Maine's Child Safety and Family Well-Being Plan (2025-2030)

HHS Committee Presentation

January 8, 2026

Maine Child Welfare Action Network

Child Safety and Family Well-Being Plan Core Team

- **Mariette Aborn,** Special Projects Manager for Child & Family Well-Being, Department of Health and Human Services
- **Christine Theriault,** Family First Prevention Services Manager, Office of Child and Family Services
- **Melissa Hackett,** Coordinator, Maine Child Welfare Action Network
- **Debra Dunlap,** Founding Member, Maine Child Welfare Action Network


State and Community Responsibility
OCFS Child Welfare Division's Responsibility
wellbeing
risk
unsafe

Maine's Child Safety and Family Well-Being Plan (2025-2030)

A movement in Maine toward **what we want to promote in families**, not just what we want to prevent.

By working together to support families earlier, we can create the conditions for strong families and limit the need for involvement by the child welfare agency.

Maine's Child Safety and Family Well-Being Plan (2025-2030)

Goal A: Parents and caregivers provide safety, health, and nurturing care for their children.

- Strategy 1: Provide economic and concrete supports for parents and caregivers.
- Strategy 2: Provide equitable and timely access to low-barrier supports and services for children, youth, and families.

Goal B: Families experience a supportive and coordinated child safety and family well-being system.

- Strategy 3: Build partnerships with families.
- Strategy 4: Promote supportive communities.
- Strategy 5: Improve coordination of state and community partners.

Link to Full Plan: https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/CSFWB%202025-2030.pdf.

A Year 1 update on how state agencies and communities are putting the "Plan in Action" will be released in early 2026.

Updates

1. Peer Learning on Prevention
2. Community Collaboration
3. Be There for ME
4. Mandated Reporting and Community Support for Families Initiative

Maine Child Welfare Action Network

1. Peer Learning on Prevention

In December 2025, a team from Maine traveled to Washington, D.C.; New York City; Albany, NY; and Bennington, VT to deepen learning on prevention and inform ongoing work through the Child Safety and Family Well-Being Plan.

Learning Objectives

- Prevention structure & investment
- Community pathways & funding sources
- Place- and site-based family support sites
- Policy, training, & community education

Participants

- **Mariette Aborn**, Special Projects Manager, Commissioner's Office, DHHS
- **Rebecca Richardson**, Manager, Child Welfare Strategy & Policy Implementation, OCFS
- **Christine Theriault**, Family First Prevention Services Manager, OCFS
- **Melissa Hackett**, Coordinator, Maine Child Welfare Action Network
- **Jamie Brooks**, Parent Lived Expert, The Center for Parent Leadership and Advocacy
- **Heidi Aakjer**, Executive Director, Maine Children's Trust

2. Community Collaboration

In October, MCWAN – in partnership with DHHS – hosted a series of regional convenings in Millinocket, Farmington, Saco, and Rockland.

The objectives of these convenings were:

- **New and strengthened community-level partnerships** to support ongoing collaboration and coordination of child and family well-being efforts
- Identification of **opportunities to partner and advance collective action**
- **Clear steps state agencies and community partners** can take to collaborate and adapt resources for families in a changing service landscape

Participants included representatives of the Maine Prevention Network, Community Collaboratives, Maine Prevention Councils, CAP Agencies, Public Health Districts First10, Community School, and other convening entities and their partners. State agency partners from the CDC, OCFS, DOE, OMS, and GOPIF also attended.

Key Takeaways

- **Basic needs is the greatest concern.** Families are experiencing compounding challenges. Partners recognized that the usual supports may not be available and are considering local/mutual aid approaches to meet needs.
- **Shared sense of purpose and readiness as partners.** Community partners are ready and eager to support efforts to ensure members of their community navigate SNAP and MaineCare eligibility changes.
- **More conveners isn't always the answer.** Some communities feel taxed by the number of conveners and how it impacts the effectiveness of the shared work. Partners wondered if funding entities could provide more flexibility to leverage existing convenings rather than requiring new ones.
- **Connecting the conveners varies by community.** In some communities, the connective tissue is already there. Other communities wondered whether the state could support/facilitate this more explicitly.

Full summary here: https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Convenings%20of%20Conveners_October%202025.pdf

3. Be There for ME

Be There for ME (https://BeThereforMe.org) aims to reduce the stigma of asking for help and provides a judgement-free place for parents and caregivers to start to find support. The campaign also speaks directly to community members, identifying opportunities for everyone to step up to support parents and caregivers in Maine.

- The 131st Legislature allocated $750,000 in one-time funding to develop the campaign and website and $262,000 in Preschool Development Grant funds supported additional content development and paid promotion (all funding ended December 30, 2025).
- In October, MCWAN launched the “Be There for ME Parent Reps,” a group of 8 trained parents to represent the campaign at events in their community.
- DHHS continues to maintain and update the website, promote the campaign, and share materials with partners.

4. Mandated Reporting and Community Support for Families

MCWAN and OCFS continue to partner on this initiative to consider 1) the definition of child abuse and neglect; 2) mandated reporting training; and 3) community support for families (i.e. community pathways).

- Steering and Work Groups continue to meet monthly to support implementation.
- The mandated reporter training and internal OCFS policy were updated in September 2025 to reflect statutory changes distinguishing poverty from child neglect.
- In development: A more comprehensive update to the training and a guide to help mandated reporters better understand their role and consider opportunities to support a family.
- OCFS, MCWAN, and partners continue to consider opportunities to strengthen pathways of community support for families.

Maine Justice for Children Task Force

Date: January 8, 2026

Presented by: Caroline Jova, Esq.
Family Division Manager, Administrative Office of the Court,
Maine Judicial Branch

Improving Safety, Permanency, and Well-Being for Children in the Child Welfare System

Introduction

Mission: Enhance child welfare outcomes for children in Maine.

Task Force Composition:

- Chaired by the Chief Justice of the Maine Supreme Judicial Court.
- Includes representatives from Maine's judicial, legislative, and executive branches.
- Also includes advocates, foster parents, and child welfare professionals.

