OPEGA

Information Brief

Purpose

On March 9, 2018, the Government Oversight Committee (GOC) directed OPEGA to determine the facts surrounding the handling and response to potential child abuse and neglect reports received by DHHS in the cases of Marissa Kennedy and Kendall Chick. This fact finding is the initial phase of a broader review of Maine's child protection system. The request for review of the system and these cases was submitted by the House Chair for the Joint Standing Committee on Health and Human Services.

OPEGA reviewed and analyzed records of entities involved with the two children. We also reviewed statutes, rules, policies and procedures, and obtained additional information through interviews.

Federal and State confidentiality laws prevent OPEGA from reporting detailed information on these two children. Consequently, this Brief includes only a high level summary of OPEGA's observations from the two cases, the role of DHHS and mandated reporters in protecting children, and potential areas for concern or improvement. Results of this review will inform the scope of the broader review.

OPEGA appreciates the considerable and timely cooperation we received from all entities. We also greatly appreciate the substantial assistance provided by staff in the Attorney General's Office in their advisory capacity on confidential information.

May 2018

RR-CPS-18

Maine's Child Protection System:

A Study of How the System Functioned in Two Cases of Child Death by Abuse in the Home

Summary

Maine's child protection system relies on a network of parties that interact with children and families to communicate information to the Department of Health and Human Services' Office of Child and Family Services (OCFS). This information serves to help identify child abuse/neglect risks that warrant the agency's involvement and inform the assessments, decisions and actions that occur in response to those risks.

Through our review of the cases of Kendall Chick and Marissa Kennedy, we were able to observe the important role those who may interact with children and families have in the system. In general, any number of parties may interact with children and/or families and be in a position to observe and report risks. These parties may include schools, local police departments, hospitals, medical providers, and other social service providers. The statutory responsibility for the protection of children, however, rests with DHHS, and, as such, this information brief focuses on DHHS' role and its contracted agents.

OPEGA's specific charge for this review was to examine how the child protection system functioned in the cases of these two children. We observed that these cases are nearly on opposite ends of the spectrum in terms of interactions with mandated reporters and other individuals that had opportunities to observe what was going on in their young lives. The two cases also differ substantially with regard to specific areas within the child protection system where there may have been missed opportunities to better protect them from harm.

There are two things, however, that both cases have in common. First, both children died from physical abuse believed to be occurring over some period of time in the two-adult home where they resided. Second, it seems that on the few occasions when individuals from outside the household observed actual physical marks that might indicate physical child abuse, one or both of the adults explained them as injuries the children themselves were responsible for causing. Observers appear to have found these explanations reasonable at those times given what they knew of the child and family.

To date, OPEGA's examination of these two cases has consisted primarily of reviewing and analyzing detailed information from numerous records obtained from multiple entities involved with these children or their families. Entities we sought records from included DHHS, Maine State Police, relevant municipal and county law enforcement, relevant local school districts and the Department of Education inclusive of Child Development Services. Information we received included records from health care and other service providers. We also reviewed at a high level the relevant statutes and rules, as well as policies and procedures we requested from several entities. Lastly, we gathered as much additional information through follow-up questions and interviews as the timeframe for our review allowed.

OPEGA cannot publicly share many details about these two cases at this time. This is primarily due to the federal and Maine State laws that govern the confidentiality of health, education and child protective records. The ongoing criminal investigations, related court proceedings and protecting rights of individuals to a fair trial are also considerations. Some details we are unable to share at this time may come out

through those proceedings. We note, however, that knowing some but not all of details could easily lead to inaccurate perspectives and conclusions about what worked, and what did not, in the child protection system.

OPEGA's overall observations about how the system functioned in these two cases and missed opportunities that may have better protected these children are as follows:

- In one case, we observed OCFS failed to follow policies and procedures in fully assessing the appropriateness of the placement and staying engaged with the child and family to ensure needed services and supports were provided. Poor job performance and inadequate supervision appear to have been factors.

