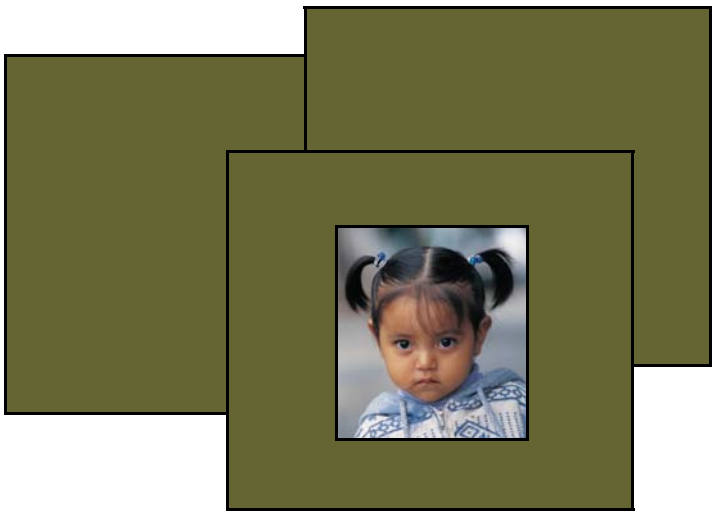
Report of the State of Maine Child Fatality and Serious Injury Review Panel 2005



Maine Department of Health and Human Services

The Child Death and Serious Injury Panel would like to thank all providers, DHHS staff and law enforcement that attended the reviews. Their attendance enriches the work of the panel. Without them, this report would not be possible. We would also like to thank Michelle O'Ryan, Glenda Hamilton (DHHS) and Jeanine Brown (Muskie) for all they do in locating information and the numerous other things they do that make this work possible

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For information about this report or to request copies, please call the
Maine Department of Health and Human Services
Office of Child and Family Services
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Maine Department of Health and Human Services

Maine Department of Health and Human Services

Commissioner's Office

221 State Street
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Augusta, ME 04333-0011

John Elias Baldacci
Governor

Brenda M. Harvey
Commissioner

December 31, 2006

Dear Friends of Maine Children:

Life's lessons are particularly difficult to learn when knowledge is gained in tragic circumstances. All would agree that a death of a child is one of life's most tragic events, whether that death is accidental or preventable. I am grateful that the Maine Child Fatality/Serious Injury Report Panel continues its work through difficult information to glean knowledge and to make improvements to our system of care.

The Department of Health and Human Services continues to make progress, bringing various disciplines together to benefit the children of Maine. The safety of our children requires not only an integrated service delivery system, but a focus on safety from both the public and private sector. It is a duty that requires us to remain diligent and vigilant, always seeking to enhance existing processes.

I thank the panel for its commitment to monthly meetings and its collaborative approach. This report will no doubt serve as a reputable resource for those who guide the development of policy that affects individuals and agencies that care for our children.

Sincerely,

Brenda M. Harvey
Commissioner

BMH/klv

A Letter from the Chairman
Child Death and Serious Injury Review Panel

December 31, 2006

Dear Friends of Maine Children:

This is our second annual report and the fifth report since the Maine Child Death and Serious Injury Review Panel began in 1992. The Panel continues to meet each month, dissecting each case in minute detail. Panel members have the difficult task of reviewing and digesting a novel's worth of history each month. Often the reading is compelling but just as often the work is mundane and tedious. Yet in that very tedium sometimes lies the most important details for the Panel to answer our sometimes weighty questions. Why did this child die? Was the death preventable? What did we do right? What did we do wrong? How can we prevent future deaths like these? In the case of serious injuries, what kept this injury from being a death and should we have reacted sooner or differently?

There is probably nothing more unfortunate than the death of a child, preventable or unpreventable. The Maine Child Death and Serious Injury Review Team (CD&SI) was established by state law in 1992 to review child deaths with a focus of systems and intervention. Maine's team is unique in that we also review serious injuries. The panel meets monthly in hopes that the Committee's findings and recommendations can help to reduce the number of preventable child fatalities in our state. Additionally, the Committee meets annually with the Child Fatality Review Teams from New Hampshire and Vermont, to share experiences, information and to review a case that involves services from more than one state.

The members of the multidisciplinary team are volunteers who give generously of their time and expertise and who represent both public and private agencies that have an interest in the welfare of Maine children. Through their commitment, the Panel has been able to build a collaborative network to foster teamwork and to share the recommendations with the larger community. We hope this report will be an instrument in accomplishing that.

The Panel has made great strides since its inception, but there is still work to be done. The Panel will continue to look at ways to implement our recommendations and to maximize the impact of these recommendations on the actions and policies of the agencies and individuals who advocate for our children.

In recognition of the commitment and dedication of the members of the Panel, I would like to present the 2005 Annual Report to the Honorable John Baldacci, Governor of the State of Maine.

On behalf of the committee,

Lawrence R. Ricci

Lawrence R. Ricci, M.D.
Chair, Maine DHHS Child Death and Serious Injury Review Panel

Team Members of the Child Death and Serious Injury Review Panel 2005

Richard Aronson, MD, MPH	Maine Center for Disease Control and Prevention
Lou Ann Clifford, AAG	Department of the Attorney General, Civil Division
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Cathy Roland, RN, CPNP	School-Based Health Centers, Western Maine Health
William Stokes, AAG	Deputy Attorney General , Chief of Criminal Division
Judge Vendean Vafiades	Augusta District Court
Lt. Gary Wright	Maine State Police, CID II

FORWARD

This report documents cases that were reviewed in 2005 by the Maine Child Death and Serious Injury Review Panel. The mission of the Panel is to provide multidisciplinary, comprehensive case review of child fatalities and serious injuries to children in order to promote prevention, to improve present systems and to foster education of both professionals and the general public.

Furthermore, the Panel strives to collect facts and to provide opinions and articulate them in a fashion which promotes change. The final mission is to serve as a citizen review panel for the Department of Health and Human Services as required by the Federal Child Abuse Prevention and Treatment Act, P.L. 93-247.

