FINAL REPORT

Children's Licensing and Investigation Services– Investigations and Follow-Up on Licensing Sanctions Completed Within Expected Time Frames; Time Frames Needed for Some Post-Investigation Activities; Procedural Guidance and Documentation Should be Enhanced to Help Ensure Thorough and Consistent Investigations

Report No. SR-DHHS DLRS -14

Recommendations OPEGA offers as a result of this review:

- Children's Licensing should enhance policies to ensure thorough and consistent investigations. (pg. 28)
- Children's Licensing should establish time frames for determining licensing actions and notifying providers. (pg. 29)
- DHHS should evaluate replacement of Children's Licensing's current documentation system. (pg. 30)
- Children's Licensing should enhance investigation documentation. (pg. 30)
- DHHS should clarify expectations for parental and public notifications of child abuse/neglect investigations. (pg. 31)

March 2017

a report to the
Government Oversight Committee
from the
Office of Program Evaluation & Government Accountability
of the Maine State Legislature

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Acronyms Used in This Report

CAP – Compliance Advisory Panel

COO – Chief Operating Officer

CPI – DHHS Child Protective Intake

DHHS – Department of Health and Human Services

DLC – Division of Licensing and Certification

DLRS – Division of Licensing and Regulatory Services

GOC – Government Oversight Committee

MACWIS – Maine's Automated Child Welfare Information System

Maine CDC – Maine Center for Disease Control and Prevention

OCFS – Office of Child and Family Services

OOH – Out of Home Investigations

OPEGA – Office of Program Evaluation and Government Accountability

POC – Plan of Correction

SOD – Statement of Deficiencies

SOP – Standard Operating Procedure

Children's Licensing and Investigation Services– Investigations and Follow-Up on Licensing Actions Completed Within Expected Time Frames; Time Frames Needed for Some Post-Investigation Activities; Procedural Guidance and Documentation Should be Enhanced to Help Ensure Thorough and Consistent Investigations

Introduction

DHHS' Children's Licensing agency regulates and licenses child care providers. It also conducts investigations of alleged child abuse and neglect occurring in a child care facility or by a person subject to licensure or inspection by DHHS.

The Maine Legislature's Office of Program Evaluation and Government Accountability (OPEGA) has completed a review of DHHS Children's Licensing and Investigation Services (Children's Licensing). OPEGA performed this review at the direction of the Government Oversight Committee (GOC) for the 127th Legislature.

Children's Licensing is an agency of the Department of Health and Human Services (DHHS), located within the Maine Center for Disease Control and Prevention (Maine CDC). The agency is responsible for the licensing and regulatory oversight of child care providers in the State of Maine, and conducts investigations of alleged child abuse and neglect[1] occurring in a child care facility or by a person subject to licensure or inspection by DHHS.

OPEGA began a review of Children's Licensing in April 2014 following publicity of child abuse and neglect at a child care center in Lyman, Maine. At the time, public concerns were also being raised about the agency's performance with regard to child care investigations and enforcement actions. OPEGA's preliminary research found that DHHS was well aware of the issues, and was actively implementing a strategic plan designed to enhance oversight of child care providers and address risks to children in care. OPEGA's review was suspended in June 2014 to provide time for implementation of these initiatives. DHHS briefed the GOC on the status of the implementation in the interim and OPEGA's review was resumed in April 2016.

OPEGA's review focused on the timeliness and effectiveness of investigations conducted by Children's Licensing on child care facilities and family child care providers. We also assessed timeliness of notifications to parents and the public.

During the period OPEGA's review was suspended, DHHS implemented a reorganization that included the child care licensing and regulatory functions. In early 2015, the director of the DHHS Division of Licensing and Regulatory Services (DLRS) was appointed to serve also as Chief Operating Officer (COO) of the Maine CDC. The COO identified opportunities to integrate the licensing functions carried out by DLRS under the organizational umbrella of the Maine CDC and developed plans for such integration. As part of that effort, Children's Licensing formally moved into the Maine CDC in April 2016. Children's Licensing now reports into the Maine CDC Division of Environmental and Community Health.

[1] The term child abuse/neglect as used throughout this report refers to child physical abuse, sexual abuse, neglect, or emotional maltreatment.

OPEGA's review focused primarily on whether Children's Licensing conducts timely and effective investigations of alleged child abuse/neglect and alleged licensing violations, and takes timely and effective action on identified issues. Additionally, OPEGA assessed whether there is timely notification of investigations and results to parents[2], as well as notification to prospective child care clients through the agency's Child Care Choices website.

The scope of our review was investigations of child care facilities and family child care providers. OPEGA's work included an extensive review of relevant written policies and procedures, and interviews with management and field staff. We also reviewed records associated with selected samples of reported cases of alleged child abuse/neglect and licensing violations, for the period January 2015 through May 2016. The scope and methods for this review are detailed in Appendix A.

Questions, Answers and Issues

1. How does Children's Licensing become aware of violations of licensing rules and potential child abuse and neglect in child care settings?

See pages 12-15 for more on this point

DHHS' Child Protective Intake Unit (CPI) operates a statewide toll-free 24-hour hotline that takes reports of alleged child abuse/neglect and licensing violations. Reports may come from parents, current and former child care staff, neighbors, anonymous complainants and other members of the public. DHHS' Division of Licensing and Certification (DLC) also transfers any complaint calls it receives to CPI.

CPI staff collect information from callers to determine the nature of the complaints and take steps to notify the Children's Licensing Manager of complaints involving a child care facility. CPI staff and supervisors notify the Manager immediately via email or telephone if they deem the situation to be high risk. Otherwise, the Children's Licensing Manager is made aware through a special alert entered in Maine's Automated Child Welfare Information System (MACWIS), the agency's electronic records system.

Occasionally, the Children's Licensing office receives complaint calls directly. These are directed to a rotating staff person on-duty, who completes the intake process. Children's Licensing may also become aware of licensing violations and alleged child abuse/neglect through routine inspections of child care facilities.

The Children's Licensing Manager assigns reports involving allegations of child abuse/neglect to the Out of Home Investigations Unit (OOH). OOH Investigators determine whether the allegations are substantiated, indicated, or not substantiated. The Manager assigns all other complaints to the Licensing Unit for Child Care Licensing Specialists to investigate whether providers are violating licensing rules.

[2] The term parent, where used, also includes guardians and custodians of children.

2. To what extent does Children's Licensing investigate reports of child abuse and neglect in a timely and effective manner?

See pages 16-19 for more on this point

OPEGA primarily assessed Children's Licensing's child abuse/neglect investigations against expectations existing in current agency policies. While some of the formal written policies were not finalized during our sample time frame of January 2015 through May 2016, the expectations they include are appropriate criteria for measuring the timeliness and effectiveness of investigations.

Four time frames established in agency policies and one established in statute set expectations for timeliness of child abuse/neglect investigations. OPEGA tested a sample of 21 reports of alleged child abuse/neglect for adherence to these time frames with the following results:

- 95% of reports were assigned to an Investigator within three business days as required by policy (20 of 21 reports);
- 81% of investigations began within three business days of the assignment as required by policy (17 of 21 investigations);
- 76% of investigations were completed within 45 days of assignment as required by policy (16 of 21 investigations);
- 100% of investigations were completed within 90 days as required by statute (21 of 21 investigations); and
- 100% of providers with findings of child abuse/neglect were notified by Children's Licensing within 10 days as required by policy (5 of 5 investigations).

OPEGA reviewed documentation for the 21 investigations conducted for evidence that Investigators had completed seven steps mentioned in agency policy relevant to an effective investigation. We noted that not all steps are applicable for every investigation depending on the nature of the complaint being investigated. For those steps that were applicable and consistently documented, we found that Investigators:

- contacted the complainant 90% of the time (18 of 20 investigations);
- reviewed provider's prior history with DHHS 100% of the time (21 of 21 investigations);
- conducted site visits to make observations 100% of the time (20 of 20 investigations);
- coordinated with the Licensing Unit 95% of the time (19 of 20 investigations); and
- recorded and saved child interviews 100% of the time (3 of 3 investigations).

Other investigation steps were inconsistently documented and/or policy guidance was not specific enough to assess whether the step had been completed as fully as expected. We observed evidence that Investigators generally interviewed collateral contacts and reviewed some on-site documentation, but we were uncertain whether the work done was thorough enough for the particular situation. We note that the Children's Licensing Manager performs a quality assurance review prior to signing off on completion of investigations and this review should serve to identify any further work Investigators need to perform.

Overall, OPEGA observes that investigations of reports of alleged child abuse/neglect were generally assigned and completed within the expected time frames set in current policy. We are uncertain, however, whether investigations were as thorough as desired in all cases.

3. To what extent does Children's Licensing investigate reports of other child care licensing violations in a timely and effective manner?

See page 20-22 for more on this point

Children's Licensing's policies set timeliness expectations for investigating alleged licensing violations that do not involve child abuse/neglect. These time frames differ from those for investigations of alleged child abuse/neglect. OPEGA tested a sample of 20 reports of licensing violations with the following results:

- 95% of reports were assigned to a Licensing Specialist within three business days as required by policy (19 of 20 reports);
- 95% of investigations began within five business days of the assignment as required by policy (19 of 20 investigations); and
- 80% of investigations were completed within 35 days of assignment as required by policy (16 of 20 investigations).

OPEGA also reviewed documentation on the 20 investigations conducted for evidence that Licensing Specialists had completed five steps mentioned in agency policy relevant to an effective investigation. The relevant steps differed somewhat from those expected in alleged child abuse/neglect investigations and not all steps are applicable for every investigation. For those steps that were applicable and consistently documented, we found that Licensing Specialists:

- contacted the complainant 82% of the time (15 of 18 investigations);
- interviewed the child care provider 100% of the time (20 of 20 investigations); and
- conducted unannounced site visits 93% of the time (14 of 15 investigations).

Other investigation steps were inconsistently documented and/or policy guidance was not specific enough for us to assess whether the step had been completed as fully as expected. We observed evidence that Licensing Specialists generally interviewed relevant individuals and reviewed some on-site documentation, but we were uncertain whether the work done was thorough enough for the particular situation. We note that the Children's Licensing Supervisors perform quality assurance reviews prior to signing off on completion of investigations and these reviews should serve to identify any further work Licensing Specialists need to perform.

Overall, OPEGA observes that investigations of alleged licensing violations were generally assigned and completed within expected time frames set in current policy. We are uncertain, however, whether investigations are as thorough as desired in all cases.

4. To what extent does Children's Licensing act on licensing violations in a timely and effective manner?

See page 23-25 for more on this point

Children's Licensing is responsible for acting on licensing violations identified during investigations. Serious or recurring licensing violations, including those associated with child abuse/neglect, typically result in licensing sanctions against the provider. Children's Licensing may issue providers a Statement of Deficiency (SOD) and may also issue a Conditional License. Providers receiving these sanctions must implement a Plan of Correction (POC). Children's Licensing dictates the POC for providers receiving a Conditional License. Otherwise, it is developed by the provider and approved by the agency.

OPEGA reviewed investigation documentation for evidence that Children's Licensing had acted on issued sanctions as prescribed by internal policy. There were few time frames set in policy against which to assess timeliness. We observed generally, that Children's Licensing is requiring providers with sanctions to make improvements, and monitoring to ensure violations are resolved.