- In one case, we observed that the risk of child abuse/neglect, particularly risk of physical abuse, was not necessarily evident without continually putting together many pieces of information held by various parties interacting with the child and/or her parents over time. We noted there was much information sharing occurring within the child protection system initiated primarily by certain mandated reporters. We also noted several junctures, particularly in the last two months of this child's life, where greater information sharing among several parties might have prompted further action or reassessment of the risk level for the family. Periodic reassessments of the whole body of information known about the family might also have prompted different approaches to addressing the risks identified. There are, however, no guarantees that further actions or different approaches would definitely have been taken. We observed overall that there was no lack of individuals from various entities persistently trying to assist the family and make a difference in their lives.

We believe we have gleaned a decent understanding of what occurred, and what did not, with regard to roles various entities played in these children's cases. We are, however, still lacking a full understanding of the context from their various perspectives, particularly around what factors impacted their decisions and actions. Additionally, we have not yet completed assessing whether the responses, decisions and actions by OCFS or any other entity were consistent with statute and rules, and the policies, procedures and training specific to those entities.

Consequently, we are unable to say yet, with any certainty, whether potential areas for concern or improvement we have noted might have changed the outcomes for these children. In reality, we may never know that for sure. Nonetheless, we have identified potential areas of concern or improvement in the child protective system that seem worth exploring further toward the goal of better protecting children in the future.

Relevant Statutes and Rules

The Child and Family Protection Act in Title 22 Chapter 1071 is the principal statute that governs child protection activities of the Department of Health and Human Services (DHHS or the Department). It directs the Department to establish rules regarding child protection. Department Rules Chapter 201 covers procedures for the receipt, investigation, and management of child protection cases.

DHHS Authority

Statute authorizes DHHS to protect and assist abused and neglected children, children in circumstances that present a substantial risk of abuse and neglect, and their families. Statute provides that children will be taken from the custody of their parents only where failure to do so would jeopardize their health or welfare. Family rehabilitation and reunification is statutorily established as a priority when it does not needlessly delay permanent plans for children. Children who are taken from the custody of their parents are to be placed with an adult relative when possible. Those children who cannot be returned to their families are to have established permanency plans early on. The legislative intent is to reduce the number of children in foster care.

Title 22 § 4003. Purposes (excerpted)

Recognizing that the health and safety of children must be of paramount concern and that the right to family integrity is limited by the right of children to be protected from abuse and neglect and recognizing also that uncertainty and instability are possible in extended foster home or institutional living, it is the intent of the Legislature that this chapter:

1. Authorization. Authorize the department to protect and assist abused and neglected children, children in circumstances which present a substantial risk of abuse and neglect, and their families;

2. Removal from parental custody. Provide that children will be taken from the custody of their parents only where failure to do so would jeopardize their health or welfare;

3. Reunification as a priority. Give family rehabilitation and reunification priority as a means for protecting the welfare of children, but prevent needless delay for permanent plans for children when rehabilitation and reunification is not possible;

3-A. Kinship placement. Place children who are taken from the custody of their parents with an adult relative when possible;

4. Permanent plans for care and custody. Promote the early establishment of permanent plans for the care and custody of children who cannot be returned to their family. It is the intent of the Legislature that the department reduce the number of children receiving assistance under the United States Social Security Act, Title IV-E, who have been in foster care more than 24 months, by 10% each year beginning with the federal fiscal year that starts on October 1, 1983; .....

Mandated Reporting

The Child and Family Protection Act statute also establishes roles and responsibilities for reporting suspected or known child abuse, neglect, or suspicious death. Specified professionals are directed to immediately report to the Department when they know, or have reasonable cause to suspect, that a child has been or is likely to be abused or neglected. The mandated reporters specified in statute include, but are not limited to, certain medical professionals, certain school personnel, social service workers, law enforcement officials, and mental health professionals. Mandated reporters must complete training approved by the Department at least once every four years.