'Jake' was an adorable boy adopted at a few months of age from another country. It appeared to be the perfect match until Jake began to display two-year-old behaviors that were intolerable to the family. He was killed at the hands of his adoptive mother before his second birthday.

The Child Abuse and Serious Injury Review Panel follows the review protocol outlined below.

1. The Panel conducts reviews of cases of children up to age eighteen who were suspected to have suffered fatal child abuse/neglect or to have suffered serious injury resulting from child abuse/neglect.

2. The Panel conducts comprehensive, multidisciplinary reviews of any specific case. The Office of Child and Family Services, the Commissioner of the Department of Health and Human Services, or any member of the multidisciplinary review panel may initiate reviews.

3. Cases may be selected from a monthly report that includes major injuries and deaths in the preceding month, as well as a summary of deaths and major injuries from the preceding year.

4. All relevant case materials are obtained by the Department of Health and Human Services staff and disseminated to the members of the review panel.

5. After review of all confidential material, the review panel will provide a confidential summary report of its findings and recommendations to the Commissioner of the Department of Health and Human Services.

6. The review panel may develop, in consultation with the Commissioner of the Department of Health and Human Services, periodic reports on child abuse fatalities and major injuries, which are consistent with state and federal confidentiality requirements.

The Maine Child Death and Serious Injury Review Panel is comprised of representatives from many different disciplines. Its composition includes the following disciplines.

- Judiciary
- Forensic Pathology
- Forensic and Community Mental Health
- Pediatrics
- Family Practice
- Nursing
- Public Health
- Civil and Criminal Law
- Law Enforcement
- Public Child Welfare
- Doctoral candidates completing their clinical or field placements

Each member of the Panel volunteers their time to review extensive case records in preparation for monthly retrospective reviews.

There are several unique functions of the Panel. Most states review child fatalities; Maine's panel reviews serious child abuse and neglect injuries, as well as child abuse and neglect fatalities, or suspicious deaths. Some states have multiple local review panels in addition to a central state-level panel. In such cases, the state-level team reviews only selected cases. Because the state of Maine is less populous than other such states, the full, central, state-level team reviews all cases. The centralized forensic medical examiner system and representation on the panel promotes standardized forensic child death investigations and post mortem exams. The State of Maine has specialized medical examiner training for child death investigation units of law enforcement, which include Maine State Police, and Bangor and Portland Police Departments. Representatives from this training sit on the Panel.

The Panel is established in state statute that permits confidentiality of the Panel's work and grants the Panel the power to subpoena relevant case documentation and testimony. This latter feature allows the Panel to conduct in-depth retrospective reviews of all relevant records, supplemented by oral presentations by key, involved service providers.

Finally, the Maine Child Death and Serious Injury Review Panel belongs to the consortium of Northern New England Child Fatality Review Teams.

'Jimmy' was an active six-year-old, sometimes living with his parents and other times with his grandparents. DHHS had worked with this family for several years to help the parents make better living conditions for their children. A few months before the fire that killed Jimmy took place, the home had been determined to be unsafe by the town fire department.

Findings and Recommendations

The results of the reviews undertaken by the Panel in 2005 lend themselves to discussion along several lines paralleling the evaluative processes such as information gathering followed by data synthesis and opinion development followed by treatment. Several other areas not easily categorized along these lines will be discussed such as prosecution, psychological evaluations, and law enforcement.

I. Information Gathering and Sharing

The ability to make accurate, skilled decisions requires effective multidisciplinary information gathering and sharing. In these areas the Panel found case examples of some concern as well as case examples of high quality work.

Case Examples

- In one case, the adoption home studies did not appear to recognize or address the parents' strongly held beliefs, values and views of child development and child rearing.
- In one case, casework was impaired by inadequate investigation and poor information. In this case, the possibility of an Osteogenesis Imperfecta (OI, Brittle Bone disease) diagnosis also complicated the issue. As often is the case, when questions of OI, however unlikely, are raised, they are often distracting to casework decision making and permanency planning for children.
- In one case, the first referral to Child Protective Services (CPS) Intake about the bruising was not forwarded to the district office.
- In one case, after-hours collaboration between two districts was accomplished quickly.
- There was one case in which there was no way to determine if it was a preventable death.
- In one case, the initial confusion over protection occurred because of debate among physicians and because of a missed fracture.

- In one case, it was not evident that a functional assessment of the family ever took place.
- In one case, a complete physical examination of the two remaining children was not done.
- In one case, the lack of meaningful communication between Probation and Parole and Child Welfare led to a dangerous presumption of child safety.
- In one case, the Child Death and Serious Injury Panel (the Panel) recognized that the police work was exceptional; leading to a good outcome.

Recommendations

- The Panel recommends that the Department of Health and Human Services (DHHS) evaluate its procedure for reviewing decisions to screen out referrals.
- The Panel recommends that DHHS review the issue of quality assurance of home studies in private adoptions.
- Joint collaboration between law enforcement, caseworkers and medical experts should happen from the beginning of a case.
- When the diagnosis is unclear, child safety should be considered foremost until diagnostic issues are fully resolved. In one case, the infant could have been kept in the hospital longer until further studies had been done and all involved professionals had met as a team to resolve diagnostic confusion.
- When a family fails to improve, a thorough functional assessment with meaningful risk oriented recommendations should be completed.
- When a death or serious injury of a child occurs, the remaining children should receive a physical examination within 24 hours.
- The lack of meaningful communication between Probation and Parole and Child Welfare in one particular case was a practice error that requires detailed internal review.

DHHS Response

OCFS is completing a Quality Assurance (QA) review of 60% screened out CPS referrals to specifically evaluate appropriateness and quality of the information gathering and decision making process.

DHHS takes an active role in licensing of private adoption agencies and holds those agencies to a high standard. Conversation will be had with the licensing unit to determine feasibility of a home study QA process.

OCFS agrees and supports the question that joint collaboration with law enforcement, medical experts and caseworker staff should happen not only at the beginning of a case, but throughout the life of the case. A major focus of the 2006 Cops & Caseworkers Conference was on the critical importance of communication and collaboration to good outcomes.

