*Maine*

# CHILD WELFARE SERVICES OMBUDSMAN

21ST ANNUAL REPORT • 2023

CHILDREN'S OMBUDSMAN

# *Table of Contents*





**The 2023 Maine Child Welfare Ombudsman Annual Report was written and prepared by:**

CHRISTINE E. ALBERI, Esq.
*Executive Director, Ombudsman*

I am honored to present the twenty-first annual report of the Maine Child Welfare Ombudsman. Maine Child Welfare Ombudsman, Inc. ("the Ombudsman") is a statutorily created non-profit solely dedicated to fulfilling the duties and responsibilities promulgated in 22 M.R.S.A. § 4087-A. The Ombudsman provides neutral objective assessment of concerns raised by individuals involved in child welfare cases through the Maine Department of Health and Human Services, Office of Child and Family Services ("the Department"). Our work continues this year with the addition of two new staff members, and I am very grateful for the increased support from the Governor and Legislature that has made this possible.

While discussions about child welfare frequently revolve around policy and practice, staffing and funding, parents' rights, and court procedures, I encourage everyone to keep at the forefront of their minds the purpose behind these and other discussions: the protection of Maine's children. Even in a system dedicated to child welfare, children seem to get lost in the shuffle. On the news, we hear stories about children involved in the most tragic child welfare cases, but in the vast majority of cases involving abused and neglected children, the children remain unnamed and their stories untold.

The examples in the following paragraph are all from actual cases involving Maine's children. Each of these children were removed from the harmful situations that they were in by the diligent work of Department caseworkers and supervisors, in collaboration with the courts and staff from the Office of the Attorney General. As these examples illustrate, frontline staff are engaged in protecting children under the most difficult of circumstances. Caseworkers, in particular, deserve our highest levels of support.

Consider the siblings who were screamed at by both parents, their prescription medications sold, and locked into an almost bare room for hours with no food or access to a bathroom; the child whose parents were actively using fentanyl and who witnessed their parent's frightening auditory and visual hallucinations; the children who were sexually abused and exposed to repeated instances of domestic violence; the newborn infant who was not gaining weight due to their parents' active refusal to feed them enough; and the child who was abandoned by their parent who was frequently intoxicated and physically abusive, who blamed the child for their desire to commit suicide.

The cumulative effects that abuse and neglect have on children can be devastating and life-long. We often discuss the trauma that removal of children from a parent's home can cause, but children also deserve to live in a home free from fear, abuse, neglect, and uncertainty. Children deserve caregivers who can give with peace and safety. The role of the child welfare system is to provide this for them. As soon as it is discovered that a child is unsafe, the child welfare system must intervene.

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

Christine E Alling

Child Welfare Ombudsman

# WHAT IS *the Maine Child Welfare Services Ombudsman?*

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

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

**MERRIAM-WEBSTER ONLINE defines an *Ombudsman* as:**

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

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

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

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

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

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

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

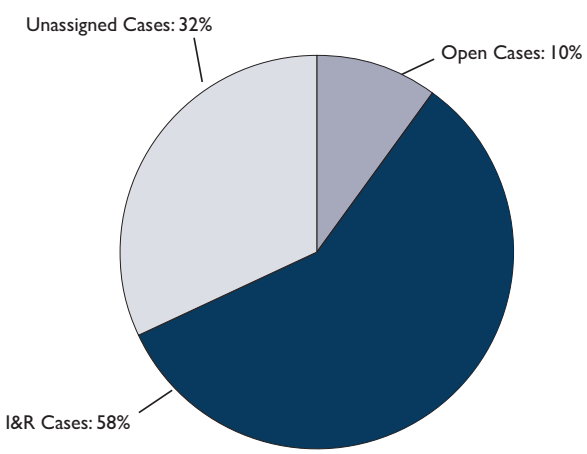
More information about the Ombudsman Program may be found at http://www.cwombudsman.org

# DATA
# *from the Child Welfare Services Ombudsman*

The data in this section of the annual report are from the Child Welfare Services Ombudsman database for the reporting period of October 1, 2022, through September 30, 2023.

