Report of the State of Maine Child Fatality and Serious Injury Review Panel 2006

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
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A Letter from the

Child Death and Serious Injury Review Team's Co-Chairmen

DATE

ADDRESS TO GOVERNOR

There is probably nothing more unfortunate than the death or serious injury of a child, preventable or not. The Maine Child Death and Serious Injury Review Team was established by state law in 1992 to review child deaths with a focus on 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 and serious injuries in our state. Among the questions the panel tries to address are; 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?

Additionally, the Panel meets annually with the Child Fatality Review Teams from all of New England to share experiences, information and review cases that involves services from more than one state.

The members of the Maine Child Death and Serious Injury Review Team are volunteers who give generously of their time and expertise and who represent both public and private agencies with 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.

The challenges facing Maine identified by the panel this year include:

- Failure to Thrive as a manifestation of child neglect is an increasingly recognized problem in Maine. The consequences of nutritional deprivation in early childhood have profound life-long adverse effects on development. We applaud the work of the Department of Health and Human Services in recognizing this issue and in taking steps to educate providers on identification and intervention.
- The panel continues to identify pockets of poor investigative coordination in the state of Maine – areas where there is inadequate communication between Law Enforcement and DHHS during an investigation. This continues to be a challenge. It is hoped that through expanding shared educational conferences and other venues to these areas this can be improved.
- The Panel remains concerned that in some cases DHHS evaluations focus too much on immediate threat issues without considering the importance and meaning of recurrent or long term threat. The Panel has found that this sometimes leads to missed opportunities for intervening with families and for protecting children. The Panel is pleased that the DHHS is aware of and concerned about this issue and sees it as important.
- The Panel continues to be distressed at the number of Maine children dying in an unsafe sleep environment. This includes unsafe bed-sharing, inadequate bedding, or even couch or waterbed sleeping. The Maine CDC has developed a thoughtful, well crafted brochure yet lack funding support for publishing and distribution. Maine needs to develop a coordinated education program for parents on safe sleeping. It is encouraging that the Pediatric community in Maine has taken an interest in this topic. The American Academy of Pediatrics has issued clear guidelines for safe sleeping that should be implemented in the state Some of their recommendations are:

- The "Back to Sleep" initiative which involves placing infants on their backs to sleep.
- Use a firm sleep surface: A firm crib mattress covered by a sheet is the recommended sleeping surface.
- Keep soft objects and loose bedding out of the crib
- Do not smoke during pregnancy
- A separate but proximate sleeping environment is recommended
- Although bed-sharing rates are increasing in the United States for a number of reasons including the facilitation of breastfeeding, the AAP task force concludes that the evidence is growing that bed sharing, as practiced in the United States and other Western countries, is more hazardous than the infant sleeping on a separate sleep surface. They therefore recommend that infants not bed-share during sleep.

- There is a perception among panel members and elsewhere in the Maine pediatric community that the numbers of infants experiencing abusive head trauma is on the increase. If this is true, and even if it were not, Maine needs a coordinated, evidence based prevention program aimed at inflicted heat trauma. The only empirically supported model that has shown promise is the New York Model now being replicate in a number of other states. With aggressive education of all caretakers after the birth of an infant and a voluntary signing of an agreement not to shake a baby the study area in New York saw a 50% decline in the number of infants with abusive head trauma. The Panel is pleased that Maine CDC has stepped in to address this issue.

- In order to accurately identify trends, serious injury and death surveillance in Maine must improve. The panel applauds the efforts of the Maine DHHS in beginning to develop such a surveillance system. However such a system does not end there. It must include law enforcement, the medical examiner's office and others.

The Panel has made a number of valuable contributions since its inception, but there is still work to be done. The Panel will continue to look at ways to clarify issues, develop and implement recommendations and to maximize the impact of these recommendations on the policies and practices of the agencies and individuals who care for Maine's children.

In recognition of the commitment and dedication of the members of the Panel and in the hope that our recommendations continue to support and improve the welfare of Maine Children we would like to present the 2006 Annual Report to the Honorable John Baldacci, Governor of the State of Maine.

On behalf of the committee,

Lawrence R. Ricci, M.D.

Co-Chair

Maine DHHS Child Death and Serious Injury Review Panel

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Forward

This report documents cases that were reviewed in 2006 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 child 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.

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 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.

The review panel may develop, in consultation with the Commissioner of the Department of Health and Human Services, periodic reports on the 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.

Findings, Recommendations and the Department's Response

Supervised Visits

The Panel views supervised visits as an opportunity for significant learning and growth on the part of parents and their children. It is also evident if not well focused; children can be harmed in a number of different ways during these visits

CASE EXAMPLES

- In one case reviewed, a mandated reporter failed to make a report regarding an incident during a supervised visit.
  - It appeared that the failure to report might have been due to the provider's understanding that someone else was going to report and the belief that their obligation was met.
  - The older child in this case was actively abused during these visits on more than one occasion.
  - Different professionals, not all of them trained supervisors, were carrying out the responsibilities of the visit supervisor.
- It also appeared that the purpose of the supervised visitation was unclear.

RECOMMENDATIONS

- The Panel recommends ongoing clarification about reporting requirements for suspected abuse and neglect, possibly in the form of a FAQ, be sent to professional organizations.
- The Panel recommends that the Department's, including third party contractors' visitation processes and procedures be reviewed in detail in juxtaposition with the national *Supervised Visitation Standards and Guidelines* published by The Supervised Visitation Network.
- There needs to be a consistent and appropriately trained visit supervisor for each family.
- The Panel recommends any supervised visitation be based on a clear plan that considers responsibility for safety as well as specific goals. Goals need to be clear, measurable and attainable, and ultimately result in the parent's ability to independently provide safe, nurturing care independently.

DEPARTMENT'S RESPONSE:

In November 2005, the Department of Health and Human Services implemented new policy relating to visitation between children in custody and their parents, relatives and others. The Department's philosophy is one which supports a belief that visitation

maintains the child's relationship with significant people in his or her life, while additionally helping facilitate a child's progress toward permanency.
In May 2006, an addendum was added to the policy. The addendum, Family Visitation Service Guidelines, specifies the individual responsibilities of the parent, the caseworker, and the visit support worker in carrying out the policy. The development of the Guidelines, as well as the development of Visitation Ground Rules, was a conjoint effort of Department staff working with contracted agency staff. In the process of developing the Family Visitation Service Guidelines and the Visitation Ground Rules, the Supervised Visitation Network's *Supervised Visitation Standards and Guidelines* were reviewed and utilized as a standard.

The policy procedures describe the planning for quality visitation, which relies upon parent participation in development of the visitation planning. The purpose and goals of this visitation are incorporated into the Child Plan and the Family Plan. Open disclosure is a key tenet, with a plan in place for communication to provide the parent with regular and constructive feedback on how the Department views the visitation progressing toward meeting of established goals.

Visitation should occur in the most natural setting which will also meet the safety needs of the child. The need for a visit to be supervised is determined based upon the individual situation, and may not be necessary in many situations. Facilitated visits are those in which the support provided during a visit promotes the building of positive family relationships. The visit support worker who facilitates the visit will among other things assist the parent by role modeling behavior, by engaging the family members in quality interactions, and by providing feedback to the parent after the visit to increase insight into the family dynamics.