Key Mandate: Identify systemic improvements and collaborate on solutions to improve outcomes.

Meetings

1

Task Force Meetings:

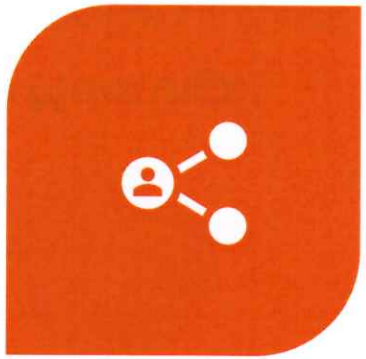
- Held quarterly, typically in March, June, September, and December.
- Virtual format.

2

Focus of Meetings:

- Updates on child welfare system status and workforce needs.
- Action steps and strategic plan initiatives.

Parent Attorney & GAL Recruitment and Retention



CHALLENGE: RETENTION AND RECRUITMENT OF PARENT ATTORNEYS AND GUARDIANS AD LITEM (GALS).

RECOMMENDATIONS: THE SUBCOMMITTEE'S RECOMMENDATIONS TO THE TASK FORCE WERE PRESENTED AND REVIEWED BY THE TASK FORCE IN JANUARY AND MARCH 2025.

Recommendations in Action

- *"PDS, the MJB, and the OAG should implement an exit interview protocol for parent attorneys, GALs, and AAGs who are no longer working with the protective custody docket. Survey results should be shared with the Task Force on an annual basis."*
  - A GAL exit survey has been created and will be disseminated to GALs who request to resign from the roster.
  - The survey has also been shared with PDS, and they have expressed interest in an exit survey.
  - Office of the Attorney General already has an exit interview protocol and has shared its data with the subcommittee.
  - Data will be shared with the Task Force at large annually.

Recommendations in Action

- *"The Maine Supreme Judicial Court should amend the civil and criminal court rules to allow students of an ABA-accredited law school to receive student practice authorization for internships and externships with contract counsel supervised by PDS."*
  - The Maine Supreme Judicial Court launched a pilot program to conditionally authorize law student externs to provide public defense services under the supervision of PDS contract counsel, effective December 18, 2024. *See* Administrative Order JB 24-03.
  - Representatives of Maine Law have indicated that interest in this program is starting to build and have offered to gather and share data with the subcommittee.
  - The pilot program expires on September 5, 2026, unless sooner modified or extended.

Recommendations in Action

- *"The MJB should prioritize implementation of an electronic billing system for guardian ad litem billing."*
  - On August 13, 2025, the MJB transitioned to electronic submission of GAL vouchers, using either eFileMaine (in courts that have implemented Maine eCourts) or ShareFile (for all other courts). Vouchers are now also being internally processed at the MJB using ShareFile.
  - Additionally, the MJB is exploring the implementation of a more robust electronic payment module for GAL vouchers. Meetings to begin mapping out such a system have begun, but implementation is still a few years away given the need for more funding and the limited capacity of the MJB's Information Technology department due to the statewide implementation of Maine eCourts.

Recommendations in Action

- *"The University of Maine School of Law should return to offering the child protection class each year and consider adding a clinic that is focused on child protection. The Maine State Legislature and/or PDS should provide financial support to establish and maintain this clinic to ensure sustainability. Additionally, the University of Maine School of Law should partner with PDS to ensure that the curriculum qualifies as the minimum standards training required for PDS."*
  - A child protection course is being offered the 2026 Spring semester. Maine Law intends to continue to offer this course, provided a qualified adjunct professor is available and willing to teach the course.
  - PDS is exploring the creation of a course that could satisfy the PDS minimum standards requirements to be rostered as a parent attorney.
  - Maine Law does not currently have a child protection clinic, but its general practice clinic does occasionally accept referrals of child protection cases, particularly cases that do not involve a change in custody. The establishment of an additional clinic specialized only in child protection cases would require significant funding and infrastructure that is not currently available.

Continuing Education Subcommittee

- Annual child protective conference (usually held during the Judicial Branch's spring administrative week).
    - Planning begins September of the preceding year.
- Strategies for professionals to better support children and families involved in the child welfare system.

2025 Conference:

Improving Family Outcomes Through Effective Communication in High Conflict Cases
April 3 and 4, 2025

The 2025 Conference featured the High Conflict Institute and presented on such topics as:

- **Flipping the Script in High-Conflict Cases: Understanding High-Conflict Personalities**
- **Conflict Tolerance**
- **Using a Structured Proposal Method for Reaching Agreements**
- **Managing High Conflict Personalities in Court (Judge Only)**
- **Communication Between Teams/Groups**

2026 Conference:

Trial Skills for Quality Representation
April 2 and 3, 2026

- The 2026 conference will be a virtual skills-based two-day course aimed at quality representation and advocacy.

- The course will be provided by the National Institute for Trial Advocacy focusing on:
  - Direct and Cross Examination
  - Exhibits and Impeachment

- 6:1 participant to faculty ratio

Conclusion

The Task Force's initiatives are driving system-wide improvements.

Collaborative work has a lasting effect on Maine's child welfare system.

Ongoing efforts will continue to strengthen the system and support Maine families.

Questions?

Thank you for your time and attention.

Contact Information:

Caroline Jova, Esq.

(207) 822-33211

caroline.jova@courts.maine.gov

STATE OF MAINE
CHILD DEATH AND SERIOUS INJURY REVIEW PANEL

ERIKA SIMONSON, CHAIR NICHOLAS MILES, MD, MSC, VICE CHAIR

Joint Standing Committee on Health and Human Services
Quarterly Child Welfare Update
January 10th, 2026

Update will review Panel's work from October-December 2025,

Follow up on question posed in September, about where Maine ranks, nationally, in child deaths per capita.

