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Michelle Ortega

My name is Michelle. I am the mother of my Gia Ortega. I am going to represent my case in front of everyone here today to hear the nightmare my daughter and I have been facing for the last two years.

In 2020, I decided to change my career during covid. I am an educated licensed Medicare broker whom decided to move my family to Maine to start a Bed and Breakfast with the intention to give my daughter a new adventure, to be able to provide for her and for her to experience the country side and farm animals. Our adventure did not turn out the way it was supposed to. I packed up our 3-bedroom house that I owned for 14 years into 4 U-Haul boxes and the rest went into a 16-foot trailer. We and our 3 dogs were driving across the country from Arizona to pursue this new life. No sooner that we were out of state, the trailer hit a bump in the road and we were jackknifed completely being pulled to the edge of a downward hill and we almost rolled over and died. Everything under the truck was damaged and the trailer was totaled. After days of trying to fix our truck to half par, I had to empty a full trailer into more U-Haul pods by myself. We had already been through a very traumatic situation and the stress was overwhelming. This accident was very terrifying for us and it extended our travel time. I had to give away our expensive trailer to the tow company for free and we had to keep going to make it to our new home. I tried to make the trip as enjoyable as possible but once we finally were able to get to Maine, we found out that the home I purchased was not going to close for a month. I had to scramble to find shelter for us and our dogs. We ended up living in a motorhome for a week and then in a hotel until out home was ready. Once we finally get into our home, we found out that all our U-Haul boxes we had been lost and shipped across to Washington State. We had no furniture, no dishes, no beds, nothing. As a single mom I did everything I could to do and went out and purchased a couch to have something to lay our heads down. It took weeks before we got our belongings.

I did everything that I thought was necessary to survive our move. Unfortunately, all of the stress unexpectedly caught up with me when the snow storm hit one night and the heating system broke, between that and the lack of sleep for three days, I thought I was having a heart attack. I called the police and I asked for help. Since I did not have family or friends here in Maine for support me, I agreed for the police to take care of my 6-year-old child so she can be safe and I can get an exam. But the Department involuntarily admitted me in a mental hospital for 10 days. I had a one-time medical emergency event in my life and I had a one-time event of medical emergency and had mental breakdown for the first time in my life.

I have never done any drugs. I am an outstanding citizen with no criminal history or even a speeding ticket. I am a church goer with Christian faith and I have always given back to my community one way or another.

I adopted my daughter at the age of 1 when her own biological parents beat the living crap out of her. Gia had cuts and bruises on her face and it was never proven who

actually hurt her but Gia stayed with me and I adopted her 1 year later. I did physical therapy with Gia as a baby to heal her from the trauma of abuse. Gia did not have overly excessive behaviors when she was in my care throughout the years.

When my daughter entered the system her medical records were up to date, she had never had a single cavity for all the years and she had a 3rd grade reading level. My daughter did not have a single bruise or bump on her body.

My daughter was assigned to Karen Gardner a clinical contracted therapist for PCHC medical. She diagnosed my daughter with PTSD, RAD, ADHD, High Anxiety, Defiant Deficient Disorder, a multiple of disorders including as a mentally unstable aggressive child. At the trial hearing this same therapist in the Judicial Court testified that my child's behaviors are not symptomatic to her diagnosis. Basically, that all the diagnoses are fabricated.

Since these diagnoses Gia has been prescribed a continued combination of 4 to 5 high large dosages of different medications of Risperdal, Sertraline, Guanfacine, Melatonin, and Ritalin on a daily basis for my child at age of 6 years old to 8 years old that has been diagnosed with illnesses she does not have for the past two years. The Department and the placement were able to get this therapist to stop my phone calls and visitations 4 months into reunification by saying it was up to a 6 year old to decide if she wants to have contact with her family without a court order.

From a very small note in the Discover share files, I learned two months after I was terminated of parental rights, Gia was also taken to the Emergency room again in June 2022 for extreme low blood pressure and low blood sugar causing severe hypoglycemia while on a combined medications and Zoloft. The Department has kept this as a secret and has never notified me and or provided records of my child in the hospital. There are no emergency room records that I have been located in the share file. The notes show my daughter was receiving finger pricks of blood sugar tests which the Department also kept this information away from me. It seems most evident since the file is hidden my child must have been at a risk of dying in the OCFS care. The Department is currently creating and twisting information in my appeal using fabricated mental health evaluations by saying my daughter was dysregulated when really there was medical overdose emergency visit to cover their tracks. The Department has continued a narrative that my daughter's behaviors are because of visitations. When you have a child that has been overdosed on medications that she is not supposed to be on, her brain is hard wired and will be in an explosive state. It's not her fault, all the medications have made her this way. She can't control it. Her brain is misfiring from all the drugs. Because these diagnoses were fabricated, medications were distributed by several doctors that didn't know it was fabricated.

