

Maine
CHILD WELFARE SERVICES
OMBUDSMAN

18TH ANNUAL REPORT • 2020





CHILDREN'S OMBUDSMAN

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I am honored to present the eighteenth annual report of the Maine Child Welfare Ombudsman. Maine Child Welfare Ombudsman, Inc., (“the Ombudsman”) is a statutorily created 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 by individuals about practices of the Maine Department of Health and Human Services, Office of Child and Family Services (“the Department”). The Ombudsman provides information about child welfare services to individuals who contact the program. Additionally, the Ombudsman provides systemic oversight of child welfare policy and programs within the confines of its statutory authority and provides authorized information to the public. The Ombudsman is provided guidance and oversight by a Board of Directors whose members have extensive legal and child welfare experience

It goes without saying that 2020 has turned out to be an extraordinary year. Three years have passed since the deaths of Marissa Kennedy and Kendall Chick. Marissa and Kendall have come to represent the many unnamed children who experience child abuse and child neglect. Through their deaths, much needed attention has been directed towards child welfare and the system’s lack of resources. Now, the COVID-19 pandemic disrupted the work of child welfare in ways that could not have been anticipated. The landscape for child welfare caseworkers has been constantly shifting underfoot as we as a state have reacted to and learned about the novel coronavirus.

As part of necessary safety procedures, child welfare staff are working outside of the office, but doing vital work. Staff are exposing themselves to coronavirus, managing possible exposure to their families at home, engaging families who are often without the necessary technology for remote communication, and bearing the brunt of the global frustrations of individuals engaged with child welfare. Despite all of these difficulties, child welfare caseworkers are still responsible for performing their complex work to protect children every day. We all owe these heroes a debt of gratitude in for their work in past years, but especially now.

We at the Ombudsman’s office continue to do our work as well. Since December of 2013, during my tenure as Ombudsman, the Child Welfare Ombudsman’s office has completed 709 case specific reviews and helped 2251 individuals through information and referrals. The Ombudsman’s case reviews and general recommendations resulting from these reviews are intended to provide objective guidance that assists the Department with the enormous task of ensuring the safety of Maine’s vulnerable children.

Reducing the number of children in state custody is the goal of every stakeholder, but that reduction must happen safely. On September 30, 2020 there were 2362 children in state custody, an increase of 164 from the same date in 2019. As it did last year, this report focuses on practice issues in two specific areas where children’s safety is often the most at risk: 1) the initial investigation of a child’s safety, and 2) the ongoing assessment of reunification and the decision at the end of a case about whether or not a child should return home to the parents. OCFS continues to struggle in these areas, and there is need for more active and consistent communication in the future.

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 and helping families stay together.



Christine Alberi

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.

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.

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 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>

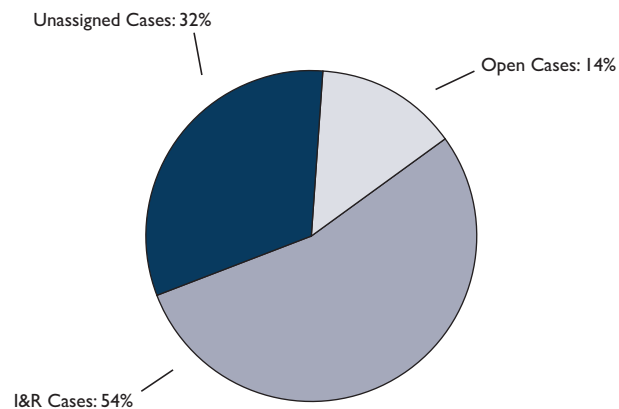
DATA

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, 2019, through September 30, 2020.