- Maine is among the **lowest** per capita for child deaths. In 2023, Maine had 15 child deaths per 100,000 children (children are considered children under 14).
- This is not CDSIRP's Data, it is data that is maintained by Maine's DHHS, Office of Data, Research and Vital Statistics that were reported to the Anne E. Casey Foundation, Kids Count Data Center. There is more detailed data on the website. KIDS COUNT Data Center from the Annie E. Casey Foundation.
- Also found on Kids Count Data Center—from national perspective; for 2023, Maine was tied with NY, PA, WY. The highest per capita child death was in Louisiana and Mississippi at 28 per 100,000 and the lowest was Connecticut at 10 per 100,000.

Panel Updates:

- Bylaw Change: Through the fall, panel members collected and reviewed information about case selection processes and approaches to prepare to decide if CDSIRP should amend our case selection bylaw. The panel voted in early December and the outcome was to NOT amend the bylaw.
- Subcommittee: Some members have volunteered to join the Parent Voice Subcommittee. This subcommittee will bring information/recommendations to the full panel for discussion of ways to incorporate parent voice and consider potential implementation.
- Recommendations Review: Panel continues to look at past recommendations from the last 15 years and their status and anticipate completing that work by our summer break. We will share any key observations, and the 2026 report will provide insight into findings and next steps.
- 2025 Annual Report: The Panel's Annual Report that will cover July 1st, 2024-June 30th, 2025, is underway, and we anticipate releasing it on time in March 2026.
- Chairs/Co-chairs of CDSIRP, MCWAP and the Justice for Children Taskforce met for our quarterly meeting in December.

Case Reviews (general observations to uphold confidential nature of some information)

Level One: Surface level review (least detailed review)

- The panel reviewed all child deaths from September-November 2025.
- The panel reviewed serious injuries for September-some of October.
- Totals: 4 child deaths and 25 serious injuries.

Level Two: Thematic Review

- In October, the panel participated in a level 2 review of three cases that had been identified as Growth Faltering, historically referred to as Failure to Thrive, cases.
- Dr. Miles provided an overview of growth faltering, including how these cases are identified, how they're evaluated and diagnosed, and how these cases are managed in the long-term.

Some key observations from case reviews during this quarter: (* indicates a potential recommendation)

- Case review provided evidence of judgement being passed on to the caregivers in growth faltering cases. The Panel reflected on the impact of judgement and bias on professionals determining if a referral to a specialist is made, if there is a mandated report to CPS, if a specific diagnosis (like growth faltering) is made and the negative impact on relationships between families and caregivers.
- The panel observed opportunities to provide referrals/connections to community support services, in conjunction with reports to OCFS.
- The panel acknowledges that families have both medical and social components that factor into their lives. Both need to be taken into consideration and both matter when interventions are being explored.
- The Panel noted that all three cases were located in under resourced regions of our state.

Follow up:

- *****Provide outreach and education to medical providers about the Spurwink Center for Safe and Healthy Families Thrive Clinic and the services that they offer.
    - Utilize Public Health Nursing to support families (children 3 and under).
    - Explore collaboration with the Centers for Disease Control (CDC), which has received funding to expand Maine's doula network and perinatal support services.
- NOTE: The panel identified 5 more cases flagged as Growth Faltering in December and January. We will be adding those cases to our ongoing thematic review, and work to develop associated recommendations.

End of remarks.
ES

Maine Child Welfare Advisory Panel Quarterly Report

Report to the Joint Standing Committee on Health and Human Services

January 8th, 2026

Panel Overview

CITIZEN REVIEW PANELS

MEMBERS

SCHEDULE

Summary of observations in the prior 3-month period regarding efforts by DHHS-OCFS to improve the child welfare system

- OCFS staff participated in panel meetings in September, October, and December. *The panel did not meet in November due to a conference that impacted panel members.*
- Designated OCFS staff continue to participate in subcommittee meetings.
- Panel leadership and OCFS collaborated on what we hope will be a new and improved process for MCWAP involvement in OCFS policy revision and development efforts.

Summary of the collaboration between MCWAP, the Child Death and Serious Injury Review Panel, and the Justice for Children Task Force

- Citizen Review Panels Chairs meet quarterly.
- MCWAP & Justice for Children Task Force:
  - MCWAP update is now a standing agenda item for the quarterly Justice for Children Task Force meetings.
- All panels have some degree of overlapping membership, including on subcommittees.

Continuing MCWAP Subcommittees

- Citizen Engagement
- Family Centered Policy and Practice – continued focus on Family Team Meetings

Monthly Meetings

September & October

The Panel met for a full day in September

- Annual Retreat (full day meeting in September)
  - Used as a reset.
  - Reviewed Citizen Review Panels 101 and the national technical assistance that is available to Panels. Panel co-chair attended a national technical assistance meeting in Fall 2025 and the hope is that this national coordination will happen quarterly going forward.
  - Reviewed MCWAP's mission and goals.
  - Director Johnson provided an annual update, to include some of the pieces of OCFS' strategic plan, released earlier this year.

October

- Focus on subcommittees & previous recommendation updates.

Monthly Meetings

December

December's Panel Meeting:

- Family First Updates and next steps
- OCFS Presentation on the Use of the Contingency Fund to Support Families

Questions?

Thank you for your interest in the activities of the Maine Child Welfare Advisory Panel (MCWAP).

Panel Co-Chairs

Ahmen Cabral, ahmen.cabral@maine.edu

Andrea Mancuso, andrea@mcedv.org

Panel Coordinator

Jenna Jockel, jenna.l.Joeckel@maine.gov

Christine Alberi, Child Welfare Ombudsman
Committee on Health and Human Services
Child Welfare Quarterly Update
Presentation of Annual Report
January 8, 2026

Good morning, Senator Ingwersen, Representative Meyer, and members of the Health and Human Services Committee. Thank you for having me here today. My name is Christine Alberi, and I am the Child Welfare Ombudsman for Maine. I am here today to present the 2025 Child Welfare Ombudsman's Annual Report.

