Maine

CHILD WELFARE SERVICES OMBUDSMAN

19TH ANNUAL REPORT • 2021

CHILDREN'S OMBUDSMAN

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The 2021 Maine Child Welfare Ombudsman Annual Report was written and prepared by:

CHRISTINE E. ALBERI, Esq.
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I am honored to present the nineteenth 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 about the Maine Department of Health and Human Services, Office of Child and Family Services ("the Department"). Additionally, the Ombudsman provides systemic recommendations about child welfare policy and programs based on case specific reviews completed during the course of the fiscal year.

The 2021 fiscal year has been marked by the ongoing challenges of living through and with the COVID-19 pandemic. The staff of the Department has been faced with the overwhelming task of completing important and complex work that is difficult during the best of times. Department caseworkers and supervisors, who are dedicated to the children and families that they serve, have persevered through multiple pandemic related difficulties.

Then, after a year of an unprecedented pandemic, in a span of less than a month, in May and June 2021, the deaths of multiple young children were reported in the media. Child deaths are the most highly visible part of child abuse and neglect, and with them came a renewed and intense scrutiny of child welfare. This scrutiny is necessary, but creates increased stress on the system, especially on frontline staff.

In response to these highly publicized child deaths, the Department asked Casey Family Services, along with Collaborative Safety, LLC, a pioneer in bringing safety science to child welfare, to review the child deaths. At the writing of this report, the Department is working to determine the best way to implement safety science in Maine. The Ombudsman has also reviewed three of the child deaths and will review a fourth. The conclusions reached from those case specific reviews are not included in this annual report.

As the child deaths created a firestorm of concern about the operations of the child welfare system, we at the Ombudsman's office continue to do our work: providing guidance to callers struggling with their cases, reviewing specific cases and making recommendations, and making broader recommendations to improve practice, and ultimately, improve the lives of children and keep them safe as much as possible. As was true last year and the year before, the analysis of closed cases in this annual report continues to focus on practice areas where children are most at risk: 1) during the initial investigation of a child's safety, and 2) during the ongoing assessment of reunification and decision-making around whether nor not it is safe for a child to return home. Practice in these areas has not improved and there are no easy solutions. The Department, the Ombudsman, service providers, legislators, and the executive branch must work together to find a solution to our state's problems involving the welfare of children.

We would like to thank both Governor Janet Mills and the Maine Legislature for the ongoing support to our program, and their continued dedication to protecting children from harm.

Christine E Alli

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.

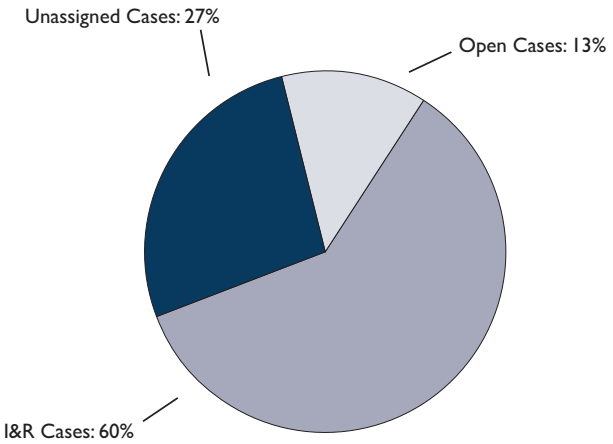
More information about the Ombudsman Program may be found at http://www.cwombudsman.org

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, 2020, through September 30, 2021.

