Maine

CHILD WELFARE SERVICES OMBUDSMAN

17TH ANNUAL REPORT • 2019

CHILDREN'S OMBUDSMAN

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The 2019 Maine Child Welfare Ombudsman Annual Report was written and prepared by:

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I am honored to present the seventeenth annual report of the Maine Child Welfare Ombudsman. Maine Child Welfare Ombudsman, Inc., is an independent non-profit solely dedicated to fulfilling the duties and responsibilities promulgated in 22 M.R.S.A. § 4087-A. The Child Welfare Ombudsman provides neutral objective assessment of concerns raised about practices of the Maine Department of Health and Human Services, Office of Child and Family Services, Child Welfare Services ("the Department"). The Ombudsman also provides information about child welfare services to individuals who contact the program. Additionally, the Ombudsman provides systemic oversight of child welfare policy and programs and provides information to the public. The Child Welfare Ombudsman provides an independent, statewide, and professional overview of child welfare practices providing feedback on appropriate application of policy and practice, when families have been treated fairly, and children's safety ensured.

The Department continues to sustain significant improvements and changes in the wakes of the deaths of Marissa Kennedy and Kendall Chick two years ago. The Department has focused on both strengthening child welfare and connected systems and rebuilding trust and providing increased transparency and insight into the successes achieved and challenges faced in child welfare. The Department has engaged with a great deal of outside expertise to enhance the significant knowledge already available within the Department. This expertise comes from organizations such as the Muskie School of Public Service, Casey Family Programs, the Annie E. Casey Foundation, and the Child Welfare League of America. The Department has plans for improving Children's Behavioral Health Services which will benefit all children and is also committed to participating in the Family First Prevention Services Act. The Department has synthesized and prioritized the many recommendations gathered in 2018 and 2019 and is embarking on an ambitious and necessary plan to implement as many recommendations as possible.

During the past six years the Ombudsman's office has completed 624 case specific reviews and made 1886 information and referral calls. Individuals contacting the program have risen steadily each year, especially in 2018 and 2019. During the 2011 fiscal year, the last year that the Ombudsman program was housed in the Maine Children's Alliance and the contract amount was decreased, there were 313 individual contacts made to the Ombudsman. This year there were 611 individual contacts. Thanks to the support of the Governor and the Legislature, funding was appropriated for additional staff and office space for the 2020 fiscal year.

In the past year, the Ombudsman and the Department have been able to work collaboratively together both during case-specific reviews and in wider policy and systems improvement discussions. We look forward to continuing this productive relationship going forward. The Ombudsman's central recommendations this year are to provide training and support to improve practice in two crucial areas of decision making: 1) in making the decision whether the child is safe during the initial assessment or investigation and 2) in making the decision whether the child will be safe in the home once reunified with parents.

At the end of October of 2019 there were 2198 children in state custody. This number has risen steadily since the spring of 2018. We all have a long road ahead to safely bring these numbers back down, and to ensure that children are safe everywhere they are.

Child Welfare Services is on a path of reform and progress, but there is still a great deal of work to do. I appreciate the statewide attention given to child welfare and to the Child Welfare Ombudsman and I would like to thank both Governor Janet Mills and the Legislature for their ongoing support to the program.

Christine Alberi, Child Welfare Services 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.

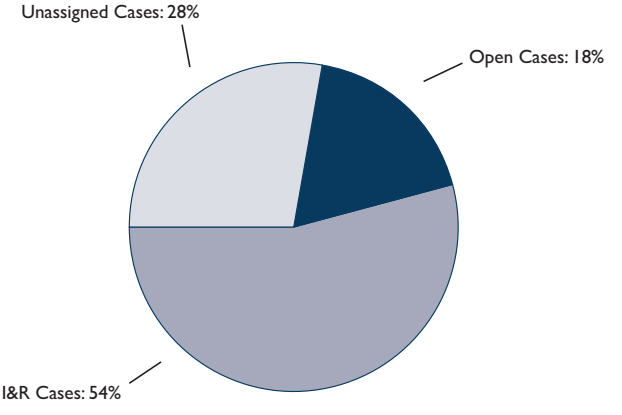
More information about the Ombudsman Program may be found at http://www.cwombudsman.org

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, 2018, through September 30, 2019.

