Maine

CHILD WELFARE SERVICES OMBUDSMAN

22ND ANNUAL REPORT • 2024

CHILDREN'S OMBUDSMAN

Table of Contents

The 2024 Maine Child Welfare Ombudsman Annual Report was written and prepared by:

CHRISTINE E. ALBERI, Esq.
Executive Director, Ombudsman

I am honored to present the twenty-second annual report of the Maine Child Welfare Ombudsman. Maine Child Welfare Ombudsman, Inc. ("the Ombudsman") is a statutorily created non-profit solely dedicated to fulfilling the duties and responsibilities promulgated in 22 M.R.S.A. § 4087-A. The Ombudsman provides neutral objective assessment of concerns raised by individuals involved in child welfare cases through the Maine Department of Health and Human Services, Office of Child and Family Services ("the Department").

Analysis of case specific reviews for this fiscal year has continued to show significant struggles in child welfare practice, especially during initial investigations and reunification of families, negatively impacting child safety. Fortunately, this year has also featured a reset of the relationship between the Department and the Ombudsman featuring an increase in collaboration and cooperation between our two offices. The Department has implemented a number of structural changes in upper management and added important positions to the districts. Work continues to effectively implement safety science, and policy work is ongoing. The Department has been receptive to recommendations from stakeholders and staff and has a clear idea what practice and policy issues need to be addressed. The work of improvement is difficult and will not happen overnight, but currently appears to be started on the right path.

Unfortunately, child welfare staff continue to operate under enormous pressure. The systems that surround child welfare are currently unable to support children and families in the way that they should. Most urgently, finding a safe place for a child who is unsafe with parents is an unsustainable drain on staff resources. Child welfare staff spend days and nights in hotels and in hospital emergency rooms with children in state custody. This immediate need takes staff away from crucial casework—either casework to investigate new complaints of child abuse and neglect, or casework to provide good faith reunification services to families.

Additionally, mental and behavioral health resources, especially the more intensive resources, are not readily available to help children who have already experienced significant trauma. This can cause placement disruption and lack of support to kinship placements and foster parents. Also, a shortage of professional visit supervisors causes hardship to families with children in state custody and takes case aids and caseworkers away from other important work.

Staff time is also eaten away by the demands of the new child welfare database, Katahdin. Despite ongoing fixes and enhancements, the system is still inefficient both when reviewing a family's history, and when entering information. Finally, the shortage of defense attorneys for parents has caused weeks and months-long delays in the progress of reunification cases, harming children, parents, and increasing staff workload.

There are other pressures on staff, but 1) lack of mental and behavioral health services for children, 2) lack of professional visit supervisors, 3) ongoing issues with Katahdin, and 4) a significant shortage of defense attorneys are having the most significant impact on the Department's ability to improve casework practice. In order to improve child welfare practice, staff need time to learn and to plan, and to help families prevent future child abuse and neglect.

I would like to thank Governor Janet Mills and the Maine Legislature for the ongoing support to our program and continued dedication to improving child welfare and protecting the children of Maine.

Christie E Allen

Child Welfare Ombudsman

WHAT IS *the Maine Child Welfare Services Ombudsman?*

The Maine Child Welfare Services Ombudsman Program is contracted directly with the Governor's Office and is overseen by the Department of Administrative and Financial Services.

The Ombudsman is authorized by 22 M.R.S.A. §4087-A to provide information and referrals to individuals requesting assistance and to set priorities for opening cases for review when an individual calls with a complaint regarding child welfare services in the Maine Department of Health and Human Services.

MERRIAM-WEBSTER ONLINE defines an *Ombudsman* as:

1: a government official (as in Sweden or New Zealand) appointed to receive and investigate complaints made by individuals against abuses or capricious acts of public officials

2: someone who investigates reported complaints (as from students or consumers), reports findings, and helps to achieve equitable settlements

The Ombudsman will consider the following factors when determining whether or not to open a case for review:

1. The degree of harm alleged to the child.
2. If the redress requested is specifically prohibited by court order.
3. The demeanor and credibility of the caller.
4. Whether or not the caller has previously contacted the program administrator, senior management, or the governor's office.
5. Whether the policy or procedure not followed has shown itself previously as a pattern of non-compliance in one district or throughout DHHS.
6. Whether the case is already under administrative appeal.
7. Other options for resolution are available to the complainant.
8. The complexity of the issue at hand.

An investigation may not be opened when, in the judgment of the Ombudsman:

1. The primary problem is a custody dispute between parents.
2. The caller is seeking redress for grievances that will not benefit the subject child.
3. There is no specific child involved.
4. The complaint lacks merit.

The office of the Child Welfare Ombudsman exists to help improve child welfare practices both through review of individual cases and by providing information on rights and responsibilities of families, service providers and other participants in the child welfare system.