We analyzed post-investigation actions for the sample of 21 investigations of alleged child abuse/neglect investigations and found:

- providers were notified of licensing sanctions in an average of 15 days;
- 100% of providers issued a Conditional License as a result of the investigation received a follow-up site visit within the 30 day time frame set by policy (3 of 3 investigations);
- 100% of providers receiving sanctions were monitored until compliance standards were met (4 of 4 investigations); and
- plans of correction were resolved in an average of 53 days.

Analysis for the sample of 20 investigations on alleged licensing violations found:

- 100% of providers with a Conditional License received a follow-up site visit within the 30 day time frame set by policy (2 of 2 investigations);
- 82% of providers receiving sanctions were monitored until compliance standards were met (9 of 11 investigations); and
- plans of correction were resolved in an average of 41 days.

5. To what extent does DHHS ***notify*** current and prospective child care clients (parents) of allegations and findings of licensing violations and of child abuse/neglect in a timely manner?

See pages 26-27 for more on this point

OPEGA assessed whether Children's Licensing had made parental and public notifications of investigations and results in accordance with policy and statute, including notifying parents of alleged victims of findings of child abuse/neglect and posting any licensing violations to a publicly available website.

For the 21 sampled investigations of alleged child abuse/neglect, we found:

- 89% contained evidence that parents of alleged victims were sent a certified letter notifying whether the allegations were supported or not (16 of 18 investigations);
- lower-level licensing sanctions, such as Statements of Deficiency, were posted to the Child Care Choices website in an average of 57 days; and

- higher-level licensing sanctions, such as Conditional Licenses, were posted to the Child Care Choices website in an average of 238 days.

For our sample of 20 investigations of alleged licensing violations, we found:

- lower-level licensing sanctions, such as Statements of Deficiency, were posted to the Child Care Choices website in an average of 29 days; and
- higher-level licensing sanctions, such as Conditional Licenses, were posted to the Child Care Choices website in an average of 41 days.

Overall, OPEGA observed that parents of alleged victims of child abuse/neglect were notified of investigation findings. We observed that the posting of licensing sanctions to the website took significantly longer for higher-level sanctions than with lower-level sanctions in the sample of child abuse/neglect investigations.

OPEGA offers the following recommendations as a result of this review. See pages 28-32 for further discussion and our recommendations.

- Children's Licensing should enhance policies to ensure thorough and consistent investigations.
- Children's Licensing should establish time frames for determining licensing actions and notifying provider.
- DHHS should evaluate replacement of current documentation system.
- Children's Licensing should enhance investigation documentation.
- DHHS should clarify expectations for parental and public notifications of child abuse/neglect investigations.

Children's Licensing Overview

Maine statute requires all child care facilities to be licensed and all family child cares to be certified. Children's Licensing is responsible for issuing licenses and certificates, and for monitoring compliance with regulations set by DHHS.

Children's Licensing has direct responsibility for issuing child care center licenses, family child care certificates, and nursery school licenses. The agency is also responsible for monitoring compliance with regulations set by DHHS. Children's Licensing ensures providers meet licensing requirements, including application and inspection procedures, fire safety standards, provider qualifications, staff supervision and ratios, record keeping, health, sanitation, and safety.

Title 22 § 8301-A governs the licensing of child care providers, requiring all child care facilities in Maine to be licensed and all family child cares to be certified. Title 22 § 8302-A provides the statutory authority for DHHS to adopt rules for child care facilities There are two types of child care facilities:

- childcare centers - provide care to 13 or more children, less than 13 years of age; and
- small childcare facilities - provide care to 12 or fewer children, less than 13 years of age.

Family childcare providers include any person providing care in their home for 3-12 children, less than 13 years of age.

Maine statute gives DHHS authority to conduct investigations of alleged abuse and neglect in child care facilities and family child care settings.

Title 22 §§ 8351-8358, also gives DHHS authority to conduct investigations of abuse or neglect to a child under 18 in any facility, or by a person subject to

licensure or inspection by the Department. Statute outlines the duties of the investigation team, including receiving reports of alleged abuse or neglect, conducting investigations, making a determination of harm, and issuing a decision.

Children's Licensing currently has 37 staff overseen by the Children's Licensing and Investigation Services Manager. As shown in Figure 1, Children's Licensing is organized in several units.

Children's Licensing Unit has two supervisors and 24 child care Licensing Specialists. This unit is responsible for licensing, inspection and investigation of complaints regarding licensing violations. One supervisor and 14 Licensing Specialists cover the northeast region of the State with one supervisor and 10 Licensing Specialists covering the southwest region.

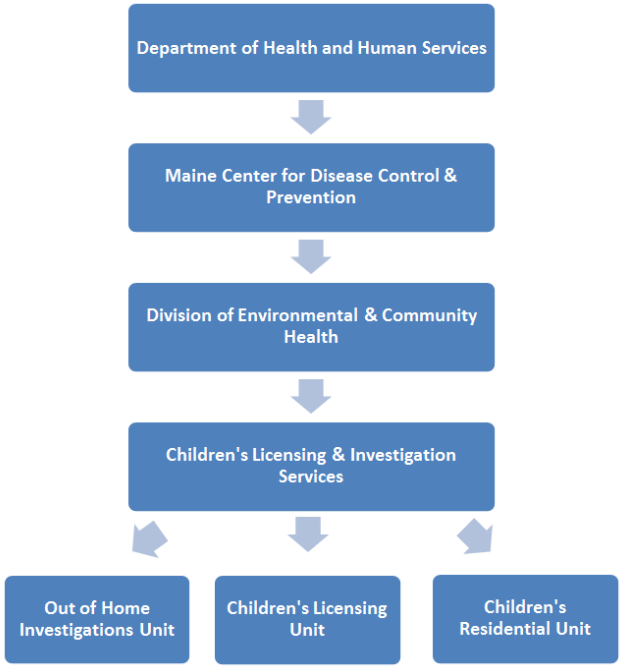
The Out of Home Unit conducts child abuse/neglect investigations. The Licensing Unit conducts licensing investigations and inspections.

Children's Out of Home (OOH) Investigations Unit includes five Investigators. This Unit is responsible for investigating alleged child abuse/neglect in child care settings and other out-of-home situations (foster care, residential programs). Recently, the agency was approved for one supervisor position for this unit.

The Children's Licensing Manager supervises the Out of Home Investigators. Two supervisors and the Manager oversee the work of Licensing Specialists.

Children's Residential Unit includes two program specialists. This group is responsible for licensing and oversight of residential care facilities, child placing agencies, and shelters for children. This unit was outside the scope of OPEGA's review.

Figure 1. Children's Licensing Organizational Structure



During the course of our review, Children's Licensing also had a Quality and Compliance Officer. This position has since been eliminated and the Compliance Officer's duties have been assumed by the Manager and supervisors. Additionally, two administrative support staff report to the Manager.

Standard Operating Procedures guide the practice of Out of Home Investigators and Licensing Specialists, and are used in training staff to conduct investigations and make decisions in a consistent manner.

The agency's work is guided by Standard Operating Procedures (SOPs), many of which were drafted and finalized during the course of our review. Currently, the agency's policies and procedures are outlined in two sets of SOPs: one for the Licensing Unit and one for the OOH unit. Many of the Licensing Unit's SOPs were in draft form in 2015. The drafting of OOH's SOPs began in early 2016. Most of the SOPs were finalized in July 2016 and are scheduled to be reviewed and updated annually. New staff receive an initial training covering these standards, and all staff receive ongoing, monthly training.

Supervisors take an active role in quality assurance as inspections and investigations occur. On a monthly basis, supervisors provide in-the-field supervision of Licensing Specialists with supervisors accompanying the Licensing Specialist on inspections and providing guidance. Supervisors also review all licensing investigations at the conclusion of the investigation, while the Children's Licensing Manager reviews all child abuse/neglect investigations.

The Compliance Advisory Panel was created to ensure consistency and fairness in the actions taken on identified licensing violations.

A team decision-making process has been instituted to help ensure consistency and fairness in the licensing actions taken on the violations identified during investigations. The Compliance Advisory Panel (CAP) consists of rotating members of the Licensing Unit staff and management. This team reviews findings and provider history prepared by the Licensing Specialist, and makes a decision on any licensing actions.

Children's Licensing staff in both the Licensing and OOH Units document investigations and inspections in MACWIS, an electronic record-keeping system. Hard copy documents are uploaded into Fortis, a document management system, as MACWIS does not have the capacity to store scanned documents.

Children's Licensing documents investigations and inspections in Maine's Automated Child Welfare Information System.

The Children's Licensing Manager and Licensing supervisors review the information documented in MACWIS when reviewing and approving investigations. They also monitor caseloads and adherence to certain time frames established in policy via monthly MACWIS reports provided by the DHHS Office of Child and Family Services (OCFS). OPEGA notes that Children's Licensing cannot query data from MACWIS and the Children's Licensing Manager must request any desired reports from OCFS staff.

Overall, OPEGA observed that MACWIS is slow and cumbersome to navigate and has limited functionality for Children's Licensing's needs. See Recommendation 3 for further discussion.

OPEGA's Approach to Assessing Timeliness and Effectiveness —

OPEGA primarily used expectations set in statute and agency SOPs as benchmarks for assessing timeliness and effectiveness of investigations, post-investigation steps and notification processes.

OPEGA's overall approach to assessing the timeliness and effectiveness of investigations and post-investigation actions, as well as timeliness of parental notifications, was to identify existing expectations and test a sample of reports of allegations received by Children's Licensing against these expectations. The expectations OPEGA identified and used came primarily from statute and Children's Licensing current SOPs, supplemented with information from interviews with agency management and staff. While some formal written policies were not finalized during our sample time frame of January 2015 through May 2016, the Children's Licensing Manager was communicating expectations verbally, via email, and through draft SOP during this period. The expectations in the finalized SOPs appear to be appropriate criteria for measuring the timeliness and effectiveness of investigations.

Selecting Measures of Timeliness and Effectiveness

The SOPs included expected time frames for assigning, beginning, and completing investigations and we used these as measures of timeliness. We also calculated number of days elapsed for key process steps that had no established time frames.

OPEGA first identified any established time frames that applied to individual steps within the investigative process, post-investigation steps, and notification processes. We found only one time frame established in statute and there were none in DHHS Rules. Therefore, we primarily selected the expectations for timeliness from two sets of SOPs: Child Care Licensing and Out of Home Children's Special Investigations. Both sets of SOPs had time frames established for the following phases of investigation:

- assigning reports to an investigator;
- beginning the investigation; and
- completing the investigation.

There was also a time frame established for notifying providers, via letter, of findings resulting from investigations of alleged child abuse/neglect.

For key steps in investigation and post-investigation processes that did not have specific time frames set, OPEGA calculated the number of days elapsed as an additional measure of timeliness.

We identified several components of an effective investigation in the SOPs including:

- reviewing provider history with the agency;
- interviewing complainant, providers, and other relevant individuals;
- conducting site visits;
- reviewing appropriate documentation; and
- monitoring providers to ensure compliance.

The specific components of an investigation that we identified as impacting effectiveness were also taken from the SOPs. While the components for child abuse/neglect investigations were slightly different than those for investigations of licensing violations, both generally addressed the following areas:

- reviewing provider history of previous agency involvement to identify frequent or repeated violations;
- contacting complainants[3] to ensure staff had a complete understanding of the allegations and had all available information;
- contacting other individuals as appropriate and necessary throughout the investigation;
- conducting on-site visits and provider interviews;

[3] Children's Licensing uses the term "referent" to refer to the individual who makes the report or complaint. OPEGA is using the term complainant as we expect it to be a more familiar term to the readers of this report.