OCFS recognizes a need to continue communication with hospital staff to assure safety when critical care factors are still unknown.

OCFS is embarking on an intensive family reunification project utilizing comprehensive and meaningful assessment tools for risks and signs of both safety and danger.

OCFS has an established protocol for the interview and assessment of all family members including other children in the home and requiring that the worker verify/identify whereabouts of any other children.

OCFS will request Program Administrators (PA) to review cases where Probation and Parole are involved.

OCFS places a high value on the Family Team Meeting (FTM) practice of team decision making, but recognizes that safety is paramount and OCFS carries a primary responsibility in assuring safety for children.

OCFS has seen a significant change in the stability of caseworker staff. They continue to develop methods to reduce the number of transitions for a case. A transfer protocol is being enhanced to address the transition for CS to Adoption. OCFS has initiated a QA review of face to face contacts that not only look at frequency but quality and purpose of the contact. Pre-service training is establishing methods to more effectively train engagement skills and assess participants outcomes.

OCFS new kinship policy provides staff with better guidelines and clearer expectations with identification, assessment and support of kinship placements.

Supervisors are continuing with an enhanced Supervisory Enhancement Initiative (SEI) that promotes supervisors supporting caseworkers in analytical and inclusive assessment.

II. Supervision and Decision Making

Once adequate data has been gathered, it is critical that responders develop a clear and comprehensive opinion and plan. Regularly scheduled, planned, purposeful supervision that addresses both the situation under discussion as well as the responses of the person receiving supervision is essential to this task. The Panel saw various instances of decisions being made where it did not appear that supervisory oversight had the desired effect.

Case Examples

- In one case, the caseworker involved was a student who was not adequately supervised. This was an incredibly complex case that should not have been assigned to a student.
- In one case, after a head injury, attention was so focused on this incident that other important safety and risk factors were not taken into consideration.
- In one case reviewed, the placement decisions regarding the older sibling were made by the parents.
- In one case, the life threatening safety issues in the homes were never adequately conceptualized. The conditions of this home were identified as the core issue rather than as a symptom of other critical deficits such as organization, problem solving and protective judgment. Repeated CIP referrals were ineffective.
- In one case, the children remained out of the home long after the medical examiner and the child abuse specialist determined the death of their sibling to be accidental. The number of changes in caseworkers may have contributed to this.
- In one case, caseworker engagement, documentation, and returning of phone calls was poor.
- In one case, there was a delay in assessment of kinship placement that may have contributed to the difficulties around placement.
- In one case, the family assessment by DHHS was focused on the single incident and did not consider the meaning of the totality of other incidents. As a result, the Department did not identify the serious threat of harm to these children from their parents. Closure of the child protective case two weeks prior to the father's release from prison reflected a lack of consideration of the mother's role in failure to protect the child.
- Several cases transitioned through many workers, but in one case reviewed, the significance of the father's history was lost.

Recommendations

- The Department needs to ensure that any undergraduate student working on a case be assigned a mentor and have adequate supervision. No student should ever be assigned the primary responsibility for a case.

- Case decisions should not be based on a single incident and should take all factors into consideration.

- While parents deserve to be heard and have consideration in placement issues, when it is obvious that parents are not making progress in their efforts to reunify, they should not be the final decision makers when a high risk of harm is present.

- The first question that needs to be answered is, "Is this child safe?" If the answer is "no", immediate action is required.

- The Department should consider ways to decrease the frequency of changes in caseworkers or to minimize the impact of frequent change on a case.

- Casework should include face-to-face contact with parents (as is the current policy) in their home or a neutral setting. Training for caseworkers in enhancing engagement skills is important in these cases.

- Staff need help developing questions that will lead to measurable and obtainable goals.

- Identification and assessments of possible kinship placements and involvement need to take place as soon as possible.

- Supervisory supports need to be in place that can help caseworkers see incidents within the larger context of their meaning regarding child safety. The Department needs to continue to assess safety and gather information throughout a case.

- Transitions should involve a thorough review of the record and follow-up by the supervisor.

DHHS Response:

OCFS agrees no undergraduate student should have primary responsibility for a case and will undertake a review of case carrying responsibilities in Field Instruction Units (FIU). OCFS will work to provide better clarity to supervisors who also have student interns outside the FIU's.

OCFS agrees no case decision should be based on a single incident. The new Family Assessment Policy (8/06) decidedly guides practice to a more thorough analytical approach to all facts that impact family function.

III. Intervention

Once information gathering and analysis have occurred the next step is effective intervention planning. Again both good and bad practices were evident to the panel.

Case Examples

- In one case, no assessment of substance abuse issues in the home were identified for kinship placements of the surviving sibling. This resulted in 3 failed placements in a short period of time.

- Medical, law enforcement and CPS all interviewed the parents at the same time. This worked well in this particular case, but as a practice, could create potential role confusion.

- In one case, there was little about mental health counseling that would help the family change their deplorable, unsafe living conditions. Little change, if any, occurred despite the years of counseling, groups and community support.

- In more than one case, Public Health Nursing was not involved in the life of the child.

- In one case, the Department pursued all the facts in the death of the child. They waited for expert opinions and took necessary precautions for the remaining children in the meantime. The children went to live with a safe relative and the parents were able to stay involved. This case represented some good casework for the family after the death of a child.

- In one case, the focus of therapy was not relevant to ameliorating risk and did not deal with child maltreatment issues. This particular case was inappropriate for a child protective mental health case.

- The Department was ready to do in-home unsupervised visits with the mother under the presumption that the boyfriend was the abuser, despite lack of clear evidence of who abused the child.

- In one case, the Department failed to respond to serious allegations of maltreatment and sexual abuse.

