OPEGA Report

Our Approach

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

Separate Reports for Each Case

Resolution of any related criminal proceedings, through the sentencing stage, has also then permitted the DHHS Commissioner to release the kind of public account found at Appendix A of this report. Both of these milestones have now been reached concerning Maddox Williams. Maddox's mother, Jessica Trefethen, was found guilty of depraved indifference murder and sentenced to a 47-year prison term. Releasing an OPEGA report after these steps have occurred allows for a more detailed report.

Acknowledgments

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

April 2023
RR-CFRMW-22

OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Maddox Williams

Summary

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

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

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

We did not endeavor to determine—nor could we—that but for different or additional OCFS intervention, Maddox Williams would have certainly lived and otherwise remained safe. We examined the documented history of safety decisions concerning Maddox Williams to reach conclusions as to whether those decisions were sound in light of prevailing child protection policy and practice, the laws governing such matters, and the information known (or that should have reasonably been known) to authorities when the decisions were

made. To the extent that it may be helpful in understanding how certain safety decisions were made or why certain actions were taken, or could not be taken, in response to various events and information, we have included descriptions of the conditions occurring at these points in the case, as well as the legal, policy, and practice frameworks through which the Department must process that information.

In completing this work, OPEGA created our own timeline from the files received. After the criminal proceedings were complete, DHHS released its December 20, 2022 Memorandum (Appendix A). OPEGA compared our timeline with that document, and then conducted interviews to explore areas where we found differences or did not understand the underlying reasons for OCFS's decisions and actions.

Overall, OPEGA concluded that OCFS safety decisions regarding Maddox Williams were not unsound within those frameworks. Through our interviews and review of records, agency policy and practice, and legal authority, we did nevertheless identify certain legal, practice, resource, and public policy issues that can be pursued to improve child protection. This case is perhaps an extreme example of the range of complexities and complications that the CPS system must assess and triage resulting from the actions of parents and others. Details on the issues we identified for further consideration and potential action begin on page 20 of this report.

Child Welfare Philosophy and Law

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

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

When allegations of child abuse and neglect meet the threshold for investigation, the Department must identify whether or not a child has been harmed and the degree of harm or threatened harm by a person responsible for the care of that child. If, after investigation, the Department determines that a child is in immediate risk of serious harm or in jeopardy, the Department must file a petition in court or assign a caseworker to provide services to the family to alleviate child abuse and neglect in the home. Two procedures are used to initiate a court case by the Department, if providing services is insufficient.

- *A Petition for Child Protection Order with a Request for a Preliminary Protection Order (PPO),* supported by a sworn statement, in which a child's immediate removal from a parent's custody is typically requested [1]. This action requires that the Department prove by a preponderance of evidence (that it is more likely than not) that there is an immediate risk of serious harm to the child. Examples of serious harm include serious physical harm, failure to protect a child from serious harm by others, domestic

[1] While the Department typically requests custody if it files a Request for a PPO, it may request any disposition under 22 MRSA §4036.

violence that is likely to cause emotional harm to the child, and inability to supervise, care for, or protect a child due to substance use or impaired mental health.

- *A Petition for Child Protection Order*, known as a "jeopardy petition" or "straight petition," in which there is no *immediate* risk of serious harm alleged, but there is evidence of serious abuse or neglect requiring court intervention. Examples of this include serious harm or threat of serious harm; deprivation of adequate food, clothing, shelter or necessary health care; or abandonment. Jeopardy may also be evidenced by truancy, in certain circumstances, or by the end of a voluntary placement where the return of the child to his/her custodian creates a threat of serious harm.

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

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

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

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

The court can only terminate parental rights on the basis of parental unfitness if there is clear and convincing evidence that: 1) the parent is unwilling or unable to protect the child from jeopardy and these circumstances are unlikely to change within a time which is reasonably calculated to meet the child's needs; 2) the parent has been unwilling or unable to take responsibility for the child within a time which is reasonably calculated to meet the child's needs; 3) the child has been abandoned; or 4) if the parent has failed to make a good faith effort to rehabilitate and reunify with the child (22 MRSA §4055).

OCFS policy directs caseworkers to file a Petition for Termination of Parental Rights (TPR) at the earliest possible time that reunification is determined to be unsuccessful. The decision to file a TPR is made by the caseworker and supervisor, in consultation with an Assistant Attorney General. Per statute, this is to occur when a child has been in foster care for 15 of the most recent 22 months. The Department must file the petition before the end of the child's 15th month in foster care; however, the Department is *not* required to file a termination petition if the Department has chosen to have the child cared for by a relative or the Department has documented to the court a

compelling reason for determining that filing such a petition would not be in the best interests of the child. (22 MRSA §4052 (2-A)).

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

- **Substance exposed infant (SEI) reports**. The Maine Child and Family Services and Child Protection Act (22 MRSA §4004-B) says that "the department shall act to protect infants born identified as being affected by substance use or withdrawal symptoms resulting from prenatal drug exposure, whether the prenatal exposure was to legal or illegal drugs, or having a fetal alcohol spectrum disorder, regardless of whether the infant is abused or neglected." The Department must receive notification, investigate as determined necessary to protect the infant, determine if the infant is affected, determine if the infant is abused or neglected, and develop a plan for safe care[2]. In practice, the OCFS Child Protective Intake Unit receives notification of substance exposed infants at birth. In a subset of those cases, there is also a report of suspected child abuse or neglect. If an infant tests positive for only prescribed drugs, the family is usually referred to services and the hospital puts together a plan of safe care. If there are concerns of abuse or neglect, OCFS investigates, identifies risk factors such as a history of illicit drug use, and looks for evidence of parental impairment and any negative effects on the child.

- **Families with significant cumulative history of CPS involvement**. When the Intake Unit screens in an allegation and it is assigned for investigation, the first step is for the caseworker and supervisor to complete the required assignment activities and identify potential safety factors, risk factors and safety threats, based on the reported information and review of prior history, alternative hypotheses, and the order of activities. Reviewing the family's prior CPS history is a key part of this first step. Risk factors considered include determining whether the caregiver has had previous CPS investigations of abuse and/or neglect, has caused an injury to a child through abuse or neglect, has had ongoing CPS involvement, has a history of drug or alcohol use, mental health issues, or domestic violence. The CPS practice model states, however, "we believe that people can change. Their past does not necessarily define their potential."

- **Parent and grandparent rights**. Per 22 MRSA §4005-D and §4005-E, grandparents have the right to request participation in a child protection proceeding, and visitation, access, and placement of a child. In cases of child removal from parents, grandparents (as kin, under 22 MRSA §4005-G) are given priority consideration for placement. Relatives of the child may also request to be designated as an "interested party." Nevertheless, as long as a parent has custody of a child, their rights take precedence over grandparent rights. Section 4004(3) states, "[E]xcept as specifically authorized by law, a person may not take charge of a child over the objection of the child's parent or custodian."

- **Compelling parents to cooperate with CPS investigations**. The goal of OCFS is to work collaboratively with families to assess and address safety concerns. Parents have the right to refuse CPS caseworkers' entry into their home, and parents can refuse to allow caseworkers to interview

[2] A plan of safe care is a plan designed to ensure the safety and well-being of an infant with prenatal substance exposure following their release from the care of a healthcare provider by addressing the health and substance use treatment needs of the infant and affected family or caregiver.

their children. The Department reports that most parents cooperate. Statute allows for an initial child interview without notification of parents under limited circumstances (22 MRSA §4021(3)(A)). Interviewing without prior notification is usually done in circumstances where the parents are not yet aware of the Department's investigation.

- **CODE Evaluations**. A Court Ordered Diagnostic Evaluation (CODE) is a comprehensive psychological evaluation of a parent involved in a child protective case. As described by the Department, CODEs are court-ordered and provide a comprehensive assessment to better understand a parent's mental health concerns, cognitive abilities, and parental capacity. The evaluations can include specific questions based on the facts of the case, for instance, how the parent's capacity might impact their ability to determine who is and is not safe around their children.

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

Timeline of Key Events and Exploration of Certain Decisions and Actions

The context in which Maddox Williams came to reside in the care and custody of Ms. Trefethen at the time of his death is important for understanding why certain safety decisions were made and why certain actions were or were not taken. That context is complicated and characterized by multiple children, relationships, reports, investigations, and court proceedings during a history of child protective services involvement that preceded Maddox's birth.

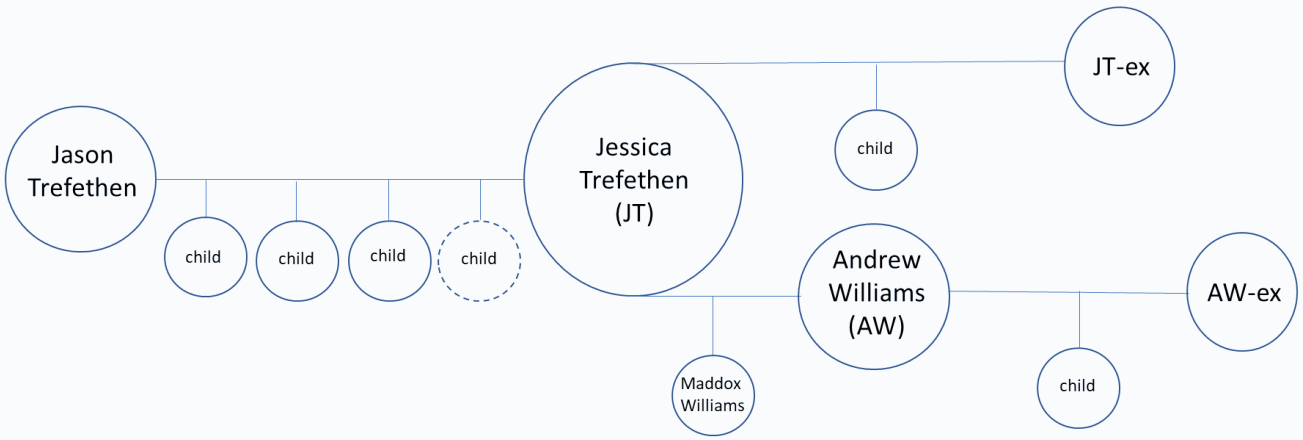
In the following section, we describe the key facts, events, decision points, and resulting actions to the extent made possible by the Department's summary memo of involvement, details emerging in the related criminal prosecution of Ms. Trefethen, and other details that have entered the public domain through the media.

