REPORT OF

MAINE'S MULTIDISCIPLINARY REVIEW PANEL

ON

CHILD DEATHS AND SERIOUS INJURIES DUE TO ABUSE OR NEGLECT

JUNE 1995

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CASE COMPOSITES:

The Panel recognizes that in spite of the best efforts of involved professionals, child abuse and neglect fatalities and serious injuries will occur.

The Panel reviewed cases where victims ranged from newborns to 16 years of age. Some child deaths and near fatal injuries were preventable and some were predictable. All were tragic.

The children without a voice are presented to you here:

- Sometime before his lifeless 15 year old body was found hanging, suspended above them in death, as he was in life, he thought his family might notice him now. None of them could recall when they last saw him alive, even though he hadn't left the house. As a little boy his neglect went unnoticed but prescriptions were written to dull his sadness and rage. As he grew older, his years of sexual abuse went unnoticed and his sadness and rage enveloped him. His young sister tastes her tears of grief but wipes them away to take care of her mother, the mother who hears voices in her head her daughter cannot hear.

- She couldn't pull herself up to the sides of her crib because one arm was tied to the crib frame. No one came when she cried with hunger. No one came to change her soggy diapers. Eventually she cried herself to sleep in the darkened room. The nurse who came when it was daytime noticed the baby's weight dropping. The baby liked to be held by her mother but this only happened when the nurse was there. When the baby was admitted to the hospital, she was diagnosed failure-to-thrive, with a severe diaper rash, an old leg fracture and restraint injuries.

- A five week old baby boy was discovered by his mother wedged between her and bedding when she awakened late in the day after an all night party. The five week old infant died from compression asphyxia due to overlaying by his mother. The baby had a 4 year old sister in DHS custody due to parental substance abuse, child abuse, domestic violence and unsuccessful parental rehabilitation. The sister had been returned home by DHS, re-injured by the mother and removed a second time to foster care.

- It only took a few seconds to make the baby stop crying. Peace and quiet, that's what the father wanted. A crying baby, changing dirty diapers and baby bottles interrupted his T.V. programs, his phone conversations, his sleep, his life. The baby's short life was beginning to ebb. The mother noticed the baby was limp. Later, at the hospital, the 8 week old baby boy died of Shaken Impact Baby Syndrome (SIBS). He had blood clots on his brain, blood behind his eyes, skull and rib fractures and bruises on his face.

Angus S. King, Jr.
Governor

Kevin W. Concannon
Commissioner

STATE OF MAINE

DEPARTMENT OF HUMAN SERVICES

Bureau of Child and Family Services
State House Station #11
Augusta, Maine 04333
(207) 287-5060
June 12, 1995

Dear Citizens of Maine:

I am pleased to issue this report of the Department of Human Services multidisciplinary Child Death/Serious Injury Review Panel to inform the public, the legislature and involved professionals of the Panel's findings and recommendations so that we can improve Maine's response to children at risk of abuse and neglect fatalities and critical injuries.

It is striking and disturbing that of the 14 child homicides in 1993 and 1994, only 3 victims had ever been known to child protective services. Predicting which children are at risk of abuse or neglect fatalities and injuries is a challenge to ourselves as child welfare professionals, investigators, evaluators, service providers, lawmakers, courts and their officers, citizens, neighbors and family members.

Here in our capitol and around the state of Maine, we have quite rightly erected memorials to honor those veterans and law enforcement officers who have died in service to others. We have not, however, formally memorialized Maine's children who have suffered fatal child abuse and neglect.

May this report also serve as a memorial to those children, to retain them in our thoughts and to move us to act upon the Panel's recommendations.

Kevin W. Concannon
Commissioner
Maine Department of Human Services

INTRODUCTION FROM THE PANEL CHAIRPERSON

Through the efforts of the Department of Human Services, the Maine Child Death and Serious Injury Review Panel began formal case reviews in May of 1992. The Panel is composed of dedicated multidisciplinary professionals. The members of the Panel have these past three years generously and tirelessly given of their time to wade through masses of records on dead and seriously injured children. At a time when serious child abuse is on the rise, when more, not fewer, children are dying annually in Maine, and in the United States, the Panel abides by its mission to identify the causes of child abuse and neglect fatalities and serious injuries to Maine children and to promote prevention. Our work has not been pleasant. It has, we believe, been important. We hope it will serve to protect the children of Maine.

Since 1992 the Panel has reviewed more than 25 cases in great depth. This first report details our findings and recommendations to date, along with a summary of our most important findings and recommendations. The Panel is not just a place where professionals talk. Members of the Panel have been active in implementing the very recommendations of the Panel.

1. **After the Panel identified the serious problem of shaken baby syndrome in Maine, the Maine Department of Human Services Division of Maternal and Child Health implemented both an educational program for parents on shaken baby and an ongoing research project to document the incidence of shaken baby in our state.**

2. **After reviewing examples of inadequate mental health assessments, members of the Panel developed mental health referral questions for child protective cases and a Panel subcommittee is actively developing a protocol and certification process for mental health professionals engaged in child abuse and neglect evaluations for the Department of Human Services.**

3. **After being asked to review a stalled case for a district attorney, the findings of the Panel led to reopened DHS and DA investigations, subsequent child protective action and criminal prosecution.**

4. **We have offered case specific recommendations to DHS regional offices at their request. These reviews have served to clarify and provide direction in complex multiproblem cases.**

5. **We have reviewed a child neglect death at the request of a legislator.**

6. **Other Panel recommendations have included: thorough record reviews including all medical and psychological records, death scene**

investigations, close collaboration between medical examiner, child protective services and law enforcement, communication among DHS regional offices, improved education of medical professionals, a state protocol for parental attachment assessments, improved assessment of safety of surviving siblings, urgent evaluation and photographic documentation of visible injuries, closer attention to domestic violence, development and utilization of statewide visiting nurse and public health nurse services for surveillance and prevention.

Maine is not without its problems. The incidence of death due to child abuse and neglect dramatically increased in 1993 and 1994; this despite what we see as improved responses by professionals throughout the state. The Panel may be a resource to stem that tide.

The hard work of this Panel is entirely voluntary. I would dare to say that no other child fatality review team in the country is as formidably configured. This Panel represents an unparalleled multidisciplinary resource for the State of Maine. We welcome any and all comment on our report.

For myself, the Panel has offered an opportunity to participate in a true multidisciplinary forum for child abuse and neglect. These cases are very difficult and very emotional. To read the voluminous records is to become immersed in the tragedies of Maine's battered children, shaken babies, sexually assaulted and murdered children, adolescent suicides and child neglect, all of whom take on a palpable reality for me and I am sure for the other Panel members.

For the profession of medicine, this Panel throws down a challenge. We have come a long way since child abuse was first recognized by Dr. Henry Kempe in 1960. We still have a long way to go both in identification and prevention.

As the Panel's Chairperson I invited the members to reflect on their experiences on the Panel, as well as offer any suggestions for the future operation of the Panel.

Lawrence R. Ricci, M.D.
Panel Chairperson

DHS MULTIDISCIPLINARY CHILD DEATH/SERIOUS INJURY REVIEW PANEL

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ACKNOWLEDGEMENTS:

THE PANEL ACKNOWLEDGES THE PARTICIPATION OF FORMER MEMBERS/ALTERNATES:

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Prosecutorial District No. One

Janet Mills, former District Attorney
Prosecutorial District No. Three

Anita St.Onge, former Assistant Attorney General
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Gratitude is also extended to the individuals who assist the Panel with the ongoing supportive functions it needs in order to operate and their efforts in compiling this report:

Donna Philbrook, DHS Clerical Support

Diane Moody, DHS Clerical Support

Robert Pronovost, DHS Statewide Intake Supervisor for Data Graphs

Phyllis Merriam, LMSW, DHS Staff Assistant to Panel

MAINE'S CHILD DEATH REVIEWS

Historically, Maine's Department of Human Services, Bureau of Child and Family Services has and continues to conduct internal reviews of children known to the Bureau who die as a result of abuse or neglect.

Multidisciplinary child abuse and neglect fatality reviews were initiated by former Department of Human Services Commissioner Michael Petit. During the mid-1980's a multidisciplinary child death review panel met regularly to review the circumstances of the deaths of children who were suspected to have died from abuse or neglect. As a result, that panel reviewed all child deaths in Maine from 1975 to 1980 and a child death study was published August 1982 and November 1983 and some significant internal Department of Human Services policy changes occurred.

Former Commissioner of the Department of Human Services, Jane Sheehan, re-activated a multidisciplinary child fatalities review panel in April, 1992, which reviewed it's first case on May 1, 1992. The panel meets monthly and to date has reviewed more than 25 cases.

The panel is composed of representatives of the judiciary, community and forensic mental health, pediatrics, nursing, public health, forensic pathology, civil and criminal law, law enforcement and child welfare, who volunteer their time to conduct retrospective reviews of child abuse and neglect fatalities and child abuse and neglect serious injuries. Extensive records are reviewed monthly and the panel's Executive Summaries with findings and recommendations are provided to the Commissioner of the Department of Human Services.

MULTIDISCIPLINARY CHILD DEATH AND SERIOUS INJURY REVIEW PANEL

MISSION STATEMENT

To provide multidisciplinary, comprehensive case review of child fatalities and serious injuries to children known to the Department of Human Services, Bureau of Child and Family Services, and to share the Panel's findings and recommendations with the Commissioner of the Department of Human Services.

