

MAINE STATE LEGISLATURE

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Report of the Maine Child Death and Serious Injury Review Panel



The Maine Child Death and Serious Injury Review Panel 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.



*Department of Health
and Human Services*

*Maine People Living
Safe, Healthy and Productive Lives*

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

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.

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“Children are among the most vulnerable members of society. This susceptibility can be further increased by biological factors, such as a genetic predisposition or disability, and by extrinsic factors in their physical or social environment and in the care provided to them.”¹⁶

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“Fatal child abuse may involve repeated abuse over a period of time (e.g., battered child syndrome), or it may involve a single, impulsive incident (e.g., drowning, suffocating, or shaking a baby). In cases of fatal neglect, the child’s death results not from anything the caregiver does, but from a caregiver’s failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns after being left unsupervised in the bathtub). ”¹

¹US Department of Health and Human Services Administration for Children, Youth and Families. (2009, April). Retrieved June 23, 2010, from Child Abuse and Neglect, Fatalities: Statistics and Interventions: www.childwelfare.gov

LETTER FROM THE CO-CHAIRS

January 20, 2015

To the Honorable Governor Paul LePage;

The Maine Child Death and Serious Injury Review Panel is a multidisciplinary team of professionals established by state law in 1992 to review child deaths and serious injuries with a focus on improving our systems of child safety and care. We meet monthly to review cases evaluating sentinel events, patterns of injury and/or death and the effectiveness of our state programs that provide for child protection, safety and care. Through the Panel's findings and recommendations we hope to help reduce the number of preventable child fatalities and serious injuries in our 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.

Additionally, the Panel meets annually with the Child Fatality Review Teams from all of New England to share experience, information and review cases that involve services from more than one state or which represent a challenge that all of our States are trying to address.

The challenges leading to case reviews from 2010 to 2013 to help improve the system of care include:

- The rate of home birth is increasing and there is evidence suggesting that home birth is not as safe in Maine as it is in other countries. Our task was to assess the safety of home birth in Maine compared to hospital based deliveries and identify ways to strengthen care for families choosing home birth in our state. The Maine Legislature has determined that birth is a natural, not a medical process, but Maine needs to develop a definition of medical practice and to define when a birth is so complicated that it rises to a level requiring medical practice. The Maine Medical Association and Maine's home birth midwives need to work together to develop systems that will improve the selection of low risk deliveries for home birth and develop a strategy that will enable a smooth transfer of care from home birth midwives to hospital care when needed. Maine families should not feel that they are being punished for choosing home birth.
- The rise of infants exposed to drugs in utero. Our task was to review specific cases in Maine, consider risk of death and disability in this group, and recommend improvements in care for these infants. These babies are known to have immature breathing patterns, which may put them at risk for unexpected infant death, and are at higher risk for developmental delay than other babies born in Maine. Professionals working in systems providing care for adults in treatment for substance abuse need to understand and consider the fragility of the infants in the care of their clients.
- Along with a rise in babies exposed to narcotics and other drugs in utero, we have seen a dramatic increase in drug ingestions in children in Maine. The problem of drug ingestions is not isolated to our state. Our poison control center serves to support Vermont and New Hampshire as well as Maine and they have documented similar poisoning, whether intentional or unintentional in children throughout Northern New England. The leading medications involved in such poisonings are psychotropic

prescribed for adults or older children, but also include medical marijuana, methadone and buprenorphine.

- Over the last 4 years we reviewed many cases where a child presented to a mandated reporter with bruises and other injuries that turned out to be inflicted and which should have resulted in a report to the Department of Health and Human Services because of concerns over child abuse. At times, the mandated reporter was quoted as saying that the injuries could not have been intentional because the caregiver, whether parent or other guardian was so nurturing and attentive to the child's needs. Our current mandated reporter laws specify the importance of suspecting that a child has been abused before making a report. The vague nature of suspicion has led to many unnecessary reports to the Department and provides a barrier in cases where a report should be made. Also, current mandated reporter laws do not go far enough to protect individuals from legal attack when they do make a good faith report.
- In order to accurately identify trends, surveillance of serious injury and death in children 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 with DHHS, it must include law enforcement, the medical examiner's office and others.
- 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 shared couch sleeping. Maine needs to develop a coordinated education program for parents on safe sleeping. Babies born prematurely and infants exposed to drugs in utero are at much higher risk of dying suddenly and unexpectedly when sharing a sleep surface with an adult or other child. The American Academy of Pediatrics has issued clear guidelines for safe sleeping that should be implemented in the state. 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.

Some of their recommendations include:

- 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

Additionally, we report on the activities of the abusive head trauma prevention workgroup, organized under the Maine Children's Trust, through whose efforts the evidence based "Shaken Baby" prevention program was implemented in every birth hospital in the state. These efforts were spawned after a past review of the CDSIRP.

The Panel has become acutely aware of the lack of parenting skill and knowledge among the young adults whose choices result in serious injury or the death of their child. We recognize that parent training is a cultural responsibility, best left to the parents and extended family. Unfortunately, in too many instances we review cases of child death and injury that have generations of abuse and neglect. We must act to break this cycle and the panel recommends implementing an evidenced based program such as Triple P for parents involved in the child welfare system, especially those with histories of generations of abuse.

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 2010-2013 Child Death Serious Injury Report to the Honorable Paul LePage, Governor of the State of Maine.

On behalf of the Maine DHHS Child Death and Serious Injury Review Panel,

Stephen J Meister, M.D.
Co-Chair

Karen K Mosher PhD
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MISSION AND PURPOSE

The mission of the Child Death and Serious Injury Review 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 to both professionals and the general public. Furthermore, the panel strives to collect facts and to provide opinion and articulate them in a fashion that promotes change. The final mission of the Panel is to serve as a citizen review panel for the Department of Human Services as required by the federal Child Abuse Prevention and Treatment Act, P.L. 93-247.

The Child Death and Serious Injury Review Panel follows the review protocol below to meet the purpose defined by 22 MRSA, Chapter 1071, Subsection 4004, the panel is to recommend to state and local agencies methods of improving the child protective system, including modifications of statutes, rules, policies and procedures.

1. The Panel will conduct reviews of cases of children up to age eighteen, who were suspected to have suffered fatal child abuse and/or neglect or to have suffered serious injury resulting from child abuse/neglect.
2. The Panel will conduct comprehensive, multidisciplinary reviews of any specific case that can be initiated by the Office of Child and Family Services, by the Commissioner of the Department of Human Services or by any member of the multidisciplinary review panel.
3. The Panel will receive a monthly report from the Medical Examiner's Office that includes child deaths in the preceding month.
4. All relevant case materials will be accumulated by the Department of 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 summary report of its findings and recommendations to the Commissioner of the Department of Human Services.
6. The review panel may develop, in consultation with the Commissioner of the Department of Human Services, periodic reports on child fatalities and major injuries, which are consistent with state and federal confidentiality requirements.

The Maine Child Death and Serious Injury Review Panel (CDSIRP), is comprised of representatives from many different disciplines. Its membership, which is mandated by state law, shall include the following disciplines; the Chief Medical Examiner, a pediatrician, a public health nurse, forensic and community mental health clinicians, law enforcement officers, departmental child welfare staff, district attorneys and criminal or civil assistant attorneys general.



MALTREATMENT

Physical Abuse, Citation: Ann. Stat. Tit. 22, § 4002

'Abuse or neglect' means 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, or failure to ensure compliance with school attendance requirements under Title 20-A, § 3272(2)(B), or § 5051-A(1)(C), by a person responsible for the child.

'Jeopardy to health or welfare' or 'jeopardy' means serious abuse or neglect, as evidenced by serious harm or threat of serious harm.

'Serious harm' means serious injury. 'Serious injury' means serious physical injury or impairment.

Neglect, Citation: Ann. Stat. Tit. 22, § 4002

'Abuse or neglect' means a threat to a child's health or welfare by deprivation of essential needs or lack of protection by a person responsible for the child.

'Jeopardy to health or welfare' or 'jeopardy' means serious abuse or neglect as evidenced by:

- Deprivation of adequate food, clothing, shelter, supervision, care, or education when the child is at least age 7 and has not completed grade 6
- Deprivation of necessary health care when the deprivation places the child in danger of serious harm
- Abandonment of the child or absence of any person responsible for the child that creates a threat of serious harm
- The end of voluntary placement, when the imminent return of the child to his or her custodian causes a threat of serious harm

Persons Responsible for the Child, Citation: Ann. Stat. Tit. 22, § 4002

The term 'parent' means a natural or adoptive parent, unless parental rights have been terminated.

A 'person responsible for the child' means a person with responsibility for a child's health or welfare, whether in the child's home or another home or facility that, as part of its function, provides for care of the child. This includes the child's custodian.

UNIQUE FUNCTIONS

Some states have multiple local review panels in addition to a central state-level panel. In such circumstances only selected cases are reviewed by the state-level team. Because the state of Maine is less populous than other states, all cases are reviewed by the full, central, state-level team. The centralized forensic medical examiner system and representation on the panel promotes standardized forensic child death investigations and post mortem exams and the State of Maine has specialized medical examiner training for child death investigation units of law enforcement. The Panel is established by a state statute that permits confidentiality of Panel's work and grants the Panel with 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.

The Maine Child Death and Serious Injury Review Panel(CDSIRP) belongs to the consortium of Northern New England Child Fatality Review Teams and works closely with the National Center on Child Death Review. Our work and methods conform to the standards of our companion States. A team of Maine panel representatives have both participated in and presented at each of the past fifteen annual Northern New England Child Fatality Review Team Meetings.



"Intervening effectively in the lives of children and families who are affected by child abuse and neglect is not the sole responsibility of any single agency or professional group, but rather a collective community concern" ⁽¹⁷⁾

ACTIVITIES

When children die or are seriously injured as a result of a caregiver's abuse and/or neglect it is an extremely saddening event. In communities with small populations like Maine, such events may seem rare and unpreventable. Nevertheless, it has been shown that when a community takes a public health approach and tracks the patterns of serious injuries and deaths of children over time they are able to identify risk factors, to help create informed policies, which result in improved outcomes for children, families, victims, and communities.

