Maine
CHILD WELFARE SERVICES
OMBUDSMAN

23RD ANNUAL REPORT • 2025

CHILDREN'S OMBUDSMAN

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The 2025 Maine Child Welfare Ombudsman Annual Report was written and prepared by:

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Executive Director, Ombudsman

I am honored to present the twenty-third 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").

As detailed in the Policy and Practice section of this report, for this fiscal year, and for the first time in many years, the Department has improved child welfare practice, according to analysis of the Ombudsman's case specific reviews. This observed incremental improvement made in child welfare practice is an encouraging step, but for sustained practice improvements adequate support must continue and expand for child welfare staff.

The Department has taken many positive steps this year, including the hiring of training supervisors to help train and support both new and experienced staff. Other highlights include the Department working towards addressing children in state custody staying in hotels by creating new emergency foster placements. Significant improvements have been made in hearing staff and stakeholders' concerns with Katahdin, the child welfare information system that is so important for recording information and documenting a family's history. Finally, the Ombudsman and the Department continue 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. 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.

Finally, as a state, we are in the midst of important conversations around the intersection of trauma, poverty, substance use, and mental health, and the impact of these on families. These issues are difficult to study and it is impossible to quantify which has the greatest impact on any given case. There have been recent serious concerns shared that children are being removed from parental custody due to poverty. The Ombudsman's office has not seen cases where children have been removed from homes for reasons other than safety. But, especially during reunification cases, poverty and service issues that fall outside of a child welfare permanency worker's control can cause reunification to fail. All stakeholders must work together collaboratively to find the best way to address all issues affecting the safety of children.

I would like to thank Governor Janet Mills and the Maine Legislature for the ongoing support of our program and 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.

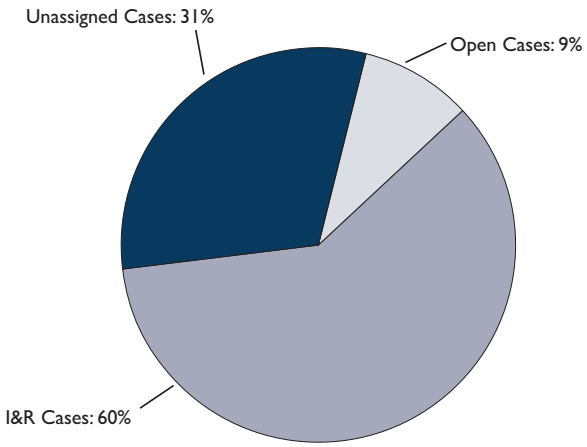
More information about the Ombudsman Program may be found at http://www.cwombudsman.org

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, 2024, through September 30, 2025.

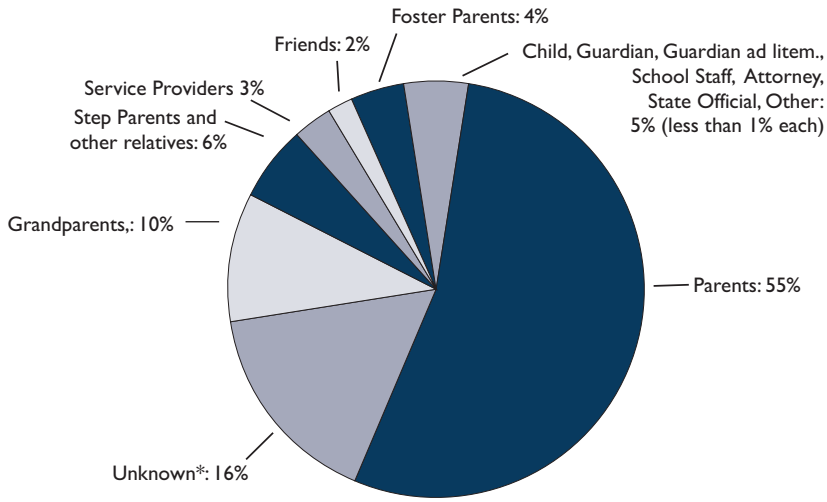
In Fiscal Year 2025, 747 inquiries were made to the Ombudsman Program, a decrease of 78 inquiries from the previous fiscal year. As a result of these inquiries, 66 cases were opened for review (9%), 449 cases were given information or referred for services elsewhere (60%), and 232 cases were unassigned (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. Many individuals have ongoing contact with the office; in total 888 phone calls were scheduled and approximately 375 email exchanges took place.