While the visitation policy provides guidance which will hopefully move visits along a continuum from supervised to facilitated to unsupervised, it is always a requirement for whoever is monitoring the visits to assess the safety of the child during the visit. If during the visit, the visit support worker observes behavior that is harmful to the child's safety, the worker will try to work with the parent to ensure the child's safety. If this is not successful, the visit support worker follows the standards set forth in the *Standards and Guidelines for Supervised Visitation Practice* and in the Family Visitation Service Guidelines and will end the visit early. As a mandated reporter, the visit support person is required to immediately make or cause a report to be made to the Department of any observations of abuse or neglect occurring during the visit. All professional staff filling the role of visit support person are provided with training on mandated reporter responsibilities prior to assuming this role. For visits which have been determined to be safe enough to take place with sporadic check-ins or with no supervision, the caseworker or contracted agency staff carefully monitors each visit to ensure the child is feeling safe during the visits. This includes follow up discussions with the child or caregiver to assess the effects upon the child of the unsupervised visit. If the child or others report statements or actions occurring during the visit which raise concerns about safety, the visitation conditions revert back to being supervised.

Following each visit, a standard documentation form is filled out and provided to the child's caseworker. While the current form contains a section relating to safety concerns,

the form is under revision to add clarity about reporting responsibilities, as recommended by the Panel. The section on the form will identify:

- **incidents of abuse or neglect which occurred during the visit,**
- **who made the mandated report to the Department, and**
- **date of the report to the Department.**

The addition of this language to the uniform documentation form will require at every visit the support worker to document whether or not any incidents of abuse or neglect occurred and will prompt the worker to document the immediate fulfillment of the mandated reporting responsibilities.

In the interests of making visits as natural and comfortable as possible for the child, the Department is encouraging the child's foster parents and the child's relatives to fill the role of visit support person. These supportive roles would however not be utilized when there are safety concerns for the child during visits with the parent. In cases where supervision of the visit is necessary in order to ensure the child's safety is maintained, the visits will be supported by a Department caseworker or by an employee of a contracted agency. Even for visits requiring high levels of supervision, our policy encourages use of facilitation to help the parent and child build a positive relationship.

From the day a child enters custody, the Department is assisting the family in exploring connections which can be utilized after reunification goals have been accomplished and the child has been returned back to the home and community. Visitation planning is one significant area in which we see an opportunity to assist the family in becoming more integrated into their extended families and communities. The visitations provide an opportunity for the family to practice participating in community activities and enhancing its natural supports, while the child is still in custody. In the past, the Department relied solely upon its own staff and professional staff contracted by the Department for supervision of visits. With our current philosophy, we are expanding our use of visit support persons to include those in the birth family's own support system. While potentially this opens the door for risk of a child being abused or neglected during a visit, we believe we have minimized the risk of this occurring by assessing the level of supervision needed for each individual case; by discussing in Family Team Meetings the goals for visitation; by documenting each visit and sharing information with the child's caseworker; by convening follow-up meetings to discuss and monitor progress made during visitation; and by continuously assessing and re-determining the level of supports needed to ensure the safety of the child during visits. We monitor closely the effects upon the child of moving along the continuum from supervised to facilitated to unsupervised visits, and adjust the conditions accordingly. We are committed to making the visitation as comfortable and natural for the child and family, as circumstances warrant.

Abusive Head Trauma

Abusive Head Trauma remains a significant health problem for Maine children. While 15% of AHT babies die, fully 50% suffer permanent significant brain damage. Prevention efforts should include education of all caretakers during the pregnancy, at the time of delivery, and afterwards with particular efforts to offer guidance about how to handle a difficult crying baby. Primary

care providers play a pivotal role in identifying at risk infants and families and in early identification of those already injured.

CASE EXAMPLES

- In one case reviewed, there was a missed opportunity at the well-baby visit, 2 weeks prior, to identify subtle indicators of Abusive Head Trauma

RECOMMENDATIONS

- The Panel recommends that all medical providers receive education on AHT early identification and prevention

- The Panel recommends the working group to explore evidence-based models for the prevention of shaken impact syndrome reconvene. Models, as well as strategies for implementing them in Maine, need to be considered.

DEPARTMENT'S RESPONSE:

Now that the Division of Early Childhood is a part of the Office of Child and Family Services, Child Welfare will be partnering with Early Childhood to explore evidence based models for the prevention of shaken impact syndrome. There has been a diverse group developed, The Evidence-Based Workgroup, that is undertaking a systemic review of evidenced based treatments for specific conditions. The first condition being looked at is Disruptive Behavior Disorders, however, Child Welfare will be requesting that this workgroup as some point over the next year explore evidence-based models for the prevention of shaken impact syndrome. Models, as well as strategies for implementing them in Maine, can be reviewed by this group with a presentation to the CDSI Review Team. Maine now has a team that has been trained in the nationally recognized Sudden, Unexplained, Infant Death Investigations (SUIDI) protocol and trainings have occurred across the state. A plan is in place to use the SUIDI protocol for death scenes by the Medical Examiner's Office.

Members of the Review Panel have agreed to work collaboratively to develop a comprehensive training for medical providers and others.

Supervision and Decision-Making

In considering reviews as a whole, it is evident that the success or failure of protecting children from harm often depends upon the skill and insight of the caseworker, supervisor and Program Administrator team. The families that come to the Department's attention are almost always complex. Both their strengths and their dysfunction occur on multiple levels. The caseworker and supervisor are constantly challenged to maintain a clear and accurate view of the family. They must also sort through information that is often conflicting and unclear to determine what issues are the "forest" and which are the "trees."

Caseworkers and their supervisors are often successful in this attempt, but sometimes they are not and occasionally the result is devastating. The magnitude of this issue is not lost on the Department. The Department's ongoing supervisory initiative is specifically based on improving practice in this area. It is most likely, however, an area which will require attention for the foreseeable future.

CASE EXAMPLES

- In more than one case reviewed the caseworker team missed the big picture in assessing risk to the children that grew out of expected conflicting and confusing family roles that are part of any initial child welfare involvement. Interventions offered to the families addressed were not effectively generalized to their needs.

- Due to unclear medical information in one case reviewed, both DHHS and Law Enforcement persisted in deferring decision making and information gathering waiting for a definitive medical finding.

- In one case reviewed, the case-closing letter was neither clear nor compassionate.

- In another case reviewed, the father's previous failure to demonstrate his ability to consistently care for and protect his children was not taken into account in the decision to reunify; it was based on his present cooperation alone.

- In one case reviewed, there were problems in defining the appropriate focus. The focus was on the level of concern or love that the parents showed for the child, and not the medical impact or their neglect on the child.

- In another case reviewed, given the lack of safe options, a Preliminary Protection Order (PPO) would have been justified and might have protected from significant injury. After the fact, involved staff participated in and benefited from a detailed review. As a result, they were able to clearly identify errors they might have made, and discuss more effective alternatives for the future.

- In more than one case reviewed by the Panel, the monitoring and follow-up of a safety plan was not appropriate. The written plan was appropriate, but wasn't monitored.