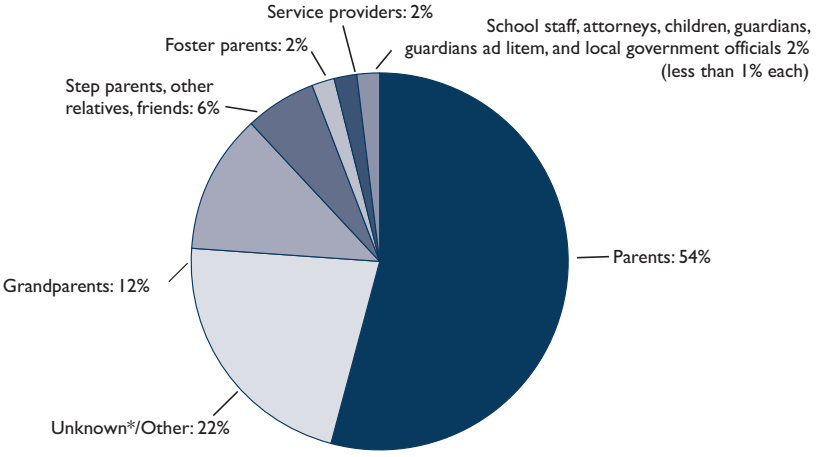
In Fiscal Year 2019, 611 inquiries were made to the Ombudsman Program, an increase of 6 inquiries from the previous fiscal year. As a result of these inquiries, 109 cases were opened for review (18%), 329 cases were given information or referred for services elsewhere (54%), and 173 cases were unassigned (28%). 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?



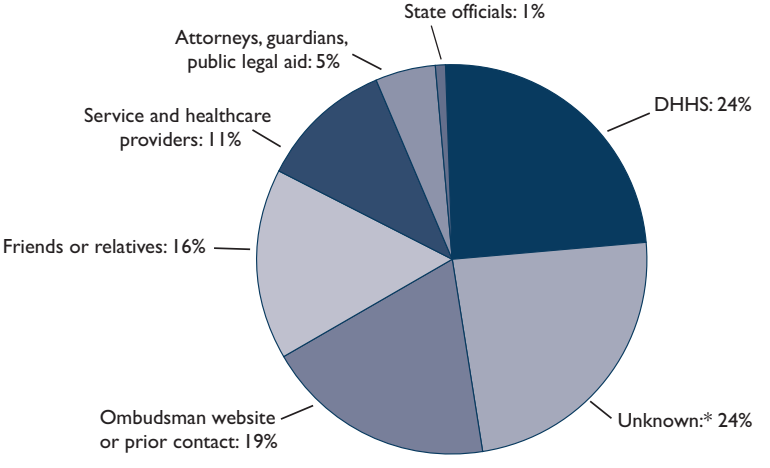
WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2019, the highest number of contacts were from parents, followed by grandparents, then other relatives/friends, and foster parents, and service providers.



HOW DID INDIVIDUALS LEARN ABOUT THE OMBUDSMAN PROGRAM?