Maddox's Birth, Family, and Early Living Arrangements

In early January 2018, Maddox Williams was born to Jessica (Trefethen) Williams and Andrew Williams, who were no longer in a relationship but still legally married. The two married in June 2017; the relationship reportedly lasted for about one month. Maddox was born prematurely and had been exposed to methadone, which his mother was prescribed as treatment for substance use disorder. CPS received a substance exposed infant report. Ms. Trefethen was referred to public health nursing and parenting support services. She initially expressed interest, but did not engage in services. Maddox was treated in the hospital for more than a month. Immediately following his release from the hospital, Maddox resided with and was cared for by Ms. Trefethen and her mother.

After her marriage to Mr. Williams, Ms. Trefethen eventually reunited with her former long-term partner Jason Trefethen, with whom she already shared two children. In addition to these children, Maddox had an older half-sibling on his mother's side, an older half-sibling on his father's side, a third Trefethen half-sibling born when he was 17 months old, and a fourth Trefethen half-sibling born after his death (see Figure 1).

Figure 1. Genogram: Maddox Williams Case



Source: OCFS document generalized and updated by OPEGA

Note: A genogram is a visual tool used to help a client and clinician understand the client's perceived identity, their family dynamics and their patterns of behavior, OPEGA employs it here to help the reader map Maddox's immediate (blended and extended) family. The dotted circle around one of Maddox's siblings indicates this child was born after Maddox's death.

Prior CPS Involvement

The Trefethens' CPS history dated back to 2013, when CPS received a substance exposed infant report at the birth of their first child. In 2015, a second substance exposed infant report was received when their second child was born. During this time, Ms. Trefethen was taking prescribed methadone as part of substance use disorder treatment, and the infants were treated for symptoms related to their in-utero exposure. The family was offered public health nursing and case management services.

In July 2017, shortly after Mr. Williams and Ms. Trefethen's relationship ended, CPS investigated an anonymous report that the Trefethens were abusing their children and dealing drugs out of their home. A caseworker checked with local police and reviewed criminal records, visited the home, observed the children, and conducted a limited interview with the parents who were reportedly defensive, hostile, and uncooperative. Due to a lack of evidence, the parents were unsubstantiated for abuse or neglect, and the children were deemed safe in their parents' care. In September 2017, CPS received a report alleging Ms. Trefethen was using illegal drugs, taking the children to an unsafe house, and the referent expressed concerns for her unborn child (Maddox). The case was referred to an alternative response program (ARP) for services. The ARP worker visited the maternal grandmother's home twice, interviewed Ms. Trefethen, observed the children, and determined that they were safe. Ms. Trefethen was initially open to engaging in prenatal care and housing search services. When the ARP worker left employment at the ARP agency, however, Ms. Trefethen chose to discontinue services, and the agency closed the case.

Sibling's Ingestion of Methadone and Removal of the Children from the Trefethen Household

On March 22, 2018, the Department received a report from law enforcement that Maddox's two-year-old half-sibling had ingested liquid methadone and the family had failed to seek medical treatment for 30 minutes. The child was administered Narcan in the ambulance and taken to the hospital.

The incident occurred at Ms. Trefethen's mother's house, which is where Mr. Trefethen was living at the time. Mr. Trefethen, the maternal grandmother, and Ms. Trefethen's sibling's child were present in the home at the time of the incident. Although Ms. Trefethen was not present for the incident, she frequented the home and had stayed there overnight at times.

In the earliest stages of the investigation, the caseworker learned that the child had ingested methadone from an unlabeled medicine bottle and the child's caregivers were unable to provide a plausible explanation for how the child was able to gain access to the methadone or where it had come from. The following day, the Department sought and obtained a Preliminary Protection Order (PPO) which placed Maddox in his father's custody and Maddox's siblings in the Department's custody. In placing Maddox, OCFS determined that Mr. Williams did not present an immediate risk of serious harm to Maddox by checking his criminal background, CPS history, and interviewing him by telephone. A caseworker visited Maddox in his father and paternal grandmother's home that day, checked for a safe sleeping area and adequate supplies, and noted that the home was warm and had running water, electricity, and working smoke detectors.

The Trefethen children were placed in foster homes, and weekly supervised visits between children and parents were arranged. Mr. and Ms. Trefethen consistently attended visits with the Trefethen children throughout the case.

A Lengthy Reunification Case and a Legal Issue Related to the Termination of Parental Rights

Following the entry of the Trefethen children into state custody, and Maddox Williams into the custody of his father Mr. Williams, the Department was obligated to provide reunification services to the parents unless otherwise relieved of this requirement by the court. These services are intended to address the specific issues facing the family and can incorporate mental health treatment, substance use treatment, drug screening, and all related transportation to and from these services. The required services and expectations are captured in a Rehabilitation & Reunification (R&R) Plan, with parents being ultimately responsible for making progress on their plan. The R&R Plan also addresses the level of supervision and monitoring of visits between the child and parents. Decisions regarding visitation (including level of supervision and monitoring) are determined by the team which includes the caseworker, supervisor, guardian ad litem (GAL), parents, parents' attorneys, resource parents, and visitation agency. The Department has the final approval of the visitation plan and these expectations are incorporated into the R&R plan that is submitted to the court for judicial reviews. The R&R Plan and the parents' progress is updated for the court prior to each judicial review of the case, which occurs once every six months at a minimum. If there is disagreement among the parties as to the plan, the court will set a contested judicial review hearing, take evidence, and decide how to move forward.

Mr. Trefethen and Ms. Trefethen's earliest R&R plan stipulated that the parents needed to obtain their own housing, remain free of domestic violence, submit to random drug screens, further assess their current substance use/abuse with providers, and complete any treatment recommendations. At the onset of the reunification case, they were compliant with the plans and voluntarily participated in a parenting class, but new concerns quickly emerged. Separately, and concurrently, Ms. Trefethen was subject to similar conditions in her reunification case with Maddox.

Ms. Trefethen began to exhibit volatile and hostile behavior toward the caseworker, GAL, foster parents, and visitation supervisors. The Department would also later become concerned about aggressive behaviors and comments in an altercation that led to Ms. Trefethen's indefinite suspension from transportation services. These behaviors prompted the caseworker and GAL to both advocate for a mental health evaluation of Ms. Trefethen, who was initially agreeable to the request. However, this began a protracted legal dispute over both the need for and the type of evaluation that eventually spanned about 15 months. Some of the many issues related to a mental health evaluation that arose during this time include the following:

- In June 2018, Ms. Trefethen had allegedly already completed a recent mental health evaluation with her existing provider. Despite requests, this was never provided to the Department.
- In August 2018, Ms. Trefethen revoked her release that allowed the provider to speak with the Department. She expressed an interest in signing a more limited release of information.
- In August 2018, Ms. Trefethen requested to have her current provider perform the mental health evaluation; Ms. Trefethen was soon discharged from the provider.
- In December 2018, upon consultation with an outside provider, the caseworker and GAL advocated for a CODE evaluation. Ms. Trefethen's attorney argued that this was not what was reflected in the agreed-upon plan. OPEGA has noted a potential opportunity for improvement related to the availability of this type of evaluation (see Potential Opportunity for Improvement 2 on Page 22).
- In December 2018, the caseworker suggested a provider to perform a mental health evaluation. The provider would consider the Department's noted concerns, observations, and documentation as part of a process and Ms. Trefethen would be required to have five to seven sessions with the evaluator. In

January 2019, Ms. Trefethen minimally participated in only two sessions and the evaluation was incomplete. No official diagnoses were made, but some preliminary, unofficial, diagnoses based primarily on the Department's account were shared with the caseworker. No further appointments were scheduled.

- In April 2019, Ms. Trefethen scheduled and completed a mental health assessment without Departmental input. The caseworker questioned the robustness of the assessment. As of June 2019, the Department had not received a copy of the assessment.
- In September 2019, Ms. Trefethen requested a referral to a provider to conduct the mental health evaluation. The Department agreed, and in October 2019, Ms. Trefethen completed the mental health evaluation. The Department and the GAL accepted this evaluation.

Mr. Trefethen's progress also stalled during this time, as he was unable to complete an Intensive Outpatient Program (IOP) for substance use due to several missed sessions of the program and a failure to produce negative drug screens.

Birth of a New Trefethen Sibling

In June 2019—during the open reunification case—Mr. Trefethen and Ms. Trefethen had another child. The Department received a report from the hospital that the baby was born substance exposed, testing positive for marijuana and methadone. The baby went into the NICU and began receiving treatment due to symptoms related to exposure in-utero. The report was screened in and investigated, and the Department filed a PPO citing Ms. Trefethen's substance use and the fact that jeopardy had not yet been alleviated as to the older children. The PPO was granted, and the Department took custody of the baby. The baby was then placed in the same foster home as one of the baby's siblings.

Filing for a Termination of Parental Rights

Statute (see discussion on page 3) recognizes that instability and impermanency are contrary to the welfare of children and allows for the termination of parental rights to eliminate the need for children to wait unreasonable periods of time for their parents to correct the conditions which prevent their return to the family, to promote the adoption of children into stable families rather than allowing children to remain in the impermanency of foster care, and to protect the best interests of the child.

Statute further specifies that the Department shall file a TPR when a child has been in foster care for 15 of the most recent 22 months and that petition should be filed before the child's 15th month in foster care—unless the Department has not provided to the family the required services deemed necessary by the court for the safe return of the child to the child's home or the Department documents to the court a compelling reason that it would not be in the child's best interest. In order to grant a termination of parental rights, the court must find by clear and convincing evidence (to a high degree of probability) that a parent is unfit and that termination is in the child's best interest. If unfitness cannot be proved by that standard, the court may not consider the child's best interest. There are four independent bases upon which the court can find unfitness: 1. The parent is unwilling/unable to protect the child from jeopardy within a timeframe reasonably calculated to meet the child's needs; 2. The parent is unwilling/unable to take responsibility for the child within a timeframe reasonably calculated to meet the child's needs; 3. the child has been abandoned; or 4. the parent has failed to make a good faith effort to rehabilitate and reunify with the child.

While Maddox never reached the 15-month threshold because he was in the custody of his father, Mr. Williams, and not foster care, the Trefethen children reached this timeframe threshold in roughly June of 2019. They eventually spent a total of 22 months in foster care before their trial home placement with the Trefethens. However, as those involved in this process stated to OPEGA, a TPR was not filed at that point (or sooner) for a few reasons—the primary reason apparently being the birth of the new Trefethen sibling. When this baby enters state custody, the Department becomes responsible for providing reunification services with respect to the new baby to Mr. Trefethen and Ms. Trefethen—which are the very same services that the Department would be asking the court to cease for the other two children if a TPR was filed. Furthermore, the parents were engaged in the reunification process—even if minimally at times—and the children were placed in a less than ideal placement situation: separated from each other and not residing in kinship placements. The caseworker and AAG did not believe that a TPR, if filed at that time, would have been granted by the court; instead, reunification efforts and the children's placements in foster care continued.

