January 27, 2021

Joint Standing Committee on Health and Human Services
Legislative Information Office
100 State House Station
Augusta, ME 04333

Re: January 28, 2021 Orientation and Presentation of 2020 Annual Report of the child Welfare Ombudsman to the Joint Standing Committee on Health and Human Services

Dear Senator Claxton, Representative Meyer, and members of the Health and Human Services Committee,

In addition to the 2020 Annual Report of the Child Welfare Ombudsman, the Ombudsman would like to offer the following supplemental information:

History

The Child Welfare Ombudsman was established as an independent, non-partisan entity following the death in 2001 of a child in state custody named Logan Marr. During that time, there have been two Ombudsmen, the first, Dean Crocker, a social worker who instituted the program until 2013, when I accepted the position.

Child Welfare came into sharp focus in 2018 when two children, Kendall Chick and Marissa Kennedy, died after involvement with child welfare. In Marissa's case, there was extensive Department involvement prior to her death.

As a result of the deaths of Marissa and Kendall, a series of policy and practice changes were implemented in the Department, and a series of child welfare reform bills were enacted, including the hiring of new staff to reduce workloads to give caseworkers time to do their jobs.

There is no possible way to prevent every death of a child due to abuse or neglect. The individuals who bear the most responsibility for the deaths of abused and neglected children are the caregivers who directly caused death. However, the State of Maine has a legal and moral obligation to investigate reports of child abuse, protect children from their caregivers when necessary, and reunite and keep families together whenever possible.

It is very difficult to pinpoint the exact systemic failures that led to the deaths of Marissa Kennedy and Kendall Chick, but it is imperative that we try. We will continue to repeat mistakes if we do not come to understand what led to the most serious systemic failures in the past. After the death of Logan Marr, there was an extensive internal reform process that led ultimately to a

child welfare system that became a model for other states. In Maine right now, we are still at the beginning of child welfare reform.

Unfortunately, there is still a lack of understanding as to what led to the problems in child welfare in 2018. There are useful methods to determine what went wrong without finger-pointing and assumption of bad faith. The OPEGA reports that were completed in 2018 were a step in the right direction. However, there are still many questions about what led to the conditions that allowed the deaths of Marissa and Kendall.

The Ombudsman and OPEGA each reviewed the deaths of Marissa and Kendall, the Ombudsman at the request of a legislator, and OPEGA at the request of the Government Oversight Committee. These deaths were well publicized which was why they received the degree of scrutiny that they did. Due to confidentiality law, other difficult cases and trends sometimes pass by the public.

For example, in 2017 the Ombudsman noticed that there was a sharp drop in initial safety assessments completed by DHHS, which appeared to be a number that was artificially low and did not reflect real world conditions, such as the increase in substance use issues in the state. In the Ombudsman's annual report that year, it was noted that there were many issues with initial safety assessments leaving children in unsafe situations. What led to that drop in initial safety assessments and whether or what the connection was to the deaths of Marissa and Kendall, or to the issues the Ombudsman identified, have still not been formally established, despite the scrutiny and attention that occurred at the time.

Some might say that it is not valuable to continue to look back to the past, but without reflection and understanding we will continue to repeat the same mistakes.

Ombudsman Process

The Child Welfare Ombudsman, Inc., is an independent non-profit solely dedicated to fulfilling the duties and responsibilities in 22 M.R.S.A. § 4087-A. Anyone can contact the Ombudsman's program and at the very least we can talk through their situation with them, give them information on law, policy, and procedure, and refer them to other agencies, individuals, or sources of information. For a smaller number of people who call, we can open a case for review. When a case is opened for review, relevant documentation is obtained from the Department, and the Department provides a formal response to the caller's complaint. Then the Ombudsman drafts a report which is shared with the district where the case is located. The case is discussed and then the report finalized once an agreement is reached as to content and wording.

A note about the Department's response on p. 16 of the Annual Report. The Department stated that in one case "the Ombudsman concluded that reunification occurred before it should have, but there was no recognition of the impact of the Court process. In that case the Department had sought termination and was denied by the Court with an order to continue efforts toward reunification."