- reviewing documentation at the provider's site; and
- monitoring providers until their plans of correction were satisfactorily completed.

Selecting Samples of Reports

OPEGA selected a stratified sample of 21 reports of alleged child abuse/ neglect and 20 reports of licensing violations from the population of 526 reports Children's Licensing received in the period January 2015 through May 2016.

OPEGA selected a stratified sample from the 526 reports received by Children's Licensing from CPI and other intake sources between January 1, 2015 and May 31, 2016. Our final sample consisted of:

- 21 reports of alleged child abuse/neglect that were assigned to and investigated by the OOH Unit; and
- 20 reports of potential licensing violations that were assigned to and investigated by the Licensing Unit.

The stratification we used to select the sample reflected characteristics such as provider type (child care facility or family child care provider), type of report (child abuse/neglect or licensing violation), and resulting actions (substantiated or unsubstantiated findings, statements of deficiency, and conditional licenses) to ensure we reviewed a range of reports. Random sampling was used as needed to select specific reports within each of the strata.

The full sampling methodology is outlined in Appendix A, but can generally be described as governed by our choices to:

- sample a larger percentage of child abuse/neglect reports than licensing violation reports given the higher risks associated with child abuse/neglect reports;
- sample a larger percentage of licensing violation reports that resulted in determinations of "Founded" rather than "Unfounded" given the higher risks associated with confirmed reports;
- sample all child abuse/neglect reports resulting in "Substantiated" or "Indicated" findings given the higher risks associated with confirmed reports; and
- sample from the entire range of post-investigatory outcomes.

Testing Timeliness and Effectiveness of Investigations and Post-Investigation Actions

We reviewed case file documentation for the sampled reports to assess the timeliness and effectiveness of investigations and post-investigation actions against the benchmarks we had identified.

OPEGA reviewed case file documentation to test the selected sample against the benchmarks we identified for timeliness and effectiveness of investigations and post-investigation actions. We reviewed documentation spanning from the receipt and assignment of the report to the investigation and subsequent administrative actions, notifications and monitoring. We recorded relevant data elements for each report from the documentation in a spreadsheet and then analyzed the results.

Most of the relevant data elements were located in MACWIS. Some were automatically recorded in the system (e.g., date of assignment), while others were manually entered by staff as an entry in a narrative log. Data elements that were not

available in MACWIS were provided to us by Children's Licensing staff from records stored on the agency's internal hard drive.

OPEGA observed that the documentation of investigations is primarily in a narrative format, and very few discrete data elements existed for testing. We also found the loading of these various screens in MACWIS to be slow and cumbersome. These issues are further discussed in Recommendations 3 and 4.

Testing Timeliness of Parental Notifications

We also reviewed case file documentation for evidence that parents of alleged victims of child abuse/neglect had been notified of investigation findings, and that providers had posted any licensing sanctions issued as a result of investigations.

OPEGA identified three avenues through which parents are notified, or otherwise made aware, of findings of child abuse/neglect and/or licensing violations resulting from investigations:

- certified letters sent to parents of alleged child abuse/neglect victims;
- the posting of licensing sanctions at the child care site; and
- the posting of licensing sanctions to the agency's Child Care Choices website.

We did not find established timeliness expectations in the form of set time frames associated with these actions. However, we did identify requirements in policy that we used as the basis of three tests to assess the extent and timeliness of parental notifications.

The OOH Unit is required to notify parents of alleged child victims identified during a child abuse/neglect investigation whether or not the allegations were supported. This notification is supposed to be done via letter at the conclusion of the investigation. OPEGA reviewed documentation in MACWIS for evidence that notification letters were sent. In particular, we reviewed documentation for recorded details on the date mailed, the list of parents receiving the letter, and the certified mail confirmation numbers.

The Licensing Specialist is required to observe whether the provider has posted licensing sanctions in a conspicuous place at their site where parents are likely to view it. We reviewed documentation in MACWIS for evidence that staff had checked for provider adherence to this posting requirement.

We then confirmed that licensing sanctions had been posted to the publicly available Child Care Choices website and assessed the timeliness of those postings.

Policy requires Children's Licensing to post licensing sanctions on the agency's Child Care Choices website. OPEGA searched the website to confirm that any licensing sanctions resulting from the investigations we sampled had been posted. We confirmed the date of posting via review of additional documentation. We then calculated the number of days that elapsed between the posting date on the website and the issuance of the licensing action as a measure of timeliness.

Receiving and Assigning Complaints

Receiving Reports of Alleged Child Abuse/Neglect or Licensing Violations

Reports of alleged child abuse/neglect or licensing violations are mainly received from the public via a 24-hour hotline operated by DHHS Child Protective Intake.

Reports of alleged child abuse/neglect or licensing violations in child care settings are received primarily through the OCFS' Child Protective Intake Unit (CPI). CPI operates a statewide, toll-free hotline staffed 24 hours a day, seven days a week with 28 staff that collect information from callers to determine the nature of the complaint and those involved. Reports may be made by parents, current and former child care staff, neighbors of child care providers, self-reporting providers, and anonymous complainants. Pursuant to DHHS Rules for Child Care Facilities and Family Child Care Providers, childcare personnel are required to report alleged child abuse or neglect to DHHS as mandated reporters.

Complaint: "A constituent report of suspected child abuse or neglect, or a violation of rule."

Violation: "An incident of observed non-compliance with a standard set in rule."

Source: Licensing Standard Operating Procedure 1

Intake staff collects information from the caller to determine the severity of the report. The Children's Licensing Manager is notified of new reports through electronic software, email, or phone, depending on risk of danger to children.

If the complaint involves a child care facility, CPI staff research in MACWIS to determine if there is already an open report (current investigation) on the child care facility. If so, they document the information they have collected in the open report, and the Children's Licensing Investigator or Specialist working on the report is notified via MACWIS. Otherwise, the CPI intake worker creates a new report in MACWIS within 24 hours of receiving the call, and the Children's Licensing Manager receives the electronic notification. High risk reports are noted as such in MACWIS, and CPI workers also email the Children's Licensing Manager, or immediately notify the Manager via telephone in the case of an emergency. CPI staff determine severity by identifying signs of imminent danger and consulting with their supervisors.

The Children's Licensing Manager is responsible for assigning the report to the appropriate Unit, based on the nature of the complaint.

For a report made in-person at either a DHHS district office or the central office, a staff person completes the intake process. If no one is available, the complainant is given the CPI hotline number and provided use of the telephone on-site.

In addition to the intake reports from CPI, Children's Licensing also may receive calls directly. These are directed to the on-duty staff person who completes the same steps as CPI workers. Children's Licensing staff are assigned intake duties on a rotating basis such that each day of the week is covered.

Prior to the reorganization of Children's Licensing into Maine CDC, one intake worker at the DHHS Division of Licensing and Certification (DLC)[4] received and documented any complaints received by DLC. These calls were generally complaints of licensing violations. Due to the organizational restructuring, DLC no longer processes these reports, and currently if DLC receives a call relating to child care settings, they transfer the call to CPI intake, or the Children's Licensing on-duty worker, if requested by the caller.

[4] Formerly known as the Division of Licensing and Regulatory Services.

Assigning Reports of Alleged Child Abuse/Neglect or Licensing Violations

Reports of allegations of physical/sexual abuse, neglect, or emotional maltreatment of children are assigned to the Out of Home Investigations Unit to determine findings of abuse. All other reports are assigned to a Licensing Specialist to investigate.

The Children's Licensing Manager is responsible for the triage and assignment of all complaints received from intake sources. According to Children's Licensing SOPs, the Manager must assign a complaint to either the OOH Unit or Licensing Unit within three business days of receiving the report from intake. High risk allegations require an immediate assignment.

Child abuse/neglect reports are assigned an Out of Home Investigator to investigate.

Licensing violations are referred to a Licensing Specialist to investigate.

Source: Licensing Standard Operating Procedure 1

Physical abuse: Inflicted, non-accidental physical injury by a caregiver. The injury may have resulted from severe physical discipline or altercation with no intent to cause injury to the child.

Neglect: Failure to provide the level of supervision and protection required by a child's age and/or development that protects the child from accidents, injury, illness, exploitation, and victimization when that failure causes or is likely to cause a child to experience a moderate injury, illness, level of deprivation or distress which requires medical attention.

Sexual abuse: Caregivers have subjected child to sexually suggestive remarks, or behaviors, sexual activities, and/or created a sexualized environment for the purpose of sexual abuse or exploitation.

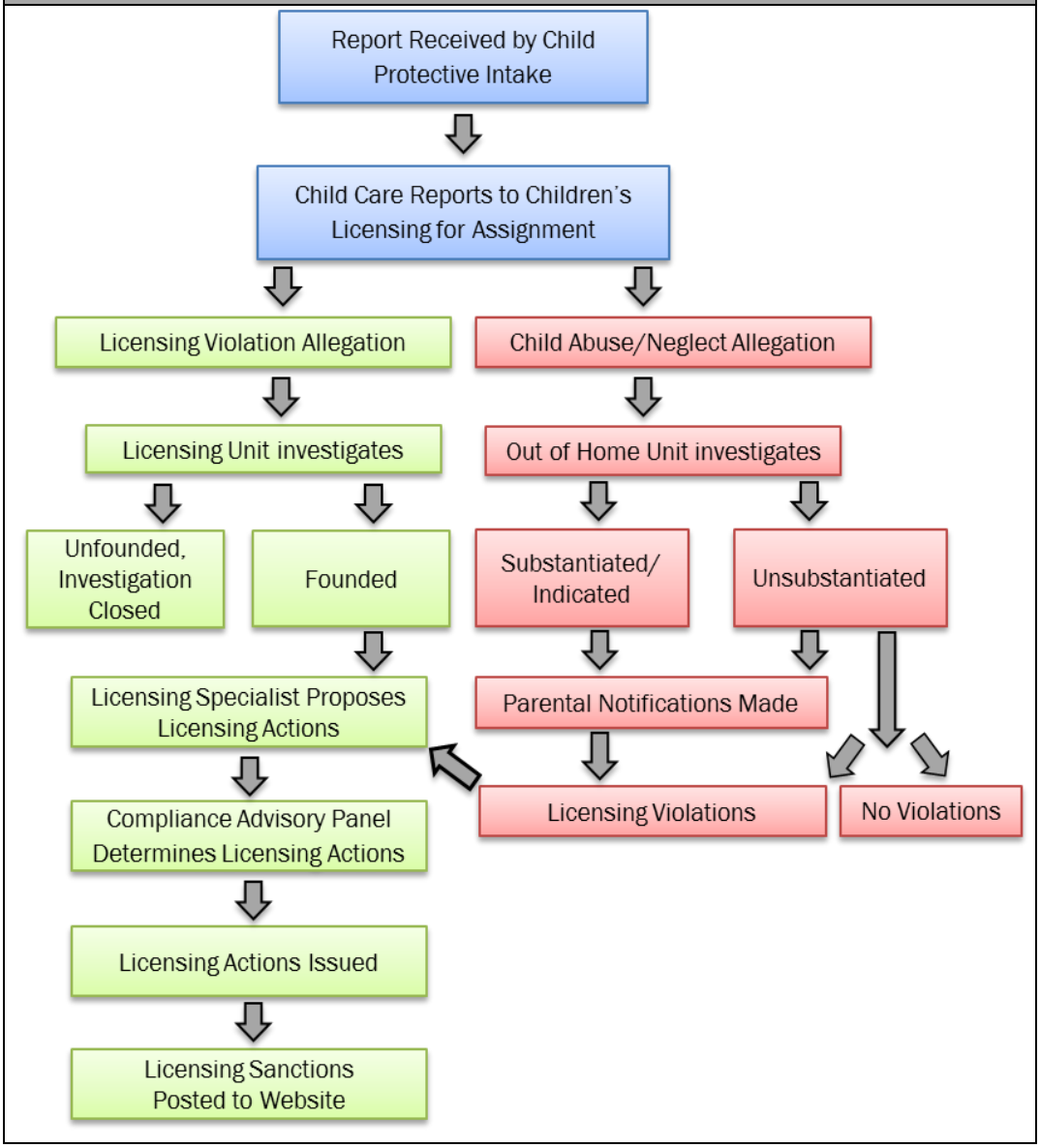
Emotional maltreatment: Severe and chronic attacks on child's development of self and social competence.