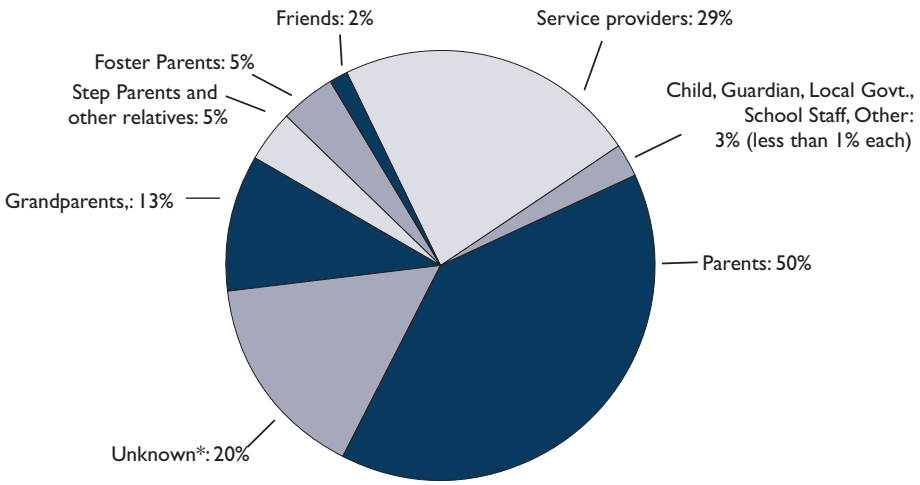
In Fiscal Year 2023, 737 inquiries were made to the Ombudsman Program, a decrease of 64 inquiries from the previous fiscal year. As a result of these inquiries, 77 cases were opened for review (10%), 422 cases were given information or referred for services elsewhere (59%), and 248 cases were unassigned (31%). An unassigned case is the result of an individual who initiated contact with the Ombudsman Program, but who then did not complete the intake process. Our scheduling protocols allow each caller an opportunity to set up a telephone intake appointment.

## HOW DOES THE OMBUDSMAN PROGRAM CATEGORIZE CASES?



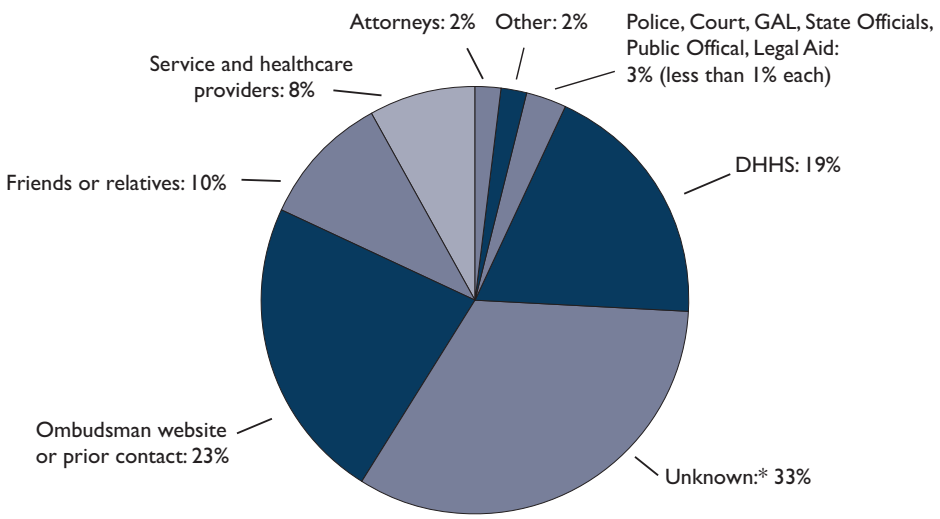
## WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2023, the highest number of contacts were from parents, followed by grandparents, other relatives, stepparents, and then foster parents.