I am pleased to report that for the first time since 2020, this year's case specific reviews indicate that the Department has halted a years-long decline in practice and instead has shown practice improvement. As with any complex system, progress is incremental and will not occur quickly, but this year's results indicate positive change. The Ombudsman's office categorizes case specific reviews with serious practice problems as having "substantial issues." In 2021 cases with substantial issues equaled those without, and from 2022 on cases with substantial issues outnumbered those without. This year, fewer than fifty percent of cases had substantial issues.

I am also happy to report that the Department and the Ombudsman have continued to build on a vastly improved collaborative relationship.

Unfortunately, child welfare staff are still struggling with complex cases and under-resourced services, as well as gaps in training and caseworker turnover. As I have said to you before, a robust system of service providers, attorneys, transportation for parents, experts to consult during both investigation and reunification cases, and a fully resourced court system are all important to support the best casework practice possible.

Services are key during child welfare involvements, but even more important are prevention services and financial support for families to prevent calls to child welfare in the first place. Most necessary services exist in Maine in one form or another but there are gaps and needs that if addressed could help prevent children from being abused and neglected.

This annual survey of case-specific reviews found that the Department still continues to struggle with practice 1) during initial investigations and 2) during ongoing assessment of the reunification of families after children enter state custody.

I wanted to take a moment to discuss this year's findings about educational neglect. The Department, both currently and historically, has struggled to respond effectively to allegations of of truancy and educational neglect. There is and has been considerable institutional resistance to having child welfare involved in reports of truancy and educational neglect, though the statute clearly indicates that this is child welfare's responsibility.

Starting on page 11 of this year's report, we have laid out the statutory and policy and practice framework currently in place.

At this time, the Department will only investigate a report of truancy as possible educational neglect if it is reported by the school. The truancy must also be as a result of parental neglect. If the school does not know why the student is not in school or does not report that the truancy is as a result of neglect, the report will be screened out and not investigated. If the truancy is reported by someone other than the school, such as a neighbor or a relative, or law enforcement, the report will not be screened in for an investigation unless there are other allegations of abuse or neglect.

If a report is screened in for the Department to investigate educational neglect, or educational neglect is discovered during an investigation, the issue is often not flagged as the serious risk factor that it is. Families can struggle for a number of reasons to get children to school and services to help are often in short supply. However, in multiple case specific reviews this year, extreme cases of truancy were not investigated thoroughly, or findings were not made, and follow-up to address the truancy was not completed.

The cases reviewed this year, some of which are summarized in the report, are cases where children have long term school attendance issues, including chronic tardiness, that the parents are unwilling or unable to address because the absences are as a direct result of serious abuse or neglect. The educational neglect is a result of parental substance use, mental health issues, domestic violence, and/or criminal activity. In the worst cases parents keep children home from school or withdraw children from school to hide bruises or because the child told school staff about abuse or neglect at home.

If you read the summaries beginning on page 12 you will see that these are cases where children are absent and unexcused from school for extended periods of time--70 days, 67 days, many years of absences culminating in parents pulling children from school entirely.

Here is one example: Reports of truancy in 2023 and 2024 were screened out and then another report was made that a child had 57 unexcused absences by March of 2024. The child remained in the parents' custody and at the end of the investigation when the child's absences had reached 70, the Department made substantiated findings of neglect for the truancy. No child protection petition was filed and a service case opened. The children remained in the parents' custody for four months. The investigation was opened initially due to a report from a relative who had seen drug paraphernalia in the home within reach of the children, and the children had actually brought the relative pieces of crack cocaine. During the first days of the investigation the parents were not asked to drug screen or sign releases. During the service case the child reported wanting to go to school but could not wake the parent up in the morning. The child was given Benadryl at night to sleep. The other parent was arrested for furnishing crack cocaine and fentanyl at the beginning of the investigation. That parent also later admitted using crack cocaine on and off for the month of May 2024. In June 2024 a report was received of drug dealing in the home with multiple people in and out and hypodermic needles found in the yard. The children came knocking at neighbor's doors because they were hungry or felt unsafe. The children eventually entered custody after the parent went to detox but then immediately returned home. After entering custody the child disclosed physical abuse by both parents.

Finally, on page 15 you will find positive findings taken from this year's case specific reports. I would like to end my presentation by highlighting one of the many positive examples of casework found throughout the state. "The permanency caseworker consistently supported a teenager who had entered custody and after placement disruption, hospitalization, and running away, kept close contact with the child, providers, foster parents, parents, and the caseworker gained the child's trust. The child was able to stabilize in a new placement after months and started to engage in treatment."

Thank you for having me here today, and please let me know if you have any questions.

