Maine

CHILD WELFARE SERVICES OMBUDSMAN

20TH ANNUAL REPORT • 2022

CHILDREN'S OMBUDSMAN

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The 2022 Maine Child Welfare Ombudsman Annual Report was written and prepared by:

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I am honored to present the twentieth 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"). I am very grateful this year for the increased support the ombudsman has received from the Governor and Legislature that has resulted in expanded resources for our office as well as statutory changes that have strengthened the ombudsman program.

In this, the twentieth year of our program, I would like to acknowledge the heroic, stressful, and often heartbreaking work performed by child welfare caseworkers in our state, every day. Now more than ever frontline staff need our support, understanding, respect, and encouragement. Caseworkers are currently trying to navigate an increasingly difficult landscape of scarce resources and complicated cases. Their work has also become ever more dangerous, both mentally and physically. These dedicated professionals feel the responsibility placed on their shoulders keenly. We have to listen to caseworkers, try to understand what steps we can take to make their jobs easier, and appreciate that they are acting in good faith and working as hard as possible to protect children and reunify families.

Child welfare caseworkers are the face of child welfare. But their role is only one part of a wider system that, when working correctly, protects Maine's most at risk children. Police, courts, mental health providers, medical providers, case managers, attorneys, Guardians ad litem, school staff, and many others, all work towards protecting children and helping families. It is imperative that all parts of our system work together, build trust, and that all fields are fully supported.

This report of the Child Welfare Ombudsman must be, by statute, focused on the Department's child welfare practice and policy. There are also other areas in child welfare cases where cases do not go as planned. There are services that are not yet readily available enough to meet many families' needs, whether that family is involved with child welfare or not. There are families that have struggled with poverty, mental health issues, and substance use issues that could be diverted from Department involvement with better preventative services in the state. We must remember that the best thing we can do for children is to make sure that their parents have the support in place that will prevent that call to child protective services, that call that no one wants to make, to report that a child is not safe.

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

Christine E Alberi

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.

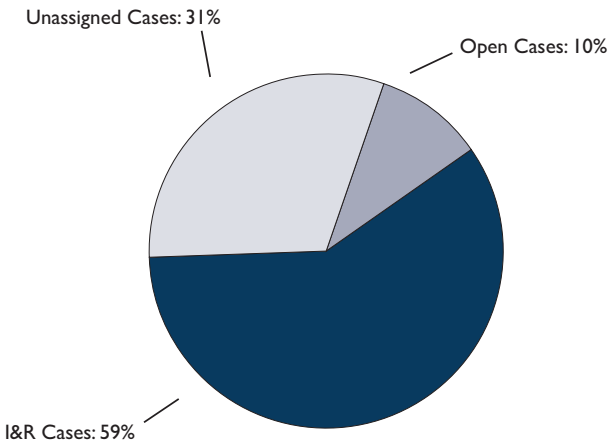
More information about the Ombudsman Program may be found at http://www.cwombudsman.org

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, 2021, through September 30, 2022.

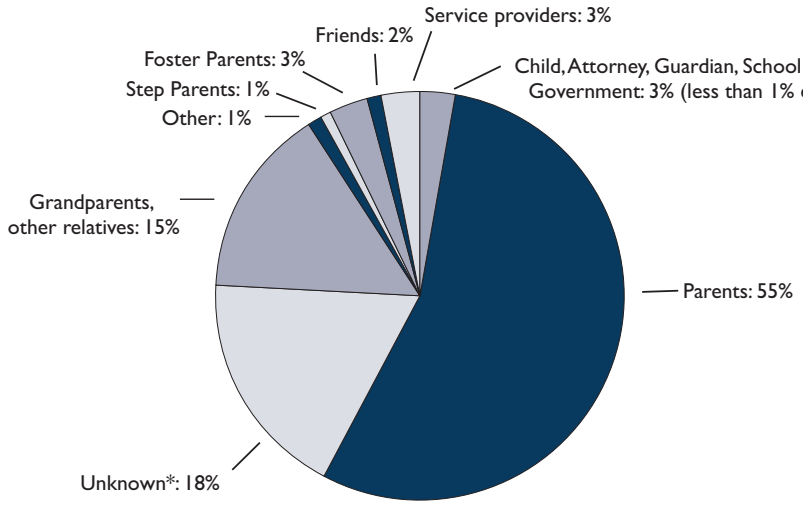
In Fiscal Year 2022, 801 inquiries were made to the Ombudsman Program, an increase of 93 inquiries from the previous fiscal year. As a result of these inquiries, 83 cases were opened for review (10%), 470 cases were given information or referred for services elsewhere (59%), and 248 cases were unassigned (31%). 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.