This therapist also refused me family therapy, visitations with my daughter without a court order, refused my daughter from allowing me to a therapy sessions when my

daughter said she wanted to speak with me on multiple occasions, allowed the foster mom to attend in all the therapy sessions when there is supposed to be one on one patient confidentiality and allowed the foster mom to tell her about abuse allegations that never came from my child. She never allowed me to attend meetings regarding to understand behaviors and at one point PCHC refused to give medical records. The Department prevented me from letting me see my child medical records, attending any meetings, and attend any doctor's appointments.

Karen Gardner knew the foster placement intentions were to keep Gia from returning home and Karen never supported reunification. She also with the foster parents told Gia that she was adopted and that the placement was going to be her new parents 4 months into the reunification process.

My daughter was later assigned to a therapist named Wendy Davis a licensed clinical social worker. My attorney was able to get Wendy to testify that none of the abuse allegations came from my daughter because Gia would never open up or talk about anything during the therapy sessions. She also claimed that children have imaginations. All the abuse allegations that suddenly appeared within 8 months into the case came from only the placement and my attorney was able to make a case to squash those allegations.

The Department has participated and allowed the placement to write fabricated incident reports of Gia Ortegas behaviors when there was a threat that a visitation or reunification may start again as severe to keep Gia from reuniting. It was recently discovered conversations between my child's therapist, the caseworker and the placement in January 2022 that all of the incident reports prior to stopping my visits were all planned and I can prove it by showing the discovery. They were deliberately planned to keep me away from my daughter. There was a meeting between all three of them and per the notes the therapist said my daughter can decide if she wants to end the visitations and the foster mom said she didn't think my daughter could do that on her own so that night the placement wrote a false incident report with severe behaviors that included and said my daughter was ready to get this adoption over with. This was done 1 day before my daughter birthday when I was supposed to give her a presents and a cake. They cancelled my visit. They first said my daughter had Covid which I can show was negative and then turned and said no more visitations and filed for termination.

The Department have also hidden information of mental health evaluations they claim to have completed to keep Gia from having visitations with me including letters, phone calls, pictures, handmade gifts, Halloween costumes, not letting me see her Christmas and not letting me see her or say Happy Birthday. In December 2021 they placed my daughter in Arcadia Mental hospital. Even when the Department claimed my daughter behaviors supposedly had continued behaviors, they denied me my right to visitations and to parent my child.

Karen Gardner testimony showing she falsified medical records which contributed to parental alienation should be shown that once you have false unethical medical malpractice entries in the medical records to conspire with the Department to terminate my rights that her claims of child abuse should false as well. My daughter therapist is not credible and her testimony should be thrown out.

In May of 2022 I was supposed to get my visitations back because the State attorney Patrick Downey said he did not believe my daughters behaviors were because of the visitations and ordered for the Department to give me a visit. The Department scrambled and made the foster parents take my daughter to an emergency room to get a mental evaluation and tell them they were not looking to change her medications. The ER refused to do it and said there was nothing wrong with Gia and that she was just a child pushing buttons so the Caseworker put a note in the discovery that she called a supervisor and gave all the medical record information over the phone to a BCBS and that the doctor there agreed to do the evaluation. A BCBS is a Behavioral health specialist coach at my daughter's school to get that input in the discovery to stop any visitations. A behavioral school coach is not a licensed practitioner. It's a person that help a child in a school setting. This is a fabrication of an evaluation. The Department were creating sever behavioral incident reports from the placement and have manufactured circumstances and fabricated medical evaluations to parental alienate me from my child. Pediatrician medical records from Northern Light and notes from the caseworker hidden in the share files have shown that my child has no such illnesses.

I was only allowed to see her only allowed me a 1-hour before permanently stopping all visitations completely without a court order. I had only seen her 4 times in 2022.

By September 2022 the Department placed my child in Spring Harbor mental hospital for two weeks. She was fine apparently at Spring Harbor and they let her go back to the placement and from there she was a mess again.

The Department have created a narrative that my child's behavioral issues are due to visitations however I have been denied visitations for over a year and my daughter decompensated further. So, her behaviors are not because of me.

The department has threatened to place Gia into a residential mental health facility. In order for a child to enter into residential mental health facilities you must first establish a behavioral health diagnosis. To begin you have to establish mental health problems you must consult a contracted child therapist and then by transporting my child to the emergency room on several occasions and making statements "they are a danger to themselves and society", and requesting multiple evaluations before my child was allowed admissions to the hospital to await standby into Arcadia Mental Hospital. In this case Gia was admitted to emergency and then to inpatient hospital for weeks before a bed was available in Arcadia. I was never notified that my child was admitted in the hospital, was forbidden any say or input in regards to my child health, refused any medical records, refused any team medical meetings and was forbidden visitations

however the foster resource family was allowed to visit her everyday in the hospital during covid restrictions.

The Department has obtained referrals from all of her medical physicians, counselors, and the child's behavioral health specialists providers to refer her to a residential mental facilities to create sever mental health illness files to a court of law to unconstitutionally sever my parental rights when my child's medical records are completely fabricated and convinced a judge my child's behaviors are a directly associated with me and it was explained to a judge that my child will remain in a residential mental hospital up until she ages out. This has impacted my rights by having the Judicial Court recognize that my child's mental behaviors have been falsified and are a risk of reunification because it may be too much for any parent to handle or and the Department have went as far to convinced the court that I do not have the understanding or capability of caring for my child's needs without even given the opportunity or services to understand her behaviors and yet I have went the extra mile to take 60 credit hours of classes and became a behavioral health professional thru the DHHS without them knowing.