## HOW DID INDIVIDUALS LEARN ABOUT THE OMBUDSMAN PROGRAM?

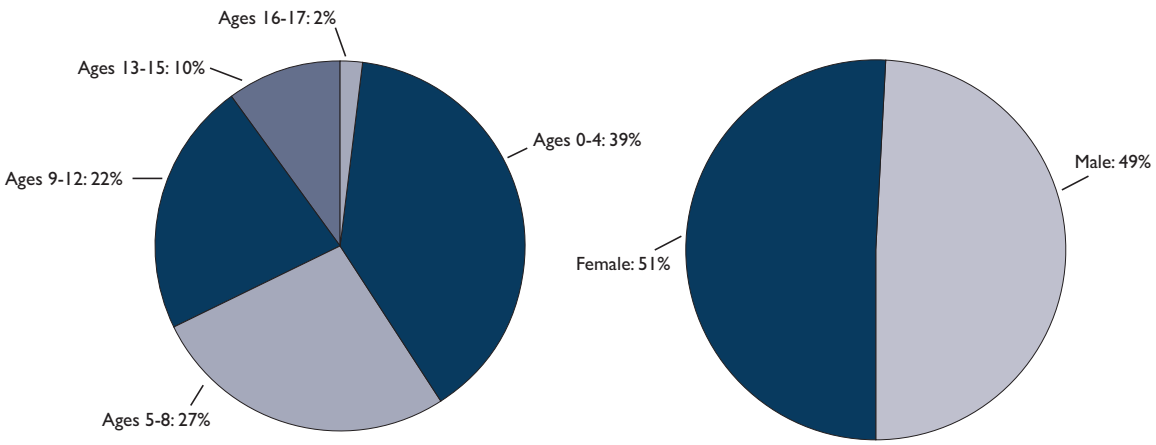
In 2023, 23.9% of contacts learned about the program through the Ombudsman website or prior contact with the office. 19% of contacts learned about the Ombudsman Program through the Department of Health and Human Services.




* *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 151 children represented in the 77 cases opened for review: 49 percent were male and 51 percent were female. During the reporting period, 66 percent of these children were age 8 and under.



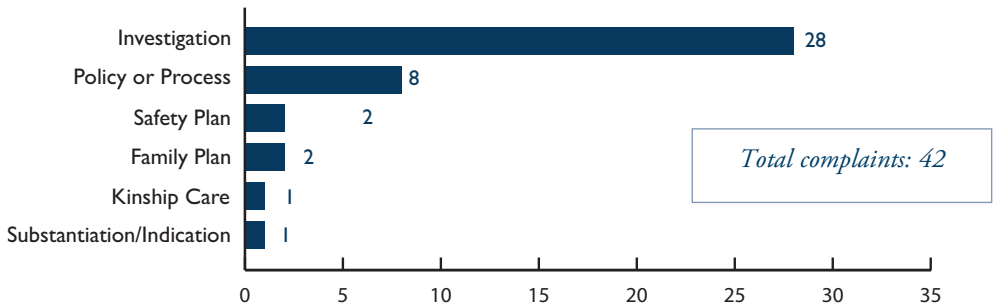

## HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

| | | | DISTRICT | CHILDREN | |
|---|---|---|---|---|---|
| DISTRICT # | OFFICE | CASES | % OF TOTAL | NUMBER | % OF TOTAL |
| 0 | Intake | 1 | 1% | 1 | 1% |
| 1 | Biddeford | 7 | 9% | 16 | 11% |
| 2 | Portland | 11 | 14% | 21 | 14% |
| 3 | Lewiston | 11 | 14% | 20 | 13% |
| 4 | Rockland | 9 | 9% | 16 | 11% |
| 5 | Augusta | 22 | 29% | 38 | 25% |
| 6 | Bangor | 10 | 13% | 21 | 14% |
| 7 | Ellsworth | 5 | 7% | 12 | 8% |
| 8 | Houlton | 3 | 4% | 6 | 4% |
| **TOTAL** | | **77** | **100%** | **162** | **100%** |