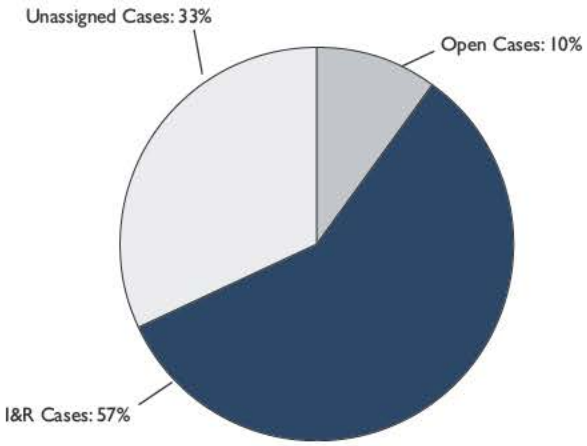
More information about the Ombudsman Program may be found at http://www.cwombudsman.org

DATA
from the Child Welfare Services Ombudsman

The data in this section of the annual report are from the Child Welfare Services Ombudsman database for the reporting period of October 1, 2023, through September 30, 2024.

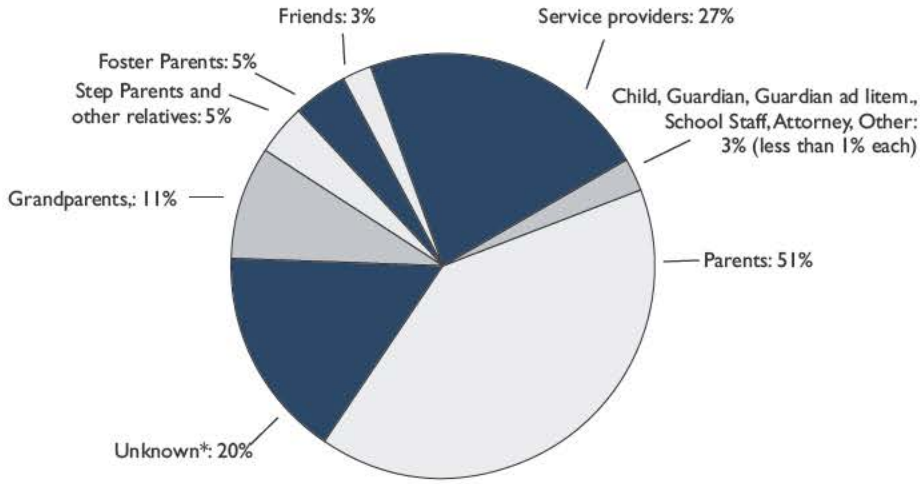
In Fiscal Year 2024, 825 inquiries were made to the Ombudsman Program, an increase of 88 inquiries from the previous fiscal year. As a result of these inquiries, 86 cases were opened for review (10%), 470 cases were given information or referred for services elsewhere (57%), and 269 cases were unassigned (33%). An unassigned case is the result of an individual who initiated contact with the Ombudsman Program, but who then did not complete the intake process. Our scheduling protocols allow each caller an opportunity to set up a telephone intake appointment. Many individuals have ongoing contact with the office; in total 989 phone calls were scheduled and 470 email exchanges took place.

HOW DOES THE OMBUDSMAN PROGRAM CATEGORIZE CASES?



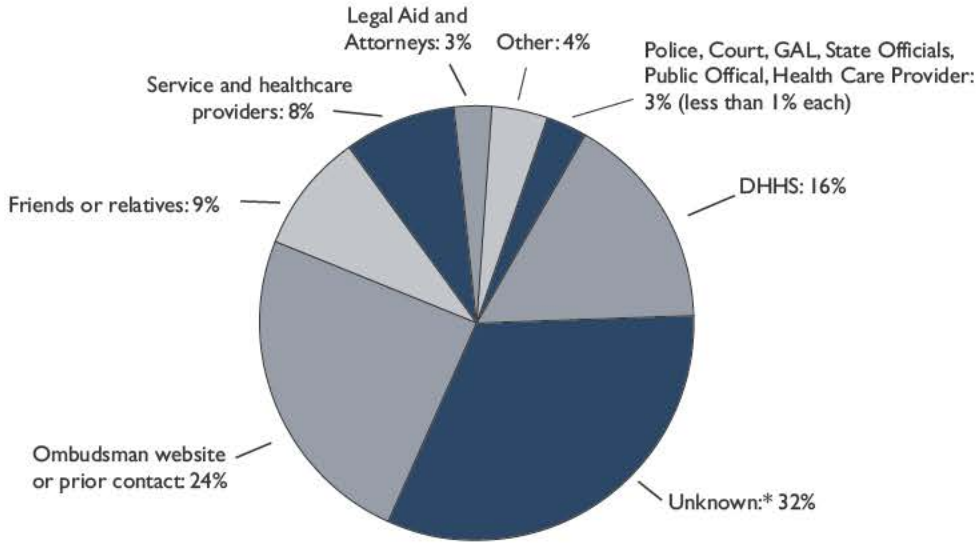
WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2024, the highest number of contacts were from parents, followed by grandparents, other relatives, stepparents, and foster parents.



