, we accordingly sought to identify the substantive elements of the statements made by Ms. Newbert; identify and obtain sources of potentially corroborating evidence, including beyond the OCFS case file; and determine whether Ms. Newbert's statements were supported by the available evidence. We also used these sources to determine what was actually occurring in the home and what was disclosed to the caseworker at the time. The results of this work, as well as descriptions of our findings and analysis of the casework performed, are set forth in the following sections.

Overarching Practice Issue

<u>Out-of-Home Child (Sylus' Older Half Sibling) Not Located</u>

Days after the birth of Ms. Newbert and Mr. Melvin's first child in 2018 (Sylus' older full sibling), the hospital made a report to CPS that Ms. Newbert and Mr. Melvin were not providing care for their substance-exposed infant while Ms. Newbert and the child were still in the hospital. This report was screened in for investigation.

The report also noted that Ms. Newbert had a prior child (with a different father than Mr. Melvin) who was living with Ms. Newbert's grandmother and other relatives in another town. The older half sibling's first name and last name—which was changed to match that of the relatives—as well as Ms. Newbert's grandmother's name were provided in the report. However, CPS Intake noted that it could not find any references to this child in the Department's information systems.

On June 7th, the day after the report was made, the caseworker met with and interviewed Ms. Newbert at the hospital, and, during that interview, Ms. Newbert referred to having an older child that lived with a relative.

Per the OCFS' Child Protection Assessment policy in place at the time, caseworkers should account for the whereabouts and safety of all children in the family during an assessment – even children reported to be placed out of the home. Caseworkers must verify with a party independent of the family (such as law enforcement, the child's school, or another CPS office that serves the area where the child resides) that the child is with the person, or persons identified by the parent/caregiver and that the child appears safe.

Despite the existence of this child being included in the initial report and disclosed directly to the caseworker, we do not see any evidence that the caseworker ever located the child and assessed their safety as required by policy. While this represents a specific practice issue, we also note that a related step appears to have been missed by caseworkers as this child (Sylus' older half sibling) should have been entered into the system as a critical case member and a person profile created or, if a profile already existed, linked to Ms. Newbert, and added in the relationship screen which would then make the information available for all subsequent involvements with Ms. Newbert. We did not see this child's information included in any of the subsequent investigations nor did any caseworker locate this child and verify their safety until August 30, 2021—one day after Sylus' death.

Recommendation:

The identified issue occurred in 2018, and, since that time, the Department has made policy changes and implemented a new child welfare information system, Katahdin—both of which appear to have addressed this issue. Current OCFS policy outlines that all critical case members are to be included in all reports, investigations, and cases, and added to the relationships screen in Katahdin. Within Katahdin, there are additional instructions explaining how caseworkers are to enter this information.

Specific Practice Issue

Safety Plan Not Documented

Following the birth of Sylus' older full sibling in June 2018, the child was residing with Ms. Newbert and Mr. Melvin (with some support from Ms. Newbert's mother) while the then-CPS investigation continued. On June 19th, Mr. Melvin contacted the caseworker to report that Ms. Newbert had just spit on him and on the previous day, had punched him in the face while he was holding the child. Mr. Melvin reported being outside of the home due to Ms. Newbert locking him out. The caseworker informed Mr. Melvin that he should not reenter the home without a police officer present. Mr. Melvin stated that he would be calling the police.

After a series of phone calls throughout the rest of the day, the caseworker learned that Ms. Newbert was going to be arrested for domestic violence assault, and she was later "bailed" at the police station with the condition of "no contact" with Mr. Melvin.[3] The caseworker also learned that Ms. Newbert's father (and his girlfriend) would be taking the child to stay with them that night (June 19th).

[3] Records show that on July 18th, Mr. Melvin recanted his story of Ms. Newbert assaulting him.

The following morning (June 20th) Ms. Newbert's physician made a new report to CPS indicating that Ms. Newbert would not be able to obtain suboxone treatment through their practice as Ms. Newbert had not complied with medical advice and recommendations made by the physician, missed multiple induction appointments, and at times did not answer or return calls from the physician. As a result, Ms. Newbert was being referred to another provider for suboxone treatment, but the physician was unsure when Ms. Newbert would be able to begin treatment with that provider, despite being flagged as a priority referral. Ms. Newbert's physician also reported having been able to contact Ms. Newbert that morning and, at that time, Ms. Newbert disclosed that Mr. Melvin had threatened to hurt her and their child the day before and was no longer living at the home. Ms. Newbert also stated that she had obtained a protection order against Mr. Melvin.

The caseworker then spoke with Ms. Newbert at her home regarding the previous day's events, the status of her substance use treatment, and observed the child (Sylus' older full sibling) who was with Ms. Newbert at the home. During that discussion, Ms. Newbert disclosed that she had been off suboxone for two days, was feeling overwhelmed, experiencing hot flashes, was sick from detoxing, but had not relapsed. Ms. Newbert also stated that she could not get to the new substance use treatment provider every day and did not feel comfortable leaving the child with Mr. Melvin—with whom she was not allowed to have contact.

At that point—according to what can be found in the record and our interviews with the caseworker and the supervisor for this investigation—it appears that the caseworker made a plan with the family that the child would stay with Ms. Newbert's father and his girlfriend until the Department determined otherwise and that Ms. Newbert could not have unsupervised contact with the child.

Shortly thereafter, the caseworker's supervisor documented in the case file the preliminary safety decision related to the most recent report to CPS from Ms. Newbert's physician. The supervisor's decision not only referenced the caseworker and family's plan but also, seemingly, considered how that plan would address their safety concerns, as the child was found to be safe at that time. In that preliminary safety decision, we noted that the plan was never referred to as a safety plan and in later interviews with OPEGA, was referred to only as an "informal safety plan"—although the caseworker did state that they had expected to find a written safety plan in the documentation as they prepared for their interview with OPEGA.

While OPEGA does not take issue with the conditions imposed by the plan, we do believe that given the caseworker's involvement in the development of the plan, the risks it sought to mitigate, the actions taken (specifically, placing the child with an out-of-home caregiver and the supervision restrictions placed upon Ms. Newbert at that time), that this was effectively a safety plan. As such, and according to policy, it should have been documented and included the following components: a description of all the safety threats; detailed action steps describing what the parent(s) will do to reduce the safety threats; a plan to monitor and verify that the plan is being followed; and an agreement between the parent/caregiver and support person participating in the plan. However, we found no evidence that this safety plan was ever formally documented, which represents a practice issue.

Recommendation:

While safety planning practice at OCFS has changed significantly from 2018, we understand that safety plans remain an area of uncertainty for some caseworkers today. OCFS' Safety Planning Workgroup should continue to clarify what constitutes a safety plan and encourage standardized practice.

Unsound Safety Decision

Placing a Child (Sylus' Older Full Sibling) in a Home Without Assessing the Safety of that Home and Caregivers

As part of the undocumented safety plan described in the preceding issue, Sylus' older full sibling was placed with Ms. Newbert's father and his girlfriend, where, by all accounts, the child was well-cared for from June 20th to approximately the end of July 2018.

However, the record reflects that the caseworker did not run background checks or otherwise assess the safety of Ms. Newbert's father and his girlfriend until well after the child was placed in their home. For example, all of the following occurred over the course of two weeks following the placement on June 20th:

- On June 27th, the caseworker contacted Ms. Newbert's father and obtained his girlfriend's name, date of birth, and phone number. This was the first time the girlfriend's last name appeared in the record.
- On June 28th, the caseworker contacted the Piscataquis County Sheriff's Office (PCSO) which provided the following information regarding Ms. Newbert's father:
    - In 2016, he was a suspect in an erratic vehicle complaint.
    - In both 2006 and 2014, he was arrested on a warrant, but PCSO did not have any more details.
    - In both 2005 and 2007, he was booked under a "Federal Code Violation," but PCSO did not have any more details.
- On June 28th, the caseworker visited Ms. Newbert's father's home for what appears to be the first time. A safe sleep assessment was performed at this time and the Period of Purple Crying template was entered into MACWIS (the Department's then-child welfare information system). During this visit, Ms. Newbert's father disclosed having been released from federal prison three years prior after having served 13 years for "dealing" (distributing) cocaine. He also reported that he was no longer on probation. While at the home, the caseworker also questioned Ms. Newbert's father regarding the medications he was currently prescribed, and then requested to do a pill count. Ms. Newbert's father was unable to provide the requisite pills and claimed they were stolen, which the father subsequently reported to law enforcement, according to the case record.

- On July 11th, the caseworker ran background checks for Ms. Newbert's father, Ms. Newbert's father's girlfriend, and Ms. Newbert's mother. Ms. Newbert's father's criminal history showed nothing after 2004[4] and there was no criminal history for his girlfriend.

In interviews with OPEGA, both OCFS staff and management indicated that these actions should have been taken *prior* to placing the child in the home of Ms. Newbert's father and his girlfriend as part of a safety plan and, given the information that was learned, would have warranted additional action and scrutiny from the Department—such as subjecting the couple to a full resource home licensing study or even possibly disqualifying Ms. Newbert's father as a potential placement for the child.

OPEGA understands that knowing with whom a child is placed and assessing the safety of those people and their home prior to placing a child in that home are fundamental components of casework, and that proceeding with the placement absent that information constituted an unsound safety decision.[5]

Potential Opportunities for Improvement

During this review, we identified three potential opportunities for improvement that may warrant further consideration by the Department and/or the Legislature but have not been thoroughly evaluated by OPEGA. These opportunities include areas in which the Department is currently making changes as well as some areas that were beyond the scope of this review. We recommend that the Department, the Legislature's Joint Standing Committee on Health and Human Services, and the Government Oversight Committee, as appropriate, consider these opportunities as they continue to oversee the improvement of child protection services.

<u>Involve Caseworkers and Supervisors in the Development of the Department's Public Memorandum</u>

Pursuant to statute, and in consultation with the Office of the Attorney General (OAG), the Department may disclose certain categories of child protective information when child abuse results in a child fatality, a parent is charged in connection with the death, and the release would no longer jeopardize the criminal prosecution of the parent.

As this may be the only public accounting of what occurred in the case (other than related prosecution), it is vitally important that the information in those memos is accurate. Here, we note that the Department's August 16, 2023, memo detailing the Newbert-Melvin family's history of CPS involvement needed to be revised and reissued a little over three weeks later to provide additional context and address some factual inaccuracies. The published inaccuracies brought undue public criticism upon a caseworker and were also a source of upset for Ms. Newbert, who then questioned the Department's veracity in this regard.

[4] Ms. Newbert's father's federal drug convictions would not have been expected to appear in a State Bureau of Identification criminal history background check at that time. Current OCFS background checks include accessing the Interstate Identification Index, which includes federal violations.

[5] In some cases, the family and law enforcement may develop a safety plan without the Department's input. When that happens, the expected investigative actions occur *after* the placement of the children to ensure the safety of the children and to determine whether the plan is supported by the Department.

One significant inaccuracy from the original memo indicated that the caseworker visited the family's home following Sylus' discharge from the hospital on August 10, 2021, when this visit did not occur at the time indicated.[6] In an interview with the caseworker, OPEGA learned that the caseworker was surprised by the inclusion of this error, which the caseworker would have identified had they been involved in the drafting and review of the public memo. This illustrates a potential opportunity for improvement: involve caseworkers and supervisors in the development or review of public memos to ensure accuracy.[7]

Obtain Relevant Call Logs When a Child Fatality Occurs

In attempting to evaluate Ms. Newbert's statements that she and others had contacted the Department prior to Sylus' death regarding safety concerns presented by Mr. Melvin, OPEGA requested OCFS call logs via the OAG. In May 2024, the Chief of the Child Protection Division in the OAG issued an investigative subpoena to the Maine Office of Information Technology requesting all call logs between July 1, 2021 and August 31, 2021, for 17 different OCFS desk lines at the Bangor District Office. We were ultimately provided the response to the subpoena from Consolidated Communications, the State's telecommunications service provider, that the information was not available, which "could be due to it being out-of-date, too far back in the past or just not available."

As this information could be useful to the Department in the future for assessing whether and how communication breakdowns occurred, the inability to obtain these records long after the events allegedly took place points to another potential opportunity for improvement: as a matter of practice, the collection of all relevant call logs (for both landlines and cell phones, including text messages) for involved caseworkers and supervisors when there is both an open case (investigation, service, or permanency) and a child fatality.

Information Sharing Between Law Enforcement and CPS

During the CPS investigation that immediately followed Sylus' birth, much of the caseworker's earliest work was determining whether Sylus could be safely discharged from the hospital and into the care of his parents. As part of that initial work, the caseworker visited the Milo Police Department (Milo PD) on July 30, 2021, to learn whether there had been any recent reports or incidents involving Ms. Newbert or Mr. Melvin. The caseworker's notes of this visit indicate that there had been no recent reports of domestic violence and only Mr. Melvin had any recent involvement or interaction with law enforcement, which last occurred the prior May. The caseworker's notes also identified the specific officers that the caseworker had spoken with.

As the investigation progressed, none of the information provided to the caseworker would alter the trajectory of the case as supports for the family were in place, reports were generally positive, and, according to the record, no safety threats were disclosed to the caseworker. However, on August 22nd – unbeknownst to both the caseworker and OCFS—Ms. Newbert's mother contacted Milo PD and spoke to a different officer than the caseworker had regarding her desire to have Mr. Melvin removed from the home he shared with Ms. Newbert. According to the officer's record of that call[8], and as described by the officer in an interview with OPEGA, Ms. Newbert's mother was worried about her daughter being with and living with Mr. Melvin as he

[6] A home visit occurred on July 30, 2021—*prior* to Sylus and Ms. Newbert being discharged from the hospital.
[7] In subsequent discussions with the Department regarding this potential opportunity for improvement, the Department reported that the inclusion of caseworkers and supervisors in the development or review of the public memo is now standard practice.
[8] Ms. Newbert's mother's account of this call differs from that of the officer. Her account is described on pages 20-21.

had abused Ms. Newbert and other women in the past. Ms. Newbert's mother stated that she had just received a call from Ms. Newbert venting and crying about Mr. Melvin.

The officer's record further documented that the officer then asked Ms. Newbert's mother whether she would like them to do a welfare check, but Ms. Newbert's mother declined—with some apparent insistence—as she didn't want to upset Ms. Newbert or Mr. Melvin by sending an officer to the home. The officer then described his history of responding to calls from the couple and how Ms. Newbert had said she would be leaving Mr. Melvin. Ms. Newbert's mother then stated that her daughter believed that Mr. Melvin had changed for the better and continued to be with him, but she didn't believe that Mr. Melvin had changed at all and wanted him to leave her daughter alone.

After learning that the officer could not remove Mr. Melvin from the home based on what she had reported, Ms. Newbert's mother stated that she would be going to court to pursue this further.

According to the officer's record, Ms. Newbert's mother did not apparently report anything to the officer that would require the officer to make a subsequent report to CPS. However, we believe that information was still relevant to the caseworker's open investigation—which, as the officer later told OPEGA, the officer was unaware of at the time. This call to Milo PD was apparently the first time that anyone involved with the family (such as extended family members or service providers) expressed a belief that Mr. Melvin should be removed from the home—which did not align with what Ms. Newbert's mother had told the caseworker earlier in the investigation.[9]

We believe that had the officer known of the active CPS investigation and informed the Department the caseworker would have had the opportunity to follow up on this inconsistency and explore Ms. Newbert's mother's concerns with her—possibly leading to better understanding the current conditions in the home. As this is not the first time[10] we have observed a scenario in which law enforcement had information that would not otherwise be reported to CPS, but appeared relevant to an open investigation, we believe this illustrates a potential opportunity for improvement: better coordination between law enforcement and CPS in terms of information sharing when there is an active CPS investigation underway.[11]

Practice Consideration

<u>Apparent Incongruity Between the Terms of the PR&R and the Department's Discussions with Ms. Newbert Regarding Visitation</u>

On October 10, 2018, the court found that Mr. Melvin, but not Ms. Newbert, caused a condition of jeopardy for their earlier-born child (Sylus' older full sibling). Both protective custody cases were dismissed, and a Family Matters court proceeding was initiated to develop a Parental Rights & Responsibilities (PR&R)

[9] On July 30th, the caseworker asked Ms. Newbert's mother about Ms. Newbert and Mr. Melvin's relationship then as compared to 2018, with a particular focus on Mr. Melvin. Ms. Newbert's mother reported that the couple had been getting along and had had only a few disagreements. Regarding Mr. Melvin, Ms. Newbert's mother noted that he was more grown up now and handled "stuff" better. She did not have any substance use concerns as he was in a program.
[10] A similar scenario was observed during OPEGA's review of two child fatalities in 2018.
[11] OPEGA wishes to emphasize, again, that the officer's record of the contact with Ms. Newbert's grandmother did not include information that warranted a mandatory report by the officer.

Order.[12] Because Mr. Melvin had been found to have caused jeopardy, the Department was a party to this proceeding, along with the parents and their attorneys.

The PR&R Order (concerning Sylus' older full sibling) ultimately issued by the judge (after negotiation by the parties) included the following language:

> *Defendant [Mr. Melvin] shall have the right to parent-child contact with the minor child at all reasonable and proper times as agreed upon by the parties and under such circumstances and conditions as determined by Plaintiff [Ms. Newbert], in her sole discretion, that will ensure the minor child's safety. Visitation shall be supervised.*

The PR&R Order did not specify who should supervise visitation and otherwise left it to the sole discretion of Ms. Newbert. Mr. Melvin was incarcerated at this time for domestic violence (against another woman) and for violating the Protection from Abuse (PFA) Order issued to protect Ms. Newbert and their then-only child together (Sylus had not yet been born).

In contrast, at a Family Team Meeting held on October 30, 2018, the caseworker and Ms. Newbert discussed visitation using an organization called Safe Havens to provide the supervision for when Mr. Melvin was freed from jail. An explicit expectation of a third-party supervisor was not included in the PR&R Order, although OPEGA understood from the record and interviews that this was the Department's preference.

The supervisor working on the case at the time told OPEGA in an interview that additional protections for Ms. Newbert and her child included that Mr. Melvin was in jail at the time, Ms. Newbert had obtained a PFA and enforced it three times in the past few months, and that Ms. Newbert was living in transitional housing for survivors of domestic violence where Mr. Melvin was not allowed. Ms. Newbert was also involved in domestic violence prevention and support programs through Partners for Peace.