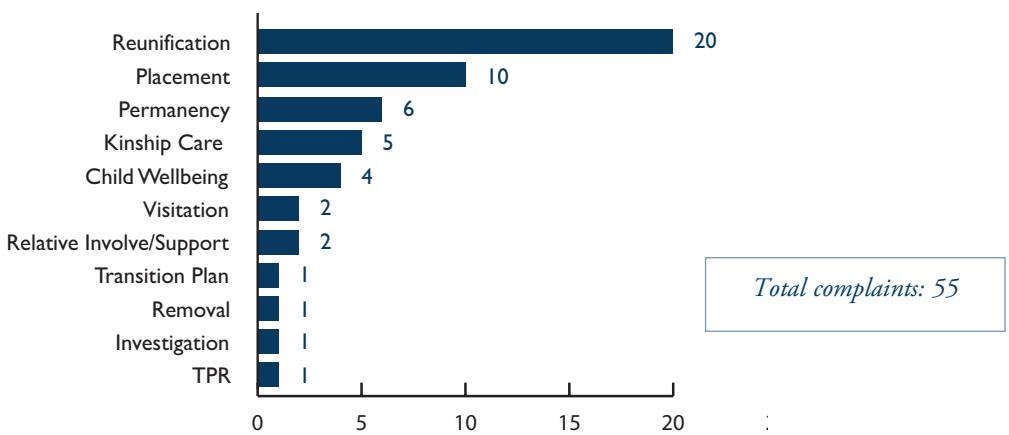
## WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 77 cases were opened with a total of 98 complaints. Each case typically involved more than one complaint. There were 42 complaints regarding Child Protective Services Units or Intakes, 55 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 108 complaints and those are summarized in the table below.

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

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

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

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

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

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

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

| RESOLUTION | CHILD PROTECTIVE SERVICES UNITS | CHILDREN'S SERVICES UNITS | TOTAL |
|---|---|---|---|
| Valid/Resolved | 1 | 0 | 1 |
| Valid/Not Resolved* | 22 | 21 | 44 |
| 1. Action cannot be undone | 23 | 21 | |
| 2. Dept. disagrees with Ombudsman | 0 | 0 | |
| Not Valid | 34 | 29 | 63 |
| **TOTAL** | **58** | **50** | **108** |

* Total of numbers 1, 2

During the surveys of the 82 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: 14 investigation, 1 trial placement, 8 reunification, 4 safety planning, 4 Policy or Process (findings policy, documentation, consultation with expert medical opinion), and 1 Intake Screening.

# POLICY AND PRACTICE
## *Findings and Recommendations*

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

Protecting children from child abuse and neglect is extremely difficult work with limited windows of opportunity to intervene. Ideally, enough services and resources would be available to families so that children are never unsafe. Unfortunately, we must continually face the reality that there are children that are or will be unsafe in their parents' care and the state is responsible for protecting those children. When we have those opportunities to intervene to protect children it is crucial that we act based on the facts available. This report is not meant as a call to take more children into state custody or reunify fewer children with parents, but to improve child welfare practice so that in each case and for each child the correct decisions can be made.

Out of the 82 cases surveyed this year, 49 had substantial issues. Cases with substantial issues are defined as cases where there was a deviation from best practices, adherence to policy, or both that had a material effect on the safety and best interests of the children, or rights of the parents. Out of these 49 cases, 27 primarily involved investigations and 18 primarily involved reunification. The remaining 4 cases had varying issues.

- Unfortunately, this year's review of case-specific reports continues to show a decline in child welfare practice. As has been true in previous annual reports, this year shows continued struggles with decision-making around child safety. Primarily, the Department has had difficulty in two areas: 1) during initial investigations into child safety and decision-making around whether a child is safe during an investigation, and 2) during reunification when making safety decisions about whether to send a child home.

Much of the public focus in child welfare has been on child deaths that continue to be reported in the news. These children who have died deserve our full attention and respect. It is equally important to remember that there are many children who are harmed repeatedly in the care of their parents, but never appear in the news. Children are living in difficult and traumatic circumstances all over the state every day. We have the responsibility, as a state, to protect those children. While there are many interlocking pieces to our child welfare system, including the courts, providers, relatives, and governmental entities--the Office of Child and Family Services has been tasked with protecting children who are experiencing abuse and neglect. They are the first responders to calls about unsafe children, and the first line of defense for those children.

The Ombudsman recommends that:

- The Department must continue to fully support the use of safety science in order to effect positive systemic change. Maine has contracted with Collaborative Safety LLC and begun to use Safety Science to review critical incidents, to improve practice, and determine the systemic and root causes of oversights and erroneous practice decisions. The results of the first year of these types of critical incident reviews have been released by the Department in the Maine Safety Science Model 2022 Report. The Department must take the findings in this, and in future safety science reports, and implement changes based on the outcomes of the safety science reviews. The Department must focus on child welfare practice issues within their own districts that are within their control, such as the need for increased staff training, time pressures affecting decision-making, and difficulties with safety planning.