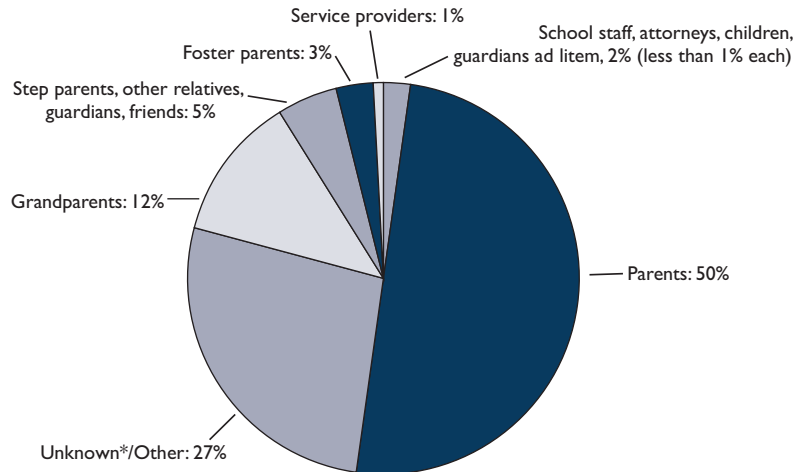
In Fiscal Year 2020, 617 inquiries were made to the Ombudsman Program, an increase of 6 inquiries from the previous fiscal year. As a result of these inquiries, 90 cases were opened for review (14%), 332 cases were given information or referred for services elsewhere (54%), and 195 cases were unassigned (32%). 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?



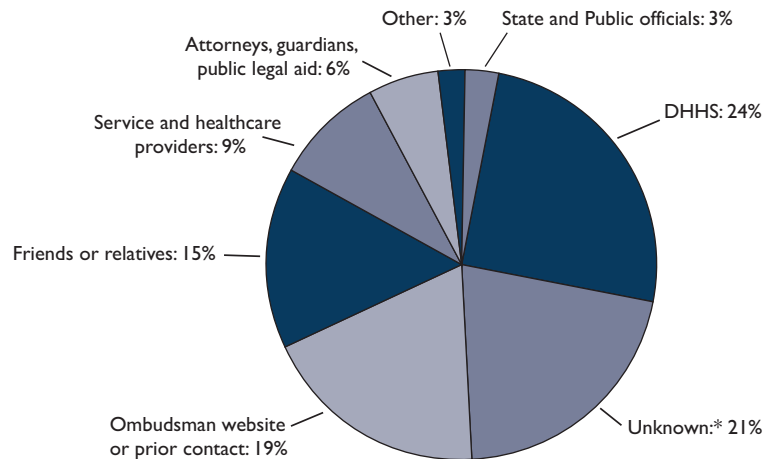
WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2020, 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?

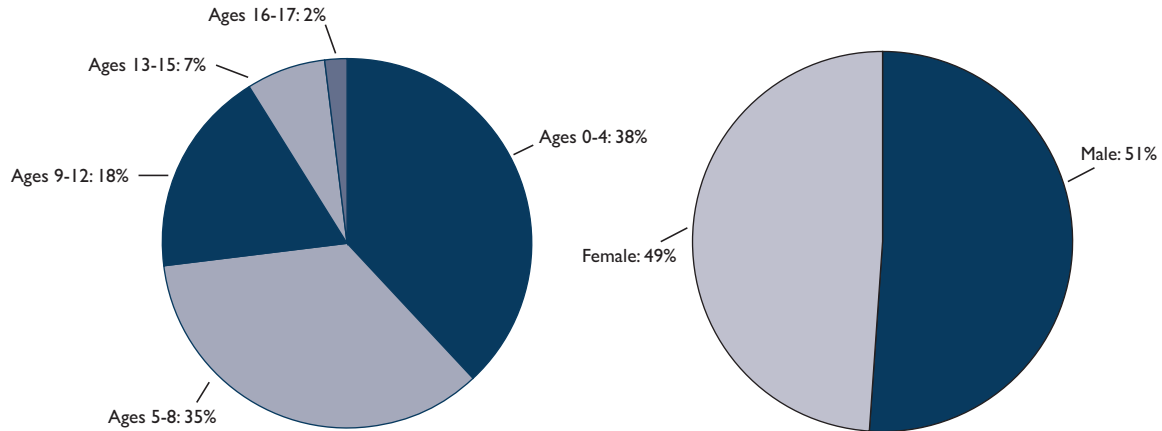
In 2020, nineteen percent of contacts learned about the program through the Ombudsman website or prior contact with the office. Twenty-five percent of contacts learned about the Ombudsman Program through the Department of Health and Human Services.



* *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 183 children represented in the 90 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.