Over time, these additional conditions changed. Ms. Newbert attempted to modify the PFA within eight days of the final closing letter from the Department. The judge dismissed the PFA on December 6, 2018 in response to Ms. Newbert's request for modification. Mr. Melvin was freed from jail in March 2019, and Ms. Newbert eventually moved from transitional housing sometime in 2020.

This record reveals the apparent incongruity of a victim of domestic violence left to decide for themselves whether to insist on third-party visitation services of a child by their domestic abuser or to supervise the visits themself. In discussing this observation with the Department and the OAG, OPEGA was advised that challenges in obtaining third-party visitation could be encountered, including availability and cost. Also, the language of a PR&R like in the case at hand is the product of negotiation among parties and overseen and approved by the presiding judge. Given the complexities, OPEGA is not able to offer a formal recommendation, but wishes to acknowledge this apparent incongruity for potential future consideration.

[12] See 22 M.R.S. § 4036 (1-A) (setting forth the mechanism for dismissing a child protective custody case and correspondingly initiating a Family Matters proceeding and the grant of a Parental Rights & Responsibilities Order).

Overall Assessment of Casework Related to Sylus Melvin

Overall, OPEGA concluded that the casework concerning Sylus was thorough and aligned with Departmental policies and expectations. Additionally, the casework reflected appropriate safety-related decision-making based on the information provided to the caseworker by the family, extended family members, the family's service providers, and other results of the investigation. In particular, we make the following observations:

- The caseworker reviewed and understood the family's CPS history, including noting the outcome of the family's 2018 CPS involvement—that Mr. Melvin had contact supervised at Ms. Newbert's discretion for their first child.
- Background checks for Ms. Newbert and Mr. Melvin were obtained immediately.
- The caseworker interviewed Ms. Newbert and Mr. Melvin separately at the hospital and neither expressed any current issues related to their relationship or Mr. Melvin.
- The caseworker obtained releases to speak with each parent's providers[13], and then spoke with Mr. Melvin's peer support worker, case manager, psychologist[14], and substance use treatment provider—all of whom expressed no concerns.
- Both Ms. Newbert's mother and father—who were supports for the family and saw the family multiple times per week—were interviewed and reported no current issues.
- The caseworker contacted Milo PD to determine whether there had been any recent reports or incidents involving the family and learned that there were no reported issues of domestic violence and only Mr. Melvin had any recent police involvement.[15]
- Appropriate referrals for Maine Families and Public Health Nursing Services (which Ms. Newbert consented to) were made by the caseworker.
- The investigation activities (many of which are described in the preceding bullets) were prioritized and conducted by the caseworker *prior* to Sylus' discharge from the hospital to ensure his safety in the home.
- The caseworker completed a home visit[16] prior to Sylus' discharge from the hospital, which included observing the home and Sylus' anticipated sleep space, conducting a safe sleep assessment, observing Sylus' older sibling and interviewing Ms. Newbert's mother who was caring for that child in the home.

[13] Ms. Newbert's providers were not contacted at that same time, and we do not see any evidence that they were contacted prior to Sylus' death. However, the investigation was still open at that time and could have still been made in accordance with policy.

[14] Mr. Melvin's psychologist had not seen Mr. Melvin since March 2020 as in-person appointments were not occurring due to COVID. While the information provided to the caseworker was dated, it was only one of several sources of information and it aligned with what else was being reported at the time.

[15] Milo PD reported that Mr. Melvin was involved in a theft incident in May where he had previously called to try to obtain some of his possessions that were in another person's home. In March, he had dropped a bag of heroin in a local store and was charged with possession.

[16] This visit has been a source of concern for Ms. Newbert as she has stated that she and Sylus never received a home visit. While that is true, the caseworker's visit, paired with their observation of Sylus and interviews of his parents at the hospital, appears to meet policy expectations. OPEGA did note that in the documentation associated with the Preliminary Safety Decision, it appears that a second home visit was to occur. However, the investigation was still open at the time of Sylus' death and the caseworker still had time to conduct that visit within the Department's established timeframes for investigations.

- The caseworker also communicated with the hospital regarding whether it was appropriate to discharge Sylus.
- The caseworker contacted Ms. Newbert to inform her that they would be on vacation the following week and wanted to make sure Ms. Newbert and her family were all set. During that call, Ms. Newbert reported that the public health nursing visits were going well, but during one visit, Ms. Newbert and Mr. Melvin's older child (Sylus' older full sibling) was acting out and Ms. Newbert was struggling with the child's behavior. Mr. Melvin was not at home at the time as he was working, and Ms. Newbert and the public health nurse talked about needing Mr. Melvin there to help. Ms. Newbert reported that she was feeling pretty good in terms of her mental health but had been overtired. According to the caseworker's notes, they explained that they were only interested in making sure Ms. Newbert had adequate support and that any feelings of depression were not impacting the children. The caseworker also informed Ms. Newbert that she could contact the caseworker's supervisor if anything came up.

Domestic Violence and Substance Use Issues Unknown to the Caseworker

Although we conclude that the decisions and actions taken during the investigation that followed Sylus' birth were appropriate and sound based on what was *known* to the caseworker at the time and reasonable inquiry, additional records and interviews occurring after Sylus' death indicate that there were safety threats within the home during that investigation that were *unknown* to the caseworker as Ms. Newbert and her mother were privately struggling with Mr. Melvin's increasingly erratic behavior and were in fear for Ms. Newbert and the children.

As part of the criminal investigation related to Sylus' death on August 29th, Maine State Police detectives interviewed Ms. Newbert on August 29th and September 2nd and obtained Ms. Newbert and Mr. Melvin's cell phone records and Facebook messages. At the same time, the Department continued to be involved with the family as their current caseworker also attended the August 29th interview with the Maine State Police, and another caseworker interviewed Ms. Newbert's mother that same day. On August 30th, Ms. Newbert sent the family's current caseworker a series of screenshots of texts that were found on a phone that Mr. Melvin had misplaced, as well as screenshots of Facebook Messenger conversations between Ms. Newbert and her mother.

Across these three dates—August 29th, August 30th, and September 2nd—the information that was provided by the family depicts what was apparently occurring in the family's home prior to Sylus' death.

<u>Information Provided August 29th</u>

After Sylus was taken to the hospital, Ms. Newbert was interviewed by the Maine State Police at the hospital with the caseworker also in attendance. Ms. Newbert disclosed that Mr. Melvin had strangled her and hit her in the face about a week prior, and that when Sylus was first born, Mr. Melvin had threatened to kill them all "so he wouldn't have to deal with it." According to the interview notes, Ms. Newbert also stated that she had recently suspected that Mr. Melvin had been using heroin and methamphetamine and selling his suboxone[17].

[17] Suboxone is a prescription medication that combines buprenorphine and naloxone to treat opioid use disorder.

At this same time, Ms. Newbert's mother was interviewed by CPS. In this interview, Ms. Newbert's mother stated that she believed Mr. Melvin had been using drugs and not taking his suboxone. She said that about a week and a half or two weeks prior, her daughter told her that Mr. Melvin was roaming in the woods and when he came back to the house, he "acted all wound up, hyped up, wired up, like he was on some sort of upper." Her daughter told her that Mr. Melvin had slapped her at that time and shoved her against the refrigerator. Ms. Newbert's mother stated they thought about reporting it to the police at the time, but since there were no marks, "it would be he said – she said". The CPS interview notes state that Ms. Newbert's mother said she *did* report this to the police a week prior to this interview from 11:30 PM to 12:00 AM and talked to an officer about what happened, the threatening remarks Mr. Melvin made, and his being out in the woods. In an interview with OPEGA, Ms. Newbert's mother also said that she told the officer she was worried about her grandchildren's safety. (The context of this call is described in the following section of this report.) Based on the timestamped screenshots of Facebook Messenger conversations provided to the caseworker after Sylus' death, Ms. Newbert and her mother discussed this call directly after it occurred. This discussion included a request from Ms. Newbert for her mother's partner to provide transportation to the courthouse in the morning to obtain a protection order.[18]

Information Provided August 30th

The following day, Ms. Newbert sent the caseworker a series of screenshots of texts that were found on a phone that Mr. Melvin had misplaced, as well as screenshots of Facebook Messenger conversations between Ms. Newbert and her mother. The screenshots from Mr. Melvin's misplaced phone appear to show that throughout the month of August, Mr. Melvin had been texting another person regarding obtaining, using, and possibly selling heroin and Xanax. Some of these screenshots showed system dates of August 8th, 9th, 18th and 21st. Others did not have system dates displayed but contextually can be timed to within the month of August.

The screenshots of Facebook Messenger posts between Ms. Newbert and her mother describe an assault of Ms. Newbert by Mr. Melvin and expressed their growing fear of his volatility and unpredictability.

Information Provided September 2nd

In an interview with Maine State Police detectives, Ms. Newbert stated that Mr. Melvin assaulted her on August 19th, and again on either August 24th or 25th, at which time she had tried to call the police. She said he had put her in an armbar, muted the phone, and told her to end the call or he would kill all of them. She said Mr. Melvin then gave her the phone back at which time she told dispatch there was no emergency, that she did not need an officer to respond, and she would contact an officer the next day.

These events described by Ms. Newbert have been added to the Timeline of the Fourth Investigation found in Appendix C.

[18] OPEGA contacted the Piscataquis courts and was advised that no protection order application was made by Ms. Newbert in July or August 2021.

Communicating Safety Threats to the Department and Law Enforcement

Although the documentation in MACWIS and our interviews do not reflect that the caseworker was ever made aware of any of the issues that the family was experiencing in August 2021—Mr. Melvin's substance use, domestic violence, and threats of harm made toward Ms. Newbert and their children—Ms. Newbert has made a number of statements[19] (both publicly and to OPEGA directly) that she and others communicated these issues to both the Department and law enforcement prior to Sylus' death—and that no agency responded.

As this allegation would suggest a major failure of the broader child protective system, we sought to identify the substance of the allegations made by Ms. Newbert, identify and obtain sources of potentially corroborating evidence, including beyond the OCFS case file, and determine whether Ms. Newbert's statements were supported by the available evidence.

Ultimately, we identified four specific statements made by Ms. Newbert and/or her mother for OPEGA to investigate using a combination of Mr. Melvin and Ms. Newbert's cell phone records, the caseworker's cell phone record, records requested from Milo PD and the Piscataquis County Sheriff's Office, and interviews with those involved with the family at this time—in particular, Sylus' Public Health Nurse.[20] The four assertions that OPEGA investigated are:

- Ms. Newbert contacted the Department through various means and communicated Mr. Melvin's issues to caseworkers.
- Ms. Newbert contacted local law enforcement without a response to the home.
- Ms. Newbert's mother contacted local law enforcement and communicated Mr. Melvin's issues to an officer, who did not take any action.
- The Public Health Nurse witnessed and mediated a dispute between Ms. Newbert and Mr. Melvin and reported concerns about Mr. Melvin to the Department.

<u>Ms. Newbert's Contacts and Communications with the Department</u>

In interviews with OPEGA, Ms. Newbert and her mother described how they contacted both the caseworker and the Department at some point after Ms. Newbert's call with the caseworker on August 20th. Specifically, they asserted that they tried to call and text the caseworker on or around August 23rd (even though they knew the caseworker was on vacation) and, when they could not reach the caseworker, Ms. Newbert contacted the Department and left a message with the "duty worker" but never received a call back.

Calls and Texts to the Caseworker

As part of the criminal investigation associated with Sylus' death, Maine State Police obtained Ms. Newbert's and Mr. Melvin's cellphone records from July 28th through August 30th. These records included the date and time of all inbound and outbound calls, the phone numbers the calls were from and to, and the duration of

[19] Ms. Newbert also made assertions of other Departmental practice shortcomings, but these appear to be based on Ms. Newbert's expectations rather than Departmental policy.
[20] A full description of the data reviewed, and our methodology can be found in Appendix B.

each call. These records also provided similar information for text messages but did not include the actual content of the text messages. We obtained these records from the Criminal Division of the OAG.

OPEGA reviewed these records and found no calls or texts from Ms. Newbert's cellphone to the caseworker's cellphone or office numbers prior to Sylus' death.

We were also able to review the caseworker's cellphone call log for that same period, and, other than the aforementioned call made by the caseworker to Ms. Newbert on August 20th, found no calls to or from Ms. Newbert prior to Sylus' death. These records, however, did not contain the content of the caseworker's incoming and outgoing text messages. Instead, the caseworker provided OPEGA with screenshots of the messages they had received from Ms. Newbert—all of which were received on August 30th.

> OPEGA's Analysis: The available evidence does not support the assertion that Ms. Newbert contacted the caseworker during the timeframe in question.

Contacting the Department and the Duty Worker

According to Ms. Newbert and her mother, when they were unable to reach the caseworker, they contacted the Department, and spoke with the duty worker[21] but never received a call back from the Department. We reviewed Ms. Newbert's cellphone records and could only identify two calls made to the Bangor DHHS District Office—which houses multiple DHHS agencies—but these calls happened August 12th and August 13th, which is prior to Ms. Newbert's call with the caseworker on August 20th.[22]

As referenced in the Potential Opportunities for Improvement section of the report, we requested OCFS call logs via the OAG. In May 2024, the Chief of the Child Protection Division in the OAG issued an investigative subpoena to the Maine Office of Information Technology requesting all call logs between July 1, 2021 and August 31, 2021, for 17 different OCFS phone numbers at the Bangor District Office. We were ultimately provided the response to the subpoena from Consolidated Communications, the State's telecommunications service provider, that the information was not available, which "could be due to it being out-of-date, too far back in the past or just not available."

> OPEGA's Analysis: The available evidence does not support the assertion that Ms. Newbert contacted the Department during the timeframe in question. The record of calls remains incomplete, however, as described above.

[21] A duty worker is one of the office's caseworkers who has been assigned that role on a particular day. The duty worker (an assignment which regularly rotates among caseworkers) is expected to be in the office on that day to receive calls from any clients being served by the office (or others) who may have a specific need in that moment that requires some level of prompt response or action. When on the phone with a client, the duty worker employs their investigative skills to discern what the client is experiencing and what the client needs, and then determines the appropriate response with the information they have obtained. For emergent or pressing concerns, the duty worker would consult the client's caseworker's supervisor to coordinate a response (which may or may not involve the duty worker).

[22] The record indicates that the call on August 12th was 3.5 hours long. When asked by OPEGA, Ms. Newbert was certain that she had never been on the phone with a caseworker for that long. The record indicates that the call on August 13th was bracketed by calls directly to DHHS's Office of Family Independence.

Ms. Newbert's Contacts with Local Law Enforcement and Their Response

Ms. Newbert has made general statements to the effect that she called local law enforcement for help, but they said there was not anything they could do. As described previously, Ms. Newbert told Maine State Police detectives after Sylus' death that Mr. Melvin assaulted her on August 19th and again on either August 24th or 25th. After the latter assault, Ms. Newbert stated that she called local law enforcement, but, under physical duress from Mr. Melvin, told the dispatcher that there was no emergency and ended the call.

OPEGA believes Ms. Newbert may have been mistaken as to the timing of this phone call. OPEGA reviewed Ms. Newbert's cell phone records and, other than the 911 call on the day of Sylus' death, there is only one record of a call from her phone to the Piscataquis County Sheriff's Office or Milo Police Department prior to Sylus' death. This was a 41 second call to the non-emergency line of the Piscataquis County Sheriff's Office from Ms. Newbert's phone on August 19th –which aligns with the first of the two alleged assaults Ms. Newbert described.

OPEGA sought, received, and listened to a recording of that call from the Piscataquis County Communications Center. In that recording, Ms. Newbert called Piscataquis County Sheriff's Office's dispatch and asked to speak with an officer from Milo PD. The dispatcher asked Ms. Newbert what she would like to speak to an officer about and Ms. Newbert stated that she just had a question. The dispatcher informed Ms. Newbert that a Milo PD officer was not on duty yet and asked whether the question could wait a half hour to an hour. Ms. Newbert said that was okay and then asked how to contact the officer at that time. The dispatcher explained that Ms. Newbert should call the same number (PCSO dispatch) again. The two then ended the call. (We saw no evidence that Ms. Newbert's subsequent call ever occurred.)

> OPEGA's Analysis: Regardless of the specific timing of this call to police, its content does not appear actionable for law enforcement and would not be expected to result in a response to the home nor a report to CPS.

Ms. Newbert's Mother's Call to Milo PD and Their Response

In interviews with OPEGA, Ms. Newbert and her mother described Ms. Newbert's mother contacting Milo PD on August 22nd (a week before Sylus' death) to report Mr. Melvin's increasingly strange behavior and the mother's desire to have Mr. Melvin removed from her daughter's home. According to Ms. Newbert's mother, she reported that Mr. Melvin was staying out all night walking on trails in the woods and spending time at an abandoned cabin, that she and her daughter suspected Mr. Melvin was using substances, and that she was worried about the safety of her grandchildren. Ms. Newbert's mother stated to OPEGA that the officer explained that Mr. Melvin could not be removed from the home based on their concerns and his status as a resident of the home and asked whether they (Ms. Newbert and her mother) could deal with Mr. Melvin.

In addition to their account of this call, we also obtained partial screenshots[23] of text messages between Ms. Newbert and her mother that appear to have occurred after Ms. Newbert's mother's call to Milo PD on August 22nd. In that text exchange, Ms. Newbert alerted her mother that the police had not arrived at her home. Her mother then explained that she spoke with an officer and informed the officer that Mr. Melvin hit

[23] These screenshots were provided to Ms. Newbert's caseworker by Ms. Newbert after Sylus' death as evidence that she and her mother had contacted law enforcement to have Mr. Melvin removed from the home.

and pushed Ms. Newbert against the refrigerator on a previous day. Ms. Newbert's mother further reported that the officer told her that if Mr. Melvin put his hands on Ms. Newbert again or the children, Ms. Newbert should call and they would remove Mr. Melvin from the home, but until that point, would not be coming to the home. Also, at a different point in the text exchange, Ms. Newbert asked her mother to ask the mother's partner to provide Ms. Newbert transportation to court at some point during the week to get a protection order against Mr. Melvin.