- Continued support and funding for an increase in the availability of services is necessary for the well-being of children and families, prevention of child maltreatment, and for the success of reunification of children with parents. Essentially every case specific review completed this year by the Ombudsman detailed a case and a family that were negatively affected by a lack of services for both children and adults. Mental health services, substance use treatment services, trauma informed services, domestic violence services, housing, and transportation, are all examples of services that that are necessary for the safety and well-being of children.
- The Department should explore all possible methods, including statute changes, to provide increased transparency to the legislature and to the public about struggles within and progress towards addressing the complex problems that arise within the child welfare system.
- The Department must consider the opinions of outside stakeholders, in both assessing and naming the primary issues in child welfare, but also in providing solutions for those issues. And finally, it is crucial that frontline staff's experiences and opinions are given the utmost consideration and their recommendations are implemented when possible.

Note: there are two case-specific reviews that were considered for this report that have pending criminal charges due a death and a serious injury and therefore are not included in the below case summaries.

**A. Reunification**

A child abuse or neglect investigation is opened after an individual makes a report to the child protective hotline and that report meets the threshold necessary to assign it to a district office for investigation. Investigation policy requires that children be observed and interviewed, parents and caregivers that reside both in and out of homes are assessed and interviewed, home environments are observed, relevant collateral contacts are spoken to, additional information relevant to child safety is followed up on, and that all areas of child abuse and neglect are explored over the course of an investigation. In other words, child protective investigators must collect enough information to determine whether children are safe in their homes.

If the children are deemed unsafe during investigation, multiple avenues are available to protect those children. Ideally, the unsafe circumstance can be remediated through service arrangement to address an issue within the home, by an unsafe individual leaving the home, or by the child and safe parent leaving the home. The child can also move to the home of another safe parent or caregiver by agreement of the parents. These would be considered safety plans and are entered into voluntarily by the parents.

If safety planning or other action will not keep a child safe, a court petition can be filed. A jeopardy petition allows children to stay in parents' legal custody while waiting for a court date, and a petition for preliminary protection order can remove children from a parent's custody immediately.

In order to make safety decisions correctly during an investigation, 1) enough facts and evidence must be collected, and 2) the facts and evidence need to be interpreted correctly. This year a survey of case-specific ombudsman reviews found challenges in both areas. In some instances, not enough information was gathered to make an informed decision about safety, and in others, enough information was gathered but the appropriate action was not taken to protect the child.

Some examples of divergence from investigation policy were: an adult caregiver's significant child protective history was not considered; adult caregivers were not background checked and assessed for safety; parents and children residing out of the home were not interviewed or located; multiple family members were interviewed together; parents were interviewed together about domestic violence; collaterals were not contacted; multiple investigations were completed without addressing deficiencies in previous investigations; child abuse

pediatricians were not consulted about bruising and other injuries; and in one case an infant was not seen or located during an investigation of older children in the home.

Perhaps more concerning were investigations that gathered enough information to determine that children were unsafe but no safety planning or court action was taken to protect the children. These were not close cases, but instances where children were experiencing significant abuse and/or neglect. In many cases a court petition was filed eventually, but only after the children remained unsafe in the home for an unnecessary duration and were subjected to additional instances of abuse and/or neglect. See below under the case summaries for more detailed examples.

Safety plans continued to be of serious concern in this year's reviews. Safety plans were implemented and then not monitored, safety plans were not designed in a way that would ensure child safety, and multiple safety plans were made after previous plans failed.

**B. Reunification**

Once a child enters state custody, the parents are provided with a reunification plan that details services and behavioral change needed to ensure that the children can be safely returned to the parents. In order to make the determination that children are safe to return to one or both parents, the Department must both provide the parents with good faith reunification services, but also perform ongoing assessment of the parent's progress in their services towards alleviating jeopardy.

For example, if a parent has a substance use issue that is causing the child to be unsafe, the parent might enroll in substance use counseling and medication assisted treatment. The Department would have an obligation to assess how the parent is progressing in treatment by talking to providers, obtaining treatment records, visiting the parent in the home and talking to the parent about their treatment engagement, providing support and encouragement to the parent, sending the parent for random substance screens, completing medication counts, and interviewing other collaterals such as family members. In assessing progress in substance use treatment, history of prior treatment and length and type of use, and the amount of time the parent has been sober are all relevant to determining the safety of the child going forward. This is one example of one issue that has contributed to unsafe circumstances for a child, but this example also makes clear that the evaluation of a parent's progress is complex and time-consuming work.