- In one case reviewed, there was a misinterpretation of Departmental policy on the part of the workers that they had to do a safety plan even if the case met the criteria for a PPO. There was a subsequent review by the Department to clarify this issue.

- In another case, interactions between culture, physical environment and parenting skills may have collided to prevent making the best plan for a family.

- In one case reviewed, the response time by the Department was not in compliance with the Department's policy.

RECOMMENDATIONS

- The Panel supports the Department's initiative to provide ongoing support, supervision and mentoring for supervisors and caseworkers on shifting from incident based response to looking at the larger context and meaning of the separate incidents and the continuing behaviors. Making more clinically based supervision available on a regular basis would enhance this process.

- The Panel recommends that when there is medical uncertainty, DHHS and Law Enforcement proceed with established protocols for investigation and assessment. Continuing with different investigations provides for mutually informed yet independent data streams, which are even more important in a situation of medical uncertainty.

- The Panel recommends that greater attention be given to written communication that is humane and clear with families.

- Training and supervision must constantly emphasize that the behavior of persons while under high levels of scrutiny may be different than from their behavior when not under scrutiny. Caseworkers must learn to differentiate between eagerness for approval while under scrutiny and an ability to independently make decisions and act in the best interest of a child.

- When signs of danger are present, the risk to the child must remain the primary focus of investigation and intervention until resolved.

- The Panel recommends continuing and expanding, if possible, the internal review process that is occurring. There is evidence that reviews are timely and occur in a manner that allows staff to reflect upon their practice and improve it. It is necessary that all staff have the opportunity to benefit from these reviews.

- It is important to continually assess the safety and well-being of all children involved in the child welfare system.

- There needs to be continued internal review and discussion around safety planning and PPOs.

- It is necessary that family plans be made considering culture, environment and family, but not to the exclusion of child safety.

- Supervisors need to continue to reinforce compliance with Departmental policy.

DEPARTMENT'S RESPONSE:

The Department is in the process of revising the Child Protection Assessment policy which identifies that the process of assessment begins with the first contact with or about a family and continues throughout our involvement with the family. This policy clarifies that families have the right and responsibility to make their own decisions, as long as doing so does not result in serious harm and/or threats of serious harm to a child. When a child is abused or neglected, the law gives priority to child safety and protection. In order for protection efforts to be effective, family members must be engaged in a respectful manner in both the assessment and planning process. The family, informal and formal supports, and the community share the responsibility for child safety.

This assessment policy supports our Practice Model in that it focuses on strengths as well as needs. It focuses on assessing the signs of safety, risk and danger and their impact on child safety as well as assessing for child abuse and neglect types. This policy promotes family engagement and inclusion in a team approach to planning and intervention, with child safety first and foremost. This policy change will support greater attention to the assessment process from the supervision to worker practice.

In support of the Panel's recommendation to continue and expand the internal review process and ensure reviews are timely and occur in a manner that allows staff to reflect upon their practice and improve the department has begun a thorough process of statewide site reviews conducted in each DHHS District Child Welfare. Each office review begins with a Self-Assessment. The structure of the site review includes five teams of two reviewers each assigned two cases to review. Three local stakeholders from the mental health provider community, the legal community and court improvement project participate as review team members. Other focus groups are conducted with support staff, casework staff, supervisors and the program administrator. To be sure continued internal review and discussion around safety planning and decision-making regarding Preliminary Protection Orders occurs, supervisors will be asked to be vigilant in staff compliance with Family Team Meeting policy. This policy requires full integration of Family Team Meetings into the way we do our work. It streamlines the work for teaming - preparation and meetings – into the workflow of engagement, collaborative assessment, planning, and intervention. This policy makes clear when Family Team Meetings must be held:

- **Development of initial and subsequent Family Plan (within 35 days of Report of Child Abuse or Neglect, if family is in need of Child Protective Services)**
- **Development of initial and subsequent Child Plan**
- **Prior to the removal of a child from home or after an emergency removal prior to the 14-day hearing**
- **Before a change in case goal**
- **Prior to recommending group/residential placement**
- **Prior to a return home to parents or kinship care**

The Department Practice Model requires that family plans developed through the Family Team Meeting process be made considering culture, environment and family, but not to the exclusion of child safety.

Coordinated Investigations and Information Sharing

No one group or entity can adequately investigate all aspects of a complicated maltreatment case. The best investigations always involve cooperation between multiple entities, all of which have differing areas of focus and expertise. The outcome of cases often rests upon the ability of the investigators to understand the competencies and roles of all involved parties and to respectfully involve them in a timely manner.

CASE EXAMPLES

- In one case reviewed, an opinion was offered as to the intent of the perpetrator (culpable state of mind) in the police investigative report. This can hamper successful prosecution and negatively impact sentencing.

- In one case reviewed DHHS staff misunderstood their ability and responsibility to share information with law enforcement.

- In one case reviewed, there was no police investigation despite the fact that the case rose to the level of endangering the life of a child.

- The Panel found several cases where there was a lack of coordination between law enforcement and CPS.

- There was an absence of law enforcement and prosecutorial assessment in one case reviewed. There was little to no focus on who harmed the child. Child maltreatment does not appear to be a priority for law enforcement in the particular region cited. As a result, staff assigned feel overwhelmed and give up prematurely.

RECOMMENDATIONS

- The Panel recommends that Investigative Reports contain facts and not opinions of the investigator.

- The "Cops and Caseworker" forum for training child welfare staff, law enforcement and assistant attorneys general could cover issues of confidentiality of records and information.

- The Panel recommends that when in doubt, referrals to the DA be made. The DA can then decide if these cases rise to the level of criminal culpability.

- A general protocol for coordination, sensitive to regional strengths and differences between law enforcement and DHHS needs to be developed by DHHS.

- In cases where a particular law enforcement agency does not get involved, the DA can ask the State Police to provide assistance.

DEPARTMENT'S RESPONSE:

The Department has been active in the planning and support of the Cops and Caseworkers Conference and supports full communication and cooperation with local law enforcement and Maine State Police. A general protocol for coordination, sensitive to regional strengths and differences between law enforcement and DHHS will be developed by DHHS through collaboration between DHHS, the Office of the Attorney general and the Maine State Police.

Mandated Reporting

The protection of children is a community concern. This fact has been captured in statute. Nevertheless, misunderstandings and situational complexities sometimes result in failure to report suspected child maltreatment.

CASE EXAMPLES

- In one case reviewed, the originating hospital failed to make a mandated report, which resulted in a lack of response.

RECOMMENDATIONS

- Mandated reporters require continuing training and information about their statutory responsibility to report suspected abuse and neglect including information about the newly developed curriculum online at the DHHS website.

DEPARTMENT'S RESPONSE:

The department has begun an initiative between CAN councils and Child Protective Intake to present joint training on mandated reporting now being referred to as "Recognizing and Responding to Stress in Families." The revised Performance Criteria for the CAN Councils relates significantly to interface with the DHHS Districts – specifically through the Future Search Committees and through the above training. DHHS has made a commitment (*especially in the more distant areas)* to have a DHHS presence at these trainings. *(Intake staff have coordinated with the CAN councils to have intake representatives at trainings, but they are not able to travel to all locals.)*

As the DHHS website is redesigned, we will consider more emphasis on the prominence of the training component.