HOW DOES THE OMBUDSMAN PROGRAM CATEGORIZE CASES?



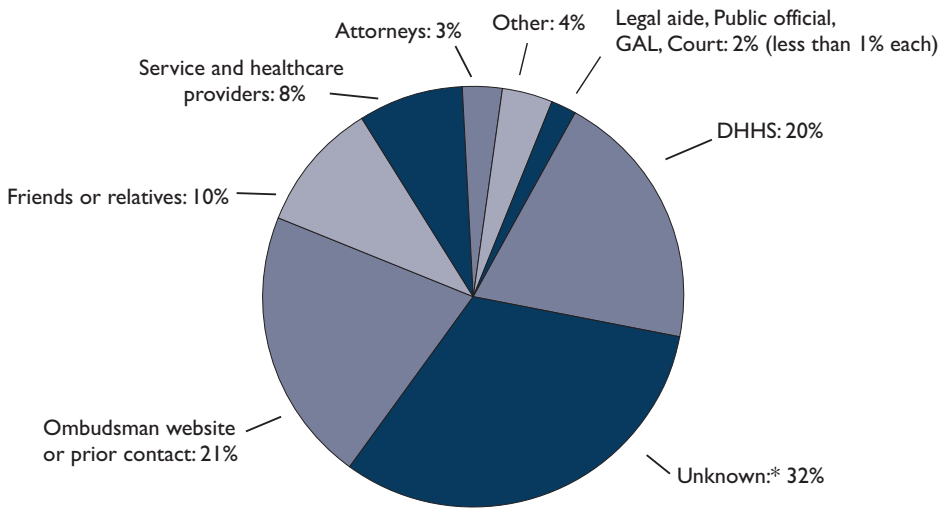
WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2022, the highest number of contacts were from parents, followed by grandparents and other relatives, then foster parents, and service providers.



HOW DID INDIVIDUALS LEARN ABOUT THE OMBUDSMAN PROGRAM?

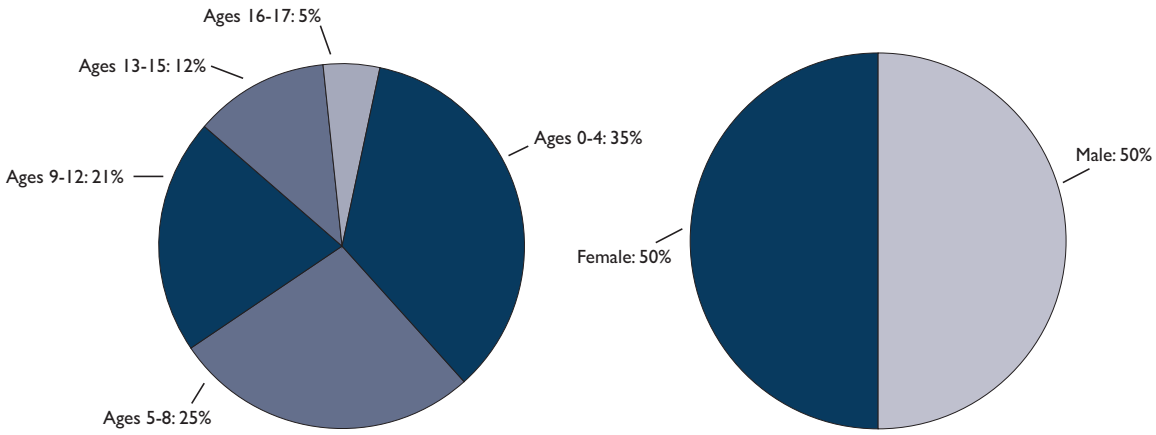
In 2022, 21% of contacts learned about the program through the Ombudsman website or prior contact with the office. 20% of contacts learned about the Ombudsman Program through the Department of Health and Human Services.