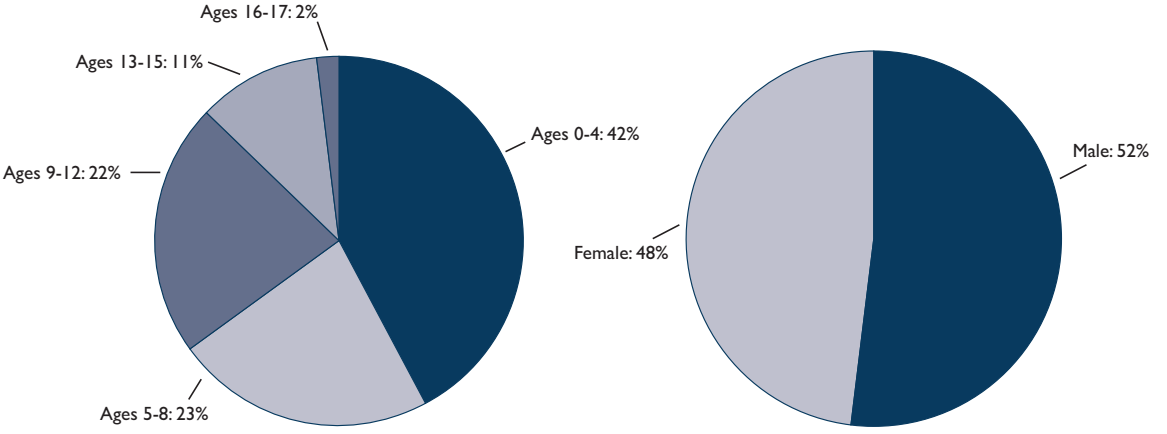
In 2019, nineteen percent of contacts learned about the program through the Ombudsman website or prior contact with the office. Twenty-four percent of contacts learned about the Ombudsman Program through the Department of Health and Human Services.



* *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 192 children represented in the 109 cases opened for review: 52 percent were male and 48 percent were female. During the reporting period, 65 percent of these children were age 8 and under.



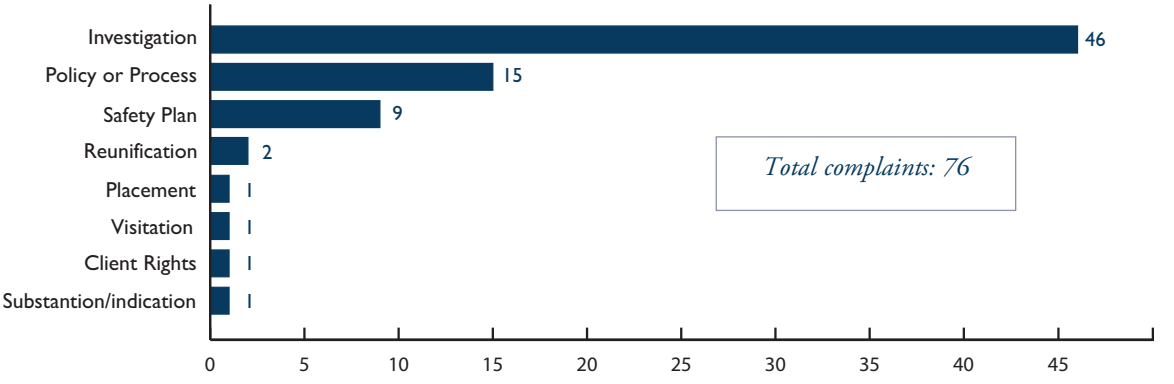
HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

			DISTRICT	CHILDREN	
DISTRICT #	OFFICE	CASES	% OF TOTAL	NUMBER	% OF TOTAL
0	Intake	3	8%	3	2%
1	Biddeford	14	13%	29	15%
2	Portland	12	11%	24	13%
3	Lewiston	17	16%	33	17%
4	Rockland	5	5%	6	3%
5	Augusta	21	19%	36	19%
6	Bangor	15	14%	24	13%
7	Ellsworth	7	6%	12	6%
8	Houlton	15	14%	25	13%
TOTAL		**109**	**100%**	**192**	**100%**