Resources and Referrals

The success of the Department in helping families develop and sustain the ability to nurture and protect their children is often dependent upon the availability, accessibility, and timeliness of the multiple services that they require. Problems in these areas add another barrier.

CASE EXAMPLES

- In one case reviewed, the mother was receiving complicated and distressing medical information and left with few resources or referrals.

- In another case reviewed, the child was seen by many providers who might have identified problems in the child's environment by virtue of the child's unusual level of overactivity. If providers had known to refer to appropriate assessment and treatment services, based upon the children's strikingly unmanageable behavior, further issues may have been prevented.

- In one case reviewed, obtaining appropriate timely services was problematic due to confusion between the Department and the providers regarding payment.

- In one case reviewed, there were many questions about why deplorable living conditions continued despite observation by family and community.

RECOMMENDATIONS

- In situations where there are complex medical situations, a referral to the Coordinated Care Program for Children with Special Health Needs would be helpful.

- The Panel recommends that DHHS, Maine Center for Disease Control and the Division of Early Childhood consider expanding current educational efforts to include some groups of children for healthcare and educational providers that would describe normal activity as opposed to over activity for small children and offer referral resources.

- The Panel recommends that difficulties with identifying payer sources for necessary providers be reviewed and problem-solved at the joint regional/central office level.

- Communities need to understand the meaning of the greater significance of a family with children living in squalor and the danger that it reflects.

DEPARTMENT'S RESPONSE:

The Department, in order to adequately and appropriately identify the presence of symptoms that interfere with healthy development and effectively address the emotional and behavioral health needs of children who come to the attention of child welfare, need an empirically-based method of screening children involved in the child welfare system. Child welfare workers must have the mechanism to provide universal screening through an instrument that has sound psychometric properties and can be utilized in the field with

fidelity, cultural competence, and respect to client rights, but also without undue caseworker burden.

A review of the literature conducted by the Department of Health and Human Services revealed that, although such a screening instrument has not been validated in the child welfare system, the Pediatric Symptom Checklist (PSC), which was originally developed for use in busy pediatrician or other primary care offices, is an appropriate screening tool. The PSC is a psychosocial screening instrument that facilitates identifying cognitive, emotional and behavioral difficulties. By identifying such challenges, appropriate interventions can be identified and initiated as early as possible in order to affect the best outcomes. The PSC was developed at Massachusetts General Hospital and validated through numerous studies, including studies with samples that would include children and families involved with child welfare agencies, such as patients of pediatricians. Based upon this literature review, DHHS selected the PSC as a well validated screening instrument that is suitable for children and families deemed appropriate for services within the Division of Child Welfare. This tool will be used statewide beginning Nov. 2007.

Risk Assessments

The Panel agrees that the development of an adequate understanding of a family's situation and the determination of steps necessary to keep children safe are dependent upon a well-focused, thorough risk assessment.

CASE EXAMPLES

- The current statute limits the Department's ability to conduct a thorough assessment immediately following the death of a child when there are no surviving children.

- An understanding of law enforcement's assessment is important, but not sufficient when formulating the approach to the child protective assessment.

- In one case reviewed, the assessment of the mother's functioning insufficiently took into consideration her functioning with her previous child. There was a failure to distinguish between immediate safety concerns and long-term risks.

- In another case reviewed, there was no adequate police investigation or child protection assessment. There was enough information to warrant a thorough evaluation. The law enforcement agency used a tool (statement validity analysis) of unproven reliability and misinterpreted the medical findings as not abuse when clearly they were.

- In one case reviewed, the Family Assessment through the Community Intervention Program (CIP) was inadequately focused. The CIP program provided a family assessment appropriate to children's mental health, but missing critical and very basic elements required for assessing a family's capacity to adequately care for, protect and

nurture their children. As a result, they were not able to develop a service plan that addressed the salient issues.

- Reviews of cases involving probable inflicted illness highlighted the difficulty treatment teams experience in determining what is happening and how most effectively to intervene.

RECOMMENDATIONS

- The Panel recommends review of this statute and the consideration of law and policy revisions.

- The Department and Law Enforcement would benefit from conduct joint training on sharing and interpreting information.

- The Panel recommends the development of a policy for situations when there is a death or a serious injury, the Department would conduct a comprehensive risk analysis of the other partner's role and responsibility, as opposed to a short-term safety assessment only.

- The Panel recommends that established collaborative relationships and training about medical and investigative techniques take place on a regular basis.

- The Panel recommends that established policies and procedures be followed in every case.

- The Panel recommends that the CIP agencies be required by contract to provide assessments, recommendations, and treatment covering the salient issues that meaningfully relate to a family's ability to care for, protect, and nurture their children. One possible resource for the CIP agencies might be the training capacity of the Child Abuse and Neglect Evaluators program revised to accommodate the needs of the level of care provided by the CIPs. Another option would be to identify and require the level of competence required in the writing and granting of the RFPs for these services.

- The Panel recommends continuing to reinforce the idea that failure to determine the specific cause of risk still means the child is at risk.

- Physicians and health care providers need to be more attuned to patterns and presentations that are suggestive or consistent with factitious illness.

- Training regarding factitious illness should include reminders that induced factitious disorder can be rapidly and unexpectedly lethal.

DEPARTMENT'S RESPONSE:

The department has proposed legislation for the January 2008 legislative session to expand the Department's ability to conduct a thorough assessment immediately following the death of a child when there are no surviving children. The department has been working closely with law enforcement in several venues, such as the Cops and Caseworker Conference, where there will be a joint presentation by MSP, Medical Examiner's office and DHHS, through joint participation on CAAN and through mutual participation in the development of the Citizen Review Panel. Additional efforts to develop collaborative training about medical and investigative techniques will be explored. Changes to policy for situations when there is a death or a serious injury to support a comprehensive risk analysis of the other partner's role and responsibility are included in the newly revised Child Protection Assessment policy that will be finalized by the end of 2007. The department has developed a more comprehensive system of oversight of CIP agencies and includes the expectation that department guidelines in policy are part of the expectations of the CIP. Joint meetings with the CIP providers has lead to more through follow through with those department expectations.

The Department has revised its internal Child Death and Serious Injury Protocol so that in each case that was a result of maltreatment, a district review is conducted, facilitated by the Program Administrator and District Operations Manager within 45 days of the injury/death. This has lead to better recognition where policy has not been followed and clarified for staff that even though no party is taking responsibility for the maltreatment or the specific cause is not discernable, risk may be even more in need of accurate assessment. The department is very open to working with the medical community to address training needs related to factitious illness concerns.

Kinship Assessments

CASE EXAMPLE

- In one case reviewed by the Panel, the kinship study was cursory and did not provide a level of detail that allowed for adequate safety and permanency planning.

RECOMMENDATIONS

- It is important that staff providing kinship studies be familiar with the formatted structure and purpose of the parental capacity assessments. At a minimum, they need a clear picture of the critical elements required in order to provide safe and adequate parenting for a child.
- Staff providing these assessments would benefit from training in conducting assessments designed to incorporate and make sense of conflicting information.
- The assessment of a potential kinship placement would be strengthened by careful assessment, sensitive to the licensing standards of foster placements

DEPARTMENT'S RESPONSE:

The department has strengthened its "Relative Placement and Kinship Care Policy" to support staff in developing a clear picture of the critical elements required in order to provide safe and adequate parenting for a child.