Christine Alberi
Child Welfare Ombudsman
ombudsman@cwombudsman.org
207-215-9591

Office of Child and Family Services Quarterly Child Welfare Update

Health and Human Services Committee

January 8, 2026

Director Bobbi L. Johnson, LMSW

Content of January Update

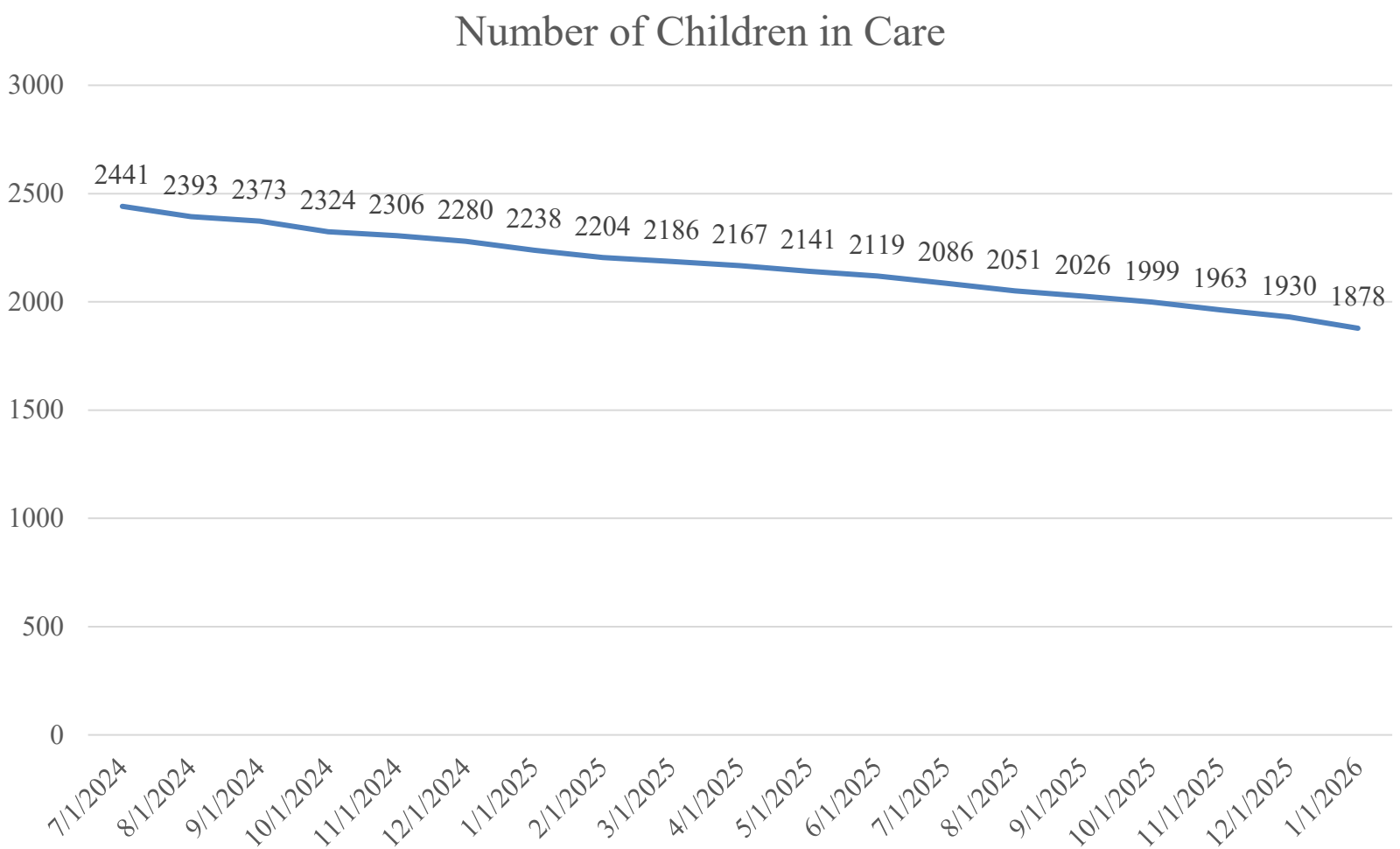
- The OCFS Strategic Plan: Guiding The Way
  - Maximizing Safety
  - Achieving Permanency
  - Increasing Well-Being
  - Navigating Policy
  - Engaging Workforce
- Additional OCFS Updates
- Federal Updates

Maximizing Safety

- Strengthening Mandated Reporting
- Improving Quality and Consistency in Intake Reports
- Strengthening Family Team Meetings (FTM) Practice

Children in Care

Not including Voluntary Care over age 18



Achieving Permanency

- Implement the Permanency Review Team (PRT) Process
- Kin First Placements
- Addressing Barriers to Permanency

Increasing Well-Being

- Psychotropic Medication Process Implementation
- Plan of Safe Care for Infants Affected by Prenatal Substance Use
- Educational Neglect and Truancy