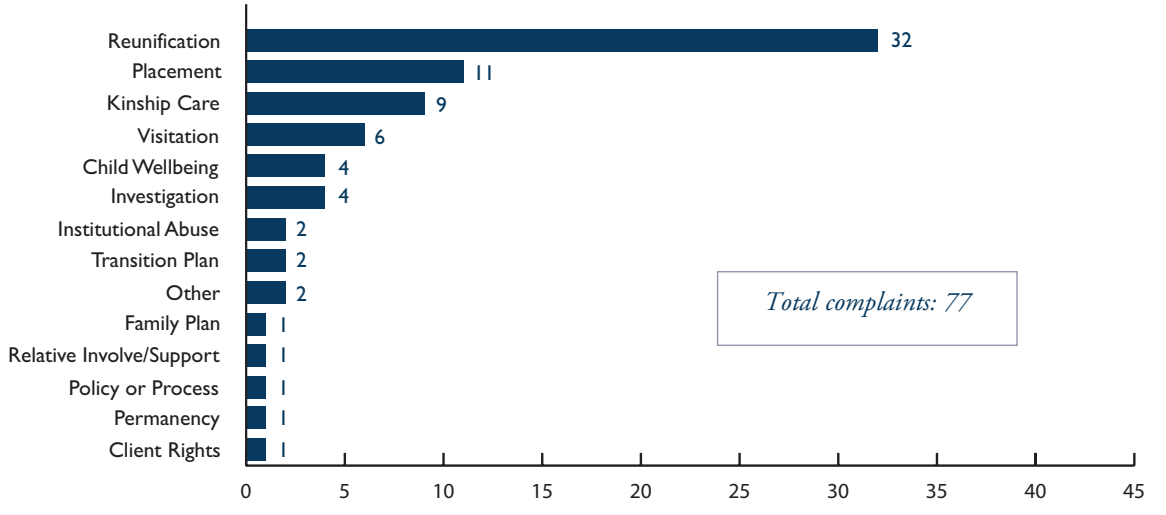
WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 109 cases were opened with a total of 153 complaints. Each case typically involved more than one complaint. There were 76 complaints regarding Child Protective Services Units or Intakes, 77 complaints regarding Children's Services Units, most during the reunification phase.

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



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 98 cases that had been opened for review. These cases included 146 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	4	5
Valid/Not Resolved*	15	15	30
1. Action cannot be undone	15	12	
2. Dept. disagrees with Ombudsman	0	0	
3. Lack of Resources	0	3	
Not Valid	42	69	111
TOTAL	**58**	**88**	**146**

* Total of numbers 1, 2, 3

During reviews of the 98 closed cases, the Ombudsman identified 10 additional complaint areas that were not identified by the original complainant. The 10 complaints were found to be valid in the following categories: 3 mental health services for child, 2 initial assessments, 2 ongoing assessment of reunification, 1 support of foster parents, 1 transition plan, and 1 child well-being.

POLICY AND PRACTICE
Findings and Recommendations

The 2019 fiscal year has marked enormous changes within the Department of Health and Human Services, Office of Child and Family Services ("the Department"). The Governor, Legislature, and the Department have worked to increase child welfare staffing. This will help social workers have sufficient time and resources to effectively and thoroughly complete the work that they are so dedicated to doing: keeping children safe and helping ensure that children have safe and permanent homes and families.

Additionally, the Department has re-affirmed its dedication to the prioritization of child safety. "Child Safety, First and Foremost" is at the head of new priorities. The framework of resources and personnel is being laid in place. However, during the fiscal year, there were still critical practice issues occurring statewide at two crucial points during child protective involvement: 1) when making the decision whether the child is safe during the initial assessment or investigation and 2) when making the decision whether the child will be safe in the home once reunified with parents.

A new investigation policy was implemented in November of 2018 and structured decision-making tools are now used during initial investigations of child safety. Policy changes and tools can be helpful, but frontline staff need continued ongoing training in investigation techniques. While the fiscal year reporting period for this annual report is from October 1, 2018 through September 30, 2019, the majority of case specific instances that are the basis of this annual report occurred between the summer of 2018 and the spring of 2019.

Out of 98 cases closed this year, the Ombudsman was in general agreement with 61 of the cases (there were no major policy or practice issues in the case). Out of the remaining 37 cases, there were 18 cases where initial assessment or investigation practice was at issue, 11 cases where reunification practice was at issue, and 7 other cases that involved truancy, transition planning, lack of mental health and behavioral services for children, and other issues. Some cases had more than one issue, but the primary issue in the case was used for this categorization. Practice issues that occurred before March of 2018 were not included.