The purpose of such reviews is to identify the causes of child fatalities and serious injuries to Maine children and to promote prevention.

REVIEW PROTOCOL

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

2. Comprehensive, multidisciplinary review of any specific case can be initiated by the Bureau of Child and Family Services, by the Commissioner of the Department of Human Services or by any member of the multidisciplinary review panel.

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

4. All relevant case materials 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 confidential 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 abuse fatalities and major injuries, which are consistent with state and federal confidentiality requirements.

LEGISLATION

As a result of the 1993 legislative session, 22 MRSA Chapter 1071 Child and Family Services and Child Protection Act was amended establishing the panel and it's functions in statute:

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-THREE

H.P. 1031 - L.D. 1383

An Act to Establish Multidisciplinary Reviews of Child Abuse and Neglect Fatalities and Serious Injuries and to Provide Access to Confidential Information for the Multidisciplinary Reviews

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §4004, sub-§1, ¶¶C and D, as enacted by PL 1979, c. 733, §18, are amended to read:

C. Cooperating and coordinating with other agencies, facilities or persons providing related services to families and children;

D. Establishing and maintaining a Child Protective Services Contingency Fund to provide temporary assistance to families to help them provide proper care for their children; and

Sec. 2 22 MRSA §4004, sub-§1, ¶E is enacted to read:

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.

Sec. 3 22 MRSA §4008, sub-§2, ¶E, as amended by PL 1989, c. 118, is further amended to read:

E. A person having the legal responsibility or authorization to educate, care for, evaluate, treat 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. This ~~shall include~~ includes a member of a treatment team or group convened to plan for or treat a child or family ~~which~~ 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;

Sec. 4 22 MRSA §4008, sub-§3-A is enacted to read:

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.

Sec. 5. 22 MRSA §4021, sub-§1, ¶A, as enacted by PL 1979, c. 733, §18, is amended to read:

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

1) The Department may apply to the District Court to enforce a subpoena.

2) A person who complies with a subpoena is immune from civil or criminal liability that might otherwise result from the act of turning over or providing information or records to the department; and

1993 CHILD HOMICIDES

DATE/COUNTY	VICTIM	MANNER	DATA
April Kennebec	8 mos. male	Blunt Head Injury	No CPS History History of Prior Injury Two Parent Family
April Kennebec	12 year female	Gunshot	No CPS History
June Washington	9 year male	Blunt Abdominal Injury	CPS History Domestic Violence One Parent Family
August York	2 year female	Asphyxiation (Arson)	No CPS History Child Visiting In Maine
October Aroostook	11 year female	Ligature Strangulation (Sexual Abuse)	CPS History Convicted Sex Offender Domestic Violence Two Parent Family
November Penobscot	5 year female	Starvation	CPS Screenout Parental Pathology One Parent Family
December Androscoggin	2 mos. male	Blunt Head Injury	No CPS History PHN Services Two Parent Family

1994 CHILD HOMICIDES

AN ADDITIONAL FOUR CHILD DEATHS WERE OF UNDETERMINED CAUSE/MANNER WHERE HOMICIDE COULD NOT BE EXCLUDED

DATE/COUNTY	VICTIM	MANNER	DATE
February Cumberland	19 months male	Poisoning Desipramine	No CPS History Two Parent Family
March Cumberland	2 year female	Blunt Injury Abdomen/Head	No CPS History History of Domestic Violence One Parent Family
July Somerset	6 year female	Gunshot	CPS History Custody Conflict One Parent Family
July Androscoggin	15 year female	Gunshot	No CPS History
July Penobscot	7 year male	Gunshot	No CPS History Custody Conflict Two Parent Family
July Penobscot	10 year male	Gunshot	No CPS History Custody Conflict Two Parent Family
November Knox	4 year female	Blunt Injury Abdomen	No CPS History History of Injuries One Parent Family

1993 CHILD HOMICIDES

IN PAST YEARS, THE USUAL INCIDENCES OF CHILD HOMICIDE ARE TWO OR THREE ANNUALLY. IN 1993, MAINE'S HOMICIDE RATE FOR ADULTS DECLINED MARKEDLY WHEREAS THE HOMICIDE RATE FOR CHILDREN WAS THE HIGHEST ON RECORD:

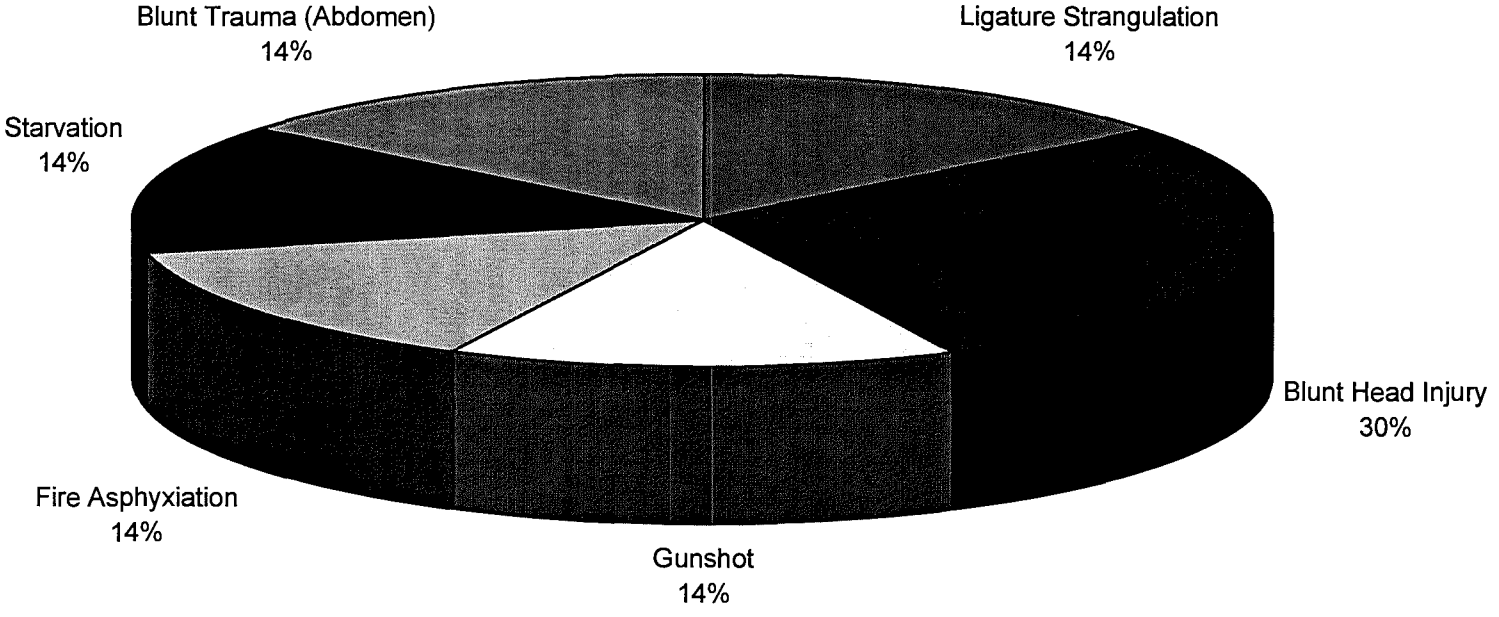
- **7 child homicides in 1993**
- 6 child victims were killed by family members:
    - 3 of the alleged perpetrators were females
    - 3 of the alleged perpetrators were males
    - unknown perpetrator(s) in one child death
- 4 of the 7 child victims were females
- 3 of the 7 child victims were males
- 5 of the 7 victims lived in two parent families
- The victims ranged in age from 2 months to 12 years of age:
    - 2 were under 1 year
    - 2 were age 5 years and under
    - 3 were latency age
- only 2 of the 7 victims had prior child protective involvement

1994 CHILD HOMICIDES

MAINE'S CHILD HOMICIDE RATE FOR 1994 EQUALED 1993. FOUR ADDITIONAL CHILD DEATHS WERE OF UNDETERMINED CAUSE/MANNER WHERE HOMICIDE COULD NOT BE EXCLUDED.