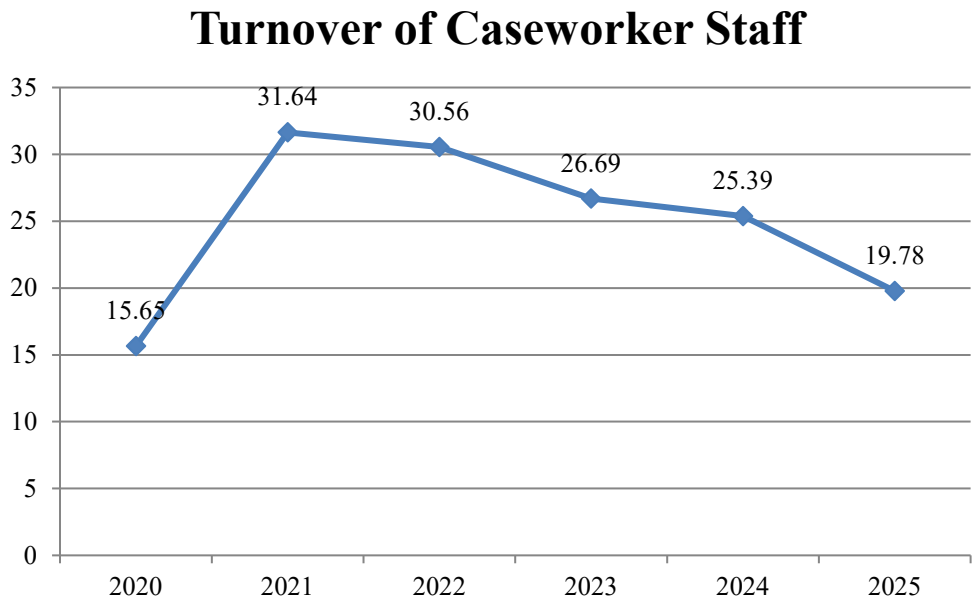
Navigating Policy

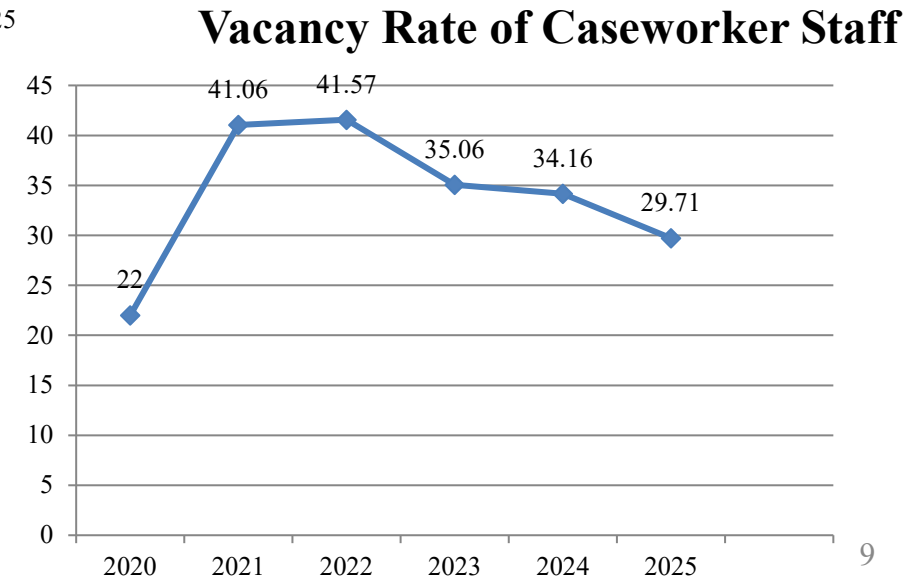
- Developed a companion practice guide for the Psychotropic Medication Policy
- Internal Web-Based Psychotropic Med Resources for Staff and an External Site for Providers
- Streamlining the Policy Development Process
- Finalizing the 2026 Policy Implementation Plan

Engaging Workforce

- Retention Workgroups
- District Visits
- EMT Advisory Committee
- OCFS Monthly Bulletin
- Hopes and Horizons

Caseworker Retention





Additional OCFS Updates

Early Care and Education Division

- Increasing awareness of Help Me Grow resources to help ensure a comprehensive, statewide, coordinated system of early identification, referral, and follow-up for children and their families from prenatal care through elementary school
- Evaluation of current efforts to increase financial security for early childhood educators to improve recruitment and retention of these critically important staff
- Increasing quality of care, including funding quality improvement awards through the Preschool Development Grant (PDG)

Children's Licensing and Investigation Services

- Updating and enhancing the plan for onboarding and meeting the annual training needs of the Out of Home (OOH) Investigation Unit
- Updating rules for Psychiatric Residential Treatment Facilities and developing rules for Therapeutic Intensive Homes (TIH)

Violence Intervention and Response Program

- Partner with the University of New England to provide foundational training for Sexual Assault Forensic Examiner (SAFE) nurses
- Ongoing efforts with Maine's Sexual Assault and Domestic Violence Service providers to address the overall decline in federal grant dollars for these services

Federal Updates

Child Care Funding

- OCFS has been closely following information coming from the federal government regarding federal funding for child care
- New CCDF rules were proposed January 5, 2026, which allow for several changes but do not mandate those changes
- ACF sent a communication to states on January 6, 2026 on the activation of Defend the Spend

A Home For Every Child

- Assistant Secretary for Family Support, Alex Adams has announced this new initiative to increase the number of resource through diligent recruitment, prioritization of kinship placements, and retention of existing resource parents

Child and Family Services Review (CFSR)

- Upcoming for Maine (onsite review begins in October of 2026)
- Preparing now by completing our statewide assessment, including numerous stakeholder groups across that state
- Stakeholder work is being done in partnership with the Court Improvement Project at the Maine Judicial Branch

Questions

Bobbi L. Johnson, LMSW
Director
Office of Child and Family Services

OCFS Child Fatality Reporting

Dashboard: https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/child-fatality-reporting

The categories of fatalities as identified by the Office of the Child Medical Examiner are:

- **Accidental** (includes causes such as motor vehicle accidents, drowning, fire, etc.)
- **Homicide**
- **Natural** (includes fatalities caused by medical conditions)
- **Other** (includes those fatalities identified by the Office of the Chief Medical Examiner as due to undetermined causes or by suicide)
- **Unsafe Sleep**
- **Sudden Unexplained Infant Death (SUID)**

Quarterly and annual data is available by fatality type, calendar year, age and gender.

What is and is not included on the Dashboard?

What is included in the dashboard?

- Any child fatality that is determined to be a homicide by the Office of the Chief Medical Examiner (OCME) – regardless of whether there is child protective history
- Any child fatality that has a finding of abuse or neglect associated with the death – regardless of whether there is child protective history
- Any child fatality where the family has prior history with the Department – this includes history before or after the child's birth and includes all types of death (including natural, accidental, suicide, and those where the cause of death has been found to be undetermined by OCME)