HOW DOES THE OMBUDSMAN PROGRAM CATEGORIZE CASES?



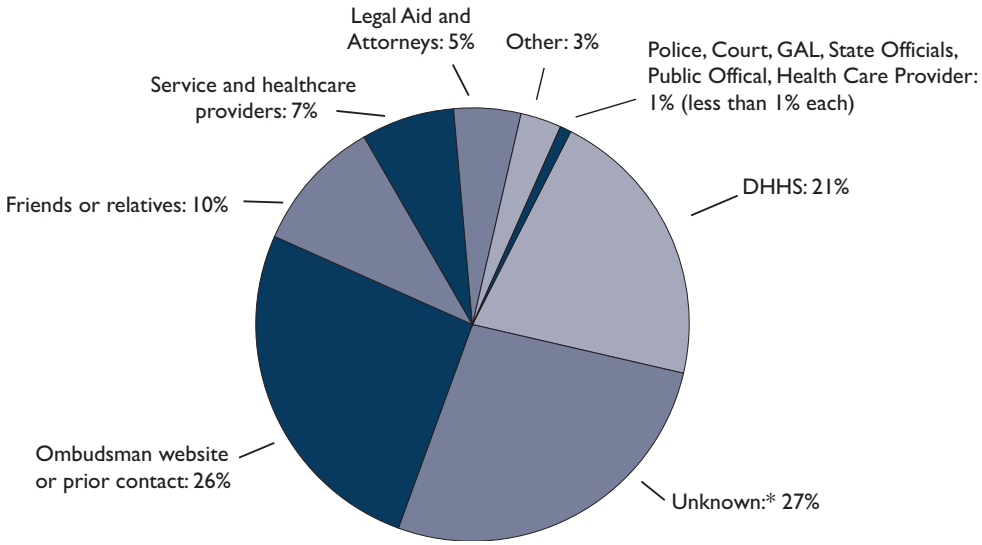
WHO CONTACTED THE OMBUDSMAN PROGRAM?

In Fiscal Year 2025, the highest number of contacts were from parents, followed by grandparents, other relatives, and foster parents.



HOW DID INDIVIDUALS LEARN ABOUT THE OMBUDSMAN PROGRAM?

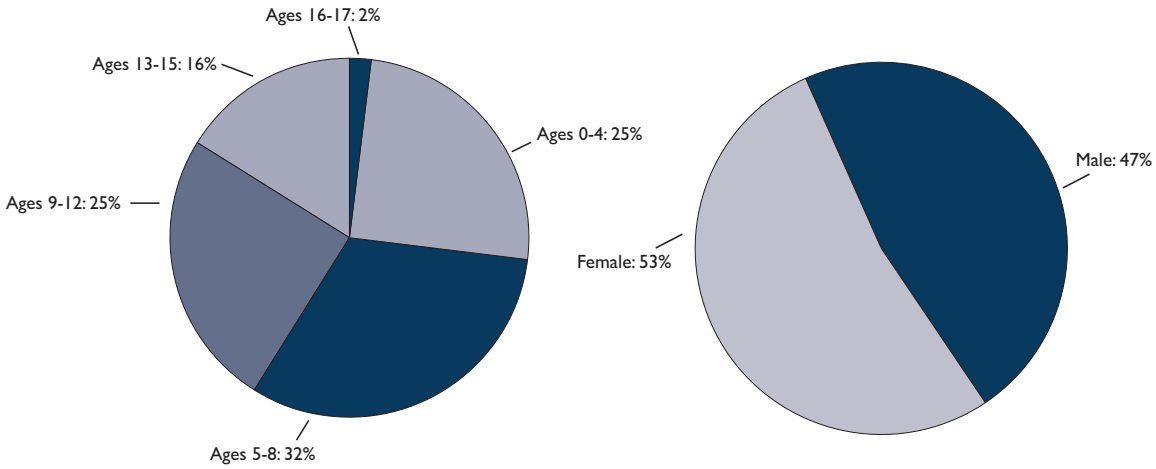
In 2025, 26% of contacts learned about the program through the Ombudsman website or prior contact with the office. 21% of contacts learned about the Ombudsman Program through the Department of Health and Human Services.



* *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 115 children represented in the 66 cases opened for review: 47 percent were male and 53 percent were female. During the reporting period, 57 percent of these children were age 8 and under.