The Department is partnering again with the Muskie School to provide training to new staff and there are other initiatives to increase training opportunities but training should stretch over the life of employment in child welfare. Fortunately, there were also many instances found in case-specific reviews where front line staff demonstrated a high level of competence fueled by dedication and experience.

1. INITIAL INVESTIGATIONS AND ASSESSMENTS

Some case specific reviews that were performed during the fiscal year involved previous assessment policy and some required the use of new investigation policy and structured decision-making tools. During a time of so much change and shifting policy, it is difficult to fully analyze causes of issues, but it seems that the change in policy alone has not yet led to significant improvement in accurately determining the safety of children at the outset of child welfare involvement.

The following are a sampling of cases where investigation and/or assessment policy were at issue:

- An assessment/investigation was open for six months during which multiple new reports were made. Collaterals were not contacted. This assessment was closed and another opened that stretched for four

months. The SDM risk tool was used and the outcome, that the risk level was high, was disregarded. Collaterals were again not contacted. Evidence that was collected was not recognized as evidence of risk.

- After parents did not cooperate, no other investigation activities were done. Truancy was not taken seriously as evidence of risk. The parents both had serious substance use issues that were only discovered many months later. The first series of investigations occurred over four months and were closed. A second series of investigations were opened, and despite sufficient evidence, the risk was not recognized or understood. Both parents had significant substance use issues.
- Despite the parent's long standing history of substance use the Department did not take seriously new risk to the child. When the child was left with a family that were acquaintances of the parent and because the family did not obtain guardianship the child was left without legal protection and resources, such as medical care. The family had a history with child protective services that was concerning given the circumstances.
- There was clear evidence of the parent's continual physical abuse of the young children. The children were placed in a foster home under a voluntary care agreement but were not taken into state custody, despite sufficient evidence. The children eventually entered custody and when a younger sibling was born, the safety of the sibling was not assessed and no new report was made to intake. The infant stayed in the care of the parent for over a month prior to entering state custody.
- No further assessment activities were completed after the initial interviews of one parent and the children. The assessment was not closed and not completed until five months later when one of the parents severely injured one of the children, an infant, causing life threatening and life-long injuries.
- There were insufficient activities to locate the parent or continue to investigate the children's significantly concerning initial disclosures. Three months later the investigation continued after a new report was made that found the children in unsafe circumstances.
- Three out of home parents were not contacted for months, the child's valid and credible disclosures were given less weight because they were made to professional collaterals and not to the Department, providers, including police who were called to the home during the assessment, were not contacted, parents were not asked to drug screen, and serious signs of risk and danger were not recognized for several months. The children were only taken into state custody once a parent became unresponsive due to substance use in front of the children.

Department's Response: On December 17, 2018, the Office of Child and Family Services (OCFS) implemented a new Investigation Policy to guide staff in their assessment work. OCFS has also implemented Structured Decision Making (SDM) to support staff in evaluating information gathered during the assessment and inform decisions regarding next steps. The implementation of both the policy and SDM have marked a significant shift in the process and procedures for conducting an assessment. OCFS recognizes that the implementation of both of these initiatives occurred at the same time in which OCFS experienced a tremendous increase in reports, assessments, and children in care. For example, in 2016 the Department received 7,463 reports of abuse and/or neglect that were deemed appropriate for assessment. In 2018, that number had surged to 11,831. In 2019, an additional 62 child welfare positions (effective 9/1/19) were authorized in the Biannual Budget, including new caseworker, supervisor, intake, and background check unit positions. These new positions are anticipated to reduce the workload associated with the dramatic increase in reports, assessments, and children in care.

Spurred by the concerns of staff and stakeholders (including the Legislature), OCFS worked throughout

2019 to study both caseload and workload. The initial report from this work was released on 10/1/19, in accordance with LD821. OCFS views the 10/1/19 report as version 1.0 in an ongoing effort to quantify both workload and caseload for frontline staff in order to ensure staffing is at a level that allows staff to complete their work in a timely fashion, as well as engage in professional development regarding assessment activities, family engagement, and other skills necessary to improve casework practice. The next report will be issued in January 2020, as required by LD821.