Our group has been meeting for many years and has provided useful information for many stakeholders, and just like prior years the activities over the past four years have been equally useful in producing meaningful recommendations and special contributions. The next few paragraphs describe and highlight some of this work.

The discussion on mandatory reporting resulted in the suggestion that each district have a "go to" person that providers could work with in order to aid their decision to report or not to report. Failure to report, false reports, level of suspicion, definition of suspicion, family and provider relationships, licensing, and level of understanding of when to report were all topics that raised emotions. The safety, health, and well-being of the child/children involved should always remain the focus of reporting. The mysteries of what providers perceive reporting means to the family (they will be torn apart) and the notion that the child welfare system functions as a negative force must be rejected. Better understanding, communication and collaboration of all stakeholders are required when it comes to mandatory reporting and ending child abuse and neglect.

Tracking of data, incorporating the use of a case reporting tool; the National Child Death Review Case Reporting System (NCDR-CRS) is a case reporting instrument that provides standardized data elements and data definitions for the purposes of analyzing and reporting information on child deaths and injuries over time. The first cases were entered into the Reporting System beginning in January 2010. Unfortunately, because of staffing challenges, which included turnover in support to the panel, we were unable to maintain this effort into 2011-2013. We are extremely hopeful that we will be able to take advantage of the National Center's database to help manage our data as we go forward.

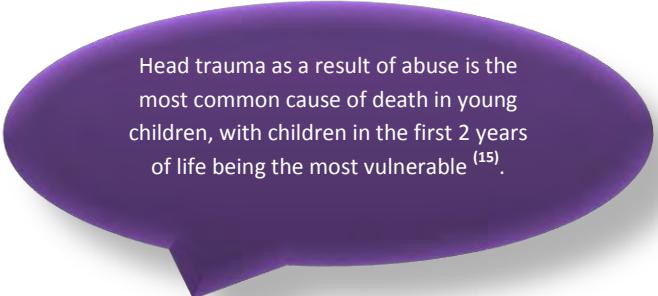
It was recommended that caseworkers should go out and do an assessment whenever there is a child death and they should be going out in conjunction with law enforcement. An example was given of a child coming into an Emergency Department and only the police being notified. If the role of the Office of Child and Family Services (OCFS) is to investigate child deaths and serious injuries, then the current process needs to be addressed. It was recognized that there would be difficulty for the caseworker doing an assessment after the police investigation, because it would cause additional emotional challenges for the family. Along the same line, concern was expressed that child deaths and serious injuries are not consistently being reported to OCFS. It was noted that a death or injury may be deemed accidental, but that does not mean it may not have resulted from child abuse and/or neglect. "Unintentional" does not mean there was not neglect, and without seeing the reports it is impossible to identify those trends. The proposed suggestion would have the Panel look at a number of such cases involving both areas of worry and, after clarifying OCFS policy expectations for those child deaths and serious injury assessments, determine if policy is being consistently practiced.

To ensure coordination of efforts in evaluating and developing a response to the challenge of our growing Drug Affected Baby (DAB) problem, we invited Attorney General William Schneider to our Panel meeting in July 2011, representatives from Maine's Office of Substance Abuse (OSA) also took part in this panel presentation;

along with some other very respected community members. An OSA representative is now a permanent member of our panel. The Panel review of and work on Drug Affected Babies has led to many policy changes to improve outcomes and influenced other New England states to examine their DAB issue.

The Panel hosted two presentations in June 2010; “Reducing Infant Mortality in Maine: Risk Factors, Protective Factors and Dilemmas,” (Ashley Oliver and Stephen Meister, MD). “Someone’s Been Sleeping in My Bed: Bed-sharing and Infant Safety”, (Stephanie Joy). Discussion followed the presentations and resulted in some notable findings and recommendations that can be found under the ‘unexpected infant death and un-safe sleep heading of this report.

During this period over three hundred summary OCFS intake reports were looked at and from these, twenty four child death and/or serious injury cases were selected for an in-depth panel analysis. These cases involved elements of abusive head trauma, unexpected infant deaths including un-safe sleep or co-sleeping, ingestions of legal and illegal substances, young adults formerly in protective placements that harmed others, home births, drug affected babies, and cases that succumbed to evidence where there was a lack of reporting based on Maine’s mandatory reporting statute. Some other significant issues were also briefly discussed and are included in this report.



Head trauma as a result of abuse is the most common cause of death in young children, with children in the first 2 years of life being the most vulnerable⁽¹⁵⁾.

ABUSIVE HEAD TRAUMA

Abusive head trauma (AHT) in infants is a serious community health problem both in the United States and worldwide. The act of aggressively shaking an infant or striking a baby’s head usually occurs because caregivers become frustrated in response to a child’s constant crying. This type of injury to a child can lead to long term mental and/or physical health issues and even death. There is also evidence lending to a belief that some of these abusive injuries may not immediately be reported to authorities, the perpetrator instead will wait a period of time to see if the child will recover^(1, 2, 3, 4).

Serious injuries that end in the death or debilitation of infants or young children are not often the result of accidents. Estimates suggest that more than 90% of severe intracranial injuries and at least 60% of all head injuries in children 1 year of age or younger are caused by violence inflicted by parents or caretakers⁽⁵⁾. Shaken baby syndrome (SBS) should also be recognized by the medical terminology pediatric **abusive head trauma** (AHT). AHT is the leading cause of death and debilitation in children among all forms of physical abuse⁽⁹⁾. The unfortunate tragedy is that AHT and especially SBS is understood to be highly preventable with parental education programs and access to support networks and services.

In 2007, the Maine Department of Health and Human Service professionals and the medical community noted an increase in the incidence of serious physical abuse and in particular abusive head trauma (shaken baby syndrome). Maine’s Center for Disease Control and Prevention in conjunction with the Office of Child and Family Services

convened a group of state and community partners to research this issue, discuss and recommend strategies to reduce serious child maltreatment. The group selected the Period of PURPLE⁽¹⁴⁾ crying as their evidence based program to introduce on a statewide basis. This program was developed and is offered by the National Center on Shaken Baby Syndrome and is still in effect today, in order to help eliminate this serious child health problem.

The following case composites have been included to acknowledge the serious nature concerning the abuse of children in Maine, in particular incidences of abusive head trauma (AHT). These summaries have been provided to bring awareness, by presenting the outcomes that are characteristic of these heinous acts, which often result in the death of the child victim, imprisonment of the perpetrator and a family torn apart.

CASE COMPOSITES

This concerns an infant with a skull fracture and an open service case at the time; the mother missed multiple medical provider appointments and reported a welt on the child's head, the injury was diagnosed six days later after the DHHS caseworker took child to the medical provider's office. The mother provided multiple conflicting stories to explain the injury.

A toddler was left home with his mother's boyfriend. The boyfriend reported that the child fell down a flight of stairs. The child died. The medical examiner's office determined that the injuries could not be explained by a simple fall down six or seven steps. The autopsy revealed numerous head injuries, broken bones and other inflicted injuries. The boyfriend ultimately pled guilty to manslaughter in the death of the toddler.

A young infant sustained inflicted trauma to his head and died from a traumatic brain injury. His father was charged with manslaughter.

A young infant was brought to the hospital by her parents; the father stated that he had dropped the baby. The child had a severe brain injury and other injuries consistent with shaken baby syndrome (SBS) or AHT. The autopsy revealed that the baby died from non-accidental craniocerebral and spinal cord trauma. The father was charged with manslaughter.

Because of the serious nature of these types of cases, legislative action was taken in 2013 to include the following amendment to Maine's mandatory reporting law.

§4011-A. Reporting of suspected abuse or neglect

7. Children under 6 months of age or otherwise non-ambulatory. A person required to make a report under subsection 1 shall report to the department if a child who is under 6 months of age or otherwise non-ambulatory exhibits evidence of the following:
 - A. Fracture of a bone; [2013, c. 268, §1 (NEW).]
 - B. Substantial bruising or multiple bruises; [2013, c. 268, §1 (NEW).]
 - C. Subdural hematoma; [2013, c. 268, §1 (NEW).]
 - D. Burns; [2013, c. 268, §1 (NEW).]
 - E. Poisoning; or [2013, c. 268, §1 (NEW).]
 - F. Injury resulting in substantial bleeding, soft tissue swelling or impairment of an organ. [2013, c. 268, §1 (NEW).][2013, c. 268, §1 (NEW) .]

Un-safe sleep related deaths are 50 times higher when a parent is impaired by legal or illegal substances

UNEXPECTED INFANT DEATH – UNSAFE SLEEP

CASE COMPOSITE

An infant was found deceased in its mother's bed in a publically supported venue. The mother was on a daily methadone dosage and also used other drugs. The infant was sick and fussy. The baby was placed between its mother and a wall on a twin bed layered with a quilt and blankets, face down for the reason that she felt it would be easier for the baby to breathe. When the mother awoke she found the infant non-responsive.

Findings & Recommendations:

Finding: Safe sleep guidelines were not emphasized or displayed.

Recommendation: Bed sharing information should be posted, emphasized and available at any public venue where infants might sleep with their parent. Such public venues need a policy promoting best practices on safe sleep in these situations.

Finding: This infant had numerous risk factors for sudden unexpected infant death (SUID). These factors include, for example, bed sharing, face down sleep position, prematurity, respiratory illness, drug affected baby, parental impairment with either prescribed or non-prescribed medications including Methadone and Suboxone. Any one of these factors would not necessarily result in infant death, but in combination the risk increases exponentially.

Recommendation: A stronger message informing parents about risk factors for unexpected infant death and SIDS needs to be developed and delivered to parents by multiple providers including: DHHS caseworkers, home visitors, public health nurses, primary care providers, midwives, case managers, and staff of methadone and suboxone treatment programs. This should include information emphasizing that bed sharing and substance use could result in the death or serious injury to their child.

CASE COMPOSITE

Children risk suffering physical and emotional harm when their parents experience social, mental health, drug and or alcohol abuse challenges.