The Department has allowed severe physical and mental abuse in the placements care such as multiple dog bites to the face, bruises on her arms and bottom, burned fingers, The Department allowed the foster parent 3 months into the case told my child that they were going to adopt her when we were in reunification, participation in parental alienation, locking Gia in her room. The most recent discovery of abuse was discovered during trial. Do you know what the placement calls the bathroom. They call it the cool down room. The time out room. They have physically removed all the breakable glass from the bathroom and have carried my child upstairs in a tight hug or restraint of a two-person stability hold and placed my child fully dressed in cold showers screaming until submission more than one occurrence to control the behaviors and said in the report that they have used this in the past as a coping tool. They say she remained in the water for less than a minute. The placement helped my daughter then redressed and dried for bed. It's saying Gia insisted that she did not like the cold water and they talked about how quickly it had helped her calm down and what she might do next time instead then.

Now we know why my daughter is having behaviors have been excessive because she trying to get away from these people that have abused her. Per the reports my daughter says: "I'm leaving this house forever, "your scary evil mothers", "I'm going to run away from this place". She has been traumatized by the people that was supposed to keep her safe.

The foster parent is an elementary school teacher at Kent University for God's sake. Even she should know better. She knew my daughter was abused as a baby and yet she has done the same abuse on my child all over again.

Gia Ortega will never be able to go into a bathroom again without the continued trauma of the abuse she is currently getting from the Department.

My daughter's therapist Karen Gardner also testified she did not know how to help Gia because Gia further decompensated especially when visitations were removed. Well now I know why. Now we know why my daughter has been trying to get away from them and fight back.

In Accordance with 22 M.R.S §7802 Corporal punishment means physical actions harmful to a child's body, including, but not limited to, the following of spraying with water as a means of controlling behaviors is an aggressive form of contact harmful to a child's body and mental state of mind.

I have emailed The Department Director Todd Landry on several occasions who had full knowledge of the abuse has allowed his employees to continue with the violations of policies. The Department Supervisors Rebecca Richardson, Kelsey Libby Kaplan, Kaitlyn El=Hajj, Kristen Sanderson, and Elizabeth McGrath, to continue to violate policy. The GAL and the Asst Attorney General Patrick Downey told the judge that the abuse is not what it looks like and that maybe if he read the incident reports that he may have another flavor to what is really happening. When you have a Judicial Court ignore the abuse presented in placements care and in turn say my child was bonded with the resource family, give permission for adoption and say the child may need other mental health treatments or residential mental health facilities then you reveal a problem.

If everything is so peachy keen with the foster placement, why the ice baths and her still freaking out. I did not make my daughter into a nut job. She wasn't this way before coming into the system. They put her in two mental institutions.

The Guardian Enlighten who is supposed to be the child's attorney and a mandated reporter needs to be disbarred for the knowledge and abuse in placement care for the knowledge of corporal punishment of cold showers. She is also known of the medical fabrications. She is supposed to make sure Gia Ortega has safe care in the Departments custody and she contributed to continuous abuse and severe mental health to illegally sever my rights as her parent. She continued that the Foster family should adopt my child even though they have abused her. She protected the foster placement from the abuse that has actually occurred to my daughter.

Also, when you have the OCFS and The Ombudsman which are intertwined working together you find out some information that is very disturbing. I reached out to Ombudsman to investigate because I can't find the help for mt child safety in the system.

After reporting the abuse to Ombudsman, the reply by email from Christine Alberi of the Ombudsman said, "she does not take these reports that a child is unsafe in the foster home when a judge makes his orders for termination of my rights. The judge in this case clearly did not find the arguments of abuse being placed in the foster home persuasive enough to represent opposite views of the same situation. Christine said, 'in this case it sounded like the foster parents are struggling to manage the child's

behaviors and reported these incidents appropriately to their caseworker". There right there is proof of a complete failure to recognize abuse.

The Department have been violating my constitutional rights by having contracted psychologists John Hale to change the results of a CODE mental health evaluation the night before the trial hearing to change and favor the outcome to terminate my parental rights. Dr. Hale is forensic psychologist, licensed alcohol and drug counselor and certified clinical supervisor. He is a contracted psychologist for the Department. He conducted a code evaluation for me in December 2022 and authored a report on the same date then 11 months later on day trial changed report. A CODE evaluation is a parental capacity evaluation. His original report was entered into State's evidence. After 11 months of no contact with me at the time of the hearing without any warning to my attorney, the Department submitted a new report generated by Dr. Hale on the day of the hearting reporting that he made significant errors in his report by reversing his findings on several parts of the report and he never issued an amended report as he said he just noticed the discrepancies prior to testifying at the trial.