We note that the time period immediately preceding the new Trefethen sibling's birth likely represented the most appropriate time with the greatest chance of success to be granted a TPR, and, if granted, may have impacted Maddox's eventual reunification with his mother—a decision which was partly based upon Ms. Trefethen's then trial home placement of the Trefethen children. More to the point, OPEGA notes here that the statute governing the TPR process makes it a mandatory action in the absence of certain factors at this point in the timeline. Of greatest concern to OPEGA, is the apparent lack of an established and formal process that ensures the decision is made and documented, to file or not to file, within the statutory timelines intended to promote permanency (see Legal Issue and Recommendation on Page 20). Typically, this process is accomplished in court through the judicial review/permanency planning hearing in which any decision regarding filing of the TPR is presented to the court, including an articulation by the Department of a compelling reason not to file the TPR if that is the plan recommended by the Department. It would appear to OPEGA to be of utmost importance to not just deliberate on but document very clear and compelling reasons to depart from the statutory presumption that a TPR is to be filed at the 15th month mark, as here, in June 2019. Although this decision should have been documented in the court records, OPEGA found that it was not.

Court Hearing Affirms DHHS's Position that the Trefethen Parents Pose a Safety Risk

A Summary Preliminary Hearing was held in court in August 2019 to determine the newborn Trefethen baby's custody. The court determined that the child was in immediate risk of serious harm and awarded custody to DHHS. The court requested that Ms. Trefethen participate in a comprehensive mental health evaluation and follow all recommendations and said that she "fails to appreciate the grave risk that her mental health and lack of treatment pose to her minor child." Mr. Trefethen's underlying substance use issues and lack of following out-patient treatment recommendations were also listed as concerns. DHHS continued reunification efforts for all three Trefethen children with their parents and for Maddox with Ms. Trefethen.

Reunification Efforts Progress

In the fall of 2019, the Trefethen parents began to demonstrate progress toward alleviating jeopardy to the Trefethen children:

- Throughout the summer and fall of 2019, even amongst scheduling and logistical issues, the visitation supervisors noted mostly high-quality visits with the children.
- In September 2019, the parents obtained housing. The caseworker and the GAL visited and made recommendations to prepare the home for visits with the children. In mid-October, OCFS deemed the home safe for supervised visits with the children.
- In late October, Ms. Trefethen participated in a mental health evaluation that satisfied the caseworker and the GAL, as it addressed the behaviors they had observed in Ms. Trefethen.
- By mid-November 2019, both Trefethen parents were cooperating with substance use and mental health evaluation and treatment expectations, and were allowed to transport the children to monitored visits in their home.
- In mid-December 2019, the parents were allowed unsupervised visits with the children, following demonstrated success during supervised and monitored visits.

It is important to note that the visitations and move to trial home placement were related solely to the Trefethen children. Ms. Trefethen had only minimal contact with Maddox during this entire period as there were several disagreements over the location of visits and whether Mr. Trefethen could be in attendance. According to OCFS records, Ms. Trefethen had not visited with Maddox, attended only two of his medical appointments, and failed to actively participate in reunification services with him during a nearly two-year span.

The Trefethen Children Enter Trial Home Placement with their Parents

In January 2020, as the Trefethen parents continued to meet treatment expectations, the GAL recommended moving to trial home placement. The Department approved this to begin on January 24. Trial home placement is a stage of family reunification that gives "an opportunity for the parents to demonstrate behavior changes they have made to resolve child welfare concerns, support the child's transition into the home and to coordinate services and supports for long-term safety, well-being, and stability." The children return to the parents' care but remain in DHHS custody. Caseworkers are responsible for frequent face-to-face contact with the family and checking with service providers and collateral contacts at least twice a month. Parents must continue to comply with the terms of their Rehabilitation & Reunification Plan.

Divorce Agreement Awards Sole Custody of Maddox to Mr. Williams

On January 15, 2020, a divorce judgement for Maddox's parents was entered in court. Mr. Williams was awarded sole parental rights and responsibilities for Maddox. Ms. Trefethen was granted visitation at the discretion of Mr. Williams. Upon entry of a Family Matter judgement (Parental Rights & Responsibilities judgement), the Department was prepared to dismiss the protective custody order for Maddox Williams against Ms. Trefethen as Mr. Williams now had sole custody and responsibility for Maddox's protection. Based on the motion from the Department, the court ordered that the child protection proceeding be dismissed on January 21, 2020.

Mr. Williams is Arrested While with Maddox

On January 28, 2020, the Department received a report from law enforcement that Mr. Williams was arrested after he was found committing a home burglary while under the influence of substances. He was carrying

Maddox in his arms at the time, and stolen items were found in Maddox's stroller. Mr. Williams was charged with burglary, endangering the welfare of a child, unlawful possession of scheduled drugs, and theft.

Maddox Enters State Custody as DHHS Files and is Granted PPOs Against Both Mr. Williams and Ms. Trefethen

On that same date, the Department obtained a PPO against both Mr. Williams and Ms. Trefethen. The PPO alleged that Maddox was in circumstances of jeopardy to his health and welfare by both his parents and further alleged an aggravating factor of abandonment with regard to Ms. Trefethen based on her pronounced lack of contact with the child. The PPO was granted that day, placing Maddox in DHHS custody. The Department placed Maddox in his paternal grandmother's care as a kinship placement.

At the PPO Court Hearing, DHHS Reconsiders its Position and Withdraws the Petition as to Ms. Trefethen, Which Effectively Grants Custody of Maddox to Ms. Trefethen

On February 12, 2020, a preliminary hearing was held regarding the PPO that was granted against both Mr. Williams and Ms. Trefethen with respect to Maddox. Mr. Williams, Ms. Trefethen, their respective attorneys, the Department caseworker, an Assistant Attorney General, the GAL and Maddox's paternal grandmother all attended and provided input. Mr. Williams was granted a continuance; however, Ms. Trefethen's hearing proceeded.

The prior PPO (2018) that placed Maddox in his father's custody was first and foremost based on the alleged immediate risk of serious harm that Ms. Trefethen presented to Maddox. Despite that allegation, the caseworker, in consideration of the fact that jeopardy had been sufficiently alleviated to begin the trial home placement of Ms. Trefethen's other children, then testified that the Department did not believe that there was an immediate risk of serious harm to Maddox in his mother's custody. The caseworker then explained the conditions that the Department would ask the court to impose on Ms. Trefethen to further ensure Maddox's safety.

The court then indicated that it cannot by law impose such conditions unless there was an immediate risk of serious harm that would allow the court to keep the preliminary order in place. The court then took a recess for the DHHS to consider its position.

During the recess, the caseworker consulted with the AAG, who provided their analysis of the case—in particular, the relative strength of argument to that of Ms. Trefethen's counsel and their overall chances of success—and, together, they considered their primary objective: protecting Maddox from harm. At this point, the caseworker and AAG found it difficult to allege that Ms. Trefethen presented an immediate risk of serious harm to Maddox considering the Department had recently approved her for a trial home placement of her other children. The AAG and caseworker then considered the conditions they had wanted to impose on Ms. Trefethen but could not absent an immediate risk of serious harm. They found that their proposed conditions were essentially the same conditions Ms. Trefethen was already subject to as part of the existing trial home placement and concluded that Maddox would be similarly protected at that time in his mother's care.

Lastly, they reconsidered the remaining component of the PPO—the aggravating factor of abandonment. Throughout conversations and negotiations occurring in and outside of the courtroom, Ms. Trefethen's attorney raised several counterpoints, primarily that Ms. Trefethen had not abandoned Maddox as she was present in court that very day requesting custody of Maddox and that Ms. Trefethen's lack of involvement in

Maddox's life was the direct result of Mr. Williams limiting her access to the child. The AAG and caseworker considered the strength of their argument and that of Ms. Trefethen's counsel, and ultimately decided to withdraw the PPO as to Ms. Trefethen as they felt it was unlikely that they would prevail. With the PPO still in effect against Mr. Williams, the court noted that this effectively granted custody of Maddox to Ms. Trefethen.

Mr. Williams, Maddox's paternal grandmother, and the GAL all disagreed with the disposition proposed by the Department, as they all wanted Maddox to remain in the care of his paternal grandmother as she had been much more involved in his life and he was clearly bonded and attached to her. However, the purpose of this particular type of hearing was strictly to determine whether Maddox was safe in the care and custody of either of his parents, and not to assess whether it was in Maddox's best interest to remain in the care of his paternal grandmother versus being in the care and custody of his mother. It is within this framework that Maddox returned to the custody of Ms. Trefethen.

Acknowledging the parties' concerns with this disposition, the court encouraged Ms. Trefethen and the paternal grandmother to work together to allow for an orderly transition for Maddox. However, the desired orderly transition did not occur, as Ms. Trefethen took physical custody of Maddox immediately after the judgment.

The Trefethen Reunification Case Ends with Custody of the Trefethen Children Returned to the Parents

In February 2020, while the Trefethen family was in trial home placement, a caseworker visited the family three times in-person, interviewed both Trefethen parents, and interviewed or observed each child. The GAL participated in one visit. They did not document any safety concerns. OCFS confirmed that Mr. Trefethen was continuing treatment and had consistent negative drug screens, and that Ms. Trefethen was doing well in mental health treatment. In March, the caseworker conducted two weekly home visits via telephone and Facetime due to COVID restrictions. The caseworker observed or spoke with each child by video and did not have safety concerns. Ms. Trefethen reported that she was continuing mental health treatment by telephone. In late April, the caseworker had a Zoom call with the family, observed Maddox and the other children, and did not have safety concerns. In April 2020, the court ordered that the parents had alleviated jeopardy, and ordered that custody of all three Trefethen children return to the parents.

Trial home placement typically lasts around 12 weeks and no more than six months, without returning to court to explain the reasons for a longer period. In this sense, the trial home placement of the Trefethen children back with their biological parents was typical in terms of length.

Mr. Williams is Reunified with Maddox and an Amended Divorce Agreement Awards Shared Custody of Maddox

After his January 2020 arrest, OCFS investigated and made findings that Mr. Williams was substantiated for neglect of Maddox. He cooperated with his OCFS Rehabilitation and Reunification plan, completing a substance use evaluation, a level of care assessment, and a mental health evaluation. He followed treatment recommendations and attended random drug screens. In late September 2020, the court found that Mr. Williams had alleviated jeopardy regarding Maddox. That same month, an amendment to the January 2020 divorce agreement was filed and agreed upon and awarded Mr. Williams and Ms. Trefethen shared parental rights and responsibilities for Maddox with substantially equal contact. The parents agreed to exchange

Maddox weekly at a location approximately equidistant between their residences and equally share the costs of his care.