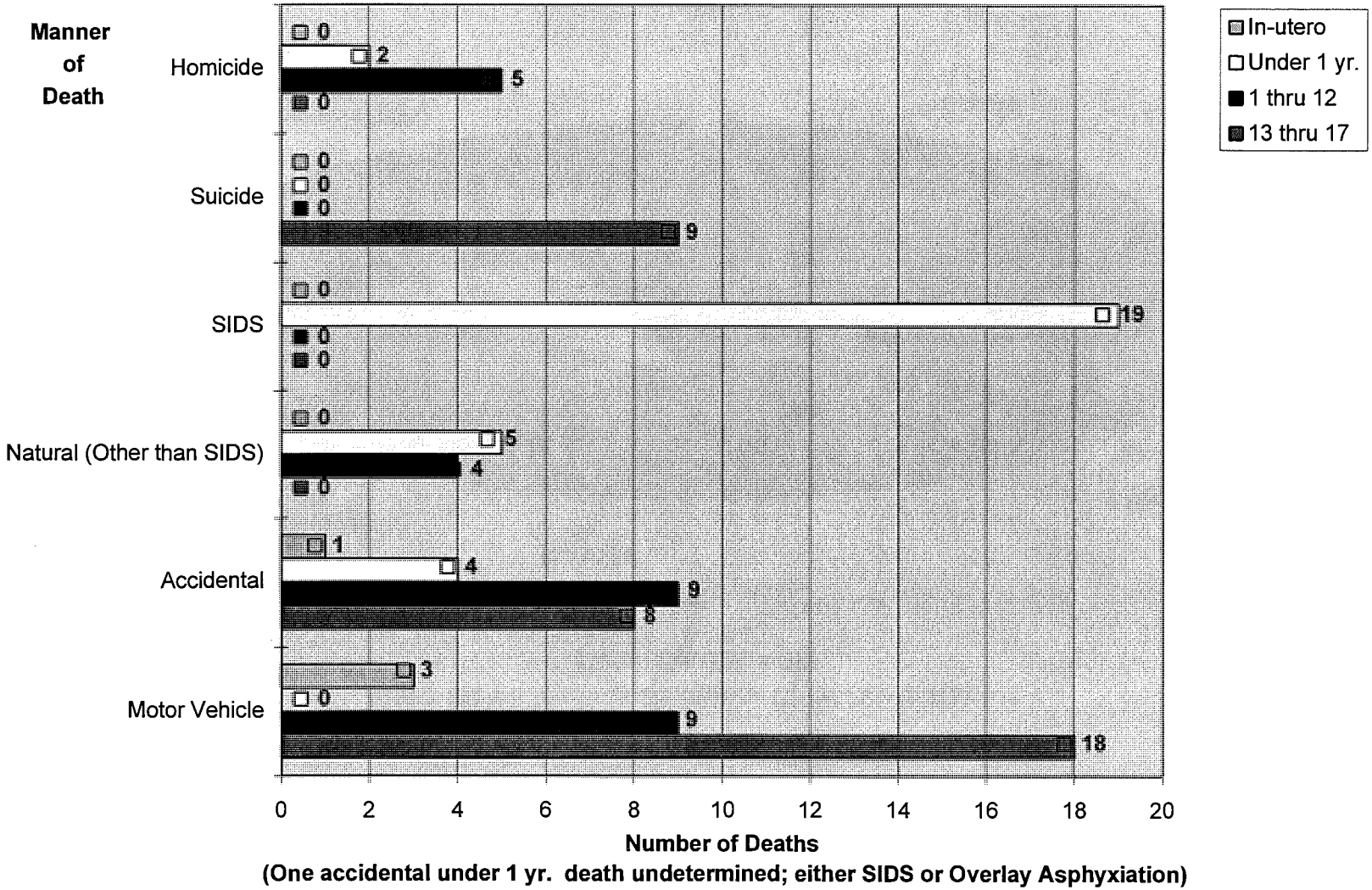
- **7 child homicides in 1994**
- 6 child victims were killed by family/or household members
- 1 child victim was killed by acquaintance
- 4 of the 7 victims were killed by gunshot
- 6 alleged perpetrators were male
- unclear perpetrator in one child death
- 4 of the 7 child victims were females
- 3 of the 7 child victims were males
- The victims ranged in age from 1 year to 15 years of age
- Only one victim had ever been known to child protective services

1993 Maine Medical Examiner Child Homicide Report
(Total Deaths = 7)



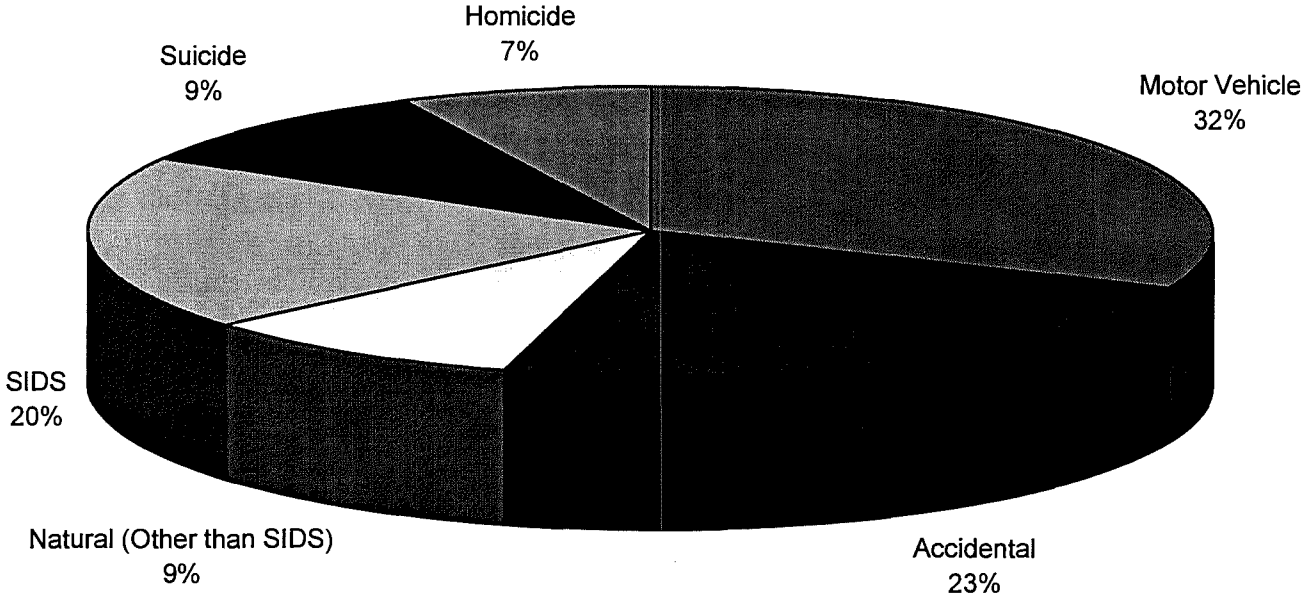
State of Maine
1993
Medical Examiner Data

Children's Deaths by Type
Total Deaths = 96



(One accidental under 1 yr. death undetermined; either SIDS or Overlay Asphyxiation)

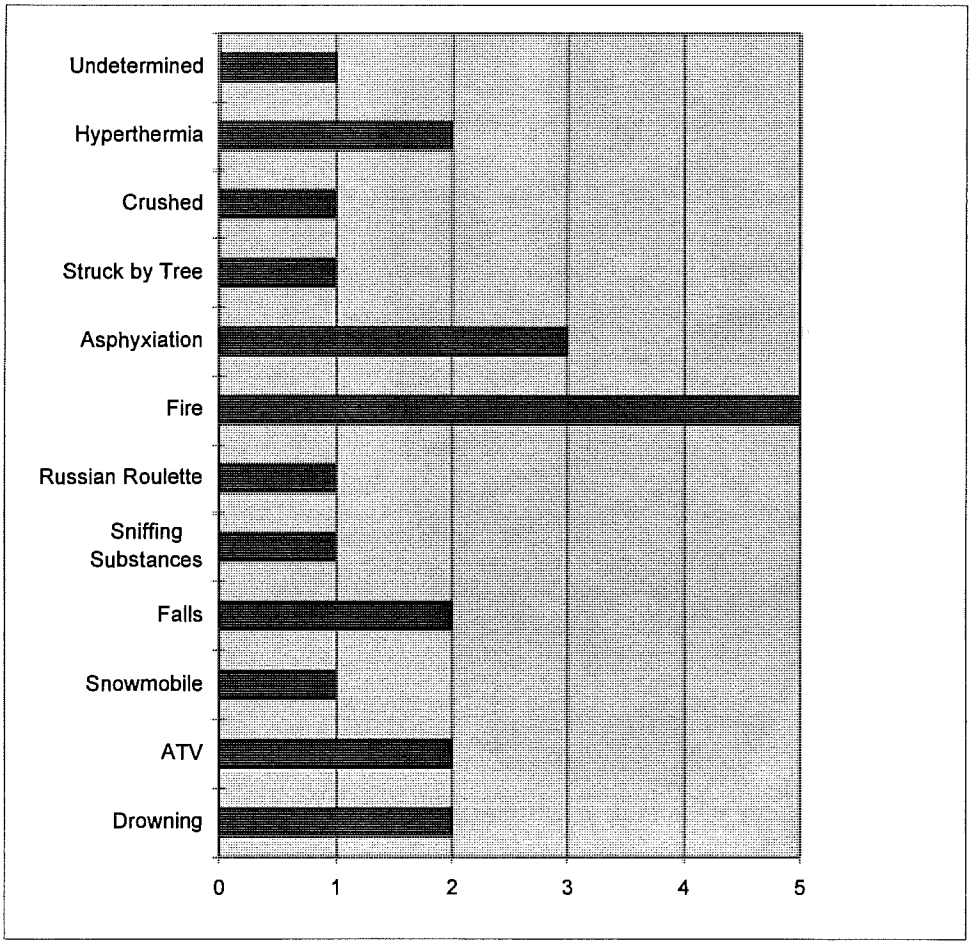
1993 Maine Medical Examiner Child Death Report
(Total Deaths = 96)