OCFS is also currently focused on the best way in which to train staff. This includes both new hires and experienced caseworkers. Recognizing that the need for high-quality training was substantial and the resources within OCFS to deliver trainings were limited, the Department has entered into a Cooperative Agreement with the Muskie School of Public Service at the University of Southern Maine. Staff from the Muskie School have considerable child welfare experience in jurisdictions throughout the country and bring expertise in effective staff training engagement. In conjunction with the Muskie School, OCFS will be working to update trainings to maximize staff engagement and learning. OCFS is exploring innovative technology to accommodate different learning styles and reduce the time staff spend travelling to and from trainings, ultimately reaching more staff. OCFS will also be partnering with the Muskie School to implement the Field Instruction Unit (FIU), which will allow OCFS to partner with students nearing completion of their studies to receive college credit for completing internships in OCFS' District offices. Students will develop critically important social work skills related to child welfare work in preparation to begin a career with OCFS upon graduation. This will result in new staff who are already trained and experienced with OCFS' policies and procedures. Additionally, staff from the Muskie School will be assisting OCFS in reviewing current policies, streamlining the policy manual where possible, and ensuring the manual is both accessible for staff and easy to navigate.

OCFS has also recognized the need to ensure that throughout the assessment process, staff have access to any and all available information that may influence child safety-related decisions. To that end, OCFS has developed and is in the process of implementing a Background Check Unit (BCU) within OCFS that will provide staff with information from national criminal history databases. The BCU has been operating as a pilot in Districts 1 and 2 for much of 2019, but with additional staffing provided in the Biannual Budget, the BCU is expected to expand coverage statewide in early 2020. This expansion will ensure that assessment staff statewide have access to information that provides a fuller picture of the risks to child safety that may be present within a family.

OCFS agrees that further work should be done to ensure consistent implementation of all OCFS policies and procedures. Over the last year, OCFS has had the opportunity to learn from staff and partner with national experts to improve casework practice. The result of that effort is a focused prioritization of strategies developed with staff, stakeholders, and national experts. Implementation of those strategies has begun. OCFS has only recently begun deploying the new caseworkers to fill the lines allocated in the Biannual Budget, effective 9/1/2019. In the coming year, OCFS hopes to reduce the workload demands on staff and improve training opportunities to ensure that staff have the time and ability to successfully learn and utilize the policies and procedures which guide their work, in particular new initiatives aimed at addressing gaps in casework practice.

2. REUNIFICATION

Once children enter state custody, the Department has a statutory obligation to reunify children with parents once the original danger that caused the children to enter state custody has been alleviated (unless the court relieves the Department of that duty.) One of the most complex decisions that is made during child welfare involvement is the decision whether to proceed towards terminating the parents' rights or to return the children to the parents.

In order to make this decision in a way that is physically and emotionally safe for the children, the Department must provide thorough ongoing assessment of the parent's progress. This includes regular face to face contact with parents, family team meetings, clear reunification plans that address all areas of risk, consistent contact with providers throughout the case, the tailoring of services to meet parents' needs, random substance abuse screening when indicated, mental health and substance abuse evaluations, and assessing additional issues and adding services as needed.

There have been multiple cases reviewed during the fiscal year where the Department did not have enough information to determine what should happen next. There were instances when trial placements were started where the evidence did not indicate that the children would be safe with the parents. There were cases where there was insufficient evidence to convince the court to terminate parents' rights if a hearing were held. In general, lack of contact with parents and lack of contact with collaterals were the most common issues.