Throughout the end of 2020, Maddox was shared weekly by his parents, until Ms. Trefethen did not return him to Mr. Williams, citing concerns of substance use by Mr. Williams. The parents went to court in early 2021, and Mr. Williams was temporarily awarded two weeks with Maddox to Ms. Trefethen's one week with Maddox until his missed time with Maddox was made up.

Report and Investigation of Alleged Methamphetamine Use and Physical Altercation – the Trefethens

On December 21, 202 —approximately eight months after the Trefethens reunified with the Trefethen children and Maddox Williams; and three months after Mr. Williams alleviated jeopardy and was granted joint custody of Maddox—the Department received a report from law enforcement that Ms. Trefethen alleged observing a female friend of Mr. Trefethen "smoking meth" in the presence of three of her children at Mr. Trefethen's home. Ms. Trefethen was reportedly staying elsewhere at the time and Maddox Williams was not present for this incident. The responding law enforcement officer reported that there were also concerns with the condition of Mr. Trefethen's home and that the youngest child appeared unclean, but there was no methamphetamine observed, and Mr. Trefethen and his friend did not appear impaired. Upon investigation, the Department learned that there was an alleged altercation between Ms. and Mr. Trefethen, but the details were unclear. While both Mr. Trefethen and Ms. Trefethen admitted to verbal conflict, they offered conflicting accounts of whether it had become physical.

The Department's investigation included a series of activities. Law enforcement was contacted and provided no new information relating to either Mr. or Ms. Trefethen. The caseworker interviewed the Trefethens, Mr. Trefethen's friend, and Mr. Williams since he had shared custody of Maddox and Maddox was a frequent visitor to the home. The caseworker attempted to interview the children, but Ms. Trefethen did not allow them to be interviewed, and the Trefethens refused to sign some release authorizations for provider records. The children, including Maddox Williams, were observed, and no marks or bruises were noted. When Mr. Williams was interviewed, he reported that Ms. Trefethen had been refusing to allow him to take Maddox as agreed in their amended divorce judgement and he intended to return to court to seek a ruling of contempt against Ms. Trefethen for non-compliance with their custody agreement. The caseworker also contacted the children's primary care provider, staff at the school at which the eldest sibling was registered, and Mr. Williams' treatment providers. Mr. Williams signed releases.

Based on the investigation the Department determined that while the family was not fully cooperative and engaged minimally, there were insufficient grounds to make findings against either Ms. Trefethen or Mr. Trefethen regarding any of the children's safety, or to pursue a court order to compel their cooperation. The investigation was closed with no findings.

Mr. Williams is Arrested While with Maddox and Maddox's Half-Sibling

On March 7, 2021—during one of Mr. Williams' weeks with Maddox—the Department received a report from law enforcement that Mr. Williams had been arrested for operating under the influence (OUI) with his two children in the car (Maddox and Maddox's half sibling). A local business had called law enforcement to report that Mr. Williams was in their establishment and appeared to be under the influence. Law enforcement responded, reviewed surveillance footage, and, based on what they saw, did not believe Mr. Williams was safe

to drive a vehicle. Law enforcement then located Mr. Williams and the children at the home of his mother (Maddox's paternal grandmother), where he was then residing. Maddox and his paternal half-sibling were in the car. Law enforcement observed Mr. Williams to be stumbling, unable to dial his phone or determine who to contact, and unable to plan for the children's safety. Mr. Williams was arrested for operating under the influence and violating conditions of pre-trial release (stemming from his January 2020 arrest) as a result of this incident.

Maddox is Temporarily "Safety Planned" into the Care of a Paternal Relative

With Mr. Williams arrested and Maddox's paternal grandmother at work, there was no immediate caregiver for the children. Maddox's half-sibling indicated that a relative lived nearby and so law enforcement left the children in the care of that relative. Shortly thereafter, Mr. Williams' sibling picked up the children; Maddox's half-sibling was returned to that child's mother, and Maddox stayed with his paternal relative.

This incident was reported to the Department and an investigation was opened. As is practice, the caseworker then visited the paternal relative's home to observe Maddox, who had no visible marks or bruises, except for a scratch on his hip (reportedly from a cat). As part of this visit, the caseworker also checked for safety concerns in the home as well as checking household members' criminal and police records, CPS history, and driving records. At this point, Mr. Williams was considered a threat to Maddox's safety and OCFS worked to ensure all caregivers would protect Maddox from Mr. Williams. (Similar steps were taken with Maddox's half-sibling's mother, who cooperated with the Department, and that half-sibling returned to the mother's home.)

Ms. Trefethen was contacted this same day to participate in a similar safety assessment to ensure Maddox's safety, but refused, stating that she had recently been assessed by the Department and a judge had determined her other children were safe in her care.

As they could not determine the safety of Maddox in the care of his mother, the caseworker and their supervisor developed a "temporary alternative care option safety plan" in which Maddox would remain with the paternal relative until Ms. Trefethen could be assessed or until March 12th—the point at which Maddox was to return to Ms. Trefethen' care per the existing divorce agreement.

Ms. Trefethen initially agreed to this plan, but later cited that custody of Maddox was shared with Mr. Williams—not the paternal relative—and that she would be retrieving Maddox from the paternal relative.

Ms. Trefethen Retrieves Maddox, as She Has Legal Custody

On March 8, 2021, Ms. Trefethen retrieved Maddox from the paternal relative, and, later, expressed a willingness to work with the caseworker and participated in the assessment. At this time, there were no known allegations of abuse against Ms. Trefethen and the Department had no authority to override the terms of the divorce agreement; Maddox remained in the custody of his mother.

On March 10, 2021, the caseworker met with Ms. Trefethen at her home. The home was observed to be cluttered, but not unclean. Ms. Trefethen and Mr. Trefethen participated in interviews and no concerns were noted. Ms. Trefethen did state that she had not previously returned Maddox to Mr. Williams because she suspected that he was using substances, and now planned to seek to modify her amended divorce agreement to gain full custody and primary residence of Maddox. Maddox and his half-siblings were observed, but Ms. Trefethen and Mr. Trefethen refused to allow the caseworker to interview the children without a parent

present. The caseworker would not conduct an interview under those conditions as it is considered a forensically unsound practice and can increase risk to children.

The investigation related to Mr. Williams and all related safety assessments for his children continued. The caseworker requested that he have no contact with the children while the investigation was ongoing due to the severity of the situation. In early April, Ms. Trefethen reported that she had allowed Maddox to speak with paternal relatives on the phone but did not allow him to visit them because she did not feel that they would protect him from Mr. Williams. During this time, Mr. Williams had been out on bail, until his bail was revoked for violating conditions of release and an arrest warrant was issued on April 8, 2021.

On May 6, 2021, the investigation was closed with substantiated findings of high severity neglect and high severity physical abuse by Mr. Williams to his children, and an indicated finding of low severity emotional maltreatment by Mr. Williams to his eldest child. As the investigation was closed, the Department opened a service case to monitor and support the families of the involved children in seeking modifications to their respective family court matters to protect the children of Mr. Williams (including Maddox) from Mr. Williams. Through this service case, the Department would also be available to Mr. Williams when he was released to provide access to supports and treatment to address his substance use issues.

An Alleged Domestic Violence Incident Results in Another Investigation

On April 8, 2021—during the Department's investigation with the family resulting from Mr. Williams' OUI—the Department received a new report from law enforcement detailing an alleged domestic violence incident occurring at the home between Ms. Trefethen and Mr. Trefethen that was witnessed by four children; the referent did not get the children's names. Ms. Trefethen had called 911 reporting that Mr. Trefethen had shoved her and threatened to kill her. Responding officers observed red marks on Ms. Trefethen where she said she had been pushed, arrested Mr. Trefethen, and charged him with domestic violence assault. OCFS Central Intake screened this report as appropriate for investigation with an OCFS response to occur within 24 hours; they also consulted MACWIS and ACES (two DHHS databases) and entered four names into the record: the three Trefethen children and Maddox, all of whom were in the legal custody of Ms. Trefethen. However, it was the three Trefethen children and Maddox's older, maternal half-sibling who witnessed this event; the record indicates Maddox was not present when this occurred.

The following morning, a caseworker and their supervisor completed the Assignment Activities Tool, which is completed prior to going into the field to conduct interviews. Building upon the information from the intake report, only Mr. Williams was identified as an out-of-home parent, as not all of the children were listed in the report (including both those that resided in the home where the incident occurred and those who resided outside of that home).

Hours later, the caseworker conducted an unannounced home visit. Ms. Trefethen was at the home with four of her five children, but not the same four children that witnessed the incident. Ms. Trefethen was interviewed outside the home as she had just gotten the two youngest children to sleep and asserted she did not want them disturbed. Two older children were observed playing outside; however, Ms. Trefethen did not permit the caseworker to interview the children citing that the children have already been through a lot with the Department. Ms. Trefethen did eventually allow the caseworker to quietly enter the home—specifically, the darkened living room—to observe the two youngest children (one of whom was Maddox). The children were sleeping soundly and no marks, bruises or injuries were observed on the uncovered parts of either child.

Over the course of the investigation, the caseworker referred Ms. Trefethen to a local, domestic abuse resource center; ran background checks on Ms. Trefethen, Mr. Trefethen, and Mr. Williams; obtained a copy of Mr. Trefethen's bail conditions (which included no direct or indirect contact with Ms. Trefethen, as well as listing his address as being in another town); contacted Ms. Trefethen's medication-assisted treatment provider using an existing release to find all drug screens were as expected; reviewed and referenced caseworker notes from recent contacts made with a pediatric office and an elementary school that occurred during the other open investigation that resulted from Mr. Williams' arrest; again, requested and was denied the opportunity to see and interview one of Ms. Trefethen' five children who was not at the home at the time of the caseworker's unannounced home visit, but had witnessed the incident; attempted (unsuccessfully) to interview Mr. Williams in jail; and obtained the police report from the domestic violence incident.

During this same timeframe, the caseworker made numerous attempts to connect with and interview Mr. Trefethen. Mr. Trefethen did attempt to contact the caseworker and left voicemails at times when the caseworker was either in the field or conducting interviews for another investigation. Reaching him proved difficult as his phone only worked when connected to Wi-Fi; ultimately, the caseworker was unable to speak to him during the investigation. However, with the police report, the caseworker and their supervisor felt that they had sufficient evidence for an indicated finding of emotional maltreatment by Mr. Trefethen to the children. As the case concluded, the Structured Decision Making (SDM) Risk Assessment Tool was run and it recommended opening a service case with the family. As there was already an existing service case open for the family through Maddox as a result of Mr. Williams' actions, a separate, new service case for the family was considered duplicative and was not opened. The investigation closed on May 13, 2021. About one week later, the caseworker had a telephone call with Mr. Trefethen in which they discussed the case findings and the investigations process.