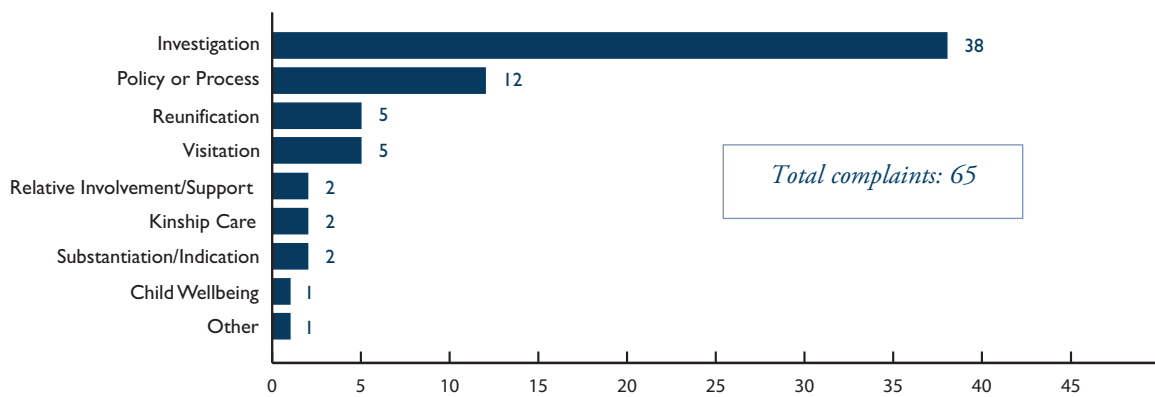
HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

DISTRICT #	OFFICE	CASES	CHILDREN		
			DISTRICT % OF TOTAL	NUMBER	% OF TOTAL
0	Intake	2	2%	4	2%
1	Biddeford	9	10%	14	8%
2	Portland	11	12%	15	8%
3	Lewiston	12	13%	24	13%
4	Rockland	5	6%	10	5%
5	Augusta	17	19%	43	23%
6	Bangor	13	14%	28	15%
7	Ellsworth	13	14%	27	15%
8	Houlton	8	9%	18	10%
TOTAL		90	100%	183	100%

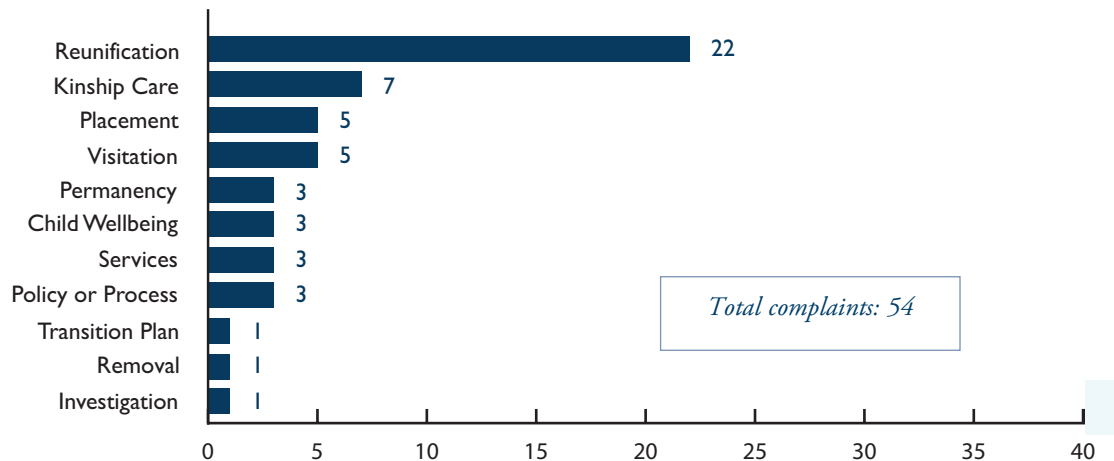
WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 90 cases were opened with a total of 119 complaints. Each case typically involved more than one complaint. There were 65 complaints regarding Child Protective Services Units or Intakes, 54 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 82 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	2	1	3
Valid/Not Resolved*	21	7	28
1. Action cannot be undone	12	7	
2. Dept. disagrees with Ombudsman	0	0	
3. Lack of Resources	0	0	
Not Valid	38	37	75
TOTAL	61	46	107

* Total of numbers 1, 2, 3

During the reviews of the 82 closed cases, the Ombudsman identified 8 additional complaint areas that were not identified by the original complainant. The complaints were found to be valid in the following categories: 7 investigation, 6 ongoing assessment of reunification, 4 lack of legal protection of child, 2 transition planning, 2 policy or process, 1 delay in permanency, 1 trial home placement, and 1 lack of mental and behavioral health resources for child.