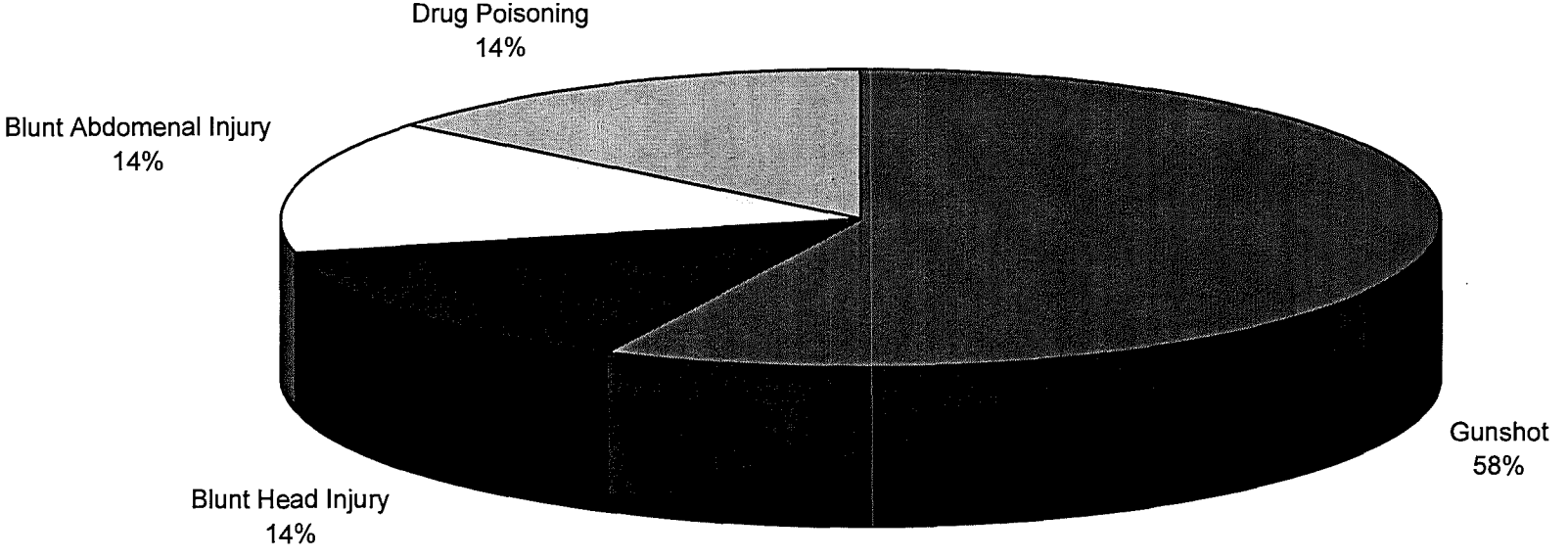
State of Maine
1993
Medical Examiner Data

Accidental Deaths by Age (Excluding Motor Vehicle Accidents)

Age	Under 1 Yr.	1 thru 12	13 thru 17	Total	
Drowning	0	0	2	2	
ATV	0	0	2	2	
Snowmobile	0	0	1	1	
Falls	1	0	1	2	(1 Accident in-utero)
Sniffing Substances	0	0	1	1	
Russian Roulette	0	0	1	1	
Fire	0	5	0	5	
Asphyxiation	2	1	0	3	
Struck by Tree	0	1	0	1	
Crushed	0	1	0	1	
Hyperthermia	1	1	0	2	
Undetermined	1	0	0	1	(Possible Overlay)
Total	5	9	8	22	