"Abuse or neglect" means a threat to a child's health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these or failure to ensure compliance with school attendance requirements."
Source: –22 M.R.S. § 4002, sub-§ 1.

DHHS' Mandated Reporting training materials defines the types of abuse/neglect as:

Physical abuse	Abusive treatment to a child that caused or is likely to cause physical injury.
Sexual abuse	A person who engaged in sexual contact with a child, or forces a child to have sexual contact with others; a sexual offender of children who has uncontrolled access to children; a person intentionally subjecting a child to purposefully suggestive remarks and behaviors, creating a sexualized environment that is likely to result in sexual abuse or exploitation.
Emotional abuse	Abusive treatment by a person that has resulted in emotional impairment or distress in a child.
Neglect	Failure to provide adequate food, clothing, shelter, supervision, or medical care when that failure causes or is likely to cause injury including accidental injury or illness.

Mandated reporting includes truancy, which is considered educational neglect. The statutory definition of child abuse/neglect includes truancy if the student is at least 7 years of age and has not completed grade 6. School personnel, as mandated reporters, would be required to report truancy to the Department.

Reports must be made immediately, by telephone to DHHS, and must be followed by a written report within 48 hours if the Department requests. Hospitals, medical personnel, and law enforcement may submit emergency reports via secure email or fax. Law enforcement officials and hospital staff are directed to make reasonable efforts to take photographs of any areas of trauma visible on a child, and make the photographs available to the Department as soon as possible.

Office of Child and Family Services

The OCFS performs a variety of professional social work services through specialized caseworker roles. Intake workers, child protective workers, permanency workers, and adoption workers all work with families and the community to promote long-term safety, well-being, and permanent families for children. Each type of caseworker performs a distinct role. The work of caseworkers also varies depending on the circumstances and needs of particular families.

The Child Welfare Services practice model guides the work with children and their families, and is based on five principles:

1. Child safety, first and foremost.
2. Parents have the right and responsibility to raise their own children.
3. Children are entitled to live in a safe and nurturing family.
4. All children deserve a permanent family.
5. How we do our work is as important as the work we do.

OCFS' child protective work has several parts: (1) the intake of reports of suspected child abuse and neglect; (2) the investigation (assessment) of reports that are deemed to be appropriate for a child protective response; and (3) the continuation of services to children and families that have been found to need departmental services as the result of an assessment. The work is divided between OCFS Central Intake and OCFS District Offices.

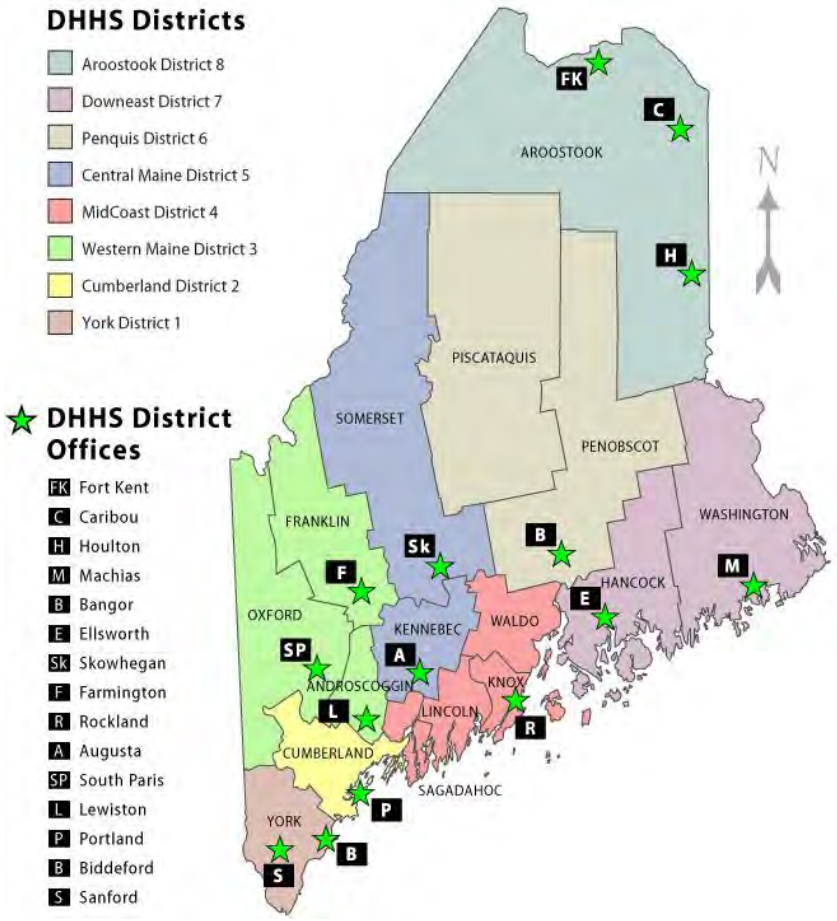
OCFS Central Intake is in Augusta and there are OCFS offices throughout eight Districts. Some districts have multiple offices. The District offices currently have caseworkers and supervisors for three separate functions: child protective, permanency, and adoption.