Decision-making around reunification of children with parents, including trial placements, continues to be a challenge for the Department. This includes effective monitoring of trial placements for child safety. Trial placements are a moment of higher risk for children, and policy requires that assessment of safety increase during this period.

Reunification issues this year have included delays in filing petitions to terminate parents' rights; lack of monitoring for trial home placements especially when children were placed out of state; lack of contact with providers; inconsistent random drug screening; court petitions dismissed by the Department before issues causing children to be unsafe are resolved; regular monthly contacts not held with parents; and service cases opened for lengthy periods without court petitions filed.

### C. Case Summaries

**1. Investigation**

1. A parent drove while intoxicated with the child and was arrested for multiple charges including assault on an officer. The parent had past charges of operating under the influence (OUI), disorderly conduct, and both parents had domestic violence charges. A safety plan was implemented but was terminated a month later and the child was allowed back in the parents' care unsupervised with no apparent improvement in circumstances. A parent continued to care for the child while impaired on drugs and alcohol and the other parent relapsed on drugs. A jeopardy petition was filed months later and a new safety plan was implemented, but the child remained in parental custody. The parent was arrested multiple times during the case. The child was unsafe in the care of the parents for over eight months.

2. A steady string of child protective reports were made for the nine months prior to the children entering custody. The facts found early in the first investigation warranted an emergency petition and subsequently there was enough information to warrant either a jeopardy petition or service case. Later investigations did not follow up on missed opportunities in previous investigations.

3. The children were taken on a high-speed police chase where drugs were found in a the car, the children were often tardy or absent from school and sometimes it was hours until the parent could be located. A child briefly entered custody due to serious medical neglect, the children met the legal threshold for truancy but no findings were made or jeopardy petition filed, the parent was summonsed for possession of methamphetamine and firearms during a traffic stop, and a bus driver found the parent passed out in a vehicle in the driveway. The children entered state custody when the children and parent were staying with the parent's significant other and during a bail check police discovered drug paraphernalia.

4. A parent took three years to reunify with a young child due to severe substance use issues. Once the child was returned and the case closed, the parent relapsed. Two investigations were opened with new reports, one with a service case and one without. The most recent investigation involved the parent admitting to relapse and the child's exposure to a domestic violence incident that involved strangulation. The parent was substantiated for threat of physical abuse and neglect, but months passed without any further work on the case or intervention such as a court filing.

5. A parent with severe mental health issues continued to care for the children for five months after the first appropriate chance to ask the court for a preliminary protection order passed. The children eventually entered state custody.

6. The parent drove while severely intoxicated with the child in the car. A very young child in the parents' care was unsafe while the parent was highly impaired. In three months, five reports were received about the parent's alcohol misuse. Four investigations and one service case were opened. Three weeks passed after the parent's OUI before a safety plan was implemented that the parent would not drive or be alone with the children. The first safety plan was violated so a second safety plan was implemented. A service case was opened but the parents refused to follow a third safety plan. A jeopardy petition was filed. During the three months of safety planning only one call to a collateral was made. The jeopardy petition was dismissed by the Department without a sufficient period of monitoring and no services for the other parent. A new report was made several months later with allegations that the parent was again drinking and caring for the children.

7. A child was not protected after the child was sexually abused and the child's primary caregiver did not believe the abuse happened.

8. A parent with a long history of substance use and mental health issues, and who had been a perpetrator of domestic violence, got into a car accident with the young child where the young child was seriously injured. The parent was impaired on substances and the child was not restrained in the car seat. Although findings were made after the investigation was closed the other parent allowed joint custody and unsupervised time with the unsafe parent to continue. Multiple investigations were opened after this. The unsafe parent was showing erratic and assaultive behavior and was abusing substances. Providers reported the parent tested positive for fentanyl. The other parent had been unable to protect the child through court action and the Department would not file in court.

9. No findings were made after children disclosed that their caregiver hit them with a metal coat hanger, "bashed" a child's head against the wall, and smacked a child around, all of which caused the children to be fearful and upset. The children involved had already experienced significant trauma in their lives with other caregivers.