HOW DID INDIVIDUALS LEARN ABOUT THE OMBUDSMAN PROGRAM?

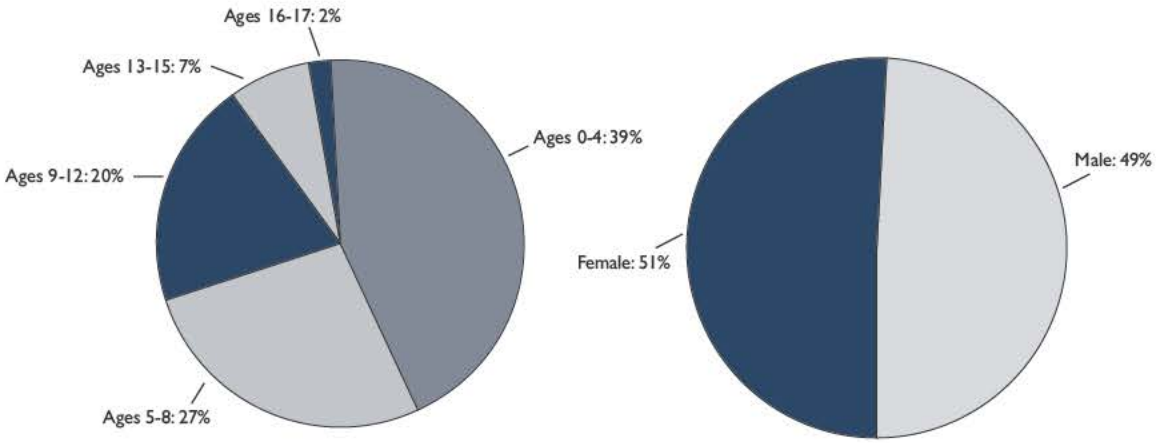
In 2024, 24% of contacts learned about the program through the Ombudsman website or prior contact with the office. 16% of contacts learned about the Ombudsman Program through the Department of Health and Human Services.



* *Unknown* represents those individuals who initiated contact with the Ombudsman, but who then did not complete the intake process for receiving services, or who were unsure where they obtained the telephone number.

WHAT ARE THE AGES & GENDER OF CHILDREN INVOLVED IN OPEN CASES?

The Ombudsman Program collects demographic information on the children involved in cases opened for review. There were 189 children represented in the 86 cases opened for review: 49 percent were male and 51 percent were female. During the reporting period, 71 percent of these children were age 8 and under.



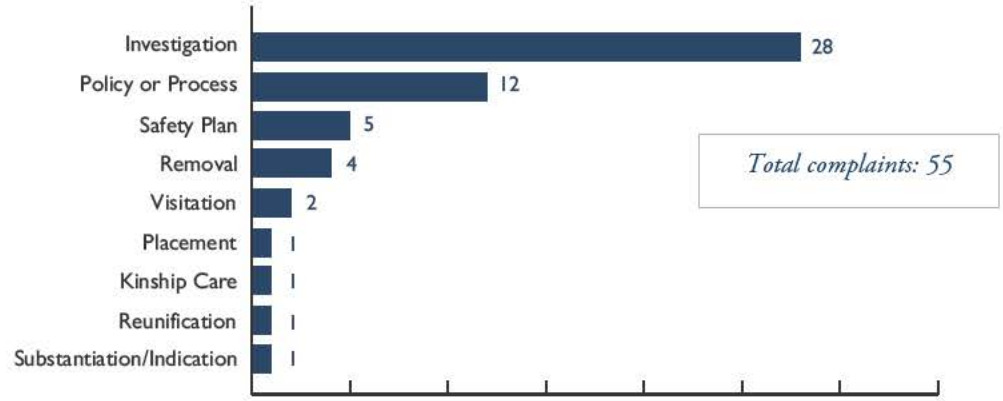
HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

			DISTRICT	CHILDREN	
DISTRICT #	OFFICE	CASES	% OF TOTAL	NUMBER	% OF TOTAL
0	Intake	1	1%	1	1%
1	Biddeford	7	8%	42	22%
2	Portland	7	8%	10	5%
3	Lewiston	10	12%	28	15%
4	Rockland	3	3%	10	5%
5	Augusta	15	18%	31	16%
6	Bangor	14	16%	30	16%
7	Ellsworth	12	14%	24	13%
8	Houlton	6	7%	13	7%
TOTAL		**86**	**100%**	**162**	**100%**

