



**State of Maine**  
**131st Maine Senate**  
**Senate Republican Office**

**PRESS BRIEFING SCHEDULE**  
**JANUARY 17, 2023**  
**WELCOME CENTER/PRESS ROOM**  
**AFTER SESSION (approximately 12:30 p.m.)**

**What:** Issues Affecting Children, OCFS/DHHS, GOC's Work and Policy Initiatives

**Who:** Senators Trey Stewart, Lisa Keim, Jeff Timberlake, Rick Bennett, Marianne Moore

**Policy Goals covered in today's briefing:**

OCFS Operational Improvement  
OCFS Oversight and Accountability  
OCFS Restructuring

**Background**

Beginning in May 2021, a series of child fatalities over the course of four months led to an order by the Legislature's Government Oversight Committee (GOC) to investigate the Department of Health and Human Services (DHHS) and its Office of Child and Family Services (OCFS) and Child Protective Services (CPS) sub-divisions.

The children killed that year include:

- Jaden Harding, 6 weeks, of Brewer, whose father, Ronald Harding, is still awaiting trial for his May 2021 death.
- Maddox Williams, 3, of Stockton Springs, whose mother, Jessica Trefethen, was convicted in October 2021 for his June 2021 murder. She was sentenced to 47 years in November.
- Hailey Goding, 3, of Old Town, whose mother, Hillary Goding, pleaded guilty to manslaughter in September 2021 for her June 2021 death. She was sentenced in November to 19 years.
- Sylus Melvin, 1 month, of Milo, whose father, Reginald Melvin, is still awaiting trial for the infant's August 2021 murder.
- Karson Malloy, 14 months, of Oakland, whose mother, Ashley Malloy, is still awaiting trial for manslaughter for his November 2021 death.

At the direction of GOC, the Committee's nonpartisan investigative agency, the Office of Program Evaluation and Government Accountability (OPEGA), began its investigation in the fall of 2021. Since then, OPEGA has issued two reports of both the environment and operations within OCFS; and it began a third investigation in October 2022 into the specific

case files of four of the five cases listed above. All of the cases were tracked by DHHS under the criteria as defined in the Child Abuse Prevention and Treatment Act (CAPTA). As discovered through trial testimony and a Dec. 20, 2022, memo issued by DHHS in the Maddox Williams case, DHHS had direct involvement with Maddox from the day he was born until months before his death.

The first report, “Oversight of Maine’s Child Protective Services” issued in January 2022, described in detail the workings of CAPTA-required Citizen Review Panels (CRPs) and the role they play along with the Maine Child Welfare Services Ombudsman’s Office.

The second report, “Child Protective Services Investigations,” was more critical of OCFS and CPS and found the following facts:

1. Caseworkers and supervisors did not have the time necessary to conduct thorough investigations and more effectively assess the safety risks to children and the needs of families. This is a function of the number of cases, staffing levels, investigative tasks and the timeframe needed.
2. The nature and extent of after-hours work requirements and expectations placed on caseworkers pose risks for the quality and effectiveness of investigation work, as well as for staff turnover. This includes after-hours coverage for Children Emergency Services case investigation and overnight supervision at hospitals or hotels.
3. Departure of standard or best practices or poor practices regarding interviews and information gathering, decision making, and safety assessment and safety plans.

Subsequent to OPEGA’s 2022 report, the January 2023 annual report by Maine Child Welfare Services Ombudsman Christine Alberi showed similar concerns in describing the welfare of Maine’s children as being on a “downward trend.”

More specifically, Alberi found the following facts:

- Case specific review found not enough investigative activities were performed to determine the safety of children;
- In some cases, enough information was collected but risk was not recognized and decisive action not taken to protect the child;
- The family’s or child’s prior protective history was not considered;
- Safety plans used during investigations or open cases also continue to pose problems, including parent violations of the plan or its refusal, plans that did not protect from current threats, and plans that were not monitored;
- Reunification cases where there wasn’t an ongoing assessment of trial placements or investigatory steps to determine it was the correct decision.

**Introduction: Sen. Trey Stewart**

**Restructure and Separate OCFS: Sen. Jeff Timberlake**

**Policy:** To reimagine and restructure OCFS into a separate cabinet-level Department of Child and Family Services

**Solutions to explore:**

- Remove OCFS from DHHS and create separate department
- Provide top-line accountability and separate budget for OCFS
- Develop a new interagency and cross system collaboration
- Hold top executive accountable under Ombudsman structure

**Legislation:**

- An Act Regarding Child Welfare (Stewart)
- An Act to Create a Separate Department of Child and Family Services (Timberlake/Bennett)

**Operational Improvement: Sen. Marianne Moore and Sen. Rick Bennett**

**Policy:** To improve the reach and efficacy of current programs and foster better results through strong families.

**Solutions to explore:**

- Evaluate implementation of evidence-based child welfare practices and approaches
- Expand formal Foundations training programs and reinstitute supervisory training
- Allow case workers access to medical information through official means
- Expand mental health and substance use programs to parents at risk
- Review efficacy of Structured Decision-Making (SDM) tools

**Legislation:**

- RESOLVE, To Ensure Access to Children's Psychiatric Residential Treatment Facilities (Black)
- An Act to Improve Child Welfare (Brakey)
- An Act to Guarantee Grandparents the Right to Visitation with Their Grandchildren
- An Act to Continue the Submission of Certain Reports to the Legislature Concerning Child Welfare (Moore)
- An Act to Create Accountability Within the Dept. of Health and Human Service and the Office of Child and Family Services (Moore)
- An Act to Improve Child Welfare (Keim)

**OCFS Oversight and Accountability: Sen. Lisa Keim**

**Policy:** To provide more accountability and transparency within OCFS and DHHS (if not separated).

**Solutions to Explore:**

- Assessment and viability of current supervisory/management staff
- Identification and elimination of retaliatory practices and culture

- Expand the investigative powers of the Maine Child Welfare Ombudsman
- Move the Quality Assurance Program (QAP) to the Ombudsman's office

**Legislation:**

- An Act to Improve the Office of the Child Welfare Services Ombudsman (Keim)
- An Act to Create Accountability Within the Dept. of Health and Human Service and the Office of Child and Family Services (Moore)
- An Act to Provide That Documents Obtained by Subpoena by the Government Oversight Committee May Be Reviewed by Committee Members and Staff (Timberlake)
- An Act to Create an Appeals Process Independent of DHHS (Bennett)
- An Act to Restore Legislative Oversight in Executive Rulemaking (Brakey)

**Q&A Session: Sen. Trey Stewart**