A family awaiting the birth of a child is vulnerable to experiencing increased economic and emotional stress. In one family a father had to move out of town in order to support his family. While Home Visitors were intermittently involved with the family, their services were not consistent, nor were they adequate to the needs of this family. In essence, the young mother was alone, without supports and experienced an overall deterioration of her mental health status, substance abuse recovery, and her organizational and self-care skills. The mother stopped attending her prenatal as well as her substance abuse treatment appointments.

At the time of birth both the mother and the baby were positive for substances including marijuana and opiates. After she went home with the baby she experienced additional family stress including her husband's arrest. Mother began to sleep with the infant and one morning found the baby had died during the night. At the death scene investigation the police found the home to be unkempt and chaotic

Key Points:

- . Studies have shown that narcotic addicted parent's compliance with an opiate treatment program effectively decreases the risk of harm from child abuse or neglect in that family. This mother was doing well with her children until she stopped following through with her services.
- . This is a situation in which the expertise of Public Health Nursing may have been able to better assess the challenges this family was facing. Consistent with the research findings on the Nurse Family Partnerships, trained professionals may well have been in a better position to support and successfully intervene to support this mother.

CASE COMPOSITE

A baby was found dead mid-morning when its mom got home from work; the father was sleeping "half on and half off" the baby in the caregivers double bed. The 911 call was made and CPR was attempted. The infant was transported to the hospital and was pronounced dead at the hospital.

Findings & Recommendations:

Finding:

In this case, a scene investigation was not conducted and law enforcement rendered an opinion on cause of death to DHHS.

Recommendation:

The panel recommends in cases of a child death, death scene investigations should always be conducted and completed thoroughly, even if the cause of death at the scene appears to be straightforward. Furthermore, it is recommended that DHHS always request and receive the initial scene investigation from law enforcement. Only the Medical Examiner can determine the official cause of death.

Finding: There was no documentation that the parents had been advised of the dangers of bed-sharing.

Recommendation: The Panel recommends that when DHHS is involved with a family, caseworkers should advise the parents of the risks associated with bed-sharing, especially when there are multiple risk factors for Sudden Unexpected Infant Death.

Finding: The final autopsy report for this case was never received by DHHS, despite the fact that the caseworkers called the ME's office several times inquiring on the status of the report.

Recommendation: DHHS always request the final autopsy report in the case of child deaths.

Response: The Medical Examiner's office agrees to automatically send the final report to DHHS when it is complete. This procedure will be more efficient than calling repeatedly to check on the status of an autopsy.

Finding: In this particular case, communication

INFANT FATALITY RISK FACTORS

- Sleeping in adult beds with adults and other children
- Sleeping in beds with comforters, blankets and duvets
- Sleeping on couches or chairs when caregivers sleep holding them
- Sleeping in cribs with stuffed animals, blankets, toys and other items
- Overdressing/overheating baby
- Propping bottles

between the involved investigating parties was fractured and inefficient. Each department, because of their differing purposes, worked at differing speeds making it difficult to correspond with each other.

Recommendation: In the case of an infant death, the panel recommends that a protocol be developed, using a subcommittee, so that a multidisciplinary team of all involved agencies meet within a specified amount of time after the date of death (DOD) to collaborate on the evaluation and to improve communication. Vermont and/or New Hampshire could be used as models for developing such protocol.

ADDITIONAL RISK FACTORS ASSOCIATED WITH SUDDEN INFANT DEATH

- Mental health challenges, including depression
- Substance use, including alcohol or drugs
- Smoking
- Obesity
- Parental isolation

CASE COMPOSITE

A young infant was found dead underneath its father on a couch. Both parents had a history of substance abuse and were involved in a methadone treatment program. Dad had consumed some alcohol, but mother reported that he “did not seem impaired.” Mom awoke in the night to find the infant partially underneath the father. The infant was deceased.

Findings and Recommendations:

Finding: Despite considerable effort, DHHS was unable to obtain records from the Methadone treatment program regarding their care of the parents of the deceased child. There are many barriers to DHHS obtaining information about the clients from Methadone treatment centers.

Recommendation: The panel recommends that an OSA representative be involved in the investigation when a child death occurs while in the care of a parent receiving services from a substance abuse treatment program. Furthermore, the panel recommends that the Department caseworkers develop a collaborative relationship with Methadone clinics in their area; doing so should increase their ability to obtain necessary records and implement crucial services for clients.

Finding: These parents were receiving Methadone treatment, which can increase the risk of SUID in the bed-sharing environment. Home Visitors were aware of the bed-sharing but did not record their efforts to dissuade the parents from this risky practice.

Recommendation: The panel recommends that all Home Visitors inform parents about the dangers of bed-sharing, including sleeping with an infant on a couch. Home Visitors should identify cases where several risk factors are present, especially with substance affected parents and ensure that these parents are aware of the risks of bed-sharing.

Finding: It was noted that Foster Parents are not exposed to training on the dangers of bed-sharing.

Recommendation: The panel recommends that Safe Infant Sleep brochures be provided to all foster parents and that the Department develops specific rules warning foster parents from bed-sharing with infants in their care.

Finding: The Department re-referred this case to Home Visitors after the baby's death, though the case was high severity substantiated.

"Message is that every baby is at risk, if you bed share, your baby could die"

Recommendation: The panel recommends that in cases where there has been a child death and a vulnerable child remains in the home, that the Department keep the case open until safety plans have been developed and implemented.

Finding: The Department is required to make decisions quickly. This does not coincide well with the resources of the Medical Examiner's office. In this particular case, the autopsy report had still not been completed even though the Department had already closed the case.

Recommendations:

- a. The panel recommends that the Medical Examiner's office prioritize child autopsy reports when reviewing an infant death, in the same way that they prioritize homicide cases. This will enable the Department to have the information they need when deciding whether or not to close and/or refer a case.
- b. The panel recommends that a multidisciplinary approach be established by the Department to ensure that interdepartmental communication and collaboration has occurred on a case by case basis, before closing any case.

Finding: In this particular case, parents were not engaged in grief counseling, though they were emotionally affected by their child's death and even though at risk children remained in the home.

Recommendation: The panel recommends that parents who experience a child death be offered and encouraged to receive grief counseling and support services, especially when another child or children remain in the home.

Finding: There were philosophical differences in the approach that each agency took towards these parents.

Recommendation: The panel recommends and encourages interdepartmental collaboration and communication of all parties involved in a specific case and that a common approach be developed to best serve each individual client's needs.

Finding: Despite the efforts that the Department takes to educate parents about the dangers of bed-sharing, many still participate in unsafe sleep practices. The manner in which the Department approaches parents with the subject of bed-sharing is vital to whether or not those parents will be honest with the caseworker and/or receptive to their recommendations.

Recommendation: The panel recommends that the Department continue its effort to educate parents. Furthermore, they suggest that when caseworker's talk to parents that they consider the family's reasons for choosing to bed-share are different and try to specialize their approach to the subject for each specific client. The panel understands that many caseworkers already do this and commends their good work.

INGESTIONS



CASE COMPOSITE

Methadone ingestion by a child caused acute cerebellitis. Numerous close family members and neighbors were reportedly taking prescription methadone. A child abuse specialist was not consulted during the hospital stay and the case was not reported to DHHS until many days into the hospitalization. The Poison Control Center helped identify the relationship between the methadone ingestion and the neurologic injury. The child survived with neurologic impairment and requires specialized services to support developmental tasks.

Findings & Recommendations:

- The Panel would like to reiterate the importance of having a child abuse specialist available for consultation to DHHS and the hospital providers.
- The panel noted that there is a need to identify signs of and screen for maternal depression
- The panel highlighted the need for better provider understanding of the risks for and identification of child abuse and neglect
- The panel would like to echo the value of having a Poison Control Center
- The panel recognizes and underscores the significance of sharing information regarding risk factors for child abuse, especially around the time of birth
- Referrals made by the hospitals and other trained healthcare providers need to be taken seriously



TYPES OF INGESTION REPORTS

"Thirteen month old female ingested prescription Adderall, pills are left in his pant pockets on occasion."

"Nineteen month old ingested a benzodiazepine while in the care of boyfriend; loose pills had been seen before belonging to relative"

"Two year old ingested a synthetic opiate while in the care of a relative. There were prior concerns about this relative caring for the child, due to allegations of physical abuse and duct taping."

"Three year old ingested 300 mg of Benadryl while in the care of mother's boyfriend."

"Two year old female was reported to have ingested an antidepressant prescribed to her great-grandfather. The child tested positive for other non-prescribed, non-indicated medications, but negative for the antidepressant. The same child ingested her great-grandfather's diabetes medication last year."

"Two year old female ingested 2 antidepressant tablets while visiting the home of her maternal great-grandmother. The medication was prescribed to great-grandmother."

"Ten month old female tested positive for opiates; parents and child were staying with maternal grandparents at the time other relatives were visiting the home, one of whom kept her medications in a baggie in her purse."

"Two and half year old female ingested mother's prescribed suboxone tablet; mother reported that the child climbed onto a piece of furniture and got the container."

"Fourteen month old ingested either suboxone or oxycodone pill while in the care of two babysitters. Mother found pills on the floor and pill fragments in the child's mouth and on the child's hands. Both caretakers were impaired by substances"

"Two year old child was left alone while all of the adults in the home were sleeping. The child took grandparent's medications while parents were sleeping.

"Two year old was found sleeping with a benzodiazepine pill next to him. The mother believed that four benzodiazepine pills were missing and brought the child to the hospital with concerns that the child had ingested the pills"

"Two year old ingested father's prescription medications while the mother was in the kitchen and the child was in the family room. The pills were in one of the father's pockets.

YOUNG ADULTS, FORMERLY IN PROTECTIVE PLACEMENTS, THAT HARM OTHERS

CASE COMPOSITE

The Panel reviewed a number of cases where children who had been in the care of the Department of Human Services ultimately committed violent crimes.