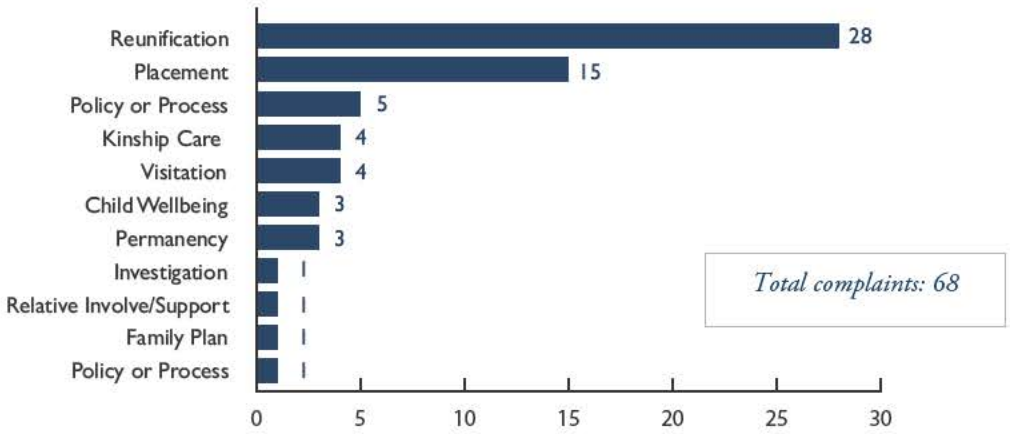
WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 86 cases were opened with a total of 123 complaints. Each case typically involved more than one complaint. There were 55 complaints regarding Child Protective Services Units or Intakes, 68 complaints regarding Children's Services Units, most during the reunification phase.

Area of Complaint: **CHILD PROTECTIVE SERVICES (INITIAL INVESTIGATIONS)**



Area of Complaint: **CHILDREN'S SERVICES UNITS (REUNIFICATION)**



HOW MANY CASES WERE CLOSED & HOW WERE THEY RESOLVED?

During the reporting period, the Ombudsman Program closed 80 cases that had been opened for review. These cases included 99 complaints and those are summarized in the table below.

VALID/RESOLVED complaints are those complaints that the Ombudsman has determined have merit, and changes have been or are being made by the Department in the best interests of the child or children involved.

VALID/NOT RESOLVED complaints are those complaints that the Ombudsman has determined have merit, but they have not been resolved for the following reasons:

1. ACTION CANNOT BE UNDONE: The issue could not be resolved because it involved an event that had already occurred.

2. DEPARTMENT DISAGREES WITH OMBUDSMAN: The Department disagreed with the Ombudsman's recommendations and would not make changes.

3. CHANGE NOT IN THE CHILD'S BEST INTEREST: Making a change to correct a policy or practice violation is not in the child's best interest.

4. LACK OF RESOURCES: The Department agreed with the Ombudsman's recommendations but could not make a change because no resource was available.

NOT VALID complaints are those that the Ombudsman has reviewed and has determined that the Department was or is following policies and procedures in the best interests of the child or children.

RESOLUTION	CHILD PROTECTIVE SERVICES UNITS	CHILDREN'S SERVICES UNITS	TOTAL
Valid/Resolved	1	0	1
Valid/Not Resolved*	19	19	38
1. Action cannot be undone	19	19	
2. Dept. disagrees with Ombudsman	0	0	
Not Valid	19	41	60
TOTAL	**39**	**60**	**99**

* Total of numbers 1, 2

During surveys of 80 closed cases, the Ombudsman identified 30 additional findings in 11 additional complaint areas that here not identified by the original complainant. The complaints were found to be valid in the following categories: 8 investigation, 7 ongoing assessment of reunification, 2 delay in permanency for child, 4 trial placement before safe, 2 safety plans, 1 lack of good faith reunification, 1 intake report screened out, 1 lack of services and foster homes, 2 kinship care and involvement, 1 domestic violence policy, 1 child well-being.

POLICY AND PRACTICE
Findings and Recommendations

The findings and recommendations in this section are compiled from surveys of the findings made in the course of case-specific Ombudsman reviews. The Ombudsman and the Office of Child and Family Services, Department of Health and Human Services ("the Department") have an agreed upon collaborative process to complete case-specific reviews.

The case-specific reviews surveyed for this report reflect what has happened during reviews this fiscal year and is by necessity backward looking. Recently, the Department has undergone a significant shift in philosophy and has renewed collaboration with the Ombudsman's office. The results of the improvements that have begun will take time to see.

Out of the 80 cases surveyed this year, 44 had substantial issues. Cases with substantial issues are defined as cases where there was a deviation from best practices, adherence to policy, or both that had a material effect on the safety and best interests of the children, or rights of the parents. Out of these 44 cases, 21 primarily involved investigations and 17 primarily involved reunification. The remaining 6 cases had varying issues.

- This annual survey of case-specific reviews shows that the Department continues to struggle predominantly in two areas: 1) during initial investigations to collect sufficient information to determine whether children are safe and to recognize risk to children, and 2) during reunification to collect sufficient information when making safety decisions on whether to send a child home.
- Case-specific reviews have also shown an increase in difficulties in determining whether children were safe in resource homes and kinship placements.