The Department argument stated that I did not address their mental health issues by not attending a therapy specific to the CODE evaluation. The Department never provided the services to me so I continued with my own professional therapist for 2 years. I was able to show the prior diagnosis was an incorrect that I was just under a tremendous amount of stress and lack of sleep and both of my clinical physicians testified that the diagnoses evaluation of me did not match his report.

Dr. Hale, for him to change the results of his report after he hasn't seen me for 11 months is medical malpractice to conspire to help the department to change the results to terminate my parental rights. His report and or testimony needs to be thrown out and his actions should technically be unethical and medically a crime and his license needs to be revoked.

I am a loving and caring mom that lost her daughter at the expense of medical malpractice fabrications. I have falsely been falsely accused of severe high abuse and yet if they had proof which they don't I would be in jail. I have concerns that I am also been being blamed for abuse that Gia's biological family has done to her. It's not ok to accuse me of abuse that never occurred and it's not ok to abuse and to medically damage my daughter in the system.

There is insufficient evidence in the record to support the court's finding of my unfitness when the court found that I had complied with all requirements of reunification and had also completed additional services on my own accord after having a singular mental health crisis. My constitutional right to parent my child was violated by the Department when they continually restricted my contact with my child and my child's service providers. I was never able to demonstrate my ability to parent my child due to the Department's actions and restrictions. I have been defamation of character and my religious rights of being of Christian faith has been used against me.

The State of Maine needs to recognize that the Department has performed Medical Malpractice abuse, physical, mental and corporal abuse of my beautiful child in the State care. They have parental alienated me, prevented me to parent my child, prevented me from reunification and have illegally terminate my parental rights in November 2022 by using the medical environment and by creating the lie to a State Court. The department has used abuse in so many ways and they have committed illegal acts of fraud on my case.

The Department is basically killing Gia. With all the medications Gia Ortega is consuming currently, she will deuterate and is suffer from real actual physical, mental and emotional illness under the Departments care where she wasn't prior to entering into the system.

My voice matters and I am not scared anymore to fight for what I want.

Gia is the center of my world and she is worth fighting for. Me and my daughters' rights are being trampled on. I am being railroaded by the State. My daughter is being medically abused and trafficked.

One person can change a lot. And if we can all come together, we can create a ripple of positive changes. I am here because the doors keep getting shut. We are not listening to each other right now, it's so loud and so gross and angry and people are being forgotten and being counted out.

No one is listening. No one is listening to parents especially when the Department are medicating their children for diagnoses that my child never had. Parents have no say when their children are on a near death for medications that they are not supposed to be on especially do to side of effect of severe low blood sugar and low blood pressure. Parents and children in the child protective system have no say when the Department is categorizing their children as mentally unstable and they're not. Me and child have no say to say stop the abuse the OCFS is doing in order to unconstitutionally terminate the parental rights on the basis of using medical mental health environment of my children when it's a full out lie. People have no say when children in the system are dying. The Department is violating our rights to due process because they don't even follow their own policies.

Technically, falsifying medical records to terminate my rights is a crime which involves **altering, changing, or modifying a document for the purpose of deceiving another person**. Falsifying medical records is not necessarily grounds for a medical malpractice lawsuit, but may be grounds for an independent civil action for fraudulent concealment or spoliation of evidence.

There is no judicial immunity anymore since the supreme court in 2020 decided in that Government officials need to now be held accountable for their actions. I am asking for arrests for all that participated medical and corporal punishment abuse of my child

including foster placement Abbey Recker and Caroline Zeigler.   The Department cannot hide anymore from their lies

I want my daughter to be taken out of the foster home immediately and start the reunification like it was supposed to be so we can heal as a family and I can get her the help she deserves. Today I am going to have absolute conviction that I am doing everything and more to help my daughter to come home.

I am asking all the people in this room to support me and my fight to get my daughter home.

Melanie Blair 5 Old Meadow Road Lisbon, Maine

Foster Parent, Maine State Parent Ambassador, Educator, Behavior Technician, Advocate for child safety

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The Honorable members of The Government Oversight Committee;

Thank you for the opportunity to testify before you today. As a concerned citizen of Maine, an invested parent to many, some long-term-some short, I am concerned about the decisions made regarding the safety of Haley Goding which led to her untimely death as well as concerns relating to the Opega analysis of the file that the department submitted on this case. While I do feel the department did a lot of good work on this case and seemed to follow basic procedure, we are still left with a deceased child. Thus, a different decision at some point could have saved her. Understandably though, outcome bias cannot soley be used, but true growth and meaningful change cannot occur void of the acceptance of responsibility and some level of ownership for wrong decisions made.

The initial decision to open an ARP case, an incomplete investigation of collateral contacts, and Hillary evades the department:

Despite a lengthy history of drug use and mental health issues, as well as substances present during Haleys birth, a decision was made during the playground incident with Haley to open an ARP case, which I am told was intended to be used for lower risk cases that did not need as many eyes on or follow up. I believe the decision to use ARP was a mistake. Other options were available that would have been appropriate while not taking full custody of Haley based on the following information I have discovered:

*Several complaints were made regarding Hillary Godings unstable behavior, drug use, and exposing her daughter to unsafe situations. Most of which were not followed up on or investigated. Extensive Collateral contacts were not consulted.