Recommendations

- A thorough home study should be done for all placements.
- The Panel recommends that the Cops/Caseworker conference in the Fall of 2006 address role confusion when medical, law enforcement and CPS personnel all work together on a case.
- When community intervention programs are unable to meaningfully effect change with a family, then it is the Department's responsibility to take over management of the case.
- The Department should be looking for measurable behavioral outcomes in mental health counseling. If someone is in therapy, progress should be measurable. If not, it should not continue.
- Intervention of any kind should be time-limited, measurable and directly related to the problem at hand.
- Provisions should be made for Public Health Nursing to be involved with families with mental health issues when a child is born and as long as is necessary for the family.
- Child maltreatment work is a specialized type of treatment. Families should participate in therapy with a professional qualified to work in this field.
- There was a practice error regarding the Department's failure to respond to serious allegations of maltreatment and sexual abuse. This requires detailed internal review at the centralized level.

DHHS Response

OCFS agrees that a thorough home study is required for all placements. The new Kinship Policy addresses the expectation that a full study is implemented in a timely manner.

The 2006 Cops & Caseworkers Conference addressed the expectations and roles of law enforcement, medical experts and caseworkers.

OCFS aggress that CIP agencies should inform the District office when intervention has not produced results in reducing risk of harm.

OCFS has undertaken significant steps to coordinate Child Welfare (CW) and Children's Behavioral Health Services (CBHS) in identifying mental health assessment evaluation and treatment to assure efficacy and value. This process has been directed at reducing an over reliance on unnecessary evaluations and assuring that the right services are delivered at the right time and for the right duration.

IV. Psychological Evaluations

In cases that the Panel reviewed, it was noted that psychological assessments could make a tremendous difference for the better or for the worse. It is important that the level of assessment is correct and the level of expertise of the examiner matches the assessment being done. In one case reviewed, it was noted that the psychological evaluation on the mother was thorough and well done. The provider was skilled at getting to the real issues. This illustrates the importance of having specifically trained providers to do these assessments.

Case Example

- In one case, the psychological reports were done without any records from DHHS. These records would have shown the past criminal history and other risk factors. A thorough risk assessment of these parents was never completed.

Recommendations

- Initial assessments should be risk-oriented.
- When a child is already in care and another is born, a formal, thorough risk assessment needs to be done before the new child is placed in the home.
- The Department is invested in a protocol developed by CANEP. Psychological evaluations with risk-focused, measurable, attainable recommendations should be developed from this.

DHHS Response

OCFS has implemented a new assessment policy that will enhance a focus on risk and signs of danger.

OCFS has undertaken significant steps to coordinate Child Welfare (CW) and Children's Behavioral Health Services (CBHS) in identifying mental health assessment evaluation and treatment to assure efficacy and value. This process has been directed at reducing an over reliance on unnecessary evaluations and assuring that the right services are delivered at the right time and for the right duration.

Table 1
Number of Child Deaths by County 2005

Androscoggin: 3	Hancock: 1	Oxford: 4	Somerset: 2
Aroostook: 2	Kennebec: 7	Penobscot: 16	Waldo: 2
Cumberland: 15	Knox: 1	Piscataquis: 2	Washington: 1
Franklin: 2	Lincoln: 2	Sagadahoc: 0	York: 5