The Ombudsman recommends that:

- A serious shortage of children's behavioral health and mental health services, both in-patient and out-patient, is causing harm to children who need the services, and a drain on child welfare staff time and resources. Additionally, this shortage can cause placement disruptions and increased trauma for children in state custody. This issue must be addressed at all levels of children's behavioral health with substantial additional resources.
- The Department should continue the current efforts to improve practice and increase staff retention. These efforts include the hiring of training supervisors statewide, continuing to work with Collaborative Safety LLC to implement safety science reviews and practices throughout the state, and to clarify policies and procedures where necessary. Training in basic best practice for both investigations and reunification cases should continue to be provided to staff.
- The child welfare information system, Katahdin, has continued to be difficult and time consuming to use despite multiple repairs made by Department staff. Clear documentation policy and improvements to make the system more streamlined and effective are fundamentally necessary to effective child welfare practice.
- The shortage of children's behavioral and mental health services, shortage of professional visit supervisors, ongoing issues with Katahdin, and the significant shortage of defense attorneys are having the greatest impact on child welfare staff. These systems must be strengthened in order for child welfare staff to have the space and time to improve child welfare practice, which in turn is necessary to ensure the safety of children.

- Prevention and community support services need to be strengthened both to prevent children from becoming so unsafe that they need to enter state custody and to support families after reunification so that no further child welfare involvement is necessary.

A. Investigations

As in previous years, the Department has struggled with practice issues during initial investigations of child abuse and neglect. Either sufficient investigation activities were not completed to determine whether a child was safe, or enough information was gathered, but the risk to the child was not recognized and protective action was not taken. Safety plans that were not sufficiently monitored or did not ensure child safety were at issue. Multiple cases reviewed had family histories of many previous investigations and involvements and the history was not taken into account. The Department struggled to recognize serious neglect (which included medical neglect, dental neglect, truancy, food, shelter, clothing, hygiene, and abandonment) and intervene.

Examples of practice issues in investigations included: lack of contact with schools when investigating truancy; lack of contact with collateral witnesses including other adults in the home; critical case members such as parents and children were not interviewed separately; parents were not asked to randomly drug screen; formal safety plans were not made; out of home children were not located; clear disclosures of abuse or neglect by children were not found credible when made to the Department or to other professionals; all areas of child safety were not assessed; there were delays in filing necessary court petitions; safety plans were not monitored; and medical experts such as child abuse pediatricians, the Department's medical director, or other doctors were not contacted.

B. Reunification

Practice decisions made during reunification and open service cases were not supported by enough information to make informed decisions about whether or not children were safe to return home to their parents, or whether they were safe in their parents' care during service cases or open court cases. The ongoing assessment of parents' progress during reunification, or reunification and service plans that did not address all areas of unsafe behavior towards a child, made permanency decision-making difficult, and collection of evidence for success in contested court hearings problematic. There were also significant delays in permanency, often caused by petitions to terminate rights filed far outside the statutory timeframes. Trial placements were started before all jeopardy issues were addressed, and trial placements were not monitored enough to ensure child safety.

Examples of practice issues in reunification cases included: regular contact with parents was not made including in the home; minimal contact was made with providers including prior to assessments or the start of counseling which impeded providers' ability to help parents resolve safety concerns; casework was not consistent, sometimes months would pass with little casework completed; the original issues as well as new areas of risk were not all addressed in service or reunification plans and appropriate services not required; the history of families was not taken into account especially to analyze patterns of behavior or the effect on children of previous time in state custody; ongoing assessment of the child's safety in the custody of a parent during an open case was often minimal including face to face contact with the child; family team meetings were not regularly held; random drug screens were not asked for when assessing recovery from substance use; cases were not held open long enough in cases of neglect to ensure that issues would not recur, including the dismissal of court petitions; and service providers were not challenged when not cooperative or objective.

C. Resource Homes and Kinship Placements

Ideally, if a child has to be removed from a parent's care, placement in a safe, familiar, and loving kinship home is the next best possible outcome. When kinship homes are not available or not safe, a child is placed in a licensed resource home. Additionally, the best outcome for a child in state custody is to stay in one home during the time in state custody, and then return to their parents or be adopted by their kinship home or now familiar resource home.

Unfortunately, this year eight reviews detailed instances where children were placed in unsafe resource homes or unsafe kinship placements and the Department did not recognize the risk to the children and delayed in changing placements. Staff are currently under a significant amount of pressure to find placements for children, and when placements cannot be found staff are then responsible for caring for children themselves in district offices, in hotels, and in emergency rooms. We do not have enough places for unsafe children in Maine, which may be contributing to this year's issues seen with out-of-home placements in Ombudsman reviews.

Lack of services for children can also have a significant effect on placement disruption. For example, if a child with serious behavioral issues is placed in a kinship placement, and the relative is struggling to manage the child's behaviors, and the child and relative cannot get support through counseling for the child and in home behavioral health services, the relative may not be able to keep the child in the home long term, causing the child to have to move to another relative, a resource home, or a therapeutic foster home.

Some examples included: a long delay in removing a child from an unsafe kinship home even after sufficient information was collected; a long-time foster home with a history of multiple licensing and child protective investigations which collected evidence over the years that the home was not appropriate for children still had children in the home; assessment of the safety of a kinship placement was not completed before a child was placed there; a relative's home under a safety plan was not assessed for safety; Title 18-A guardianship (probate guardianship) was used in inappropriate circumstances and without investigation; a new placement for children was allowed to call the children by different names immediately; investigation into neglect in a foster home was not thorough or timely; and clear risk in a foster home was not recognized.