* *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 162 children represented in the 83 cases opened for review: 50 percent were male and 50 percent were female. During the reporting period, 62 percent of these children were age 8 and under.



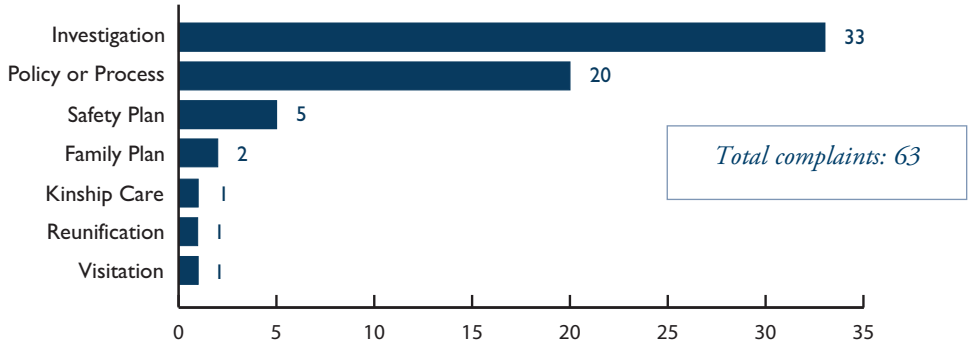
HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

			DISTRICT	CHILDREN	
DISTRICT #	OFFICE	CASES	% OF TOTAL	NUMBER	% OF TOTAL
0	Intake	2	2%	4	2%
1	Biddeford	13	15%	24	15%
2	Portland	13	16%	26	17%
3	Lewiston	11	13%	28	17%
4	Rockland	8	10%	14	9%
5	Augusta	14	17%	24	15%
6	Bangor	10	12%	16	10%
7	Ellsworth	9	11%	22	13%
8	Houlton	3	4%	4	2%
TOTAL		**83**	**100%**	**162**	**100%**

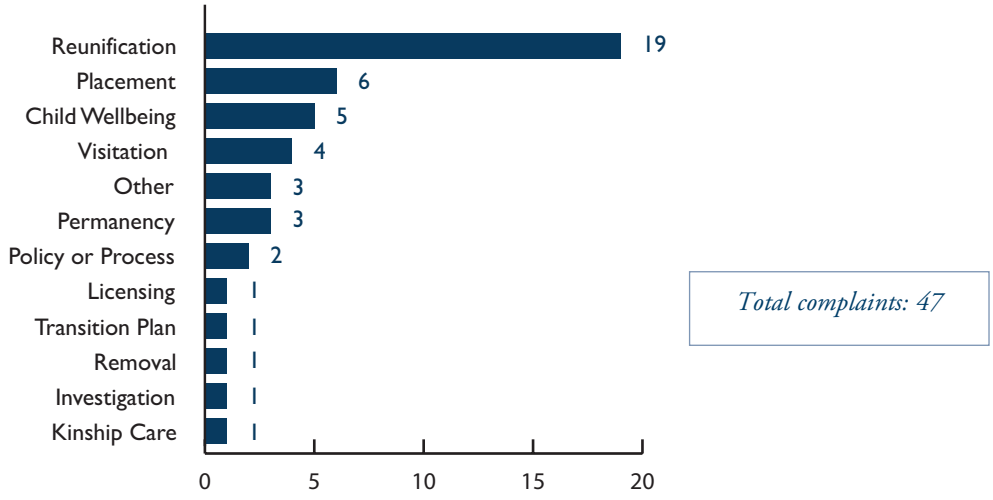
WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 83 cases were opened with a total of 110 complaints. Each case typically involved more than one complaint. There were 63 complaints regarding Child Protective Services Units or Intakes, 47 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 85 cases that had been opened for review. These cases included 107 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	0	0	0
Valid/Not Resolved*	27	16	43
1. Action cannot be undone	27	13	
2. Dept. disagrees with Ombudsman	0	0	
3. Lack of Resources	0	3	
Not Valid	26	38	64
TOTAL	**53**	**54**	**107**

* Total of numbers 1, 2, 3

During the surveys of the 85 closed cases, the Ombudsman identified 5 additional complaint areas that were not identified by the original complainant. The complaints were found to be valid in the following categories: 7 investigation, 3 trial placement, 3 permanency, 7 reunification, and 4 safety planning.