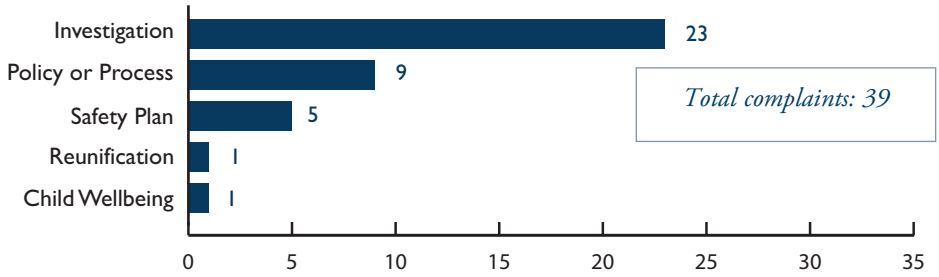
HOW MANY CASES WERE OPENED IN EACH OF THE DEPARTMENT'S DISTRICTS?

			DISTRICT	CHILDREN	
DISTRICT #	OFFICE	CASES	% OF TOTAL	NUMBER	% OF TOTAL
0	Intake	1	1%	3	3%
1	Biddeford	5	7%	8	7%
2	Portland	12	20%	23	20%
3	Lewiston	9	15%	14	12%
4	Rockland	6	8%	12	10%
5	Augusta	14	21%	23	20%
6	Bangor	13	18%	25	22%
7	Ellsworth	1	2%	1	1%
8	Houlton	5	8%	6	5%
TOTAL		**66**	**100%**	**115**	**100%**

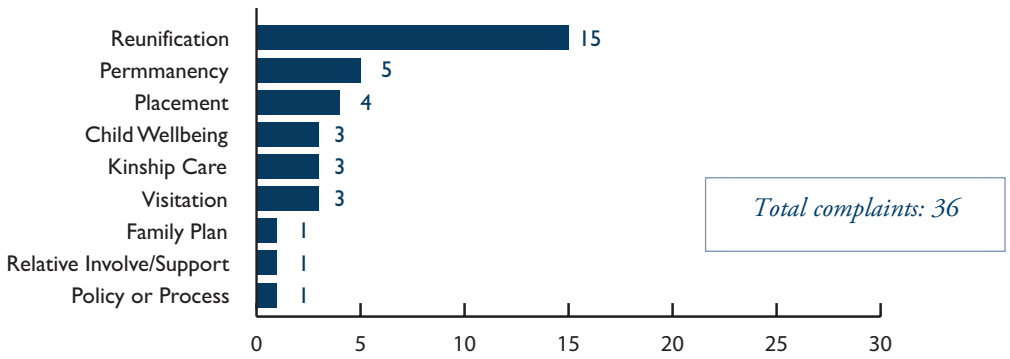
WHAT ARE THE MOST FREQUENTLY IDENTIFIED COMPLAINTS?

During the reporting period, 66 cases were opened with a total of 75 complaints. Each case typically involved more than one complaint. There were 39 complaints regarding Child Protective Services Units or Intakes, 36 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 76 cases that had been opened for review. These cases included 106 complaints and those are summarized in the table below.

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

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

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

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

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

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

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

RESOLUTION	CHILD PROTECTIVE SERVICES UNITS	CHILDREN'S SERVICES UNITS	TOTAL
Valid/Resolved	1	1	2
Valid/Not Resolved*	19	16	35
1. Action cannot be undone	18	14	
2. Dept. disagrees with Ombudsman	0	2	
Not Valid	31	38	69
TOTAL	**51**	**55**	**106**

* Total of numbers 1, 2

During surveys of 76 closed cases, the Ombudsman identified 39 additional findings in 12 complaint areas that were not identified by the original complainant. Additional findings were identified in the following areas: 15 investigation, ongoing assessment of reunification 6, trial home placement started 3, educational neglect 3, referrals for services for children 2, assessment of new concerns during service case 2, resource homes/kinship placements 2, reunification services for fathers 2, intake screening 1, lack of consultation of expert medical opinion 1, permanency 1, and chronic neglect 1.

POLICY AND PRACTICE
Findings and Recommendations

The findings and recommendations in this section are compiled from surveys 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 complete case-specific reviews.

For the first time since 2020, this year's case specific reviews indicate that the Department has halted 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.