The Department firmly believes that whenever possible children need to be placed with relatives or with someone with whom they have a significant bond or connection. Determining who constitutes family is a critical component of our work. It is a fluid process. It needs to begin from the moment that we first interact with a family, and then be assessed, examined, and reexamined throughout the life of the case.

Even when we have not made the decision to remove children from the home, we have a responsibility to establish family and community connections. Strong and nurturing relationships can often provide the necessary supports that enable families to remain together and prevent the need for separation and removal. We partner with children and families early on, to develop the best possible child-driven, family-focused, and culturally-sensitive plan for the child(ren).

The department recognizes that some families have significant problems related to child abuse, substance abuse, and domestic violence. In some instances, there may be impaired relationships between the potential caregivers and their own children. Children should not be placed where these circumstances presently exist and the past existence of such dynamics are assessed to determine the relatives' ability to provide for the safety and well being of the child.

Staff are required to refer the family for a full and comprehensive home study as soon as possible after a initial kinship study has been completed to ensure immediate safety.

Failure-to-Thrive as an indicator of Medical Neglect

Failure to thrive in the context of medical neglect is a serious pediatric health problem with often profound long term adverse developmental effects. Primary care providers play an important role in early identification and aggressive intervention including when indicated seeking involvement of the Department of Health and Human Services. DHHS worker likewise should have ongoing education on the seriousness of FTT and on its assessment and intervention. Recently the panel co-chair Lawrence Ricci has noted much improved early identification and intervention from the DHHS caseworkers.

CASE EXAMPLE

- In one case reviewed, there was a significant missed opportunity by the primary care physician, between 8 and 16 months of age, to intervene aggressively.
- In this same case, the Department missed an opportunity to intervene with a petition for a child protection order when the parents refused hospitalization and to comply with the child protective assessment.

- In this case, the Department did not obtain the birth records and the records from the first two pediatric appointments.

RECOMMENDATIONS

- When non-organic failure-to thrive is suspected, a protocol, such as that of the American Academy of Pediatrics must be followed, including assessment by a multi-disciplinary team including pediatric nutritionist and when indicated a child abuse pediatrician.

- When failure-to-thrive is suspected, it is important that the case not be closed until the cause is determined and any necessary interventions established.

- When failure-to-thrive is suspected, in home services, including public health nursing, knowledgeable and skilled in FTT intervention, would be beneficial.

- It is important that the focus of a failure-to-thrive case remain on signs of danger and medical data, not on parental explanations.

- Detailed growth charts that determine to what extent a child is failing to grow at a normal rate are critical in failure-to-thrive cases.

DEPARTMENT'S RESPONSE:

The Department is committed to developing policies that clarify protocols and procedures where high-risk infants are involved, including those with non-organic failure to thrive. Partnering with our Early Childhood Division and with our medical partners will occur to develop a protocol, such as that of the American Academy of Pediatrics that will include assessment by a multi-disciplinary team including pediatric nutritionist and when indicated a child abuse pediatrician.

Guardians-ad-litem

CASE EXAMPLE

- In one case reviewed, the Guardian-ad-litem went beyond her competence in providing an unqualified medical opinion.

RECOMMENDATIONS

- The AAG has the option of objecting to and/or refuting an unqualified opinion.
- The Panel supports the Family Division of the Court's development of a meaningful and effective mechanism for the review and supervision of Guardians-ad-litem.

DEPARTMENT'S RESPONSE:

The Department supports the efforts on behalf of the Family Division oversight of Guardians ad litem. The department has revised policy relating to the roles and responsibilities of Guardians ad litem. Relevant changes are underlined:

a. **Guardian ad litems must meet the qualifications established by the Supreme Judicial Court.**

b. **The guardian ad litem shall be given access to all reports and records relevant to the case. In general the guardian ad litem shall ~~represent~~ act in pursuit of the best interest of the child. S/He will investigate to ascertain the facts, including:**

   (l) Reviewing relevant mental health, medical, school or other records/materials regarding the child, parents, or other persons having or seeking care or custody of the child;

   (2) Interviewing the child with or without other persons present;

   (3) Interviewing parents and other persons involved with the child;

   (4) Subpoenaing, examining and cross-examining witnesses;

   (5) Making a report and recommendations to the court with a copy to |each party.

   (6) The GAL shall have face-to-face contact with the child in the child's home or foster parent home within seven (7) days of appointment by the court and at least once every three (3) months thereafter.

c. **The GAL is responsible for acting in pursuit of the best interest of the child and reporting to the court his or her objective and informed findings. Staff should include the GAL in as much of the process of the case as possible, inviting the GAL to Family Team Meetings (FTM) and other relevant group decision making processes. Clear and factual information about the child is to be provided to the GAL in a timely manner.**

d. **The GAL role is expected to extend to advocacy for the best interest of the child and may include recommendations on placement, visits, services and educational needs. Staff should be considering these recommendations in case planning.**

e. **Staff should support regular contact with the child, informing the child of the initial visit.**

f. **Prior to changes in placement, the caseworker should consult with the GAL wherever possible. The GAL must be informed of any changes in the child's placement within two (2) working days. Both the caseworker and GAL should discuss the extent to which the child will be involved in the court process (present at court, meeting judge.)**

g. **GAL has the authority to ask questions of witnesses in the hearing and offer recommendations at the hearing.**

The Department believes this clarity will support improvements.

Emergency Room Procedures

CASE EXAMPLES

- In one case, the initial ER doctor discharged the patient home and reached conclusions about his safety without gathering or looking at evidence.

- In this same case, there was a loss of information when the emergency duty worker handed the case over to the child protective caseworker. Important information and the attendant analysis of that information were lost.

- In another case, the child was dressed at the hospital after death.

RECOMMENDATION

- The Panel recommends that DHHS consider facilitating a meeting of one of their medical consultants who is a child abuse specialist and the administration of this hospital, in order to discuss what appears to be a pattern of practice.

- The office in question has changed the process by which emergencies are managed. It is evident that they are aware that the information was lost and have taken steps to prevent this from happening in the future. The Panel supports this outcome of their review of this matter.

- The Panel recommends that there be a standard emergency room protocol about dressing/cleaning an infant after death.

DEPARTMENT'S RESPONSE:

The Department will work closely with our medical consultants to clarify hospital practice in general and to develop a standard emergency room protocol about dressing/cleaning an infant after death.

Infant Deaths, SIDS and Co-sleeping

Co-sleeping as a cause of infant death is a pressing public health problem. Education of families about co-sleeping risks is virtually non-existent in Maine. Urgently required is leadership from the child welfare system in Maine to both identify how often babies die when co-sleeping and how to educate families about the risk.

CASE EXAMPLES

- In one case of an infant death, DHHS was not notified even though there was another child in the home.

- In this same case, the focus was on SIDS to the exclusion of other risk factors, including co-sleeping, that should have been addressed.

RECOMMENDATIONS

- There is already a policy in place that DHHS always be notified of an infant death when there are other children in the home.
- The Panel recommends that safe sleeping practices be discussed with families.
- In the case of unexplained infant death, it is prudent to consider rule-out homicide.