Total = 65

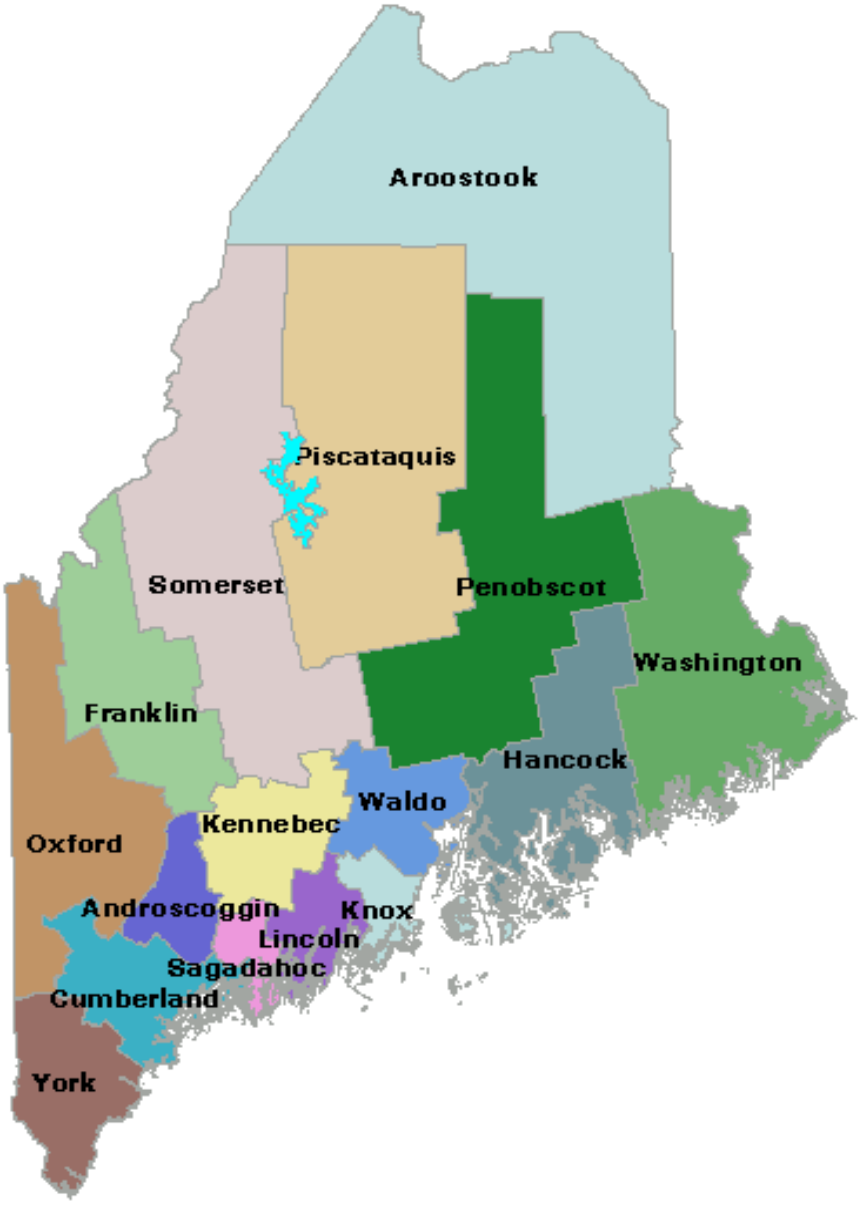


Table 2
Manner of Deaths of Maine Children 2005

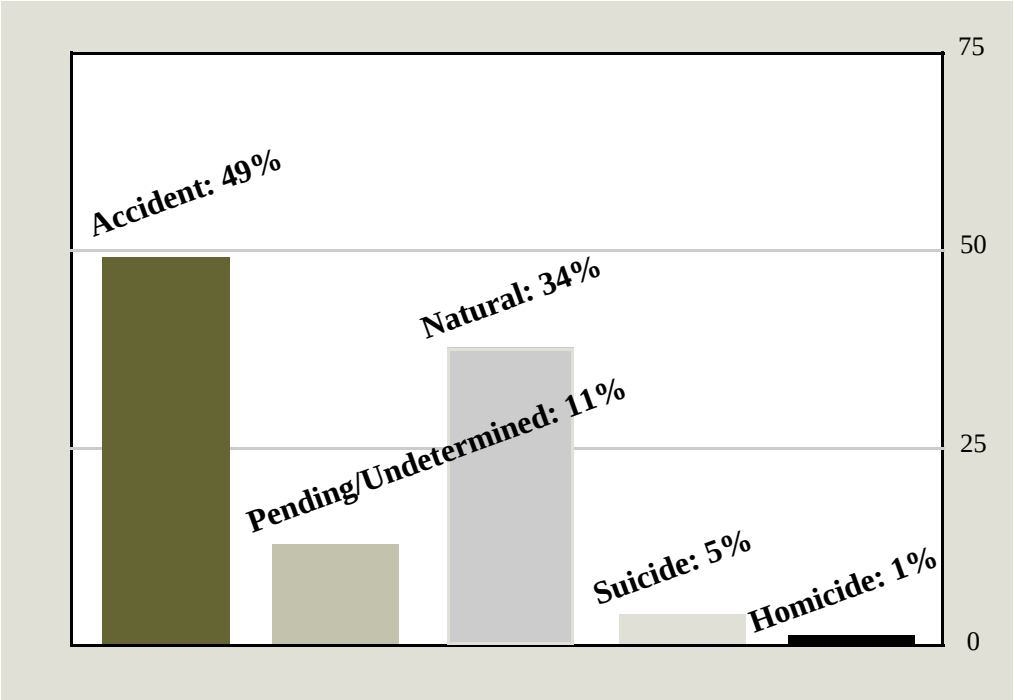


Table 3
Causes of Deaths and Serious Injuries in Cases Reviewed 2005

Deaths

Victim Age	Cause of Injury	Perpetrator's Relation to Victim	Perpetrator Age
1.5 months	Unknown	Unknown	—
22 months	Unclear - possible shaking	Adoptive Mother	29
3 years	Accidental - fall	N/A	—
6 years	Home Fire	N/A	—

Serious Injuries

Victim Age	Cause of Injury	Perpetrator's Relation to Victim	Perpetrator Age
7 weeks	Broken bones - possible shaking	Unknown	—
2 months	Burns on hands, rib fractures	Father	24
4 months	Unknown	Unknown	—

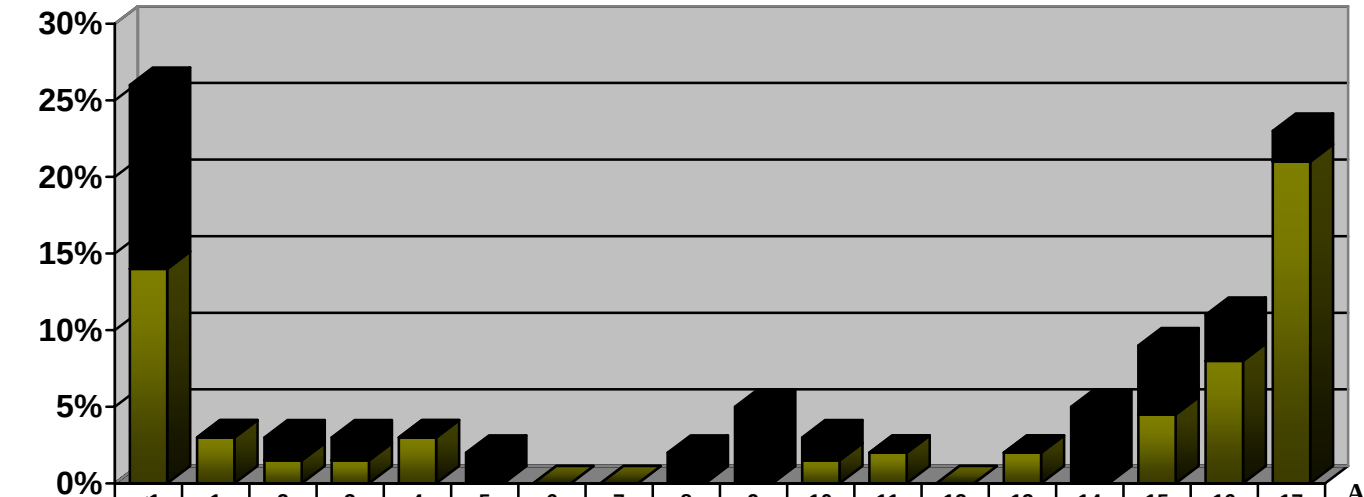
The Panel reviewed 7 cases in 2005. In 6% of the cases, the event which caused a serious injury or death was witnessed by at least one person. Of these cases 2 were inflicted injuries. The Panel determined that 4% of the time the injuries or deaths could have been prevented.