POLICY AND PRACTICE

Findings and Recommendations

The 2020 fiscal year cannot be discussed without acknowledgement of the unprecedented circumstances set off by the novel coronavirus that causes COVID-19. While the Department of Health and Human Services, Office of Child and Family Services (“the Department”) was in the midst of building on additional staffing and focusing on a new list of priorities, COVID-19 and the resulting restrictions arrived in March of 2020. Child Welfare Staff appear to have done an extraordinary job transitioning practices to try to ensure that children, families, and child welfare professionals were and are as safe as possible during the pandemic.

The Ombudsman recognizes the difficulties caused by COVID-19, but outside of and notwithstanding the pandemic, the Department continues to struggle with practice issues and decision-making around the two crucial points of child welfare involvement: 1) when making the decision whether or not the child is safe during the initial investigation and 2) when making the decision whether the child will be safe in the home once reunified with the parents. The Ombudsman’s office has been bringing these concerns to the Department’s attention through the fiscal year through case specific reports and other communications and interactions.

The Department reportedly continues to work on new policies and practice initiatives, but more practical, ongoing training and coaching is needed in investigation and casework techniques. The Ombudsman recommends more staff training and support, and particularly recommends the training of casework supervisors.

Child welfare has been able to expand the workforce significantly, including hiring new caseworkers and supervisors. This has addressed, to some extent, the major issue of unmanageable caseloads. New Caseworker Training is currently being evaluated by the Muskie School.

Unfortunately, for current child welfare staff, there are no ongoing or refresher casework training requirements. To address the practice issues identified in this report, all staff, but especially supervisors, need ongoing training to be able to effectively manage cases, recognize risk, and efficiently protect children.

Out of the 82 cases closed this year, the Ombudsman was in general agreement with 44 of the cases (there were no major policy or practice issues in the case). Out of the remaining 38 cases, there were 28 cases where initial investigation practice was at issue, 20 cases where reunification practice was at issue, and 3 other cases that involved other issues that did not fit an identifiable pattern. 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 2019 were not counted, although some were cumulative practice issues that had been ongoing from prior to March 2019.

Department Response:

OCFS would strongly counter the assertion that there is no ongoing or refresher training for caseworkers and supervisors. These include both mandatory trainings to meet continuing education requirements for social work licensure and trainings required by OCFS (both refresher trainings and trainings to educate on policy or practices changes). OCFS also encourages staff to engage in ongoing training opportunities, regardless of whether or not they are required. OCFS has an internal Policy and Training Team and

has also partnered with the Muskie School of Public Service at the University of Southern Maine. Muskie is providing support on reviewing and revising policies, improving the quality and quantity of training available to staff, and strengthening OCFS' ability to effectively engage staff in ongoing training opportunities that are relevant to their work. OCFS has also purchased a Learning Management System which allows us to track the trainings completed by each staff person and also provides for digital training opportunities that are especially important as we face the current pandemic.

All caseworker and supervisory staff are licensed as social workers and must comply with the licensing board's expectations regarding completion of continuing education within each licensing period. OCFS supports staff by providing a regular schedule of trainings, including opportunities which allow staff to gather necessary continuing education credits. In addition, OCFS also provides ongoing training opportunities to advance the skills and abilities of staff and before practice changes and new policies and tools are implemented staff receive training in order to ensure they are able to appropriately incorporate changes into their work.

OCFS' upcoming trainings for current staff can always be viewed at the following website: <https://www.maine.gov/dhhs/setu/ocfs-training.shtml>. At the time of writing this response there were 9 different types of training being offered to current staff in November and December of 2020. Topics included:

- Goals and Action Steps
- SDM Permanency Tool Refresher
- Various levels of Advanced Topics in Domestic Violence
- Indian Child Welfare Act (ICWA)
- Psychosocial Assessment
- Supervisory Training Academy
- SDM Investigations Refresher

At the time of writing this response, 212 staff had enrolled in these trainings. Trainings are delivered by experienced child welfare staff with the assistance of outside entities as required by the subject area.