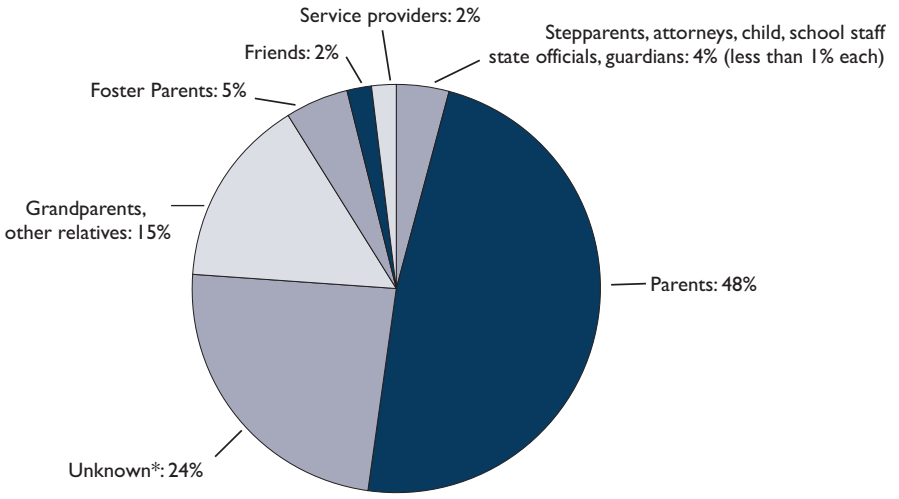
In Fiscal Year 2021, 708 inquiries were made to the Ombudsman Program, an increase of 91 inquiries from the previous fiscal year. As a result of these inquiries, 95 cases were opened for review (13%), 421 cases were given information or referred for services elsewhere (60%), and 192 cases were unassigned (27%). 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?



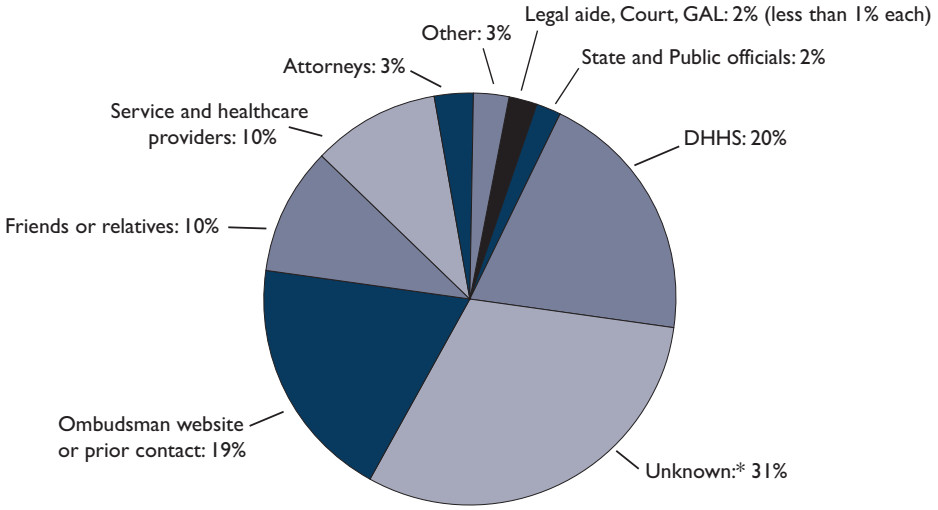
WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2021, 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?

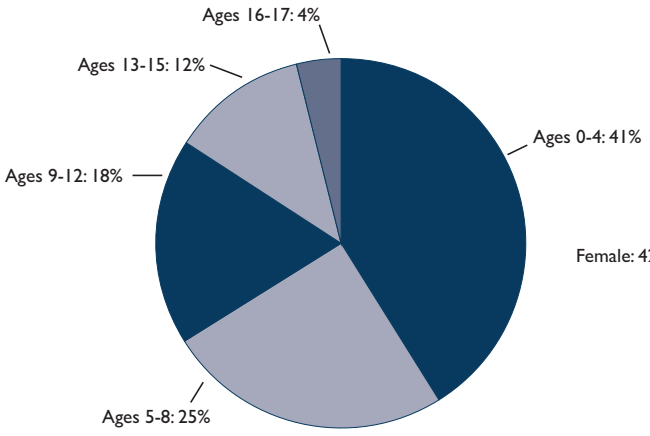
In 2021, nineteen percent of contacts learned about the program through the Ombudsman website or prior contact with the office. Twenty percent of contacts learned about the Ombudsman Program through the Department of Health and Human Services.

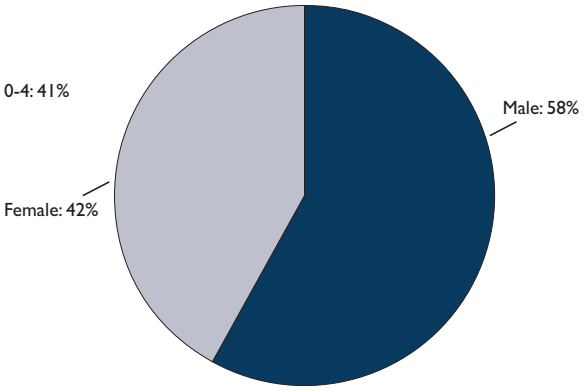


* *Unknown* represents those individuals who initiated contact with the Ombudsman, but who then did not complete the intake process for receiving services, or who were unsure where they obtained the telephone number.