Source: OOH Standard Operating Procedure 1

The Manager assigns reports of alleged child physical abuse, sexual abuse, neglect, or emotional maltreatment to OOH. Reported allegations of licensing violations, not involving child abuse/neglect, are assigned to the Licensing Unit, specifically to the Licensing Specialist assigned to the child care provider identified in the complaint. The Investigator or Licensing Specialist being assigned the report receives an electronic notification in MACWIS. Additionally, the Manager sends an email to the worker, alerting her/him to the new assignment.

Figure 2 shows the flow of activity from assignments to both the Out of Home and Licensing Units.

Figure 2. Child Care Complaints and Investigations Process Flow



Children's Licensing received an average of 31 complaints of alleged child abuse/neglect and potential licensing violations each month in the period of January 2015 through May 2016.

Counts of Reports Received by Children's Licensing

Between January 2015 and May 2016, Children's Licensing received an average of 31 reports per month of licensing violations and alleged child abuse/neglect in child care settings. These reports were fairly equally divided between child care facilities (56%) and family child care providers (44%), as shown in Table 1.

Table 1: Summary of Reports by Provider Type for January 1, 2015 – May 31, 2016

Provider Type	January 2015 - May 2016		
	Total Count	Average per Month	Percentage of Total
Child Care Facility	292	17.2	56%
Family Child Care Provider	234	13.8	44%
Total Child Care	526	30.9	100%
Source: Data file provided by Children's Licensing from MACWIS			

The majority of reports received by Children's Licensing are complaints of licensing violations, as opposed to allegations of child abuse/neglect.

Table 2 shows that reports of alleged child care licensing violations are much more common than reports of alleged abuse/neglect. About 82% of the reports received were referred for investigation of potential licensing violations and 18% were referred for investigation of alleged child abuse/neglect.

Table 2: Summary of Reports by Type of Report for January 1, 2015 – May 31, 2016

Report Type	January 2015 - May 2016		
	Total Count	Average per Month	Percentage of Total
Child Abuse/Neglect	93	5.5	18%
Licensing Violation	433	25.5	82%
Total	526	30.9	100%
Source: Data file provided by Children's Licensing from MACWIS			

Identifying Licensing Violations Through Routine Inspections

Licensing Specialists conduct routine formal inspections of child care sites to determine overall compliance with licensing rules and assess for areas of high risk to children. The monitoring schedule is based on providers' past performance.

The inspection process is another avenue for identifying child care licensing violations. Inspections are the formal review of a child care site and records to determine compliance with licensing rules.

Renewal inspections are in-depth inspections conducted every two years as a condition and requirement of the license renewal process. Interim inspections are more targeted, abbreviated inspections conducted during the term of the license with a focus on overall compliance and areas of high risk to children.

Interim inspections occur at least every six months and may be more frequent as indicated by Children's Licensing differential monitoring system. Differential monitoring varies inspection frequencies depending on the provider's past compliance with licensing rules. Children's Licensing's differential monitoring policy outlines four levels of inspection frequency as shown in Table 3.

Table 3: Differential Monitoring

Provider Status	Frequency of Visits
Demonstrated history of compliance	Six months
Generally in Compliance, some past non-compliance	Four months
Issued Statement of Deficiencies at last inspection	Three months
Operating on Conditional License	One month
Source: Licensing Standard Operating Procedure 9	

Child Abuse and Neglect Investigations

Conducting Investigations of Alleged Child Abuse and Neglect

The OOH Investigator's initial work after receiving an assignment is to plan and prepare for the investigation. First, the Investigator reads the report received from intake to assess the urgency of the allegations and to identify individuals to contact or interview. Interviewees may include the complainant, victim(s), witness(es), offender(s), the provider, and other relevant individuals. The investigation formally begins with the Investigator making the first contact with the complainant to ensure the intake report is complete and to gather any additional information. The Investigator is required to begin the investigation within three business days of assignment.

After receiving an assignment, the OOH Investigator plans for the investigation, which formally begins with the first contact with the complainant. The Investigator is required to begin the investigation within three business days after receiving the assignment.

During the planning stage, the Investigator reviews the provider's prior history with the Department and any prior history on the alleged victim and/or offender. This information is available in MACWIS. The investigator collects any documentation available from other involved agencies (i.e., OCFS, law enforcement). The Investigator coordinates with the Licensing Specialist assigned to the provider and with any other involved agencies that are responding to the report, and coordinates provider site visits with these agencies, if necessary.

During the investigation, the Investigator interviews the individuals identified in the planning stage of the investigation. The Investigator also conducts a site visit, with the Licensing Specialist whenever possible. The site visit has two main investigatory objectives: assessing the environment and collecting supporting documentation. The Investigator conducts a walk-through of the facility to visually observe the physical site and observe children. In addition to focusing attention on the aspects directly related to the alleged abuse/neglect, the Investigator and Licensing Specialist are alert for licensing violations. Documentation relevant to the investigation is reviewed and collected, and may include child records, personnel records, incident reports, and attendance logs. Steps completed in the investigation are documented in MACWIS, mostly in a narrative format.

The Investigator conducts interviews, assesses the child care environment, collects supporting documentation, and collaborates with other agencies as part of the investigation process.

Child Interview Policy & Procedure

- Notify child's parent or legal guardian prior to interview (unless not in best interest of child)
- Assess child's ability to participate in interview based on age, cognition, disability
- Interview privately whenever possible
- Establish interview rules with child
- Establish credibility of child
- Establish rules for adults present (parents or multi-agency investigators)
- Audio or video record the interview using proper equipment from DHHS; record date, time, location, interviewer, interviewee; store completed interview on designated server

Source: OOH Standard Operating Procedure 3

OPEGA observed that the SOP does not specify which individuals or agencies are appropriate to interview in particular circumstances. Policy also does not detail which supporting documentation should be collected during site visits for different types of allegations. This issue is discussed further in Recommendation 1.

The Investigator may interview children to determine whether the abuse/neglect has occurred. The SOP outlines the steps for conducting a forensically sound

interview so that the child interviews are reliable enough to be admitted into evidence in the case of legal proceedings.

A key component of an OOH investigation is the child interview. The SOP outlines the steps required to ensure the interview is conducted in a forensically sound manner.

The SOP also details the steps for documenting child interviews, directing Investigators to fill in narrative entry dropdown boxes, including contact date and time, contact method, contact name, contact telephone, etc. The Investigator then enters the details of the interview in narrative form. These details include how rapport was built with child, how the child's credibility was established, and a summary of the content of the interview.

Determining Investigation Findings

The Investigator determines the outcomes of child abuse/neglect investigations based on the facts and the evidence gathered. The Investigator uses definitions outlined in policy and consults with the Children's Licensing Manager, to determine the findings. There are two possible outcomes for child abuse/neglect investigations:

Child abuse/neglect investigation outcomes include substantiation, indication, or no findings. Investigators use agency definitions to help determine findings.

1. A finding of child abuse/neglect as either Substantiated (higher severity) or Indicated (lower severity); or
2. A finding of Unsubstantiated.

Substantiated: facts and evidence gathered during an assessment/investigation to support a decision that a person responsible for a child has, by preponderance, subjected that child to specific *high* severity abuse and/or neglect thus causing the child to be in danger.

Indicated: same as above, but with a *low or moderate* severity abuse and/or neglect.

Unsubstantiated: facts and evidence gathered support a decision that a person responsible for a child has *not*, by preponderance, subjected that child to specific abuse and/or neglect.

Source: Out of Home Standard Operating Procedure 4

The Investigator documents the individuals interviewed, information provided, credibility of interviewees, and other pertinent evidence in MACWIS.

Once a determination is made, the Investigator prepares a "Children's Special Investigations Findings Report," which includes a summary of the investigation and the findings, and submits it to the Children's Licensing Manager for approval. The SOP provides detailed guidance on how to write the findings report, including documenting relevant people interviewed, information provided, credibility of those interviewed, those not interviewed and why, and other pertinent evidence supporting the findings of the investigation.

The Findings Report is submitted and approved in MACWIS. The Manager's approval indicates the completion of the investigation which, per policy, is to occur within 45 days. OPEGA notes that current statute, which took effect in October 2015, allows 90 days for completing an investigation. The prior statute allowed for six months.

Both statute and policy set a time frame for completing investigations of child abuse/neglect. Policy allows 45 days and statute allows 90 days.

Investigators have 10 days from the date of contact to document their work in MACWIS. OPEGA noted that MACWIS does not timestamp when documentation is entered, and there is no way to verify if workers enter documentation within the 10 day requirement. This is discussed in Recommendation 3.

Completing an Investigation

Once the investigation is completed, the Investigator is responsible for sending several closing letters. These include:

The OOH investigator concludes the investigation by notifying the provider and parents of findings. The case is then turned over to the Licensing Specialist, who determines whether there are any accompanying licensing violations.

- a letter to the individual(s) against whom there is a finding of substantiated or indicated child abuse/neglect containing information related to the findings and outlining the appeals process with OCFS;
- a letter to the provider on whether the allegation was unsubstantiated, indicated or substantiated, and a notice of the right to appeal if child abuse/neglect is indicated or substantiated; and
- a letter to the parents of alleged victims, and, in some cases, to parents of non-victims containing information on whether allegations were supported or not.

The OOH Investigator turns the investigation results over to the assigned Licensing Specialist to determine whether there are any licensing violations. OPEGA notes that all findings of child abuse/neglect have concurrent Rules violations (i.e. the right to freedom from abuse and neglect) and are subject to licensing sanctions. We discuss follow-up actions and parental notifications on pages 23-27.

OPEGA's Assessment of Timeliness and Effectiveness

Timeliness of Investigations

Identified time frames for investigations are:

- 3 business days to begin investigation;
- 45 days to complete investigation, per agency policy;
- 90 days to complete investigation, per Maine Statute; and
- 10 days to notify providers of investigation findings.

OPEGA identified four established time frames in agency policy and one in statute for assigning a report, beginning the investigation, concluding the investigation, and notifying providers at the conclusion. We tested the sample of 21 child abuse/neglect reports against these time frames.

Agency policy requires the Children's Licensing Manager to assign reports of child abuse/neglect to an Investigator within three business days. OPEGA reviewed documentation in MACWIS for the dates intake received the reports and the dates the reports were assigned. Twenty (95%) of the 21 reports tested were assigned to an Investigator within the required time frame.