Child Deaths Reported to the State of Maine Office of Chief Medical Examiner 2005

Total Deaths in 2005

65 child deaths were reported to the State of Maine Office of the Chief Medical Examiner in 2005. 26% of these children were under the age of one, and 23% were 17 years of age. 49% of the deaths were the result of accidents; while 1% were homicides. 66% of the children were male. More deaths occurred in Penobscot County than any other region; followed by Cumberland.

Table 4
Child Deaths by Age and Sex 2005



	<1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Female	12.0%	0.0%	1.5%	1.5%	0.0%	2.0%	0.0%	0.0%	2.0%	5.0%	1.5%	0.0%	0.0%	0.0%	5.0%	4.5%	3.0%	2.0%
Male	14.0%	3.0%	1.5%	1.5%	3.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	2.0%	0.0%	2.0%	0.0%	4.5%	8.0%	21.0%

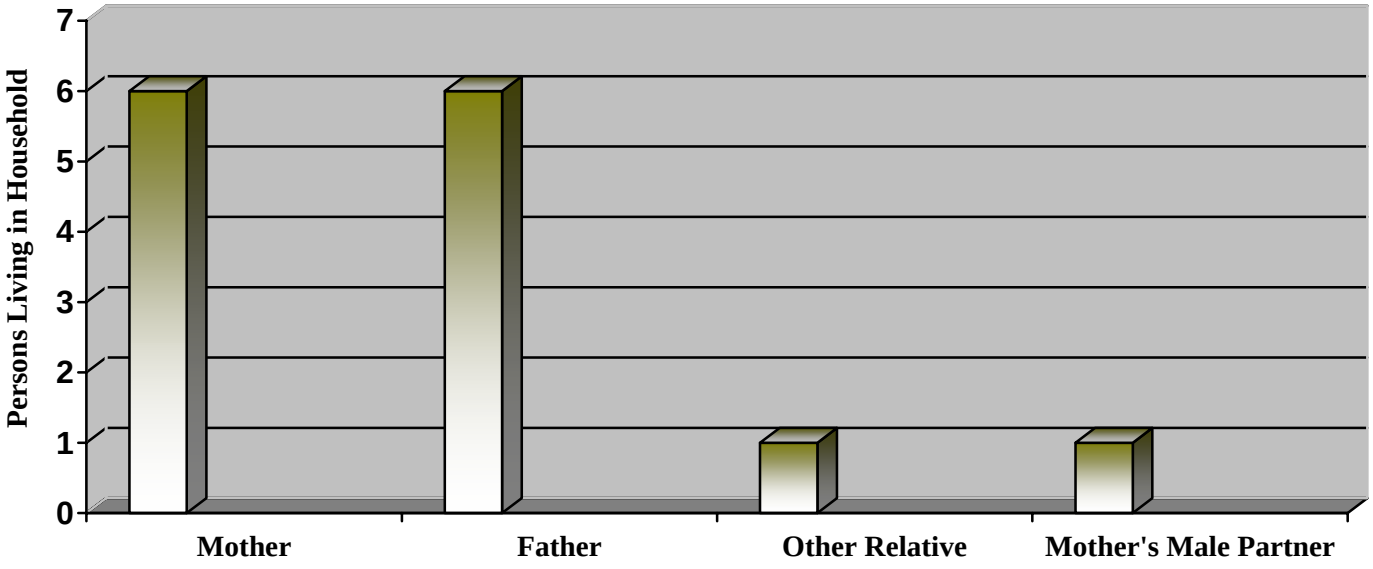
Case Demographics: Cases Reviewed by the Maine Child Death and Serious Injury Review Panel 2005

In 2005, the Maine Child Death and Serious Injury Review Panel reviewed seven cases. Below is a summary of these cases, including demographic information about the children and families reviewed, causes of the deaths and injuries and summaries of finings and recommendations of the Panel.

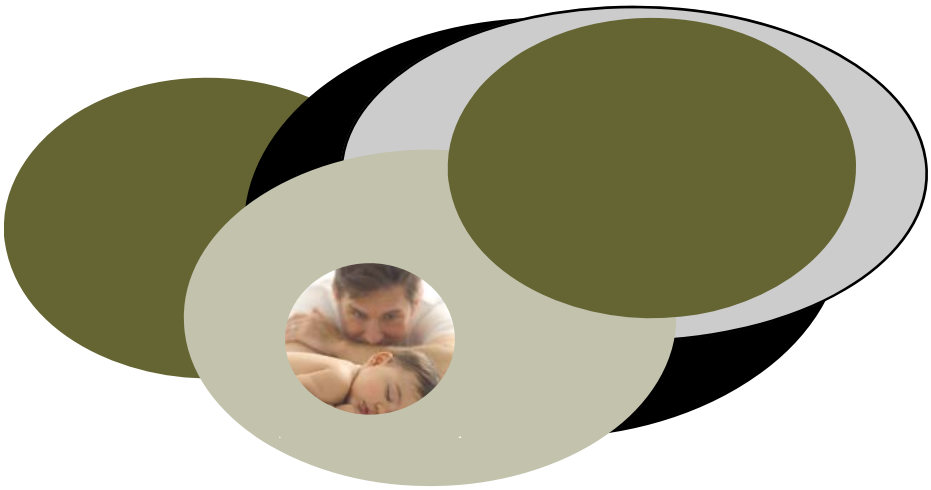
Demographic Information

The ages of the children in the cases reviewed by the Panel ranged from newborn to ten years. Three cases involved children under the age of six. Four of the cases, or fifty-seven percent focused on male children. Most of the children from the cases that the Panel reviewed lived in homes with two caregivers. In the majority of cases the caregivers were the biological mother and father. In 86% of the cases reviewed, children lived with their biological or adoptive mothers; 86% of the time, children lived with their biological or adoptive fathers. Two children resided with their parents' partners. More specifically, one child lived with a stepmother; and one child lived with the mother's male partner. In one case reviewed, there were other non-related persons residing with their family.