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 172 children represented in the 95 cases opened for review: 58 percent were male and 42 percent were female. During the reporting period, 66 percent of these children were age 8 and under.





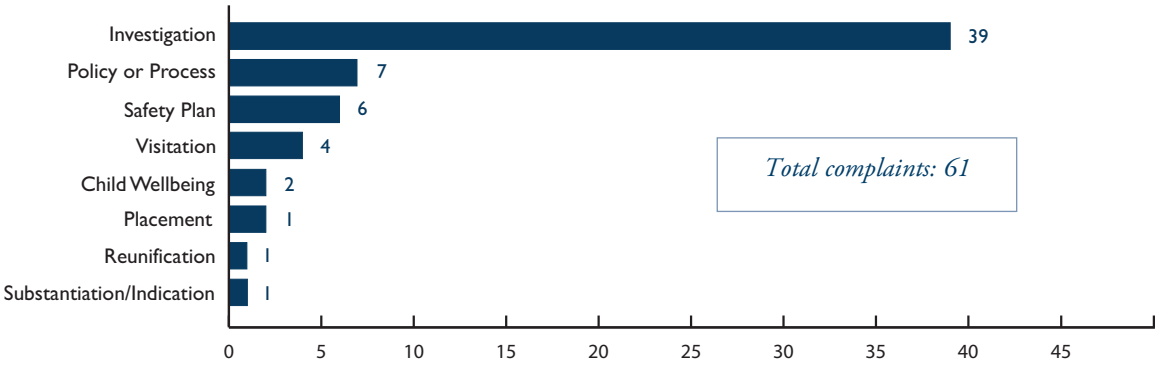
HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

			DISTRICT	CHILDREN	
DISTRICT #	OFFICE	CASES	% OF TOTAL	NUMBER	% OF TOTAL
0	Intake	2	2%	3	2%
1	Biddeford	11	12%	19	11%
2	Portland	9	9%	13	8%
3	Lewiston	19	20%	38	22%
4	Rockland	6	6%	9	5%
5	Augusta	18	19%	41	24%
6	Bangor	14	14%	20	12%
7	Ellsworth	7	7%	10	6%
8	Houlton	10	11%	19	11%
TOTAL		**95**	**100%**	**183**	**100%**

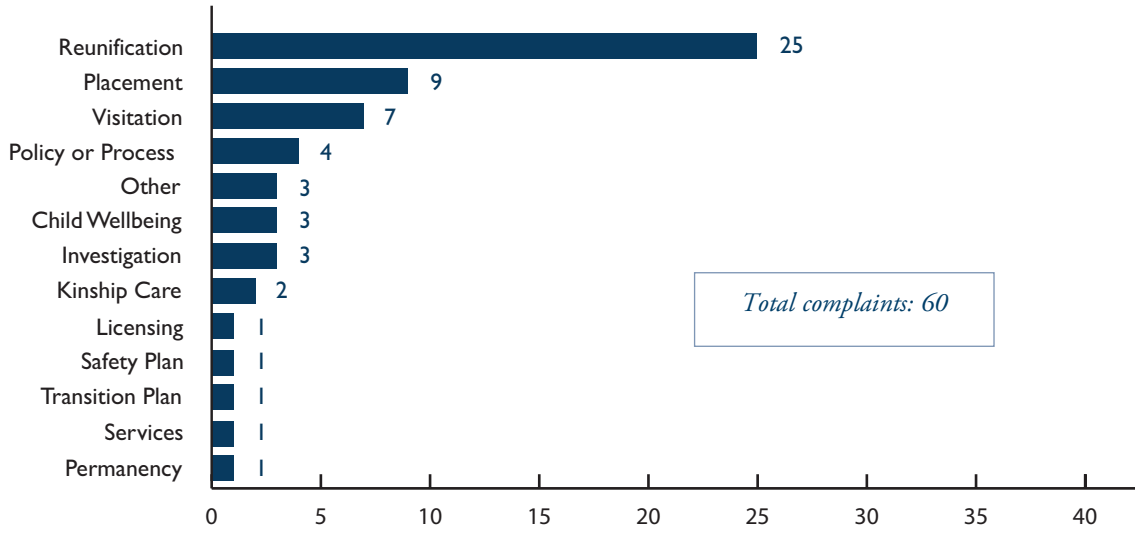
WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 95 cases were opened with a total of 121 complaints. Each case typically involved more than one complaint. There were 61 complaints regarding Child Protective Services Units or Intakes, 60 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 84 cases that had been opened for review. These cases included 106 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	14	41
1. Action cannot be undone	23	10	
2. Dept. disagrees with Ombudsman	1	0	
3. Lack of Resources	0	4	
Not Valid	36	29	65
TOTAL	**63**	**43**	**106**