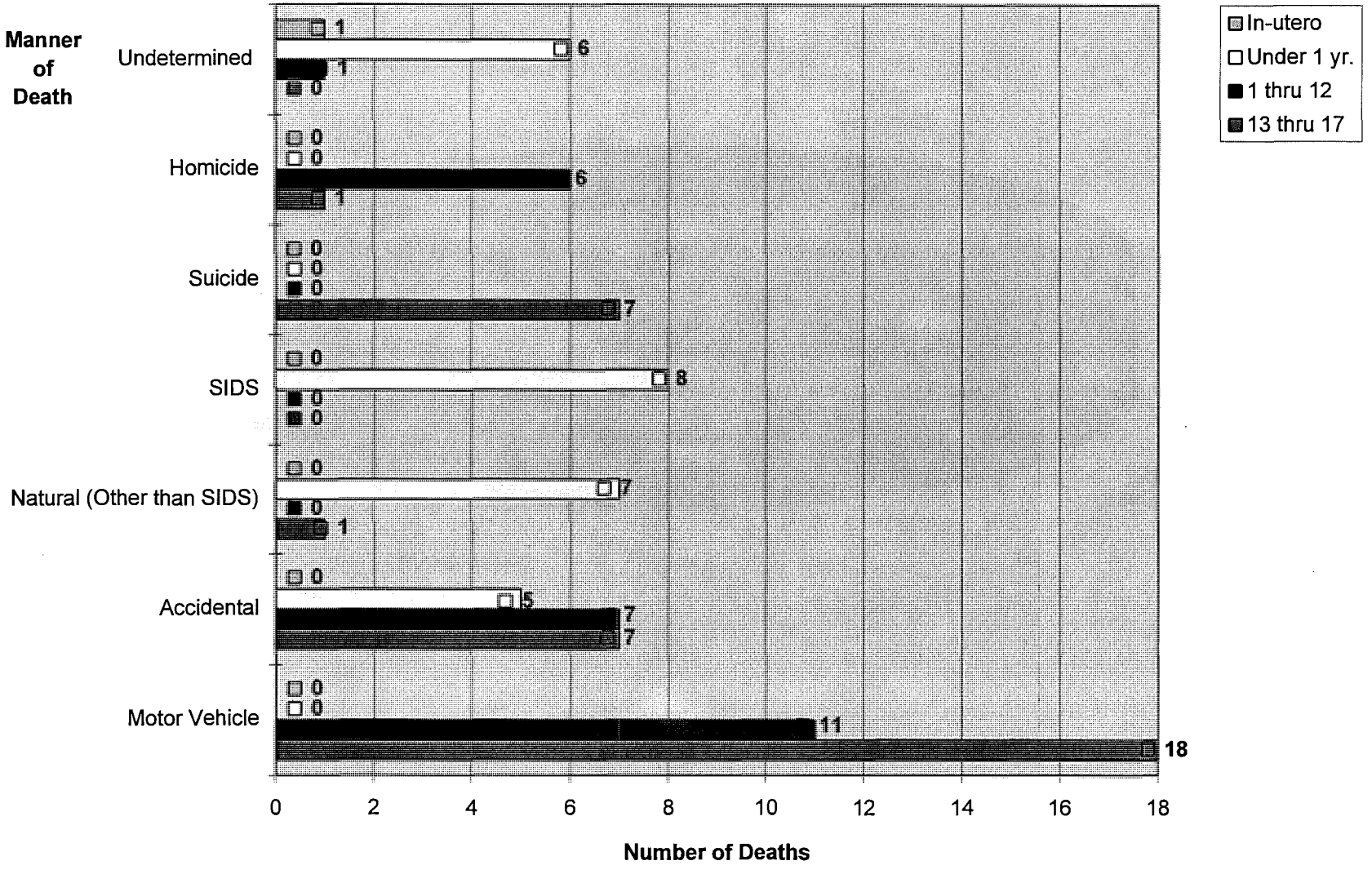


1994 Maine Medical Examiner Child Homicide Report
(Total Deaths = 7)

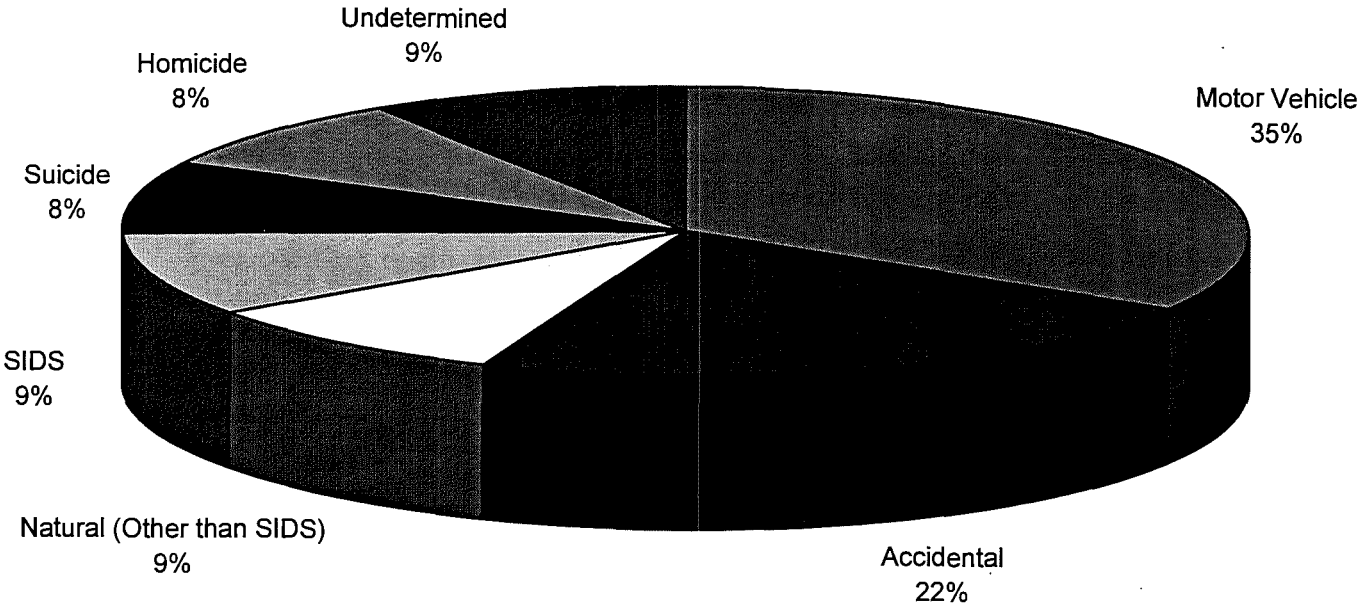


State of Maine
1994
Medical Examiner Data

Children's Deaths by Type
Total Deaths = 86



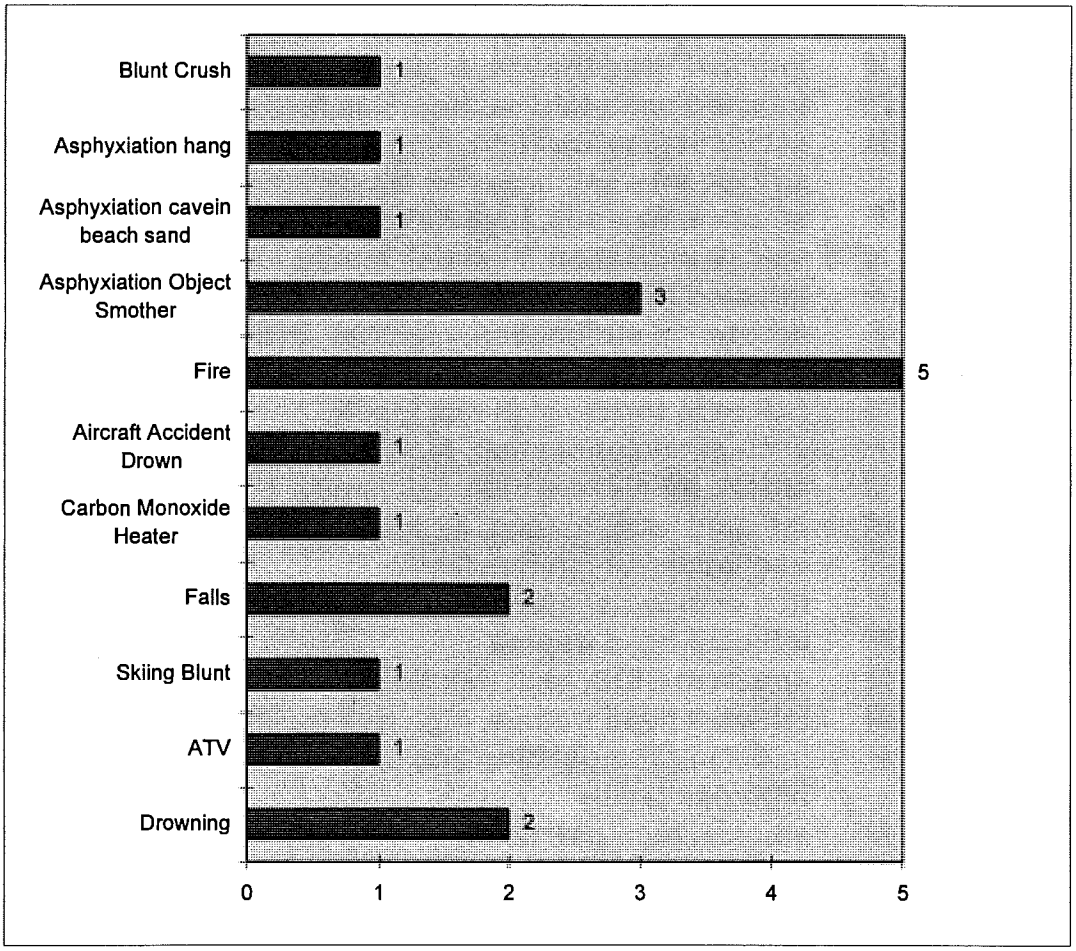
1994 Maine Medical Examiner Child Death Report
(Total Deaths = 86)



State of Maine
1994
Medical Examiner Data

Accidental Deaths by Age (Excluding Motor Vehicle Accidents)

Age	Under 1 Yr.	1 thru 12	13 thru 17	Total
Drowning	0	1	1	2
ATV	0	0	1	1
Skiing Blunt	0	0	1	1
Falls	0	1	1	2
Carbon Monoxide Heater	0	0	1	1
Aircraft Accident Drown	0	0	1	1
Fire	2	3	0	5
Asphyxiation Object Smother	3	0	0	3
Asphyxiation cavein beach san	0	1	0	1
Asphyxiation hang	0	1	0	1
Blunt Crush	0	0	1	1
Total	5	7	7	19



DETAILS OF 26 CHILDREN IN 25 CASES REVIEWED BY PANEL

ID #	AGE	SEX	DEATH OR DISABILITY CAUSE	OUTCOME
1.	9 mo.	M	accidental suffocation, high risk family	died
2.	3 mo.	M	possible SIDS, high risk family	died
3.	3 mo.	M	possible SIDS, high risk family	died
4.	1 mo.	M	inflicted head injury, high risk family	lived
5.	24 mo.	M	inflicted abdominal injury, high risk family	lived
6.	22 mo.	F	accidental drowning, high risk family	died
7.	17 mo.	M	inflicted head trauma, high risk family	lived
8.	1 mo.	M	inflicted head trauma, high risk family	lived
9.	24 mo.	M	accidental suffocation, high risk family	died
10.	180 mo.	F	suicide attempt, high risk family	lived
11.	11 mo.	F	smoke inhalation, high risk family	died
12.	24 mo.	M	smoke inhalation, high risk family	died
13.	5 mo.	F	inflicted head trauma	lived
14.	2 mo.	F	accidental suffocation, high risk family	died
15.	1 mo.	F	inflicted head trauma, high risk family	died
16.	14 mo.	M	failure to thrive, high risk family	lived
17.	1 mo.	F	accidental suffocation, high risk family	died
18.	27 mo.	M	smoke inhalation, high risk family	died
19.	3 mo.	M	inflicted head trauma, high risk family	lived
20.	0 mo.	F	neonaticide, high risk family	died
21.	60 mo.	F	non-accidental starvation	died
22.	8 mo.	M	inflicted head trauma	died
23.	2 mo.	M	apparent SIDS, high risk family	died
24.	30 mo.	M	inflicted head trauma, high risk family	died
25.	132 mo.	F	inflicted strangulation and sex assault, high risk family	died
26.	192 mo.	M	suicide, high risk family	died

ANALYSIS OF FIRST 26 CHILDREN REVIEWED BY PANEL

The panel reviewed 25 cases involving 26 children. 10 (38%) were female and 16 (62%) were male. Average age of all children was 3 years (excluding the three children over 10 years of age leaves an average age of 11 months). 8 (30%) lived while 18 (70%) died.

Of the deaths, 8 (44%) were female while 10 (57%) were male. Average age of the dead children (excepting the 2 over 10) was 9 months.

8 children sustained inflicted head trauma. 6 were male while 2 were female. Average age was 7 months. 3 died while 5 lived. Most victims were in high risk families.

There was one accidental drowning and 4 accidental suffocations all in high risk families.

There were 8 inflicted head injuries, 1 inflicted abdominal injury, 1 inflicted strangulation associated with a sexual assault and 1 neonaticide (newborn homicide), all in high risk families.

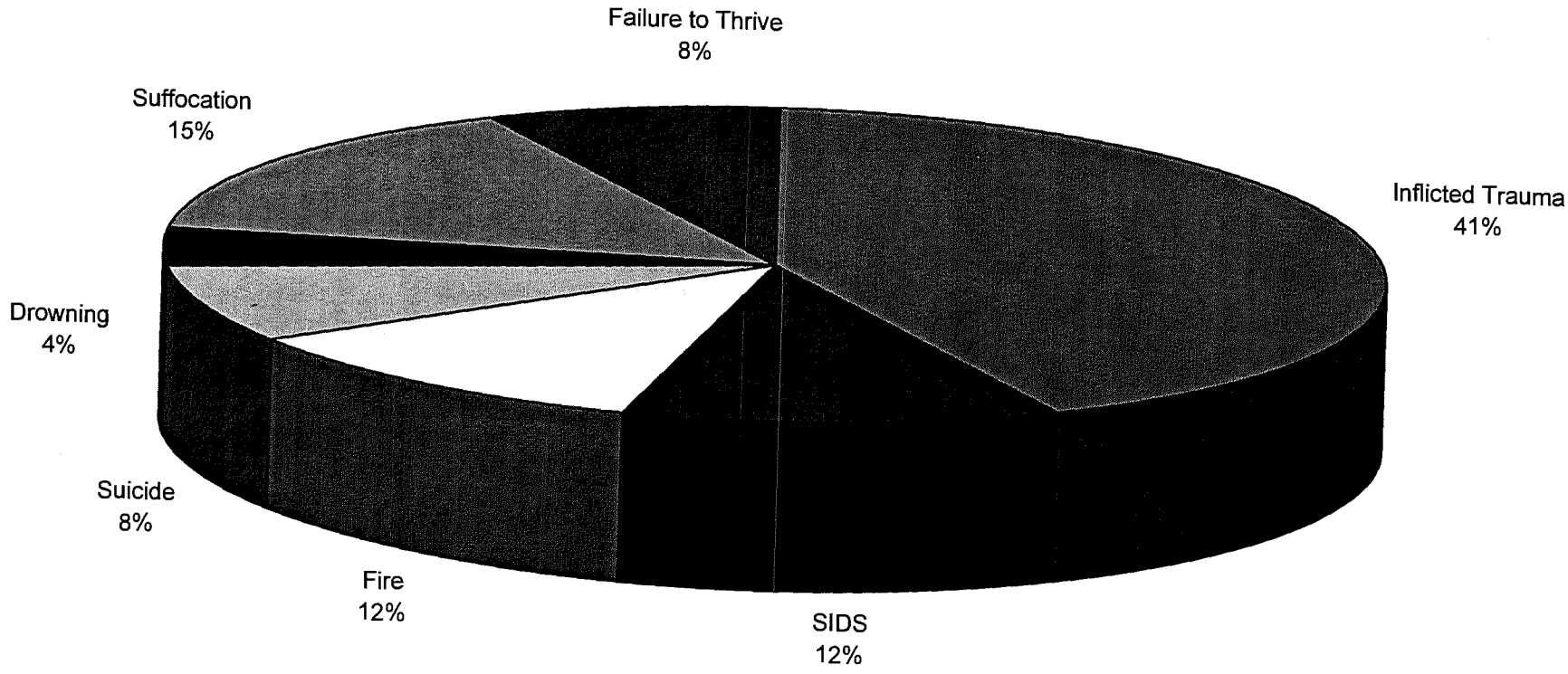
There was 1 non-accidental starvation death and 1 social-situational failure to thrive in a high risk family.