10. An investigation was completed where all family members were interviewed together, the home was visited and family interviewed for less than an hour, the allegations in the report were only addressed for ten minutes, and one brief collateral call was made to the other family member who was not home.

**2. Reunification**

1. A mother tested positive for cocaine and fentanyl during pregnancy and had a previous termination of parental rights for an older child, as well as multiple serious mental health diagnoses that were untreated at the time of the birth. The child entered state custody but the mother did not engage in reunification services until a year after the child's birth. The mother became pregnant again and finally began intensive services. One month later the mother tested positive for fentanyl. The new baby was born and a request for a preliminary protection order was filed but then vacated by the Department after either one or two months of sobriety. The infant had tested positive for unprescribed drugs at birth. The newborn infant remained in the mother's custody for many months before the mother again tested positive for fentanyl and the baby entered state custody.

2. One five-year-old child has had the Department involved for all but 16 non-consecutive months of the child's life. The child has been in state custody twice. The parent has extensive history including not being able to reunify with older children. The parent has followed the same pattern of behavior throughout and despite this, trial placement started only six months into the current involvement. The most recent incident that precipitated the child re-entering custody was a frightening incident of domestic violence, where the child and parent had to be rescued by police. Both parents had been using heroin and cocaine.

3. Two years and ten months after children entered state custody petitions to terminate the parents' rights have not been filed. The Department stated that a petition to terminate the rights would be filed at the two-year mark but this did not occur. The parents have a significant child protective history including their rights terminated to two older children.

4. The child entered state custody after being exposed to domestic violence in the parent's care, including an assault on the child's other parent and on the child's caregiver during a safety plan. The court ordered the parent to participate in several services, but the parent only completed some and did not engage in individual counseling or a mental health evaluation as required. Other providers were not contacted. There were also concerns about the parents' continued relationship and reports that the parent had not changed despite participation in services. The other parents' providers had not been contacted in over a year. Eighteen months into the case, a trial placement began.

5. After children entered state custody regular monthly contacts with parents did not occur for eight months. Regular contact with the parents' services providers did not occur. Despite continuing reports of domestic violence, trial placement began. Visits to the home during trial placement did not occur as outlined in policy.

6. The family had a history of 18 years of child protective involvement, including 42 reports made to Intake and 12 investigations. The Department had not intervened during any period until the children's recent entry into state custody. As a result of this the children have significant needs including mental health issues, behavioral issues, and engagement in the juvenile justice system. The investigation before the current case closed without intervention or services despite the risk level having been assessed as high and the parent arrested for disorderly conduct in front of the children. Police reported serious concerns for neglect, physical abuse, and emotional maltreatment. These issues are ongoing and services and resources in the state are not sufficient to help the children.

7. A child with highly challenging behaviors returned home on trial placement before the parent had alleviated jeopardy and without adequate services in place. The parent did not have a safe and stable place to live. The parent also did not attend substance use counseling or mental health treatment consistently, not attending random drug screens, and had not completed a psychological evaluation. This continued during the trial placement. The parent refused to take the child to counseling and the child frequently missed specialized programming. Concerns about the child being brought around the other unsafe parent were not assessed.

8. After the court denied termination of the parents' rights despite ongoing safety concerns, children were reunified. Less than six months later the children witnessed a serious incident of domestic violence. There were also concerns for neglect and the condition of the home. A safety plan was implemented and an unsafe person was assigned to monitor the plan. Then a partial out of home safety plan was created. Safety plans and a service case continued for approximately a year with multiple reports and ongoing issues including bruising on the children. A jeopardy petition was filed ten months after it was clear that further intervention was needed. The three oldest children entered custody, while the youngest and most vulnerable remained in the care of the parent.

9. A child was in state custody for four years and the courts, the Guardian ad litem, and the Department have made a series of decisions over the four years that delayed permanency too long for the child, resulting in an outcome that was not in the child's best interests. These decisions left the child at serious risk of emotional harm.

10. A petition to terminate the parents' rights was denied by the court due to lack of communication with the parents' providers. The child has been in state custody for four years. Psychological evaluations were completed for both parents and these findings, as well as the jeopardy findings, were not shared with the parents' counselors or other mental health providers. The counseling services provided did not appear to focus on one of the important aspects of reunification.