Policy also requires child abuse/neglect investigations to begin within three business days of assignment to the Investigator. The expectation of what marks the beginning of an investigation changed over our sample time period. Initially, the beginning of the investigation was signaled by any first contact that the Investigator made. Over the course of 2015 and 2016, the Manager refined expectations and first contact, or attempted contact, with the complainant is now used as the date the investigation begins.

20 of 21 reports of alleged child abuse/neglect were assigned to an Investigator in the required time frame. We noted the investigation began within required time frames for 17 of the 21 reports.

OPEGA reviewed the narrative log in MACWIS to identify when complainants were contacted. Of the 21 reports tested, 13 showed evidence of the Investigator making contact with the complainant within three business days. In an additional four reports, the Investigator contacted the relevant Licensing Specialist within the three day time frame and later contacted complainants. In the remaining four reports, complainants were contacted, but there was no evidence the investigation was started within the three day time frame.

We identified two established time frames for the completion of child abuse/neglect investigations. As of October, 2015, statute requires these investigations to be completed within 90 days; agency policy requires completion within 45 days. Prior statute allowed six months for completion. OPEGA reviewed

the documentation in MACWIS for the dates the reports were assigned and the Children's Licensing Manager approved the completed investigation, signaling the completion of the investigation. Sixteen of the 21 investigations (76%) were completed within the 45 day deadline and 100% of investigations were completed within the 90 days allowed by statute.

16 of 21 investigations were completed within 45 days, as required by agency policy. All investigations were completed within 90 days, as required by state statute.

SOP requires Children's Licensing to notify providers of investigation results within 10 days of the end of the investigation. OPEGA tested the five investigations in our sample that had substantiated or indicated findings. All five (100%) had evidence of the closing letter being sent to provider within the 10 day time frame.

Effectiveness of Child Abuse/Neglect Investigations

All investigations with findings of child abuse/neglect contained evidence of the provider being notified of findings within the required time frames.

OPEGA identified required investigation activities within the OOH SOP and tested our sample of 21 investigations for evidence against these expectations. Though these policies were not in final form during our sample time frame, they contain the components of an effective child abuse/neglect investigation, appropriate to assess effectiveness.

Per SOP, the Investigator is required to contact the complainant to ensure staff has a complete understanding of the allegations and has all available information. OPEGA reviewed the narrative log in MACWIS for our sampled child abuse/neglect investigations for evidence that the Investigator contacted, or attempted to contact, the complainant. We excluded one of the sampled investigations from this test because the complainant was an anonymous caller. Of the 20 remaining investigations, 18 (90%) contained evidence that the Investigator contacted, or attempted to contact, the complainant. OPEGA noted that for in one of the cases with no documentation of the Investigator contacting the complainant, the Investigator's direct supervisor—the Children's Licensing Manager—had completed the intake with the complainant.

18 of 20 investigations contained evidence that the Investigator contacted the complainant.

The Investigator is required to review the provider's previous involvement with the agency to be aware of the provider's history when conducting the investigation. OPEGA reviewed the "Children's Special Investigations Report" in MACWIS for cases in our sample and found the Investigator documented reviewing the provider's previous agency involvement in all 21 investigations (100%).

We saw evidence of Investigators conducting interviews with relevant individuals, but were not able to assess whether interviews included all persons that were relevant for each case.

The Investigator is required to identify and interview other relevant persons during the course of the investigation. Policy does not specify the conditions under which any particular persons would be considered relevant. We discuss this lack of guidance in Recommendation 1. Consequently, we were unable to assess whether all appropriate contacts were made. OPEGA did observe interviews were conducted with a range of persons, including child care staff, parents, and external agencies (e.g. law enforcement and Child Protective Services).

All investigations with child interviews contained evidence of interviews being properly recorded and saved.

The Investigator is required to conduct child interviews in a "forensically sound" manner, which includes recording the interview and saving it on the agency's internal hard drive. Of the 21 investigations we reviewed, only three involved child interviews. Investigators recorded and saved interviews onto the internal hard drive in all three of these investigations.

15 of 16 investigations had evidence of the Investigator reviewing some documentation. OPEGA was unable to assess whether this included all documentation that was relevant for each case.

Policy also requires the Investigator to conduct a site visit and make visual observations. We tested 20 investigations and found all 20 contained evidence of a site visit occurring. We did not test one investigation, as the allegation was retracted when it was discovered the child had never attended the child care facility in question and a site visit was unnecessary.

The Investigator is expected to gather evidence, including supporting documentation, during the course of the investigation. OPEGA notes that policy does not describe the conditions under which any specific documentation should be reviewed. We discuss this lack of guidance in Recommendation 1. As a result, we were unable to assess whether Investigators reviewed all appropriate supporting documentation. We did observe that *some* documentation was reviewed in 15 of 16 investigations. In the other five investigations, there did not appear to be a need for any document review based on the nature of the report.

19 of 20 investigations contained documentation of the Investigator collaborating with the Licensing Specialist during the course of the investigation.

Investigation results are transferred to the Licensing Unit at the end of a child abuse/neglect investigation. The Investigator is required to collaborate with the assigned Licensing Specialist during the course of the investigation. In 19 of 20 investigations, we observed evidence that the Investigator either attended the investigation site visit with the Licensing Specialist or called or met in person with the Licensing Specialist to provide an update on the investigation.

Licensing Investigations

Conducting the Investigation

After receiving an assignment, the Licensing Specialist plans and prepares for the investigation. The investigation formally begins with the Specialist's first contact, which is generally with the complainant. The Specialist is required to begin the investigation within 5 business days of assignment.

Each child care provider has an assigned Licensing Specialist who conducts routine inspections. When the Children's Licensing Manager receives a report of licensing violations from a complainant, and that violation does not meet the guidelines for a child abuse/neglect investigation, the Manager assigns the report to the Licensing Specialist to investigate.

The Licensing Specialist is required to begin the investigation within five business days of receiving the assignment. The Licensing Specialist's initial work includes reading the intake report in MACWIS, reviewing the provider's history of licensing inspections and investigations, and formulating a plan for how he/she will proceed with the investigation. The investigation formally begins with the Investigator making the first contact, which is generally the complaint, to obtain additional information about the complaint.

Next, the Licensing Specialist conducts an unannounced site visit to the child care facility and discusses the general nature of the licensing complaint with the provider. Other primary investigative actions include conducting interviews, reviewing relevant documentation and observing the facility.

The Licensing Specialist always interviews the child care provider and staff. Depending on the nature of the complaint, the Specialist may interview other relevant individuals, such as parents, fire marshals and local code enforcement officers. Licensing Specialists never interview children.

Licensing investigations include an unannounced site visit to interview the child care provider and staff, review records and other documentation, and conduct observations of child to staff ratios and indoor and outdoor environment. Other relevant individuals may also be interviewed.

- The Specialist's documentation review may include children's files, incident reports, parent notifications, staff personnel files, background checks and/or attendance records. The Licensing Specialist may take pictures or make copies of documents or make notes regarding the documentation review.

- Observations made by the Specialist can include child to staff ratios, observing classroom and outdoor play area environment. Other observations may be made, depending on the nature of the complaint.

The Licensing Specialist documents the investigation in MACWIS. Documentation includes interviews, on-site documentation review and on-site observations. Each contact is documented as a separate entry in MACWIS, with a narrative description. Licensing Specialists receive ongoing supervision during the investigation and update their supervisor on the status of the investigation.

Staff have ten days from the date of contact to document their work in MACWIS. OPEGA noted that MACWIS does not timestamp when documentation is entered, and so there is no way to verify if workers enter documentation within the 10 day requirement. This is discussed in Recommendation 3.

Completing the Investigation

The Licensing Specialist makes a determination on whether the complaint is founded or unfounded based on the evidence gathered. The SOP requires the investigation to be completed within 35 calendar days. The Specialist documents the investigation and findings in MACWIS. This indicates the conclusion of the investigation.

At the conclusion of the investigation, the Licensing Specialist writes an investigation summary, and a determination of any findings. The Licensing Specialist categorizes findings based on the results of the investigation as either:

- Founded: There is a preponderance of evidence (51% or greater) that a component of the complaint is true and is also a regulation deficiency; or

- Unfounded: There is evidence that the complaint is not true or there is a lack of evidence to prove that the complaint is true.

Children's Licensing provides a template to Licensing Specialists to document the investigation summary, which is mostly in narrative format. The template is a Word document that the Licensing Specialist completes and copies and pastes into MACWIS. This is discussed further in Recommendation 4.

The completed report signals the conclusion of the investigation, which the Licensing Specialist has 35 calendar days to conduct. The Licensing Specialist notifies the supervisor upon completion of the investigation.

Identified time frames for investigations were:

- 3 business days to assign investigation;
- 5 business days to begin investigation; and
- 35 calendar days to complete investigation, per agency policy.

OPEGA's Assessment of Timeliness and Effectiveness

Timeliness of Investigations

OPEGA identified three established time frames for licensing investigations in agency policy: assigning the report, beginning the investigation and concluding the investigation. We tested a sample of 20 licensing violations reports against these time frames.

Agency policy requires the Children's Licensing Manager to assign reports of licensing violations to a Licensing Specialist within three business days of receiving the report from intake. OPEGA reviewed documentation in MACWIS to

determine the date the Manager received the report and the date the Manager assigned the report. Of the 20 reports tested, 19 were assigned to a Licensing Specialist within the three business day deadline. OPEGA observed while one report did not meet the time requirement for assignment, the investigation did begin within three business days from the date of intake and the assignment date did not adversely impact the timeliness of the investigation.

The Licensing Specialist is required by policy to begin the investigation within five business days from the date of assignment. The first contact is generally with the complainant and signals the beginning of the investigation. OPEGA reviewed the narrative log within MACWIS to determine the start date of the investigation and calculated the number of business days from the date of the assignment. Of the 20 reports tested, 19 were initiated within the five business day time frame.

16 of the 20 investigations were completed within the 35-day time frame required by Children's Licensing internal standard operating procedure.

Licensing investigations, per SOP, are to be completed within 35 calendar days. OPEGA reviewed MACWIS to determine the date the Licensing Specialist completed the investigation summary. Children's Licensing considers this to be the investigation end date. We calculated the number of calendar days from the date of assignment to the investigation end date. Of the 20 reports tested, 16 (80%) were completed within the 35 day time frame.

Effectiveness of Investigations

OPEGA identified required investigation activities within the Licensing SOP. We tested our sample of 20 licensing investigations for evidence these activities had been completed.

15 of 18 investigations contained evidence of the Licensing Specialist contacting the complainant. The two remaining complaints in our sample were reported anonymously.

Per SOP, the Licensing Specialist is required to contact the complainant to ensure staff has a complete understanding of the allegations and has all available information. OPEGA reviewed the narrative logs in MACWIS for our sampled licensing investigations for evidence that the Licensing Specialist contacted, or attempted to contact, the complainant. Two of the investigations were excluded from the test because the complainant was an anonymous caller. Of the remaining 18 investigations, 15 (82%) contained evidence that the Licensing Specialist had attempted to, or made contact, with the complainant.

All 20 investigations contained evidence of the Licensing Specialist interviewing the child care provider.

The Licensing Specialist is also required to interview the child care provider. OPEGA reviewed the narrative log in MACWIS, and found evidence of provider interviews in each of the 20 investigations.