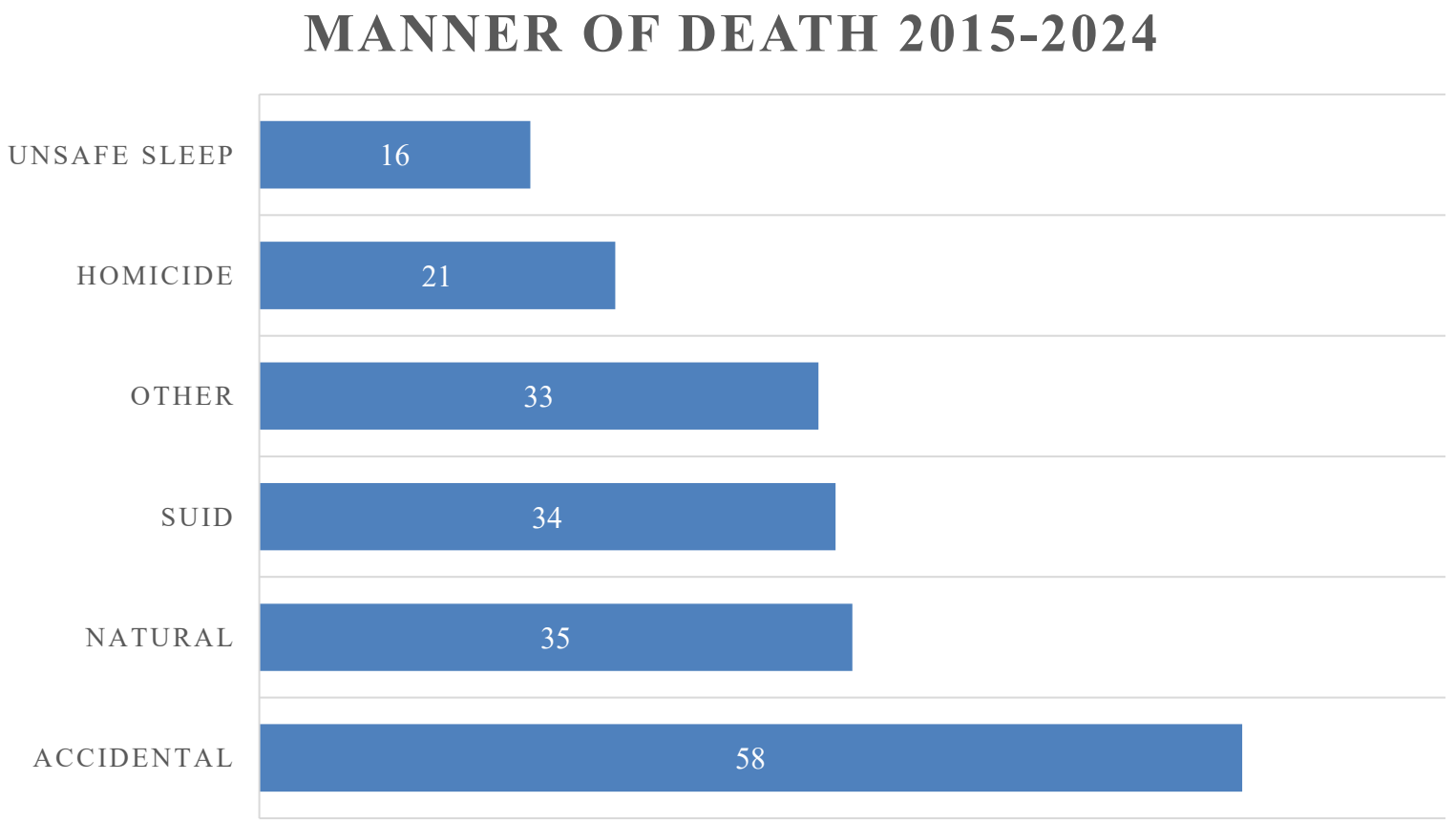
What is not included in the dashboard?

- OCFS' dashboard is not a comprehensive list of all child deaths in Maine
- Not all child fatalities are referred to the OCME (for example, a death of a child from a known medical condition where the child's physician certifies the death)
- Some child fatalities known to the public and the Department are not included due to pending criminal investigation/prosecution (these are added to the dashboard once prosecution is complete

Common Misconceptions

- Data only includes children who died while in DHHS custody
- Data only includes fatalities due to abuse and/or neglect
- There is a clear direct or proximate cause between the family's history with OCFS and the fatality

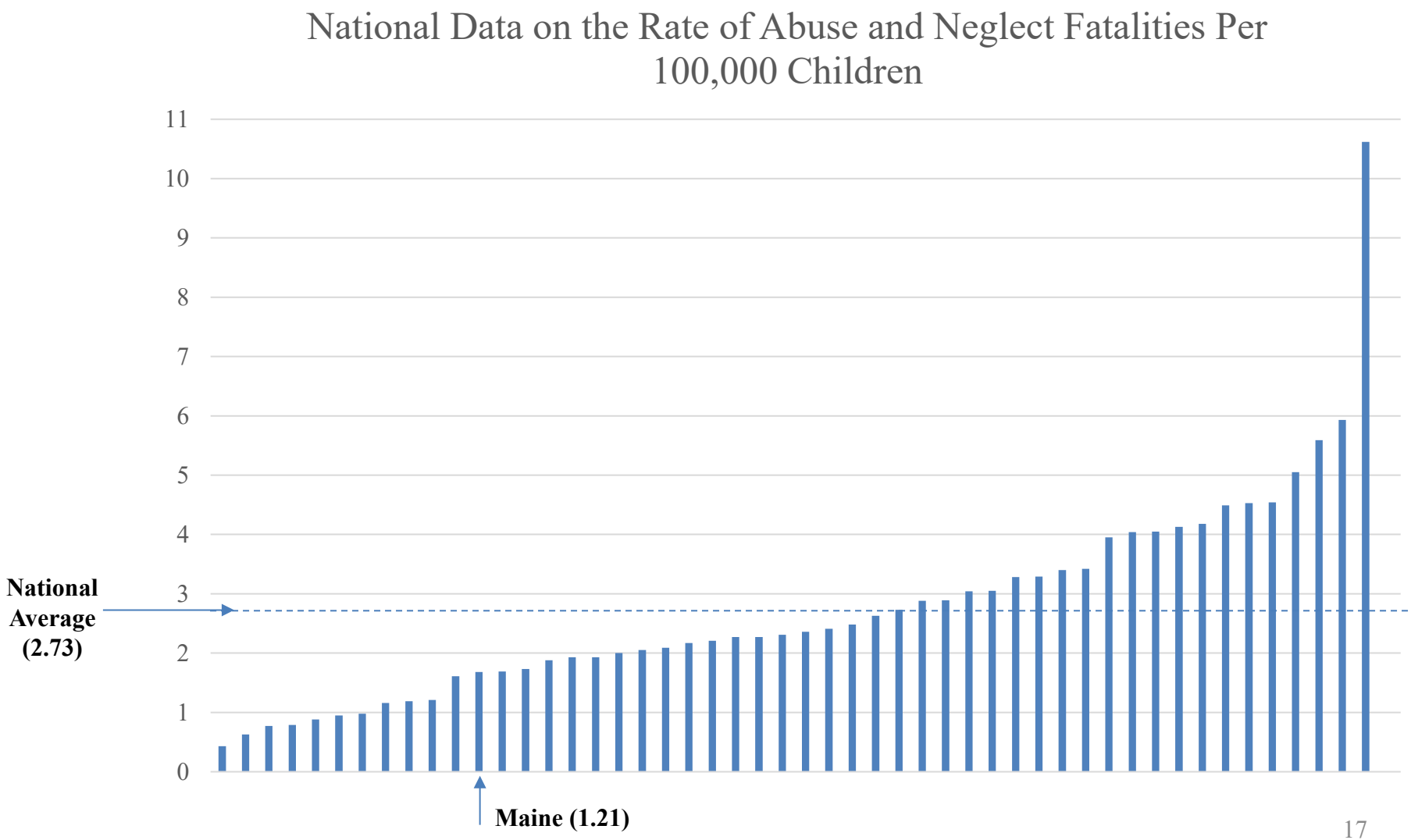
Fatality Dashboard Data



There were 21 reported homicides in this time period and 176 fatalities with a manner other than homicide.