Summary of Intake Processes and Decisions

The child protective process in Maine generally begins when a reporter makes a call to the 24-hour Child Protective Intake Unit in Augusta via a statewide toll-free number. If district offices receive reports of child abuse or neglect, they also route this information to Central Intake.

Intake workers receive the reports of suspected child abuse and neglect and, along with their supervisors:

- screen the reports;
- determine whether they are appropriate for child protective response;
- determine the urgency needed for a response; and
- assign the reports to the responsible District office.



Intake is also responsible for identifying families that may benefit from prevention services even if they do not rise to the level of risk requiring a child protective assessment. Since May 2017, Intake has been using a Structured Decision Making Intake Screening and Response Priority Tool (SDM SCRPT Tool) to assist in the screening of reports and decision-making with regards to report appropriateness, assignment, and urgency.

Intake workers document call information into a report in MACWIS, the agency's electronic record-keeping system. Sometimes the reporter's information is not sufficient to determine if a report is appropriate for child protective response. In these cases, the intake caseworker may, with supervisory approval, contact at least one professional person who may have direct knowledge of the child's current condition prior to creating a report in MACWIS. Intake workers may also access additional information including previous MACWIS reports or entries, and relevant information from other systems including:

- Automated Client Eligibility System (eligibility for assistance programs);
- Bureau of Motor Vehicles (10-year driver history report, includes all driving violations);
- State Bureau of Identification (criminal history, based on arrests in Maine); and
- Sex Offender Registry.

Intake is responsible for making a decision on the disposition of all reports within 24-hours of receipt. The intake caseworker reviews the information, including additional sources as needed, and determines whether the report(s) are:

- appropriate - meets the definition of abuse or neglect;
- inappropriate - does not meet the definition of abuse and neglect;
- involves a substance-exposed newborn or drug-affected baby with no allegations; or
- other.

An intake supervisor reviews all intake worker decisions, even reports that are screened out because they do not involve children or allegations of abuse. When the intake worker, with the supervisor, determines that a report requires an immediate response, the worker calls the report into the assigned District Office to alert them. All other appropriate reports are completed by the intake worker and submitted to the intake supervisor for approval by the end of the intake worker's shift. Once approved by the intake supervisor, reports are sent to the appropriate district supervisor for assignment for Child Protective Assessment or referred to a Community Intervention Program.

If a suspected criminal act of abuse to a child is alleged, Intake staff make a referral to the District Attorney (DA) responsible for the area where the alleged crime occurred. This includes reports involving child death and/or serious injury, ingestion, and domestic violence homicide. In addition, reports with allegations involving physical abuse, sexual abuse, sex trafficking, and child endangerment require a referral to the DA.