While it is very true that many things happen in child welfare cases that are out of the Department's control, the specific case that the Department refers to here is not a good example

of that type of situation. The Department is referring to example #1 on p. 15, where an infant died. Again, it is difficult to talk about case specifics due to confidentiality law. However, it should be noted that the court's order in that case was discussed at length and quoted from in the relevant case specific report drafted by the Ombudsman. In that case, practice issues before the hearing occurred that led to the denial of the termination and the continuation of reunification. The court's order to continue reunification also did not relieve the Department of the responsibility to provide ongoing assessment of the case and new assessment of the safety of the infant. The relevant case-specific report, like all Ombudsman reports, went through the process described above, a draft was sent, the case was discussed with various Department staff, and the Ombudsman made agreed to changes to the report. Had the court's order put the Department in a different position than occurred in the case, this example would not have been included.

The case in example #1 was not an outlier, it could have occurred in any district in the state. Parents who cause the death of a child are outliers, but the Department's practice mistakes here were not. The practice issues that are often a problem in reunification cases, the "ongoing assessment of reunification," are similar in many cases: not giving providers objective information about the case, not keeping in contact with providers, not keeping in contact with parents, not assessing new significant others during open cases, inconsistent random drug screening, planning for child centered visits, and failure to adequately monitor trial placements.

A general note about court decisions in these cases: Courts can only make decisions with the information available, presented by attorneys and Guardians *ad litem* involved in a case. The Court must weigh the performance and obligations of the Department in assessing whether the Department has met their burden to justify terminating a parent's rights. Progress of a parent towards reunification is difficult to analyze at the best of times. If the Department does not have information to present to the court at a court hearing, the court cannot make an informed decision.

Training

There is a clear, statewide, consensus that caseworker and supervisor training needs improvement. The OPEGA Information Brief: "Frontline Workers in the State Child Protective System: Perspectives on Factors That Impact Effectiveness and Efficiency of Child Protective Work," February 19, 2019, addresses this explicitly. Staff were clear that they needed both more training than was available, as well as time needed to attend trainings. At that time 55% of assessment workers and 41% of permanency workers agreed or strongly agreed that they had the training they need to do their jobs. 54% of supervisors agreed they had the training needed to do their job.

The report of the Public Consulting Group: "Maine Office of Child and Family Services: Child Welfare Evaluation and Business Process ReDesign," February 8, 2019 offered a similar assessment of the situation.

When caseworkers begin their employment, they participate in the new caseworker training. After the first year of training, there are no regular refresher trainings for general casework required. The trainings listed on page 10 of the Annual Report are all valuable trainings but are

not required and do not address the fundamentals of caseworker practice, such as initial investigations and ongoing assessment of reunification cases.

There have been new trainings added since 2018, but they are trainings such as how to use the new permanency SDM tool, not the casework practice techniques needed to enter accurate information into the tool.

The Department has contracted with the Muskie School starting on 11/1/19, to address the consensus that training needs improvement. The contract specifies that the University will conduct an expedited policy review and revision, develop a long-term policy making approval process, and create a plan for producing a child welfare procedure manual. The University will also assess the current training capabilities and begin design of a robust training system, including new caseworker pre-service training.

It appears that the Department and the Ombudsman are in strong agreement that training for OCFS staff needs improvement.

Conclusion

Child welfare work is complex and often heartbreaking, and the caseworkers that perform the day-to-day work need all of the help and support that we can give them. The work of the Ombudsman is to investigate the circumstances of the Department's actions and involvement in children and families' lives. While it is often difficult to listen to and absorb criticism, it is crucial for improvement in practice and I very much appreciate the collaborative process that has developed with the districts across the state over the years.

Corrections

There are some corrections that should be noted in the report:

p. 5 "Twenty-five percent of contacts learned about the Ombudsman Program through the Department of Health and Human services" should read "Twenty-four percent"

p. 6 "52 percent were male and 48 percent were female" should read "51 percent were male and 49 percent were female"

p. 8 On the table where it reads, "Action cannot be undone" the number should be "21" and not "121"

Sincerely,

/s/ Christine Alberi

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