* Total of numbers 1, 2, 3

During the reviews of the 84 closed cases, the Ombudsman identified 6 additional complaint areas that were not identified by the original complainant. The complaints were found to be valid in the following categories: 11 investigation, 11 reunification, 3 safety planning, 3 policy or process, placement and transition planning 1, and lack of resources 1.

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 complete case reviews. Unfortunately, case specific reviews by the Ombudsman for fiscal year 2021 show a downward trend in child welfare practice. While the causes of this are complex and not well understood, the amount of stress that Covid-19 has had on child welfare at all levels cannot be understated.

Out of the 84 cases closed this year, 42 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 42 cases, 22 involved investigations and 14 involved reunification. The remaining six cases had varying issues.

- As has been consistent over several years of Ombudsman reviews, practice issues continue to appear most prominently during two phases: 1) initial safety investigations of reports when the safety of children is not accurately determined and 2) once children are in state custody, during ongoing assessment of parents' progress in reunification. Issues with assessments of children's safety at the beginning and end of child welfare cases are concerning as these are the times when the risk to children can be at its highest.

The reasons why these practice issues continue are only beginning to be understood. The reviews of the three child deaths completed in July of 2021 shed light onto some of the problems that caseworkers face in the field that contribute to missed opportunities in child welfare practice. Learning and reform will be an ongoing process and will take time.

The Ombudsman recommends that:

- Frontline staff have their voices heard and their experiences and opinions considered in child welfare reforms, from the start to the finish of all processes. Collaboration and transparency with stakeholders is also an important part of any child welfare reform process.
- Maine should strongly consider the implementation of Safety Science in child welfare.
- Although outside of the scope of the Child Welfare Ombudsman's review practice, prevention services are crucial to reducing risk for children and preventing entry of children into state custody. The fact that services and resources for families are minimally discussed in this report should not discount their importance.
- Training for staff and supervisors should be aligned with national best practices and supervisor training and support should be prioritized.

A. Investigations

When a report of possible child abuse or neglect is made, the Department completes an initial investigation to determine whether the child in question is safe. Investigations continue to show practice deficits. These included: all areas of child abuse and neglect are not explored, and instead the focus is only on the issues in the initial report; full interviews are not completed and appropriate collaterals are not contacted; children are not seen regularly when investigations exceed 35 days; one parent is assessed but not the other; all out of

home children and parents are not located and assessed; substance use issues are not fully explored; mental health issues and domestic violence are not fully explored; and the investigation did not follow up on new information as it came to light.

Even when enough information is collected during an investigation, there is often failure to recognize risk to the children and act accordingly. Parents' mental health issues, substance use, cognitive issues, and exposure of the children to domestic violence are not recognized as presenting the risk that they do; truancy of children as a sign of risk is underestimated and the issues underlying the truancy are not explored; children are not protected from physical abuse until it becomes serious; and intervention by the Department is not proportional to the risk to children discovered during the investigation.

High risk cases continue to be transferred to the Alternative Response Program ("ARP"). Cases referred to ARP are low to moderate risk cases sent to contracted agencies for monitoring instead of kept as an open service case by the Department. It is common for a family to have multiple involvements with the Department over a period of a year or more. When these result in unsubstantiated assessments or ARP referrals, the lack of child abuse and neglect findings is mistakenly thought to be evidence of safety. Missed opportunities in previous assessments are not addressed in the subsequent ones. It is not well understood that the existence of many reports and assessments alone elevates the risk to children.

Practice confusion over the appropriateness and implementation of safety planning was found in multiple cases. Safety planning occurs when the Department has parents agree to a temporary plan in order to make time for investigation to take place, to engage services, or to have legal protection to go into effect.