* Hillary testing negative for substances 3 times following the playground incident. This should raise red flags for anyone to think 3 tests in such a brief time is sufficient to assure that there is not a substance abuse problem. Anyone who knows even a little about substance abuse knows that is NOT a good decision. Also, collateral contacts would have shared pertinent information had they been spoken to. Hillary had a lengthy history of manipulating behavior to cover up her drug use. This should have resulted in longer monitoring in a full-service case.

*Hillary refuses to meet with and evades the department. This is a huge concern and a common problem in cases the department needs legislative help to alleviate. Evading the department when you have had a prior department case SHOULD be considered an aggravating factor in which a judge can order that the parent be found by law enforcement and brought in.

Opega's review process and recommendations:

I have profound respect for the tremendous effort and timely diligence that Opega is doing. I would however ask the committee to consider the following for future case reviews:

When reviewing a case like this, I believe it is an injustice to the deceased to only review the files that the department provides. In listening to the director's analysis, I did not hear that Opega staff made collateral contacts and interviews themselves. Or if they did, WHO did they interview? This could provide more details to review and consider, especially since it has been disclosed to me that calls were made to the department regarding Ms. Goding that were not returned or acted upon. Therefore, that information, which could be extremely helpful, would naturally not be in their files.

Regarding Suggestion 1:

- Specific training is needed for caseworkers to recognize characteristics of substance abuse in order that they do not become a victim of their manipulation. Caseworkers straight out of college and many others do not have lived experience. Training should be live, experiential training in detail before going on a call like this.

Regarding Suggestion 2:

* Ensuring services are provided and available. Services are definitely needed and important but should not be an end all be all as it often is portrayed. As I stated in a testimony last year, In the review published of the child deaths between 2007 and mid 2021, approximately

70 % of those cases had previous or were currently receiving services from the department. Preventive and proactive services are not enough and are often the only statements made when a tragedy like this occurs. A person who has demonstrated a history of struggling with mental health or substance abuse issues needs more than a quick 35-day fix with three negative drug tests. Regular and long-term follow-up is crucial as well as creating a strong support system. If services fail, and the department does not act diligently, tragedies like this will keep happening.

As a mom, an educator, and a rec basketball coach, I would be doing my kids a great injustice to not teach them to reflect on choices they make that have unintended negative consequences. More success, growth and learning are gained when you can recognize, reflect on, and admit to wrong doings even when they are unintentional. A state bureaucracy should not be exempt from doing this. If anything, I would say a little ownership and accountability would go a long way with the citizens of Maine.

TINY TIKES DAYCARE

The Great Deflection

The predictive risk was apparent form birth when Hailey Going entered this world while her mother tested positive for Marijuana and Oxycodone on January 29, 2018. After this call was made to the department five more separate calls were made with concerns about Hilary and for Hailey's safety over the course of 3 years and nothing was done except for short term safety plans when there was high risk of something happening to this child.

The lies from Hilary Goding were continuous throughout this case. She stated when Hailey was born that she took one Percocet from an old prescription but denied any other usage. Just a few short months later in September after a call was made to the department after Hilary left a five year old on the beach she reported that she had not used since she was fifteen. That statement in itself shows that Hilary story was not consistent and warranted a second look.

Making a report to DHHS is on of the hardest things a mandated reporter has to do. There is a enormous amount of mental anguish that goes along with making a report. First as a mandated reporter you are worried if you are making the right call. Then after the call is made you wonder if there will be an back leash or if there will be any follow through will your call at all. Thirdly one of the worst things is wondering if the child is in more danger because a call can infuriate the abuser Personally, this is something that keeps me up at night wondering if there was more I could have done. I am sure this is something that the individuals that called about Hailey Goding feel everyday as well.

TINY TIKES DAYCARE

Please see the following list of misconduct by our licensor... and I do have a separate timeline for each of these offenses:

1. **Abuse of Authority during State of Emergency**

The OCFS/DHHS Licensing Agency abused its authority by overstepping Governor Janet Mills State of Emergency provisions. In March 2020 Janet Mills enacted the State of Emergency allowing child care providers to operate over capacity which was inevitably extended to September 30, 2021. On July 21, 2021 I was written up for over capacity (although, I followed procedure by being previously approved by my licensing specialist) and was unfairly forced to return to my pre-COVID capacity. This was a direct insubordination by OCFS/DHHS and cost thousands in financial damages to my program.

2. **Mandated Reporters are Ignored + Retaliated Against**

I am the only mandated reporter to receive a violation for reporting suspected child endangerment in Maine (as well as the nation per my independent investigation). Mandated reporters are being ignored and retaliated against. My personal experience of being disregarded by OCFS/DHHS has led to children in my care being seriously injured, hospitalized, and even one death in March of 2022. To receive a violation for an "incomplete incident report" after calling 3 separate times for a particular child in my program being endangered has been mentally anguishing.