Table 5
Members of Household in Cases Reviewed 2005



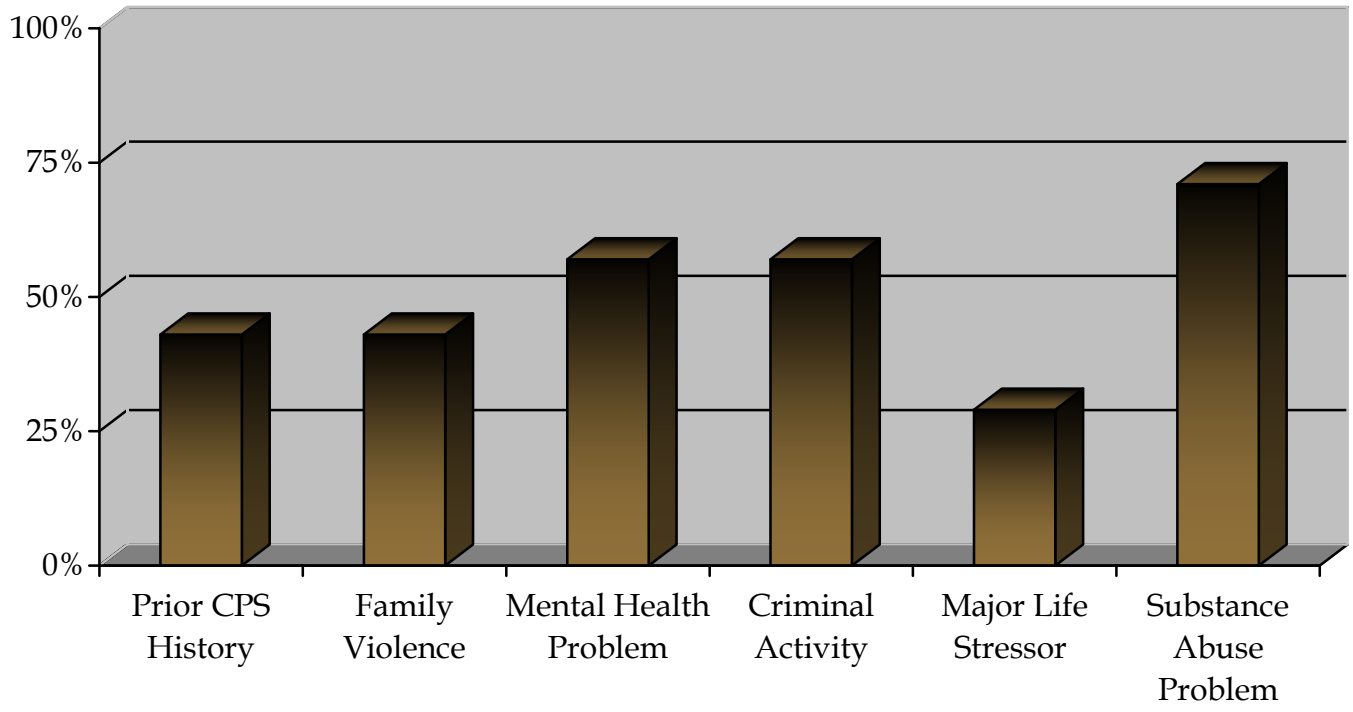
There was an average of four people living in the households (other than shelters) of cases that the Panel reviewed. In 3 cases, there were other children living in the home. The average age of these children was 20 months. The average age of caregivers in the cases that were reviewed was 26 years. The caregivers who held legal custody of the children were most often not married 5 cases. Married parents were only 2 cases of those reviewed.



Parental Risk Factors

The caregivers in the cases that were reviewed often presented with more than one significant risk factor as noted below. Forty-three percent of the cases had prior histories or open cases with child protective services. Three of the cases had a history of, or a current problem with violence in the household and 2 had experienced a major life stressor within the twelve months prior to the child's death or serious injury. Seventy-one percent of cases had parental caregivers with substance abuse problems, 4 had a history of criminal activity and finally, 4 of the cases involved at least one caregiver with a mental health problem. Clearly, substance abuse and mental health issues were a huge factor in the cases reviewed.

Table 6
Risk Factors 2005



State of Maine Child Protective Activities 2005
Department of Health and Human Services

Activities Based on Reports

The Department's ability to respond to reports of child abuse or neglect is based on factors such as the number of caseworkers, the seriousness or complexity of the cases receiving services and the availability of resources. Current staff resources are not sufficient for the Department to assign all of the reports of child abuse and neglect that it receives.

The Department of Health and Human Services has contracts with private agencies to respond to reports of child abuse and neglect. This has resulted in a significant decrease in the number of reports that were not assigned for assessment. There were **2,617** Appropriate reports which were assigned to a Contract Agency.

There were **9** Appropriate reports which were not assigned for assessment.

There were **5,324** reports involving **10,707** children assigned to a caseworker for a safety assessment.

Table 7
State of Maine New Reports Assigned for Assessment 2005

Families	Children Involved by Age Group					
Office	**Reports**	**0-4**	**5-8**	**9-12**	**13-15**	**16-17**
Portland	725	586	315	260	184	68
Sanford	287	197	137	150	89	38
Biddeford	514	387	233	197	141	57
Lewiston	853	796	367	306	227	96
Augusta	715	591	309	273	204	80
Rockland	432	310	224	160	104	54
Skowhegan	271	211	108	109	60	27
Bangor	697	600	301	254	136	71
Ellsworth	162	111	76	67	37	17
Machias	181	134	74	70	41	25
Houlton	142	109	60	39	41	17
Caribou/Fort Kent	331	273	186	141	108	40
Central	14	8	5	8	3	0
STATEWIDE	**5324**	**4313**	**2395**	**2034**	**1375**	**590**

Child Protective Referrals

Title 22 MRSA, Chapter 1071, Subsection 4002 defines abuse or neglect as "a threat to a child's health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these by a person responsible for the child."

The following report provides a summary of the number of referrals to Child Protective Services, the number of inappropriate referrals that were screened out and a series of detailed reports on the characteristics of the referrals that were assigned to caseworkers for assessment.