- Out of the 76 cases surveyed this year, 36 had substantial issues. Cases with substantial issues are defined as cases where there was a deviation from best practice, 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 36 cases, 21 cases primarily involved investigation, 10 involved reunification, 2 involved investigation and reunification, and 3 had other issues. Educational neglect was an issue in 11 cases. See below for recommendations regarding educational neglect as a serious risk factor for child abuse and neglect.

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.

The Ombudsman recommends that:

- The Department should continue to strengthen basic investigative practices during both investigations and reunification cases. The safety of children must be evaluated on a case-by-case basis. Decision-making that is based on sufficient evidence and information is the best way to both keep children safe and avoid unnecessary removals. Staff should never be forced to make decisions based on workforce staffing issues, lack of foster placements, lack of services, or general systemic strain. Timely investigation and intervention, at the earliest time possible, will lessen the damage to children and families over the long term.
- In a time of uncertainty and a changing funding landscape, the state of Maine must continue to strengthen prevention services and financial support for families both to stop child protective involvement before it starts, and to make it possible for parents to have sufficient services and resources to reunify with children.
- The Department should continue to review cases using Safety Science and implement the recommendations aggregated from those reviews.
- An important part of supporting staff in effective casework practice is to provide support services around child welfare practice such as timely and effective visit supervision, transportation for children, a sufficient supply of foster placements, administrative staff including legal staff, and continued support of expertise embedded in district offices such as current training supervisors, domestic violence liaisons, and substance use experts.
- Mental health and behavioral services for children need to be further supported so that children, particularly those who are struggling with the most severe mental health and behavioral issues, have ready access to appropriate services including crisis stabilization, psychiatric hospitalization, treatment level foster homes, residential treatment, and services for children with neurobehavioral, developmental, and intellectual challenges including inpatient treatment.

A. INVESTIGATIONS

When a report to intake is referred to a district for investigation, the Department must quickly investigate and collect enough information to determine whether or not a child is safe in the home, and if the child is not safe, decide what action can be taken to protect the child. The most consistent issue found in this year's case specific reviews were incomplete investigations where either: 1) all of the necessary investigatory steps were not taken, therefore not enough information was gathered to make an accurate decision about the safety of a child or 2) enough information was gathered, but the risk to the child was not recognized.

Consistent issues found throughout these investigations were:

- Out of home parents and other relevant collaterals such as relatives, neighbors, service providers, medical providers, probation officers, and police were not interviewed.
- Police records or records of recent arrests were not obtained as part of background checks.
- Substance use was not always assessed well, parents were not asked to drug screen, and releases were not obtained from former and existing service providers.
- The scope of the investigation was not adjusted according to the complexity of the issues.
- History was not taken into account.
- Risk factors such as exposure to domestic violence, alcohol use, and truancy were not recognized.
- Repeated, credible disclosures of children were not believed to constitute sufficient evidence for intervention.
- Court filings necessary to protect children were delayed.
- Safety plans were not sufficiently monitored.
- The safety of young teenagers was assumed when they were living in various unsafe situations, likely due to their age.
- In general, the damage that long-term neglect can do to children was not recognized and the Department had more difficulty intervening in cases of chronic neglect with multiple closed investigations and screened out reports.

B. REUNIFICATION AND PERMANENCY

One of the most difficult judgments that must be made once a child enters state custody is whether and when the child is safe to return home to one or both parents. Parents are provided with reunification plans, and the Department has the responsibility to monitor the plan to see if the parents have made enough changes to alleviate what was causing their children to be unsafe. The practice issues in this area are consistent with previous years.

In this year's reviews:

- The Department did not always have enough meaningful contacts with the parents during the case, did not have contact with collaterals such as counselors and other providers to determine whether 1) the provider had an objective understanding of what issues the parent needed to work on and 2) whether the parent was effectively working on that issue.
- Enough drug screens were not administered, interpretation of screens was inconsistent, and pill counts were not completed.
- Provider records were not obtained.
- Substance use issues in general were not assessed and alcohol use left off of plans.
- New boyfriends or girlfriends of parents were not assessed.

- Regular family team meetings were not held.
- Children's providers were not consulted with.
- There were delays in filing petitions to terminate parents' rights in accordance with the statute.
- Trial home placements were begun without sufficient evidence that the home was now safe and then were not monitored according to policy.
- Fathers were not offered sufficient reunification services or included in service cases.
- Guardianships were used in place of child protection petitions and were not assessed for safety or were not suitable as permanency solutions for young children.