Findings & Recommendations:

- The panel inquired as to whether there is anything in place at this time to provide structure to teens aging out of foster care, the panel indicated that DHHS should be aware that children are not fully developed when they turn eighteen, lacking the skill to self-regulate, and still need structure. Teens are provided with life skills and the V-9 program to provide educational assistance.
- The panel questioned whether the same type of situation, with multiple reports of maltreatment, would result in the same response at this time. It cannot be determined with certainty, but the Department would most likely become involved.
- Foster parents who are caring for children, who are aggressive when they enter foster care, require special training and supports in order to optimally care for these children.
- The Department would attempt to meet many of these children's needs in different ways now. Screening, educating and supporting resource families continues to be a necessary focus of attention.

HOME BIRTH

The Maine Child Death and Serious Injury Review Panel completed a report on Home Births in Maine in June 2012. The report was approved for public release by the Commissioner; the letter of response to the panel was received on October 2, 2012, respective to their work on this significant project. The next four pages are dedicated to that work.

HOME BIRTH REVIEW, LETTER TO THE COMMISSIONER

Commissioner Mayhew
State of Maine
Department of Health and Human Services

Dear Commissioner Mayhew,

Please accept this special report from the Child Death and Serious Injury Review Panel concerning Home Birth in Maine.

In 2009, the Child Death and Serious Injury Review Panel (CDRP) was asked by the Department of Health and Human Services to consider the safety of Home Birth care in Maine. This request was based on anecdotal reports concerning serious adverse events necessitating transfer of mother and child from home to a hospital either during or immediately after birth.

In 2007, a bill was brought before the State Legislature proposing licensure of Certified Professional Midwives (CPMs). In the process of considering the bill; a “Sunrise Review” was requested by the Joint Standing Committee on Business, Research and Economic Development, charged with considering the argument for licensure. A law allowing CPMs in Maine access to and the right to administer certain medications in the practice of midwifery was signed into law by Governor Baldacci in May, 2008, with final implementation of rules under the Pharmacy Board occurring on Feb. 9, 2009.

The Child Death and Serious Injury Review Panel’s standard process includes a review of the scholarly, and sometimes the popular literature as it relates to the cases, interviews of professionals, family members and others involved, and a detailed review of the specific cases. The process culminates in a report summarizing the review process followed by specific findings and recommendations. In applying this process to evaluate outcomes of Home Birth in Maine, it was not the Panel’s intent to revisit the debate surrounding the need for licensing of Certified Professional Midwives as this had already been addressed by the legislature. Ultimately, the Panel’s charge was to identify areas in the system of care that could be changed to improve outcomes and prevent or minimize risk of harm to infants and mothers in our State.

In the 3 years since initiating the review the CDRP has had the opportunity to look at a number of home births that have had problematic outcomes, as well as a number with positive outcomes. The panel has reviewed the literature on the subject, consulted with experts in relevant areas, and has carefully considered and analyzed the findings. The emergence of a few very clear directions that can be promoted, with confidence, to improve the safety of home birth and to further the development of a system of care are found in the report. These findings and recommendations are summarized below:

We find the rate of perinatal mortality is unacceptably high in home births in Maine. Certified Professional Midwives and other non-licensed providers of home birth support are offering to deliver moderate and high risk pregnancies (including breech and twin pregnancies) at home because of a mistaken belief that they can perform these deliveries safely. We reviewed the results of their unfortunate and uninformed opinion and conclude that the

high rate of poor outcome from home birth in our state is because the home birth midwives are not selecting only low risk pregnancies for delivery at home.

Families are rationally choosing home birth, even when there is risk to their unborn child, because of their desire for personalization of care and fear of unwarranted surgical intervention. Our current rate of cesarean section deliveries is too high and not in our young mothers best interest. Another problem often occurs when families and their home birth caregiver decide to transfer care to a hospital. In cases where the transfer of care is readily accepted by the hospital and hospital based professionals, care is enhanced as are birth outcomes. In situations where the professionals and hospital staff are disdainful of the family's choice and disrespectful toward the home birth caregiver, transfer is delayed and outcomes are impaired.

The State of Maine needs to define a standard where birth rises from a natural process, which anyone can attend to a medical process requiring the care and services of a licensed medical practitioner. It is recommended that the assignment of risk include consideration of the recommendations promulgated by the American College of OB/GYN as published in the annual Compendium of Selected Publications. It is further recommended that:

- 1- Any low risk birth be considered as appropriate for home birth delivery.
- 2- No high risk birth be considered acceptable for home birth delivery.
- 3- The possibility that some circumstances exist where a moderate risk birth is acceptable for home delivery, these circumstances should be carefully defined.

The midwives need to adopt consistent, written, and agreed upon standards, which define low risk, moderate risk and high risk births

Midwives and the families they care for would benefit from developing a well thought through written crisis plan that could include things such as:

- 1- Information sharing with EMTs.
- 2- Information sharing with hospital providers.
- 3- A transport plan.
- 4- Consideration of weather, distance, accessibility.
- 5- Any other factor that the midwife or the family believes or fears might arise.

The families need to be offered informed consent, which:

- 1- Explains the true, statistical risks and benefits of home birth.
- 2- Explains the true, statistical risks and benefits of hospital birth.
- 3- Explains the value, risks and benefits of blood spot and hearing screening and the risk of not screening.
- 4- Explains the value, risks and benefits of Group B strep testing and screening for gestational diabetes and the true risk of not testing.
- 5- Explains the value, risks and benefits of Vitamin K, and the true risk of avoiding treatment.
- 6- Explains the possibility of transfer, and the circumstances under which transfer will and must occur including the importance of a crisis plan.

The EMT system, hospital and hospital providers, and midwives need to adopt policies where:

- 1- Hospital Professionals and staff readily accept transfer of care
 1. where they are supportive and respectful toward the family and the midwife;
 2. where they are aware of the birth during the pregnancy as well as the date of delivery and develop a plan of care should support be required; and
 3. care needs to be collaborative and respectful.
- 2- The midwives need to encourage the development of relationships with, access support and consultation with the medical/hospital providers without becoming the ostensible agent of the medical provider.

Statutes should not be developed that codify medical practice; however, statutes can require standards of care.

In terms of the development of standards, it is recommended that a combined advisory work group include respectful representatives of the Professional societies, the midwives, and public members including families.

This work group would be advisory to the medical director for Maternal and Child Health who would draft the final legislation to be promulgated by the department. Families also need to be engaged in this process; we need to ensure the consumer has access to accurate information so they have every opportunity to make a highly informed choice.

Sincerely,

Stephen Meister MD, MHS, FAAP
Chair
Maine Child Death and Serious Injury Review Panel



DRUG AFFECTED BABIES

The panel's activities with regard to Drug Affected Babies (DAB) prompted a forum, which included an examination of rules, laws, treatment, narcotic overdoses, and a discussion regarding an infant who died in a shelter while co-sleeping with mother who was attending a methadone clinic.



The conversation surrounded the rise in infants born affected by drugs and diverted narcotic use in Maine. The major focus was on the impact on infants and children affected by narcotics. Involved professionals shared information on what steps are currently underway to address these issues. Invited guests included: Mark Publiker, MD, an addiction medicine specialist and a physician, Kelley Bowden, a Nurse practitioner who cares for mothers and infants with narcotic addiction, Daisy Goodman RN, PhD, a Nurse Midwife with a PhD from Harvard on managing pregnant woman with narcotic addiction and Darrell Crandall, Northern Commander with the Maine Drug Enforcement Agency (MDEA).

Mark Publiker, MD indicated that mothers are usually motivated to seek treatment due to pregnancy but comprehensive treatment is not universally available. A high percentage of women who are addicted also have a history of being sexually molested, involved in toxic relationships, have no family support and experience poverty. Caution should be taken when screening, as the population that makes up the group living in poverty is not the only group who might be addicted to narcotics. The poverty group also has limited trust and is a reason why medicated assisted treatment needs to be assessed and it must be coupled with comprehensive treatment. It should be mentioned that opiates do not cause birth defects; it is the recurrent episodes of withdrawal that are the problem, this causes stress on the infant, imposes a low birth weight and is highly likely to induce prematurity. Opiate addiction is a chronic brain illness; treatment works and it is effective but difficult to access across the state.

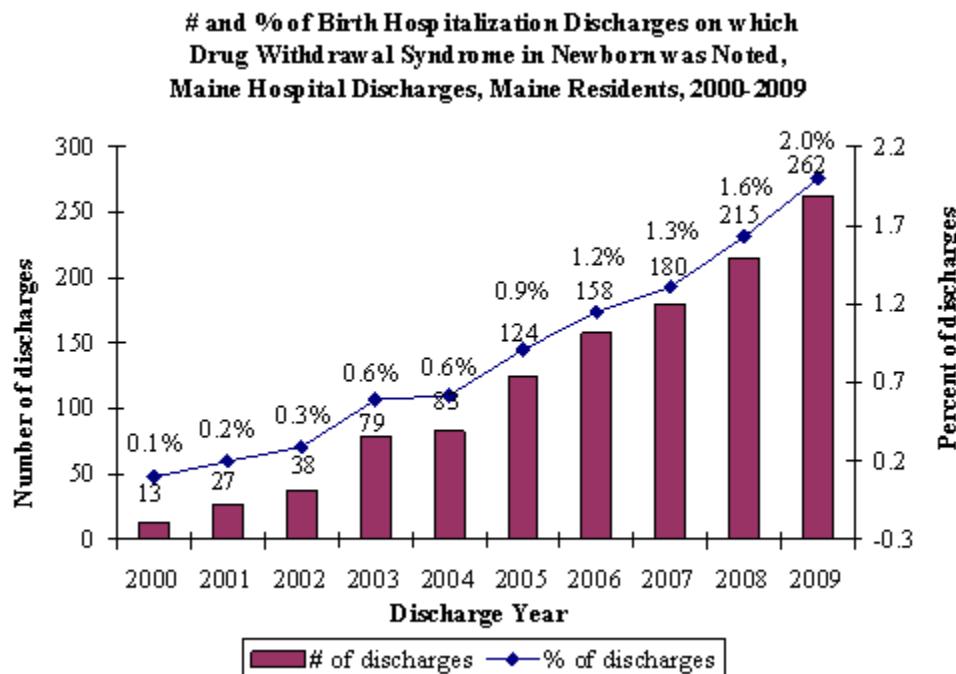
Kelley Bowden, RN discussed her work with hospitals around the state, in terms of education and consultation. Kelley said, "That she receives numerous requests to talk about narcotic exposed infants," which identifies an awareness of the issue. As a nurse, Kelley indicated she had no education on addiction and stated that this knowledge is often not studied in many common nursing educational programs. During screening, mothers are asked questions such as, do you smoke, drink, or use drugs, and many mothers normally do