Summary of Child Protective Assessments

Once a report is sent to a OCFS District Office, the family must be seen within the response time specified by Central Intake as either 24 or 72 hours, dependent on the result of Intake Screening Tool. A Child Protective Assessment is the first stage of departmental involvement with a family to determine whether or not child abuse or neglect is present in a family, whether children are safe, and whether or not there is a need for OCFS to play a continuing role with the family beyond the assessment period.

Assessments are conducted by child protective workers or contracted Alternative Response Program (ARP) workers. The worker will make contact with a family and gather and analyze information within the framework of child abuse and neglect to assess signs of safety, risk, and danger for children in the family. Child protective workers begin making contact with a family and conducting a face-to-face contact with each alleged child victim within 24 or 72 hours, depending on the severity of the alleged abuse and other factors. Immediately following the first face-to-face contact with each alleged child victim, the child protective worker consults with her/his supervisor and makes an initial safety decision. If the child protective worker determines that children are safe, the worker will continue with assessment activities.

OPEGA understands that assessment activities may include speaking with family, school officials, medical professionals, and involved professionals, along with gathering records. The steps a child protective worker will take are individual to each assessment. Overall objectives of the assessment are to determine:

- if a child has been abused or neglected and how severely;
- the impact of the abuse and neglect on the child(ren);
- signs of safety, signs of risk, and signs of danger;

- how likely it is for a child to experience abuse and neglect within the next six months;
- caregiver strengths and needs related to child safety;
- if this is a family in need of Child Protective services; and
- whether a plan should be developed to assist the family in keeping the children safe.

At the end of the assessment period, the child protective worker makes a finding on whether the initial allegations of abuse or neglect were indicated, substantiated, or not found. Indicated abuse is of a low/moderate severity, while substantiated abuse is of a high severity.

Child protective workers, with their supervisors, are also responsible for determining whether families are in need of continuing OCFS services. At any point during an assessment, a child protective worker might identify signs of danger for children that require immediate intervention or court action to remove the child from the home. OCFS would continue services with this family. An assessment may also find that signs of danger are not as emergent, but it is determined that a family needs continued OCFS services. In these cases, the department might file a court action that alleges that the children are at risk in their home if no changes are made in that environment. OCFS would also be continuing services with a family in this situation.

Summary of Prevention Role

Until October 2017, some OCFS District offices had a role for prevention social workers in addition to child protective, permanency, and adoption workers. In four districts, prevention workers were assigned cases in high-risk neighborhoods that did not rise to the level of needing a Child Protective Assessment, but were still identified as having family risks that could benefit from caseworker support. The prevention worker would offer to work with the family to mitigate the identified risks and to connect the family with services. Family participation with the prevention worker was voluntary.

Prevention workers were required to make a new report to Intake if they encountered information during their work with a family that caused them to have reasonable suspicion that a child had been, or was likely to be, abuse or neglected. In this case, the District's Child Protective unit would conduct an assessment with the family and the prevention worker would close their case. According to DHHS, prevention workers documented their work in a system other than MACWIS. If a case was transferred from one OCFS service to the next, information was shared through staff to staff interactions, typically through a family team meeting.

DHHS describes these prevention services as having been a pilot program aimed at offering additional services in areas of the State identified as high risk for child abuse and neglect. The Department decided to end the prevention services due to a lack of consistency between District offices and lack of data to show success. The Department also notes that they decided to focus OCFS caseworkers on the child welfare work that falls within the statutory mandate of the office.

Summary of ARP Role and Assessments/Services

In addition to the internal caseworker roles, OCFS has contract-based prevention services throughout the State intended to focus on early family intervention and the prevention of child abuse and neglect. OCFS describes the purpose of these services as reducing the risks associated with maltreatment of children and addressing family needs. These services, referred to as Alternative Response Program (ARP), occur after an OCFS District supervisor has determined that a case is appropriate for this type of intervention.