During the fiscal year, of the 16 cases reviewed where a safety plan was implemented, in 14 cases, there were substantial issues found with safety planning. Policy and practice around safety planning has changed several times since 2017. Safety plans can be a valuable tool to decrease trauma to children and make time for investigation while keeping children safe but use of safety planning has been inconsistent. In 2021, children were safety planned out of their homes to unassessed or unsafe caregivers; once in place, safety plans were not monitored; after safety plans were violated, new plans were made without reason to think the plan would now be followed; and safety plans were put in place without ensuring that a child's medical, educational, and mental health needs would be met. Aside from leaving children in unsafe environments, safety plans can delay court filings and therefore permanency for the children and infringe on parents' rights to services and reunification.

B. Ongoing Assessment of Reunification

Once a child enters state custody or the Department opens a service case, parents are given a reunification plan to follow over a period of time to complete services focused on changing parents' behaviors that made the children unsafe in the parents' care. At the end of the reunification period, the Department must decide whether the child will be safe back in the parents' care. In order to make the decision accurately, the Department must complete ongoing assessment of the parents' progress in reunification.

Ongoing assessment of reunification continues to be at issue. During this fiscal year, the Department made decisions about reunification that were not supported by the information gathered, or not enough information was gathered to make a sound decision.

The issues in these cases included: high risk mental health issues are not well understood and not appropriately treated; medication compliance necessary to the treatment of high risk mental health issues is not monitored; providers are not given enough information early in the case to provide effective treatment or are not held accountable for lack of objectivity; substance use screening and pill counts are not consistently used to monitor progress in substance use treatment; contacts with parents, service providers, and other collaterals is not consistent; interventions and services required did not always match the level of risk; children would enter state

custody while their siblings or other similarly situated children were unassessed and continued to be exposed to or cared for by unsafe parents; assessment of new significant others did not timely occur; informal safety plans and formal safety plans were not monitored; and decision making around trial placement in general is inconsistent and reasoning behind the decision to start trial placement is unclear. Trial placements are not effectively monitored, ended when high-risk behavior indicates the children are still unsafe, and a second trial placement might be started after the first was not successful.

Note: The Department and parents often have problems finding appropriate providers that can provide evidence based and objective treatment to parents. This issue is not in the control of the Department when providing reunification services to parents during a case.

C. Older Youth and Resources

Lack of resources for older youth or children with high needs continue to affect the safety and well-being of children. There are not enough therapeutic foster homes, not enough high-quality residential treatment facilities, and a general lack of mental health resources for both young and old. As a result, children can be placed in either unlicensed or non-therapeutic foster homes. Services do not easily follow children from one home to another. In one example included in closed cases this year, a teenager with high needs in state custody was placed in an unlicensed home and then a homeless shelter for respite. While at the homeless shelter the teen was sexually assaulted. In another case during an investigation, despite the fact that a teen was abandoned by the parents and had high behavioral needs, the teen was considered safe in a homeless shelter. Department caseworkers are often without options due to lack of resources, and older youth are left unsafe and untreated.

D. Case Summaries

The following are case summaries to assist in providing context and detail to the concerns outlines above.

1. Investigations

1. The Department and ARP were consistently involved with a family for a year and a half. The child made more than one disclosure about physical violence, including strangulation, perpetrated an adult in the home. Finally, the child was strangled by the adult again and had to be transported to the hospital and the adult was arrested. The perpetrator had held the child off the ground with feet off the floor. It was later learned that the child had been exposed to repeated domestic violence in the home.

2. The Department did not fully assess a parent's safety or make a family plan before and during COVID-19 lockdown. After a zoom tour of the apartment, the Department decided to dismiss the pending court petition. The parent was not in services and the Department did not check with the previous provider.

3. After multiple reports of child abuse or neglect, the Department had not thoroughly investigated the safety of several children. There were multiple cases intertwined that stretched over years. The initial assessments identified a number of serious safety concerns. These issues were not fully explored or addressed. Additional assessments and cases have progressed on the foundation of inadequate assessments, which left the safety of many of the children unknown. Two cases had been open for two of the major family units for over a year and some of the children had entered state custody.

4. The Department completed a thorough safety assessment for the infant but did not assess the safety of the older two children who spent time in the home. The Department implemented a safety plan for the infant keeping the infant out of the unsafe parent's care but did not monitor it for two months. Then the parent moved with the infant back into the unsafe parent's home without the Department's knowledge.