A Departure from Policy Leads to a Missed Opportunity

OCFS's Child Protection Investigation Policy required the identification and interview of "critical case members." Critical case members are defined in policy as follows:

- any person under 18 years of age alleged to have been abused and/or neglected; or reported to be, or found to be, residing in or visiting the home due to being the child of a parent/caregiver residing in the home where child abuse and/or neglect is alleged to have occurred or findings have been made;
- any parent/caregiver, custodian, or person responsible for the child in or out of the home, when the child has been reported to child welfare or found by child welfare to be a victim of child abuse and/or neglect; and
- any adult who was in a caregiver role and has been reported to be abusing or neglecting a child.

In accordance with this policy, there was one specific interview that OPEGA expected to see occur, but did not: an interview with Ms. Trefethen's eldest child's father, who had custody of that child. Although there was initial confusion surrounding which children were present for the incident, the caseworker did identify the correct children and, per the record, did learn about the eldest's child's custodial arrangement. Not contacting and interviewing this parent represents a departure from policy and a missed opportunity for the caseworker to have potentially learned more about family functioning and additional risk and safety concerns within the Trefethen home.

Potentially more valuable than any information the father may have had is the opportunity that was presented when his child would be in his care and physical custody. At that point, he could have granted the caseworker permission to interview his child who witnessed the alleged domestic violence incident.

We do not endeavor to claim that had this parent been contacted that the outcome for Maddox would have changed. The father could have refused to cooperate or allow his child to be interviewed by the caseworker. Even if they had cooperated, there is no guarantee that either would have disclosed any concerns to the caseworker. Regardless, not attempting to contact Ms. Trefethen' eldest child's father represents a missed opportunity. To address this, we recommend that OCFS provide guidance to supervisors and caseworkers on the practice of exploring custodial arrangements of the identified children in the household and should reinforce this practice through communication and training of staff (see Practice Issue and Recommendation on Page 20).

A Challenge in Conducting Comprehensive Investigations

Additionally, we noted the scope and focus of this investigation to be limited to the most critical and relevant risk and safety concerns and the most critical and relevant individuals with respect to reported allegations, rather than serving as an exhaustive, comprehensive review of all potential risk and abuse. This approach is consistent with our observations from our earlier work reviewing quality assurance and Child and Family Services Review[3] (CFSR) results for individual sampled cases. That work, in conjunction with other survey and interview results for that review process, identified an issue surrounding workload demands for caseworkers and supervisors that necessitates the triaging of investigative tasks associated with their cases and across their overall caseloads (see OPEGA's Child Protective Services Investigations report).

In this investigation, the tasks conducted by the caseworker were directly driven by and largely limited to the concerns identified during the case. We would note that the underlying decisions made regarding the scope of the investigation were based on the following considerations:

- Ms. Trefethen was an alleged victim—not an alleged perpetrator—of domestic violence;
- the alleged perpetrator of that violence (Mr. Trefethen) was arrested, charged, and had bail conditions prohibiting him from contacting Ms. Trefethen;
- the police report clearly described what had occurred and was, in and of itself, sufficient to make findings;
- Ms. Trefethen was compliant with her medicated-assisted treatment program;
- at no point during this investigation—nor during any of her prior CPS involvements—did a caseworker find or was provided with any evidence that Ms. Trefethen posed a threat of physical abuse to her children; and
- the Department already had an existing, open service case with the family that would include continued contact with the family and observations of the children.

However, to the extent that comprehensive investigations that explore *all* areas of potential child abuse or neglect while working with a family is expected by OCFS, the Department must address persistent staff

[3] Child and Family Services Reviews (CFSRs) are periodic reviews of state child welfare systems aimed at achieving better outcomes for children, youth, and families.

vacancies which appears to be the most acute factor presently impacting workloads (see Resource Issue and Recommendation on Page 21).

Service Case Visit for May 2021 is Pushed to June 24, 2021 by Ms. Trefethen; Maddox Dies June 20, 2021

As a result of the CPS investigation that resulted from Mr. Williams' OUI arrest in March, a service case[4] was opened on May 6, 2021 to support the families of his two children. The caseworker's primary goal was to ensure that the families modified their respective family court matters to prevent the children from having unsupervised visits or being transported by Mr. Williams. Monitoring of the Trefethen family to ensure their safety following the alleged domestic violence incident in April was also added to this service case.

The caseworker was expected to visit the family monthly and observe or interview all the children in the Trefethen home. On May 24th, the caseworker contacted Ms. Trefethen by phone call, text message, and email to attempt to set up a visit; the caseworker also contacted Ms. Trefethen's attorney. Although she had no obligation to participate in the service case, Ms. Trefethen responded on May 27th. She said that due to her work schedule and the children's school schedules, she and the children would only be home for a daytime visit on two dates, both in June. On June 4th, she proposed June 17th, but the caseworker was unavailable that day and subsequently scheduled for June 24th. On June 20th, Maddox Williams died.

[4] A service case is that in which child protective services remains involved with the family to provide additional intervention services to address child abuse or neglect concerns.

Overall OPEGA Conclusions

The tragic case of Maddox Williams offers several opportunities to explore further the current legal, policy and practice framework of child protection in Maine. We identified one Legal Issue, one Practice Issue, and one Resource Issue, all with corresponding recommendations; one Public Policy Consideration; and two Potential Opportunities for Improvement.

Legal Issue: Existing Process May Not Adequately Ensure Robust Documentation of Legal Justifications for Not Filing an Otherwise Statutorily Mandated TPR Petition

The reunification of the Trefethen children with their parents spanned over two years with the children placed in separate foster homes for the vast majority of that time. According to statute, the Department shall file a TPR when a child has spent 15 out of the last 22 months in foster care unless certain legal justification not to do so is present; in this specific case, a TPR was not filed at that point. While the underlying reasoning for that decision may not have been unsound, we observed this decision to be passive, i.e., absent an explicit reason that would prompt the caseworker to consider a TPR, with there being no formal decision documented at the presumed milestone—and reunification continued. This is relevant here because the facts in the case at hand (see page 9) disclose that the status and certain determinations concerning the Trefethen children, including in early 2020 essentially governed some of the results for Maddox's placement.

Recommendation:

OCFS should look to better formalize and more robustly document this specific decision in its process and system to prompt staff to make this decision according to the timeframe specified in statute in an effort to promote permanency for children in foster care.

Practice Issue: Custodial Arrangements Were Not Explored for All Children in the Home

In a departure from OCFS policy, we noted that in April 2021 (see page 17), Ms. Trefethen's eldest child's father, who had legal custody of that child, was not interviewed in a domestic violence investigation. Although there was initial confusion surrounding which children were present for the incident under review, the caseworker did identify the correct children and, per the record, did learn about the eldest's child's custodial arrangement. Not contacting and interviewing this parent represents a missed opportunity for the caseworker to have potentially learned more about family functioning and additional risk and safety concerns within the Trefethen home. The caseworker also could have sought permission from the father to interview the child when the child returned to his home.

Recommendation:

OCFS should provide guidance to supervisors and caseworkers on the practice of exploring custodial arrangements of the identified children in the household. Understanding the composition of the household, including any out of home parents and the corresponding custodial arrangements (such as when the child will be residing with the other parent), may be a means of obtaining information about the family and the potential risk and safety concerns. It also may be a means of gaining permission to interview or observe children during the course of an investigation, who are otherwise being prevented from being accessed by another parent. OCFS should reinforce this practice through communication and training of staff and amend

the investigations policy and pursue any related forms, if necessary, to ensure this investigative task is always completed by caseworkers.

Resource Issue: Staff Vacancies May Impact Casework

Notwithstanding the departure from policy, we observed the focus of the April 2021 domestic violence investigation to sufficiently address the allegations of the report, but did not include an exhaustive investigation of all potential forms of child abuse and neglect. Although we note that the caseworker had 15 additional cases at the time of this investigation, staffing issues were not specifically cited as a factor in this case. However, the approach to the investigation was similar to that which we observed in our prior work. In our 2022 Child Protective Services Investigations report, we identified the issue of high workloads impacting the thoroughness of investigation casework. We found four factors that impacted overall workload: the number of investigations, staffing levels, investigative tasks, and investigative timeframes.

At that time, we recommended OCFS continue to evaluate workload, complete its review of required tasks and timeframes of investigations, and update the workload analytic tool to reflect current expectations for investigations and thoroughness. We understand that OCFS is in the process of extending its investigation timeline from 35 days to 45 days, and addressing duplicative work through practice changes. This work is in progress as necessary changes to the child welfare information system (Katahdin) must be developed and deployed in addition to policy changes.

Staffing issues—particularly caseworker vacancies, however, continue to persist. For example, the April 2021 domestic violence investigation was assigned to District 4 (Rockland). As of March 1, 2023, 40% of the caseworker positions in the Rockland office were vacant, as illustrated in Table 1:

Table 1: District 4 Child Protective Services Caseworkers, March 2023

Caseworker Type	Allocated Lines	Vacancies
Investigation	14	7
Permanency	13	4
Adoption	3	1
Total	**30**	**12**

Source: OCFS

Additionally, District 4's Program Administrator noted that as of that date, there were no currently qualified applicants to interview for these positions.

In order to comprehensively evaluate the risks posed to children, workloads must be manageable for caseworkers. Persistent staffing vacancies create higher workloads and a need to triage cases to meet minimum required expectations and to address the cases in which children are at the highest and most immediate risk. Though the Legislature has approved additional staffing positions and a pay increase in recent years, vacancies and the recruitment and retention of staff clearly remain a challenge. Appendix C contains a list provided by OCFS that outlines the efforts they have undertaken to recruit and retain field staff.

Recommendation:

OCFS should conduct a comprehensive examination of CPS caseworker vacancies to identify and propose new strategies to recruit and retain staff. Resulting strategies should be specifically targeted and focused on child protective caseworker positions to address the staffing vacancies within this area of social work. This examination should include the following:

- continue to determine the underlying reasons for CPS caseworker vacancies through exit and stay interviews and how concerns of child protection caseworkers specifically may be alleviated;
- examine the fundamental structure of caseworker and supervisor jobs, and assess whether any restructuring would promote staff retention;
- explore changes to the retirement system and other incentives specific to child protective services casework to promote staff retention and longevity (The Department notes that the work of OCFS field staff is substantially analogous to that of other first responders, including law enforcement, but these staff do not benefit from the same treatment in statute and policies.);
- examine the Department's current requirement that caseworkers be licensed social workers;
- work with the State Board of Social Worker Licensure to develop a means of getting otherwise qualified applicants the requirements they need to become licensed; and
- report back to the Legislature on the status of these efforts and the current number of vacancies.