During State Fiscal year 2020 the OCFS Policy and Training Team offered many other trainings. Topics included:

- Legal Training
- Ethical Decision Making
- Social Work Ethics
- Motivational Interviewing
- Advanced Medical Indicators
- Drug Identification
- Behavioral Health Training
- Rights of Recipients
- Train the Trainer for Mandated Reporters
- Trauma Toolkit
- Cultural Diversity
- Human Trafficking
- Methamphetamine Awareness and Response

In addition, several trainings are being reviewed for improvements and new trainings are being developed. OCFS has partnered with the National Center on Crime and Delinquency (NCCD), Muskie, and OCFS' Supervisor Advisory Team to review and revise the supervisory tools available

to staff. NCCD is also providing coaching training for all supervisory staff and ongoing coaching development is being incorporated into the OCFS supervision framework, which includes policy, training, coaching, and tools.

OCFS is very aware of the importance of ongoing training and support to staff. This awareness is reflected in the significant effort currently underway to improve policies and trainings, as well as the numerous ongoing training opportunities available to staff. OCFS believes there is always room to improve the training opportunities available and will continue to do so in the coming year.

Initial Safety Assessments/Investigations

A new investigations policy and structured decision-making tool was implemented in the winter of 2019. Despite the change in policy and addition of the tool, the same basic investigation practice issues that have been repeated for many years are still occurring: not recognizing risk when the evidence is clear, basic investigation practices are not completed, the caregiver's history warrants a thorough investigation that was not done and questions are not tailored to the issues, safety plans are made and not monitored, children and parents are not seen regularly during an open assessment or safety plan, and children are left without legal protection. The initial month of child welfare involvement is crucial to determining not only the immediate safety of the child, but to determining the course of the case through the end of the case and permanency for the child. Practice issues in initial investigations can leave children unsafe for a period of months or years.

The following are a sampling of cases where investigation policy was at issue:

1. An assessment was closed in the summer of 2019 with a safety plan in place that the parent was unlikely to follow. The plan was not followed, causing the child to witness a severe incident of domestic violence against the parent. The second assessment was closed with the perpetrator incarcerated, but the parent was not assessed further. The parent had older children that could only be seen through supervised visits, and the parent's mental health and substance use issues were not explored.
2. DHHS conducted numerous assessments over eight plus years about a child's safety with various caregivers, but the child never had legal protection from the unsafe parents. A pattern developed where DHHS would investigate briefly and then close the investigation due to previous assessments that were not adequately conducted, or out of home safety plans. There were many points in the child's history where the child could have entered state custody. Neither parent was fully assessed. The child went to live with a relative with DHHS approval, although no kinship assessment was conducted. The child returned to the care of the parents and was exposed to serious drug related criminal activity. After the child was exposed to this criminal activity, DHHS implemented a safety plan where the child would continue to stay with the mother.
3. Two children were left in unsafe circumstances for months due to incomplete assessment and then once information was gathered, the risk was not recognized. An investigation was opened due to a drug affected baby's birth. The older child lived with relatives, who were not assessed thoroughly. The older child was not seen by DHHS for five months. The infant returned to the mother's care. Safe sleep concerns for the infant were reported and not assessed quickly. Six months after the DAB report, a PPO was filed to take the infant into state custody. The infant could not be located for four days. After both children were out of the home, DHHS identified serious current and historical safety concerns for the relatives.