Supervisors make two distinct types of ARP referrals:

(1) Supervisors receive cases from Intake that have been determined appropriate for a child protective assessment but have low to moderate severity allegations. They may refer these cases to ARP to conduct the child protective assessments. This type of referral requires ARP to complete an assessment of allegations of abuse and neglect, a family plan, and referrals to appropriate community services.

(2) Supervisors may also refer cases to ARP after an OCFS child protective worker has completed an assessment with the family. These post-assessment referrals occur when OCFS has determined that a family may benefit from additional support in connecting with community services.

The OCFS Intake Screening and Assignment policy refers to situations where reports may be screened out as inappropriate, but intake workers still identify risk factors for families such that the families would benefit from Community Intervention Program or Prevention Services. In these cases, the policy directs Intake staff to make referrals directly to Prevention Services or send reports to the District Office. ARP may receive these referrals as well.

ARP staff are mandated reporters. Additionally, ARP contracts require the ARP caseworker to make a decision whether or not a sign of danger is present following the initial parent/caregiver and child interviews. Very serious parental behaviors, conditions and child or family circumstances that either have caused, or very soon could cause, high severity child abuse/neglect are considered signs of danger. If any sign of danger is present, the assessment is to be immediately returned to the Department. The contract also requires ARP to notify the Department by telephone or voice mail by the next business day when a family refuses services, and also to notify the Department when a family cannot be located within 35 days.

If ARP workers encounter information in a case that rises to the level of a new report of abuse or neglect, they are required to report this information to OCFS Intake. Within this reporting, they disclose information that they learned during their work with a family that caused them to have reasonable suspicion that a child has been, or is likely to be, abused or neglected. The case would then be re-assigned to OCFS Child Protective for assessment.

ARP workers document their work and interactions with a family in MACWIS, including their activities to locate a family. OCFS has access to the information ARP has entered to MACWIS. In addition, information could be shared through direct conversations between the ARP staff and OCFS Child Protective staff.

Summary of Permanency Unit Role

Once the child protective worker and supervisor determine that a family needs continuing services and the assessment is closed, the child protective worker will transfer the case to a permanency worker who continues the next stage of OCFS involvement. Permanency work involves working with a family to establish safety, working with families towards reunification in cases where children have been removed from their homes, or working towards other forms of permanency for children.

Permanency workers are responsible for:

- facilitating family team meetings and developing individualized solutions for families;
- arranging services for children and parents working toward reunification, including setting up visitations;
- working with foster families, if applicable; and
- assuring ongoing safety for children through frequent contact with children and their caregivers.

As necessary, permanency workers may take court action and/or work towards permanency outside of the child's birth family through adoption or other placement. At all times, permanency workers are responsible for meeting federal and state mandates and timeframes and keeping written case records.

Permanency work moves past assessment of safety and danger, though this is an ongoing process for all social workers, to the work of making plans and arranging services to best meet the safety, well-being, and permanency needs of children.

Recent Changes to OCFS processes and procedures

In certain instances of child death or serious injury, DHHS conducts a Child Death/Serious Injury (CDSI) Internal Case Review using the CDSI Review Tool. The review consists of a record review, interviews with staff, analysis, conclusions and implementation of practice or policy changes if applicable.

CDSI Internal Case Reviews were conducted following the deaths of both children whose cases OPEGA reviewed. During a May 15, 2018 meeting, OCFS staff described processes that they have modified as a result of the internal reviews.

- Intake will automatically consider a case appropriate for assessment after three reports of child abuse that individually would have been deemed inappropriate. Previously, the first factor considered in the Child Protective Intake process was the severity of the individual child abuse/neglect report, and then the entire record and the context of the case was to be considered.
- Beginning September 2018, OCFS will implementation the Structured Decision Making (SDM) model for child protective assessments. DHHS has been using the SDM tool for Intake decision-making since May, 2017.