Milo PD records obtained by OPEGA through the OAG confirmed that Ms. Newbert's mother contacted an officer on August 22nd at 11:28 pm. However, the officer's report of that call and their later interview with OPEGA provide a different account of what was discussed and requested during that call.

The officer's report of that call indicates Ms. Newbert's mother contacted law enforcement to ask what she could do to have Mr. Melvin removed from the home he shared with Ms. Newbert. Ms. Newbert's mother was worried about her daughter being in a relationship and living with Mr. Melvin as he had abused Ms. Newbert and other women in the past, and she had just received a call from Ms. Newbert venting and crying about Mr. Melvin.

According to the officer's report[24], the officer then asked Ms. Newbert's mother whether she would like the officer to do a welfare check, but Ms. Newbert's mother declined—with some apparent insistence—as she did not want to upset Ms. Newbert or Mr. Melvin by sending an officer to the home. The officer then described how Ms. Newbert had told the officer multiple times in the past that she was going to leave Mr. Melvin. Ms. Newbert's mother reported that her daughter still had not left Mr. Melvin as she believed that Mr. Melvin had changed for the better—but Ms. Newbert's mother did not believe he had changed at all, and she wanted Mr. Melvin to leave her daughter alone. The officer asked again what Ms. Newbert's mother wanted the officer to do, and she stated that she just wanted Mr. Melvin out of her daughter's residence.

The officer then explained that they could not do that as Mr. Melvin was a resident of the home. The officer stated that they could not give legal advice but suggested that Ms. Newbert's mother contact the court to ask about evicting Mr. Melvin. Ms. Newbert's mother stated that she was going to pursue that.

In an interview with OPEGA, the officer stated that they and Ms. Newbert's mother had discussed court actions that Ms. Newbert's mother could use to further her objective of removing Mr. Melvin from her daughter's home. The officer also stated that they told Ms. Newbert's mother that she would need Ms. Newbert to be on board with these actions as they (mother and daughter) did not appear to agree when it came to Mr. Melvin.

The officer also told OPEGA that the call was informational in nature, and that they had no recollection of having received an accusation of current domestic violence at that time from Ms. Newbert's mother. The officer also reported that Ms. Newbert's mother did not mention any threats to the children.

> OPEGA Analysis: Both parties, as well as supporting documentation, confirmed that Ms. Newbert's mother's call to Milo PD did occur on August 22nd. However, while there is some degree of overlap, there are significant differences between the parties' accounts of what was discussed on that call.

[24] OPEGA learned from the OAG that this officer's report was documented after Sylus' death in response to a request during the OAG's criminal investigation.

Those differences—namely, whether or not current domestic violence and threats of physical harm to Ms. Newbert and the children were disclosed to the officer—directly impact law enforcement's subsequent response.

OPEGA was unable to resolve the differing narratives.

The Public Health Nurse's Report to the Department

In public statements, Ms. Newbert indicated that the public health nurse assigned to Sylus mediated a dispute between Ms. Newbert and Mr. Melvin during one visit to the family's home. Ms. Newbert also asserted that—from what she understood at the time—the public health nurse tried to report concerns to the caseworker.

In the case record, the caseworker noted a phone conversation between the public health nurse and the caseworker on August 12, 2021, which was one day after the public health nurse's first visit to Sylus' residence.[25] Along with information regarding the baby's health and weight gain, the record states that the public health nurse expressed their concern for Ms. Newbert's depression score and that they had reported those concerns to Ms. Newbert's doctor and Ms. Newbert had plans to discuss this with her doctor at her appointment the following day. The public health nurse also told the caseworker that Ms. Newbert believed she was doing all of the childcare and Mr. Melvin was not helping. The public health nurse also expressed that the parents were "just not on the same page" and Ms. Newbert was finding it difficult to split her time between her 3-year-old and the newborn. According to the case record, the PHN encouraged Ms. Newbert to start working with Mr. Melvin and her mother to make a plan to work together. The record ends with a note that the public health nurse reported working with Ms. Newbert to fill out a questionnaire called "the SAFE tool", which evaluates the potential for domestic violence. The public health nurse stated to the caseworker that the parents raised their voices and called one another names but stepped outside to do so.

OPEGA interviewed the public health nurse associated with this case. They told OPEGA that in their phone conversation with the caseworker, they stated that Sylus was doing well, and that Mr. Melvin was not being helpful around the house. The public health nurse did witness an argument between Ms. Newbert and Mr. Melvin regarding his lack of assistance but did not remember them screaming at each other although they spoke with raised voices and called each other names. The public health nurse did try to calm Mr. Melvin and to focus him on how to solve the problem. The public health nurse stated to OPEGA that Mr. Melvin was agitated and used the coping techniques that he had been taught by his mental health providers to disengage when he felt overwhelmed. The public health nurse felt that he had been using those techniques to avoid helping in the home.

After Mr. Melvin was no longer present at the home, the public health nurse used the SAFE questionnaire with Ms. Newbert to screen for a potential domestic violence situation. The public health nurse told OPEGA that Ms. Newbert did not signal that she was experiencing domestic violence and Ms. Newbert never discussed a desire to have Mr. Melvin removed from the home. The public health nurse stated that had they suspected domestic violence, they would not have left the home until the situation was safe. The public health nurse said they had done this at other times during their career.

[25] The public health nurse conducted three home visits in total: August 11th, 13th, and 23rd.

In their interview with OPEGA, the public health nurse also added a few details not found in the case record. They noted that Ms. Newbert's suboxone prescription was a lower dose than Ms. Newbert said she had prior to her pregnancy and that they reported that to Ms. Newbert's doctor to get it corrected. They also told OPEGA that they helped Ms. Newbert develop a safety plan, not in fear for her safety, but regarding broadening Ms. Newbert's support system as Mr. Melvin was not helping with the children.

The public health nurse also stated that Ms. Newbert had told them that a caseworker had not visited the residence[26] and the public health nurse attempted to call OCFS about that. They spoke with a supervisor who said that the caseworker was on vacation and would follow up when they returned.

OPEGA also spoke with the public health nurse's manager from Bangor Public Health and Community Services. Although we were unable to view the records directly, the manager told OPEGA that there were no concerns about safety or violence listed in the chart which was maintained by the public health nurse at the time of their visits.

> OPEGA Analysis: From the case records and interviews with the public health nurse, OPEGA found evidence to support the claim that the public health nurse mediated a verbal dispute between Ms. Newbert and Mr. Melvin. The public health nurse did contact the caseworker and the Department; however, we did not find evidence to support the notion that the public health nurse informed the caseworker or the Department of any threatening behavior from Mr. Melvin toward either Ms. Newbert or the children—particularly as the public health nurse reported not having those specific concerns.

Overall Conclusions Related to the Information Provided to the Department

OPEGA concludes that Ms. Newbert's mother did in fact contact Milo PD on August 22nd and expressed a desire to have Mr. Melvin removed from her daughter's home, and that Milo PD did not go to Ms. Newbert and Mr. Melvin's residence. However, we are unable to reconcile Ms. Newbert's mother and the officer's conflicting accounts of the details of that call and are thus not able to establish any basis for concluding that Ms. Newbert's mother actually conveyed actionable information in that call and law enforcement somehow failed to respond appropriately.

Overall, OPEGA concludes that the evidence available after Sylus' death reveals numerous instances in which Ms. Newbert privately appeared to be struggling with safety threats from Mr. Melvin, but OPEGA found no evidence to support that these concerns were communicated to the Department or other mandated reporters prior to Sylus' death.

Additional Context for Three Noteworthy Points in the Family's Timeline of CPS Involvement

In addition to the findings described in the preceding sections, OPEGA also highlights three instances from the timeline of this family's CPS involvement in which a reasonable person might still question how the

[26] Case records and the revised public memo indicate that the caseworker visited the home with Ms. Newbert's mother and Sylus' older sibling present on July 30th, 2021. Ms. Newbert was in the hospital at the time and may have been unaware of this visit.

Department responded considering what was known at those times, and to provide the additional context we were able to obtain for those responses.

All three of these instances occurred in 2021, well after the closure of the family's prior case in October 2019. When that case closed, Ms. Newbert and her child (Sylus' older full sibling) were living in transitional housing for survivors of domestic abuse and Mr. Melvin and Ms. Newbert's PR&R was still in effect, which, importantly, stipulated that Mr. Melvin had a right to parent-child contact under the circumstances and conditions determined by Ms. Newbert and that visitation between Mr. Melvin and the child would be supervised.

Screened Out Report Indicating Mr. Melvin Living with Ms. Newbert and Their Child

On March 16, 2021, Ms. Newbert's medical provider reported that Ms. Newbert was pregnant (with Sylus) and lacked organizational skills which could be a hindrance to caring for a newborn. The provider also reported that Mr. Melvin was the father and was living in the home with Ms. Newbert and their child. Mr. Melvin had attended prenatal visits and the provider found him to be trying hard and appropriate. This report was deemed inappropriate for investigation by CPS Intake.

OCFS staff explained that this report did not meet the criteria for an investigation as the referent made no specific allegations of suspected child abuse or neglect. Similarly, Mr. Melvin's presence in the home by itself would also not warrant an investigation because the contact restrictions placed upon Mr. Melvin through the PR&R were now over two years old, and the referent did not articulate any concerns related to Mr. Melvin's presence in the home or current domestic violence or substance use issues.

Mr. Melvin Living with Ms. Newbert and Their Child During Last Investigation

On July 29, 2021, the Department received a report from a hospital social worker that Sylus Melvin had been born substance exposed and that hospital staff had additional concerns related to the family's past domestic violence issues. The referent noted that Ms. Newbert had reported that the Department had been involved in the past and that it was up to Ms. Newbert to determine whether and how Sylus' older full sibling could be around Mr. Melvin. Ms. Newbert also reportedly stated that the couple had been living together for the past year, that the police had not been called to the home during that time and they were getting along much better now. When adding the family's CPS history to the report, CPS Intake noted that Mr. Melvin had supervised visitation with Sylus' older full sibling, but Ms. Newbert was not to be the supervisor due to the parents' history of domestic violence and both parents having been substantiated in the past for the threat of physical abuse.[27] This report was deemed appropriate for investigation.

We asked the caseworker assigned to this investigation how they were able to reconcile Mr. Melvin's contact restrictions with him living in the home at that time. The caseworker cited that Mr. Melvin had been living in the home for a significant period of time (without the Department's knowledge) and that there were no reported concerns by Ms. Newbert, Ms. Newbert's family members or Mr. Melvin's providers (as he had engaged in counseling and other services between the previous investigation and this one). Without any

[27] Here again OPEGA notes the incongruity between such statements and the PR&R order in effect.

disclosed concerns, Mr. Melvin's presence in the home, by itself, did not warrant any additional action other than what was conducted during the investigation.

Assessing Mr. Melvin's Substance Use During Last Investigation

At the caseworker's earliest interaction with the family on July 30, 2021, Mr. Melvin reported being currently prescribed Suboxone as part of a substance use treatment program for a few months. Later that day, the caseworker went to the Milo PD to ask for any recent reports on the family. They reported that Mr. Melvin was involved in a theft incident in May and in March had dropped a bag of heroin in a local store and was charged with possession. Despite this information, we did not observe that the caseworker asked Mr. Melvin to submit to a drug screen during the remainder of the investigation.

The caseworker reported to OPEGA that they were aware that Mr. Melvin had dropped a bag of heroin in a store four months prior, but because there was not a current allegation of substance use by him, the caseworker relied on the drug screening results and information from Mr. Melvin's substance use treatment provider, which were that his drug screens were as expected and Mr. Melvin's participation and attendance in the program were good. The caseworker noted that had the provider raised concerns, they would have asked Mr. Melvin to drug screen.

OPEGA is mindful that a reasonable person may still question these responses and are including them here in the interest of developing the most complete record possible for further study of case practice.

Timeline of Key Events and Exploration of Certain Decisions and Actions

June 4, 2018: Report of Substance Exposed Infant Referred to Services

The Department received a substance-exposed infant report from hospital staff for Ms. Newbert and Mr. Melvin's first child (Sylus' older full sibling) due to Ms. Newbert's use of prescribed Subutex[28] during pregnancy. As was practice at that time, Intake referred this report to CradleME, which provides health services to newborns and childcare advice to parents and includes visits to the home. (This referral was in addition to those made by the hospital to public health nursing and Maine Families.[29])

June 6, 2018: Second Report and Investigation

Initial Investigation Activities and Preliminary Safety Decision

Two days later, a second report from the hospital indicated that neither parent was caring for the child as Ms. Newbert stated she was in too much pain after complications from the birth and Mr. Melvin stated that he had a brain injury and explosive anger and insisted it was not his job to care for the baby. The report also noted the parents appeared to have a volatile relationship as they had separated and reconciled multiple times during the pregnancy and had argued when together in the hospital and over the phone. Ms. Newbert was also reported to have been terminated from her Subutex provider due to missed appointments. The referent also noted that Ms. Newbert stated that she had had a previous child (Sylus' older half sibling) whom she had placed with a relative (See Overarching Practice Issue - Out-of-Home Child Not Located - on Page 7) because she was being treated for liver cancer; however, the referent had contacted Ms. Newbert's medical provider who said that Ms. Newbert had never had liver cancer. CPS Intake screened this report as appropriate for investigation.

The assigned caseworker visited the hospital the next day and conducted separate interviews with the parents. The caseworker learned from Ms. Newbert that she had been discharged from her medication-assisted treatment (MAT) provider and would not have access to Subutex upon leaving the hospital. Ms. Newbert reported that she had been diagnosed with bipolar disorder and anxiety. Ms. Newbert denied physical violence in the relationship with Mr. Melvin, characterizing the altercations as verbal arguments. Ms. Newbert described that Mr. Melvin had anxiety, could become triggered, and "explosive." She reported that Mr. Melvin had been diagnosed with a traumatic brain injury resulting from a car accident. He was currently in counseling once per month with his psychologist. She also noted that she had previously spoken with someone regarding obtaining CradleME services and she agreed to work with Public Health Nursing (PHN) and Maine Families for in-home visits. The caseworker obtained signed releases to contact the service providers of the parents.

In his interview with the caseworker, Mr. Melvin spoke of his CPS history as a child and seeing his psychologist since 2014. He stated that he had known the psychologist since he was five years old. The caseworker asked Mr. Melvin about saying that it was not his job to care for the baby. Mr. Melvin denied

[28] Subutex is a brand of buprenorphine which is used to treat dependence on opioid drugs.
[29] Maine Families offers family visitors to provide parenting support to all Maine families with newborns.

saying this and stated that he has fed, changed, and burped the child. Mr. Melvin also stated that Ms. Newbert's mother and father would be helping with the baby.

The caseworker observed the baby who was still in hospital care, talked with hospital staff, and interviewed Ms. Newbert's mother and father who the family expected to help with the newborn. The caseworker also went to the family's home with Mr. Melvin, examined the home, and conducted a safe sleep assessment at the residence.

The intention of the family was for Ms. Newbert's mother to stay with the family for the first week back in the home with the child. Ms. Newbert and Mr. Melvin also developed a plan to have Mr. Melvin's father come and pick Mr. Melvin up if Mr. Melvin was emotionally triggered.

On June 7th, the caseworker's supervisor, in consultation with the caseworker, made the preliminary safety decision (PSD) that the child was safe in the care of Ms. Newbert and Mr. Melvin, but noted there were signs of risk that needed to be monitored. Although risk was noted in the PSD, no safety threats were identified at this time. The family was set up with services and home visits from a public health nurse as well as a Family Visitor from Maine Families. Based on the subsequent activities conducted by the caseworker, the priorities at that point in time appeared to be stabilizing Ms. Newbert's MAT to mitigate the risk of relapse and addressing the volatile relationship between Ms. Newbert and Mr. Melvin.

Investigation Continues

On June 8th, a social worker at the hospital reported that Ms. Newbert was requesting an unusual amount of pain medication and feared Ms. Newbert was relapsing while in the hospital. The caseworker and the social worker discussed whether Ms. Newbert would be discharged with a prescription for pain medication (as Ms. Newbert had told the caseworker), and the social worker explained that Ms. Newbert's physician did not think Ms. Newbert needed that. The caseworker expressed that they would be concerned if Ms. Newbert was sent home with pain medication. The social worker also reported that Ms. Newbert's child had spent most of the previous day in the nursery again, and that the social worker was worried that the child would fail to thrive.

Hours later, a hospital physician contacted the caseworker's supervisor regarding their concerns for the baby going home with Ms. Newbert and Mr. Melvin. The physician reported that Ms. Newbert was not interacting or caring for the baby except for three hours in five days but did note Ms. Newbert had been caring for the baby that day. The physician stated that Ms. Newbert and Mr. Melvin had been arguing and Ms. Newbert was reported to have thrown something; the baby was not in the room when this occurred. The physician was very concerned about the welfare of the child going home. The caseworker assured the doctor that the Department was aware of the risk factors and that the maternal grandmother would stay with the family for a time and that the family would be receiving home visits from public health nursing and Maine Families.

On June 8th, the caseworker also spoke to Ms. Newbert's substance use treatment provider. The provider reported that although Ms. Newbert's urine screens were as expected and she never tested positive for opiates, Ms. Newbert would no longer be in their program because she had missing medication. Ms. Newbert had said that she lost one pill in a couch, one in a drain, and, at the end of her pregnancy, said the entire prescription was stolen. The provider thought it was in Ms. Newbert's best interest to switch to daily dosing,

but Ms. Newbert couldn't make it to her appointments. The provider continued Ms. Newbert's care with the understanding that they would not continue to prescribe Ms. Newbert's medications after the baby was born and that Ms. Newbert would go to a different provider.

Ms. Newbert and Child (Sylus' Older Full Sibling) Discharged from Hospital and Investigation Continues

Shortly after the child's discharge from the hospital, the caseworker made an unannounced visit to Ms. Newbert's home on June 11th, but no one was home. The caseworker called Ms. Newbert who informed the caseworker that she had gone to the hospital for complications related to the birth. Ms. Newbert explained that her mother had not been able to stay at Ms. Newbert's house due to the death of her mother's friend. She said that her father and his girlfriend had been coming to the house to help and that the baby would be staying with them that night.