Reminder: The Dashboard reflects deaths of children with some history of child welfare involvement, not just those in custody or with an open investigation

Data on Abuse and Neglect Fatalities



January 27, 2026

Hon. Henry Ingwersen, Chair
Hon. Michele Meyer, Chair
Joint Standing Committee on Health and Human Services
c/o Legislative Information Office
100 State House Station
Augusta, ME 04333

Dear HHS Committee Members:

On behalf of the Maine Child Welfare Advisory Panel (MCWAP/the Panel), we write to provide a brief follow up summary in lieu of our in-person presentation, as our presentation during the Child Welfare Quarterly Update was cut short by the fire alarm on January 8th.

MCWAP is working on our 2025 annual report, which will look a bit different than past reports. As we noted in our update to you in the Fall 2025, MCWAP is in a period of transition, with some members who have been key leaders of our work in recent years now having moved on into different roles or retirement. Rather than issuing new recommendations, the Panel has been working to gather status updates on past recommendations.. Our 2025 report, which we hope to issue in February, will focus on those status updates.

Panel Observations of OCFS Efforts:
OCFS staff participated in panel meetings in September, October, and December. *The panel did not meet in November due to a conference that impacted panel members.* Designated OCFS staff continue to participate in subcommittee meetings as able.

This Fall, Panel leadership and OCFS collaborated on what we hope will be a new and improved process for MCWAP involvement in OCFS policy revision and development efforts. This will begin in 2026 and will include having a member of the Panel, in a representative capacity, participating in OCFS policy working groups. The Panel is looking forward to receiving from OCFS an anticipated schedule of policy work for 2026. OCFS invited MCWAP to a listening session on efforts to improve identified issues with family team meetings, an area of continued focus for the Panel.

Panel Collaboration:
Chairs of MCWAP continue to meet quarterly with the chairs of the Child Death and Serious Injury Review Panel and the coordinator from the Justice for Children Task Force. MCWAP

updates are a standing agenda item for the quarterly Justice for Children Task Force meetings. MCWAP provided an update at the December meeting.

All three panels have some degree of overlapping membership, including on subcommittees.

Monthly Activities Summary:

The Panel met in September, October and December. The September meeting was the Panel's full day annual meeting. This meeting was used as a reset. The Panel discussed the general role of Citizen Review Panels as well as the national technical assistance that is available to all Citizen Review Panels. A Panel co-chair attended a national technical assistance meeting in Fall 2025 and the hope is that this national coordination will happen quarterly going forward. At this meeting, the Panel reviewed MCWAP's mission and goals, and Director Johnson provided an annual update, to include some of the pieces of OCFS' strategic plan, released earlier this year. Also in September, members of MCWAP attended MCWAN's full day workshop with many other community-based providers

The Panel's meeting in October was spent primarily working in subcommittees, Subcommittees spent time reviewing the status of past years' recommendations. As noted above, this will be our short-term focus, and updates will be reflected in our annual report.

During the Panel's December meeting, OCFS presented information to the Panel on the use of their Contingency Fund and an update on the Families First Prevention Services Act.

Panel member observations during the Contingency Fund presentation and discussion included:

- There are discrepancies between the legislation that governs the contingency funds and current implementation practices, as the enabling legislation allows for much broader usage than what OCFS has implemented and does not cap how much can be allocated to any given family or how frequently a family may access support.
- Members observed that utilization of contingency funds varies across the state. For example: District 7 has extremely limited use of the funds, with no requests in a given year. This suggests a need for additional outreach and training to ensure staff and families are aware of how to access available resources.
- Panel members identified additional barriers faced by families involved with OCFS that funds could be used to support in addition to those that are current permitted under the Contingency Fund program OCFS has developed. Contingency funds currently support families with an open investigation or a trial placement, but do not extend to families in active reunification who are experiencing financial hardship. Members

emphasized the need for resources to support families during the transition to trial placement.

- OCFS noted that, when the Contingency Fund program was created, there was a desire to building some guardrails around what was seen as likely to be a scarce resource. However, the full amount of the Contingency Fund allocation each year has never been expended, and OCFS agreed with Panel observations that it is time to look at whether current limitations can be reconsidered.
- Transportation challenges were also highlighted, with observations that current transportation practices do not align fully with existing contracts. OCFS relayed awareness of some structural program challenges and shared that they are doing a transportation study beginning January 2026to explore improvements.

Christine Theriault, Family First Prevention Services Program Manager from the Office of Child and Family Services, provided a presentation on the Family First Prevention Services Act Updates. This included a brief overview of the Family First Prevention Services Act, information about programs that have been implemented and broadened in Maine, prevention implementation, data, lessons learned, important intersections with community partners, and next steps towards goals. There was some discussion by the Panel about the regional limitations on available programming. For example, some programming, like the Intercept Program, is only available in Southern Maine. OCFS noted that they are aware of regional disparities.

The Panel will meet next in early February. If committee members have any questions, please do not hesitate to let us know, and we can discuss those with Panel members during our February meeting and follow up with Attorney Broome.

Sincerely,

Ahmen Cabral, Chair

Andrea Mancuso, Chair