3. **Intentional Misrepresentation and Defamation**

The department has willfully posted inaccurate information regarding my childcare program on the public state run website childcarechoices.me causing intentional misrepresentation and defamation. Before completion of an investigation, the department changed my license status from "compliant" to "noncompliant," which has not been done to any other program. In March of 2021 my program had zero licensing violations found during an inspection, again in June of 2021 my licensing specialist visited 2 separate times and also found zero licensing violations, yet 18 days later when a new investigator came for a false CPS report a full 17 pages worth of

violations was issued. Notably, my licensing specialist resigned within 24 hours after I sent a letter to refute these 17 pages of inaccurate violations.

4. **Mishandling of Federal Funds**

DHHS does not accurately pay its' licensees the proper payment for providing services for childcare. I have documentation showing the more I raised concerns regarding the state's lack of security measures and child safety issues, the more my program's federal funding became jeopardized with slower and lower compensation for our subsidized low income and foster children. I have filed a constituent service inquiry and contacted the government's Children's Cabinet (Ana Hicks, Senior Policy Analyst and Children's Cabinet Coordinator, Governor's Office of Policy Innovation and the Future) only to have OCFS/DHHS refuse to research the problem. DHHS also refuses to review its own records or work performance to help licensees get paid properly. Daycare provider's pockets are easy to pick... instead of blatant robbery, DHHS does this through "paperwork errors."

5. **Investigation Incompetence/Obstruction**

DHHS caseworkers have consistently shown to be incompetent and resistant to a fair and impartial investigation. I was able to document each of these:

- impartiality did not exist
- incomplete questioning
- incomplete documentation
- intentional omission of evidence and statements
- inaccuracy of reporting
- intimidation by investigators
- inappropriate conduct
- intentionally accepting tainted evidence.

6. **Insurance Fraud by DHHS**

TINY TIKES DAYCARE

Last, but certainly not least, I witnessed and documented insurance fraud by DHHS. An OOHI caseworker, Pam Sennett, and Dr. Ricci, who is subcontracted by DHHS, charged my insurance company for x-rays that were previously found not needed by a physician not associated with DHHS. Despite ordering these frivolous and expensive x-rays 69 days after the alleged event, neither Pam Sennett nor Dr. Ricci ever laid eyes on the child in question. It is a deceptive tactic used by DHHS in order to discredit the integrity of people, like myself, that raise concerns.

Due to the abundance of documentation and diligence I can show the direct reckless conduct of individuals in the OCFS that are responsible for the damages caused to my business, my staff, children and families enrolled at Tiny Tikes Daycare, and the community that my child care program serves.

Testimony of Melissa Hackett
Maine Children's Alliance and Maine Child Welfare Action Network
Before the Government Oversight Committee
Public Comment, Hailey Goding Report
March 9, 2023

Senator Hickman, Representative Fay, and esteemed members of the Government Oversight Committee. My name is Melissa Hackett. I am a policy associate with the Maine Children's Alliance, a nonprofit, state public policy organization. I also serve as the coordinator for the Maine Child Welfare Action Network, a group of organizations and individuals in Maine working together to align, strengthen, and sustain efforts to ensure the safety and well-being of all Maine families.

We all want children in our state to grow up in safe and supportive environments. The loss of any child is a tragedy for their families, for our communities, and for our state. We appreciate the work of this committee and OPEGA, in coordination with the state, to ensure we are doing all that we can to support the child welfare agency's ability to be effective in providing safety for children and support for families in crisis.

This OPEGA report references the opportunity to "improve service availability and to enhance OCFS's ability to ensure recommended services are provided." In this case, as in many other instances, a parent was referred for needed supportive services to address concerns to child safety and parental stability. Yet often, services are unavailable or have long wait lists.

As noted in the report, "part of OCFS's larger charge is the preservation and rehabilitation of families—the success of which may depend heavily on a family's participation in services to improve family functioning and mitigate risks to children... However, from our work on this case and other child protective services reviews, we understand that there is a pronounced lack of available services that may vary based on the geographic location or the specific type of service sought. To the extent that these services may improve family functioning and reduce future risk to children, increasing the availability of needed services... presents a potential opportunity for improvement in the broader child protective system."