Potential Opportunity for Improvement 1: Continue OCFS Research into Identifying Risk Factors Related to Targeted Children

In discussions with OCFS management, an observation was shared that the Marissa Kennedy, Kendall Chick, and Maddox Williams cases all involved children who resided in or were cared for in homes with multiple children, yet only one child was the victim of physical abuse. OCFS management is currently researching the concept of targeted children, including a focus on attachment between parents and child victims of abuse. OCFS should continue current research into this area and, if possible, consider how to incorporate any evidence-based approaches to this situation into future training, policies, practices, and/or risk assessments.

Potential Opportunity for Improvement 2: Increase Availability of CODE Resources

The court-ordered diagnostic evaluation (CODE) program provides forensic child maltreatment risk and needs assessments of parents, guardians, other caregivers, children, and their families. Through interviews with the Department, we have learned that there is a lack of CODE evaluators throughout the state. Our understanding is that there are three evaluators covering the state. While OPEGA has not fully evaluated the capacity of CODE evaluations and is not in a position to opine on the merits of these evaluations, the Department has indicated a lack of available evaluators statewide and a lack of internal resources to assist in the recruitment of evaluators. We were unable to assess the reasons for the lack of CODE evaluators as part of this review, but OCFS management indicated that more resources allotted to this program could provide an opportunity to better recruit and retain evaluators.

According to the Department, the Governor's proposed FY2024-25 budget would make some changes to this program:

- move the oversight and administration of the CODE program to State Forensic Service (SFS);

- increase the rates for these evaluations so it is equivalent to other SFS evaluations; and
- increases funding for the SFS to hire a psychologist to oversee the program providing quality assurance on CODE evaluations, as well as allowing for recruitment and training of new evaluators to expand the roster.

Public Policy Consideration: Persistent Disconnect Between Public Expectations for the CPS System and the Current Legal and Policy Framework and Capabilities of OCFS

Throughout our review of the child protective services system, OPEGA has observed a disconnect between what the public expects the system is (or should be) doing and what the system is actually doing or capable of doing (as informed by law and policy). The field of child welfare exists as an array of competing interests that strike a delicate balance. Not everyone will agree as to what best serves a child, but it is a topic worthy of further discussion. We do note that the Department has not requested any changes to their current legal authority.

Appendix A. DHHS Memorandum

December 20, 2022

FROM: Jeanne M. Lambrew, Ph.D., Commissioner
SUBJECT: Maddox Williams

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

Child's Name: Maddox Williams

Child's Age at Time of Death: 3 years

Child's Caregiver(s) at Time of Death: Mother, Jessica Trefethen (formerly Jessica Williams); Father, Andrew Williams (incarcerated at the time of Maddox's death); Mother's Boyfriend, Jason Trefethen

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

- January 2018 – The Department received a report from a health care provider following Maddox Williams' birth. His mother, Ms. Trefethen, had used prescribed methadone during her pregnancy, according to the referent. Maddox was born at 30 weeks and remained hospitalized following his birth. Medical staff also reported that the day after Maddox was born, his mother went to the parking garage of the hospital where she ingested a Tramadol from an old prescription. This report was referred to Public Health Nursing.

- February 2018 – The Department received a report from a health care provider expressing concern that Ms. Trefethen had abruptly left a doctor's appointment for Maddox and the referent was concerned that Ms. Trefethen might not follow through on medical care for Maddox as a result of being upset. This report was screened out.

- March 2018 – The Department received a report from law enforcement that Maddox's two-year-old sibling had ingested liquid methadone and the family had failed to seek medical treatment for 20 minutes. This child was administered Narcan in the ambulance and taken to the hospital. The Department sought and obtained a Preliminary Protection Order, which placed Maddox in his father's custody and Maddox's siblings in the Department's custody on the day following this incident. The Department made findings of substantiated neglect against Ms. Trefethen and Mr. Trefethen as a result of this incident. A Jeopardy Order[5] as to Ms. Trefethen regarding Maddox (and his siblings) was entered by the Court on July 16, 2018, with Ms. Trefethen's agreement. Mr. Trefethen agreed to jeopardy as to Maddox's siblings on this same date. The Court made findings that jeopardy was based on domestic violence and untreated substance use issues. Maddox

[5] More information on the court process is available here: https://www.courts.maine.gov/courts/family/child-protection.html#:~:text=4.-,Jeopardy%20Hearing,date%20the%20Petition%20was%20filed.

remained placed with his father.
    - Mr. Trefethen's history of substance use was identified as an issue in the Jeopardy Order, and he was ordered to complete an Intensive Outpatient Program (IOP). He began the program in the summer of 2018, but did not complete it until April 10, 2019, due to his failure to produce negative drug screens and several missed sessions of the program. At discharge, the provider's recommendations included outpatient treatment and counseling.
    - Ms. Trefethen's history of substance use and mental health issues was identified in the Jeopardy Order. Ms. Trefethen's engagement in services was satisfactory according to her providers.

- June 2019 – The Department received a report during the open case after Ms. Trefethen gave birth to a new baby. This Department immediately sought and obtained custody of the baby due to Ms. Trefethen's substance use and the fact that jeopardy had not yet been alleviated as to the older children.

- January 2020 – The case regarding Maddox was dismissed by the Court on January 21, 2020, with Maddox remaining with Mr. Williams pursuant to a Parental Rights and Responsibilities Order included in a Divorce Judgment between his parents that was entered in the Belfast District Court. The case regarding Maddox's siblings continued until they were reunified in April of 2020.
  The Department received a new report one week after the Court dismissed the case involving Maddox. Law enforcement reported that Mr. Williams had been arrested after he was found burglarizing a home while under the influence of substances. Stolen items were found in Maddox's stroller and Maddox was in Mr. Williams' arms in one of the homes when law enforcement discovered him. Mr. Williams was found in possession of several substances. Law enforcement invoked interim care under 15 MRSA §3501 and called the Department for an immediate response. The Department sought and obtained a Preliminary Protection Order granting the Department custody of Maddox on the day the report was received. Maddox was initially placed with his paternal grandmother, but the court granted custody to Ms. Trefethen on February 12, 2020.
    - The Department substantiated Mr. Williams for neglect based on this incident. The Court found Jeopardy as to Maddox regarding Mr. Williams on May 12, 2020, with Mr. Williams' agreement.
    - The Department developed a Rehabilitation and Reunification Plan with Mr. Williams. Pursuant to that plan, Mr. Williams was to complete a substance use evaluation and level of care assessment, as well as a mental health evaluation. He was ordered to follow all treatment recommendations that resulted from the evaluations and assessment. As part of his treatment, he was also required to attend random drug screens. Mr. Williams engaged in the required services consistently and providers reported positive progress. The Court found that Mr. Williams had alleviated jeopardy regarding Maddox on September 29, 2020, and entered an Amended Divorce Judgment in which the parents were awarded shared custody of Maddox. All parties and the Guardian ad Litem were in support of this resolution.

- December 2020 – The Department received a new report from law enforcement regarding Ms. Trefethen and Mr. Trefethen. Allegations included possible substance use in Mr. Trefethen's home and a physical altercation between Ms. Trefethen and Mr. Trefethen.
    - During this investigation interviews were completed with Ms. Trefethen, Mr. Williams,

and Mr. Trefethen.
    - The Department learned that there was an altercation between Ms. Trefethen and Mr. Trefethen, but the details were unclear. While both Mr. Trefethen and Ms. Trefethen admitted to verbal conflict, they offered conflicting accounts of whether it had become physical.
    - During his interview with the Department, Mr. Williams said he was unhappy that Ms. Trefethen was not allowing him to take Maddox as stipulated in their Amended Divorce Judgment. Mr. Williams reported that he planned to take Ms. Trefethen to Court in February, seeking to find her in contempt for failing to comply with their custody agreement.
  - Ms. Trefethen completed drug screens during this investigation and tested positive for THC and her prescribed methadone.
  - During the investigation, Ms. Trefethen and Mr. Trefethen refused to sign most releases presented to them by the Department and would not allow the children to be fully interviewed by the Department.
  - The Department contacted the children's primary care provider, who indicated that the children were behind on their well child checkups but expressed no other concerns. The Department followed up with the parents on this and they reported that there had been some delays due to COVID.
  - The Department contacted Mr. Williams' treatment providers, who reported that he was engaging in treatment, and they had no concerns.
  - The Department contacted law enforcement, who had nothing to report relating to Ms. Trefethen or Mr. Trefethen.
  - The Department contacted staff at the school where Maddox's older sibling was a student. Staff reported that they were working to address the sibling's attendance issues with remote learning.
  - Based on the information the Department was able to gather, there were insufficient grounds to make findings against Ms. Trefethen or Mr. Trefethen regarding any of the children's safety and well-being, or to pursue court intervention to compel their engagement with the Department.

- March 2021 – The Department received a report from law enforcement regarding Mr. Williams. A local business had called law enforcement to report that Mr. Williams was in their establishment and appeared to be under the influence. Law enforcement responded, reviewed surveillance footage, and, based on what they saw, did not believe that he was safe to drive a vehicle. Law enforcement located Mr. Williams at home. Maddox and an older half-sibling were in the vehicle when law enforcement arrived. Law enforcement observed Mr. Williams to be stumbling, unable to dial his phone or determine who to contact, and unable to plan for the children's safety. Mr. Williams reported to law enforcement he had taken prescribed medication (Suboxone and Xanax). Mr. Williams was arrested for OUI and violating conditions of release as a result of this incident. The Department substantiated Mr. Williams for threat of physical abuse and neglect to Maddox and his other child.
  - Maddox was taken by law enforcement to the home of paternal relatives and his paternal aunt later picked him up. Maddox was observed by the Department at his aunt's home on March 7, 2021 and appeared happy and healthy. He was active, playing with the other children, and had no visible marks or bruises, except for a scratch on his hip (reportedly

from a cat).