POLICY AND PRACTICE
Findings and Recommendations

The findings and recommendations in this section are compiled from the findings and recommendations made in the course of case specific Ombudsman reviews. The Ombudsman and the Office of Child and Family Services ("the Department") have an agreed upon collaborative process to finalize case specific reviews. Unfortunately, a survey of case specific reviews for the fiscal year 2022 continue to show a downward trend in child welfare practice. Of particular note this fiscal year, there were multiple instances where the Department did not recognize risk to children, both during investigations and reunification cases.

Out of the 85 cases closed this year, 46 had substantial issues. Cases with substantial issues are defined as cases where there was a deviation from best practices or 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 46 cases, 24 primarily involved investigations and 17 primarily involved reunification. The remaining 5 cases had varying issues.

- As has been true over the last several years of Ombudsman findings, the Department has struggled with practice issues primarily in two areas: 1) during investigations and the decision making around whether or not a child is safe once the investigation is completed, and 2) during reunification when making decisions about whether or not it is safe to send a child home. Some of the issues during both investigations and reunification resulted from not gathering enough information, but increasingly there are cases and situations where the Department had sufficient facts to determine that the child was unsafe but did not recognize the risk to the children and act accordingly.

The intense scrutiny of child welfare that began with the highly publicized deaths of children in the spring of 2021, has continued into 2022. The Ombudsman has completed four case specific reviews of these child deaths. These cases were considered in this report's numbers and findings but are not summarized below even in a de-identified way.

The Ombudsman recommends that:

- Frontline staff's experiences and opinions are given heavy weight in moving forward with improvements in policy and practice and with child welfare reforms.
- Maine should continue to broaden the use of Safety Science to improve systemic issues and waste no time in implementation of recommendations from those reviews, federal reviews, OPEGA reports, and Ombudsman reports.
- Training for staff and supervisors should be aligned with national best practices.
- Stakeholders at all levels have shown understandable concern that the intense focus on child welfare will cause a pendulum swing that will decrease reunification and increase removals of children from parents. Removals of children from parents should never be based on an overall philosophy, but on the specific facts of each child's circumstances. This year's case specific reviews show a pattern of delay in removal of children from families when circumstances for those children are clearly unsafe, and reunification of children with families when parents have not made enough changes to alleviate the jeopardy to the child. Both decisions are characterized by delays in filing court petitions or acting to protect children in other ways, such as through safety plans. These delays do not prevent removals of children from their homes, or prevent reunification; instead, the lack of recognition of risk to children, even when all facts are collected, leave children unsafe or delay permanency for the children,

or both. A better way to think of the pendulum swing is not to think of the Department's actions causing too many or too few removals, but instead to hope that the Department's practice will become more risk averse. More decisive removals should not affect the overall numbers of children in custody. In fact, in many of the cases below, children were removed eventually, just left in the care of their parents for too long.

- As stated in the Introduction of this report, the Department is the most visible of the many systems that help keep children safe in Maine. Service providers for adults and children, schools, courts, medical professionals, and many other stakeholders all collaborate and have a part in the lives of our children who are most at risk. This report is by necessity focused on the Department due to the nature of the statute that is the basis of the Ombudsman program. Most clearly right now, there is a need for an increase in mental health and substance use services for adults and children in Maine. Lack of services can strongly affect the safety of children.

A. Investigations

The Department investigates thousands of reports of child abuse and neglect each year. Investigations in our case specific reviews had two main issues: 1) not enough investigative activities were performed to determine the safety of children and 2) enough information was collected, but risk to the child or children was not recognized and decisive action was not taken to protect the children.

Some common issues with investigations included: out of home parents not contacted; collaterals not interviewed including professional collaterals; police records, court orders, and other documents not collected; an over-reliance on prior incomplete investigations; service provider records not sought or obtained; parents not asked to drug screen; new information reported during the investigation was not investigated; the focus of the investigation was on the initial allegation and not on all forms of child abuse and neglect even when new was reported; investigative subpoenas were not used; and the family's child protective history was not considered.