C. EDUCATIONAL NEGLECT

The Department, both currently and historically, has struggled to respond effectively to allegations of findings of educational neglect.

Maine's truancy law, 20-A M.R.S.A. § 5051-A, defines truancy for all ages. Under the Child Protection Act "abuse or neglect" can include educational neglect under the truancy law if a child has not completed sixth grade when "truancy is the result of neglect by a person responsible for the child." The Child Protection Act considers truancy to be serious neglect and according to 22 M.R.S.A §4002(6) "…Jeopardy means serious abuse or neglect, as evidenced by…" truancy.

Currently, the Department will only investigate a report of truancy as possible educational neglect if it is reported by the school. 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 summarized below and the recommendations made below as a result of these cases and many other cases over the years, do not reflect instances of a family going through a temporary struggle with illness or poverty, or a homeschooling family forgetting to register, or cases where families were able to address their child's absences with the school without state involvement.
- These 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.

The Ombudsman recommends the following:

- Intake policy and practice should be changed so that intake can screen in reports of truancy when the school does not allege neglect, but either the history of the family or the frequency of absences indicates that truancy may be as a result of neglect.
- Intake policy should be changed so that reports of truancy can be screened in for investigation when made by referents other than school staff such as police, service providers, medical providers, relatives, friends, and neighbors.
- Intake policy should be changed so that reports can be screened in for children who have never

been enrolled in school or homeschooling of any kind.

- Practice needs to be encouraged that empowers frontline staff to take truancy seriously as the indication of risk to the family that it is, particularly when the missed school is a long-standing issue, the number of absences is very high, or both. Chronic tardiness should also be able to be viewed as a risk factor for abuse or neglect.
- If caseworkers discover truancy during an investigation that was not initially reported, it should be evaluated and addressed.
- Staff should be empowered to file petitions in court based on truancy as a result of neglect.
- Children from seventh grade and up also miss school, and frontline staff should be able to investigate the causes of this to assess for child safety, even if findings cannot be directly made under the current statutory framework.

D. CASE SUMMARIES

Educational Neglect

1. 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.

2. A family had a long history of reports of educational neglect and substance use. In the past all investigations and service cases were closed with the child still in parental custody. Some reports of truancy were screened out because neglect was not stated as the cause of truancy by the school. A report was made in 2017 that the six-year-old child had 60 unexcused absences, followed by a report made in 2018 that the seven-year-old child had 15 unexcused absences by October. In 2020 the nine-year-old had missed 14 days of school by November with 8 being unexcused. In 2023 the child was in sixth grade and had been absent 67 days by February (a month later the absences had grown to 80 days). The school had made an IEP referral but were unable to complete assessments due to attendance. The parent attended an IEP meeting under the influence. After the meeting the child stopped going to school entirely. The child was not registered for homeschooling and had not attended school at all for years when the most recent investigations were opened. The now young teen was left unsafe in the care of the parents for eight months before a preliminary protection order was obtained and the child entered state custody. At the outset of the involvement substantial evidence existed that the parents were using and dealing substances from the home. There was also evidence of medical neglect, educational neglect, and child sexual exploitation (sex trafficking). Child welfare and juvenile justice did not effectively coordinate and communicate during the case. There were multiple opportunities where a safety plan, jeopardy petition, or PPO would have been appropriate. The child only entered state custody when there was an overdose death in the home.

3. A child had never been enrolled in school or homeschooling and many reports had been made by a relative about this over the course of five years. The child was frequently exposed to domestic violence and substance use, had limited medical care, had lost heat, electricity, and running water in the home. During a previous investigation the case was closed as unsubstantiated despite clear evidence that the child was not

receiving any schooling and was subject to other forms of neglect. Further similar reports were made to the Department and the child entered custody via PPO. The child's circumstances had not changed during the five-year period of reports to the Department and the Department's involvement. The child started school for the first time at age nine and was diagnosed with several developmental and medical deficits due to chronic neglect.

4. An initial investigation was not thorough and the Department did not recognize the risk to the children. The children had been chronically truant and school reported at the end of February that the ten-year-old and the twelve-year-old had only attended one week of school since December. The five-year-old was enrolled but unable to attend due to lack of immunizations, no showed an appointment for immunizations, and had not been to the doctor for any reason for the past five years. During the open investigation a report was received that substance use was happening in the home and police and the Department responded to the home to find the twelve-year-old caring for multiple younger children. The ten-year-old reported that the ten and twelve-year-olds were frequently left to care for the younger children. The twelve-year-old reported school was not attended due to frequent illness, lack of transportation, or being too tired to go. The child was observed with dark undereye circles and dirty fingers and dirty clothing and a shaved head. The police found clear evidence of substance use in the home and an extremely neglected dog. All of the children entered state custody via PPO.