There were 3 possible/probably Sudden Infant Death Syndromes all in high risk family situations. (many Sudden Infant Death Syndromes are not from high risk families. The panel purposefully chose high risk families for review in this category).

There were 3 smoke inhalation deaths all in high risk family situations.

There was 1 teenage suicide attempt and one teenage suicide, both in high risk families.

Children Reviewed by Panel
May 1992 - April 1995



CHILD PROTECTIVE SERVICES DATA: 1993 & 1994

During the calendar year 1993 the Department of Human Services received 17, 292 referrals and in 1994, 18,439 referrals for Child Protective Services intervention in a family situation. In 1993, 10,913 referrals presented situations with evidence of serious family problems or dysfunction but did not contain allegations of child abuse or neglect. For 1994 the number was 11, 991 referrals.

In 1993 there were 2,093 Appropriate referrals and in 1994 there were 2,438 Appropriate referrals which were not assigned for assessment due to Insufficient Staff. The allegations in these referrals warranted Child Protective Services intervention but were not assigned because the regional DHS offices had reached their upper limits of capacity to investigate and assess.

In 1993 there were 4,286 referrals involving 9,567 children and in 1994 there were 4,010 referrals involving 8,902 children which were assigned to a caseworker for a complete assessment.

FAMILY STRESS FACTORS IDENTIFIED DURING ASSESSMENT

	1993	1994
Family Violence/Assaultive Behavior	**1056**	**953**
Alcohol/Drug Misuse by Parent/Caretaker	**915**	**822**
Mental/Physical Health Problem of Parent	**853**	**767**
Parent/Child Conflict	**790**	**705**
Mental/Physical Health Problem of Child	**732**	**634**
Severe Acting Out Behavior of Child	**556**	**509**
School Problems	**522**	**464**
Divorce Conflict	**494**	**401**
Child Withdrawn/Depression	**252**	**279**
Runaway	**127**	**106**
Alcohol/Drug Misuse by Child	**71**	**80**
Failure to Thrive Child	**33**	**23**

The Department's ability to respond to referrals of child abuse or neglect is based on factors such as the number of caseworkers, the seriousness or complexity of the cases receiving services and the availability of resources. For several years now, staff resources have not been sufficient for the Department to assign all of the referrals for Child Protective Services it receives. This situation is unlikely to change without availability of staff and resources to meet the demands for services.

A study conducted by the Associated Press found that 42% of the 1,300 children who died of abuse and neglect in the United States in 1993 had come to the attention of state child protective services before their deaths. In Maine, 21% of children who died of abuse or neglect in 1993 and 1994 had been known to child protective services.

FINDINGS

After reviewing the circumstances of 26 children who suffered death or serious injuries as the result of abuse/neglect, the following parent/caretaker characteristics may be generalized to situations where children may be at risk of serious injuries or fatal child abuse:

- Parent/caretakers volatility - particularly where the parent/caretaker is a male in his twenties - can be triggered by normal needs and behaviors of children such as:

    - crying/"fussy" infants/toddlers
    - diapering
    - toilet training
    - feeding
    - vomiting
    - bathing
    - ill child

- Parent/Caretaker Conditions/Behaviors such as:

    - lack of/diminished attachment to the child
    - parental narcissistic attachment to parenting role (the parent is attached to their success as a parent, rather than attached to and nurturing toward their child and when their child is not cooperative, the parent feels threatened, defeated and angry)
    - child neglect, including lack of supervision
    - substance abuse
    - domestic violence
    - multiple caretakers of child
    - frequent relocation (moving/transiency)
    - little/no child development knowledge
    - little/no protective judgment
    - cultural stigma attached to asking for help with parenting, making it difficult for parents, particularly educated parents, to come forward and ask for help

FINDINGS/RECOMMENDATIONS

The Panel recognizes the efforts of all individuals who strive to ensure the physical safety and emotional health of children. When the Panel found the work of individual professionals exemplary, letters of commendation were sent to those individuals and their supervisors.

Based upon the comprehensive case reviews it has conducted the Panel believes these specific findings/recommendations can reduce risks to children, and need to be carried out statewide:

CHILD ABUSE/NEGLECT ASSESSMENTS:

- A comprehensive training and quality assurance program is needed to develop a pool of qualified clinicians capable of conducting child abuse and neglect evaluations for DHS and the courts.

  This recommendation has resulted in an initiative by DHS and the State Forensic Service collaborating to develop a child abuse and neglect forensic evaluation service with: 1) standards, 2) evaluation protocols, 3) training, 4) quality assurance, 5) and peer consultation and review.

- The Panel concludes that many Maine mental health clinicians need training and confidence to make recommendations to cease rehabilitation efforts, when there is no hope of rehabilitation for a particular parent. The anticipated child abuse and neglect forensic evaluation service will be able to assist evaluators in this difficult, yet critical decision for children when family reunification is no longer a possibility.

- Enhance the capacity in DHS caseworkers, other in-home service providers and mental health evaluators, to recognize parental attachment problems and parenting abilities and deficits.

DHS needs to review and reinforce the year long risk assessment process already in place in child protective services and implement similar risk assessment protocols in Children's Services (foster care and adoption). This recommendation can assist DHS child welfare staff achieve consistent criteria, standards and protocols for: 1) gathering relevant information, 2) organizing, analyzing and documenting that information and 3) utilizing the information to make supportable decisions about child abuse/neglect, risk to children and parental capacity to protect. Such review, reinforcement and implementation could actually reduce the size of case records, many of which contain volumes of disorganized information too overwhelming to be useful to assist caseworkers and their supervisors: 1) determine whether or not a child is safe, 2)

measure whether or not the family is able/willing to change and 3) measure whether or not DHS interventions and services are effective.

EARLY IDENTIFICATION/PREVENTION:

- Promotion/encouragement of primary prevention efforts such as recent public education efforts in Maine regarding:
  - "Back to Sleep": Reducing The Risks of SIDS
  - "Shaken Baby Syndrome" (also called Shaken Impact Baby Syndrome - SIBS)

- A greater emphasis on improving and applying comprehensive community/family systems intervention is needed to improve protective risk assessments of disturbed children and adolescents who grow up to have children.

- Expand the use of the instrument: A.I.M.S.: DEVELOPMENT INDICATORS OF EMOTIONAL HEALTH (Attachment Interaction Mastery Support) to include the prenatal period. The Panel supports both this approach and the DHS Bureau of Health's grant to expand pre-natal services in Maine to include this trial assessment system of early identification of family pathology.

- During hospitalizations of high risk infants, the AIMS instrument needs to be routinely utilized by hospitals for earlier identification of these high risk infants.

- DHS reinforce training and education for mandated reporters of suspected child abuse/neglect, to reinforce statutory reporting responsibilities under 22 MRSA Chapter 1071 Child and Family Services and Child Protection Act.

- More public awareness and public education is needed to encourage parents to seek help, and concerned others to offer follow through with help, when needed. Accessible and acceptable services must be available to support healthy families and provide assistance to children and families at risk.

STANDARDIZED ASSESSMENTS/QUALITY ASSURANCE:

- The Panel urges caution and awareness of possible bias on the part of professionals when they assess cases where the people being assessed are also professionals, or appear to be very similar to, or very different from the evaluator.

- DHS urge Maine's judiciary to assess the quality of Interstate Compact on the Placement of Children (ICPC) reports from potentially receiving states and that the judiciary request additional information if ICPC reports are incomplete.

- DHS seek a mechanism, at the federal level, whereby national standards/protocols with a peer review process for ICPC reports, are developed in order that courts may have sufficient, relevant information to make dispositional orders which best protect children.

- DHS staff may benefit from training to assist in identifying cases where evaluations by experts are needed. The State Forensic Service has a library, including a text, O'Connell, Michael A., Leberg, E., & Donaldson, C.R. (1990) Working With Sex Offenders: Guidelines for Therapist Selection. Newbury Park, CA Sage Publications, Inc., a book designed to assist judges, attorneys, child protection caseworkers, probation and parole officers, therapists, etc. in selecting qualified, experienced, well trained professionals who can perform appropriate sex offender evaluations and treatment interventions.