The importance of child protective history to a current investigation cannot be overstated. There were multiple cases this year where the history alone indicated a high level of risk, but staff did not have the history at the outset of the investigation or during the course of the investigation. The reasons for this are likely due to lack of time for staff while investigating multiple families. Child protective history also comes into play when there have been multiple investigations of the safety of children in a family, all of which have been closed as unsubstantiated. The Department often relies on a previous unsubstantiated investigation to show that a particular allegation of risk to the child is not true. However, sometimes the previous investigations have missed information or do not recognize the risk. Each case should be approached with a fresh perspective, with no assumptions or confirmation bias, and with enough historical information about the family to inform decision-making about a child's safety.

Safety plans used during investigations or open cases also continue to pose problems. Safety plans are agreements made with a parent or parents that they will temporarily modify their behavior or living situation or allow for supervision in the home because without the plan the child would likely be unsafe. Some examples in cases this year include: a safety plan did not protect the children from current threats, parents violated safety plans multiple times, several different safety plans were instituted and not monitored, a child was in an out of home safety plan for a year, a safety plan that the parent did not cooperate with or agree with was not monitored, a safety plan was made instead of court action, and one safety plan increased the risk to the children for some types of child maltreatment.

Safety plans should be short term solutions that allow the Department time to investigate or allow one parent to take court action, such as a victim of domestic violence obtaining a protection from abuse order. When the Department uses relatives or friends to monitor a safety plan, those relatives or friends must also be assessed for their own risk of child maltreatment as well as protective capacity. Children should not be in out of home safety plan placements with lack of legal protection for extended periods of time. Safety plan practice varies widely across the state, and clear policy and practice guidelines are needed.

B. Reunification

After an investigation is conducted and a child enters state custody the Department and the parent agree to a reunification plan that lists the steps that both the family and the Department need to take to return the child to the parent safely. For example, if the parents were engaged in substance use that was making their child unsafe, the reunification plan might include steps such as an appropriate level of substance use treatment, random drug screens of the parents, pill counts, and other supportive services. The Department would have an obligation to keep the child safe while residing in state custody (hopefully in the care of a close relative) and at the same time carefully monitor the parent's progress towards sobriety. This includes random drug screens, talking to the parents' substance use providers to gauge progress, obtaining substance use records, talking to family members and other collaterals, such as visit supervisors about how the parents are doing, talking with the parents in person and getting to know them and encourage them as well as holding them accountable, and visiting the parents where they are living to gauge their circumstances. Most of all, the Department must have an understanding of substance use and addiction, the parents' history of addiction, what a period of sustained recovery looks like, and whether or not the circumstances of the case indicate that the child will be safe if returned home. This is no easy task.

As with investigation, there are two components of reunification cases that have shown practice deficits: 1) the ongoing assessments of reunification cases, including assessment of trial placements, sometimes lacks the appropriate investigatory steps to ensure that the correct decision is being made at the end of the case, and 2) even if enough information is collected throughout the case, a decision might be made to reunify a child when it is clear that the jeopardy to the child has not been alleviated. In other words, the risk to the child is not recognized.

Cases often show practice issues such as: a lack of contact with parents; a new romantic partner of a parent is not assessed; there is a lack of contact with service providers; there are not enough random drug screens to be reasonably certain parents are sober; custody is given to a parent without fully investigating parental capacity; ongoing new reports of abuse are not investigated; appropriate mental health services and evaluations are not sought or are not available or both; each of the issues of parents have are not addressed either from the outset of the case or when they are learned of later in the case.

Trial placement is another area where ongoing assessment of the reunification case is inconsistent. When children are sent home for a trial placement with parents, the expectation is that the placement will be successful, but even in cases where the ongoing assessment of reunification has been very thorough, and the decision to start a trial placement is based on sound information, trial placement is a time of high risk to children. Having children back in the home, no matter how loved, adds significant stress to sometimes fragile parents, especially when services do not always follow the children into the home. Trial placements must be long enough, must include unannounced visits to the home, increased contact with providers, random drug screens, and collateral contact with supports to increase the likelihood of success.