The caseworker made another unannounced visit to the home the next day, observed the child, and spoke with Ms. Newbert and Mr. Melvin. Ms. Newbert disclosed that she had been prescribed pain medication when she had gone to the hospital the previous day and the caseworker conducted a pill count of her medications. For one medication, Ms. Newbert stated that one of the pills had fallen out when she got out of the car. For the other, Ms. Newbert stated the count was off because she had had one left over from a previous prescription. The caseworker expressed their concern that this mirrored the times Ms. Newbert had told her provider that her medication had been lost or stolen. The caseworker stressed that there is very little wiggle room when it comes to the safety of a newborn being cared for by a parent that is dealing with substance use issues. The caseworker instructed Ms. Newbert to work with PHN and Maine Families.

To mitigate the risk of relapse, getting Ms. Newbert into a medication-assisted treatment program was considered a high priority by the caseworker. Over the next several weeks, the caseworker and Ms. Newbert, herself, contacted numerous MAT providers attempting to enter treatment. Transportation difficulties contributed to five missed induction appointments, and longer-term transportation problems were exacerbated by requirements for daily dosing at some facilities that were almost an hour from Ms. Newbert's home. During this time, the caseworker scheduled several drug screens – some of which were requirements of potential MAT providers. In one of these drug screens Ms. Newbert tested positive for buprenorphine and oxycodone when the caseworker believed these should have been out of her system. After first denying that it was from illicit use, she later admitted that she purchased a Suboxone[30] tablet from a friend.

Over the next few days, the caseworker followed up on the referral to Maine Families as the organization had not initially received the referral from the hospital. Mr. Melvin's psychologist was also contacted, and the caseworker received a report regarding Mr. Melvin's traumatic brain injury.

On June 14th, the record indicates that the caseworker ran criminal background checks on Ms. Newbert and Mr. Melvin. Ms. Newbert's criminal history included forgery and theft convictions six and four years prior, respectively. Mr. Melvin's history included convictions for domestic violence terrorizing, violation of a protection from abuse order, domestic violence assault, obstructing the report of a crime, criminal mischief, aggravated assault, and another domestic violence assault. These incidents occurred between 2012 and 2014.

[30] Suboxone is a prescription medication that combines buprenorphine and naloxone to treat opioid use disorder.

Domestic Violence Incident

On June 19th, Mr. Melvin called both the police and CPS to report that Ms. Newbert had spit on him and punched him in the face while he was holding the baby. DHHS records also note Ms. Newbert's view, as expressed by what she told her mother who spoke with the caseworker. Ms. Newbert told her mother that the couple had been arguing all day because Mr. Melvin was not tending to the baby. At one point during the day, Mr. Melvin picked up the baby and was calling Ms. Newbert names. Ms. Newbert attempted to take the baby and Mr. Melvin turned away, put the baby in the bassinet, and claimed that Ms. Newbert scratched him. Ms. Newbert was later arrested for domestic violence assault, and eventually "bailed" at the police station with the condition of "no contact" with Mr. Melvin.[31] During this period, the caseworker also learned that Ms. Newbert's father and his girlfriend would be taking the baby to stay with them that night (June 19th).

A New Report and Another Domestic Violence Incident

The following morning (June 20th) Ms. Newbert's physician made a new report to CPS indicating that Ms. Newbert would not be able to obtain suboxone treatment through their practice as Ms. Newbert had not complied with medical advice and recommendations made by the physician, missed multiple induction appointments, and at times did not answer or return calls from the physician. As a result, Ms. Newbert was being referred to another provider for suboxone treatment, but the physician was unsure when Ms. Newbert would be able to begin treatment with that provider, despite being flagged as a priority referral. Ms. Newbert's physician reported having been able to contact Ms. Newbert that morning and, at that time, Ms. Newbert disclosed that Mr. Melvin had threatened to hurt her and the baby the day before and was no longer living at the home. Ms. Newbert also stated that she had obtained a protection order against Mr. Melvin.[32]

The caseworker then spoke with Ms. Newbert at her home regarding the previous day's events, the status of her substance use treatment, and observed the child (Sylus' older full sibling) who was with Ms. Newbert at the home. During that discussion, Ms. Newbert disclosed that she had been off suboxone for two days, was feeling overwhelmed, experiencing hot flashes, was sick from detoxing, but had not relapsed. Ms. Newbert also stated that she could not get to the new substance use treatment provider every day and did not feel comfortable leaving the baby with Mr. Melvin—with whom she was not allowed to have contact.

At that point—according to what can be found in the record and our interviews with the caseworker and the supervisor for this investigation—it appears that the caseworker made a plan with the family that the child would stay with Ms. Newbert's father and his girlfriend until the Department determined otherwise and would prohibit Ms. Newbert from having unsupervised contact with the child.

Shortly thereafter, the caseworker's supervisor entered the preliminary safety decision related to the most recent report to CPS from Ms. Newbert's physician. The PSD noted that bail conditions prohibited contact between Ms. Newbert and Mr. Melvin with a court date in August and that Mr. Melvin had left the home, however, there was a risk of relapse as Ms. Newbert had yet to find a new suboxone provider. The supervisor also noted that the caseworker had made a plan with the family that the child would stay at Ms. Newbert's

[31] Records show that on July 18th, Mr. Melvin recanted his story of Ms. Newbert assaulting him.
[32] This information was also reported to the Department on June 21st by a home visitor from Maine Families who helped Ms. Newbert fill out the paperwork for a protection order.

father's house, and that Ms. Newbert was not to be alone with the child until her substance use treatment was stabilized. With this plan in place, the preliminary safety decision of the supervisor was that the child was safe at this time. As the supervisor's decision not only referenced the caseworker and family's plan but also appeared to consider how that plan would address their safety concerns, OPEGA concludes that this was a safety plan, which should have been documented as such, but was not (See Specific Practice Issue – Safety Plan Not Documented – on Page 8).

An Unsound Safety Decision (Sylus' Older Full Sibling)

Records indicate that the baby was placed in Ms. Newbert's father's home on June 20, 2018, prior to the caseworker seeing the home, assessing a safe sleep environment, or running background checks on the caregivers. On June 27th, the caseworker obtained the name and date of birth of Ms. Newbert's father's girlfriend. The next day, the caseworker contacted the Piscataquis County Sheriff's Office for information regarding Ms. Newbert's father. They reported that in 2016, he was a suspect in an erratic vehicle complaint. In 2006 and 2014, he was arrested on a warrant, but the Office did not have any more details. The Sheriff's Office also noted that he was booked under a "Federal Code Violation" in 2005 and 2007 but had no further details regarding those incidents.

It was eight days after the child was placed in the home before the caseworker visited the home, assessed the child's sleep environment, and presented the caregivers with the Period of Purple Crying information. Ms. Newbert's father told the caseworker that he was recently (three years) out of federal prison for being convicted of selling cocaine 20 years prior. He was also convicted of stealing firearms in the late 1980s. Ms. Newbert's father said that he has never been addicted to drugs or alcohol but was prescribed Oxycodone and Methadone for pain. He assented to the caseworker counting his opioid prescriptions. Upon attempting to retrieve his medications, Ms. Newbert's father could not find them and claimed they were stolen. He subsequently reported this to law enforcement.

Another two weeks passed before the caseworker ran the criminal background checks to verify the information provided by Ms. Newbert's father. In 2018, OCFS background checks did not routinely have access to federal criminal history.[33] Ms. Newbert's father's state history included guilty verdicts for theft, burglary, negotiating a worthless instrument and forgery between 1987 and 2004. His girlfriend had no criminal record.

OPEGA interviewed the caseworker and supervisor. Both stated that the caseworker should have visited the home and conducted background checks prior to the baby being placed there. When OPEGA asked the supervisor why the baby was placed there, we were told Ms. Newbert's father and his girlfriend had stable housing, a stable relationship, and were concerned for the baby and Ms. Newbert. The federal charge had happened 20 years prior, and Mr. Newbert had been out of prison for three years. OPEGA notes that from all indications in the historical record, the baby was well cared for by Ms. Newbert's father and his girlfriend. In the OPEGA interview, the supervisor also stated that had this happened today, the current policy is clear: Ms. Newbert's father and his partner would have required a full licensing study. They might have applied to be a kinship placement, but because of the criminal history it would not have been immediately approved as a

[33] Background checks at OCFS have since been centralized and now includes both state and interstate/federal databases.

kinship placement and would be subject to a rigorous licensing process. The supervisor also stated that a supervisor would not be the person to make that decision today. The supervisor further stated that while this licensing study is in progress, the Department would likely still attempt to find other suitable kinship placements prior to resorting to a preliminary protection order (PPO) to remove the child from Ms. Newbert and Mr. Melvin. (See Unsound Safety Decision – Placing a Child in a Home Without Assessing the Safety of that Home and Caregivers - on Page 10)

Statute, in 22 M.R.S. §4036-B (3), requires the Department to make reasonable efforts to prevent removal of the child from the home. The caseworker and supervisor noted in the records that the safety threat from domestic violence was mitigated by Ms. Newbert's conditions of release and by the PFA. The risk of Ms. Newbert relapsing, and its effect on the child, was mitigated by the informal safety plan which included the baby and Ms. Newbert staying with her father. The caseworker and Ms. Newbert agreed that she would not be allowed unsupervised contact with the baby until her substance use treatment was stabilized.

From contacts with Ms. Newbert, Maine Families, and the police, the caseworker determined that Mr. Melvin was attempting to contact Ms. Newbert and sending her messages on Facebook. Ms. Newbert informed the police of this, even though the PFA had yet to be delivered to the police department. The attempts to contact Ms. Newbert escalated over the next week and on June 27, 2018, Mr. Melvin was arrested for coming to Ms. Newbert's home and banging on the door in violation of the PFA.

End of Investigation Phase and Initiating Court Action (Sylus' Older Full Sibling)

The investigation closed with both Desiree Newbert and Reginald Melvin being substantiated for "physical child abuse (threat of)". The child was currently considered safe, staying in the home of Ms. Newbert's father and his girlfriend. It was noted that Ms. Newbert needed to stabilize her MAT prior to being alone with the baby. The safety of the baby was considered by the Department as compromised in the care of Mr. Melvin until he demonstrated stability with his mental health.

While a PPO was not requested, the caseworker and supervisor believed there was enough risk of future harm to bring the case before a judge and so, jeopardy petitions against both parents were filed on July 2nd.

The case was to be transferred to a permanency caseworker to provide monitoring and services that would prevent the baby being placed in state custody while the court considered the petition. Separate transfer family team meetings (FTM) were scheduled for July 18th. At that point in time, Ms. Newbert and Mr. Melvin were no longer living together and were prevented from having contact by both the conditions of Ms. Newbert's release for the assault charge that had yet to go to court, as well as the PFA order against Mr. Melvin. With the investigation over, the role of the permanency caseworker was to ensure the child's safety while making reasonable efforts to prevent the child's removal.

Stabilization of Medication-Assisted Treatment (MAT)

On the same day the jeopardy petition was filed (July 2nd), Ms. Newbert attended her induction appointment at a Bangor hospital. She was prescribed suboxone and was to be on daily dosing. Her treatment required participation in seven group therapy sessions within the first 45 days of the program, and biweekly individual therapy progressing eventually to monthly sessions. Ms. Newbert was concerned that the travel from the Dover-Foxcroft area to Bangor every day without a vehicle increased the chance of missing appointments.

On July 5th, she inducted at a second Bangor hospital, tested positive for only buprenorphine, and was able to receive weekly doses of suboxone. However, at the time, the second hospital's treatment did not include therapy sessions for substance use disorder treatment, but they were planning to add this service.

Over the next few weeks, as reports from the second hospital showed consistent attendance and good drug screens, the caseworker eased the restriction for supervised contact with the baby. But soon thereafter, Mr. Melvin showed the caseworker a screenshot of texts purported to be between Ms. Newbert and a known drug dealer. While investigating this claim, the caseworker again restricted Ms. Newbert to supervised contact with her child. Drug screens continued to be positive only for buprenorphine and the medical providers reported accurate pill counts and gave encouraging reports. The investigation into Ms. Newbert's contact with the drug dealer was inconclusive.

Since the second hospital did not yet provide therapy for substance use disorder, Ms. Newbert reported to her MAT supervisor that she had contacted a group called My Recovery Opportunity to engage in therapy. At the same time, the CPS caseworker was attempting to schedule mental health treatment and medication management through Milo Family Practice. Neither of these attempts to obtain therapy are recorded to have been successful.

Changes in Ms. Newbert's Living Arrangements

The case transferred to a permanency caseworker and permanency supervisor on July 18, 2018. By July 26th, Ms. Newbert was making a case for she and the baby to move out of her father's house where family tensions had mounted according to the caseworker's notes. Ms. Newbert was working with Partners for Peace, a domestic violence victim support group, to obtain transitional housing because she was being evicted from her apartment for being behind on rent, and wanted to move back to her old apartment while the transitional housing was being arranged.

The caseworker contacted the Maine Families home visitor and the public health nurse for their perspectives. The Maine Families home visitor stated that the situation at Ms. Newbert's father's house was volatile and felt that Ms. Newbert should move back to her apartment. The public health nurse did not answer the question because they were being replaced with a different public health nurse. OPEGA interviewed the permanency supervisor, who reported that the thinking was that since MAT had stabilized, this was a chance for Ms. Newbert to show she could parent on her own with the family supports still in place. On August 1st, the caseworker relaxed the restriction of supervised contact with the baby, and reviewed expectations that Ms. Newbert would continue to be consistent with her services, and that she would not have unsafe individuals in the home. The caseworker told Ms. Newbert that unannounced visits would occur, and she would continue to be asked for random drug screens. Eventually, Ms. Newbert was served eviction papers to vacate on September 11th and received the keys for her transitional housing through Partners for Peace the next day.

The Relationship with Mr. Melvin

The caseworker's notes indicate that Ms. Newbert was ambivalent regarding her relationship with Mr. Melvin. Over the end of summer into fall she both enforced the PFA and continued communications with Mr. Melvin. Communication in relation to the baby by telephone or text was allowed under the PFA. The caseworker strongly discouraged the communications that were not strictly in reference to the child because

Mr. Melvin was not consistent in his efforts to rehabilitate. There were several attempts by Mr. Melvin to establish physical contact. Ms. Newbert enforced the PFA by calling law enforcement on June 24th, August 7th, and September 22nd.

While enforcing the PFA showed a degree of protective capacity for herself and the baby, Ms. Newbert also vacillated over the summer regarding whether she wanted the protection order. On July 16th Ms. Newbert filed a motion to dismiss the PFA which had been granted on July 5th. On August 9th, at the hearing on that motion, she withdrew the motion to dismiss. She filed another motion to dismiss on August 20th and on August 23rd, that motion was denied because neither Ms. Newbert nor Mr. Melvin were present for the hearing.

Mental Health Assistance – Ms. Newbert

From early in the investigation, Ms. Newbert had been willing to accept aid from several service providers and was actively searching for therapy for substance use disorder. The caseworker also made numerous inquiries seeking therapy, but appropriate options were limited. Ms. Newbert eventually stabilized in a MAT program and was waiting until they expanded staff to provide therapy. During the wait she attended group sessions with Partners for Peace which were geared toward developing skills and resiliency for survivors of domestic violence. Counseling through the second hospital was to begin on September 10th; however, Ms. Newbert needed to reschedule for the 19th as she was being served her eviction. In a subsequent conversation, Ms. Newbert told the caseworker that the provider rescheduled the appointment again. The caseworker called the provider and verified that the issue was on their end. Based on the DHHS record, Ms. Newbert started substance use disorder counseling on October 25, 2018.

Mental Health and Domestic Violence Concerns – Mr. Melvin

In contrast with Ms. Newbert, Mr. Melvin chose to engage with the caseworkers minimally. According to caseworker notes, he had moved out of the house and was staying with a series of relatives and friends until they each asked him to leave. On June 27th he was arrested for violating the PFA and was accused by Ms. Newbert of threatening the baby (Sylus' older full sibling) and herself. The caseworker's notes from a conversation with Mr. Melvin in the Piscataquis County jail state that Mr. Melvin denied being at Ms. Newbert's house even though a neighbor confirmed seeing him banging on the door.

The caseworker's narrative log notes their concern that Mr. Melvin was not getting adequate mental health treatment. The caseworker recorded that Mr. Melvin did not understand this and asked for examples of his mental health issues. The caseworker said to Mr. Melvin that he had explosive anger and Mr. Melvin denied this even though he had, himself, stated this at the hospital when his child was born. A few days later, the caseworker's notes continue: [Mr. Melvin] informed me that he wants to turn over his [parental] rights to [Ms. Newbert]. He informed me that he doesn't want to do this anymore." The caseworker told Mr. Melvin that he should speak to his lawyer prior to making that decision. The caseworker expressed to Mr. Melvin that they believed he should have more intensive treatment than seeing his psychologist once per month.

The caseworker records that at the transfer family team meeting (FTM) on July 18th, Mr. Melvin admitted "that he made up the story that Desiree had punched him in the face while he was holding the baby." He denied being domestically violent, however. With respect to his mental health, Mr. Melvin claimed that he

could not take medications on doctor's orders. The caseworker discussed with him that he had been on Buspirone (for anxiety) previously and records showed it seemed to help. The caseworker further reminded Mr. Melvin that he said he was going to see his PCP on the 20th so he could be put on medications. Case notes say that Mr. Melvin said that "since he has had time to think about the situation … he cannot be on them [medications]." Discussions at the FTM also included Mr. Melvin's need for stable housing and access to transportation. The caseworker instructed Mr. Melvin on how to use the Lynx transportation van for his service appointments and was working to get case management services to aid Mr. Melvin in finding stable housing.

Two days later, the caseworker referred Mr. Melvin for case management services as well as for a "level of care" assessment to determine if he was eligible for the Batterer's Intervention Program. The caseworker also wrote a letter to Mr. Melvin's PCP to confirm his appointment for medication management and to inform the PCP of Mr. Melvin's involvement in a CPS case. On July 23rd the caseworker discussed the case with Mr. Melvin's PCP who said that they had prescribed Buspirone about a year previously but did not believe Mr. Melvin took it. The PCP stated that Mr. Melvin is now prescribed hydroxyzine (an antihistamine with sedative properties). The PCP said that Mr. Melvin could be referred to medication management and therapy if necessary.