5. Three child protective investigations were completed in one year and a fourth opened the year after for the same family. The reporter's allegations about one child were thoroughly assessed, but the safety the other children, both in and out of the home, were not always assessed and parents and guardians were not contacted. As part of this, the Department did not complete sufficient activities to locate children who were in the care of their other parent. This parent was not allowed contact with children in a separate case.

6. The Department had conducted three child protective assessments over the past year and a half and had not adequately investigated reports of abuse and neglect and left the children unsafe. The assessments were lengthy involvements and did not address serious concerns of substance use, mental health issues, and domestic violence in the family.

7. The Department implemented many safety plans during the case that were not sufficient to ensure the safety of two young children. The safety plans often included either unassessed or unsafe individuals monitoring the plans or providing care to the children. Safety plans were kept in place even when continually violated. The Department did not recognize serious risk to the very young children and they were left unsafe in their parent's care for months. Despite the high level of risk, the case was transferred to ARP, but quickly transferred back when a new report was made. After more safety plans, the children entered custody via an emergency petition.

8. The parents violated three safety plans implemented due to domestic violence concerns. One parent was granted custody of the child with the Department's agreement but continued to violate the court order that was intended to protect the child from the domestic violence. Yet another safety plan was implemented that required the parent's contact with the child be supervised. The Department then filed another petition in court, but custody still remained with one parent.

9. An investigation was opened into a child's safety, and despite several reports (and direct observation by the Department) of significant bruising on the child, alcohol intoxication while caring for the child, untreated mental health issues, driving while intoxicated with the child, and domestic violence in the home, the high level of risk was not recognized and the plan was to refer the case to ARP. As the case was being transferred, the young child eloped from the home for many hours.

10. During one assessment the Department collected sufficient information that the parent had relapsed, including an admission by the parent and positive drug screen. The parent had also allowed an individual, who had probation conditions of no contact with the parent due to domestic violence, back into the home. The Department did not implement a safety plan and intended to close the case with no findings and refer to ARP. A new report with similar concerns was called in and another investigation opened. A safety plan was implemented and jeopardy petition filed.

11. The Department did not recognize that children were in immediate risk of serious harm and were left unsafe with the parents for months due to substance use and mental health issues. The Department then filed a jeopardy petition and while the jeopardy petition was pending one child died due to unsafe sleep, a known issue. (This occurred outside of the 2021 fiscal year reporting period.) Another child entered state custody, but the Department did not assess the safety of older children although they were often in the parents' care. A significant period of time passed and another one of the children entered state custody after ingesting substances. Then, the Department investigated the safety of the remaining children, and though there were serious safety concerns, did not act to protect the children for additional months until a jeopardy petition was filed.

12. The parent had been actively using heroin for an undetermined amount of time and the Department completed multiple assessments without protecting the very young children. The most recent assessment was closed with a safety plan in place monitored by an individual who was unlikely to report concerns to the

Department. Despite the fact that the two children likely had safe out of home parents, the safety plan was conducted in the unsafe parent's home with a relative supervising contact.

13. The Department opened multiple investigations into the truancy and mental health of children without assessing the parent's underlying issues. Without addressing the parent's problems, the services for the children only provided temporary solutions. Despite recent assessments being scored as high risk by the SDM tool, no service case was opened or jeopardy petition filed.

14. A safety plan was implemented with a parent due to concerns of domestic violence perpetrated by the out of home parent. The parents violated the safety plan. The Department implemented a second safety plan choosing a previous victim of the out of home parent's domestic violence to monitor the plan and provide supervision of the parent and child. The safety plan supervisor had a child welfare history and could not be relied on to report violations of the plan. The out of home parent was not sufficiently assessed.

15. Children were safety planned to an inadequately assessed parent's home, though there was a recent court order requiring that parent to have supervised visits with the children. The parent had previously been substantiated by the Department and had a drug use history that was inadequately explored. The children remained with the parent under the safety plan for over a year. There was little ongoing assessment and no resolution.

16. After an incident when the parents of an infant were intoxicated and fighting the Department implemented a safety plan for the infant and an older child. The children were planned to relatives that were not assessed. After a week one of the relatives dropped the infant back off with the parent. The Department then discovered significant medical needs for the infant. An emergency petition was granted taking the infant into state custody, but no new plan was made for the older child, now living with an out of home parent who was not assessed. The older child was not seen regularly.