D. Katahdin

On January 18, 2022, the new child welfare database, Katahdin, went live. This was a long-planned move due to the age of the previous database, the Maine Automated Child Welfare Information System (MACWIS). We are now approaching our third year with Katahdin, and the system continues to be a struggle to use, both for caseworkers entering information, and for Department staff and Ombudsman staff to review cases.

The Department has continued to work on Katahdin and implemented many fixes, most notably the ability to print out information in chronological order throughout a case (Discovery Print.) However, Katahdin is still not user friendly, and Ombudsman staff have consistently noted that case reviews take longer than they did using the previous MACWIS system. This is particularly true when there is a long history, a complicated family, or if investigations are performed during service cases. When cases are printed out in chronological order, there are often missing narratives and narratives appear under a different date than they are entered under. With the narratives that are entered, the reasoning behind decisions is difficult to determine. Collateral contacts, emails, text messages, phone conversations, and

other documentation are not often entered. Court orders, medical records, Guardian ad litem reports, police reports, counseling records, drug screens, and other necessary documentation is sometimes uploaded and sometimes not. Sometimes these are uploaded under a person and sometimes under a case.

When searching for cases, searching under different family member's names brings up different reports, investigations, and cases, therefore all names must be searched and involvements compared. Genograms in cases are not reliable. Staff can find it difficult to draft petitions, including petitions to terminate rights due to the difficulty of summarizing information from Katahdin.

E. Case Summaries

a. Investigations

1. A month passed between the initial report and when the child was seen by a medical professional. 44 days after the initial report the child was hospitalized and diagnosed with severe malnutrition. The child was thin and pale, had a distended belly, dangerously low heart rate, hypothermia, anemia, and had elevated liver enzymes (likely caused by prolonged starvation). A child abuse pediatrician concluded that the malnutrition was as a result of neglect of the parents. The child was returned to the parents after discharge from the hospital and remained in the home for a month before entering custody due to the parents' lack of cooperation. Ultimately the child's siblings were also removed from the home due to further disclosures of abuse and neglect.

2. An infant was born substance exposed and the parents determined unsafe. The infant was voluntarily placed with a relative, but the relative's home was not assessed, there was no home visit before or after the child was placed there, no knowledge of who was residing in the home, no written safety or prevention plan, and the infant's name was not documented in the database. The unsafe mother had been residing in the home and caring for the infant. The infant died two and a half months after placement due to ingestion of fentanyl and cocaine. A previous ombudsman report had detailed concerns about the relative's safety as a caregiver for other children.

3. The child were left in an unsafe home for six weeks after the initial report to the Department and further subjected to sexual abuse by a parent. The parent was a registered sex offender and had rights terminated to an older child due to sexual abuse of that child. The child in the current case made clear and credible disclosures to school staff and to the Department. The parent's treatment provider was not cooperative. After the initial interviews, no further casework was done until the children entered custody via PPO.

4. A child was left in an unsafe home for three and a half months after the removal of another child from the same home. The stepparent in the home with the child had significant history that included findings of abuse to older children, allegations of sexual abuse to another older child, and multiple criminal charges that included of domestic violence assault and endangering the welfare of a child. During a previous investigation the stepparent had been determined unsafe by the Department and there was a protection from abuse order in effect for another child.

5. The children were unsafe with both parents for years despite multiple child welfare involvements and with minimal support from the courts. The most recent investigation was also insufficient to determine the children's safety, but they are likely protected due to one parent's incarceration. In the past four years the family has had ten investigations and three open cases that included two court petitions and a safety plan. The children were subjected to emotional abuse and physical abuse. One parent has significant substance use issues and has never been a safe caregiver, due to substance use, drug trafficking, and exposure to unsafe people. One child has developed significant behavioral issues. The other parent has also struggled on

and off with substance use. One child made a series of reports of physical and emotional abuse by a parent to school staff. This was investigated and despite the severity of what was discovered, only low to moderate severity findings were made. When one parent tried to protect the child from the other, that safe parent was unable to obtain a protection from abuse order from the court. When the unsafe parent was released from jail, the Department determined that the child was safe due to the denial of the protection from abuse order. The children began to have contact with the unsafe parent again, who, two months later, was arrested for trafficking methamphetamines along with another adult with significant child protective and criminal history who was also living in the home with the children.

6. A child, previously in state custody, was abandoned by the adoptive parents. The safety of the other children in the home (also adopted from state custody) was not investigated despite reports of neglect. The safety of the biological parent where the child first went to stay was not investigated. The safety of the unrelated community home was not initially assessed after the child went there. The parents made regular abusive statements to and about the child and refused to arrange for schooling, medication, financial support, or other services. No court petition was filed by the Department and no higher-level findings were made as to the adoptive parents. The community placement obtained guardianship.