DEPARTMENT'S RESPONSE:

The Department supports a campaign of informing parents and other caregivers of safe sleeping methods. As soon as available the department will promote the *Safe Sleeping For My Baby* Brochure by providing it to families accompanied by discussion and having it available in office lobbies. The Department will consider the development of a power point presentation that follows the brochure guidelines.

Adverse Childhood Experiences

CASE EXAMPLES

- In most cases reviewed, the parent(s) had a number of experiences that would have triggered a screening for adverse childhood experiences (ACE).

RECOMMENDATIONS

- The Panel recommends consideration of a caregiver's history and possible screening for ACEs. This may prompt earlier referrals.
- The Panel recommends additional training in professional communities about the significance of ACEs take place.

DEPARTMENT'S RESPONSE:

The Department's revisions to the Child Protection Assessment policy place emphasis on gathering historical information on caregivers to allow for more thorough assessment of the number and type of experiences that indicate responses related to adverse childhood experiences. The department clearly recognizes the established link between childhood traumas and adult health and mental health risks and outcomes and is closely watching

evolving evidence of what factors in a child, caretakers, or the community protect the child and reduce the risk of harmful outcomes of stress or trauma.

Abusive Serious Injury and Death Surveillance

The Panel reviews approximately 10 cases of serious injury and death each year. Most are preventable deaths. The Panel would like to recommend that the CDSIR Panel, the Medical Examiner's Office, DHHS and others gather together to develop a systematic injury surveillance system.

DEPARTMENT'S RESPONSE:

The Department has developed a database to track all serious injury and death cases that are reported to us. This data base will be utilized by the CDSI Review Panel to do a more systematic approach to identifying all serious injuries and deaths, whether identified as a result of maltreatment or not.

THANKS

We want to thank the Panel for its recommendations which support learning as we increase our efforts to reinforce and carefully monitor safety of the child as our primary responsibility We will continue our efforts to assist the parent in resuming the parental role and make every effort to help facilitate the development of healthy and safe relationships amongst the child, parents, and others in their extended family and community support system and make assurances that each child has a safe, nurturing permanent connection.

Table 1
Number of Child Deaths by County 2006

Androscoggin: 10	Hancock: 1	Oxford: 9	Somerset: 2
Aroostook: 8	Kennebec: 2	Penobscot: 18	Waldo: 1
Cumberland: 18	Knox: 4	Piscataquis: 2	Washington: 2
Franklin: 0	Lincoln: 1	Sagadahoc: 1	York: 8

TOTAL = 78 **UNDETERMINED: 1**

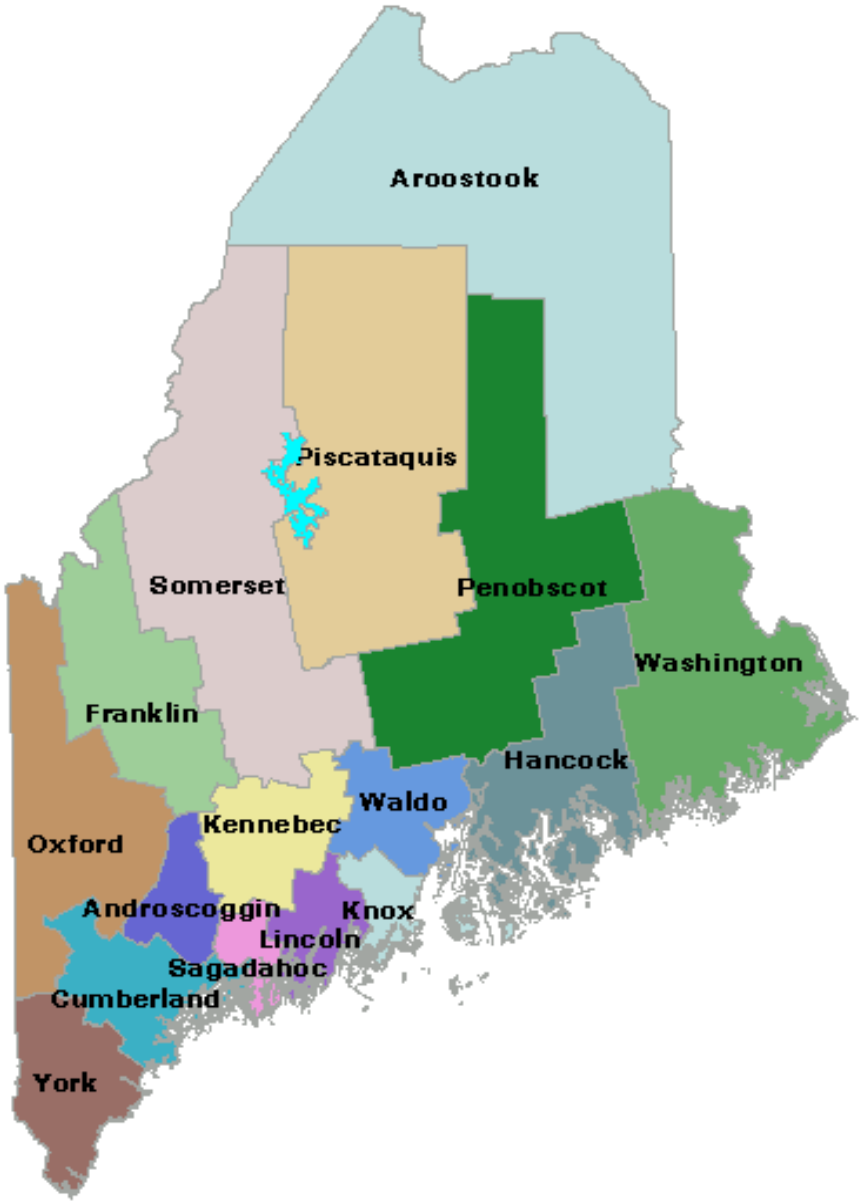


Table 2
Manner of Deaths of Maine Children 2006

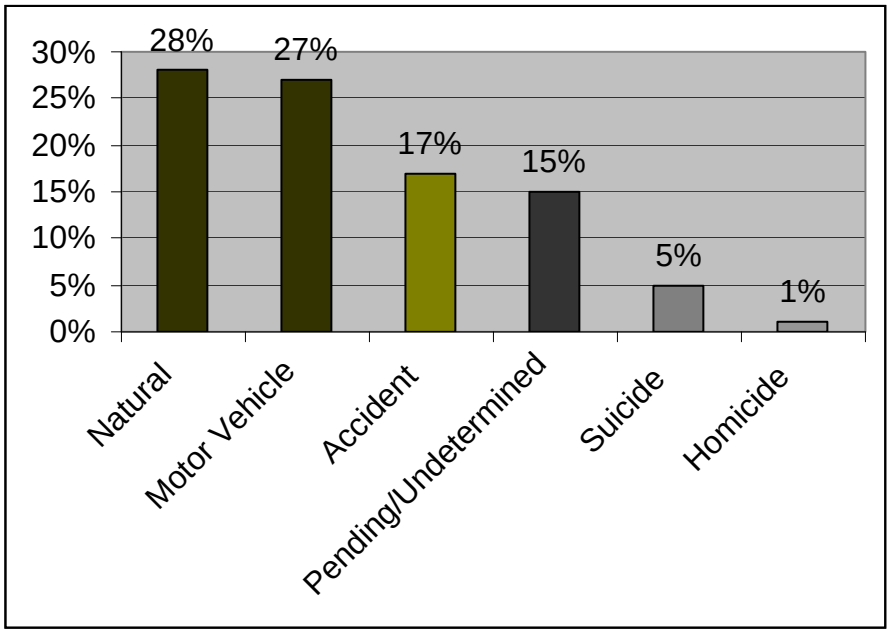


Table 3
Causes of Deaths and Serious Injuries in Cases Reviewed 2006

Deaths

Victim Age	Cause of Injury	Perpetrator's Relation to Victim	Perpetrator Age
5 weeks	Unknown SIDs	N/A	—
3.5 months	Cardiac arrest	N/A	—
2 years	Homicide – Blunt Abdominal Injuries	Mother's male partner	26