- Any case open with ARP that receives a new appropriate report of abuse/neglect will be automatically closed with ARP and opened with OCFS Child Protective. Previously in these situations, the ARP caseworker would contact the OCFS District Office to discuss and evaluate whether to turn the case back over to OCFS Child Protective or have it remain with ARP.
- OCFS is re-emphasizing with ARP their responsibility to notify DHHS if the family refuses services or if the ARP worker cannot make contact with the family.
- Any case open with ARP that receives a new report of child abuse/neglect that is deemed inappropriate becomes a separate child abuse/neglect report in MACWIS. Previously, the information obtained from the reporter was entered into the narrative log and no new report of abuse/neglect was created in MACWIS.

DHHS has since provided additional information on practice and process changes. These include:

- Increased real-time quality review of casework practice statewide through implementation of the Quality Improvement Program to increase oversight of casework practice through continuous, real-time review of Child Welfare caseworker documentation.
- Implementation of the case review toolkit for supervision by caseworker supervisors to utilize with caseworkers in order to strengthen high quality, consistent casework practice and increase oversight and organization of supervisor practice related to caseworker supervision.
- Discontinuing Out of Home Safety Plans to mitigate risk related to the practice of agreeing to place a child outside of their parents' home(s) and place them with another caretaker without the court's oversight.
- Increasing high quality statewide practice through continued implementation of Family Teaming Practice to increase engagement of the caregivers and their informal supports to create a plan to meet the safety needs of the children who are involved with Child Welfare interventions.
- Increasing Child Welfare oversight and review of cases by adding a clinical psychologist to increase the level of clinical supervision and Child Welfare case reviews available to the District staff therefore increasing high quality casework practice.
- Increasing ability to holistically review reports of abuse by updating the Intake process to make all Reports of Abuse separate reports to increase high quality practice in the review of reports of abuse and ensure that the gravity of repeat reports is easily noticed and assessed within the decision making for dispositions of reports of abuse.

Potential Areas for Concern or Improvement to Consider in Planning a Broader Review

OPEGA identified a number of potential areas for concern or improvement in the child protection system from our review of these two cases and relevant statutes, rules, policies and procedures. We expect these observations will help inform GOC and OPEGA consideration of potential areas of focus for a broader review of Maine's Child Protection System, as will information gleaned from the Public Comment period the GOC has scheduled on this report. The potential areas OPEGA identified, in no particular order of priority, include:

- guidance and training for mandated reporters, including expectations for what constitutes "reason for suspicion" for those in various roles;
- timeliness of answering phone calls regarding potential child abuse and neglect by OCFS Intake workers via the statewide, toll-free number;
- timeliness and comprehensiveness of OCFS and ARP assessments of risk for a child or family and junctures at which a comprehensive re-assessment of risk could be or should be conducted;
- appropriateness of caseloads and adequacy of supervision and training of OCFS and ARP staff;
- compliance with policies and procedures, and consistency and appropriateness of decisions made, by caseworkers and supervisors in OCFS Central Intake and District Offices;
- compliance with contractual obligations, and consistency and appropriateness of decisions made, by ARP caseworkers and supervisors;

- factors that impact OCFS or ARP decision-making on appropriate action to take in response to assessed risk levels, and information received or situations observed with a child or family;
- extent to which OCFS and ARP monitor whether families are participating in voluntary services intended to reduce the risk of child abuse and neglect and take action when they are not;
- extent to which mandated reporters, OCFS and ARP seek to verify, and can verify, information reported by a child's parents;
- effectiveness of the child protection system in identifying and responding to child abuse/neglect risks that are not considered to be imminent physical safety risk, i.e. emotional maltreatment, neglect, truancy; and
- extent and manner of communication and information exchange among the various key entities that are part of the child protection system including schools, law enforcement, health care providers, counselors and therapists, community service providers; OCFS Intake, OCFS Field Offices and ARP providers.

There were also many individuals who contacted OPEGA wanting to share their concerns regarding the child protection system. We did not have time to gather information from them all, but we are prepared to share the perspectives we did get when working with the GOC on areas of focus for the broader child protection system review.