The following are a sampling of cases where ongoing assessment of reunification was at issue:

- After a year and half, the Department had not visited the parents in their home or assessed their living situation, despite the fact that the original jeopardy to the children included failure to recognize unsafe individuals and an unsafe living environment. Collaterals were not contacted and one parent was not assessed for mental health or substance abuse issues despite behaviors that would indicate that one or both existed.
- Providers were not checked in with or given information about the case that would allow them to treat the parent for significant mental health and cognitive issues. The current romantic partner of the parent was not assessed, and frequent unsafe individuals in and out of the parent's life were not assessed. The impact of the parent's lack of basic living and parenting skills was not assessed. The parent failed to understand or agree to the reasons the children entered custody, but this was not considered significant.
- A mental health evaluation gave one diagnosis and the parent's therapist was working under the impression that the parent had an entirely different diagnosis. The other parent had serious mental health issues and providers were not contacted. With no recent family team meetings and no documentation as to how the decision was reached, visits went from fully supervised to check-in status.
- The parents' previous child had died in an unsafe sleep incident several years earlier. The infant had died on the day of discharge from the hospital after birth (the safety of the child was not sufficiently assessed before discharge) when the parent rolled over and suffocated the infant. After the death the parent tested positive for multiple substances but no findings were made. When a new infant was born, the circumstances were similar to the previous child's and the infant was quickly taken into custody. The parents continued to exhibit concerning behaviors, but without clear reason visits started in the home with the parents and supervision was quickly reduced. The Department did not learn for nine months that the parents had not been in substance abuse treatment of any kind.
- The trial placement was started too soon and the case was dismissed without enough evidence to show that the children would be safe. The parent never completed recommended substance abuse treatment

and providers were not contacted. Trial placement was started two months after a positive substance abuse screen. After trial placement started there was no further substance abuse screening and no contact with providers.

Department's Response: OCFS agrees that ongoing assessment activities and strong parental engagement are key factors in the ability of OCFS staff to assess case progress and make informed decisions regarding permanency that ensure child safety. As outlined above, OCFS staff have been challenged with the current workload based on the increase in the number of calls, assessments, and children in care. This is an issue OCFS is actively working to quantify and address. Included in this work is the continued refinement of the Workload Analytic Tool developed during 2019. The initial report that resulted from the use of this tool was issued 10/1/19 and the first annual follow-up is due in early 2020. Currently, OCFS is focused on reviewing the tool to ensure it takes into account the additional time needed to address complex cases, such as those that involve larger sibling sets and the Federal Indian Child Welfare Act (ICWA). These additional refinements are likely to improve OCFS' ability to ensure an appropriate level of staffing within all areas of child welfare so that staff have additional time to conduct necessary assessment activities throughout the life of the case and devote more efforts to parental engagement.

OCFS also recognizes the efforts underway throughout the Department to improve the State's services to address substance use, including opioids. This includes increasing substance use treatment providers statewide, MaineCare expansion, and investments in new and innovative treatment options. A significant percentage of OCFS' cases involve at least one parent that is struggling with substance use disorder and substance use treatment is frequently a part of rehabilitation and reunification plans. OCFS believes that the efforts to improve substance use-related services statewide will increase the ability of parents to successfully engage in treatment and enable safe reunification of children with their parents.

Within OCFS there is an effort underway to increase the information available to staff as they make child safety related decisions. Within permanency, one of the new initiatives is the Family Visit Coaching Pilot currently underway in Penobscot County. This Pilot includes both evaluation and coaching components meant to aid the Department in decision making regarding permanency and child wellbeing. OCFS plans to evaluate the outcomes of this Pilot in 2020 and review how the information learned can be integrated into visitation practice statewide. OCFS is also continuing to train staff in the use of the Structured Decision Making (SDM) tool. As with the Initial Investigation and Assessment recommendation, OCFS believes that efforts underway to improve training for staff and improve the policy manual will also contribute to increase the skills of staff to make decisions regarding reunification and permanency.

3. Truancy

Truancy is considered to be abuse or neglect under the definitions section of the child protection statute (22 MRSA § 4002(1)). If the child is at least seven years of age and has not completed sixth grade and has the equivalent of seven full days of unexcused absences or five consecutive days of unexcused absences during a school year that child is considered truant. The existence of truancy, or educational neglect, alone constitutes jeopardy under the statute and is considered "serious abuse or neglect." Recent changes to the truancy statute have expanded the definition of truancy, but have not expanded the abuse and neglect definitions around truancy.