- DHS needs to uniformly carry out its policy of immediate law enforcement notification by DHS when there may be violations of the law related to child abuse and neglect, so that timely coinvestigations occur.

- When DHS is confronted with confusing/complex cases, the best chance of resolving troublesome cases would be to gather together all professionals involved in the case, under the leadership of DHS, for multidisciplinary collaboration to discuss the facts of the case and formulate case directions.

MEDICAL ASSESSMENTS OF ABUSE/NEGLECT:

- When DHS is faced with cases of conflicting medical opinions, an authoritative opinion should be sought by DHS either to provide an independent review, or to seek consensus. All medical opinions regarding child abuse/neglect, but particularly where controversy exists, are best requested in writing.

- Physician and hospital education is needed regarding the importance of bone surveys in suspected physical abuse, particularly in children under the age of two, and notification of DHS prior to hospital discharge so that investigation can proceed while the child is in a safe setting.

ASSESSMENT OF SURVIVING SIBLINGS:

- When a family system experiences child abuse/neglect and/or violence and the perpetrator is removed, care should be taken to obtain evaluations of remaining family members/alternative caretakers, their histories, behavior patterns, protective judgment and attachments, as they relate to risk to surviving siblings.

- In homes where there is child protective involvement or history, and a child dies from whatever cause, the welfare of surviving siblings needs to be evaluated.

UTILIZATION OF AVAILABLE LEGAL PROTECTIONS FOR CHILDREN:

- When DHS believes it needs expert testimony, motions for medical/psychological evaluations can be sought during discovery and before disposition, a legal mechanism currently underutilized by DHS in child protective proceedings.

CRIMINAL INVESTIGATION/PROSECUTION:

- Development of a behavioral sciences component of the Maine State Police Crime Lab so that a partnership and training could be maintained with experts in their field, who could assist law enforcement in evidence gathering during investigations, e.g. time-lining access and opportunity by the perpetrator, with the events, and the onset of victim's symptoms.

- Consider collating information from statewide jury surveys in order to determine if there are more effective ways to investigate and prosecute child abuse and neglect deaths and serious injuries.

- A protocol be developed whereby law enforcement notifies Child Protective Services of these child deaths and child protective, in turn, locates relevant case files and gives that information to Office of Chief Medical Examiner by a requested deadline. (This protocol has been instituted effective 3-1-95.)

NEGLECT CASES:

- DHS and the Office of the Attorney General undertake a multilevel workgroup to develop a training program and practice guidelines to effectively intervene in chronic child neglect cases in the DHS and court systems.

CHALLENGES

Although case reviews revealed many instances of high quality work, the need for professional standards, protocols, increased multidisciplinary consultation/collaboration, quality assurance across disciplines was clear. Many of the Panel's findings and recommendations can be categorized as challenges for systemic changes/resource allocations/training needs for all involved entities:

- Lack of commitment of funding resources for staff allocations in DHS, law enforcement and community resources to meet caseload demands.

- Lack of shared/integrated data gathering to facilitate case specific communication among the various involved professional entities such as:

    - DHS
    - Medical Examiner
    - Hospitals/Physicians
    - Vital Records
    - Corrections
    - Law Enforcement

- Quality Assurance programs are needed to evaluate efficacy of interventions.

- Stalled/delayed child protective hearings/judicial reviews/termination of parental rights orders due to:

    - high court caseloads
    - diminished funding for courts
    - a combination of high DHS caseloads and the need for DHS to implement risk assessment procedures in Children's Services (foster care and adoption) as a way to facilitate decision making.

- Working with "closed", involuntary clients continues to challenge DHS, community service providers and training curriculum planners.

- DHS child welfare staffing patterns should authorize a supervisory ratio which allows for time to review agency records and reflect upon the demanding child safety decisions with which supervisors are daily confronted.

- Front line staff in DHS and private sector mental health find it very difficult to maintain self-confidence and professionalism in the face of adverse publicity and lack of support, particularly when they take an assertive stance and lose court cases or something goes awry in a case.

- Increased multidisciplinary case consultation/collaboration.

- DHS and other involved professionals need to develop an ongoing public education forum to aid the public's understanding of child abuse and neglect and to help prevent catastrophic outcomes for children.

PANEL WORK PRODUCTS AND INITIATIVES

As a result of reviewing child fatality and serious injury cases, the panel developed three work products and initiatives which are designed to enhance the ability of child protective and mental health services to evaluate risk to children.

Mental health evaluations and child abuse and neglect evaluations are critical components in assessing risk to children who are suspected to have been abused or neglected.

The Panel concludes from reviewing many mental health evaluations that a program for quality mental health evaluations in child abuse/neglect cases, which includes an evaluation protocol that requires complete records review, appropriate collateral contacts, in addition to clinical interviews is a critical need.

This recommendation has resulted in an initiative by DHS and the State Forensic Service collaborating to develop a child welfare forensic evaluation service with: 1) standards, 2) protocols, 3) training, 4) quality assurance, and 5) a peer consultation and review system.

POSSIBLE MENTAL HEALTH REFERRAL QUESTIONS IN CHILD PROTECTIVE CASES

By Sue Righthand, Ph.D. and Karen Mosher, Ph.D.

Mental health evaluations can be useful when assessing whether some parents can provide their children with safe, nurturing environments that meet their developmental needs. Sometimes evaluations of the parent, parents or parental figures may be sufficient for this assessment. However, particularly when a child appears to have special intellectual, emotional, developmental and/or behavior management needs, an evaluation of the child may be necessary.

In addition to individual assessments, direct clinical observations and assessments of the parent/child relationship can be extremely useful. Observations of spontaneous, as well as structured and unstructured, activities yield much information on parent/child attachments, interactional styles, communication skills, behavior management methods, etc.

Our clients typically do not volunteer for our services. They frequently are resistant to protective interventions and mental health evaluations.

In addition, not all mental health professionals have experience working with involuntary clients. When referring a client to a mental health professional, ask about their experience with this population. Also ask how they conduct these assessments, i.e., do they review the case record, seek out third party observations and reports, consult with or obtain records from treating therapists, etc.

After referring a case to a mental health professional, it is up to the clinician to determine how to address the reasons for the referral. The caseworker can guide the evaluation by providing clear and specific referral questions.

Some questions that concern protective workers (such as, did he or she abuse their child?) are factual in nature and are beyond the scope of a mental health evaluation. By their nature, mental health evaluations are clinical assessments and, as such can provide valuable information when used appropriately. Caseworkers can increase the likelihood that a mental health evaluation will provide useful information by asking referral questions that are within the scope of the mental health professionals' areas of expertise. Such referral questions can include, but are not limited to the following:

- What is the nature and quality of the parents' emotional attachments to their children? What factor or factors impede their relationships. How can these relationships be enhanced?

- To what extent are the parents able to differentiate their needs from their children's and place their children's needs before their own? Do they respect their children as separate, autonomous individuals and appreciate that they are, albeit temporarily, dependent upon them for their guidance and support?

- To what degree do the parents have reasonable, developmentally appropriate expectations of their children and adequately and respectfully communicate with them through active listening and developmentally appropriate language?

- How able are the parents to accurately perceive, value and validate their children as unique and special individuals, and accurately assess their strengths as well as their weaknesses?

- To what extent are the parents able to recognize and respond to their children's developmental and, when present, special needs?

- What are the parents' behavior management styles, e.g., to what extent are the parents able to set appropriate limits, be consistent, utilize positive disciplinary methods and model appropriate coping skills?

- To what extent are the parents able to be appropriately available to their children, physically and emotionally?

- To what extent are extended family members or friends present? To what degree are these relationships supportive, conflictual, etc.?

- How well do the parents' problem solve and utilize effective decision-making strategies in child rearing as well as in general? Does the parent know when there is a problem? Does parent correctly identify problems? Can parent conceptualize alternative problem solving solutions? Can parent accurately predict outcomes of these various alternatives? Can parent choose an alternative and follow through with it consistently? How consistent are their problem solving abilities over time and across situations?

- What factors increase or decrease the risk of continued abuse and/or neglect by the parents or significant others?

- How able are the parents to exercise satisfactory protective judgment? What verbal and behavioral evidence reflects their protective judgment abilities? How consistent is their protective judgment across time and situations? What factors enhance or interfere with the parents' protective judgment? How predictable or controllable are these factors?

- What factors interfere with positive parenting abilities, e.g., inadequate parenting, sexual abuse perpetration, child abuse and/or neglect, poor protective judgment, parental conflict and/or domestic violence, substance abuse, criminal behavior, mental illness, personality disorders, impulsivity, extreme emotionality, etc.? How frequent or consistent are these factors? How predictable are these factors? To what extent can these factors be remedied or managed? What is necessary in order to effect change? What interventions could be effective? How long are such remediation efforts likely to take?

- How aware are the parents of their strengths as well as their problems and deficits? How motivated are they to resolve their difficulties and improve their parenting skills? How consistent is this motivation? How is their motivation demonstrated?

- What factors are likely to increase or decrease the parents' motivation to effectively utilize protective services and recommendations and comply with appropriate mental health treatment?

RECOMMENDATIONS FOR MENTAL HEALTH AND RISK ASSESSMENT

By Karen Mosher, Ph.D. and Sue Righthand, Ph.D.

Detailed risk assessment protocols , like those recently implemented by DHS in child protective services, should be used to assess all families. The assessments should pay particular attention to the age of the child, understanding that infants are at the highest risk of death. Sometimes in addition to the standard risk assessment, a mental health evaluation also may be helpful.