7. Three investigations were completed, including one that led to a service case, without the children being protected or all of the issues resolved. The parent was on the sex offender registry, but the sex offender treatment provider was not spoken with, and records were not obtained of the reported treatment. The third investigation was opened after one of the children reporting inappropriate touch by the parent. Both parents in the home were substantiated, and the non-offending parent was relied upon for supervision despite that parent's denial of risk. The non-offending parent then left the state with one child. The safety of the other two children who resided out of the home part of the time was unresolved.

8. Eight investigations had been opened since 2015 without thoroughly investigating or intervening for child safety. Past truancy reports sent to ARP were not addressed effectively. During the most recent investigation critical case members, collaterals, and the child were not interviewed separately. The parent was newly in substance use treatment, but other than the self-report from the parent, this was not further assessed. The child witnessed the stepparent overdose and die. The child had missed a considerable amount of school, counseling appointments, and had poor hygiene. The parent and child were living in an unsafe home.

9. All of the information that resulted in the removal of the children in the home was available in the 2021 investigation and during the first six or seven weeks of the current involvement. One parent had a significant history, both parents admitted recent methamphetamine use, and one parent and a relative reported domestic violence in the home. Instead of filing for custody, the Department made a safety plan with the parents. The child stayed with the parents and the plan was not monitored, no announced or unannounced visits were conducted. The Department learned that both parents had continued to test positive for illicit substances but attempted another safety plan with the parents. The parents did not cooperate, so the child entered state custody.

b. Reunification

1. The parent had kept the children out of school and had not provided the necessary mental health and behavioral services for most of the children's life. The children had been in state custody previously in two different states. The family moved from state to state to avoid child protective services. The older youth could not read. The younger child had speech delays and intellectual disability that services were only sporadically received for. DHHS filed an emergency petition, but then returned the children. Despite a pending jeopardy petition, assessment of the safety of the children and progress of the parent did not

occur once the children were returned home. Further investigation into possible sexual and physical abuse did not occur. The parent did not engage in services and the children were not regularly seen. The school reported significant absences of the children, but the court case was dismissed.

2. Trial placement was started for children in state custody before the parent completed necessary reunification services. The children entered state custody due to substance use, domestic violence, mental health issues, and exposure to unsafe people. The parent did not agree with the needs laid out in the jeopardy order. The parent had only been in some services for a few months when trial placement started. During trial placement the parent was not able to explain why services were needed. The parent stopped services entirely two months into the trial placement and then the case was dismissed. Two months later, the children re-entered custody due to the same issues.

3. The child has been in state custody for three years without a petition to terminate the parents' rights filed and without trial placement started. There was a lack of assessment of the parents' progress in services including communication with the parents' providers to ensure effectiveness and that the services matched the parents' reunification needs. A lack of documentation in the case made it difficult to understand the history.

4. Trial home placement with the parent began before it was safe, and the case was ultimately closed giving custody to that parent. The parent had a significant history of domestic violence as a perpetrator to the other parent, dating back years. The parent did not complete batterer's intervention. The parent did not begin to engage in services until a year after the child entered custody. The reunification plan required substance use program completion, but this was not done. No random drug screens were completed. The Department did not see the parents' home until the trial placement started.

5. Two children were appropriately placed with their respective out-of-home parents, but after placement the safety of the children was not effectively monitored during the open case. Both children were not seen in the parents' home for six months, but instead seen at school or at the Department's office (with one exception). One child's stepparent had not been assessed or met with even after reports of low-level abuse and neglect began. After that parent and stepparent abandoned one child, both the parent and stepparent were substantiated for physical and emotional abuse.

6. An investigation was opened, high severity findings were made against both parents, and a service case opened. One parent was safety planned out of the home and required to have supervised contact. One parent and new partner agreed to do services that would not address the high severity findings, and the degree of participation was not documented. The children were seen only twice during the service case. The service plan, length of the service case, and monitoring the service case did not match the severity of the issues in the home. The case was closed without progress.

7. The child was subjected to significant trauma, abuse, and neglect in the parents' care for the past nine years and is still not close to permanency. The older child is in state custody for the third time and the younger sibling and older child have been in state custody for two and a half years. The older child has significant behavioral issues. Communication with the parents' service providers has been inconsistent and not substantive. This lack of communication includes the providers not having objective sources of information about the parents' history or needs. The ongoing assessment of the parents' sobriety has also been inconsistent. One parent tested positive for cocaine twice recently. The issue of domestic violence has not been addressed, nor has neglect. Neither parent has acknowledged any accountability for their role in the trauma that their children have experienced. A petition to terminate rights was not filed until a year and half after statutorily appropriate.

c. Other

1. Removal of the child from the kinship placement was delayed although there was clear evidence that the child was neglected in the home and remaining in the home was not in the child's best interests. There were multiple historical instances of abuse and neglect with the kinship placement reported by the family. The kinship placement was obstructive to reunification with the parent. The child was ultimately removed.