The SOP requires the Licensing Specialist to interview relevant individuals, based on the nature of the complaint. The SOP does not specify, however, the conditions under which any particular individual would be considered relevant. We discuss this lack of guidance in Recommendation 1. Consequently, OPEGA was unable to assess whether all appropriate individuals were interviewed. In general, however, OPEGA was able to observe that interviews were conducted with various individuals, including parents, child care staff, fire marshals, code enforcement officers, and local law enforcement. Other investigations did not appear to warrant additional interviews.

The Licensing Specialist is required to visit the child care site and to conduct this initial visit unannounced. Children's Licensing informed OPEGA, however, that there was no established guidance for documenting whether visits were

unannounced and that Licensing Specialists record this differently. We discuss documentation issues in Recommendation 4. Of the 20 investigations reviewed, 18 explicitly stated whether a site visit occurred. Of these 18 investigations, three did not appear to require an unannounced visit as the provider self-reported the potential licensing violations. For the remaining 15 investigations in which an unannounced site visit would be expected, 14 contained documentation of an unannounced site visit. OPEGA notes that Children's Licensing updated the SOP and associated template during the course of our review to include guidance on how to document unannounced site visits.

We found evidence that site visits occurred in 18 of 20 sample investigations. OPEGA could not assess whether all site visits conducted were unannounced due to inconsistent documentation.

The SOP specifies that "pertinent" documentation should be reviewed at the child care site. However, it does not describe the conditions under which the Licensing Specialist would be required to review any specific documentation. We discuss this lack of guidance in Recommendation 1. Consequently, OPEGA was unable to assess whether the Licensing Specialist reviewed all pertinent documentation. OPEGA did observe evidence that the Licensing Specialist reviewed *some* documentation in 15 of the 20 sampled investigations. For the remaining five investigations, we did not believe the particular type of licensing violation required a documentation review (e.g. an environmental issue).

Licensing Follow up Actions

Taking Action on Investigation Findings

The Licensing Unit is responsible for issuing licensing sanctions as a result of both licensing and child abuse/neglect investigations. The Licensing Specialist monitors the corrective actions of the child care provider.

The Licensing Unit is responsible for issuing licensing sanctions resulting from both licensing investigations and child abuse/neglect investigations. The Unit also conducts the required follow-up for all licensing actions.

At the conclusion of an investigation, the Licensing Specialist assigned to the provider makes a determination on whether licensing sanctions are warranted. The sanctions are most commonly Statements of Deficiencies (SOD) and Conditional Licenses.

If the Licensing Specialist identifies frequent, repeated, or serious deficiencies, Children's Licensing may issue an SOD. A SOD summarizes the provider's non-compliance with particular rule requirements.

A Statement of Deficiencies identifies which rules the provider is out of compliance with. A Plan of Corrections is the provider's strategy to meet compliance standards.

The Licensing Specialist develops a draft SOD and presents it to the Compliance Advisory Panel (CAP). The CAP is an internal group of Children's Licensing and Maine CDC staff that meets weekly to review licensing actions. The CAP's role is to ensure licensing actions are supported by evidence, objective, equitable, and are administered on a consistent basis. The CAP makes decisions based on the severity of the case, risk level, provider history, and the provider's willingness to become compliant. OPEGA observed that there are no established time frame requirements for the Licensing Specialist to bring the SOD draft to the CAP, and we discuss this further in Recommendation 2.

The agency sends the SOD to the provider via certified mail. The provider has ten days to submit a Plan of Correction (POC) back to the agency. The POC is the provider's plan to come into compliance with the standards in rule or to prevent further incidents of non-compliance. The Licensing Unit approves the POC once it

is acceptable and monitors the provider via site visits to ensure the provider is following the POC. Once a provider is back in compliance, Children's Licensing sends a Notice of Compliance. Children's Licensing manually tracks the various approvals that occur during this stage in an Excel spreadsheet, as MACWIS does not have this capacity. MACWIS' limited functionality is discussed further in Recommendation 3.

The Compliance Advisory Panel makes a collaborative decision on licensing sanctions by assessing severity, risk, provider history, and provider willingness to be compliant. The CAP was instituted to ensure objectivity and consistency in issuing sanctions.

In addition to the SOD, Children's Licensing may also issue a Notice of Conditional License if serious and/or habitual non-compliance with rules is identified. A Conditional License may also be issued when "extremely serious" deficiencies are found, such as rights violations, harmful practices, or serious injury to a child.

If the CAP approves the issuance of a Conditional License, a certified "Notice of Conditional License" letter and an accompanying "directed POC" is sent to the provider. The Licensing Specialist develops the directed POC, which describes the corrective actions needed. The provider has 10 days to either appeal the Conditional License or waive the right to appeal. When a Conditional License is issued, the Licensing Specialist must conduct monthly site visits throughout the duration of the Conditional License, even if the appeals process is in progress. The provider is required to post the Conditional License on site.

Other sanctions Children's Licensing and the CAP may issue include denial of license renewal, and in the case of immediate risk of harm to children, administrative closure. The DHHS Commissioner signs an administrative closure, and it is hand-delivered to the provider immediately. It lasts 10 days, which allows DHHS time to decide if Emergency Closure is necessary. If so, that decision is made in a hearing with the Attorney General's office.

OPEGA's Assessment of Timeliness and Effectiveness

OPEGA was unable to assess whether licensing sanctions were being issued for providers with a history of repeated violations due to a lack of readily discernable information in MACWIS.

Policy indicates that an SOD will be issued when the provider's history shows repeated violations of the same nature. OPEGA was unable to assess the extent to which Children's Licensing adhered to this policy due to a lack of readily discernable information on provider history documented in MACWIS. While there was a list of allegations for each provider and a corresponding date, recurring violations and types of licensing violations reports received were not arranged it an accessible, systematic manner within MACWIS. OPEGA observes this situation likely creates difficulty for the Licensing Specialist, and the supervisor, in ensuring SODs are recommended to the CAP when the provider has recurring violations. This limitation and other MACWIS functionality issues are discussed in Recommendation 3.

OPEGA observed a lack of established time frames for post-investigation actions including deadlines for deciding on licensing actions or notifying providers of licensing sanctions.

OPEGA also noted that the SOPs contain only one established time frame for post-investigation actions. This requirement is for the Licensing Specialist to conduct a provider site visit within 30 days of issuing a Conditional License. OPEGA noted that delays in some of the post-investigation actions, like submitting the proposed licensing sanction to the CAP and sending notification letters to providers, may subsequently delay provider corrections and/or notifications to parents. We discuss the need for time frames in Recommendation 2.

Without time frames to use as benchmarks, we were unable to assess whether timeliness of post-investigation actions met expectations overall. Instead, we provide a sense of timeliness for several post-investigation actions by analyzing the time it took to complete them.

Licensing Actions From Investigations of Child Abuse/Neglect

The nine providers receiving sanctions stemming from child abuse/neglect investigations were notified of those sanctions in an average of 15 business days from the end of the investigation.

Of the 21 child abuse/neglect investigations OPEGA reviewed, nine resulted in the following licensing sanctions:

- six providers received a SOD and were required to submit a POC for approval;
- two providers received a SOD, a Conditional License and an agency-directed POC; and
- one received a SOD, a Notice of Denial of License Renewal and an agency-directed POC.

OPEGA found it took an average of 15 business days from the end of the investigation until the provider was notified of licensing sanctions.

Licensing Specialists conducted follow-up visits with all nine providers. The two providers with Conditional Licenses received follow-up visits within the 30 days required by policy. POCs had been resolved for four providers within an average of 53 calendar days.

Documentation OPEGA reviewed showed evidence that Children's Licensing actively monitored all nine of the providers by conducting follow-up visits up until each provider's POC was resolved. We also saw evidence that both providers receiving a Conditional License had received follow-up visits from the Licensing Specialists within the required 30-day time frame.

At the time of our review, POCs had been resolved for four of the providers. The average time between the date Children's Licensing accepted the provider's proposed POC and the date the POC was resolved was 53 calendar days. The remaining five providers had either closed the child care site or were still receiving on-going monitoring.

Licensing Actions From Investigations of Licensing Violations

Ten providers received sanctions stemming from the 20 investigations of licensing violations we reviewed. OPEGA saw evidence that Licensing Specialists conducted follow-up visits with eight of them. The two providers with Conditional Licenses received follow-up visits within the 30 days required by policy.

Of the 20 licensing investigations OPEGA reviewed, ten resulted in the following licensing sanctions:

- eight providers received a SOD and were required to submit a POC for approval; and
- two providers received a SOD, a Conditional License and an agency-directed POC.

Documentation OPEGA reviewed showed evidence that both providers receiving a Conditional License received follow-up visits from the Licensing Specialists within the required 30-day time frame. We also saw evidence that Children's Licensing had actively monitored six of the remaining eight providers by conducting follow-up visits up until each provider's POC was resolved. For the remaining two investigations, we did not find any evidence of a follow up visit or any documentation of any correspondence with the provider indicating proof of correcting the violation.

POCs had been resolved for four providers within an average of 41 calendar days.

At the time of our review, POCs had been resolved for eight of the providers. The average time between the date Children's Licensing accepted the provider's

proposed POC and the date the POC was resolved was 41 calendar days. The remaining two providers were still receiving on-going monitoring.

Notifications of Investigations and Licensing Actions

Direct Notifications to Parents, Guardians and Custodians

Maine Statute Title 22 § 8357 authorizes, but does not require, DHHS to make certain notifications to parents[5] when there is a report alleging abuse/neglect of a child in a child care facility or family child care. This section of statute was enacted in June 2015 via Public Law 2015 Chapter 283.

Per statute, the investigation team *may* notify the alleged victim's parents:

- that there is a report alleging the child has been abused or neglected;
- whether an investigation is being conducted; and
- upon conclusion of the investigation, whether the investigation team determined the allegations are supported or not supported.

Upon conclusion of the investigation, the investigation team *may* also notify parents of other children served by the child care provider, if the team determined a violation of law or rules occurred.

Agency policy is to notify parents of alleged victims in high risk cases that an investigation is being conducted. These parents are also notified at the conclusion of investigation whether allegations are supported.

Children's Licensing's current policy is more directive than statute regarding notification of child abuse/neglect reports. The Investigator is required to notify parents of alleged victims at the outset of the investigation if the allegations are of high severity. Policy specifies this notification should occur via a Department-approved letter within three days of obtaining contact information for the parents. Parents of any alleged victims are also to be notified at the conclusion of the investigation as to whether the allegations were supported or not supported. This notification is also made via Department-approved letter. Children's Licensing explained that its current practice is to notify all parents of alleged victims at the beginning of the investigation and upon conclusion of the investigation, regardless of the severity of allegations.

Children's Licensing notifies parents of non-victims at the beginning and end of an investigation on a case-by-case basis, dependent on whether the alleged abuse/neglect may be a systemic issue.

Agency policy also specifies that parents who were involved in the investigation (i.e. contacted for interviews or other information) *may* be notified of whether the OOH Investigations Unit determined the allegations were or were not supported. Policy does not specify whether or when parents of any other children served by the child care provider should be notified though it does reference the agency's legal authority to notify parents if violations are found. Children's Licensing explained that its current practice is to notify parents of children not named as alleged victims at the beginning and conclusion of an investigation on a case-by-case basis, taking into account whether the alleged abuse/neglect may be systemic.