Timely permanency has also shown itself to be an issue in multiple cases this year. There is no doubt that COVID and court delays and the difficulties of evaluating substance use recovery contribute to children remaining in state custody longer than they should. However, in six cases this year filing of petitions to

terminate rights was delayed long after the required statutory timeframe. In one case the Department did not file a petition to terminate rights until the child was in state custody for 16 months, the parents were not making progress, and the parents' rights had been terminated to more than five children already. In another case four years passed with multiple opportunities to file a petition to terminate parents' rights when the facts clearly supported filing. In another case, a petition to terminate rights was not filed for 24 months despite the lack of progress for the parents.

The law supports timeliness to permanency and the idea that it is not in children's best interests, and is sometimes unsafe, for children to remain in state custody indefinitely. The Department is sometimes reluctant to file petitions to terminate rights because of fears that filing will discourage parents or negatively affect the Department's ability to work with parents. However, there are many cases where petitions to terminate a parent's rights are filed and the parents go on to reunify, maybe just needing a little more time, or the petition is a wake-up call that they need to succeed. It is better for children to file petitions too soon, rather than too late. It does not help parents or children to delay the filing of petitions, or the pursuit of permanency.

Finally in reunification cases, recognition of ongoing risk to the child or children has been difficult when making decisions to move to unsupervised visits, trial placement, or file for a petition to terminate parents' rights. Below are two cases summarized where infants were injured in the parents' care, and then either reunified or allowed to visit unsupervised after neither parent acknowledged responsibility for the injuries. In another case parents were moved to unsupervised visits and trial placement despite refusing to randomly drug screen and refusing to cooperate with the Department. In another case where the parent had extremely significant mental health and cognitive issues, the parent stopped services despite clear evidence that without significant services and support the child would be exposed to further harm. As with investigations, history is also very important. To be clear: when jeopardy to children is alleviated, children should return home to their parents. But when parents have not engaged in services, not cooperated with the Department, and most importantly, have not acknowledged and understood their abusive or neglectful behavior, child will likely be unsafe back in the home.

C. Case Summaries

1. Investigation

1. An infant was born premature and diagnosed with failure to thrive. The parents did not follow medical advice. Multiple investigations were completed during the first 15 months of the child's life. Both parents had significant issues that greatly affected parental capacity. Another investigation was started and a safety plan implemented that had both young children remain in the home. It was learned that police had been called more than eight times to the home due to concerns for domestic violence. One parent was eventually arrested for another incident of domestic violence and another safety plan was implemented. The children entered custody a few days later five months after the start of the most recent investigation and service case. The children were unsafe in the home throughout. The reunification case was not well documented and the children started a trial placement too soon.

2. A month after the previous court case was dismissed, a new report and investigation was opened for similar issues. The parent was substantiated for neglect again and a plan was made. There was not sufficient ongoing assessment of the resulting service case, service providers were not contacted, pill counts were not completed, and other services were not begun. The children's collaterals were never contacted. The parent did not acknowledge or agree that there were any concerns and planned to continue risky behaviors and informed the Department of this. The service case was closed.

3. Many investigations were conducted from the time of the child's birth over the course of many years. The investigations involved substance use, issues with limited parental capacity, mental health issues, unsafe living conditions, and severe neglect of the child such as restraining the child for long periods of time and not interacting with the child. One of the investigations resulted in a jeopardy finding. The previous jeopardy case closed and another case opened a month later due to similar concerns. Ultimately five months passed with continued reports of domestic violence, neglect, medical neglect, and exposure to unsafe parent until the children entered state custody.

4. The parent had child welfare involvement for a year in the form of investigations and a service case. The parent was unable to maintain a period of sobriety for longer than four months. During the service case the parent admitted to relapsing and there was evidence that suggested the parent had been misusing substances for the last six months with the infant/toddler in the parent's care. The parent relapsed again at the end of the service case and stopped cooperating, but the investigation into the relapse was closed as unsubstantiated despite drugs and drug paraphernalia found in the parent's room where the child was also living. The service case was then also closed due to the parent revoking releases and refusing to cooperate.

5. During investigations and a service case that took place over the course of a year, the Department did not act to protect the child during multiple instances when filing for a preliminary protection order or jeopardy petition would have been appropriate. The child was exposed to substance misuse including witnessing an overdose, and a court filing only occurred after the child been present for another frightening drug fueled incident. There were several safety plans implemented, but the parents never truly agreed to the plans and did not cooperate with the Department including agreeing to random drug screens or starting services.