**3. Positive Findings**

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

1. When the parents were in jail the caseworkers made many efforts to keep both parents engaged. The caseworker understood the parent's previous history of substance use and previous attempts at treatment and slowed down the case to accommodate this. The caseworker toured the parent's sober living facility and met the other residents prior to allowing overnight visits. The caseworker transported the children

to the first overnight visit. Regular family team meetings were held throughout the case and were well attended by providers. The children were successfully reunified with the parent.

2. The caseworker was able to clearly articulate and document how the parent's cognitive limitations negatively impacted the parent's ability to care for the child. A neuropsychological evaluation with a parenting component was requested to better inform decision-making. A petition to terminate the parents' rights was filed in accordance with the statute.

3. In multiple investigations victims of domestic violence were referred to domestic violence programs and/or referred to the district's domestic violence liaison, caseworkers met with victims of domestic violence separately from perpetrators, and appropriate findings were made regarding an unsafe parent exhibiting a pattern of domestically violent behaviors towards partners.

4. Child protective caseworkers worked closely with law enforcement, Spurwink, and the Child Advocacy Center to investigate allegations of sexual abuse. The caseworker's interviews with the mother and alleged perpetrator were thorough and all of the allegations were carefully considered. Multiple collateral contacts were made during both investigations, which were generally thorough.

5. The caseworker performed a thorough investigation both before and after the children entered custody. The caseworker supported visits for the children and their fathers and was careful to assess how the children felt about visiting with (and ultimately living with) an out-of-state father. Good faith reunification services were offered to the out-of-state father and the appropriateness of the placement was carefully assessed.

6. The initial investigation and safety planning was thorough and all plans were monitored effectively, both by checking in at the homes frequently and contacting plan monitors. Plans were modified due to changing facts and circumstances. Caseworkers visited children and homes frequently and checked in with children and their providers, grandparents, and foster parents as appropriate. Caseworkers investigated new information and allegations. The caseworker's ongoing assessment of how the parent was doing in reunification and articulation of how the mother could alleviate jeopardy were very thorough.

7. The caseworker made an unannounced visit to the home and then called police for assistance when there was an adult in distress. A preliminary protection order was denied and the caseworker continued to investigate. Further information was gathered, and another preliminary protection order was granted. A close relative was encouraged to make repairs to the home to become a kinship foster placement and was encouraged to keep in contact with the child. The new caseworker had the Guardian ad litem attend the first visit with the child to ease the transition.

8. The caseworker held several family team meetings in the most recent involvement and made sure that all of the providers were sharing information. The caseworker also made sure that providers had the most accurate history of the case. The caseworker held detailed conversations with the child and despite significant needs the child understood the caseworker well.

### D. Katahdin

On January 18, 2022, the new child welfare database, Katahdin, went live. This was a long-planned move due to the age of the previous database, the Maine Automated Child Welfare Information System (MACWIS).

Any child welfare database serves different purposes for different individuals. Caseworkers must be able to easily enter and upload the correct data and documents, be able to see the history of cases and families and provide discovery to the attorneys if there is a court case. Supervisors, program administrators, and

central office staff must be able to use a database to supervise cases and perform reviews of cases and critical incidents. Quality Assurance staff use the database to collect federal reporting data and perform case reviews that inform practice improvements in individual cases, as well as systemic reviews. Other central office staff use the database to present to the safety science selection team and the Serious Injury and Death Review Panel.

Katahdin has been in use for over a year. In any transition to such a complex database, there will be setbacks and training issues, and cultural adjustment to the change. However, Katahdin's issues go deeper this. Katahdin is negatively affecting the ability of child welfare staff to effectively do their work, and therefore keep children safe.

The Department has been working to address multiple issues within Katahdin, and has already implemented many fixes, but Katahdin continues to be a complex problem without an easy solution.

# ACKNOWLEDGMENTS

As the twenty-first 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, Pamela Morin, Donna Pelletier, Courtney Beer, Craig Hickman, and Anne Sedlack.*

# CHILD WELFARE OMBUDSMAN

P.O. Box 92 • Augusta, Maine 04332 • 1-866-621-0758 • 207-213-4773
EMAIL: ombudsman@cwombudsman.org • WEB: www.cwombudsman.org