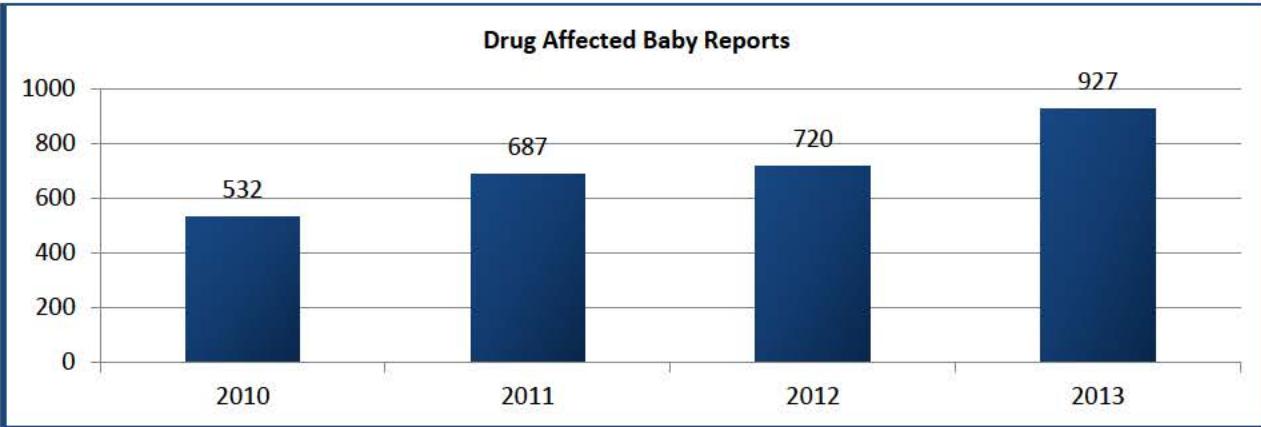
Reducing an infant's exposure to legal or illegal drugs, alcohol and tobacco would likely have a large financial benefit to the state. Not to mention the moral issue of protecting these infants who are more apt to suffer from the long term ill effects of exposure due to their small developing bodies.

not disclose that information. Other mothers that are being treated for pain are not informed that their babies are at risk for withdrawal, and many babies go home to withdraw. Alcohol screening is seriously important, because of the relationship to birth defects and mental health illness. The AAP Narcotic Affected Infant policy introduced in 1998, which is under revision now, encourages a 5 day monitoring in the hospital.

Daisy Goodman RN, PhD talked about the challenges in rural settings, such as the issues that arise from having very limited addiction support, behavioral health treatment programs, and margins for those with a dual diagnosis. Although mothers are often apt to enter treatment when pregnant, Maine law requires treatment for any female prisoner if pregnant there are disadvantages in rural communities because of the limited number of resources.

Darrel Crandall embarked on the Drug Endangered Child (DEC) protocol which addresses those children who are exposed to environments where drugs are used or manufactured. The DEC protocol arrived as a result of meth labs and now allows for inter-agency collaboration with child welfare. One of the Task Forces of the MDEA identified that 50% of arrests had a direct relationship to prescription medications/drugs.





*MACWIS

The Director for the Division of Child Welfare, Therese Cahill-Low, at the time requested the expertise of the Child Death and Serious Injury Review Panel (CDSIRP) to help in the development of clear, specific guidelines in what to consider when assessing and determining if child abuse or neglect is present in drug affected baby (DAB) reports. Thus, a strategy for addressing Child Protective Response to Drug Affected Infants was worked on during this period.

Although there had been work done to improve the reporting process from the medical provider and improve consistency across the state, there was a need for better guidance on how to determine the assignment process; which cases are assessed by child protective and which are the cases that can safely receive services in the community, such as, Home Visiting and Public Health Nurse (PHN). It is not always clear there is an informed correlation of the needs of the infant, resources of the family and identified risk factors. Direction was needed on how to assess the interaction of risk factors. If certain conditions exist, what are the concerns and what are the relevant questions that should be posed to the medical professionals and would it be beneficial to use one of the tools in the Signs of Safety model, such as, using scaling questions? An example; you might ask a physician on a scale of 1 to 10 with 10 meaning CPS should request a court order to place the child in an alternative home immediately or 1 being there are no concerns, the child is functioning well and the parents have the capacity to fully care for the child with no additional supports. Then have a response follow up with, what makes it an 8 or what would it take to get to a 7? This could give CPS a better understanding of what action would be recommended and better develop a safe plan of care. There was discussion that this line of questioning would be helpful.

A further dialogue between the Attorney General and the panel was conducted, this exchange surrounded the differences in reporting, which convinced the panel chair to connect with the area hospitals about the variations in reporting but still consider if and when hospitals do make a report, is that information sufficient guidance to make decisions from the response side?

An identified issue that can interfere with reporting is fear by the parents and perhaps the nursing response to that; how presentation should shift to understanding and offer services rather than continue the perception of a CPS report as a threat.

Another identified issue around the state is the question surrounding a ‘drug exposed baby’ and/or ‘drug affected baby’; what does it mean for the baby? This can be interpreted differently in different hospitals.

Should there be differences in responses related to what drugs are used? Should there be consistent ways to validate risk? What are the factors to consider that bring it to a high stakes case and what are indicators that lead

to CPS intervention? Some items were generated and listed below that should be used for consideration in the assessment process:

- *Methadone or other medication assisted therapy*
- *Marijuana use*
- *Illegal drug use*
- *Life style – not a lot of science to make determinations*
- *Refusal to accept treatment*
- *Infant experiencing seizures*
- *Environmental factors*
- *Plan of Care for infant at discharge – family supports*
- *Concern about mother's mental status – depressed, flat affect*
- *Mother under influence at time of delivery – were drugs in system, what is current use.*
- *Domestic violence indicators*

Other discussion points:

Often normal newborn care is provided and the infant does not go home on medication. Research shows that if parents are receiving treatment or using and are bed sharing, deaths of infants go up 50 times. Information on co-sleeping needs to be widely distributed. Caseworkers need to look at bed/sleeping environments and provide information on unsafe sleep environments. What are identified compromised parental conditions? Medication assisted therapy – who is prescribing, how obtained, impact on functioning. More targeted education is needed for the population of individuals receiving treatment who are pregnant or could become pregnant. Information that can focus on the neuro-developmental status of the baby is important and should/ needs to be provided to parents. Compromised DAB infants do not have protective capacity to startle and wake up, which would otherwise be expected with a case for a non-affected baby in a co-sleeping situation.

In conclusion, the Panel review of and work on Drug Affected Babies has led to many policy changes to improve outcomes and our presentation to the New England Child Death Review (NE CDR) group in Rhode Island during the Spring of 2012 resulted in all states in New England beginning a review of DAB in their states.

OBSERVATIONS

- *There were examples cited of mothers at WIC after taking their methadone that are falling asleep while holding their infants. The question was raised about how WIC communicates the risks of drug use and unsafe sleep environments.*
- *Confidentiality can be an issue as identified when there are cases of children in care and limited ability to communicate with the clinics where the parents are receiving treatment. What areas do caseworkers currently explore and what additional guidance can be provided?*
- *If there is evidence at time of birth that the mother is under the influence, then what questions do hospitals ask about the patterns of use and the environment? All agree that partnering with hospitals, having a consistent system to refer to Public Health Nurse (PHN) from hospital and the development of a decision making matrix is necessary.*

- Panel members believe clinical and legal components must be coordinated but is this consistent with other's thinking? What are the model programs that can be mirrored? The panel needs sense of what is best data/ what are best outcomes.
- What are interventions for women who are in prescribed treatment, but also use illegal drugs? The panel does not want to criminalize drug use during pregnancy but what would be the alternatives? If there is evidence to increased criminal activity, how can law enforcement expand their role?
- What is occurring in the state to address the Doctors who over-prescribe medications if there is a serious injury in an infant when a child has been identified as a DAB?
- How long do NAS symptoms persist? Is there a baseline of higher irritability – what does that look like? Is it more related to substance abuse or parent/trauma issues? – Is it less about the fact of a child being a DAB? What is optimal practice for responding to infants in a medical setting?
- What percentage of infants born experiencing drug withdrawal in Maine end up dead or impacted by substance use? What factors affect morbidity and mortality and how do we hold parents accountable? Is there a recommended continuum of response?
- Neurochemistry in addiction information might benefit support systems, build on best responses, possibly allow for better outcomes by looking at different approaches and may even help when trying to engage family in a therapeutic response?



MANDATORY REPORTING - FAILURE TO REPORT ABUSE

§4011-A. Mandatory Reporting of suspected abuse or neglect

1. Required report to department. The following adult persons shall immediately report or cause a report to be made to the department when the person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred:

A. When acting in a professional capacity:

(1) An allopathic or osteopathic physician, resident or intern; (2) An emergency medical services person; (3) A medical examiner; (4) A physician's assistant; (5) A dentist; (6) A dental hygienist; (7) A dental assistant; (8) A chiropractor; (9) A podiatrist; (10) A registered or licensed practical nurse; (11) A teacher; (12) A guidance counselor; (13) A school official; (14) A youth camp administrator or counselor; (15) A social worker; (16) A court-appointed special advocate or guardian ad litem for the child; (17) A homemaker; (18) A home health aide; (19) A medical or social service worker; (20) A psychologist; (21) Child care personnel; (22) A mental health professional; (23) A law enforcement official; (24) A state or municipal fire inspector; (25) A municipal code enforcement official; (26) A commercial film and photographic print processor; (27) A clergy member acquiring the information as a result of clerical professional work except for information received during confidential communications; (28) A chair of a professional licensing board that has jurisdiction over mandated reporters; (29) A humane agent employed by the Department of Agriculture, Conservation and Forestry; (30) A sexual assault counselor; (31) A family or domestic violence victim advocate; and (32) A school bus driver or school bus attendant; [2009, c. 211, Pt. B, §18 (AMD); 2011, c. 657, Pt. W, §5 (REV).]