6. One parent was subjected to severe domestic abuse by the other, including strangulation. Despite resulting criminal charges and reports that a parent had spanked an infant, and additional reports of serious untreated mental health issues, the investigation was closed as unsubstantiated. A new investigation was opened within months due to further domestic violence in the presence of the infant. The infant was then left in the custody of the parents for a further eight months, despite multiple safety plans being violated, and no evidence that the parents had engaged in treatment, acknowledged the issues, or made behavior changes. The child entered state custody.

7. A parent had a jeopardy finding and cease reunification for an older child due to treatment that was heinous or abhorrent to society. Despite this and the parent's significant child protective and criminal history, two child protective investigations were completed that left the younger children in that parent's care. The children entered state custody four months after the second investigation began. The Department's actions were not proportionate to the extremely high risk indicated by the history and facts of the case.

8. Over the course of six investigations and service cases over the two years, the Department did not complete enough investigatory activities to ensure the safety of the children. Collateral sources such as out of home parents, relatives, medical records, police records, a probation officer, and babysitters, were not contacted. New allegations were not consistently investigated. Safety decisions were made about individuals prior to assessing them. A safety plan was implemented that did not protect the children from safety threats. The monitor of the plan was not a safe person with good judgment. The current investigation was opened after the mother gave birth to a baby and self-reported to the hospital substance use for the majority of the pregnancy. The infant was allowed to remain in the custody of the parents despite reports of ongoing substance use, untreated mental health issues, and domestic violence. No court petition was filed to protect the children despite the parents' disagreement with the safety plan and lack of cooperation.

9. Due to difficulty recognizing serious neglect and lack of understanding of the effects of long-term neglect on children, the Department completed several investigations over the course of 18 months that were either incomplete or did not recognize the risk to the young children.

10. A child's safety had been investigated three times since birth. The concerns had been consistently reported as untreated mental health and substance use issues, and general neglect. The parents would only minimally engage in the investigations and refused to drug screen or sign releases for providers. Relatives, neighbors, and out of home parents were not contacted. Given the severity of known historical issues and current credible reports, an investigative subpoena could have been obtained to seek further information about the safety of the child.

11. An older youth's medical needs were not being addressed and the parent refused to cooperate with an alternative response program (ARP) investigation. The parent refused to cooperate with the child protective investigation and there were no further investigation activities completed until a new report was made that the child was now residing out of the parent's home. The investigation was closed without assessing the safety of the child out of the home and determining whether the child's medical needs were being met. A new report was made after the child was dropped off at another relative's home in medical distress and showing signs of neglect. The child had been deprived of medication and exposed to domestic violence and substance use in the care of the parent. The Department documented that the only concern in the case was medical neglect, and a petition would not be filed despite the concerns for neglect, physical abuse, domestic violence, and emotional maltreatment. It was documented that law enforcement strongly disagreed with the decision not to file in court. The child made further disclosures of physical abuse. A preliminary protection order was obtained, and custody given to the out of home parent without assessing the out of home parent's ability to care for the child's high needs. The case was closed prior to the out of home parent participating in any services.

2. Reunification

1. An infant entered custody after sustaining inflicted bruises. The reunification case did not address the injuries to the infant and the perpetrator of the injuries was not determined. Another child was born prior to jeopardy being alleviated and allowed to remain in parental custody. That infant was then seriously injured as well. The Department did not fully investigate one parent's significant child welfare history of injuries to older children until after the second child was injured.

2. An infant was found to have serious, inflicted, head injuries. The perpetrator was unable to be determined. Two children entered custody due to the injuries. The children had also experienced serious neglect. The children were in state custody for a substantial amount of time and the Department started unsupervised visits despite not knowing which parent inflicted the injuries. During the unsupervised visits more safety concerns arose. The children were in state custody for almost two years and a petition to terminate the parents' rights had not been filed.

3. Extremely limited ongoing assessment of the parents' progress in reunification was conducted over the course of two years; at the end of two years a petition was filed. There were very few monthly contacts with parents, irregular contact with both the parents' and the child's providers. Appropriate mental health diagnoses were not determined for the parents. Insufficient evidence was collected to support the pending petition to terminate the parents' rights.