On July 26th, Mr. Melvin told the caseworker that he planned to see his long-time psychologist four times per month. The caseworker talked with the psychologist and asked if the psychologist felt Mr. Melvin needed a more intensive mental health program. Mr. Melvin's psychologist stated that they were not sure at this point. After a few months of meeting once per week the psychologist believed they would better be able to make that determination.

By early August, Mr. Melvin had moved in with another girlfriend. On August 7th, Ms. Newbert called in a report to CPS intake regarding Mr. Melvin being in that home since the woman was allowed only supervised visits with her own children who were in state custody. The woman asked Mr. Melvin to leave. That same day Mr. Melvin was arrested again for violating the PFA against Ms. Newbert. Mr. Melvin remained in jail for a short time and was also charged on August 12th with criminal trespass and felony domestic violence assault against the other girlfriend he had been living with.

On September 19th, Mr. Melvin was arrested for the third time for violating the PFA. He had come to Ms. Newbert's new transitional housing residence three times in one day, banging on the door. In late October, Mr. Melvin was convicted for criminal trespass and domestic violence assault against his other girlfriend and violation of the PFA for Ms. Newbert and the baby and was sentenced to seven months in jail.

Court Findings Regarding the Protective Custody Case

On October 10, 2018, the court found that Ms. Newbert did not create conditions of jeopardy for the child (Sylus' older full sibling), but Mr. Melvin did. Upon entry of a parental rights and responsibilities order (PR&R) under a family docket number, the child protective matter was dismissed. As agreed to by the parties and their attorneys and put into effect by the judge, the PR&R stated that:

"By agreement, the Parties are awarded shared parental rights and responsibilities for the various aspects of the welfare of the minor child. Plaintiff, Desiree Newbert, will have the right to make the final decision in all aspects of the welfare of the minor child in any situation where Plaintiff and Defendant are not in agreement…

… The primary physical residence of the minor child will be with Plaintiff.

Defendant [Mr. Melvin] shall have the right to parent-child contact with the minor child at all reasonable and proper times as agreed upon by the parties and under such circumstances and conditions as determined by Plaintiff [Ms. Newbert], in her sole discretion, that will ensure the minor child's safety. Visitation shall be supervised.

If any party seeks to modify this order, the Department shall be provided notice."

Preparations were made to conduct a final family team meeting for Ms. Newbert and the baby later in the month. Mr. Melvin did not attend as he was incarcerated. Ms. Newbert had engaged with the Department and had actively sought help for her substance use disorder and general mental health, as well as actively working with Partners for Peace regarding domestic violence prevention strategies. She seemed to continue to vacillate in her affection for Mr. Melvin; however, she had enforced the PFA three times, which demonstrated protective capacity for her child. At the time of case closure, the PFA was still in effect and Mr. Melvin was incarcerated. The PR&R also restricted Mr. Melvin's visitation of the child to be supervised, and under conditions solely at the discretion of Ms. Newbert. (see Practice Consideration – Apparent Incongruity Between the Terms of the PR&R and the Department's Discussions with Ms. Newbert Regarding Visitation – on Page 13)

The Department closed the case with closing letters to each parent on November 7, 2018. Eight days later, records indicate that Ms. Newbert filed a motion to modify the PFA. The PFA was vacated on December 6, 2018. As there was no CPS case at the time, this was not communicated to the Department.[34]

November 2018 – April 2019: Four Screened Out Reports

Between the closure of the first case, discussed above, and the beginning of the second investigation the following spring, there were four reports to CPS intake regarding Sylus' older full sibling. The first report to CPS occurred two weeks after the first case had closed on November 26, 2018. This report was from the child's medical provider notifying that there had been no-shows for the child's medical appointments. The last appointment attended was September 20, 2018, but Ms. Newbert and the baby did not show up for subsequent appointments that she had scheduled for October 30, 2018 and November 15, 2018. This had resulted in the child not being up to date on vaccines according to the PCP. This report was determined to be inappropriate for investigation. A further report was submitted on January 21, 2019, which noted, "[t]here have been scheduled appointments on December 19th, 24th, 31st and January 15th. [A]ll of these appointments were cancelled or no-show appointments. There is another rescheduled appointment for January 24th." This report was also determined to be inappropriate for investigation.

[34] OPEGA received feedback from the OAG during this review that this may have been unusual as often judges will make a report to CPS Intake if a parent moves to dismiss a PFA in such quick succession after the closure of a child protection case. OPEGA did not independently validate this observation.

The third report was made on March 26, 2019 by a social worker from a medical provider's office. The social worker reported that their client—a neighbor of Ms. Newbert—had told them that Mr. Melvin had been staying at Ms. Newbert's even though Ms. Newbert was living in an apartment provided to her through a domestic violence support program and Mr. Melvin had been Ms. Newbert's abuser. The social worker's client believed that Mr. Melvin was not supposed to be around children but did not know why. The client did not report overhearing or observing any violence in the home since Mr. Melvin arrived at Ms. Newbert's home. This report was determined to be inappropriate for investigation.

The fourth report was made on March 30, 2019 by an anonymous referent who lived near Ms. Newbert. The referent reported that Mr. Melvin had recently been released from jail and was living with Ms. Newbert. The referent knew that the Department had been involved in the past and that Mr. Melvin was not to be at Ms. Newbert's home. The referent also reported that they had called law enforcement to let them know Mr. Melvin was back in Ms. Newbert's home, but they stated that there was nothing they could do when there was no active PFA or any new incidents of domestic violence. This report was determined to be inappropriate for investigation.

<u>April 3, 2019: Report and Second Investigation</u>

Four days later, the Department received yet another report of Mr. Melvin being in the home of Ms. Newbert, which this time was reported by a representative from Penquis CAP. The referent reported that Mr. Melvin was in Ms. Newbert's home with Ms. Newbert's permission, and they were being secretive about it knowing that it was against the conditions of the lease. Due to the volume of reports related to Mr. Melvin being in the home (March 26th, March 30th, and now April 3rd) as well as a reliable and known referent, the initial screening decision was overridden by an intake supervisor and the report was determined to be appropriate for investigation.

While the assigned caseworker attempted to contact Ms. Newbert, they reviewed Ms. Newbert and Mr. Melvin's prior CPS history. The caseworker entered the case aware of the family's situation, evidenced by their notes where they summarized the history on the Department's assignment sheet. The caseworker detailed the prior history of the family noting the difficulties with substance use, mental health, and domestic violence dynamics. The caseworker wrote about recognizing the potential threat of physical and emotional abuse to the 10-month-old (Sylus' older full sibling) due to the history of domestic violence in the child's presence – including past direct threats to harm the child. The caseworker noted that there was no information regarding whether concerns for domestic violence had been resolved. The caseworker summarized Ms. Newbert's prior demonstrations of protective capacity and her understanding of the Parental Rights and Responsibilities Order which gave the father visitation rights supervised by anyone the mother chose.

Initial Investigation Activities and Preliminary Safety Decision

After leaving two unreturned messages and visiting the home unannounced with no one there on April 4th, the caseworker connected with Ms. Newbert and observed the baby (Sylus' older full sibling) the following day. The 10-month-old appeared happy and healthy, and Ms. Newbert was very attentive to the baby. The apartment was extremely neat, clean, and organized. The caseworker observed a diaper change and saw no observable marks, injuries, or illness.

The caseworker's notes from interviewing Ms. Newbert state that Ms. Newbert denied that Mr. Melvin was at her apartment. She said that she still used the services of Maine Families and Partners for Peace. She attended Narcotics Anonymous twice per month. There was a transition of staff with the public health nurse, and she had conflicting appointments when the new PHN tried to schedule so she was still working on that. Ms. Newbert said that she continued to go to her MAT provider and had no slip ups regarding substance use.

The caseworker asked about her child's missed medical appointments detailed in prior reports to central intake. Ms. Newbert stated that transportation was a continuing issue. The Lynx service contracted by the state often did not allow children. The caseworker said that they would check into that issue. Over the next few weeks, the caseworker verified from Partners for Peace and Maine Families that it was a common problem experienced by others using the service that certain drivers or routes did not allow children to be transported.

Ms. Newbert was asked whether she had any concerns about the development of her child; Ms. Newbert stated that the child had a developmental assessment and she believed it was conducted by the state's child development services (CDS). There were no concerns, and it was recommended to have another assessment between nine and twelve months. Ms. Newbert said she had planned to do this at one year of age.

Ms. Newbert said that Mr. Melvin was released from jail on either the 21st or 22nd of March. She said that she only talked to him once when he called about getting his things that were still in her apartment. The caseworker said that the Department was concerned about Mr. Melvin's history of domestic violence. Mr. Melvin was restricted from coming to her home due to the lease which precluded having anyone with a domestic violence history in transitional housing. The caseworker and Ms. Newbert mutually decided that Ms. Newbert would not supervise contact between Mr. Melvin and his child. Ms. Newbert said that her mother had agreed to supervise contact.

Caseworker notes of the recorded interview continued with Ms. Newbert appearing to probe several times for when the Department would allow contact with Mr. Melvin, saying that he wanted to better himself and she wanted the child to have a relationship with him as a father. The caseworker told Ms. Newbert that Mr. Melvin needed to participate with the Department and make significant changes prior to that happening. The caseworker stressed that because of his diagnoses, "even if he's doing well there is potential for it to go backwards." The caseworker stated that Ms. Newbert would always need to judge how he's doing in order to protect her child.

Regarding her mental health, Ms. Newbert said she had talked with her MAT provider who set her up for a medication management appointment. She said she attended the initial appointment and was told, in addition to bipolar disorder, she had ADHD, which she had not realized. Ms. Newbert stated that she missed the second appointment due to a snowstorm and now another appointment was not available for several months.

After this interview, the caseworker consulted with her supervisor for the preliminary safety decision which was that the child was safe in the care of Ms. Newbert and should remain in the home. The PSD noted next steps to include:

- a law enforcement welfare check, ostensibly to ensure Mr. Melvin was not in the home;
- interview Mr. Melvin as a non-custodial parent;

- follow up with service providers: Public Health Nurse, Partners for Peace, Maine Families, and the primary care physician; and
- continue assessment activities.

On April 9th, the caseworker requested the criminal history for Ms. Newbert and Mr. Melvin. No new history was returned for Ms. Newbert and the charges against Mr. Melvin were already noted in the CPS history.

Mr. Melvin Refuses to Participate in the Assessment

According to caseworker records, in late April, Mr. Melvin left a message for the caseworker and gave a number to call him at the place where he was staying. The caseworker returned the call and asked Mr. Melvin's relative to give him a message to call again. Ten days later the caseworker called again to ask if the message had been delivered. The relative said that Mr. Melvin said that he never called the caseworker. Later that day, Mr. Melvin called the caseworker and said that he did not think DHHS needed to be involved. He said he was starting medication and would be seeing his psychologist soon. The caseworker asked to meet with him about participating in the assessment. Caseworker notes state that Mr. Melvin got defensive and hung up.

The End of the Second Investigation and Referral to ARP

Over the next few months, the caseworker continued to speak with Ms. Newbert and her providers and did not find any evidence that Mr. Melvin was with Sylus' older full sibling unsupervised, or supervised only by Ms. Newbert, or that Mr. Melvin was in Ms. Newbert's residence in violation of the transitional housing lease. The caseworker also monitored Ms. Newbert's MAT and assisted with re-connecting with the public health nursing service, as well as monitoring the baby's health needs. On June 20th, the child was seen for a one-year checkup. Two prior appointments were cancelled, rescheduled, and ultimately not attended. The results of that checkup noted that there were no medical or developmental concerns for the child.

Home visitors from Maine Families and Partners for Peace continued to report no evidence of Mr. Melvin at the residence and on July 12th, the investigation concluded. There were no findings of abuse or neglect for Ms. Newbert who had physical custody of the child. Mr. Melvin was also unsubstantiated for abuse or neglect. Although he had not participated in the investigation or cooperated with the Department, there was no evidence that he had unsupervised contact with the child.

On July 18, 2019, an add-on report was entered into the DHHS database system that was originally reported on June 29th, prior to the case being closed. The report from an employee of Partners for Peace stated that Mr. Melvin was seen by a coworker of the referent smoking a cigarette on Ms. Newbert's front porch. That same day the supervisor called the referent and left a message. On August 5th, the supervisor talked with the referent. The referent stated that Ms. Newbert said that Mr. Melvin occasionally delivered things for the baby such as milk and diapers and left them on the front steps. The supervisor told the referent from Partners for Peace that they were closing the investigation and asked the referent to call with any new worries or if they saw the two together.

After the investigation closed, the Department referred Ms. Newbert to ARP services, which she accepted. The ARP worker visited on August 7th and August 21st, noting that Ms. Newbert's child was well-cared for,

and the home environment was clean and organized. On August 30th, the ARP worker received a call from a distressed Ms. Newbert saying that the police were at her apartment and Mr. Melvin was found hiding in a closet.

Three New Reports Related to the Same Incident

Two child protection intake reports were made by a representative of Partners for Peace regarding this incident, naming each of the parents separately. These reports were based on observations from the representative of the same incident and were classified as appropriate for investigation. Another report from the ARP worker was also submitted, based upon what Ms. Newbert told the ARP worker. This third report was considered a duplicate report and provided additional information and perspective to the Department.

Ms. Newbert's Perspective as Told to the ARP Worker

Based upon the ARP worker's notes, Ms. Newbert told the worker her perspective on the events leading up to Mr. Melvin being found in the house. Ms. Newbert reportedly said that she, her child, her mother, and her mother's boyfriend left the house for shopping and errands. Ms. Newbert's sibling had stayed behind. Ms. Newbert had a meeting scheduled at noon at her apartment with her landlord which would also be attended by a representative from Partners for Peace. The group was running late so Ms. Newbert called her landlord who said they would wait. Ms. Newbert's sibling had left the house by this time to meet the rest of the family at a nearby location on their way home. Ms. Newbert continued - saying that when the family returned to the apartment, she noticed a lot of cars around the buildings, so they took a side road to the house to use the back entrance. Ms. Newbert said she entered the kitchen to prepare her child's bottle of formula.

Ms. Newbert stated that she was calling the police about the cars outside when a police officer that was already out in front of the residence told her to get herself and the baby outside. The police entered the residence and found Mr. Melvin inside her apartment in an upstairs closet. Ms. Newbert told the ARP worker that Mr. Melvin told the police that she let him in. She claimed that she did not let him in and did not know he was there. She stated to the caseworker that the only thing she could think of was that her sibling let him in the apartment.

The ARP worker's notes further stated that after this phone conversation, she went to Ms. Newbert's apartment to meet with her. When she arrived, Ms. Newbert and the worker took the baby for a walk. Ms. Newbert showed the worker a text Mr. Melvin sent to her after the police came, stating that Ms. Newbert's sibling let him in the apartment, and that he was sorry he lied. Ms. Newbert reported to the worker that Mr. Melvin had been bringing diapers and milk and they had been texting. Ms. Newbert said for the past week she had had no communication with Mr. Melvin as she believed he was doing drugs. She said she was hoping he would change for the baby's sake (Sylus' older full sibling), but now realized he had not. She stated that she still had some of Mr. Melvin's things in her apartment and that he had been asking for them.

The ARP worker's notes state that Ms. Newbert told her she was afraid that DHHS was going to take her child into custody. She also told the worker that her landlord said Ms. Newbert should expect an eviction notice.

The Perspective of the Representative of Partners for Peace as Related by the Intake Report

The intake reports from the representative of Partners for Peace were submitted at roughly the same time as the ARP worker's report. The report by the referent notes that Ms. Newbert was in transitional housing due to a history of domestic violence from Mr. Melvin. The referent and the landlord from Penquis CAP arrived for a noon meeting with Ms. Newbert but received a text from her that she was running late. The referent reported that she saw Mr. Melvin's skateboard outside the apartment and heard what sounded like the television as well as people in the apartment.

The report states that Ms. Newbert had walked out of the apartment when she saw the police and asked why they were there. Upon entering the apartment, the police found Mr. Melvin in a closet. Ms. Newbert stated that she had just returned and did not know Mr. Melvin was in the home. The referent from Partners for Peace confronted Ms. Newbert stating that Ms. Newbert appeared untruthful because both they and the landlord were parked by both doors since noon time, and no one was observed entering or leaving the home. Speaking to the referent, Ms. Newbert denied knowing Mr. Melvin was in the apartment, stating that she would not want to risk losing her child.

The report was classified as appropriate for investigation and assigned a 72-hour response time. The intake supervisor wrote that the prior CPS history showed that Ms. Newbert had taken some steps to protect the child by maintaining a separate household from Mr. Melvin, but Ms. Newbert's recent behavior suggested she was less reliable, and her ability to protect a vulnerable one-year-old needed to be reassessed.

The Third Investigation Leading to Another ARP Referral

A caseworker and supervisor from the Department were assigned to the investigation and the caseworker met with Ms. Newbert and observed and interacted with her one-year-old child on September 3rd. The case records indicate that the child was well-groomed, clean, free of bruises and marks, and was clearly attached to Ms. Newbert. Ms. Newbert and the caseworker discussed the family's history with the Department as well as the events which led to Mr. Melvin being found in Ms. Newbert's transitional housing unit. Ms. Newbert stated that her sibling had said that they did not let Mr. Melvin into the house, so she assumed now that he had broken in. While there was concern noted in the narrative that Ms. Newbert may have invited Mr. Melvin into the home contrary to her assertions, the caseworker judged her claim to have arrived at the backdoor unseen as plausible.

The preliminary safety decision was that the child was safe in Ms. Newbert's care; but would be unsafe with Mr. Melvin. The next steps listed in this document included contacting Ms. Newbert's mother to compare her details of the event with her daughter's and contacting Mr. Melvin and attempting to interview him. An interview with Ms. Newbert's mother later that afternoon corroborated Ms. Newbert's story that she was running errands with her mother that morning, yet it was unknown if Mr. Melvin was in the house prior to that time.

Mr. Melvin was eventually contacted and agreed to be interviewed at the DHHS office on September 13th. In this interview, Mr. Melvin denied physical domestic violence with Ms. Newbert, but admitted to a history of violence with others. He said that he and Ms. Newbert only argue verbally. Mr. Melvin stated that he was in Ms. Newbert's house only to get his backpack and Ms. Newbert's sister had let him in. He denied any current

substance use other than medical marijuana which he was prescribed. Mr. Melvin spoke of his brain trauma from a car accident and said that he had been diagnosed with other mental health disorders. The caseworker followed up with Mr. Melvin's healthcare providers.