2. Reunification

1. A parent with a serious substance use history overdosed. Several months after the parent was determined to have neglected the child due to serious substance use, the parent overdosed again and police responded to the home. Despite ample evidence of continued use, the Department then decided that the parent was now safe and left the child in the parent's care. Signs of substance use continued until the case was closed. After the case closed, the Department did not investigate a new report that the parent had overdosed again in the home.

2. After an assessment that was not completed for many months, a court petition was filed to protect the children and a service case opened. The petition was necessary due to the difficulty of engaging the parent, a significant Department history, untreated mental health of the parents and children, along with concerns of substance use disorder and domestic violence. The Department later dismissed the petition prior to the hearing although the home was still unsafe. Providers that evaluated the family were not given information by the Department and based their evaluations on self-reports from the parents. There was little ongoing assessment of the family and little contact with service providers in general. Since the case closure, the Department has received reports with similar concerns, including ongoing police involvement.

3. There has been a clear reunification plan in the case for three years. the Department has not conducted ongoing assessment of the parent's safety or progress in alleviating jeopardy over several years. Regular face to face contact with the parent, mental health and substance use providers, and requests to attend random drug screens, have not occurred. A psychological evaluation was completed, but the services recommended were not implemented. Trial home placement was started and the child's safety has not been adequately monitored.

4. The child has been in state custody for almost two years and the parents have made no progress towards alleviating jeopardy and a petition to terminate rights has not been filed. One parent has remained in a caregiver role to out of home young children who are significantly vulnerable. The custodial parent of the out of home children does not appear to recognize the risk that the other parent presents.

5. The Department had an investigation open for ten months prior to filing a jeopardy petition. The petition was dismissed two months later. During the year of the Department involvement, assessment of the children's safety and the parents' progress was sporadic. Weeks and sometimes months would go by without knowing where the children were. The Department was relying on an informal arrangement with relatives to keep the children safe. The parent continued to use substances and was not in substance use treatment. The case was transferred to ARP and ARP was not able to drug screen the parent or monitor whether the parent started services.

6. Older youth were subjected to serious abuse and neglect in the care of their parent, who had a significant substance use problem. The parent was physically and verbally abusive. During more than one Department involvement, the youth lived with a relative either through a formal or informal safety plan. They were not given legal protection and the parent was not asked to do any services. The youth continued to return home when the parent was still unsafe.

7. A parent had significant mental health issues and the inability to protect the children from domestic violence. Throughout the case, despite the fact that the parent was engaged in treatment, the treatment was not effective. Providers were not objective and recommendations in a psychological evaluation were not implemented. After a significant period in state custody, trial placement began and then it was discovered that the parent was still in a relationship with the perpetrator. Trial placement was not ended. In general, the parent's level of treatment did not match the severity of the illness. The risk to the children remained high.

8. A parent had a history of prior termination of parental rights, unsafe partners, mental health issues, and substance use. The children entered state custody after it was determined that these problems continued. The parent was uncooperative through the year the children were in state custody despite good faith reunification efforts by the Department. A month after the parent started to cooperate minimally, trial placement was started. The reason for the decision to start trial placement was unclear and jeopardy had not been alleviated. A child was placed with an out of home parent at the beginning of the case. The parent was not assessed and the child was not seen for regular monthly contacts. The child was eventually removed and entered state custody.

9. During the reunification period neither parent was adequately assessed on an ongoing basis and new issues were not addressed as they arose. This included: lack of regular face to face contact with the parents, drug screens and medication counts, contact with service providers, and assessment of new adults in one parent's life. New concerns were not assessed. After a plan to have the child remain out of the parent's care was implemented, the Department quickly switched to unsupervised visitation and planned to head to trial placement without evidence that the parent had alleviated jeopardy.

10. Children had been in state custody for almost three years. Trial placement began but once Covid restrictions went into effect and the parent was no longer held accountable by the Department, police, and the court, the parent allowed the unsafe parent into the home and relapsed. The children were exposed to extremely unsafe situations due to the parents' drug use. One parent was incarcerated, released and engaged in treatment, and four months later trial placement was started again.

3. Positive Case Summaries

1. The child protective worker completed a thorough assessment of the child's safety, including clear communications with the mother and safety plan supervisors, and contact with the mother's providers. The permanency worker, in the short time she has been on the case, has already done a thorough job of assessing the case, contacting the mother's providers, and keeping in touch with the mother and family. Family team meetings have been held regularly, have included providers and family members, and have been scheduled in response to case events.