OPEGA noted that there is no statutory or policy guidance on when an investigation is to be considered concluded. Children's Licensing considers the investigation concluded once the Manager has approved it in MACWIS and notifies parents at this time. At the time of our review, however, Maine CDC's

[5] The term parent, where used, also includes guardians and custodians of children.

16 of 21 investigations contained evidence of parental notification of investigation findings by letter. The remaining investigations either contained documentation of notification by other means or did not require notification.

Legal and Policy Team was of the opinion that an investigation was not concluded until the provider's appeals process has been either waived or exhausted. As the appeals process may take several months, this interpretation can have a significant impact on the timeliness of parental notification. The need to define the conclusion of an investigation is discussed further in Recommendation 5.

OPEGA reviewed the sample of 21 child abuse/neglect investigations for evidence that parents of alleged victims of child abuse/neglect were notified of the investigation's findings. We found parents were notified via certified letter in 16 of the 21 investigations. Of the remaining five investigations, two contained documentation that parents were either notified by other means (phone call, letter sent by DHHS' consulting medical doctor), and three contained documentation that no formal closing letter was required (the complainant or victim recanted) or a decision was made not to send a formal letter for other reasons.

Public Posting of Licensing Violations

Parents may become aware of licensing violations, including those associated with child abuse/neglect investigations, by viewing the Statement of Deficiency, required to be posted by the child care provider on-site.

As described on page 23, Children's Licensing may issue SODs, sometimes accompanied by Conditional Licenses, to child care providers when investigations find serious or recurring licensing violations. This includes violations associated with cases of substantiated or indicated child abuse/neglect. The SODs and Notices of Conditional License are posted by two methods. It is through these postings that child care clients and prospective clients become aware of licensing violations at a particular child care facility or family child care provider.

Agency rules require a child care provider to post the SOD outlining the licensing violations next to the child care license at the facility. Policy further specifies that the SOD must be placed in a "conspicuous" place at the site where it is likely to be observed by parents. The SOD is to remain posted until the Licensing Specialist determines that the conditions in the agreed upon POC have been met.

Licensing sanctions are posted to the Child Care Choices website once the provider has submitted an acceptable Plan of Corrections. Child care providers issued a Conditional License are posted once the appeals process has been waived or exhausted by the provider.

Additionally, statute authorizes DHHS to publish information regarding an investigation on the department's website upon the conclusion of an investigation.[6] Children's Licensing posts SODs, and related POCs and Notices of Conditional License, to its Child Care Choices website which allows the public to search for licensed child care providers and any licensing sanctions they may have received. We were unable to identify any established time frames on which to base the timeliness of these notifications. This is further discussed in Recommendation 5.

Currently, an SOD is only published to the website after a provider's POC has been accepted by Children's Licensing so that both documents can be posted simultaneously. Prior practice was to publish the SOD to the website on the date it was issued, but this was changed to ensure the public also has information on how the provider will address the violations.

If a provider is also receiving a Conditional License, then the SOD, POC, and Notice of Conditional License are not posted to the website until after the provider waives the right to appeal or the appeal process has been exhausted. The provider has 10 days after receiving the Notice of Conditional License to file an appeal. The appeals process may take several months, thus delaying posting to the website. This delay is discussed further in Recommendation 5.

[6] Maine Statute Title 22 Chapter 1674 § 8357.5

Investigations of alleged child abuse/neglect that resulted in a Statement of Deficiencies were posted to the website in 57 days, on average. Those with additional sanctions were posted in 238 days, on average.

In OPEGA's sample of 21 child abuse/neglect investigations, nine resulted in SODs. OPEGA found all nine of these licensing sanctions were posted to the Child Care Choices website. The six with only an SOD and POC were posted to the website in an average of 57 calendar days after the SOD was mailed to the provider. The other three with additional sanctions were posted to the website an average of 238 calendar days after the provider was notified.

Investigations of alleged licensing violations that resulted in a Statement of Deficiencies were posted to the website in 29 days, on average. Those with additional sanctions were posted in 41 days, on average.

For our sample of 20 investigations of alleged licensing violations, 14 resulted in an SOD being licensed (including those issued a Conditional License with corresponding SOD). We found all 14 SODs, and accompanying POCs, were posted to the website in an average of 29 calendar days. Those additional sanctions were posted to the website in an average of 41 calendar days after the provider was notified.

OPEGA was unable to determine whether the total of 23 SODs from all investigations were posted at the child care sites as required by agency rule. Though the Licensing Specialist is expected to ensure SODs are posted during site visits, there is no established procedure for documenting that they have verified the posting of the SOD. This documentation limitation is discussed in Recommendation 4.

Recommendations

1

Children's Licensing Should Enhance Policies to Ensure Thorough and Consistent Investigations

OPEGA observed several instances where the guidance in Children's Licensing's policies was not specific enough to ensure thorough and consistent investigations. For example:

- Policy directs Licensing Specialists and Investigators to conduct interviews with appropriate individuals or collateral contacts, and to collect or review documentation pertinent to the allegation. However, policy does not discuss which parties are expected be interviewed, or what documentation is expected to be reviewed, for different types of allegations.
- Policy directs Investigators to coordinate and consult with relevant "special services," but these "special services" are not described.
- Policy states that a complaint with "high-risk" allegations must be assigned for investigation immediately, but what constitutes "high-risk" is not defined.

OPEGA also observed notable differences in the extent and detail of investigation documentation among field staff. The Children's Licensing Manager confirmed there is variation among field staff in the thoroughness of documentation and how investigations are conducted. The Manager also indicated these variations have become somewhat systemic as newer staff tend to perform and document investigations in a style similar to the existing staff that trained them.

Lastly, we noted that, while there are policies for processing reports of serious or urgent licensing violations reported by the general public, there is no written policy for handling serious or urgent violations found during routine licensing inspections. According to Children's Licensing, the current expectation is that the Licensing Specialist would remain on-site and contact the supervisor. The Specialist would address the violation with the provider at that time and ensure children are safe before leaving. The violation would be documented in MACWIS and follow up work would be performed as necessary.

Recommended Management Action:

Children's Licensing should enhance its policies to set expectations for conducting thorough and consistent inspections and investigations. Policy and procedures should provide specific and clear guidance on what actions are to be taken during an investigation and under what conditions. Although it may not be feasible to specify actions for all types of allegations that may be investigated, the expected actions for investigating common allegations should be established in policy with examples as necessary to provide further clarification. Children's Licensing should use the enhanced policies as the foundation for training new Licensing Specialists and Investigators. Written policy and procedure should also describe the protocol to be followed when a serious or urgent violation is identified during a routine inspection.

Children's Licensing Should Establish Time Frames for Determining Licensing Actions and Notifying Providers

After an investigation is concluded, the Licensing Specialist determines whether licensing actions are warranted. If so, the Specialist prepares a draft of the proposed action, typically a Statement of Deficiency, for review by the Compliance Advisory Panel (CAP). Once the CAP agrees upon the action, the provider is notified.

OPEGA noted that Children's Licensing has established no specified time frames for when a completed licensing investigation must be presented to the CAP for final decisions on licensing actions, nor for when the provider should be notified of any licensing actions being taken. Delays in either of these administrative actions may cause delays in correcting the identified violations and getting the provider into compliance.

Recommended Management Action:

Children's Licensing should establish time frames for presenting proposed licensing actions to the CAP and for subsequent notification to the providers of any actions being taken. The agency should also review whether other time frames need to be established for other post-investigation actions to ensure provider takes steps to correct violations as soon as possible.

DHHS Should Evaluate Replacement of Children's Licensing's Current Documentation System

Children's Licensing currently uses MACWIS as its electronic documentation system. OPEGA observed that MACWIS lacks the functionality needed for efficient documentation and effective supervisory review of investigations. Examples of challenges Children's Licensing faces in using the system include:

- Children's Licensing cannot query data from MACWIS. Instead, Children's Licensing must rely on monthly reports run by the Office of Child and Family Services and provided to Children's Licensing for information on intake reports and investigation activity.
- MACWIS is not capable of tracking the various approvals occurring during the development and drafting of SODs. Instead, staff track these approvals in an external spreadsheet.
- Most of the investigation documentation put in MACWIS is in a narrative format. There are very few discrete fields for data elements that would be helpful for supervisory monitoring and review of investigations.
- MACWIS does not have the capability to timestamp documentation when it is entered in the system, making it problematic for supervisors to determine whether the agency's 10-day goal for entering documentation is being met.
- MACWIS does not have the capability to store scanned documents so Children's Licensing instead uses another documentation system, FORTIS, for this purpose.
- MACWIS does not have the capability to systematically track frequent, repeated or serious violations by a provider, thus impacting staff's ability to efficiently review provider history.
- Navigation and loading of screens in MACWIS is slow and cumbersome.

According to DHHS, MACWIS was originally designed to manage, record, and document child welfare activities and is primarily used by the DHHS Office of Child and Family Services Child Welfare staff for those functions. DHHS also explained that MACWIS is a legacy system built on old architecture and is generally lacking in functionality desired for modern management of any function. The Department is in the process of evaluating options for updating or replacing MACWIS.

Recommended Management Action:

OPEGA understands that Children's Licensing has previously explored options for replacing MACWIS with other systems that would better suit its needs. DHHS should consider Children's Licensing needs in evaluating what to do about MACWIS, including considering, as appropriate, any options for replacement systems Children's Licensing has identified.

4 *Children's Licensing Should Enhance Investigation Documentation*

Children's Licensing Specialists currently use a Word document template for documenting licensing investigations. The Children's Licensing Manager explained that the template was developed to guide staff in capturing the important details of an investigation. Specialists fill in the template and then copy and paste it into MACWIS. Supervisors review this documentation in MACWIS to ensure field staff is conducting all steps necessary for an effective investigation.

OPEGA noted that the template consists primarily of narrative fields and provides little guidance to field staff in the form of prompts as to what information and data should be included in the narratives. The narrative descriptions also allow for inconsistent documentation and make it difficult for supervisors to quickly check whether Specialists completed all the desired investigatory steps.

The OOH Unit is not currently using a template to document investigations and instead enters the documentation directly into MACWIS. We note that, while OOH's written policy provides sufficient detailed guidance on investigation steps and what information should be captured, the documentation in MACWIS is still primarily in narrative form.

OPEGA observes there is an opportunity to enhance the Licensing investigations template with a series of fields designed to prompt the Licensing Specialists to take desired actions and to document the results of those actions consistently. Where appropriate, the fields could capture discrete data elements that are useful for supervisory review of the investigation rather than having that data located somewhere within a narrative description. A similarly designed template for OOH Investigators may also be beneficial for consistently documenting investigations in a way that provides for more efficient supervisory review.

Recommended Management Action:

As described above, Children's Licensing should enhance the existing documentation template used by Licensing Specialists, and consider developing a similar template for use by OOH Investigators, thereby also improving the documentation in MACWIS.

5 *DHHS Should Clarify Expectations for Parental and Public Notifications of Child Abuse/Neglect Investigations*

OPEGA observed several instances where a lack of clear expectations may impact who Children's Licensing notifies, and when, of child abuse/neglect investigations and results. These include:

- Policy states parents of alleged victims will be notified at the onset of the investigation if allegations are high risk. In practice, however, parents of alleged victims are notified in all cases.

- Agency policy specifies that parents of named victims shall be notified whether allegations were or were not supported, but does not describe any scenario in which parents of non-victims would be notified. Statute allows

for notification of other parents and the policy cites this authority to do so but does not provide specific guidance on when notifications, other than to parents of alleged victims, should occur.