4. An initial investigation did not review a parent's prior records and history thoroughly, did not follow up on concerns about a parent's mental health issues expressed by a provider, and was open for four months without regular contact with the children and family.
5. DHHS had sufficient information from the outset of the assessment to determine that the parent's out of state child protective history made the parent an unsafe caregiver for the infant. The infant was left in the parent's care for six weeks in unsafe circumstances, although this was somewhat mitigated by the other parent's presence.
6. Three assessments completed over a five month period were not thorough and failed to recognize risk to the children. In the first assessment insufficient information was gathered to complete the SDM tool but its finding that the case was low risk was relied upon anyway. In the second assessment the SDM risk tool indicated high levels of risk and recommended opening a case but the assessment was closed as unsubstantiated.
7. A previous case was closed without legal protections for the children from the parent. The children were in the other parent's care but returned to the unsafe parent in the interim. When a new assessment was opened one of the children was again living with the unsafe parent. The other children were living with their safe parent but their safety was not assessed at all and they were not seen. Nothing was done in the case for three months and DHHS did not confirm the unsafe parent's completion of substance use treatment. The child was again in the care of the safe parent when the case was closed, without legal protection although the safe parent had filed for custody.
8. Two young children were in their parent's custody. One entered state custody and jeopardy was found as to the parent. The other child remained in the parent's care, then was the subject of an out of home safety plan with an unassessed relative. DHHS was not aware of whether the safety plan was being followed or where the child was and the assessment was closed. The child returned to the parent's care at some point and was not removed until a half-sibling was born and a DAB report was made.
9. A PPO had been obtained to protect the teenager from the father, but the five-year-old was left in the home for three months without protection. In addition, an infant born during the three months was not assessed or observed.
10. Children were safety planned to a relative's home and there was no assessment of the relative's home, the children were not visited there, and the appropriateness of the home was not assessed. The children were in the home for seven months before DHHS completed a face to face contact with the children in the relative's home. The safety plan continued for months after this. The parent had agreed to the safety plan but could not take care of the children although the parent was considered the safe. The initial investigation was not completed for approximately four months and there was inconsistent ongoing assessment of the other parent for many months.
11. Four investigations were completed in the past two years for the family. Due to reliance on previous incomplete assessments, the safety of the child in the parent's home is unknown. The parent had a lack of protective capacity in general and the parent's partner had mental health issues, severe alcoholism, a history of domestic violence, possible sexual abuse to a child, and lack of effective substance use treatment. The child appears to have credibly disclosed sexual abuse and DHHS determined, without expert consultation, that the disclosures were not sufficient.
12. Four child protective investigations were completed during the past year which failed to adequately assess the substance use issues of the parents. Multiple additional reports were made both during and between investigations. The third assessment remained open for months and the parent was

substantiated for substance use, assaultive behavior towards others, and unstable home but no further action was taken to protect the children. The most recent assessment contained only initial interviews and a few other contacts with parents. Another report was made and investigated during the assessment. The assessment had not reached any conclusions two months in.

Department Response:

In State Fiscal Year 2020, OCFS received nearly 13,500 reports of suspected abuse and/or neglect that were considered appropriate for investigation. This represents a significant increase from SFY 2018, when 12,025 appropriate reports were received and a slight decline from SFY 2019 when 14,227 appropriate reports were received. What is particularly remarkable about the fact that nearly 13,500 appropriate reports were received in the last State Fiscal Year is the fact that for 1/3 of the Fiscal Year (March, April, May, and June) the current pandemic resulted in a decline in the number of appropriate reports.

The workload for staff conducting investigations has remained high over the last year. OCFS has benefitted from several financial initiatives that have resulted in additional caseworker and supervisor positions. While OCFS' efforts to fill these positions and train new staff have been quite successful, there is also recognition that it takes time and experience to build new staff's casework skills. At the same time, a large portion of our supervisory staff are relatively new to the supervisory role. The creation of new supervisory positions required to ensure adequate oversight of caseworkers has decreased the overall level of experience among supervisory staff in some offices since many of the new supervisor positions were filled by promotions of caseworkers. That is why OCFS has focused specific attention on training and support targeted to supervisory staff.

OCFS is also continuing work to evaluate the implementation of Structured Decision Making (SDM) in the investigation phase. This has included training supervisors and Quality Assurance staff to conduct regular reviews of the use of the tool, efforts with the National Center on Crime and Delinquency (NCCD) to revise the tool as needed, and refresher trainings for caseworkers and supervisors. As staff experience with the tool continues to grow and Quality Assurance staff are conducting reviews and providing feedback, the effectiveness of the SDM tool will continue to improve.

In the last few months OCFS has also identified a need to review and refine policy and procedures surrounding Family Team Meetings (FTMs). In 2018, a directive was issued that ended the process of out-of-home safety plans, whereby a child is placed outside of his or her home with a relative or close family friend pursuant to a plan agreed to by the child's parents. OCFS has engaged with staff and stakeholders and has identified FTMs as a key point in the investigation, prior to the removal of a child, to allow the family and its supports to develop a plan that prevents the need for removal. OCFS is currently in the process of developing new and updated guidance on FTMs, as well as staff training on the topic. The goal is to improve the ability of staff to make safe plans for children that are informed not just by the investigation but also with the input of the family and their safe supports. The goal is for the holistic review of the entire situation surrounding a family to, whenever possible, prevent the trauma associated with the removal of a child from his or her home and parents.