B. Any person who has assumed full, intermittent or occasional responsibility for the care or custody of the child, regardless of whether the person receives compensation; and [2003, c. 210, §3 (AMD).]

C. Any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to the members of that church or religious institution, while acting in that capacity, regardless of whether the person receives compensation. [2003, c. 210, §4 (NEW).]

Whenever a person is required to report in a capacity as a member of the staff of a medical or public or private institution, agency or facility, that person immediately shall notify either the person in charge of the institution, agency or facility or a designated agent who then shall cause a report to be made. The staff also may make a report directly to the department. [2009, c. 211, Pt. B, §18 (AMD); 2011, c. 657, Pt. W, §5 (REV) .]

1-A. Permitted reporters. An animal control officer, as defined in Title 7, section 3907, subsection 4, may report to the department when that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected. [2007, c. 139, §2 (NEW) .]

2. Required report to district attorney. When, while acting in a professional capacity, any person required to report under this section knows or has reasonable cause to suspect that a child has been abused or neglected by a person not responsible for the child or that a suspicious child death has been caused by a person not responsible for the child, the person immediately shall report or cause a report to be made to the appropriate district attorney's office. [2007, c. 586, §11 (AMD) .]

3. Optional report. Any person may make a report if that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that there has been a suspicious child death. [2007, c. 586, §12 (AMD) .]

4. Mental health treatment. When a licensed mental health professional is required to report under subsection 1 and the knowledge or reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred comes from treatment of a person responsible for the abuse, neglect or death, the licensed mental health professional shall report to the department in accordance with subsection 1 and under the following conditions.

A. The department shall consult with the licensed mental health professional who has made the report and shall attempt to reach agreement with the mental health professional as to how the report is to be pursued. If agreement is not reached, the licensed mental health professional may request a meeting under paragraph B. [2001, c. 345, §5 (NEW).]

B. Upon the request of the licensed mental health professional who has made the report, after the department has completed its investigation of the report under section 4021 or has received a preliminary protection order under section 4034 and when the department plans to initiate or has initiated a jeopardy order under section 4035 or plans to refer or has referred the report to law enforcement officials, the department shall convene at least one meeting of the licensed mental health professional who made the report, at least one representative from the department, a licensed mental health professional with expertise in child abuse or neglect and a representative of the district attorney's office having jurisdiction over the report, unless that office indicates that prosecution is unlikely. [2001, c. 345, §5 (NEW).]

C. The persons meeting under paragraph B shall make recommendations regarding treatment and prosecution of the person responsible for the abuse, neglect or death. The persons making the recommendations shall take into account the nature, extent and severity of abuse or neglect, the safety of the child and the community and needs of the child and other family members for treatment of the effects of the abuse or neglect and the willingness of the person responsible for the abuse, neglect or death to engage in treatment. The persons making the recommendations may review or revise these recommendations at their discretion. [2007, c. 586, §13 (AMD).]

The intent of this subsection is to encourage offenders to seek and effectively utilize treatment and, at the same time, provide any necessary protection and treatment for the child and other family members.

[2007, c. 586, §13 (AMD) .]

5. Photographs of visible trauma. Whenever a person is required to report as a staff member of a law enforcement agency or a hospital, that person shall make reasonable efforts to take, or cause to be taken, color photographs of any areas of trauma visible on a child.

A. The taking of photographs must be done with minimal trauma to the child and in a manner consistent with professional standards. The parent's or custodian's consent to the taking of photographs is not required. [2001, c. 345, §5 (NEW).]

B. Photographs must be made available to the department as soon as possible. The department shall pay the reasonable costs of the photographs from funds appropriated for child welfare services. [2001, c. 345, §5 (NEW).]

C. The person shall notify the department as soon as possible if that person is unable to take, or cause to be taken, these photographs. [2001, c. 345, §5 (NEW).]

D. Designated agents of the department may take photographs of any subject matter when necessary and relevant to an investigation of a report of suspected abuse or neglect or to subsequent child protection proceedings. [2001, c. 345, §5 (NEW).] [2001, c. 345, §5 (NEW) .]

7. Children under 6 months of age or otherwise non-ambulatory. A person required to make a report under subsection 1 shall report to the department if a child who is under 6 months of age or otherwise non-ambulatory exhibits evidence of the following:

A. Fracture of a bone; [2013, c. 268, §1 (NEW).]

B. Substantial bruising or multiple bruises; [2013, c. 268, §1 (NEW).]

C. Subdural hematoma; [2013, c. 268, §1 (NEW).]

D. Burns; [2013, c. 268, §1 (NEW).]

E. Poisoning; or [2013, c. 268, §1 (NEW).]

F. Injury resulting in substantial bleeding, soft tissue swelling or impairment of an organ. [2013, c. 268, §1 (NEW).][2013, c. 268, §1 (NEW) .]

Failure to Report Rev. Stat. Tit. 22, § 4009

A person who knowingly violates a provision of this chapter commits a civil violation for which a forfeiture of not more than \$500 may be adjudged.

False Reporting Rev. Stat. Tit. 22, § 4014(1)

Immunity from any criminal or civil liability for the act of reporting or participating in the investigation or proceeding is not extended in instances when a false report is made and the person knows the report is false. Nothing in this section may be construed to bar criminal or civil action regarding perjury.

CASE COMPOSITE

A young child died of acute physical trauma while in the care of his mother's boyfriend. Prior to this tragedy the young child's sister had been seen at a local hospital because the day care provider was concerned about bruising on her face. The police investigating stated the bruise was inflicted, but the mother convinced the physician's assistant in the ED that the bruises were not inflicted; meanwhile the caseworker investigating this referral also observed facial bruises on the young male child. There were too many caregivers to easily pinpoint the abuser. Ultimately the perpetrator (mother's boyfriend) was convicted of manslaughter.

Findings and Recommendations:

Finding:

The Department did not respond to a report from a hospital of physical injury to a two year old for several days.

Recommendation:

The Panel recommends that the Department provide immediate response for any child under age 6 reported by a hospital.

(Global estimates of child homicide suggest that infants and very young children are at greatest risk, with rates for the 0–4-year-old age group more than double those of 5–14-year-old⁽¹⁵⁾)

Finding:

The family primary care physician was not consulted in the initial assessment. The PCP did not have information about the family's adverse experiences; i.e., parental and other family member substance abuse and domestic violence.

Recommendation:

Information about a case needs to be shared between DHHS and medical providers. Currently, DHHS and medical providers work in their separate silos, leading to fragmented and poorly informed decisions. We need to improve collaboration and trust between the professionals investigating and providing care to these children and families.

Finding:

A two year old presented to the emergency room with suspicious facial bruising, yet the child did not undergo a complete physical exam and her sibling did not undergo a physical exam.

Recommendation:

When a child presents with facial bruises the whole body should be examined at the request of the Department.

Recommendation:

When there is suspicion of inflicted injury to one child, all children in the family should be medically evaluated.

Recommendation:

When the Department receives a referral that a child has physical injuries, a child abuse specialist/s* should be consulted and digital photos should be taken. Professionals involved; police, medical provider, CPS worker should coordinate the contact with the specialist.

Finding:

The referent's report was not given as much weight as the parent's explanation of the injuries.

Recommendation:

The Department should make an assessment of the reliability of the reporter and this should be weighed with the other evidence in the case.

Finding:

All household members and the alleged perpetrator were not interviewed in the initial assessment of the family.

Recommendation:

The Department should ensure that policy is followed in the interviewing of all household members and alleged perpetrators.

Finding

Caseworkers do not get consistent training in what injuries are typical and atypical.

Finding

There was no analysis of the mother's responsibility in the abuse.

Recommendation

All caregivers should be assessed.

DISCUSSION

The Panel discussed why professionals and medical care providers are not reporting as we would expect them to. The Panel questioned whether the professionals are not recognizing injury/incident as child abuse. The medical literature shows that medical practitioners only report 73% of injuries considered likely or very likely caused by abuse and only 24% of injuries considered possibly caused by child abuse.² The notion of suspicion of abuse is vague and fraught with confusion and error. Because a missed report may result in a child's death or serious injury, the Panel recommended mandated reporting of specific injuries to a child younger than 6 months of age. Please see the preceding description of the statute **§4011-A. Mandatory Reporting of suspected abuse or neglect #7 A-F** on page 35 of this report. There is a need to have mandated reporter training as part of professional licensing criteria, there should be an education avenue for mandated reporters and it should include all personnel having contact with children and families. Pennsylvania already requires the submission of two hours of mandated reporter training for licensing.

Some findings related to lack of reporting:

- Many clinicians in Maine and across the US, with high suspicions of child abuse do not report and do not consult with colleagues that have child abuse expertise
- Providers are not being sued because they didn't report, but a number of providers do get taken to court by people who allege the report was "malicious."
- Providers should be reporting to a caseworker on an open case; there is a need for improved communications between medical personnel and DHHS; an avenue to build trust in order to support collaboration between these groups.

²Berkowitz, Carol, D.(2008) *Child Abuse Recognition and Reporting: Supports and Resources for Changing the Paradigm*, American Academy of Pediatrics, http://pediatrics.aappublications.org/content/122/Supplement_1/S10.full.html

- Central intake office should have secured email for reporting as it has become a preferred method of communication for many people. (*There is currently a 5-6 year wait to get proposed information technology projects off the ground and implemented in DHHS.*)
- The mandatory reporting law states that when the Department/OCFS becomes aware that a mandated reporter failed to report, OCFS will send that information to the licensing board; it is up to the licensing board to determine what action to take with the information.

It was pointed out that there is a need to train everyone in a medical practice so that they would be able to identify and be aware of families at risk. Peer training should be regarded as a tool equal to DHHS training. A program in England, whereby “the named person” with child abuse expertise is a resource and provides advice to those questioning whether a report should be made was a topic of panel discussion. A similar program is currently active throughout the State of Florida. All Panel members agreed this type of support would aid a referent in their decision to ‘report’ or ‘not report’ by providing advice. DHHS central intake currently acts in this role but many mandated reporters are unaware of this service.