- Ms. Trefethen was contacted by the Department on March 7, 2021, and reported she was not willing to participate in a safety assessment or allow the child welfare caseworker into her home. She reported she had recently been assessed by the Department and there were no findings and a Judge had already decided her children were safe in her care. The caseworker attempted to meet with Ms. Trefethen and asked her to participate in the assessment, but Ms. Trefethen replied that she was going to get her child from his aunt's house regardless. Ms. Trefethen retrieved Maddox on March 8, 2021.
- Three days following the initial report, the Department was able to meet with Ms. Trefethen at her home after Ms. Trefethen agreed to participate in the assessment. The Department observed Maddox and his siblings during this visit. Mr. Trefethen was also present. Interviews were conducted and no concerns were noted. Both Ms. Trefethen and Mr. Trefethen engaged in interviews, but they refused to allow the Department to complete interviews with the children.
- Ms. Trefethen reported that she had recently been held in contempt of court for not returning Maddox to Mr. Williams, but reported that she had not returned Maddox because she was concerned that Mr. Williams was possibly using substances. Ms. Trefethen reported that she had tried to obtain a Protection from Abuse (PFA) Order on behalf of Maddox but was denied. She reported that she had begun the process of modifying the Amended Divorce Judgment to ensure Maddox's safety in light of Mr. Williams' apparent substance use and pending criminal charges.
- The Department opened a service case to monitor and support the family as Mr. Williams' criminal cases were adjudicated and as Ms. Trefethen and the mother of Mr. Williams' other child sought modifications to their respective family matter orders. Multiple attempts were made by the caseworker with Ms. Trefethen to have contact with Maddox and his siblings during the open service case. Ms. Trefethen would either fail to respond or not make herself available for the caseworker's visits. Based on the information the Department was able to gather, there were insufficient grounds to pursue court intervention to compel Ms. Trefethen's engagement with the Department.

- April 2021 – During the service case, the Department received a new report from law enforcement. Ms. Trefethen had called 911 reporting that Mr. Trefethen shoved her and threatened to kill her. Maddox and his siblings were present in the home during this reported incident. Law enforcement observed red marks on Ms. Trefethen where she said she had been pushed. Law enforcement arrested Mr. Trefethen and charged him with domestic violence assault. The responding officer reported that the children were visibly upset, noting that the oldest child was crying and holding the younger children. The officer also reported that the home was very messy. Ms. Trefethen reportedly told the officer that Mr. Trefethen was using heroin. The Department made an indicated finding of emotional abuse against Mr. Trefethen as a result of this incident.
  - Ms. Trefethen refused to allow the Department to interview the children but did allow the caseworker to observe them. This observation, on April 9, 2021, was the last day the Department saw Maddox, who was sleeping during the observation. The caseworker did not observe any marks or bruises and Maddox appeared comfortable. Ms. Trefethen refused to allow the caseworker to go to her mother's home to observe or speak with one of the older children.

- The Department attempted to contact Mr. Trefethen, including by mail and phone, to meet with him. Mr. Trefethen did return the phone calls but did not make himself available to meet with the Department.
- Based on the information the Department was able to gather, there were insufficient grounds to pursue court intervention to compel Ms. Trefethen's engagement with the Department.

- June 2021 – The Department received a report on June 20, 2021, from medical personnel who reported that Ms. Trefethen had presented at the hospital with Maddox, indicating that he had been kicked in the stomach by a sibling and pushed or pulled to the ground by a dog. Ms. Trefethen reportedly told medical personnel that following these incidents Maddox walked into the home complaining of stomach pain and saying he was thirsty. Ms. Trefethen reported that she did not like how he looked and that is when she decided to bring him to the hospital. Ms. Trefethen reported that when she arrived at the hospital Maddox stopped breathing and was unresponsive in the parking lot. The medical personnel reported that they found Ms. Trefethen's account strange, as Maddox was pale, cold, and his pupils were dilated and not reactive to light. Medical staff observed bruising all over Maddox's body, including swelling on part of his head. Maddox's abdomen was tense, indicating abdominal trauma. Maddox was in full cardiac arrest and could not be revived. Ms. Trefethen left the hospital approximately 10 minutes after Maddox was pronounced dead.
  - The Department conducted an investigation in coordination with law enforcement, including interviewing family members and other collateral contacts.
  - Law enforcement had interviewed the other children prior to the caseworker's arrival. The siblings did not provide information consistent with Ms. Trefethen's report to medical personnel at the hospital.
  - Mr. Trefethen was interviewed and reported he did not see the incident described by Ms. Trefethen or anything else of concern.
  - Mr. Williams had been incarcerated for over nine weeks and had no recent contact with Maddox.
  - The Department completed a background check on Ms. Trefethen's mother. She had no criminal history except for a 1982 conviction for negotiating a worthless instrument and a 1998 conviction for harassment by telephone. She had no adverse driving history and was not on the sex offender or the child abuse registry. A walk-through of her home was completed, and it was found to be safe and appropriate. Mr. Trefethen signed a safety plan placing the children in the care of Ms. Trefethen's mother for the night. Ms. Trefethen was not available to engage in the safety planning process as she could not be located by law enforcement.
  - On June 21, 2022, the Department gathered information from hospital personnel and Maine State Police. Initial findings during Maddox's autopsy indicated that Maddox had died of multiple blunt-force, non-accidental trauma. Based on this information the Department sought a preliminary protection order from the Courts and custody of Maddox's siblings was granted to the Department. All three children were placed in resource (foster) homes. The Department also coordinated with the Spurwink Center for Safe & Healthy Families (formerly the Child Abuse Program) and the local hospital to complete comprehensive physical examinations of each sibling.
  - It was later learned that Maine State Police had obtained photos (from surveillance cameras

outside the home) of Ms. Trefethen at her mother's home on the night of June 20, 2022, and the morning of June 21, 2022. Based on the timestamp on these images, it was clear that Ms. Trefethen's mother had allowed Ms. Trefethen to be present in the home with the children who were there pursuant to the safety plan. The safety plan specified that Ms. Trefethen's mother was not to allow contact with Ms. Trefethen until Ms. Trefethen could be assessed by the Department. It further specified that if Ms.
Trefethen attempted to make contact with the children, Ms. Trefethen's mother would notify DHHS and law enforcement. Ms. Trefethen's mother later told police that Ms. Trefethen had been at her home.

- Maine State Police located blood in several locations in Ms. Trefethen's home during a search.
- Ms. Trefethen was arrested on June 23, 2022, and was charged with depraved indifference murder.
- Based on its investigation, the Department made the following findings:
    - Substantiated neglect by Ms. Trefethen's mother to all the children
    - Substantiated physical abuse, emotional abuse, and neglect by Ms. Trefethen to all the children
    - Substantiated neglect and emotional abuse by Mr. Trefethen to all the children
    - Substantiated physical abuse by Mr. Trefethen to Maddox.

Appendix B. OPEGA's Methodology

To complete this review of the Maddox Williams case, OPEGA staff collected and analyzed information from multiple sources. The Attorney General's office provided OCFS case files that contained over 200 CPS investigative files and reports, more than 200 medical records, 61 court documents, and 43 background check documents. OPEGA also listened to approximately 500 minutes of recorded interviews between CPS and parties in the investigations. After a first review, OPEGA requested several additional documents and reports. The Attorney General's office and OCFS researched and fulfilled our request.

Table 2: Records Reviewed in the Maddox Williams Case File Review

Record type	Number of documents	Pages
OCFS records*	215	4,521
Medical records	209	13,753
Court documents	61	746
Background checks	43	723
Total	**528**	**19,743**

*Not including 17 recorded interviews (506 minutes) and 40 photos

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

OPEGA staff reviewed a June 28, 2021 internal Briefing Memo from the CPS Regional Associate Director to the Associate Director of Child Welfare Service regarding the death, and the December 20, 2022 Memorandum publicly released by DHHS Commissioner Jeanne M. Lambrew after the criminal case and sentencing was complete (see Appendix A). We also reviewed a draft report from the Maine Child Welfare Ombudsman based on the office's review of the Williams case requested by a relative, and interviewed the Ombudsman about her findings.

OPEGA created a timeline of each CPS contact with Maddox Williams' parents. The staff team identified and discussed each significant decision-making point, and compared them to Maine statute, agency rules, and CPS policy to determine whether we understood the rationale for each decision made. OPEGA then conducted interview with about a dozen CPS staff and other individuals with firsthand knowledge of the case. Key individuals provided more insight into the reasons for their decisions and actions. After completing all the initial discussions, we conducted follow-up interviews with several of those interviewed for further clarification. Finally, the OPEGA team identified several issues in practice and policy that arose during this case, developed recommendations, and identified two potential opportunities for improvement of the child protective system.

Appendix C. OCFS Reported Recruitment and Retention Efforts

Table 3. OCFS Efforts on Recruitment and Retention as of March 2023.
• Worked with Bureau of Human Resources to develop a marketing and recruitment video using current caseworkers to promote the job.
• Paid out $504,000 in recruitment and retention bonuses to Child Welfare Caseworkers, Caseworker Supervisors and Case Aides
• Contracted with Pulse Media to create a digital marketing campaign for Child Welfare caseworker positions.
• Advertised Child Welfare Caseworker position with the American Public Human Services Association (APHSA) Career Center.
• Expanded College Job Fair participation to include all New England states.
• Expanded College Job Fair participation to reach out to HBCU.
• For districts with difficulty hiring new staff, in particular Lewiston and Rockland, we advertised in local newspapers and circulars.
• Advertised Child Welfare Caseworker position with the National Association of Social Workers – Maine Chapter.
• Used paid sponsored ads on Indeed to increase online visibility for advertised positions.
• Expanded Onboarding and Exit Interviews to affect workforce policy.
• Expanded college outreach through in-class presentations: o UMaine Seniors-Social Work class o UMaine Juniors to talk about Field Instruction Program o UMaine Child Development Class Presentation o UMA Seniors-Mental Health and Human Services Class o UMFK- multiple presentation times o UMF-Rehabilitation Classes
• Expanded outreach to Community Colleges to stimulate interest in the social work career field while looking at other OCFS positions as a stepping to Child Welfare Caseworker positions. Met with KVCC in October 2022.
• Participated in the Social Work Advisory Council sponsored through UMPI Social Work Department. The purpose of the council is to inform curriculum development, provide data regarding employment outlooks and other general feedback for the program, and support networking.
• Worked with Quality Improvement Center for Workforce Development (QIC WD) Child Welfare Workforce Analytics Institute to build and strengthen the partnership between child welfare and HR, to identify workforce challenges and explore data to address those challenges, and to develop workforce metrics to inform workforce decisions.
Source: OCFS

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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April 7, 2023

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Dear Director Schleck:

Thank you for the opportunity to review and respond to OPEGA's Case File Review on the Maddox Williams case. The Department of Health and Human Services (DHHS) and the Office of Child and Family Services (OCFS) thank the staff of OPEGA for their thorough review and analysis of the records in this case. We have confidence in the objective nature of OPEGA's work and as such will not be responding to any of the factual information in this review and upcoming case file reviews unless there is disagreement with the characterization or representation of any of the facts. In this case, we have no concerns with the factual information.

DHHS and OCFS appreciate the opportunity to respond to both the conclusions section and the "Potential Opportunities for Improvement" in the report. We do so in the order in which they appear in the report.

Termination of Parental Rights

OPEGA raised a concern about existing practice regarding the timeline and passivity of a potential petition for a Termination of Parents' Rights (TPR) of the children in the Trefethen household.