On September 20th, the caseworker received a letter from Mr. Melvin's PCP stating that Mr. Melvin had been diagnosed with a mood disorder and PTSD for which he receives counseling from a local psychologist. The PCP said that Mr. Melvin had been prescribed various medications which were not therapeutic for his condition and said that he found the best treatment to be counseling and medical marijuana. The letter concluded with the statement:

> "As long as Mr. Melvin continues his current treatment[s] which have been effective, it is reasonable for him to have unsupervised visits with his [child]."

On October 4th, the caseworker followed up and spoke with Mr. Melvin's psychologist who had known Mr. Melvin since he was five years old. The psychologist said they had been seeing Mr. Melvin almost weekly in the last month or so. The psychologist stated that it appears Mr. Melvin was genuinely committed to getting and staying in treatment and that their sessions were currently working on impulse control and judgement. The Department did not change the supervision requirements at that time based on these opinions.

The caseworker also spoke with Ms. Newbert's landlord who stated that while they believed Ms. Newbert was not being truthful about the incident with Mr. Melvin being found in her apartment, there had been no further incidents. The landlord stated that they were going to extend a lease to Ms. Newbert and would not evict her because of the incident. At the same time, Partners for Peace would be helping Ms. Newbert find more permanent housing. Separately, the caseworker also referred Ms. Newbert to a mental health professional as she was open to receiving that help.

The investigation was closed without findings of abuse or neglect and closing letters to Ms. Newbert and Mr. Melvin noted that the Department was still concerned about the child's safety and well-being based on the family's significant history with domestic violence. The letter also stated that:

> "[i]t is not clear how and why [Mr. Melvin] was in [Ms. Newbert's] apartment on the 30th of August. However, it is clear that [Ms. Newbert and Mr. Melvin] have some desire to unite as a family unit, and the Department would prefer to have you work with Community Care to come up with a safe plan for that to happen. Without any findings and no court action, it has been decided that this assessment will be referred once again to ARP to provide oversight and monitoring of services."

The letter closed stating the Department's expectation that Mr. Melvin "is not to have any unsupervised contact with [their child] until he has demonstrated a noticeable difference in his mental health and behavior."

ARP Services Winter 2019/2020

Ms. Newbert's and Mr. Melvin's separate ARP services started on November 7, 2019. Ms. Newbert's services lasted until February 12, 2020, while Mr. Melvin's ended February 27, 2020. During that time, Ms. Newbert completed her GED and began training toward becoming a Certified Nurse's Assistant and began working part-time as a Personal Support Specialist. The ARP case notes show examples of protective behavior in that she had called police to serve a no trespass order on Mr. Melvin when he came to her apartment about two

weeks prior to starting the ARP service. Over the ensuing months, visits between Mr. Melvin and their child were supervised by Ms. Newbert's mother and father. Mr. Melvin obtained his own apartment, continued to see his psychologist, and worked with his case manager on getting his full supplemental security income restored.

On December 20th, Mr. Melvin informed his ARP worker that his psychologist said it was okay to have unsupervised visits. The worker stated that this decision was not his psychologist's to make; the PR&R required supervised visits, and it had not been modified. The Department did not act upon the statements made by either Mr. Melvin's PCP the prior September to allow unsupervised visitation, nor this new suggestion by Mr. Melvin's psychologist. Likewise, Ms. Newbert made no attempt to modify the PR&R Order at this time either.

Ms. Newbert's ARP case was closed with the following signs of safety:

- Understands her primary role and responsibility is to protect, nurture and provide for the well-being of the child.
- Demonstrated caregiver affection, attentiveness, concern, nurturance, responsiveness, etc.
- Child turns to caregiver for comfort, getting needs met, support.
- Previous demonstration of protective action.
- Demonstrated self-awareness/positive self-esteem.
- Safe home environment.
- Basic child needs are being met in a timely, effective, and consistent manner.
- The caregiver demonstrates empathy towards the child.
- The caregiver demonstrates help seeking behaviors. Caregiver is receptive to ARP involvement/intervention. Open communication among family members.
- Demonstrates the management of stress.

The only sign of risk was that the child was at a significantly vulnerable age. There were no recorded danger signs. The recommendations included:

- abiding by the PR&R, which stated that Mr. Melvin was allowed only supervised visits at Ms. Newbert's discretion;
- Mr. Melvin was not allowed in Ms. Newbert's apartment as long as it was in transitional housing; and
- continue to work with Maine Families and Partners for Peace.

Mr. Melvin's case was closed, noting signs of safety that he was actively seeking help and was receptive to ARP involvement and intervention. The risk, again, was that the child was vulnerable, and it was recorded that there were no apparent signs of danger as the child was residing with the mother. Mr. Melvin was given the same recommendations to abide by the PR&R, which included only supervised contact with the child; and to avoid going to Ms. Newbert's residence; along with continuing to work with his service providers.

February 2020 – July 2021: A Year and a Half Without Departmental Involvement

After the ARP cases closed in February of 2020, the Department had no investigations or service cases with the family for almost a year and a half prior to the birth of Sylus. During this time, the only relevant court order was the Parental Rights and Responsibilities Order negotiated between the parents and their attorneys in Family Court. This order simply stated that Mr. Melvin was allowed supervised visits with his child at the sole discretion of Ms. Newbert. The only other active restriction was that Ms. Newbert's transitional housing for victims of domestic violence did not allow Mr. Melvin at her apartment.

While the Department had no active investigations during this year and a half, three reports were made to central intake prior to the birth of Sylus.

On May 12, 2020, Mr. Melvin reported that Ms. Newbert was verbally abusive to him during video chats with their child. When asked by the intake worker whether the child appeared upset on the chat, Mr. Melvin stated that the child did not seem to be upset by this. This report was deemed inappropriate for investigation (i.e. "screened out") as the information did not meet the threshold of suspected child abuse or neglect.

On July 31, 2020, a physician reported that Ms. Newbert and Mr. Melvin's child had not been seen for a wellness check in the prior ten months and was not up to date on their vaccinations. This report was deemed inappropriate for investigation as the information did not meet the threshold of suspected child abuse or neglect.

On March 16, 2021, Ms. Newbert's medical provider reported that she was pregnant and lacked organizational skills, which could be a hindrance to caring for a newborn. The provider also reported that Mr. Melvin was the father and lived in the home. Mr. Melvin had attended prenatal visits and the provider found him to be "appropriate and trying hard". This report did not meet the threshold of suspected child abuse or neglect and was deemed inappropriate for investigation.

Ms. Newbert's Pregnancy

During this extended period of minimal involvement with the Department, Ms. Newbert had moved out of transitional housing, the couple had moved in together, and Ms. Newbert had become pregnant with Sylus.

July 29, 2021: Report of Substance Exposed Infant and Investigation (Sylus)

On July 29th the Department received a report from a hospital social worker that Sylus Melvin had been born substance exposed to prescribed buprenorphine. The report noted additional concerns by the hospital staff due to the past mental health and domestic violence history of the family. The hospital staff also noted that it was unusual that Mr. Melvin was only allowed supervised visits with his child but was living in the home.

The referent, a hospital social worker, also added that Ms. Newbert stated that the couple had been living together for the past year and the police had not been called to the home during that time. Ms. Newbert had said to the hospital social worker that the couple were getting along much better now. She self-reported that she was doing well in her substance use treatment and had no relapses. The report noted six prenatal drug screens that were positive for Subutex only. The text of the report included a brief CPS history of the prior investigations as well as the three intervening reports that were determined to be inappropriate for

investigation. Due to the CPS history of the family, this report was classified as appropriate for investigation and was given a 72-hour response priority.

A timeline of this investigation in the form of a calendar can be found in Appendix C.

Initial Response

Prior to the first visit, the caseworker performed several activities as per the Department's policies. They noted the signs of safety in the report which were that the substance affecting the infant was prescribed throughout pregnancy, and that there were no recent reports of abuse or neglect. The caseworker listed prior reports of maltreatment and the history of domestic violence as signs of risk. The caseworker ran criminal background checks and found that Ms. Newbert had no additional criminal history since prior investigations. Mr. Melvin had two additional charges, having been fined for two misdemeanor violations of unlawful possession of a scheduled drug.

The caseworker met with Mr. Melvin on July 30th in an empty hospital room less than 24 hours after the submission of the report. Mr. Melvin told the caseworker he had moved back into the home "a month or two ago". He also stated that Sylus' sibling was at home with Ms. Newbert's mother. The caseworker asked Mr. Melvin to describe his CPS history and what was different between then and now. He stated that back then he was a first-time dad and felt lots of pressure. He said that he felt that he now had more patience and was more understanding.

The caseworker's interview notes described that because Mr. Melvin was disabled, he had a peer-support worker and a case manager. He had stopped seeing his psychologist during the COVID pandemic when in-person visits were not an option, but he wanted to resume seeing the psychologist. He was using the same organization as Ms. Newbert had previously used for substance use disorder treatment. The caseworker noted that Mr. Melvin said he was prescribed suboxone and had been using it for a few months. He said he was not on any mental health medications but used medicinal marijuana. Regarding his relationship with Ms. Newbert, he stated that they had been getting along perfectly.

The caseworker separately interviewed Ms. Newbert discussing substance use, mental health, and the couple's relationship. Ms. Newbert stated that she did not use marijuana and only took Subutex. She said Mr. Melvin had been charged with possession since the prior investigations and he had been on suboxone since December. She stated that Mr. Melvin's timelines were not accurate due to his brain injury. Regarding her mental health, Ms. Newbert said that she suffered from depression, and she talked with Partners for Peace for support.

Ms. Newbert told the caseworker that Mr. Melvin lied in the 2018 investigation about her being domestically violent. The case against Ms. Newbert was dismissed when Mr. Melvin admitted that he lied. She said that he was the one who shoved her and made threats to stab and punch her. She stated to the caseworker that nothing like that had happened since then. She said that they had moved in together about a year prior, in August of 2020, and they had had only two mild arguments since then.

The caseworker asked Ms. Newbert about the plans for the infant's sleep space and the current care for the 3-year-old. They obtained releases from the parents to contact providers as well as contact information for family members. The caseworker then observed Sylus who was being cared for by nursing staff in the NICU.

Home Visit and the Preliminary Safety Decision (Sylus)

In the afternoon of July 30th, the caseworker visited the family's home and observed Sylus' older sibling with Ms. Newbert's mother present. The child displayed no marks or bruises. The caseworker recorded speaking with Ms. Newbert's mother who stated things were going well with the couple. She mentioned that she felt Mr. Melvin had grown up and Ms. Newbert and Mr. Melvin had been getting along with no problems. Regarding domestic violence, she reported that there had been little in the way of disagreements, but, if there is a disagreement, she encourages Ms. Newbert and Mr. Melvin to separate. Ms. Newbert's mother stated that she was not concerned about Mr. Melvin's substance use because he was in a program. She also said that she comes to visit almost every day and she expects to help with the children. The caseworker completed a safe sleep assessment and noted that the home was clean, safe, and appropriate. The older child's room was organized and full of toys.

The caseworker stopped at the Milo Police Department to ask for recent reports on the family in their files. They reported that Mr. Melvin was involved in a theft incident in May where he had previously called to try to obtain some of his possessions that were in another person's home. In March, he had dropped a bag of heroin in a local store and was charged with possession. The police noted no recent domestic violence incidents.

At this point the caseworker consulted with her supervisor who made the preliminary safety decision that the children were safe at this time, with a note that they were still assessing. The summary listed the facts that have been discussed above, adding only that the parents said they were willing to take drug screens if asked. Using the SDM Safety Tool[35], no safety threats were identified, and the supervisor determined that the children could remain in the home (with Sylus still in the hospital) as the investigation continued.

Collateral Contacts (Sylus)

Signed releases were sent to Mr. Melvin's and Ms. Newbert's service providers and the caseworker contacted them. Mr. Melvin's case manager spoke to the caseworker saying that they saw Mr. Melvin at least once per month but more often if needed and that they worked with Mr. Melvin on mental health and support for general life activities. The case manager said that there were challenges in the parents' relationship. The case manager described this as the parents having different personalities and they were going to try to navigate the responsibilities of having a second child. Still, they had no specific concerns or issues. Mr. Melvin's peer-support worker was also contacted and told the caseworker that they had no concerns. The peer-support worker described Mr. Melvin as cordial, polite, and typically in a good mood. Mr. Melvin's psychologist had not seen him in over a year but provided the opinion that they had not experienced Mr. Melvin in any way to be a danger to his children. The psychologist believed Mr. Melvin to be very caring with his older child.

The caseworker also contacted Ms. Newbert's father who stated that the couple seemed to be doing well. He said he saw them four or five times per week and that they spent time with and took good care of their older child. Ms. Newbert's father said the couple was getting along better and he had no concerns.

[35] SDM Structured Decision-Making tools were in the initial stages of being implemented by the Department at this time. SDM tools are a structured way to assess a family's situation regarding safety, risk, a management of resources.

The caseworker made referrals for in-home services. A public health nursing service was to be provided by the CradleME program using Bangor Public Health and Community Services. Maine Families was to supply in-home visits as well.

In a series of emails with the hospital staff, the caseworker related that they had visited the home with Ms. Newbert's mother present and spoke with providers and family supports who all provided positive feedback. The caseworker stated that unless any other concerns arose, they were okay with Sylus' discharge from the hospital to his parents' care.

Sylus at Home – Week 1

Sylus Melvin was discharged from the hospital on Tuesday, August 10, 2021. The next day, he was seen by his primary care physician for a discharge follow up. On this visit, it was recorded that he had diaper rash, but no other concerns were noted. The same day, the public health nurse (PHN) visited Ms. Newbert and her children. The PHN performed a weight check with no clothing and recorded no notable concerns. Ms. Newbert scored high on a depression scale which the nurse reported to Ms. Newbert's doctor.

On August 12th the record details a telephone conversation between the caseworker and the public health nurse. The PHN reported that the baby had gained a little weight. The PHN told the caseworker of Ms. Newbert's depression score and that it had been reported to Ms. Newbert's doctor. The PHN told the caseworker that they had been at the house for two hours the previous day and the parents were "just not on the same page". Ms. Newbert was struggling with the responsibilities of a 3-year-old and a newborn, and Ms. Newbert felt that she was doing all the childcare and Mr. Melvin was not helping. The PHN encouraged Ms. Newbert to work with her mother and Mr. Melvin to make a plan to work together. The PHN also told the caseworker that they and Ms. Newbert had worked through a SAFE Tool questionnaire which was used to assess a situation through the lens of possible domestic violence. The PHN told the caseworker that the parents raised their voices when arguing but stepped outside to do so.

The records show that the nurse visited a second time that week on the very next day, August 13th. The baby's weight was checked, and no concerns were noted during this second visit. OPEGA interviewed the public health nurse, who has since moved on from that position, regarding their visits with Ms. Newbert. The PHN told OPEGA that they found that Ms. Newbert's suboxone dose was not up to the level of her prior dosage and that they felt that some of Ms. Newbert's symptoms were due to withdrawal. The nurse told OPEGA that they had contacted Ms. Newbert's doctor and got this resolved. Regarding the relationship between Ms. Newbert and Mr. Melvin, the PHN told OPEGA that Mr. Melvin often used the disengagement technique that had been taught to him over the years to cope with situations that overwhelmed him and that they believed that he used that often as an excuse to not be helpful. The PHN told OPEGA that while the parents raised their voices to argue, they did not see Mr. Melvin as threatening and Ms. Newbert did not signal that she was experiencing domestic violence. The PHN felt that Ms. Newbert wanted more help from Mr. Melvin rather than trying to distance herself from him. The PHN told OPEGA that had they suspected domestic violence, they would not have left the house until safety was assured. The PHN stated that they had done that before in their career.

The public health nurse was also somewhat critical of the Department and expressed this to OPEGA, as they were told by Ms. Newbert that the Department had not made a home visit. While it was true that the

caseworker had not yet been to the home while Ms. Newbert was there, the caseworker had visited the home, as per policy, prior to Ms. Newbert and Sylus being discharged from the hospital and the investigation had not yet concluded. The PHN further told OPEGA that there was very little documentation regarding the home situation in the referral and was only aware that Mr. Melvin was in the home and needed to be monitored. However, there was no information as to why he needed to be monitored, nor did it include a description of concerns regarding the baby.

Sylus at Home – Week 2

The visit from the public health nurse scheduled for August 18th was rescheduled for the 23rd. On Thursday, August 19th, both parents took Sylus to his primary care physician's office for a weight check. The report of this visit raised no concerns.

On August 20th, the caseworker called Ms. Newbert to check on the family. The record of that phone call states that Ms. Newbert said that she had to reschedule her appointment with Maine Families due to a conflict and it was now scheduled for the following Wednesday. She also told the caseworker that public health nursing visits were going well and that she liked the PHN a lot. Ms. Newbert stated that Mr. Melvin was gone a lot, working under the table. They discussed her need for him to be there to help. Regarding her own mental health, the caseworker's record of the call states that Ms. Newbert said that she was overtired but working on it and her mother had been coming to help.

At the end of the call record, the caseworker wrote that they notified Ms. Newbert that they were going to be on vacation the following week. The caseworker said that they wanted to be sure the family was all set before leaving and that Ms. Newbert could call their supervisor if anything major came up.

Sylus at Home – Week 3

While the caseworker was on vacation, the PHN's third visit with the family occurred on Monday, August 23rd. At the time the PHN did not report any concerns but later, on August 31st, they added to the report that they had noticed that the tip of Sylus' penis was purple. They had believed it was a vein and had suggested to Ms. Newbert to discuss it at Sylus' next doctor's appointment. On Friday, the 27th, Sylus was seen at Northern Light's Lafayette Center for neonatal anemia. The lab results suggested hemolysis. The staff educated Ms. Newbert regarding the signs and symptoms of worsening anemia and planned to do follow-up testing. They noted that the anemia was severe, but he had been doing okay.

<u>August 29, 2021: Sylus' Death</u>

On Sunday, August 29th, Sylus sustained injuries early in the morning and died later that afternoon.