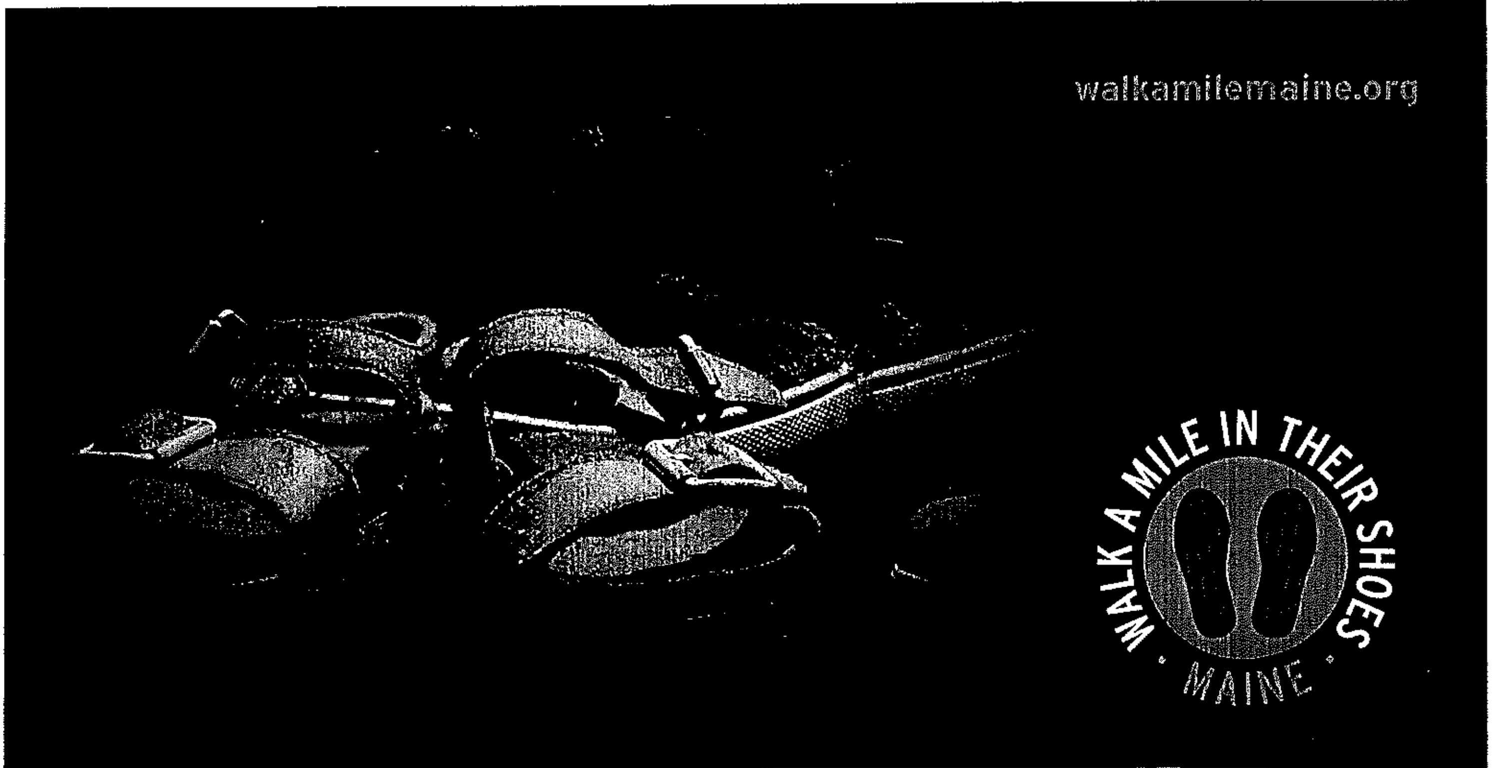
We strongly support this recommendation and appreciate the Department's response that acknowledges this need, including their reference to initiatives in the Governor's budget designed to provide significant and needed investment to bolster the state's behavioral health system. This funding is critical to improving parent access to services to address challenges that impact child safety.

As this case and report focused on the issue of substance use disorder and its impact on child safety, we would also urge the committee to consider the role of stigma, particularly as it relates to substance use disorder and parenting or pregnant mothers seeking treatment. We know that stigma and fear prevent women from seeking help that could provide them with the resources, support, and services necessary to engage in treatment and recovery for substance use disorder. Many women who seek help are able to successfully engage in treatment and recovery, so they can safely parent their children. Our public discussion of this issue, and our state policies and practices with parents experiencing the challenge of substance use disorder, should reflect our recognition of the roles of fear and stigma, particularly for pregnant or parenting mothers, to ensure services are promoted and provided in ways that reduce

stigma and promote support. As it relates particularly to newborns exposed to substances, we would encourage the committee to seek out experts in this field in our state who could share best practice on this issue.

We all care deeply about the safety and wellbeing of children. Any efforts to respond to tragedy must consider, and then look beyond any particular case, to systemic issues and challenges. This should include policy and funding solutions to ensure state services are available for parents to access when they are experiencing challenges. Preventing future tragedies starts with reducing child abuse and neglect, and that starts by in investing in families with children.

We encourage the committee to continue to explore and support ways to improve the way our child welfare system supports the Maine children, youth, and families it is meant to serve. This should include the role of government in our efforts to prevent child maltreatment, in interventions to support families experiencing challenges, and in ensuring the state child protective agency is working effectively to keep children safe. Thank you.



Dedicated to the Children in the State of Maine's Care

Walk a Mile in Their Shoes is a nonprofit corporation registered in the State of Maine. We are guided by a Board of Advisors consisting of experts in the field of child protection, state government agencies and child welfare.

Our mission and purpose are the prevention of child homicides and the abuse of children who are under the supervision or care of the State of Maine or who are or have been associated with the state Child Protection System in any manner.

Senator Bill Diamond, founder of **Walk a Mile in Their Shoes**, will focus on initiating in-depth research on child welfare, holding public forums to promote wide-ranging discussions by experts in the field of child protection, and creating public awareness pertaining to the ongoing problems within the Office of Child and Family Services (OCFS) under the jurisdiction of the Maine Department of Health and Human Services (DHHS).