4. Trial placement was started too quickly without a transition plan for the child and before the parent had a safe and stable place to live. Ongoing assessment of the case was not consistent and service providers were not contacted regularly. The parent's living situation changed multiple times during the start of trial placement. Services for parent and child did not continue during trial placement. The child then re-entered custody.

5. The children had been in state custody for the majority of the past four years, reunifying and then quickly re-entering custody prior to the previous case dismissal. The parents struggled with substance use, untreated mental health issues, and domestic violence. Neither parent took responsibility for the reasons the children spent so much time in state custody. A petition to terminate parents' rights was not filed in either the first or second cases until almost four years in, despite many fact-based opportunities. Trial placement started due to the foster placement disrupting.

6. Parents subjected two children to years of severe neglect and abuse that included non-organic failure to thrive. The parents showed no remorse and did not accept any responsibility for the serious harm done to the children. Despite this, custody was returned to the parents. After custody was returned, evidence of continued neglect and emotional abuse was gathered, but the case was dismissed and closed without further court action.

3. Positive Findings

The following represents positive findings taken from case specific reviews representing each district in the state:

1. Both investigations completed in 2021 were thorough. Caseworkers contacted relevant collaterals, followed up on all allegations, and interviewed and background checked all adults living in both homes. After completion of the investigations, both were appropriately closed as unsubstantiated.

2. The parent was provided with good faith reunification services throughout the case. The initial investigation was very thorough and a safety plan was appropriately used and monitored. The caseworker made sure that the parent had a support present when the child was removed. Regular family team meetings were held throughout the case. The permanency caseworkers have had regular communication with the parents when the parents allowed, and with providers throughout the case.

3. The child's relationship with a parent who the child previously had no relationship with was supported and the child only benefited from the new relationship. Evaluations and services for the parent were appropriate to reported areas of concern. Visits with the other parent were stopped once it was clear that the visits were detrimental to the child's mental health. Permanency caseworkers worked hard to engage the disengaged parent. The permanency caseworker built a trusting relationship with the child, supervised some visits, and understood the child's behaviors. The caseworker followed up with a serious behavioral incident of the child's by interviewing the foster mother and a service provider.

4. A meeting was scheduled for a parent prior to that parent's release from prison to ensure that the team had a concrete plan for services and visitation. During trial placement the caseworker followed up on a screened-out report to intake on the same day that resulted in the discovery of an unsafe situation during trial placement, and the trial placement was correctly ended.

5. The investigation was thorough, and all children participated in forensic interviews. Relative placements were explored for all children. The assigned caseworkers worked well with children during monthly contacts, placement changes, and in discussions regarding the children's hopes for how the case would progress and how permanency would be achieved.

6. A child with complex needs entered state custody and is now gaining weight, thriving, and happy. The child protective worker and permanency worker both advocated strongly for the specialized equipment that the child needed. The caseworkers kept on top of and documented the child's medical appointments, medications, and needs, and worked to understand the complexity of the situation. Prior to placement, a potential foster parent was included in a medical team meeting. Despite the parents' lack of engagement, the caseworker continued to communicate with them regularly about expectations for visitation and reunification. The Department prevailed in a contested jeopardy hearing and contested judicial review and continues to protect the child.

7. When children were placed on a six hour hold by police, the caseworker ensured that the children did not see the parent's arrest. During the six-hour hold, caseworkers completed two home study/kinship assessments and found placements for the children with relatives or parents. Excellent ongoing assessment of the parent's progress in reunification was provided. The permanency caseworker, despite the parent's lack of engagement, clearly laid out expectations for the parent, concerns for the children's safety, and what was expected to change. This was done in person, over the phone, through family team meetings, and by letter. The permanency worker has a good relationship with the parent to the point when the parent called the caseworker when having a mental health crisis. The caseworker completed a medication count for the parent on a rare occasion when allowed into the parent's home.

8. The same permanency worker had the case since the outset and has developed a close and trusting relationship with the children. The caseworker supported the children through termination of their parents' rights, planned adoption and disruption of the adoptive placement, and a transition to a new foster home. The caseworker has been able to accurately gauge the children's level of adjustment to their new situation.

ACKNOWLEDGMENTS

As the twentieth 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 Dr. Todd Landry, 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, Virginia Marriner, Pamela Morin, Donna Pelletier, Courtney Beer, and Craig Hickman.

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