5. At the end of 2024 a report was made that an eleven-year-old missed 32 days of school so far that year. An older child in the home who had been previously reported as truant was now being homeschooled. A report was made in March 2025 that the five-year-old had missed 63 days of school and the eleven-year-old had been pulled from school and was being homeschooled. One of the children had not been registered for homeschooling and the parent did not cooperate with the Department's efforts to verify that this had occurred. By May of 2025 two other children in the home who were still in school were in school more, but one had missed 47% of school and the other 50% of school. The majority of the intake reports made since 2023 have been concerns from the schools about the parent being impaired by substance use, truancy, a child not receiving medications consistently, unsanitary living conditions, lack of food, and other neglect related concerns. The family had struggled with lack of running water and electricity due to poverty and an impossible landlord, but the parent's substance misuse was not assessed. The Department closed the most recent investigation without addressing educational neglect and other neglect.

6. Children were left unsafe with a parent or without legal protection during two investigations and a service case, including lack of assessment of the safety and suitability of a legal guardianship that was supported by the Department. The school reported two times during the involvements that the children were truant, but because the school was not able to state that the truancy was as a result of neglect investigations were not opened.

7. In May 2025 police called intake to report that the children had not been attending school since 2022 and they had been evicted from the location that the family had been illegally squatting in for the past three years. The report was screened out.

8. During the 2023-2024 school year, an eight-year-old child with longstanding truancy issues had been absent 44 times and tardy 34 times. (Once in state custody the child struggled with school and reported feeling stupid and embarrassed due to being behind.) The most recent investigation left the children unsafe in the care of the parents for months after an investigation was opened and a jeopardy petition filed. This case illustrated clearly the devastating impact that long-term neglect can have on children. The evaluations completed for the children upon entering state custody found that the children had limited prenatal care and were exposed to alcohol and non-prescribed substances prior to birth. The following are some of the findings of their evaluations (these are not attributed to any particular child or age of child due to confidentiality concerns): suspicion of fetal alcohol syndrome, hearing problems, communication problems, overeating, social emotional issues, emotional reactivity, anxiety, withdrawn behavior, sleep problems, attention problems, and aggressive and defiant behavior including self-harm. The children had not been to a doctor since prior to age one and had never been to a dentist. Expert evaluators noted that chronic stress and trauma like these children experienced had been shown to have an impact on a child's developing neurological systems and have been associated with increased risk of developmental delays and neurodevelopmental disorders, emotional/behavioral dysregulation, and poor attachment to caregivers. Prenatal substance use created further risk and "implies a neurological system that may have been particularly vulnerable to the impact of…" child maltreatment.

Investigation

1. Children were left unsafe with parents over the course of three months including a period after which both parents were substantiated for untreated mental health and substance use issues. Police and child protective were called to the home when one parent pepper sprayed the other in the presence of the children during a domestic violence incident. Parents made paranoid and irrational statements, admitted to use of crack cocaine and methamphetamine, and one parent was witnessed by a relative acting extremely paranoid and incoherent while caring for the youngest child who was naked and without food or supplies. When the parent did drug screen no prescription drugs were present in the screen. Constant reports of unsafe behaviors by the parents continued to come in including a report that one parent was holding the other parent hostage in the home with the children. A PPO was finally obtained three months and twelve days after the initial report.

2. A fourteen-year-old child was the subject of an investigation that resulted in a much younger child entering state custody. The children had the same caregivers and the caregiver was substantiated as to both children. The fourteen-year-old was only seen once at the beginning of the investigation in unsafe circumstances. Although a service case was opened, the Department did not find out where the child was living, assess the child's other parent (who has a significant history of violence), determine if the child had any needs, or determine why the child had not been in school or received any homeschooling since before COVID when the child was eight or nine years old.