At the request of the Director of OCFS, Therese Cahill-Low, injuries in children that were unlikely to occur unless they were inflicted were supplied to the Department by members of the CDSIRP; the Department then used this information to support appropriate changes and inform legislation.

- *Bruise in child under six months*
- *Fracture in child under six months, excluding birth injury*
- *Bleeding from nose or mouth, bleeding from frenulum*
- *Injury inconsistent with developmental age*
- *Injury inconsistent with explanation*
- *Changing history (the panel discussed whether the reporter will have the expertise to make this decision.)*
- *Reported to be inflicted*
- *Multiple locations, especially bilateral*
- *Atypical locations*
- *Adult bites (the panel questioned whether someone without experience will be able to make the distinction between adult and child bites.)*
- *Any injury in an infant less than six months old*
- *Burns – pattern burns, cigarette burns, all immersion burns*
- *Unexplained genital injuries*
- *Sexual disease, pregnancy in child under 14*
- *Implement pattern bruise*

PASSAGES - REASONS GIVEN FOR FAILURE TO REPORT

“Lack of knowledge inhibits reporting” (doctor)

“A guide indicating suspicious injuries at varying ages and advising when to report would be useful” or “consultation would be helpful in situations with questionable signs of maltreatment”(doctor)

“He might have made a report, had he received any training about when to report” (doctor)

"He did not feel the bruises were inflicted and felt the explanation of the parents was plausible" (law enforcement)

"Need for a decision tree to assist reporters/providers in determining whether to file a report" (doctor)

"When should the medical community be questioned regarding children in care? He indicated that he received conflicting information and recommendations of care during the case and did not know how to address his concerns" (caseworker)

"Impression of the family and their love of the baby, coupled with having an extra set of eyes going into the home, swayed him toward not reporting" (doctor)

"She worried more about a failure to provide care and neglect, than inflicted injuries" (nurse)

"He observed bruising and was told that it was the result of the child moving and wedging against the crib bars" (doctor)

"She had the support of her mother and the hospital staff and was appropriate in her care and paid attention to the baby making you feel the babies were safe in the home" (doctor)

"All the diagnostic testing made things confusing for the reporters/providers working with the family"



WHO REPORTS IN MAINE



REFERRAL SOURCE	2010	2011	2012	2013
Anonymous	8%	10%	11%	11%
Child Care Personnel	1%	1%	1%	0%
Law Enforcement Personnel	12%	16%	16%	17%
Medical Personnel	9%	13%	15%	15%
Mental Health Personnel	6%	9%	10%	10%
Neighbor/Friend	4%	6%	5%	4%
Other	2%	2%	1%	1%
Relative	6%	8%	8%	6%
School Personnel	12%	18%	17%	17%
Self/Family	6%	8%	8%	8%
Social Services Personnel	8%	10%	9%	10%

*Percentages are based on only the reports that were assigned for child protective assessment; excludes reports referred to licensing, out of home investigations, service requests and reports received where a case was already open and the information was not a new incident.

SIGNS OF SAFETY

CHANGING THE PRACTICE MODEL

During 2011, the Child Death and Serious Injury Review Panel reviewed a case in which the perpetrator of the child's injuries could not be determined, but appeared to be one of the parents. As the child was returned to the care of the parents, despite the inability of the Department to identify the perpetrator, the panel expressed concern for the safety of the child and the decision of the Department to return care to a likely perpetrator. Casework staff at the review talked about their use of a new initiative, Signs of Safety. This raised substantive debate among panel members as to the possibility of protecting children in situations where the agent of the maltreatment and the source of risk have not been clearly identified. Based upon that debate, the panel requested that DHHS Office of Child and Family Services (OCFS) leadership meet with the CDSIR Panel to provide an overview of Signs of Safety, an approach to family engagement, safety planning, and service planning recently implemented by the Department.

At the March 2011 meeting, Paul Martin, Child Welfare Program Specialist with OCFS, provided the panel with an overview of the OCFS program developed in conjunction with *Signs of Safety, author, Andrew Turnell*⁽¹³⁾. He discussed the Department's strategy to place a child back in the home with confidence, even in situations of denied child abuse, through the development of an ongoing support system and safety plan that will remain in place when the Department is no longer involved with the family. Mr. Martin presented the approach as moving from "who did it" to "who in the family system will be responsible for protecting the child in the future." He indicated that this practice does not dismiss the importance of accountability and recognizing responsibility in the harm to the child, but focuses more on the common goal of preventing any further harm to the child in the future.

It was reported that the practice of Signs of Safety (SoS) in other states has shown promising results. He also indicated that the Department's historic emphasis on outside service interventions, such as therapy, has not created safety for the child beyond the life of the case. In the past, the Department has assumed the majority of the responsibility for safety planning. In contrast, Signs of Safety creates a network of support for the family and the Department works with the family and safety network to assess safety for the child.

This presentation raised a combination of interest and concern in some panel members. Members expressed concern that parents who may have injured a child were not held accountable and that, as a result, specific service planning could not be done. Additionally, some panel members raised concern about the dynamics of the perpetrator and the continued access to the child. Members questioned whether family members opposed to the plan might be excluded and stressed the need for seek out the "cynics" in the family. Other members, however, saw potential usefulness in a process that holds the entire family and support system accountable for safety planning and future child safety.

Department leadership agreed with the panel that the overall effectiveness of the initiative would best be reported through careful tracking of child safety outcomes related to the development of these plans. The Department indicated that data is being collected to show the effectiveness of the program and agreed to be held accountable to report these outcomes. They also invited a panel member to participate in the trainings in order to gain a more detailed understanding of the process.

The findings in this area are not specifically critical of the Signs of Safety model, as the model appears to have significant promise in its intended form. Implementation changes within the State, along with changes in Department leadership subsequent to those conversations, have left the panel uncertain of the progress in addressing child safety. The panel has, however, identified some issues that might inform the ongoing dissemination and implementation of this and other initiatives. They are as follows:

Planning around child safety, regardless of the model used, requires that the model be carefully understood and embraced by Department staff, as well as by the numerous stakeholders who participate in safety planning for

children and are called upon to implement the practice. It also requires diligent critical review and adjustment to adequately establish a new practice pattern. The implementation of a partially understood “hybrid” model is not a fair test or representation of a new treatment or planning process. Sometimes the new model works well and sometimes it can become a disastrous mix of the worst elements of old and new.

Child Welfare is a huge system with profound responsibilities in life and death matters. Any implementation of change in practice pattern will, by its nature, require careful planning, oversight, and ongoing expert supervision in order for it to be properly implemented and carry a reasonable chance for success. Additionally, there needs to be an ongoing review of data to ensure that the practice is increasing child safety and wellbeing.



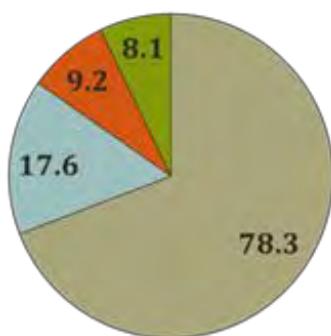


COLLABORATIVE RELATIONSHIPS WITH OTHER GROUPS

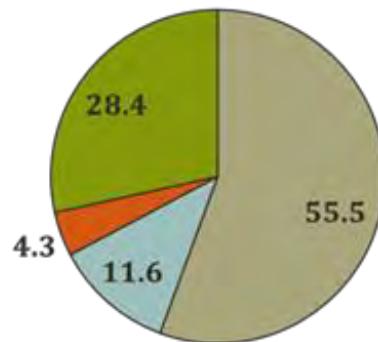
The Child Death and Serious Injury Review Panel understands that there are many effective ways to acquire knowledge and understanding; the relationship that the panel shares with the National Center for Child Death Review (NCRPCD), the American Academy of Pediatrics Child Death Review (AAP CDR), and the Northern New England Child Death Review (NNE CDR) is evidence applying to the CDSIRP stratagem, to enlist and join other organizational entities in an effort to increase awareness and eliminate factors that result in serious injuries and deaths to children in Maine communities and across the nation. Focusing on better, more significant, ways to prevent the physical harm and deaths of children; these long-standing advocacy forces meet annually and discuss new areas and prominent issues surrounding the abuse and/or neglect of children and their families. This collaborative effort expands the approach, improves accuracy, and supports legislation; locally, regionally and nationally.

The following diagrams depict the nature of abuse and neglect nationally and here in Maine.

National Rates of Abuse and Neglect (2010)



Maine Rates of Abuse and Neglect (2010)



Child Welfare Information Gateway (2012). Child Maltreatment 2010: Summary of key findings. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Maine Department of Health and Human Services



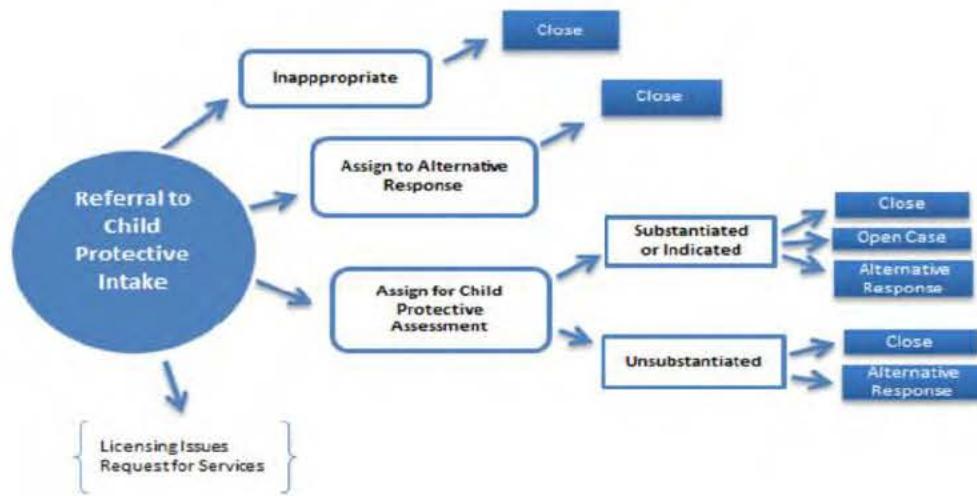
REFERRAL REPORTS

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 Department's decisions and ability to respond to reports of child abuse or neglect is based on factors such as the seriousness or complexity of the allegations and the availability of resources.