While the statute provides a timeline for the filing of a petition for a TPR, these decisions are made on an individual, case-by-case basis in consultation among the caseworker, supervisor, and Assistant Attorney General assigned to the case. These decisions are based on the specific circumstances of the case. When a new child is born during an open protective custody case, the Courts often merge that new child's case with the existing case for efficiency, yet rehabilitation and reunification must still be engaged in for the new child. OCFS notes that there is no statutory timeframe within which the Courts must hear a termination petition after it is filed.

In the case of this family, the Trefethen child was born in June of 2019, just as the older children were reaching 15 months in care. The decision not to file a TPR petition was based on these facts and informed by the AAG and the Department's experience, as the Courts generally allow the parents additional time to rehabilitate and reunify after the birth of a new child. In this case, the birth of a new child seemed to renew the parents' engagement in services and changed the trajectory of the case from termination to a focus on reunification.

In January of 2022, OCFS implemented its new Comprehensive Child Welfare Information System (CCWIS), known as Katahdin. Beyond modernizing electronic child welfare records, one of the goals of Katahdin was to simplify the process of documenting information in the record. Built into the legal summary for Judicial Reviews and Permanency Planning Hearings is the requirement to include information regarding decisions around filing for TPR. OCFS plans to take the feedback provided by OPEGA in its report and review the current process in Katahdin to determine if there is any opportunity to enhance this documentation.

Custodial Arrangement

OCFS agrees with the practice issue regarding exploring custodial arrangements for all children in the home and acknowledges that the father of Ms. Trefethen's oldest child should have been contacted and interviewed. OCFS recognized this issue in its own review of the case and noted that the father was not screened into the case at Intake as he should have been. This was a deviation from practice expectations and has been emphasized with Intake staff as a result.

OCFS would also note recent efforts to create a safeguard around this issue in the Investigation Policy which requires at least phone contact with all out of home, adult critical case members during the initial 24- or 72-hour response to a new investigation when in person contact is not possible. This is then followed-up with a full interview during the investigation.

Staff Vacancies

OPEGA flags that staff vacancies may impact casework. Below is data on District 4 vacancies in the months preceding Maddox's death. Based on these data, the Department does not believe that staffing vacancies significantly contributed to this case, although OCFS recognizes that District 4 has historically experienced challenges with staffing.

Date	Vacancies
1/8/21	3
2/5/21	3
3/5/21	1
4/2/21	1
5/14/21	0

That said, OCFS has frequently discussed the challenge of vacancies and workload. The number of vacancies statewide has increased significantly in the past two years. OCFS agrees that staff vacancies are a concerning issue. Maine is not alone in this concern. Child welfare systems in jurisdictions throughout the country are experiencing similar (if not more severe) issues, with some reporting vacancies as high as 35-50 percent of their child welfare workforce, as noted in the annual Workload Report. Through OCFS' work to address staff vacancies, OCFS notes the additional challenge presented by positions that while staffed are impacted by "operational vacancies" including Family Medical Leave Act (FMLA), sick time due to illness (including COVID), etc. These operational vacancies can have a similar impact as vacant positions.

OCFS appreciates the specific recommendations of OPEGA with regard to addressing staffing. OCFS' responses to the individual recommendations are set forth below:

Recommendation: Continue to determine the underlying reasons for CPS caseworker vacancies through exit and stay interviews and how concerns of child protection caseworkers specifically may be alleviated.
Response: OCFS appreciates the recommendation to continue this practice. OCFS has expanded both onboarding and exit interviews beginning in 2021 to inform improvements to workforce policy. All departing staff are requested to provide feedback through requests for an interview or written feedback (or both). The Department has recently conducted stay interviews to learn more about the factors influencing staff decisions to remain in the employment of OCFS.

Recommendation: Examine the fundamental structure of caseworker and supervisor jobs and assess whether any restructuring would promote staff retention.
Response: OCFS (through the 2021 Collaborative Safety review) also identified this as an opportunity and throughout 2022 sought feedback from staff, considered possibilities for improvement, and ultimately sought and received funding and positions for OCFS' Children's Emergency Services (CES) unit which provides afterhours and weekend coverage. This change directly addressed one of the highest priority issues brought forward by staff (including both current and departing staff), that the demands of on-call and afterhours work was having a significant negative impact on their work/life balance and causing burnout. As of March 31, all of the Supervisor positions had been filled and 13 of the 16 caseworker positions are currently filled.

Recommendation: Explore changes to the retirement system and other incentives specific to child protective services casework to promote staff retention and longevity. (The Department notes that the work of OCFS field staff is substantially analogous to that of other first responders, including law enforcement, but these staff do not benefit from the same treatment in statute and policies.)
Response: OCFS believes that shifting the perspective on child welfare staff to view them as first responders could have significant positive impact not just on the staff themselves but on the public perception of staff and their dedication to their critically important public safety work. In some situations, OCFS staff enter potentially dangerous and volatile situations to ensure the safety of children, with no or little recognition. Furthermore, child welfare field staff are frequently the subject of violent and disturbing threats. Staff regularly report concerns about their own personal safety and that of their family members. In recent memory, the Department has neither considered nor responded to legislation to apply the same retirement benefits and other treatment of state employee first responders to child welfare workers, but will explore this recommendation.

Recommendations: Examine the Department's current requirement that caseworkers be licensed social workers and work with the State Board of Social Work Licensure to develop a means of getting otherwise qualified applicants the requirements they need to become licensed.
Response: Holding a social work license is a state requirement for the caseworker position classification. OCFS' Recruitment and Retention Manager works very closely with the State Board of Social Work Licensure to determine whether prospective OCFS staff are eligible to obtain a social work license. For instance, if an individual has a degree that does not automatically qualify under the licensing rules, the Manager closely reviews their transcript for sufficient credits necessary to meet the Board's requirements, but ultimately the determination on whether an individual's course of study is sufficient is made by the Board. The Board is also responsible for any changes to the licensing procedures.

OCFS would note that in other jurisdictions the standard is higher (for instance, in some jurisdictions, a child welfare staff person must hold a master's degree or higher). OCFS believes that the current requirement of social work licensure represents best practice in the child welfare field. Licensed social workers are also subject to comprehensive ethics rules which inform their practice and allow for professional accountability when a licensee deviates from accepted practices.

Recommendation: Report back to the Legislature on the status of these efforts and the current number of vacancies.
Response: OCFS provides reports on a regular schedule to the Health and Human Services Committee on workload. This report includes vacancy data and data produced by the Workload Analytic Tool which analyzes staffing in each office as well as workload to determine where additional staffing may be needed. The 2023 report, as well as previous reports, is available on OCFS' website: https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/child-welfare-reports.

OCFS also reports quarterly on a broader basis about child welfare to the Health and Human Services Committee and has included data on hiring and staffing in each of those reports.

Targeted Children

OCFS appreciates OPEGA's recognition of OCFS' work on this topic. OCFS has consulted with national partners on this emerging topic and partnered with the Assistant Attorney General who handled this case. The information gathered from this work is being used to consider changes to the Structured Decision Making (SDM) tools that staff use when assessing risk and making decisions at critical junctures in investigations and cases. This work will inform future efforts with Evident Change (developer of the SDM tools) to update Maine's tools. OCFS is also taking advantage of additional opportunities to look at this concept on a national level.

CODE

OCFS shares OPEGA's belief that additional resources for CODE would be beneficial by ensuring that staff have the most comprehensive information possible when making decisions regarding permanency regarding the ability of parents to safely care for their children, as well as when advocating for a specific outcome (such as a termination of parental rights). In recognition of this need, OCFS has sought additional resources through the Governor's proposed biennial budget. The requested funding will be used to increase the rate paid for CODEs to align the payment with that paid for other similar evaluations completed through the State Forensic Service (SFS). Funding will also be used to contract for a dedicated coordinator within SFS who will be a professional with the expertise and experience necessary to recruit and train new CODE evaluators, as well as oversee the program and conduct quality assurance within the program.

Public Expectations for Child Welfare

OCFS agrees with OPEGA's observations about public expectations of child welfare versus the system's abilities under current law and federal and state policy. OCFS has a narrow role: to receive reports of alleged or suspected abuse and neglect, to investigate those reports identified as meeting criteria for investigation based on statute and policy, seek state intervention through the Courts when needed to provide for the safety of children, work under the supervision of the Courts to attempt to rehabilitate and reunify families whenever safely possible, and seek safe and permanent homes for children who cannot safety reunify.

The Department has striven to contextualize OCFS's role in its four-part effort to keep children safe by improving (1) the child welfare system, (2) the array of services offered to children and families, (3) the coordination of services and systems such as child care, education, and law enforcement, and (4) prevention of child maltreatment in the first place. On child welfare, the 130th legislature made historic investments, expanded the Office of the Child Welfare Ombudsman, and improved the laws. On services, efforts have continued to improve Maine's behavioral health service array, with the current biennial budget seeking an investment of $237 million in behavioral health for children and others. On coordination, through the Children's Cabinet, the Departments of Education and Health and Human Services are implementing programs to support young children getting supportive services by, for example, advancing Help Me Grow and the Early Childhood Consultation Program.

On prevention, as directed by the Governor, the Department is currently focusing significant time and resources on our work, in partnership with the Maine Child Welfare Action Network (MCWAN), to develop a statewide child safety and family wellbeing plan. This plan is premised on the goal of early addressing the needs of children and families so that, whenever possible, there is not a need for OCFS' child welfare staff to become involved in their lives. The statewide child safety and family wellbeing plan currently under development will consider how Mainers can collectively support families to prevent abuse and neglect, thereby preventing adverse childhood experiences and the need for state intervention. This effort recognizes that while parents love their children and want the best for them, not all families have the same resources or abilities to meet the challenges of parenting and some need additional support to be successful. Through this work, the plan looks to make improvements in the overall

socioecological system of support and services for children and families which comprise the broader child welfare system. Maine's children are the future of this state and families that need assistance to safely care for their children should be met with resources and support long before the need for the State's involvement in their lives.

While this work will never bring back the children tragically lost to abuse and neglect, we believe it will prevent future harm to children and improve the overall well-being of Mainers. Any fatality involving a child is a tragedy. OCFS recognizes the significant work of our staff and our partners, including the Child Welfare Ombudsman, the Child Death and Serious Injury Review Panel (CDSIRP), the Domestic Violence Homicide Review Panel, and Collaborative Safety to review this case (and others) to look holistically at the child welfare system and identify areas for improvement, both within OCFS and the larger child welfare system in Maine. While we work to prevent tragedies through our focus on early intervention and prevention and seek to reduce the need for state agency intervention in the lives of children and families, we will also continue our work to improve OCFS' policies and practices based on review and analysis of critical incidents.

Sincerely,

Jeanne M. Lambrew, Ph.D.
Commissioner

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