2. The Department has carefully followed domestic violence policies and has made sure to hold meetings with each parent separately. The Department safety planned a child to one parents' home after adequately assessing the safety of that parent.

3. The Department implemented a safety plan when a parent posed a risk to the child and monitored the family through an open service case. The child protective worker developed a positive working relationship with both parents and the relatives involved in the case. The investigation was thorough and determined the risk to the child. The Department then acted to protect the child.

4. The initial investigation was completed during Covid lockdown and an appropriate safety plan was put into place. The investigation began with an unannounced visit, and the initial interviews were very thorough and the child made disclosures. The child protective worker made collateral contacts and collected collateral reports. The safety plan was signed by all family visit supervisors and the caseworker clearly explained both the safety plan and the jeopardy petition that was filed.

5. The adoption caseworker has tirelessly worked to help the child adjust to each placement and was understanding when the child did not trust the caseworker. The record reflects a caring professional who understands the limitations of the available resources while always working towards the best interests of and permanency for the child.

6. The Department provided the parents with good faith reunification services and consistently provided both parents with visitation. The permanency caseworker had clear communication with the parents throughout the case. The children were placed together and achieved permanency together.

7. The Department fully supported the foster mother, had a thorough understanding of the child's complex medical needs, and had done a great deal of work throughout the case to problem solve and communicate to make sure that the child was in a safe and stable home.

8. The permanency caseworker has provided good faith reunification services to both parents and done excellent ongoing assessment of reunification in the case. The caseworker had many clear conversations with both parents and the expectations of reunification were clearly communicated both in writing and verbally. The caseworker made a report and acted to protect similarly situated children new to the case.

9. The child protective caseworker responded the same day to a report with an unannounced visit. The safety plan was thoroughly monitored and the family members responsible for the safety plan were interviewed multiple times. Interviews with the parents were very thorough including out of home parents. The case was monitored thoroughly during the initial Covid lockdown and afterwards.

10. Although the Department provided thorough ongoing assessment of the parents' progress in reunification, the court denied the termination of parental rights and the children returned home. The Department did an excellent job supporting the difficult transition home for the children, and thoroughly monitored the trial placement.

11. The Department facilitated the children's kitten moving to the foster home.

12. The permanency caseworker has done an exemplary job supporting the children. The caseworker has gone above and beyond to make sure the children were supported and the reunification with the parents was supported if possible. The children fully trust the caseworker and rightfully so. The caseworker has always acted in their best interests. The permanency worker also provided excellent ongoing assessment of the case.

13. The permanency caseworkers provided thorough ongoing assessment of the reunification case. This included many substance use screens to verify sobriety. Validity of new reports were quickly evaluated. The caseworker was very consistent on following up with new concerns both big and small. The caseworker has had many clear and well-articulated conversations with a parent's service provider and provided ample information, including relevant documentation, to the provider regarding the Department's concerns with the parent.

14. The initial investigation after the infant's birth was thorough and assessed the children as safe. The assessment followed the parents until the family had been established in services. The investigation continued even at the onset of Covid restrictions. The open case was carefully monitored even though no court petition was filed. Caseworkers listened to and sorted through the many allegations made by many case members. The parents were regularly drug screened during the assessment and open case.

Correction for 2020 Annual Report

The following should replace the case summary on p. 15, #1.

"1. A child was reunified with a parent too quickly due in part to lack of ongoing assessment of the progress of the parent and assessment of the new partner. The parent and the new partner had an infant during the open reunification case and the assessment of the infant's safety was not adequate and a case was not opened for the infant. The infant sustained fractured ribs at the hands of one or both of the parents which was discovered when the child was admitted to the hospital due to serious illness. The infant later died due to the illness. The older child re-entered state custody. (Of note, this case was referred to the Ombudsman for review. There is otherwise no statutory or regulatory protocol for the Ombudsman to be notified of or automatically review cases involving the death of a child.)"

A year following the infant's death, new medical information was released to the Department and shared with the Ombudsman regarding the cause of death. The Ombudsman re-reviewed the case and consulted with medical experts which resulted in the above correction.

ACKNOWLEDGMENTS

As the nineteenth 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, and Craig Hickman.

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