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 years 2010 through 2013 the Department of Health and Human Services received a large number of referrals for Child Protective Services intervention in a family situation. The following reports provide a summary of the number of referrals to Child Protective Services and the number of unassigned (inappropriate) referrals that were screened out.



TOTAL REFERRALS

NUMBER OF REFERRALS BY CALENDAR YEAR				
Year	2010	2011	2012	2013
TOTAL REPORTS	17457	18037	18867	19236

*Excludes reports referred to Licensing, Out of Home Investigation Unit, Service Requests, and reports received where a case was already open and the information was not a new incident.

APPROPRIATE REFERRALS

When reports contain allegations of abuse or neglect and are “appropriate” for intervention, the report may be assigned for a child protective assessment, or assigned to an Alternative Response Program (ARP).

NUMBER OF APPROPRIATE REPORTS				
Year	2010	2011	2012	2013
Total Reports	8119	6890	9071	8757

ALTERNATIVE RESPONSE

The Department of Health and Human Services has contracts with private agencies to provide an alternative response to reports of child abuse and neglect when the allegations are considered to be of low to moderate severity. Between 2010 and 2013, there were **5617** reports which were assigned to a Contract Agency for alternative response at the time of the initial report. Referrals were also made to Alternative Response Programs at the conclusion of a child protective assessment or case with a family, when ongoing services and support were deemed necessary.

NUMBER OF REPORTS ASSIGNED FOR ALTERNATIVE RESPONSE				
Year	2010	2011	2012	2013
Total Reports	2135	1458	865	1159

INAPPROPRIATE REFERRALS

Some examples of reports that would be deemed inappropriate include:

- **Parent/child conflict:** Children and parents in conflict over family, school, friends, or 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.

The following is the breakdown of the total number of inappropriate reports received over the past four years.

NUMBER OF INAPPROPRIATE REPORTS				
Year	2010	2011	2012	2013
Total Reports	9338	9425	9315	8889

CHILD ABUSE AND NEGLECT VICTIMS BY ABUSE TYPE

The following reports show the victims by age group which includes both male and female and type(s) of abuse found during the child protective assessment for the past four years. Children may be counted multiple times if they were the victim of more than one abuse type in a given assessment, or the victim of subsequent abuse in following calendar year.

2010				
AGE	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
0-4	51	219	1205	339
5-9	37	110	520	318
10-14	36	95	353	311
15-17	63	75	306	253
Total	187	499	2384	1221

2011				
AGE	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
0-4	45	241	1252	270
5-9	47	152	639	456
10-14	75	119	443	402
15-17	41	51	151	155
Total	208	563	2485	1283

2012				
AGE	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
0-4	73	359	1469	332
5-9	95	221	883	544
10-14	83	171	581	503
15-17	20	56	180	134
Total	271	807	3113	1513

2013				
AGE	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
0-4	57	424	1436	323
5-9	78	241	750	509
10-14	75	171	459	438
15-17	29	55	151	147
Total	239	891	2796	1417

**Children may be counted multiple times if they were the victim of more than one abuse type in a given assessment, or the victim of subsequent abuse in following calendar year.*

FAMILY STRESS FACTORS IDENTIFIED

RISK FACTOR	2011	2012	2013
Prior History with CPS	71%	71%	72%
Mental Health Problems	47%	46%	44%
Involved with Court	22%	22%	21%
Spouse Abuse/Family Violence	21%	21%	21%
Drug Misuse by parent	20%	20%	19%
Pregnancy/New Child	19%	19%	19%
Heavy Child Care Responsibility	18%	18%	14%
Unstable Living conditions	13%	14%	14%
ADD/ADHD	13%	13%	12%
School Related Problems	15%	13%	12%
Parent / Child Conflict	12%	11%	12%
Alcohol Misuse by parent	11%	12%	11%
Physical Health Problems	12%	11%	11%
Severe Acting Out Behavior by Child	11%	10%	10%
Emotionally Disturbed child	11%	10%	9%
Divorce Conflict	9%	10%	8%
Former Foster Child	10%	9%	8%
Learning Disability	8%	8%	8%
Inadequate housing	5%	5%	5%
Social Isolation	4%	3%	4%
Physical Disability	3%	3%	3%
Drug Misuse by child	2%	2%	2%
Premature Birth	1%	1%	1%
Runaway	1%	1%	1%
Alcohol Misuse by child	1%	1%	1%
Abuse to Animals	1%	1%	1%
Visual/hearing impairment	1%	1%	1%
Previous Child Death	<1%	1%	1%
Failure to Thrive child	<1%	<1%	<1%
Fire Setting	<1%	<1%	<1%
Fetal Alcohol Syndrome	<1%	<1%	<1%



ENABLING LEGISLATION

22 MRSA 4004 (1)

E. Establishing a child death and serious injury review panel for reviewing deaths and serious injuries to children. The panel consists of the following members: the Chief Medical Examiner, a pediatrician, a public health nurse, forensic and community mental health clinicians, law enforcement officers, departmental child welfare staff, district attorneys and criminal or civil assistant attorneys general.

The purpose of the panel is to recommend to state and local agencies methods of improving the child protection system, including modifications of statutes, rules, policies and procedures ; and [2007, c. 586, §3 (AMD).]

F. Investigating suspicious child deaths. An investigation under this paragraph is subject to and may not interfere with the authority and responsibility of the Attorney General to investigate and prosecute homicides pursuant to Title 5, section 200-A. [2007, c. 586, §4 (NEW).][2007, c. 586, §§2-4 (AMD) .]

22 MRSA 4008 (2)

E. A person having the legal responsibility or authorization to evaluate, treat, educate, care for or supervise a child, parent or custodian who is the subject of a record, or a member of a panel appointed by the department to review child deaths and serious injuries, or a member of the Domestic Abuse Homicide Review Panel established under Title 19-A, section 4013, subsection 4. This includes a member of a treatment team or group convened to plan for or treat a child or family that is the subject of a record. This may also include a member of a support team for foster parents, if that team has been reviewed and approved by the department; [2005, c. 300, §5 (AMD).]

3-A. Confidentiality, The proceedings and records of the child death and serious injury review panel created in accordance with section 4004, subsection 1, paragraph E are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The commissioner shall disclose conclusions of the review panel upon request, but may not disclose data that is otherwise classified as confidential. [1993, c. 294, §4 (NEW) .]

22 MRSA 4021 (1)

Subpoenas and obtaining criminal history, the commissioner, his delegate or the legal counsel for the department may:

A. Issue subpoenas requiring persons to disclose or provide to the department information or records in their possession that are necessary and relevant to an investigation of a report of suspected abuse or neglect or suspicious child death, to a subsequent child protection proceeding or to a panel appointed by the department to review child deaths and serious injuries.

B. Obtain confidential criminal history record information and other criminal history record information under Title 16, chapter 7 that the commissioner, the commissioner's delegate or the legal counsel for the department considers relevant to an abuse or neglect case or the investigation of a suspicious child death. [2013, c. 267, Pt. B, §19 (AMD).]

LIST OF COMMON ACRONYMNS

AAG – Assistant Attorney General
AAP – American Academy of Pediatrics
ACES – Adverse Childhood Experiences Study
AHT – Abusive Head Trauma
AP SAC - American Professional Society on the Abuse of Children
ARP – Alternative Response Program
CAPTA – Child Abuse and Prevention Treatment Act
CARES – Child Abuse Recognition Experience Study (AAP)
CARRET - Child Abuse Recognition, Research, and Education Translation
CDC – Centers for Disease Control and Prevention
CDS – Child Development Services
CDR – Child Death Report
CDSIRP – Child Death and Serious Injury Review Panel
CJA – Children’s Justice Act
CME – Chief Medical Examiner
COCAN - Committee on Child Abuse and Neglect (AAP)
COD – Cause of Death
CPM–Certified Professional Midwife
CPS – Child Protective Services
CR – Child Resistant
CW – Child Welfare
DA – District Attorney
DAB – Drug Affected Baby
DHHS – Department of Health and Human Services
DEC – Drug Endangered Child
DOB – Date of Birth
DOD – Date of Death
ED – Emergency Department
EPIC – Educating Physicians in the Community
ER – Emergency Room
EMS – Emergency Medical Service
EMT – Emergency Medical Treatment
FD – Fire Department
HIPAA—Health Insurance Portability and Accountability Act
LE – Law Enforcement
MACWIS – Maine Automated Client Welfare Information System
MDEA – Maine Drug Enforcement Agency
MOD – Manner of Death
MRSA–Maine Revised Statute
OB/GYN – Obstetrician/Gynecologist
OCFS – Office of Child and Family Services
OSA – Office of Substance Abuse
PA – Physician Assistant
PD – Police Department
PFA/PA – Protection from Abuse
PHN – Public Health Nurse
PPPA – Poison Prevention Packaging Act
PURPLE – Peak, Unexpected, Resist, Pain Like, Long-Lasting, Evening
FTM – Family Team Meeting
SACWIS – State Automated Child Welfare Information System

SBS – Shaken Baby Syndrome

SoS – Signs of Safety

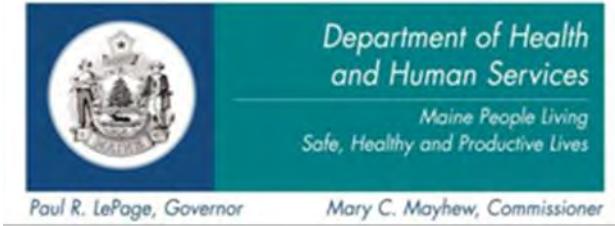
TPR – Temporary Protection Order

WIC–Supplemental Nutrition Program, for Women, Infants and Children

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