<u>Additional Information Unknown to the Caseworker</u>

OPEGA obtained records from the Office of Attorney General that were generated or collected by the Maine State Police during the investigation of Sylus' death. These records, combined with interviews by the Department after Sylus' death, reveal a different picture of events in contrast to what was presented to the caseworker prior to Sylus' death. The records show that Ms. Newbert and her mother were privately struggling with Mr. Melvin's behaviors and were afraid for Ms. Newbert and the children.

In an August 29th interview with State Police, attended by the CPS caseworker, Ms. Newbert revealed that Mr. Melvin had choked her and hit her in the face about a week prior, and that when Sylus was first born, Mr. Melvin had threatened to kill them all "so he wouldn't have to deal with it". According to the interview notes, Ms. Newbert also stated that she had recently suspected that Mr. Melvin had been using heroin and methamphetamine and selling his suboxone.

On August 30th, the day after Sylus died, Ms. Newbert sent the caseworker a series of screenshots of texts that were found on the phone that Mr. Melvin had misplaced, as well as screenshots of Facebook Messenger conversations between Ms. Newbert and her mother. The screenshots from Mr. Melvin's misplaced phone appear to show that throughout the month of August, Mr. Melvin had been texting another person regarding obtaining, using, and possibly selling heroin and Xanax. Some of these screenshots showed system dates of August 8th, 9th, 18th and 21st. Others did not have system dates displayed but contextually can be timed to within the month of August.

The screenshots of Facebook Messenger posts between Ms. Newbert and her mother also describe an assault of Ms. Newbert by Mr. Melvin and expressed their fear of Mr. Melvin. From notes of an interview with a Maine State Police detective on September 2nd, Ms. Newbert stated that Mr. Melvin assaulted her on August 19th, the day before she spoke to the DHHS caseworker on the phone. There is no mention of this incident in the caseworker's notes of their conversation on August 20th. On the contrary, the case notes reveal that Ms. Newbert spoke of public health nursing going well, feeling good about her own mental health even though still depressed; and wishing Mr. Melvin would help more since taking care of a 3-year-old and newborn was very difficult.

In the interview with State Police detectives on Sep 2nd, Ms. Newbert also stated that she was assaulted again by Mr. Melvin on either the 24th or 25th of August, at which time she had tried to call the police. She said he had put her in an armbar, muted the phone, and told her to end the call or he would kill all of them. She said Mr. Melvin then gave her the phone back at which time she told dispatch there was no emergency, that she didn't need an officer to respond, and she would contact an officer the next day.

OPEGA believes Ms. Newbert may have been mistaken as to the timing of this phone call. OPEGA reviewed Ms. Newbert's phone records supplied by the State Police through their search warrant associated with the criminal case. Other than the 911 call on the day of Sylus' death, there is only one record of a call from her phone to the Piscataquis County Sheriff's Office or Milo Police Department prior to Sylus' death. This was a 41-second call to the non-emergency line of the Piscataquis County Sheriff's Office from Ms. Newbert's phone on August 19th. OPEGA sought, received, and listened to a recording of that call from the Piscataquis County Communications Center. The content of that 41-second call is similar to what Ms. Newbert described to state police detectives as having occurred on the 24th or 25th rather than on August 19th. Regardless of the timing of this call to police, it was using the non-emergency number, and its content was not actionable by law enforcement.

When Sylus sustained his injuries and was taken to the hospital, DHHS caseworkers began a new phase of the investigation focused on protection of Sylus' older full sibling. This included fact-finding about the incident as well as interviews with relatives to evaluate possible placements for the child. Ms. Newbert's mother was interviewed by DHHS caseworkers on the morning of August 29th. In this interview, Ms. Newbert's mother stated that she believed Mr. Melvin had been using drugs and not taking his suboxone. She said that about a

week and a half or two weeks prior, her daughter told her that Mr. Melvin was roaming in the woods at night, and when he came back to the house, he acted like he was on some sort of upper. Her daughter told her that Mr. Melvin had slapped her at that time and shoved her against the refrigerator. Ms. Newbert's mother said they thought about reporting it to the police at the time, but since there were no marks, "it would be he said – she said." The interview notes state that Ms. Newbert's mother said she *did* report this to the police a week prior to that interview from 11:30 PM to 12:00 AM and talked to an officer about what happened, the threatening remarks Mr. Melvin made, and his being out in the woods. In an interview with OPEGA, Ms. Newbert's mother also said that she told the officer she was worried about her grandchildren's safety.

The report[36] of that call, as recorded by the Milo PD officer that spoke with Ms. Newbert's mother notes that Ms. Newbert's mother called on August 22nd at 11:28 PM. This was one week prior to Sylus' death. Ms. Newbert's mother stated that she was worried about her daughter living with Mr. Melvin. The officer asked what her worries were, and she reported that Mr. Melvin had a history of abuse toward her daughter and other women, and she wanted to know what she could do to get Mr. Melvin out of the house. The officer stated that he could not give legal advice but suggested contacting the courthouse to ask about an eviction notice. The police report stated that Ms. Newbert's mother shared that she had just received a call from her daughter venting about Mr. Melvin and crying. The officer asked if she wanted them to do a welfare check on her daughter. The notes relate that Ms. Newbert's mother was very stern and said no, and that she was going to talk to her daughter tomorrow and take her to the courthouse. The officer noted that Ms. Newbert's mother did not want to make either Ms. Newbert or Mr. Melvin upset by having an officer show up at their home. The officer wrote in the report that they discussed Ms. Newbert having told the officer multiple times in the past that she was going to leave Mr. Melvin. The officer stated that Ms. Newbert's mother said that her daughter still had not left Mr. Melvin as she believed that he had changed for the better. Ms. Newbert's mother stated that she did not believe he had changed, and she wanted him to leave her daughter alone. The officer asked again what Ms. Newbert's mother wanted them to do. She said she just wanted Mr. Melvin out of her daughter's residence. Since Mr. Melvin had lived in the house for so long and established residency, the officer said they could not evict him. Ms. Newbert's mother stated that she would take her daughter to the courthouse and the phone call ended. The officer's report of the phone call did not mention current acts of domestic violence, or any threats made by Mr. Melvin to Ms. Newbert and the children. In an interview with Milo PD, OPEGA was told that if current acts or threats of domestic violence with children present were alleged, it would have prompted a different response from law enforcement as well as a report to CPS. In that interview with the officer, OPEGA was told that the officer did not know that there was an active CPS investigation with the family at the time. (See Potential Opportunities for Improvement – Information Sharing Between Law Enforcement and CPS – on Page 12)

Based on the timestamped screenshots of Facebook Messenger conversations provided to the caseworker after Sylus' death, Ms. Newbert and her mother discussed this call directly after it occurred. This included a request from Ms. Newbert for her mother's partner to provide transportation to the courthouse at some point during the upcoming week to obtain a protection order. OPEGA contacted the Piscataquis courts and was advised that Ms. Newbert had not made any application for a protection order during July or August 2021.

[36] OPEGA learned from the Office of the Attorney General (OAG) that this officer's report was documented after Sylus' death in response to a request during the OAG's criminal investigation.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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MEMORANDUM

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

SUBJECT: Sylus Melvin

DATE: September 8, 2023 [Revised from August 16, 2023]

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

Child's Name: Sylus Melvin

Child's Age at Time of Death: 1 month

Child's Caregiver(s) at Time of Death: Mother, Desiree Newbert, and Father, Reginald Melvin

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

- June 2018 – The Department received a substance exposed newborn report from the hospital following the birth of Sylus' older sibling due to Ms. Newbert's use of prescribed Subutex during pregnancy. Ms. Newbert accepted referrals for Public Health Nursing and Maine Families. This report was referred to CradleME.

- June 2018 - The Department received a second report from the hospital indicating that both parents were refusing to care for the child. Ms. Newbert reported she was in too much pain from the birth and other medical conditions. Mr. Melvin reported that he had a brain injury and explosive anger, and it was not his job to care for the baby. It was reported by the hospital that Ms. Newbert had been terminated from her Subutex provider due to missed appointments.

  The Department opened an investigation and interviewed both parents, gathered records, and spoke with providers and other collateral contacts. It was learned that Mr. Melvin was in a car accident in 2015 and was diagnosed with traumatic brain injury and short-term memory loss. Mr. Melvin's providers and records documented that Mr. Melvin had major neurocognitive disorder due to a traumatic brain injury with behavioral

disturbance. Mr. Melvin was also diagnosed with a conduct disorder, ADHD, bipolar I, intermittent explosive disorder, and significant learning disabilities. It was reported Mr. Melvin experienced his first psychiatric hospitalization as a child at around five or six years old.

Ms. Newbert reported she had depression, anxiety, and bipolar disorder. She reported that she started using substances when she was 16 years old and had used both prescription opiates and heroin. Ms. Newbert reported she had an older child in the custody of Ms. Newbert's grandmother.

Ms. Newbert stated that the plan was to have her mother come and stay with them for a week. They had a plan to have Mr. Melvin's father come and pick Mr. Melvin up if Mr. Melvin were emotionally triggered. The initial safety decision was to allow the parents to take the newborn home at discharge based on this plan.

The hospital contacted the Department a few days later with additional concerns. The hospital reported that the child spent most of the time in the nursery and there were concerns that Ms. Newbert was requesting more medication than was typical for her medical circumstances. The child's doctor reported that Ms. Newbert had provided care for the child for only about three hours in five days.

The Department contacted Ms. Newbert's Subutex provider and confirmed that she had been discharged due to losing Subutex and having a prescription stolen. She had not failed any drugs screens. Ms. Newbert's providers also reported concerns about drug-seeking behavior and reported that pill counts were slightly off.

The child was discharged home with the parents with the understanding that the maternal grandmother would be in the home helping the parents. Soon after they were discharged, the Department made an unannounced home visit and learned that Ms. Newbert had been readmitted to the hospital with an infection and the maternal grandmother could not stay with the family due to the death of a friend. As a result, Mr. Melvin was caring for the child. A plan was made for the child to stay with the maternal grandfather that night and for Ms. Newbert's mother to return to the home with her the following day and stay with the family. Investigation activities continued. Referrals were made for Public Health Nursing and Maine Families Home Visiting.

Ms. Newbert's criminal history included convictions for forgery and theft. Mr. Melvin's criminal history included charges for domestic violence terrorizing, violation of a protective order, domestic violence assault, obstructing the report of a crime, criminal mischief, aggravated assault, and domestic violence assault.

During the child welfare investigation on June 19, 2018, Mr. Melvin called the Department to report that Ms. Newbert had spit on him and punched him in the face while he was holding the baby. Ms. Newbert was arrested for domestic violence assault and the baby stayed with the paternal grandfather overnight. Both Ms. Newbert and her

mother (who continued to be present in the home) reported that this did not happen but that the couple had been fighting. After this incident, an informal safety plan was made that Ms. Newbert would not be alone with the baby and both grandparents would be responsible for care. Mr. Melvin was residing elsewhere. Ms. Newbert's bail conditions prevented contact between the parents and Ms. Newbert sought and obtained a Protection from Abuse (PFA) order against Mr. Melvin.

Ms. Newbert tested positive for illicit substances on June 27, 2018. The Department made multiple attempts to connect Ms. Newbert with a new substance use disorder treatment provider, but Ms. Newbert repeatedly missed the scheduled intake appointments. While the parents remained separated at this time, there was concern from family members that they would reunite. Mr. Melvin's behavior continued to be erratic, and he made threats against Ms. Newbert and the child. He was arrested for going to Ms. Newbert's home on June 27, 2018.

As a result of ongoing concerns regarding domestic violence, mental health, and substance use, the Department filed a jeopardy petition, and a safety plan was made under which the child was to reside with the maternal grandfather and his partner. Ms. Newbert was permitted to stay at her father's home.

In July of 2018, Ms. Newbert started substance use treatment and mental health treatment. Due to participation in these services, Ms. Newbert was allowed unsupervised contact with the child, but it was quickly learned from relatives that Ms. Newbert was seeing Mr. Melvin and considering getting back together with him. As a result, her visits with the child were returned to supervised.

The investigation portion of the Department's involvement concluded in July and both Mr. Melvin and Ms. Newbert were substantiated for physical abuse due to the threat posed to the child by the domestic violence in their relationship. A case was opened pursuant to the pending jeopardy petition.

During this time, Ms. Newbert continued to reside with her father and the child. Separate Family Team Meetings (FTMs) for each parent were held and during Mr. Melvin's meeting he reported he had made up the story about Ms. Newbert hitting him while he was holding the baby, but he denied any domestic violence on his part. He denied having any violent history and blamed his victims.

Several days after the FTMs, Ms. Newbert asked the Department about the potential impact of amending the PFA she had against Mr. Melvin, stating that she loved him and wanted to be with him, but not live with him. It was also learned from the Guardian ad Litem that, according to the maternal grandfather, Ms. Newbert was often away from the home and had been heard saying to someone on the phone, "this [expletive] baby is driving me insane." Ms. Newbert moved out of the home a few days after this and back into her own apartment. The Department met with Ms. Newbert and reminded her she needed to ensure that unsafe individuals were not in her home.

In August of 2018, the decision was made to transition the child home with Ms. Newbert. This was based on reports from providers that Ms. Newbert was engaged in treatment. In mid-August the Department completed an unannounced visit and conducted a count of Ms. Newbert's medication which was correct. Ms. Newbert reported she was not yet in counseling, and she continued to miss appointments with other providers. Ms. Newbert also reported that Mr. Melvin had come to the home on three occasions, beating on the door, threatening her, and calling her names. He had also been texting her and she was texting him back.

In October of 2018, the Court issued a finding of jeopardy against Mr. Melvin but dismissed the jeopardy case against Ms. Newbert with no finding. A parental rights and responsibilities order was put on the record that provided Mr. Melvin with only supervised visitation. Mr. Melvin was incarcerated at this time due to multiple violations of the PFA against him.

The Department closed its case in November of 2018 with Ms. Newbert engaged in medication-assisted treatment but no other services. She reported she was attempting to establish counseling but had missed multiple appointments. It was determined her reasons for missing these appointments were valid.

- November 2018 – The Department received a new report from the child's medical provider that Ms. Newbert had not appeared for the baby's one and two month well child checkups, as well as appointments Ms. Newbert had scheduled in October and November of 2018. It was reported that the child was behind on vaccinations, but the provider had no concerns at the child's September 2018 appointment. This report was screened out because the information did not meet the threshold of suspected child abuse and/or neglect.

- January 2019 – The Department received a report from the child's medical provider that Ms. Newbert continued to fail to appear for appointments. This report was screened out because the information did not meet the threshold of suspected child abuse and/or neglect.

- March 2019 – The Department received a report from Ms. Newbert's neighbor that Mr. Melvin had been released from jail and had been staying with Ms. Newbert since his release. The referent reported no concerns about violence in the home since Mr. Melvin had moved into the home. This report was screened out as the report did not contain concerns about violence in the home and although there was information that he was present in the home, there was no information indicating that Mr. Melvin was unsupervised with the child.

- March 2019 – The Department received an additional report from Ms. Newbert's neighbor with similar information that Mr. Melvin had been living in the home since he was released from jail and that Ms. Newbert had dropped the PFA. The referent reported

calling law enforcement who indicated there was nothing they could do because there was no active PFA and there were no new incidents of domestic violence. This report was screened out as the report did not contain concerns about violence in the home and, although there was information that he was present in the home, there was no information that Mr. Melvin was unsupervised with the child.

- April 2019 – The Department received a new report from the transitional housing program where Ms. Newbert's apartment was located. The referent reported that Mr. Melvin had recently been released from jail and had moved into Ms. Newbert's apartment in violation of her lease. Due to the credibility of the referent, this report was opened for investigation.

  The caseworker met with Ms. Newbert and observed the child. The home was clean, and the child looked well. Ms. Newbert reported that she had been attempting to modify the PFA, but the Judge dismissed it saying that the PFA was not needed if Ms. Newbert desired to have contact with Mr. Melvin. Ms. Newbert initially denied that Mr. Melvin had been present in the home but later said perhaps her sister had let him in when she wasn't home.

  Ms. Newbert was not in counseling or medication management but indicated she was still engaged in medication assisted treatment. Her provider reported that Ms. Newbert struggled with transportation at times but continued to remain compliant with treatment. Maine Families reported that Ms. Newbert had cancelled the last three visits but had been consistent before that.

  During the investigation, it was clearly communicated to Ms. Newbert that if Mr. Melvin was to be unsupervised with the child the Department would file a petition initiating court action. Ms. Newbert asserted that she agreed that Mr. Melvin was not a safe person to be around their child unsupervised.

  In July 2019, the investigation was set to be closed without findings after Maine Families reported that Ms. Newbert had been much better about keeping appointments, Ms. Newbert's treatment provider reported that the transportation issues had been resolved, and the child's medical provider reported they had seen the child for a well child checkup with no concerns. Before the investigation closed, the Department received a new report from a provider who had witnessed Mr. Melvin on Ms. Newbert's porch smoking a cigarette.

  The Department followed-up on this report and Ms. Newbert indicated she had run into Mr. Melvin at the food bank, and he had offered to give her a ride home. She reported she had declined but he had dropped the food off for her at the home. The Department contacted the referent who reported that Ms. Newbert had reported the same information to them. The Department requested the referent report any new concerns.

  The investigation was closed without findings in August of 2019.

- August 2019 – The Department received two reports (one on each parent) after a provider and the landlord had arrived at the home for a scheduled meeting and noted Mr. Melvin's skateboard outside the home. Mr. Melvin was found hiding in the closet of the apartment and Ms. Newbert reported that she had just returned home and did not know Mr. Melvin was there. Drug paraphernalia was also found in the home and Ms. Newbert stated Mr. Melvin was using heroin again. Police issued a no-trespass order on Mr. Melvin at the request of the landlord. These reports were opened for investigation.

  During the investigation Ms. Newbert reported that she had been out with her mother who had dropped her off behind the building (due a lack of parking in front), that she had come into the apartment the back way, and that she was shocked to find Mr. Melvin in the home. Ms. Newbert's mother corroborated this account.

  This investigation was closed with no findings in October of 2019 with a referral to the Alternative Response Program (ARP). During Ms. Newbert's involvement with ARP, she continued to work with providers on safe visitation between the child and Mr. Melvin. ARP closed their involvement in February of 2020.