- Both statute and policy require or allow notifications at the conclusion of any investigation, but this is not defined and is currently an unresolved issue within the larger organization. The agency has interpreted the conclusion of the investigation to be the Children's Licensing Manager's approval of the investigation, whereas it is the opinion of the Maine CDC's Legal and Policy Team that the end of an investigation can only occur once the Conditional License appeals process has been waived or exhausted. As the appeals process may take several months, this interpretation can have a significant impact on the timeliness of parental notification. OPEGA understands the current Out of Home Investigations draft Rules intend to resolve this discrepancy.

- Statute allows the Department to publish information regarding an investigation to its Child Care Choices website upon conclusion of the investigation. Policy indicates that the SOD and POC will be posted to the website once the POC has been approved. Additionally, agency practice is to post Conditional Licenses with accompanying SOD and POC once the Conditional License appeals process has been exhausted. Conditional Licenses are issued in the case of serious or recurring violations, including violations associated with findings of child abuse/neglect. OPEGA observes there is no time frame established for how soon after accepting the POC it must be posted to the website.

We also observed that statute only specifies that parents of alleged victims of child abuse/neglect *may* be notified of allegations and findings, and that otherwise the only requirements for notifications are in agency policy, which is subject to change. This could potentially result in a scenario in which parental notifications are not required at all if the requirement in agency policy were to change. We understand there was considerable, recent discussion about the use of the word "may" instead of the word "shall" during legislative consideration of the bill that established this statutory language and that "may" is intended to allow DHHS needed flexibility. Consequently, we make no specific recommendation as to possible statutory changes.

Recommended Management Action:

Children's Licensing should review the situations outlined above and ensure that agency policy reflects expectations. The agency, in collaboration with Maine CDC's Legal and Policy Team and other resources as needed, should also establish what constitutes the end of an investigation and develop guidance outlining when notifications can and should occur.

Acknowledgements

OPEGA would like to thank the management and staff of Children's Licensing for their cooperation throughout this review. We also appreciate the information provided by:

- management and staff at the Department of Health and Human Services, including Child Protective Services and the Office of Child and Family Services; and
- management and staff at the DHHS Maine Center for Disease Control and Prevention, including the Divisions of Environmental and Community Health and Licensing and Certification.

Agency Response

In accordance with 3 MRSA § 996, OPEGA provided Children's Licensing and DHHS an opportunity to submit additional comments after reviewing the report draft.

Appendix A. Scope and Methods

The scope for this review, as approved by the Government Oversight Committee, consisted of four questions. These questions were later split into separate parts for a total of five questions. To answer these questions fully, OPEGA used the following data collection methods:

- document reviews including laws, rules, policies and related materials;
- staff interviews; and
- file reviews for a sample of licensing violations and child abuse/neglect investigations.

Document Review

OPEGA reviewed relevant documentation to understand the context and regulatory guidance for reporting avenues. Specific materials reviewed include, but are not limited to:

- Maine Statutes;
- DHHS Rules for the Licensing of Child Care Facilities;
- DHHS Rules for the Certification of Family Child Care Providers; and
- Children's Licensing Standard Operating Procedures for both Licensing and Out of Home Units.

Staff Interviews

OPEGA interviewed DHHS staff to gain an understanding of current practices related to the various components of an investigation and any follow-up actions. Interviews were conducted with the following individuals:

- Children's Licensing Manager
- Child Protective Intake Program Administrator
- Division of Licensing and Certification's Complaint Triage and Investigation Unit Office Specialist
- Children's Licensing Supervisor
- Child Care Licensing Specialists
- Out of Home Investigation (OOH) Children's Special Investigators
- Office of Children and Family Services Management Analyst
- Office of Children and Family Service Planning and Research Analyst
- Children's Licensing Quality and Compliance Officer
- Maine Centers for Disease Control Regulations and Enforcement Manager

Sample Selection

Children's Licensing provided OPEGA with a data file generated from MACWIS that contained the 526 reports received from the public between January 1, 2015 and May 31, 2016. Given resource constraints and the estimated time needed to perform file reviews in MACWIS, we attempted to limit the sample to approximately 40 reports of both reports of alleged child abuse/neglect and reports of licensing violations. The following conditions describe the resulting sample:

Child Abuse/Neglect Reports:

- Although far less frequent than licensing violation reports, child abuse/neglect reports were sampled at a higher rate because of the higher risks involved.
- Child abuse/neglect reports can have two results: unsubstantiated allegations and either indicated or substantiated allegations. Because of the higher risks associated with confirmed reports, all reports with "Indicated" or "Substantiated" findings were sampled.
- The remaining sampled reports were randomly selected with the goal of capturing both child care facilities and family child care providers.

Licensing Violations Reports:

- We sampled a larger number of licensing violation reports with a higher-level sanctions (Statements of Deficiency and Notice of Conditional License) as an outcome, as compared to unfounded reports because of the higher risks associated with the founded reports.
- The remaining six unfounded were randomly selected with the goal of capturing both child care facilities and family child care providers.

The final sample, by strata, is shown in Table A:

Table A: Population and Sample Sizes of Reports to Children's Licensing
January 1, 2015 - May 31, 2016

Report Type	Population of Events	Sampled Events	Sampled Percentage
❖ Child Abuse/Neglect	92	21	23%
➢ Child Care Facilities	53	11	21%
➢ Family Child Care	39	10	26%
❖ Licensing Violation	433	20	5%
➢ Child Care Facilities	239	12	5%
➢ Family Child Care	194	8	4%
Total Reports	**526**	**41**	**8%**

Source: Data file provided by Children's Licensing from MACWIS

File Review

Between November 18, 2016 and November 28, 2016, OPEGA conducted the on-site file review testing at Children's Licensing. Two analysts reviewed the files of the 41 sampled reports in MACWIS, collected various data points and recording results in two separate spreadsheets. Upon conclusion of the testing, the separate spreadsheets were reviewed to ensure the recorded data was the identical, and compiled the data into one sheet. In cases where documentation could not be found by Analysts, we consulted with the Children's Licensing Manager and administrative assistant to assist in finding the expected data fields within MACWIS.

Appendix B. Licensing Investigation Summary Template

Investigation Summary

Report#:
Report Date:
Date Assigned:
Date of First Contact:

Referent Complaint & Contact:

On date, Child Care Licensing Specialist _____ completed an announced/unannounced complaint investigation at _____ Family/Center/Nursery School.

History:

Summary of Evidence:

Rules Violations:

Closure:

Investigation Summary sent to supervisor for review on date.

No further review necessary/ Recommended for review by the Compliance Advisory Panel.

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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March 21, 2017

Ms. Beth Ashcroft, Director
Office of Program Evaluation and Governmental Accountability
State of Maine Legislature
82 State House Station
Augusta, Maine 04333-0082

Re: OPEGA Report on Children's Licensing and Investigation Services

Dear Ms. Ashcroft:

The Department of Health and Human Services ("DHHS" or "the Department") appreciates the opportunity to respond to the above mentioned draft report. We offer the following comments in relation to the recommendations of this report.

For your convenience, below we include the summary recommendation followed by our response. Each response includes the Department's proposed corrective action plan.

Recommendation # 1:
Children's Licensing should enhance policies to ensure thorough and consistent investigations.

Response: In response to OPEGA's recommendation that Children's Licensing should enhance policies to ensure thorough and consistent investigations, the Department would note the continuous quality improvement that has occurred over the past four years. Major efforts to improve the program include: a change in leadership in the spring of 2013; a reorganization of the program structure; increased staff; and the implementation of an aggressive strategic plan focused on resource utilization, accountability, work force development, provider relations, and an established regulatory and legislative agenda. A primary objective of the strategic plan included the development and implementation of Standard Operating Procedures, as none previously existed for the Children's Licensing and Investigation Program.

The Department appreciates OPEGA's thorough review and recommendations regarding Standard Operating Procedures and will incorporate details where applicable to create more explicit procedures for staff. With respect to specific recommendations, the Department provides the following feedback:

- For both child care and the Out of Home Investigation Team (OOH), Children's Licensing will make revisions to Standard Operating Procedures to provide examples of expected actions for investigating common types of allegations, including parties that should be interviewed and documentation that should be reviewed. Current procedure is not explicit with details surrounding coordination and consultation with special services. OOH investigates a wide range of programs; and, depending on the provider type and nature of the allegation, there can be significant variation in participants of a multi- agency investigation.

However, for both child care and OOH, Children's Licensing will revise Standard Operating Procedures to provide examples of the types of special services that should be contacted when investigating common types of allegations.

- A definition of "high-risk" is not included in Standard Operating Procedures and will be incorporated. The definition exists elsewhere in policy. When a complaint is entered into the Maine Automated Child Welfare Information System (MACWIS), the allegations are identified as high-risk and are clear to both the assigning Program Manager and receiving Investigator, but not necessarily to others.

With reference to recommendations for additional and clarifying Standard Operating Procedures around documentation and field response in the event of a serious or urgent violation, the Department concurs that greater detail in these areas would be beneficial.

Children's Licensing Program Manager will follow up with these changes with a completion date of July 1, 2017.

Recommendation # 2:
Children's Licensing should establish time frames for determining licensing actions and notifying providers.

Response: The Department concurs that formalizing established timeframes into Standard Operating Procedures for post-investigation actions would increase internal consistency and potentially expedite corrective action taken by the provider.

Children's Licensing Program Manager will follow up with making these changes with a completion date of July 1, 2017.

Recommendation # 3:
DHHS should evaluate replacement of Children's Licensing's current documentation system.

Response: DHHS concurs with OPEGA's recommendation that the Department evaluate replacement of Children's Licensing's current documentation system. Efforts to enhance the Maine Automated Child Welfare Information System (MACWIS) are currently underway. Children's Licensing has concurrently taken steps to complete a comprehensive gap analysis and has explored risks and benefits to moving child care licensing from MACWIS to a new data management system designed for children's licensing and inspection functions. In addition to a new data management system the Department has explored replacement of the current duplicate paper forms being used for inspections with a tablet. The advanced technology would yield higher quality inspection reports while increasing efficiency. Further analysis is required and the Department will do its due diligence to ensure that the benefits of a replacement system would justify the expense incurred.

Recommendation # 4:
Children's Licensing should enhance investigation Documentation.

Response: The Department concurs with OPEGA's recommendation that Children's Licensing should enhance investigation documentation. Given the limitations within the MACWIS system Children's Licensing developed a standardized template for Child Care Licensing staff to follow when documenting a complaint investigation. Incorporating prompts into the template that do not currently exist would benefit both licensing staff in the field and supervisors in their review of completed investigations. A template will also be developed and implemented for use by the Out of

Home Investigation team as the Department also believes a template would enhance quality, improve consistency, and streamline supervisory review.

Children's Licensing Program Manager will follow up with making these changes with a completion date of July 1, 2017.

Recommendation # 5:
DHHS should clarify when parental notification can and should occur.

Response: The Department is revising Standard Operating Procedures to address minor inconsistencies that currently exist with related statute.

The Department concurs with the recommendation to establish a timeframe for posting licensing actions to the Child Care Choices website. Children's Licensing Program Manager will establish and implement this change immediately.

Thank you for your consideration of the Department's response to OPEGA's findings.

Sincerely,

Mary C. Mayhew
Commissioner