Our nonprofit will reach out to all interested people and groups who want to join us in our efforts to protect vulnerable children in Maine. We seek advice and support from all; especially those who are subject to State rules and regulations and work directly with OCFS on a regular basis such as foster care parents, child care professionals, adopters and others.

We acknowledge that within the OCFS there are many sincere people who continue to dedicate themselves to the well-being of children under their supervision.

Advisory Board

Governor John Baldacci
Served four terms in US House of Representatives and two 4-year terms as Governor State of Maine. Former adviser and consultant to Pierce Atwood law firm. Bangor native former small business owner.

Lou Ann Clifford
Long time attorney and former Maine Assistant Attorney General assigned to the Department of Health and Human Services/Office of Child and Family Services. Resides in Carrabassett Valley.

Senator Michael Carpenter
Former member Maine House of Representatives, Maine State Senate and Maine Attorney General. He is currently a guardian ad litem, Houlton native, and small business owner.

Michael Petit
Former commissioner Maine Department of Health and Human services. Served as a consultant to various states focusing on child welfare problems. Resides in Portland.

Senator Joyce Maker
Served three terms in the Maine House of Representatives and one term in the Maine Senate. Served on the Education and Cultural Affairs Committee. Resides in Calais.

walkamilemaine.org

Janet T. Mills
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Jeanne M. Lambrew, Ph.D.
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January 25, 2023

Office of Program Evaluation and Government Accountability
82 State House Station
Room 104, Cross State Office Building
Augusta, ME 04333-082

Dear Director Schleck,

Thank you for the opportunity to review and respond to OPEGA's Case File Review on the Hailey Goding case. The Department of Health and Human Services (DHHS) and the Office of Child and Family Services (OCFS) would like to thank 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 in this review and upcoming case file reviews unless there is disagreement with the characterization or representation of any of the facts of the case. In this case, we have no concerns with the factual information.

DHHS and OCFS appreciate the opportunity to respond to the section "Potential Opportunities for Improvement" in the report. The number of overdoses and prevalence of substance use, particularly opioids, has a significant impact on children and families. In response, OCFS is providing additional training for staff regarding the impact of substance use on families and strategies to address the concerns that substance use disorder often creates related to child safety and well-being. OCFS has developed and implemented the first of three planned mandatory child welfare staff trainings on these topics. OCFS plans to complete implementation of the remaining two trainings in 2023 in partnership with the Maine Drug Enforcement Agency and the Northern New England Poison Center. OCFS has also partnered with the Maine CDC to ensure lock boxes for safe storage of substances and other items that may be dangerous to children are available to staff in each District office for distribution to families.

OCFS agrees with OPEGA's recommendation to improve the resources available to staff for substance-use related questions. As such, OCFS is considering how best to establish resources in the District Offices to aid field staff in understanding and addressing both the nuances of substance use disorder and the treatment options available in different geographic regions of the state.

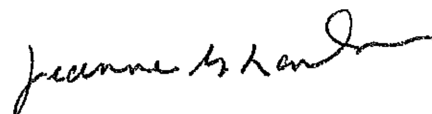
In cases of child fatalities due to child abuse or neglect, OCFS has specific procedures in place to review past history with the family and develop opportunities to improve practice, training, etc. In this case, part of that work included outreach to the Northern New England Poison Center regarding the likelihood that dermal exposure to fentanyl could result in testing positive on a

drug screen. The Center informed OCFS that, in general, an individual would not test positive due to dermal exposure only. However, a positive test is possible if the substance was transferred (for example, if an individual touched the substance and then put their fingers in their mouth). This information will be incorporated into future training for staff.

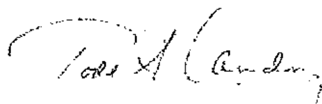
OCFS also agrees with OPEGA's recommendation regarding services. Service availability is a common challenge across multiple human services systems in both Maine and nationally, which is why the Department has advanced multiple funding initiatives to address the state's behavioral health needs in the Governor's proposed budget. These initiatives include $213 million to continue increased MaineCare reimbursement rates based on rate studies conducted in 2022 and payments to behavioral health providers for cost-of-living adjustments due to higher-than-expected inflation, as well as $17 million to expand the range of behavioral health services available to children and families, and $7 million dedicated to addressing substance use (in addition to Maine's $28 million in opioid litigation settlement funds). These funding initiatives build upon MaineCare's new rate system reform process developed and implemented in 2022.

Any fatality involving a child is a tragedy. OCFS has dedicated significant resources to learning from cases, like this one, where abuse or 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. OCFS' ongoing efforts include policy and training improvements (part of the Cooperative Agreement with USM), implementation of the Safety Science approach to critical incident reviews which seeks to identify opportunities for system improvement while avoiding hindsight bias, and reviews by the Child Death and Serious Injury Review Panel (CDSIRP) and Domestic Violence Homicide Review Panel (where appropriate).

Regards,



Jeanne M. Lambrew, Ph.D.
Commissioner



Todd A. Landry, Ed.D.
Director, Office of Child and Family Services