A Referral is any written or verbal request for Child Protective Services intervention in a family situation on behalf of a child in order to assess or resolve problems being presented.

During calendar year 2005 the Department of Human Services received over **17,681** referrals for Child Protective Services intervention in a family situation. **9,731** referrals presented situations with evidence of serious family problems or dysfunction but did not contain allegations of child abuse or neglect.

Table 8
Completed Assessments in 2005

Office	Completed	Child Abuse/Neglect Found	Unsubstantiated	Findings Rate
Portland	740	316	424	**42.70%**
Sanford	290	99	191	**34.14%**
Biddeford	537	138	399	**25.70%**
Lewiston	875	357	518	**40.80%**
Augusta	715	195	520	**27.27%**
Rockland	436	144	292	**33.03%**
Skowhegan	273	111	162	**40.66%**
Bangor	716	328	388	**45.81%**
Ellsworth	172	84	88	**48.84%**
Machias	181	80	101	**44.20%**
Houlton	227	75	152	**33.04%**
Caribou	199	75	124	**37.69%**
Fort Kent	59	31	28	**52.54%**
Institutional Abuse	193	19	174	**9.84%**
CPS Total	**5613**	**2052**	**3561**	**36.56%**

Inappropriate Referrals Received

Parent/Child Conflict: Children and parents in conflict over family, school, friends, behaviors with no allegations of abuse or neglect. Includes adolescents who are runaways or who are exhibiting acting out behaviors that parents have been unable to control.

Non Specific Allegations or allegations of marginal physical or emotional care which may be poor parenting practice but is not considered abuse or neglect under Maine Law.

Conflicts over Custody and or visitation of children which may include allegations of marginal/poor care.

Families in Crisis due to financial, physical, mental health, or interpersonal problems but there are no allegations of abuse or neglect.

Source of Reports Assigned for Assessment

School Personnel	801
Social Services Personnel	643
Law Enforcement Personnel	754
Medical Personnel	527
Anonymous	377
Neighbor/Friend	369
Relative	470
Other	429
Mental Health Personnel	446
Self/Family	425
Child Care Personnel	77

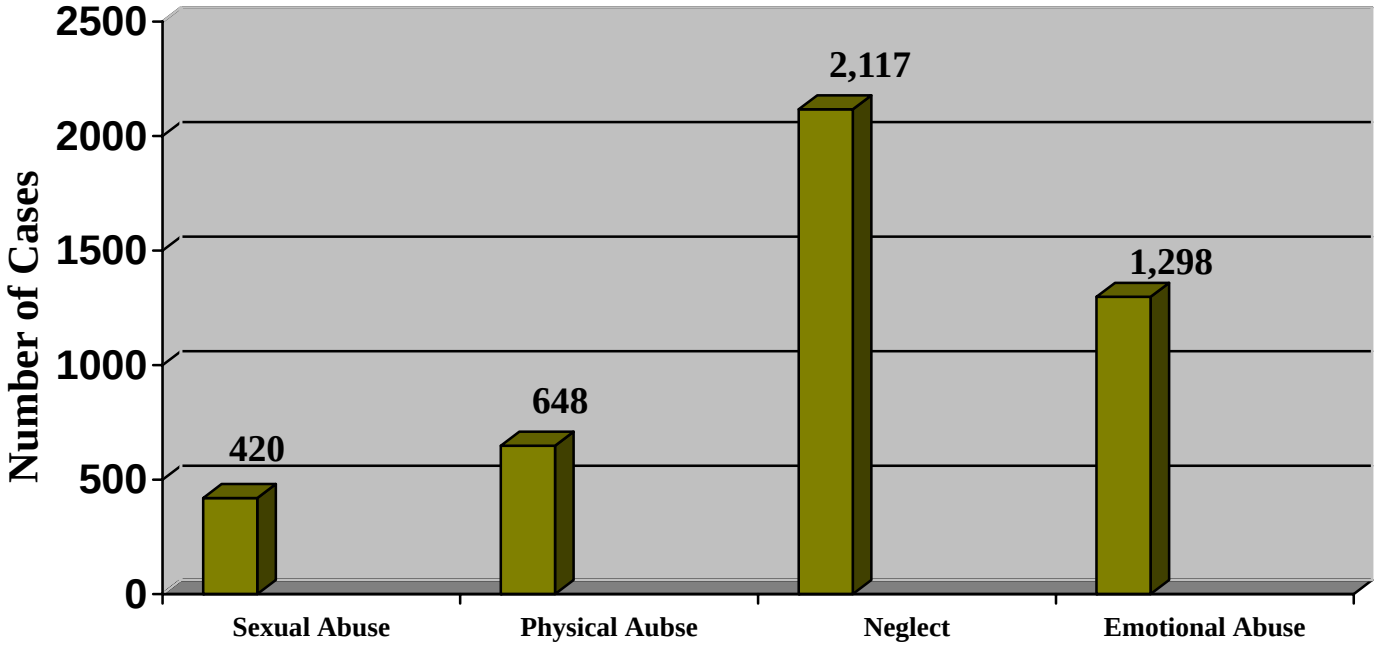
Family Stress Factors Identified During Assessment

Family Violence	1017
Alcohol/Drug Misuse by Parent/Caretaker	1475
Mental/Physical Health Problem	2609
Severe Parent/Child Conflict	665
Severe Acting Out Behavior of Child	662
School Problems	627
Divorce Conflict	545
Emotionally Disturbed Child	488
Runaway	113
Alcohol/Drug Misuse by Child	140
Failure To Thrive Child	24

Household Type/Living Arrangement of Reports Assigned for Assessment

Two Parent Married	1327
Two Parent Unmarried	1020
One Parent Female	2198
One Parent Male	332
Adoptive Home	25
Relative	184
Non Relative	40
Other	84
Shelter/Facility	40
Unknown	11

Table 9
Department of Health and Human Services
Types of Substantiated Cases of Child Maltreatment 2005



What's done to children,
they will do to society.
- **Karl Menninger**

A special thanks to the many volunteer hours that Panel Members dedicated to make this report a reality.