2. The child was in a resource home (non-kinship) that was unsafe and not in the child's best interests. The child had experienced significant previous placement disruptions in part due to lack of behavioral health resources. Despite firsthand credible information relayed by multiple professionals the child was not moved. After hearing, over the Department's objections, the court removed the child from the resource home.

3. Intake did not refer a case for investigation to the district despite allegations of long-term neglect, including educational neglect. Multiple reports had been received recently that included the parents' mental health challenges and substance use, the child being exposed to unsafe people, neglect, isolation of the child, lack of follow-through with medical and developmental needs of the child, and poor school attendance. An investigation was then opened but little work was completed on the investigation for four months.

d. Positive Findings

The following positive findings were taken from all eight districts in the state:

1. The documentation throughout the Department's involvement was extremely thorough and detailed, especially face-to-face contacts. Caseworkers also demonstrated extreme caution when documenting information related to the parent's location given the concerns of significant domestic violence. It was clear that the caseworkers genuinely cared about the parent's success and the family's well-being. For example, investigation and permanency workers often met with the family in person more than once per month.

2. The most recent investigation was extremely thorough, and new allegations made during the investigation were assessed. After one parent denied access to the child, the caseworker worked with the other parent to interview the child at school. The caseworker contacted animal control to see if there were any concerns about the home. The caseworker completed an unannounced visit later in the investigation to the home of concern.

3. This case is a stellar example of thorough, supportive, detailed, and thoughtful permanency work by the caseworker. The caseworker regularly attended family recovery court with the parent and kept in touch with all providers, checking in regularly before family team meetings. The parents were met with in their home face to face when possible and the caseworker went over concerns clearly and frequently throughout the case. A petition to terminate rights was filed less than a year into the case, but the caseworker had developed such a good relationship with the parents that they did not give up on reunification.

4. The caseworker provided the parent with the reunification plan throughout the case at almost every contact, allowing the parent to stay up to date with expectations even when not actively engaged in reunification. When the parent told the caseworker the parent wanted to go to a rehabilitation center two hours away, the caseworker offered to give the parent a ride if one was not available.

5. The caseworker assigned to the last two investigations was incredibly thorough. Collaterals were contacted multiple times throughout the investigation to check on the situation and any concerns that might have arisen. Records were requested for both the parent and child, extended family members were educated on what the Department's involvement would be if they petitioned for guardianship of the child, and appropriate referrals were made for the family.

6. The caseworkers and supervisors in the case went above and beyond to facilitate communication and mediate disputes between the parents, and that modeling of good behavior and instruction clearly has helped the safe parent and made the child's life much easier and more stable. An appropriate reunification plan was made (and a family plan before that) that recognized the serious emotional harm one parent was causing. Reunification was ultimately successful with one parent.

7. In a previous investigation the caseworker reached out to collaterals to suggest they call intake if they learned the unsafe parent was having contact with the children once released from jail. This eventually led to the children entering custody as a collateral made a report after seeing the unsafe parent with the children. When the children had to be removed, caseworkers made many efforts to help the children feel comfortable. The children were provided with stuffed animals on their way to a resource home, provided (an older child) with a copy of the caseworker's number to call the caseworker directly, and the caseworker continued to have conversations with the children about what had happened in their parents' home, for example, exploring with the older child why that child felt responsible for the care of the younger child.

8. The caseworker quickly and effectively completed the initial investigation, appropriately coming to the decision to file a preliminary protection order. Relative resources were explored and it was explained to a grandparent why that grandparent would not be an appropriate placement. During reunification regular family team meetings were held regarding the parents' progress. The parent's mental health counselor and case manager were invited to attend the most recent family team meeting to speak to progress.

ACKNOWLEDGMENTS

As the twenty-second year of the Maine Child Welfare Ombudsman Program comes to a close, we would like to acknowledge and thank the many people who have continued to assure the success of the mission of the Child Welfare Ombudsman: to support better outcomes for children and families served by the child welfare system. Unfortunately, space does not allow the listing of all of these dedicated individuals and their contributions.

The staff of public and private agencies that provide services to children and families involved in the child welfare system, for their efforts to implement new ideas and provide care and compassion to families at the frontline, where it matters most.

Senior management and staff in the Office of Child and Family Services, led by Director Ms. Bobbi Johnson, for their ongoing efforts to make the support of families as the center of child welfare practice, to keep children safe, and to support social workers who work directly with families.

The Program Administrators of the District Offices, as well as the supervisors and social workers, for their openness and willingness to collaborate with the Ombudsman to improve child welfare practice.

The Board of Directors of the Maine Child Welfare Services Ombudsman, Katherine Knox, Pamela Morin, Donna Pelletier, Courtney Beer, Craig Hickman, and Anne Sedlack.

CHILD WELFARE OMBUDSMAN

P.O. Box 92 • Augusta, Maine 04332 • 1-866-621-0758 • 207-213-4773

EMAIL: ombudsman@cwombudsman.org • WEB: www.cwombudsman.org