3. The parents agreed after multiple investigations and a service case that they were struggling with substance use and were not safe caregivers. One thirteen-year-old went to stay with a friend and during approximately seven months the child was not seen and the home where the child was staying was not assessed. Background checks were not run on the child's soon-to-be guardians and their suitability and financial ability to care for a child with difficult needs was not assessed. Two of the child's younger siblings went to stay with a relative and the Department supported the relative filing for probate guardianship. A background check was not run on the relative and the relative's suitability as a long-term guardian for young children was not assessed, including the ability to support the children financially. Both guardianships were initially set for six months and there was no plan in place to help the guardians assess whether the parents were again safe caregivers.

Reunification

1. A child entered state custody in the fall of 2021. The latest a petition to terminate the parents' rights should have been filed was March 2023. The parents did not even minimally engage with the plan until June 2023. In general, over the years, there was not enough ongoing assessment of the parents' progress in reunification for the Department to be able to make a determination about whether the child was safe to reunify. One parent had extensive criminal history, abuse of alcohol which fueled criminal behavior and violence, was not honest with providers, and was not able to take responsibility for the child entering custody. The parent was also a perpetrator of multiple incidents of domestic violence against the other parent including strangulation during pregnancy. Both parents had significant mental health diagnoses. The parents continued to live together after the child was removed and there was another incident of domestic violence a year and a half into the case. Months often went by with no casework recorded. There was little or no communication with the parents' providers, but overnight and unsupervised visits began. Neither parent was honest with providers. Four years after entering state custody there was no clear plan for the child.

2. The young child entered custody after police found both parents and the child asleep in a car in the gas station. One parent was arrested due to possession of drugs and drug paraphernalia. The other had drug paraphernalia, reported use the day before, and was observed to have track marks. Police allowed the parent to leave with the child. Caseworkers responded to the home the next day and both parents were back in the home and admitted to actively using cocaine and fentanyl. The child entered state custody. The parents continued to use and were essentially out of contact with caseworkers until eight months later. Nine months later both parents were in sober houses and were starting visits. Then work on the case was not documented for six months. A family team meeting was held for one parent where it was stated that a trial home placement could be started a month later. The trial home placement was started in a relative's home who had a volatile relationship with the parent. One parents' substance use provider was contacted at this point for the first time. No drug screens were completed by the Department until after trial

placement started. Records were obtained but the other parent's providers were not spoken with. Other indications of use were not followed up on such as a reported episode of drinking over the holidays and a relapse noted in the records.

Positive Findings

The following are positive findings taken from cases in all eight districts.

1. 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.

2. Caseworkers worked closely with parents, continued to attempt to communicate with them despite lack of contact and hostility, and due to this the parents were aware of what they needed to do to reunify with their children. The caseworker followed up with the children's providers as to how the visits with the parents were affecting the younger children. The older child's wishes and comfort level were also taken into account in a sensitive way.

3. When a report was received from a primary care doctor that a child's bone had a fracture and the parent's explanation did not match the presenting injury, an investigation was opened and the caseworker responded promptly. The caseworker consulted with a child abuse pediatrician, provided records, and quickly learned that the explanation could match the injury.

4. During the first investigation the caseworker made an unannounced visit to the home, completed pill and strip counts, and contacted an expert to determine whether the results of a drug screen made sense with a parent's explanation.

5. The caseworker demonstrated strong professional judgment in navigating complex and conflicting information, making sound findings, appropriate interventions, and well-reasoned safety decisions. Both parents appeared to be using the child welfare system as leverage in an ongoing custody dispute.

6. Numerous records were requested and uploaded into the online discovery folder. The investigation was thorough, well documented, and included conversations with many collaterals. The original safety plan was extremely detailed and outlined who would monitor the plan, what would happen if the plan was not followed, and how monitors could contact caseworkers during the workday and after hours.

7. The caseworker continued to thoroughly investigate the child's safety and gather evidence and information even after the preliminary protection order was granted. The investigation was extremely thorough. The caseworker completed an unannounced visit, stopped questioning the child when the child made possible disclosures of sexual abuse so that a Child Advocacy Center interview could be completed, came to the home to pick the parent up for a visit right after the child entered custody, showed real compassion to the parent, and made an unannounced visit to a new kinship placement.

8. Throughout the case, which was almost three years long, face-to-face meetings with the parents occurred every single month, even when one parent was incarcerated, when a child was on vacation, etc. The case was complex with many children in three different resource homes and parents who were unhoused for most of the Department's involvement. Caseworkers listened to the children and acted in their best interests and developed trust and understanding.

ACKNOWLEDGMENTS

As the twenty-third 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 Ms. Bobbi Johnson, 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.

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