OCFS is acutely aware of the importance of appropriate decisions regarding safety and risk in the investigation phase of child welfare operations. OCFS is dedicating significant time to continuing support for staff as they make these decisions. At the same time there is a recognition that child welfare work is incredibly complex. OCFS acknowledges that there may be investigations among the

nearly 13,500 appropriate reports received in the State Fiscal Year where decisions or outcomes were problematic. For every review conducted by the Ombudsman the Department receives a report with the Ombudsman's findings. Each of those reports are reviewed at all levels within child welfare, including the caseworker, supervisor, district management team, and child welfare leadership. The reports are used as an opportunity to learn and improve practice among staff. District management and supervisors address concerns with individual staff involved and the information gathered by child welfare leadership informs future policy and training decisions. OCFS has also conducted an internal review of each of the specific cases identified by the Ombudsman in this report in order to identify practice concerns, detect themes, and consider the impact of historical investigation and case decisions on the investigation under review. This process has provided an additional opportunity to evaluate and address practice decisions made by staff, as well as utilizing themes identified to structure and target future training opportunities.

In Federal Fiscal Year 2020 the Ombudsman reviewed 82 OCFS investigations and cases in total. Of those, 6 (7% of all those reviewed) resulted in a change based on the Ombudsman's recommendation. In her biannual interim reports to the Department the Ombudsman noted that, "often the District came to the same conclusions simultaneously to the report... There are several cases where DHHS had already taken actions that the Ombudsman recommended independent of the Ombudsman's findings, prior to the Ombudsman's report." OCFS has worked diligently over the last few years to develop a system that includes significant opportunity for quality assurance and improvement. This information from the Ombudsman indicates that efforts to incorporate quality assurance and improvement activities in investigations and cases has been effective in the majority of cases. OCFS believes that ongoing efforts to provide training opportunities and practice improvements will only serve to continue this focus on real-time improvements to the quality of OCFS' work.

Ongoing Assessment of Open Case and Reunification

As with initial investigations, ongoing assessment of open cases continues to be an issue. Often the Department arrives at the end of a case or at other crucial decision-making points (such as lifting visit supervision requirements) without enough information to make an informed decision. Whether or not a child is safe to begin trial placement is one of the most complex decisions made in child welfare.

In order to have the information necessary to make this decision, ongoing assessment of the parent's progress in reunification is essential. The ongoing assessment of a case includes having meaningful contacts with parents, making sure that parents' significant others are thoroughly assessed, talking to service providers periodically throughout the case including giving the service providers objective information at the outset of a case, in cases of substance use completing pill counts and random drug screens, in cases of mental health issues doing pill counts where appropriate and contacting all providers, providing visit and transition plans that provide meaningful information about the parents' abilities to care for the child, setting up trial placements with supports and services in place that will allow the placements to succeed, and thoroughly monitoring trial placements. Trial placement, when a child is still in state custody but placed home with a parent for monitoring prior to case dismissal, is a point of heightened risk.

Trial placement policy asks that caseworkers perform a higher level of scrutiny while monitoring the safety of the children than during initial investigations or ongoing assessment of reunification. These practice issues are necessary not only to ensure the safety of the child and the rights of the parent, but also to build an evidentiary case for court hearings.

Unfortunately, practice in many of these areas continues to be inconsistent. While there are many positive examples of casework in these areas, child welfare staff need more support, training, and resources statewide in this area.

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

1. A child was reunified with a parent too quickly due in part to a 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 died due to injuries sustained at the hands of one or both parents a few months after the reunification case was closed. 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.)
2. An infant with fractured arms and failure to thrive was granted unsupervised visits with one parent when it was still undetermined which caregiver had inflicted his injuries or what had caused the failure to thrive.
3. A trial placement was started for the parents when it had never been determined which of four caregivers (two parents and two relatives) had inflicted the injuries to the seven-month-old. The timing and placement of the injuries indicated that the injuries were escalating in severity.
4. Given the parent's history, a trial placement with an infant was started too soon. Significant issues such as the parent's consistent involvement in domestically violent relationships were not addressed. The parent's mental health issues were not assessed and there was not enough assessment of her sobriety to determine whether it was sustained. The parent was uncooperative with DHHS. There was no transition plan for the child to residing full time with the parent.
5. Children were in state custody for almost four years. They re-entered custody two months after the first case was closed. The previous involvements had issues with ongoing assessment during reunification as well as the safety assessment/initial investigation prior to the children re-entering custody. The sustained policy and practice issues from the earlier case have strongly affected the safety, well-being, and best interests of the children. The children both have severe behavioral issues and one has experienced multiple placement disruptions since re-entering care.
6. The parent had tested positive for amphetamines and methamphetamine, admitted to relapsing on other occasions and had not been in substance use treatment. The parent exposed the child to two unsafe partners and became homeless. DHHS relied on relatives to ensure the safety of the child with the parent but did not contact the relatives for months at a time. DHHS had a long open service case and clear guidance was not given to either parent. There was no family plan documented or communicated. The unsafe parent made little progress during the ten months of DHHS involvement and the child continued to reside part time with the unsafe parent.
7. In the past year DHHS has not provided ongoing assessment of the parents' progress. There was a lack of consistent contacts with parents, collateral contacts with service providers, assessment of live-in significant others, and regular family team meetings. One parent's mental health issues were not addressed in the two years of DHHS involvement. DHHS had not gathered enough information to say whether the children would be safe if reunified.