Serious Injuries

Victim Age	Injury	Perpetrator's Relation to Victim	Perpetrator Age
3 months	Shaking	Father	26
8 months	Failure to Thrive	Mother	38
14 months	Bilateral Subdural Hematoma	Unknown	___
14 months	Fractured femur & tibia	Unknown	___
3.5 years	Head injury	Mother's male partner	21

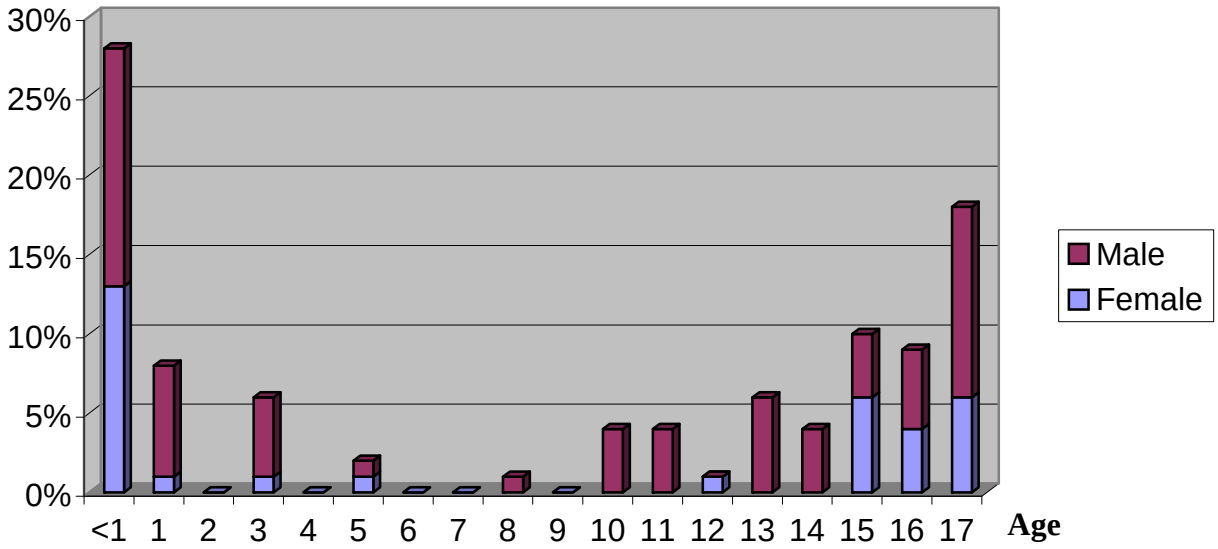
The Panel reviewed 8 new cases in 2006. In 63% of the cases, the event, which caused a serious injury or death, was witnessed by at least one person. Of these cases 3 were inflicted injuries. The Panel determined that 50% of the time the injuries or deaths could have been prevented.

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

Total Deaths in 2006

78 child deaths were reported to the State of Maine Office of the Chief Medical Examiner in 2006. 28% of these children were under the age of one, and 18% were 17 years of age. 44% of the deaths were the result of accidents including motor vehicle accidents and drowning; while 4% were homicides. 63% of the children were male. More deaths occurred in Cumberland County than any other region; followed by Androscoggin.

Table 4
Child Deaths by Age and Sex 2006



*Note: percentage do not equal 100% due to rounding to nearest number

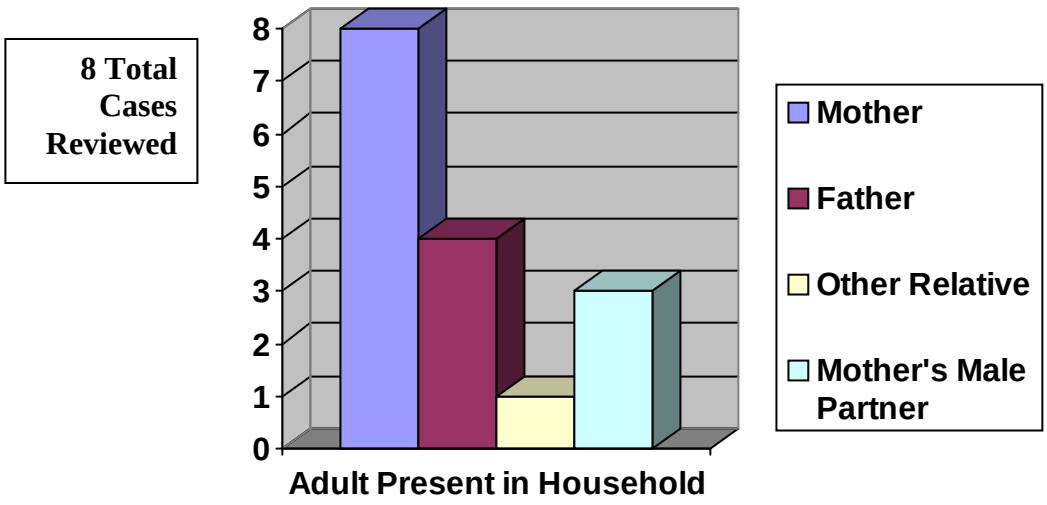
Case Demographics: Cases Reviewed by the Maine Child Death and Serious Injury Review Panel 2006

In 2006, the Maine Child Death and Serious Injury Review Panel reviewed nine cases. One was re-review from several years ago, so will not be included in this data. 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 5 weeks to 3 ½ years. Five of the cases, or sixty-three percent focused on female children. All but one of the children from the cases that the Panel reviewed lived in homes with two caregivers. In half of the cases the caregivers were the biological mother and father. In 100 of the cases reviewed, children lived with their biological mothers; 50% of the time, children lived with their biological fathers. Three children resided with their mother's male partners. In one case reviewed, there were other non-related persons residing with their family. In half of the cases, one or more siblings were living in the home.