The Ombudsman does not recommend removal of children from the parents' custody due to truancy.

However, educational neglect rarely exists as an issue in isolation. Ombudsman case specific reviews reveal that it is often a sign of other serious underlying issues in the home that may indicate a high level of risk. The issue of the Department not recognizing truancy as a sign of risk to a child is a long standing pattern. Particularly for elementary aged students, it is unusual that a child is not consistently in school. In four cases reviewed this fiscal year that involved educational neglect (two with children between the ages of seven and sixth grade, one with a child who had been truant for many years but was now older than sixth grade, and one teenager) all of the children involved were unsafe.

Children are usually twelve years old at the end of sixth grade. Even if truancy of a thirteen, fourteen, or fifteen year old is not considered abuse or neglect under the statute, this still may be a sign of risk. Additionally, if truancy existed before sixth grade but the child is now older, this could also be taken as a sign of risk to a child. Finally, if a child is in kindergarten or preschool and starts experiencing significant attendance issues, the root cause of this should be determined. Educational neglect should be added to child protective investigative policy and structured decision-making tools. Inquiries around educational neglect should be broadened and whether or not a child is in school should be considered a sign of risk at all ages.

Department's Response: When truancy is an issue for a family, the assessment of the truancy issue and its cause(s) should be a part of a thorough and complete assessment of child safety and wellbeing. As outlined above, OCFS has undertaken a number of initiatives to improve casework practice throughout all areas of child welfare. OCFS will work with the Muskie School and our partners at the National Center for Crime and Delinquency (NCCD) which provides our Structured Decision Making (SDM) tools to determine how best to support staff in making informed decisions regarding the impact that truancy may have on child safety and wellbeing and the way in which such a risk factor should be considered in assessing and determining next steps within an assessment or case. OCFS is also partnering with the Department of Education to provide additional training and support to local school districts and district child welfare staff.

CONCLUSION

Maine is still struggling in the aftermath of the deaths of Marissa Kennedy and Kendall Chick. Many changes followed in the wake of these deaths, some necessary, some unnecessary, some implemented too quickly, some too slowly. Practice issues detailed above might have been rectified and this may become evident during the next fiscal year. The Department's current thorough and deliberative approach under the leadership of Dr. Todd Landry is appropriate and comprehensive. The Ombudsman's office looks forward to continued partnership with the Department in working towards keeping children safe.

ACKNOWLEDGMENTS

As the seventeenth 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 Acting Director Elissa Wynn and 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, Ally Keppel, Allie McCormack, Virginia Marriner, and Katherine Knox for their support and dedication to our agency.

At the end of each case specific report of the Child Welfare Ombudsman a section lists positives noted during the review. Here are just a small number of examples from across the state: the caseworker did an excellent job of keeping the mother informed and involved; the initial assessments were extremely thorough and quickly done; the parent was immediately interviewed in jail and many collaterals were contacted; there have been regular family team meetings and both permanency workers have had consistent face to face and other contact with parents and providers; the caseworker supported the parent through anxiety at a random drug test so that it was successfully completed; the caseworker called for a welfare check on a distraught parent; the parents' progress in substance abuse services and recovery was thoroughly monitored with regular contact with providers and regular random substance abuse screens; in general the caseworkers offered excellent good faith reunification services to the parents and excellent ongoing assessment of the case; the caseworker was able to talk the relative placement into getting a foster license so the children did not have to move; after a concerning prenatal report was made the caseworker made a referral to public health nursing; the assessment worker formed a good relationship with the child and went out of the way to see the child during the reunification phase of the case; the assessment of the safety of the children and progress of the mother in this case was excellent initially and has been excellent on an ongoing basis; and the caseworker had a thorough understanding of the child's medical needs and the challenges in caring for the child. These examples are just the tip of the iceberg of the collective knowledge and compassion of child welfare staff in the state of Maine.

CHILD WELFARE OMBUDSMAN

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