8. After good faith reunification services and excellent ongoing assessment of the parent's progress, DHHS did not monitor the transition plan and trial placement. The child was not observed during any unsupervised overnight visits leading up to trial placement and the parent was not interviewed. DHHS visited in the home twice in two months after trial placement started. Six weeks went by with no home visits. A third visit was completed in response to a new report due to the parent's new unsafe partner being in the home. DHHS discovered a different unsafe individual in the home and learned that a third unsafe individual had been living in the home prior to the start of trial placement.

Department Response:

In recent years OCFS has specifically identified a need to improve the process for making permanency decisions. This is reflected in OCFS' prioritized strategies for improving the child welfare system. Among the 12 strategies was the development of a Permanency Review Process. On 9/8/2020, OCFS implemented tools to guide staff as they make permanency decisions in child welfare. Staff were trained in the tools in the months preceding this implementation. As with the tools available in the investigation phase, OCFS has also trained members of the Quality Assurance Team, as well as all supervisors, in order to allow them to conduct quality reviews and ensure fidelity to the tool. OCFS has plans in place to conduct regular reviews that provide feedback to inform both systemic improvements (training, policy, etc.) and to target training to specific staff who need additional support in implementation of the tools.

OCFS has also dedicated staff and intern time to reviewing entries and exits from care to identify trends. With exits, there is a specific focus on barriers that exist to exiting children to safe permanency in a timely manner. These reviews focus on all aspects of the system, including OCFS staff efforts, service availability, the role of the Courts, and that of parents and their attorneys. OCFS is currently collaborating with staff and stakeholders to develop a permanency review process that looks at the life of a case holistically, considering the impact of all the various aspects of the system and focusing on safe exits from care in a timely manner.

As with the Ombudsman's recommendation regarding investigations, OCFS has reviewed each individual case discussed in this report and the data gleaned will inform decisions about opportunities to enhance caseworker practice. At the same time there is a need to recognize that while OCFS has a primary role in the child welfare system, there are many other variables and players within the system that impact outcomes in cases. For example, in one case the Ombudsman concluded that reunification occurred before it should have, but there was no recognition of the impact of the Court process. In that case the Department had sought termination and was denied by the Court with an order to continue efforts towards reunification. There are numerous other analogous situations where the Department's decisions and timing are impacted by factors that are not completely within OCFS' control.

ACKNOWLEDGMENTS

As the eighteenth 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, Ally Keppel, Allie McCormack, Virginia Marriner, and Katherine Knox for their support and dedication to our agency.

Included in every case specific report are positive findings that highlight some of the many instances of highly competent and professional casework observed throughout the state. Here are some examples of these positives from different reports:

- The caseworker developed a very positive relationship with the child and it was clear that the child felt comfortable talking to the caseworker and sharing how she felt.
- The caseworker consistently engaged both parents in reunification services and successfully reunified the child.
- The caseworker showed great compassion for the mother and supported her through the termination hearing for her youngest child and kept in close contact with her during pandemic restrictions.
- The current permanency worker has kept in touch with providers and collaterals, been clear about ongoing concerns with the parents, and held regular family team meetings. Ongoing assessment of the parents' progress in reunification has been excellent.
- Both child protective workers completed thorough interviews that took into account the complex family dynamics and all of the many allegations of abuse and neglect were explored.
- The ongoing assessment of the mother's progress was consistent and well done throughout the almost three years of her reunification case. The caseworker did excellent work communicating with providers, arranging two provider meetings, and doing everything possible to kindly and supportively encourage the children to visit with their parents.





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