- May 2020 – The Department received a report from Mr. Melvin that he was having contact with his child via video chats, and he alleged that Ms. Newbert was verbally abusive to the child because she had answered the phone while saying to the child, "your piece of [expletive] junkie father is on the phone, come talk to him." This report was screened out because the information did not meet the threshold of suspected child abuse and/or neglect.

- July 2020 – The Department received a report from the child's medical provider that the child had not been seen for a well child checkup since September of 2019. There were no known health concerns. This report was screened out because the information did not meet the threshold of suspected child abuse and/or neglect.

- March 2021 – The Department received a report from Ms. Newbert's medical provider that she was pregnant but lacked organizational skills which could be a hinderance to adequately meeting the needs of a newborn. The provider reported Ms. Newbert was compliant with medication assisted treatment but unsuccessful attending counseling and keeping appointments. It was reported that Mr. Melvin had attended approximately three quarters of the prenatal appointments and the provider found him to be appropriate. The report was screened out because the information did not meet the threshold of suspected child abuse and/or neglect.

- July 2021 – The Department received a report from the hospital after Sylus' birth due to his exposure to his mother's prescribed Subutex. It was reported that Mr. Melvin was residing in the home. This report was opened for investigation. On July 30, the caseworker observed Sylus in the hospital and completed the Safe Sleep and Period of

Purple Crying assessments with both parents. On this same date, the caseworker also met with Ms. Newbert's mother at the home of Ms. Newbert and Mr. Melvin and during this visit noted that there was a safe sleep environment available for Sylus. During this visit, Ms. Newbert's mother reported: the parents were getting along better; she had no concerns about Mr. Melvin; and she had no concerns about domestic violence between the couple. Ms. Newbert and Mr. Melvin's oldest child was also observed during the caseworker's visit to the home on this date

During the investigation it was learned that Ms. Newbert and Mr. Melvin had been living together for a year. Mr. Melvin was seeing a peer support worker and case manager weekly. He was not taking any medication for mental health concerns but reported that his symptoms were managed. He reported that he wanted to reengage with therapy as he knew having a new baby would be stressful. He reported he had started medication assisted treatment approximately two months prior. The Department spoke with Mr. Melvin's providers who reported no concerns.

Law enforcement was contacted and reported their recent involvement with Mr. Melvin was a theft incident in May of 2021 and an incident where he had dropped a bag of heroin in a store in March of 2021.

Sylus was discharged from the hospital on August 10, 2021, with a referral to Public Health Nursing (PHN). PHN visited the home on August 11, 2021. During this visit, Ms. Newbert scored high on the depression scale. The PHN noted that the parents were having challenges and that Ms. Newbert thought she was providing all of the care for Sylus and that Mr. Melvin was not helping her. The PHN encouraged Ms. Newbert to work with her mother and Mr. Melvin to provide her support in caring for Sylus. During a standard PHN screening regarding domestic violence the PHN learned that Ms. Newbert and Mr. Melvin raise their voices during disagreements, but there was no indication of physical violence.

The Department called Ms. Newbert the following week to check-in with her and she reported she felt things were going well at that time. She indicated her mother was coming to the home often to help.

Sylus was monitored by providers following his discharge. On August 11, 2021, he was seen at his primary care provider with the provider having no concerns. PHN visited the home again on August 13, 2021, and noted no concerns. On August 19, 2021, Sylus was seen again by his primary care provider with no concerns reported. PHN visited the home on August 23, 2021, with no concerns documented.

Sylus was seen at the hospital on August 27, 2021, to follow-up on his neonatal anemia. Ms. Newbert was educated on signs and symptoms of worsening anemia and a plan was made to continue following this issue. It was noted during this visit that Sylus' anemia was severe but that he was doing well. No injuries or other concerns were noted.

The investigation remained open at the time of the August 29, 2021 report from Maine State Police which indicated that one-month old Sylus was deceased and there was possible bruising to his face. It was reported that Mr. Melvin was the last person to have contact with Sylus.

- The Department conducted an investigation in coordination with law enforcement.
- Mr. Melvin reported that he propped a bottle for Sylus while he went to the bathroom. He didn't know how long he was gone. When Mr. Melvin was confronted with evidence of Sylus' rib fractures, he was adamant that he didn't cause the injuries and stated that Ms. Newbert could have dropped Sylus. He also denied putting makeup on Sylus to cover a mark and stated that Ms. Newbert put makeup on the children.
- Ms. Newbert reported she had fed Sylus around 3:30-3:45 a.m. and fallen asleep. She reported that she awoke to the sound of the doorknob and saw Mr. Melvin going out the front door with Sylus. She stated that Mr. Melvin was saying something about trying to spit and that Sylus had choked on his bottle, and he was trying to get him to breathe.
- Sylus was pronounced dead by medical providers at 1:14 p.m. on August 29, 2021.
- Based on the information gathered during the investigation, the Department sought and was granted a preliminary protection order from the Court and Sylus' older sibling was placed in a licensed resource home.
- There is no documentation of a call or other contact from Ms. Newbert or any member of her family after August 20, 2021. During her interview with the Department after Sylus' death on August 29, Ms. Newbert did not mention a request for a home visit, nor did she report that she had attempted to contact the Department with no response. After Sylus' death, Ms. Newbert shared new information with the caseworker indicating that Mr. Melvin had threatened to "kill them all" prior to Sylus' discharge from the hospital and that he had assaulted her after the last phone call with the caseworker (on August 20). She had not disclosed this information to the caseworker prior to Sylus' death. This contributed to the court-approved petition for the older sibling to enter state custody following Sylus' death.
- The medical examiner ruled Sylus' death a homicide as a result of multiple blunt force trauma of multiple body segments with fractures of bones, lacerations of organs, and hemorrhage in the head and abdomen.
- Mr. Melvin was charged with depraved indifference murder on August 31, 2021.
- Based on its investigation, on October 18, 2021, the Department substantiated Mr. Melvin for physical abuse to both Sylus and Sylus' older sibling and substantiated Ms. Newbert for neglect to both children.

Appendix B. OPEGA's Methodology

To complete this review of the Sylus Melvin case, OPEGA staff collected and analyzed information from multiple sources. The Child Protection Division of the Office of the Attorney General (OAG) of the State of Maine provided CPS reports, investigations, narrative logs, medical records, and background check results associated with the family of Sylus Melvin from early June 2018 through the end of the year, 2021.

Additionally, OPEGA staff reviewed:

- the Department's Internal Briefing Memorandum produced on 8/30/2021;
- the DHHS Public Memorandum regarding the case that was published on 8/16/2023;
- the 9/8/2023 revision of the DHHS Public Memorandum; and
- the undated confidential report from the Maine Child Welfare Ombudsman to DHHS for the case of Sylus Melvin, including the Department's responses.

For our earlier work on child protective services, OPEGA had collected and examined relevant state statutes, agency rules, and various iterations of OCFS policies in order to document the framework within which OCFS delivers child protective services. We drew on this documentation to aid our interpretation of the CPS casework and court decisions in this case.

Based on the OCFS records, OPEGA created a timeline of each recorded CPS contact with the family of Sylus Melvin. We identified and discussed each significant decision-making point, and compared them to Maine statute, agency rules, and CPS policy to determine whether we understood the rationale for each decision made.

Interviews of OCFS Staff

OPEGA conducted interviews with the various CPS caseworkers and supervisors, as well as other members of CPS management with knowledge of the case. These individuals provided more insight into the reasons for their decisions and actions.

Public Statements

Additionally, public statements were made by persons involved with the case that, if true, would suggest a broader failure of the child protection system. As such OPEGA exercised due diligence to verify these allegations, if possible. Public statements were found in the following sources:

- "Rewind: Desiree Newbert 1645", George Hale – Rick Tyler Radio Program, 08/25/2023. (REWIND 08 25 Desiree Newbert 1645 | VOM (wvomfm.com))
- Allen, Emily. "Frustrated Mother Says State Failed to Protect her Baby", Portland Press Herald, 08/16/2023. Frustrated mother says state failed to protect her baby (pressherald.com)
- Clarke, Talia. "One-month-old killed by father in Milo, now DHHS shares interactions with family", WMTW News, 08/19/2023. One-month-old killed by father in Milo, now DHHS shares interactions with family (wmtw.com).

Physical Records

OPEGA obtained records from the Office of Attorney General's Criminal Division regarding the prosecution of the case which included:

- Maine State Police case logs and interview summaries;
- video recordings of Maine State Police interviews;
- Milo Police Department report on a "call for information";
- Milo Police body cam video;
- phone records from Ms. Newbert's and Mr. Melvin's cell phones;
- Facebook records (including Facebook Messenger) records from Mr. Melvin; and
- additional forensic records.

Additionally, the Child Protection Division of the OAG produced an investigative subpoena to obtain DHHS phone records for 17 Department phone numbers which included the 2 main telephone lines of the Bangor DHHS Office along with the caseworker, supervisor and the 14 other caseworkers and supervisors that were duty workers during the week Sylus' caseworker was on vacation. The Child Protection Division also provided the cell phone records of Sylus' caseworker.

OPEGA also reviewed the series of screenshots of texts and Facebook Messenger communications provided to the caseworker by Ms. Newbert on August 30, 2021.

Interviews

Interviews of eyewitnesses to various events within the life of Sylus included:

- Ms. Newbert;
- Ms. Newbert's mother;
- The Public Health Nurse who attended Sylus in the home.
- Two officers of the Milo Police Department.

Because the Public Health Nurse had moved on from her prior position, OPEGA also talked with the supervisor at the Bangor Public Health Nursing and Community Services, who could consult the medical chart for this case.

Lastly, OPEGA obtained and reviewed a recording of a phone communication between Ms. Newbert and the non-emergency number of the Piscataquis County Sheriff's dispatch center.

With this information from physical records and interviews, OPEGA staff reviewed the history of the cases, isolated specific safety decisions and actions and compared these to policy and the requirements of statute. OPEGA evaluated practice issues, the soundness of safety decisions, and potential opportunities for improvement. OPEGA also evaluated the veracity of public statements made regarding the case.

Appendix C. Timeline of the Fourth Investigation

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			28 Sylus is Born.	29 Report of Substance-Exposed Infant to OCFS	30 Assignment Activities Completion; Initial Interviews with the Family; Home Visit	31
1	2 Collateral Contacts and Provider Interviews	3	4	5	6	7
8	9	10 Sylus is Discharged from Hospital.	11 Sylus is seen by his PCP, no concerns noted. PHN makes her first home visit.	12 Caseworker speaks with PHN.	13 PHN's second home visit	14
15	16	17	18 No PHN visit, rescheduled for the 23rd	19 On Sep 2, Ms. Newbert tells State Police that Mr. Melvin assaulted her on this date. Ms. Newbert calls Piscataquis County Sheriff's Office for 41s at 5:40am. Sylus is seen by his PCP for a weight check, no concerns noted.	20 Caseworker calls Ms. Newbert to check in (tells her they are on vacation next week & how to reach supervisor).	21
22 Ms. Newbert's mother calls a Milo Police Officer at 11:28 PM.	23 PHN's third visit	24 On Sep 2, Ms. Newbert tells State Police she was assaulted on either Aug 24th or the 25th.	25	26	27 Sylus is seen at the Lafayette Center for neonatal anemia.	28
29 Sylus sustains injuries in early morning and dies in early afternoon.	30	31				

Black text = Information known to the caseworker.
Red text = Contacts with Law Enforcement.
Blue text = Information provided after August 29th.

Janet T. Mills
Governor

Sara Gagné-Holmes
Acting Commissioner

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September 13, 2024

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Dear Director Schleck,

Thank you for the opportunity to review and respond to OPEGA's Case File Review on the Sylus Melvin case. The Department of Health and Human Services (DHHS) and the Office of Child and Family Services (OCFS) thanks the staff of OPEGA for their thorough review and analysis of the records in this case. We have confidence in the objective nature of OPEGA's work and as such will not be responding to any of the factual information, as we have no concerns.

While OPEGA's report noted thorough child welfare work that met all policy standards during Sylus' life, we also appreciate that OPEGA's comprehensive review identified opportunities for improvement in the work conducted during the OCFS involvement with the family in 2018, prior to Sylus' birth in 2021. In the intervening years, OCFS has undertaken significant system improvements and appreciates OPEGA's acknowledgment of this work, which includes participating in the Casey Family Programs and Collaborative Safety review of several cases and implementing the recommendations of the subsequent report, as well as integrating many of the recommendations of the Citizen Review Panels and the Child Welfare Ombudsman, the Legislature and other stakeholders, and input from the larger Safety Science reviews of critical incidents, which is now embedded in the work of child protective services.

OPEGA noted two practice issues from 2018 in its report. One of the issues involved the process OCFS uses to make temporary arrangements to ensure child safety (known as Safety Planning), specifically, the decision to place Sylus' older sibling in a home without assessing the safety of the individuals in that home. We agree that this constituted a practice issue and over the last few years, OCFS partnered with the Catherine Cutler Institute at the University of Southern Maine to develop new policies and update the entire Child Welfare Policy Manual. Through this work we continue to improve policies and practices to reflect the challenges staff encounter when working with families. In addition (and as noted by OPEGA), OCFS has developed a Safety Planning Workgroup made up of a cross-section of child protective frontline staff, supervisors, and leadership to update, improve, and standardize guidance surrounding safety planning practices.

The other practice issue identified by OPEGA centered on the lack of efforts by OCFS to locate Sylus' older half-sibling during its involvements. Here too, we agree this constituted a lapse in expected practice. We appreciate OPEGA's acknowledgment of when this occurred, and the

system improvements that have strengthened practice in this area since, specifically the development and implementation of the Child Welfare Information System "Katahdin" and updates to the Child Welfare Policy Manual. The current policy requires that all critical case members (which would have included the half-sibling in this case) be included in the assessment at all phases of an involvement and that these relationships be captured in Katahdin. Katahdin provides better structure and accountability for staff in documenting these relationships than the system in place in 2018 required.

Recognizing the critical role that child protective supervisors play in ensuring frontline staff adhere to policy and practice expectations, OCFS has also developed a Supervisory Framework and Policy that aids in tracking completion of key required tasks.

The OPEGA report also notes three opportunities for improvement that do not reflect challenges in specific casework but instead focus on larger system improvement areas. The first of these is one that OCFS had already identified and addressed: the inclusion of staff directly involved with a family/investigation in the development of the Department's media memo regarding a critical incident. When available, staff who were directly involved are now asked to review each of these memoranda and provide edits, comments, and additional information.

OPEGA also highlighted the need for ongoing work to improve collaboration between law enforcement and child protective services. This need was also highlighted in the 2021 Casey Family Programs and Collaborative Safety report. Since then, OCFS established a workgroup, which includes representation from OCFS leadership, the Office of the Attorney General, and law enforcement and health care professionals. This workgroup spurred the introduction and passage of a bill introduced by DHHS and enacted as P.L. 2021, Ch. 146, *An Act to Improve Collaboration Between Mandatory Reporters and Law Enforcement in the Investigation of Alleged Child Abuse and Neglect.*

Recognizing the ongoing need for this work, OCFS has continued to develop new opportunities to improve communication and collaboration between partners in the child welfare and criminal justice systems. OCFS is also developing an updated "Cops and Caseworkers" training for child protective staff and law enforcement, one of the goals is to build relationships and communication pathways.

OPEGA also suggested maintaining call logs related to OCFS' involvement with families when there is a subsequent fatality. OCFS agrees that this could be helpful for evidentiary and case review purposes and employs reasonable efforts to ensure those records are available, should they be needed for these purposes. In this case, the issue of whether or not family members contacted the Department to express concern about Mr. Melvin prior to Sylus' death was not raised until years later and thus OCFS had not taken measures to preserve those records.

OPEGA's report also makes observations related to the ending of OCFS' involvement with the family prior to Sylus' birth, and upon the filing of a Parental Rights and Responsibilities Order in court pertaining to Sylus' older sibling. OPEGA rightly noted that there were multiple considerations that went into the development of this order, including the Guardian ad Litem's recommendation, the negotiations between the parties, the family's limited resources for

supervised visitation, and the efforts Ms. Newbert had made by that point to improve safety for her child. Unfortunately, eight days after the order was entered, as OPEGA observed, Ms. Newbert changed course and dismantled some of the protections that had been in place. This information was not known to the Department. OCFS appreciates OPEGA highlighting that the family had information related to domestic violence and substance use that was not shared with the Department prior to Sylus' death. We will never know how the outcome in this case might have been different had this information been reported to OCFS, yet this situation highlights one of the most difficult parts of child protective work – that decision-making is limited by the information available, or unavailable, at the time.

After a case is closed, and absent a new report or investigation, parents have the right to determine if they will provide updates or information to the Department. At times, families decide not to share information with the Department and the unfortunate outcome is that child protective staff are not fully equipped with all pieces of information that would be helpful when they are required to make decisions about child safety. This can also limit OCFS' ability to offer services and supports that may be beneficial. Frontline staff have noticed that families seem more reluctant to engage with them out of mistrust, which deprives them of information vital to their work. Anecdotally, this is attributed to the negative public discourse relating to the child welfare system. To turn the tide in this area, OCFS is continuing to collaborate with its state and community partners to bolster supportive services for families that are targeted at preventing the need for child protective involvement in the first place. Such initiatives include the Child Safety and Family Well-Being Plan and the Be There for ME website and resources, among others.

Any fatality involving a child is a tragedy and if that fatality occurs in a case where there has been OCFS involvement, it deeply impacts the staff and leadership of this Department. OCFS has dedicated significant resources to learning from cases like this one, where abuse and neglect by a parent is a primary cause of the child's death. These cases present an opportunity to look holistically at the child welfare system and identify areas for improvement, both within OCFS and the larger child welfare system in Maine. As demonstrated in OPEGA's report and this response, OCFS is committed to introspective work related to critical incidents as well as our strong partnership with the Child Welfare Ombudsman, the Citizen Review Panels, Collaborative Safety, and other stakeholders. These partnerships are stronger than ever and OCFS will continue to lean into every opportunity to strengthen the child welfare system and improve outcomes for Maine children and their families.

Regards,

Sara Gagné-Holmes
Acting Commissioner

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