Table 5
Members of Household in Cases Reviewed 2006

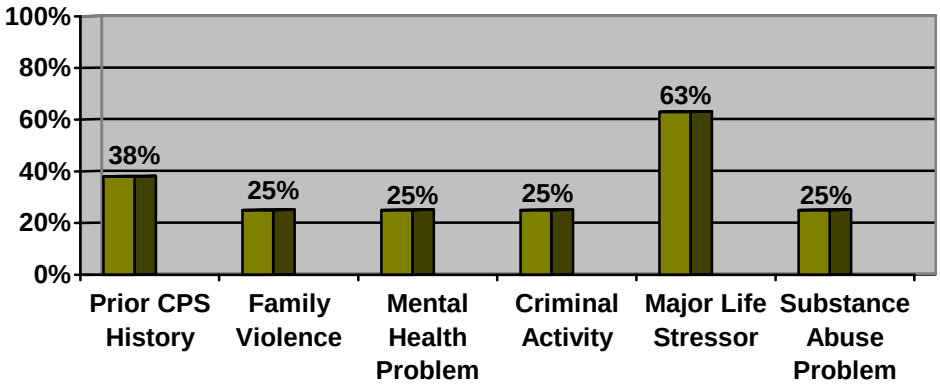


There was an average of 3.5 people living in the households of cases that the Panel reviewed. In 4 cases, there were other children living in the home. The average age of these children was 2 years. The average age of caregivers in the cases that were reviewed was 27 years. The caregivers who held legal custody of the children were most often not married (5 cases). Married parents were 3 cases of those reviewed. Only one of these was living with their spouse.

Parental Risk Factors

Some of the caregivers in the cases that were reviewed presented with more than one significant risk factor as noted below. Thirty-eight percent of the cases had prior histories or open cases with child protective services. Two of the cases had a history of, or a current problem with violence, substance abuse, mental health problems or criminal activity in the household 63% had experienced a major life stressor within the twelve months prior to the child's death or serious injury.

Table 6
Risk Factors 2005



The 2006 Report

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**

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The Department of 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 2,401 Appropriate reports which were assigned to a Contract Agency.**

There were 6,234 reports involving 12,101 children assigned to a caseworker for a Child Protective Assessment.

New Reports Assigned for Assessment

Families		Children involved by age group				
Office	**Reports**	**0-4**	**5-8**	**9-12**	**13-15**	**16-17**
Portland	888	641	417	325	224	123
Sanford	285	205	134	107	80	52
Biddeford	603	394	256	211	167	84
Lewiston	945	724	497	389	269	108
Augusta	779	616	323	280	193	100
Rockland	611	482	305	225	164	72
Skowhegan	335	243	148	107	87	48
Bangor	877	724	335	250	178	74
Ellsworth	190	129	67	61	46	22
Machias	181	130	62	50	51	20
Houlton	149	121	78	50	34	15
Caribou/FK	368	283	170	136	126	46
Central	23	19	9	11	3	1
Statewide	6234	4711	2801	2202	1622	765

Source of Reports Assigned for Assessment

School Personnel	1029
Social Services Personnel	781
Law Enforcement Personnel	828
Medical Personnel	607
Anonymous	518
Neighbor/Friend	358
Relative	522
Other	445
Mental Health Personnel	558
Self/Family	498
Child Care Personnel	90

Household Type/Living Arrangement of Reports Assigned for Assessment

Two Parent Married	1531
Two Parent Unmarried	1351
One Parent Female	2495
One Parent Male	391
Adoptive Home	22
Relative	216
Non Relative	32
Other	156
Shelter/Facility	230
Unknown	10

Family Stress Factors Identified During Assessment

Family Violence	1122
Alcohol/Drug Misuse by Parent/Caretaker	1833
Mental/Physical Health Problem	3058
Severe Parent/Child Conflict	810
Severe Acting Out Behavior of Child	704
School Problems	751
Divorce Conflict	660
Emotionally Disturbed Child	514
Runaway	112
Alcohol/Drug Misuse by Child	168
Failure To Thrive Child	26

Completed Assessments

Office	Completed	Child Abuse/Neglect Found	Unsubstantiated	Findings Rate
Portland	899	362	537	40%
Sanford	291	96	195	33%
Biddeford	600	197	403	33%
Lewiston	956	346	610	36%
Augusta	784	235	549	30%
Rockland	603	198	405	33%
Skowhegan	337	152	185	45%
Bangor	889	384	505	43%
Ellsworth	196	111	85	57%
Machias	179	83	96	46%
Houlton	194	54	140	28%
Caribou	287	108	179	38%
Fort Kent	48	27	21	56%
Institutional Abuse	199	9	190	05%
CPS Total	6462	2362	4100	37%

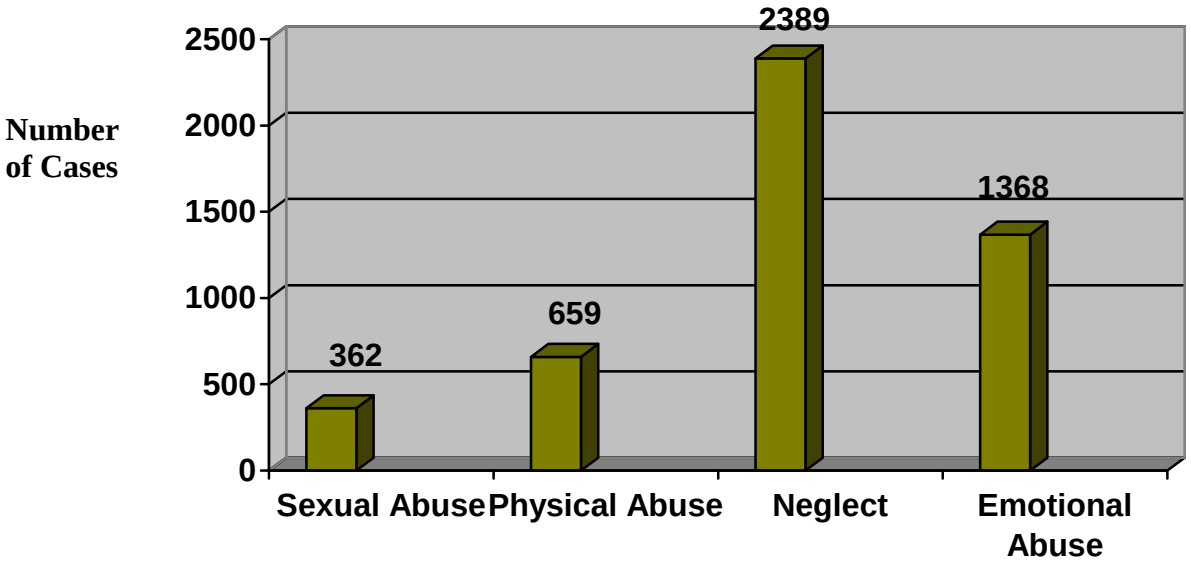
Data compiled on for Assessments begun during calendar year.

Child Abuse & Neglect Victims by Age and Sex

Male	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
0-4	41	151	616	218
5-8	33	86	263	193
9-12	29	64	181	162
13-15	13	43	112	101
16-17	4	12	44	25
Total	120	356	1216	699

Female	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
0-4	49	106	557	187
5-8	57	70	235	145
9-12	50	51	175	159
13-15	65	56	157	139
16-17	21	20	49	39
Total	242	303	1173	669

Table 8
Department of Health and Human Services
Types of Substantiated Cases of Child Maltreatment



“What’s done to children, they will do to society.”
-Karl Menninger

A special thanks for all the
hours that Volunteers Panel members
commit to making this
report a reality.