In obtaining mental health assessments, the dilemma of dual roles between the supportive function of a treating mental health professional versus an investigative forensic function must be considered. In many cases, there is not an investigative mental health professional available.

A forensic service for child welfare cases is needed. It is recommended that a State Forensic Service for Child Welfare cases be established and develop protocols and standards for parenting capacity/risk assessment evaluations.

It is recommended that the same body develop a network of providers able to perform these evaluations to standard.

Protocols for focusing and clarifying information gathered in risk assessments and mental health evaluations need to be developed. The evaluator's discussion of the relationship between neglect, attachment, protective judgment, failure to follow through with recommendations, and risk to the child needs to be clearly delineated. Recommendations for treatment in this area should be tied specifically to risk so that DHS caseworkers and finders of fact are provided with better information.

If state funding does not permit such a move at present, it is recommended that DHS, the Child Death/Serious Injury Review Panel, and other interested parties begin to develop such standards.

In cases involving young, early verbal victims, planned and structured interviews by the most skilled interviewer available might be considered.

Careful and professional substance abuse evaluations including collaboration with collateral's in all such cases should be obtained. These evaluations can be part of a comprehensive mental health evaluation.

In the event of a suspicious death, the safety of the surviving siblings should be carefully evaluated. This evaluation should include the perpetrator as well as consideration of intergenerational and familial patterns that enabled the abuse to occur. Just because the perpetrator of a violent or abusive act is removed from a home does not mean that the children are safe. A comprehensive systems evaluation should be obtained to decrease the possibility that similar family patterns will be repeated with different players.

Families' success or failure at changing patterns of relationships that maintain children at high risk should be carefully documented and explained.

As a result of reviewing cases, the Panel recommends the following issues be assessed by mental health professionals when child protective services requests specialized assessments which address risk to children:

I. PROTECTIVE JUDGMENT:

Assessment of each parent's protective judgment, both verbal and behavioral.

Assessment of consistency of parental protective judgment, both verbal and behavioral.

Assessment of factors effecting changes in prenatal judgment if factors or judgment varies.

Predictability and controllability of those factors and changes which may result in variable risk.

II. MOODS AND EMOTIONS: (AFFECT)

Assessment of moods and emotions and the extremes of those.

Assessment of where the parent's affect is at various times as well as most of the time, according to self-report, direct observation and observation and history by other providers.

Assessment of factors effecting changes in moods and emotions, predictability and control of those factors.

III. IMPULSIVITY:

Assessment of impulsivity, variability of impulsivity, factors effecting the variance and the predictability and control of the variance.

What mental health treatment is the parent receiving? How do those treatments relate or not relate to protective judgment, emotional difficulties and impulsivity? Are the parents consistent and predictable? What are the parents' problem-solving and decision-making strategies?

IV. PROBLEM SOLVING:

What are parental attitudes toward problem-solving? Do they have a short-term or long-term problem-solving skills?

1. Can the caretaker accurately identify problems, i.e., do they know when something is wrong?

2. Can they conceptualize alternative problem-solving strategies?

3. Can they assess potential plusses and minuses of various strategies?

4. Can they choose a strategy and apply it behaviorally?

5. Can they apply the strategy consistently and under various situations?

6. Can they assess the success of the strategy and self-correct?

7. Does the chosen strategy relate to long-term goals or short-term relief?

Assess how well the caretaker understands their problems with protective judgment, emotional difficulties, impulsivity and problem-solving.

Assess the parents' history of insight regarding their deficits in the above and their compliance with treatment.

Assess how successful treatment has been in addressing specific issues that relate to severity of risk to the child.

The systematic development and documentation of this type of information will provide child protective workers, mental health professionals and finders of fact with clear information on the risk to children including children of mentally ill and mentally retarded parents.

Other referral questions for evaluation that might clarify risk in similar situations are:

1. Is this caretaker able to differentiate self from child?
2. Does the caretaker have an accurate perception of the child?

3. What are the caretaker's skills at communicating concrete and emotional information.
4. What is the physical and emotional availability of the caretaker to the child?

GUIDELINES FOR FORENSIC EVALUATIONS OF ALLEGED OR CONVICTED PERPETRATORS OF CHILD ABUSE OF NEGLECT

By Sue Righthand, Ph.D., Consultant to State Forensic Service

I. IDENTIFYING INFORMATION:

Include all aliases, dates of evaluation, etc.

II. REASONS FOR REFERRAL:

III. INFORMATION SOURCES: (USE AS MANY AS POSSIBLE)

Department of Human Services (in/out of state) written records and updated
Federal, State and Local police investigative reports/pictures, audio/video tapes
Arrests/convictions records
Probation and parole records
District attorney discovery
Victim witness advocate reports
Treatment records (mental health, substance abuse, medical, etc.)
School, work, military records
Victim reports, victim's medical and/or mental health reports
Guardian ad litem reports
Interview with family/friends/employers, etc.
Self-report/clinical interview
Psychological testing

IV. INFORMED CONSENT/DISCLOSURE STATEMENT:

Document that the alleged/perpetrator has been informed of the purposes of the evaluation, has been told that communications during the evaluation and the evaluation report are non-confidential, how the report will be distributed and who may have access to the evaluation.

V. REPORTED CHILD ABUSE AND/OR NEGLECT:

Discuss current and previous child abuse and/or neglect reports. Detail sources, level of substantiation (e.g., departmental, judicial, non substantiated, etc.) Due to the potentially severe consequences of child abuse and neglect allegations, to the accused as well as his or her family, perpetrators and alleged perpetrators frequently deny, minimize and/or distort their abusive/neglectful behaviors. Information from collateral sources is essential. Unsubstantiated information may be valid, but clearly note it is unconfirmed. Then, evaluate the difference between the alleged/perpetrator's report and others. Describe the impact of the abuse on the child(ren) to the extent it is relevant to the alleged/perpetrator's assessment.

VI. SIGNIFICANT HISTORY:

Discuss family of origin. Include mental health, child protective, criminal histories, religious influences, stresses, positive coping, etc.

Describe relevant pre/perinatal/childhood/adolescent circumstances, e.g., social, sexual, abusive (as victim and/or victimizer), medical, education, mental health, substance abuse, etc.), relevant adult history, e.g., social, sexual, marital, abusive (as victim and/or victimizer), education, military, vocation, substance abuse, hobbies, recreation, stress management, etc.

VII. PREVIOUS INTERVENTIONS:

Discuss prior child protective, legal, criminal, mental health, etc. interventions, the extent to which they were effective in managing the risk of child abuse and neglect, why they failed, etc.

VIII. CURRENT FUNCTIONING:

FAMILY:

Significant other/marital relationship. To what extent is this relationship positive and helpful vs. conflictual and hurtful. Include relevant information about partner's/ex-partners' current functioning (e.g., restraining orders, involved in treatment, etc.)

PARENT/CHILD(REN) RELATIONSHIP:

Discuss strengths and weaknesses. Evaluate quality of emotional attachments, developmental expectations of children, accurate perceptions of individual children, ability to differentiate adult needs from the children's and act in the children's best interests.

Assess communication and listening skills, thinking errors and cognitive distortions. Evaluate discipline styles, e.g., to what extent are the alleged/perpetrators able to set appropriate limits, be consistent, utilize positive parenting techniques and model appropriate coping skills. Is the alleged/offending parent/caretaker able to be physically and emotional available to the child(ren) and value and validate each child as unique and special. Evaluate protective judgment, e.g. the alleged/offending parent/caretaker's awareness of personal child abuse and neglect risk factors, and those of others, his or her ability to assure appropriate supervision and environmental controls, utilize appropriate problem solving strategies and access needed social supports. Assess how consistent protective judgment is across time and situations. Discuss relevant information about the child(ren)'s current functioning (e.g., disability, acting out, special needs, etc.) as well as the alleged/offending parent/caretaker's ability to identify and meet the children's individual and collective needs.

SOCIAL/SEXUAL:

Discuss the individual's ability to satisfy social/sexual needs in non-abusive, age appropriate ways. To what extent are family members, friends, community supports helpful and available. To what degree are these relationships positive and supportive vs conflictual and detrimental.

FINANCIAL:

Note financial and vocational problems, e.g., unemployment, job insecurity, work stress, frustration/actualization of goals, etc.

MEDICAL:

Note current difficulties, sleep disturbances, relevant medications/compliance.

PSYCHOLOGICAL/CLINICAL ASSESSMENT:

Discuss factors that inhibit and/or facilitate positive parenting, e.g., life stress, depression, over/under controlled hostility and aggression, impulsivity, impaired empathy, psychopathy, personality disorders, mental illness or retardation, sexual dysfunction, etc. Evaluate social skills, problem solving strategies, coping methods, the ability to appropriately access social supports and resources, etc. Assess the extent to which these abilities/difficulties are consistent over time and situations.

Psychological testing can be useful for assessing defensiveness, anxiety, depression, psychopathy, attitudes, values, beliefs and other psychological factors related to child abuse and neglect. Psychological tests and instruments, relevant to the referral questions, can provide valuable risk assessment and management information. However, no psychological test, instrument or clinical interview can determine whether child abuse and/or neglect has, in fact, occurred. Although some perpetrators of child abuse and neglect share some characteristics, they are heterogeneous. There is no offender profile.

IX. RISK ASSESSMENT:

What factors increase/decrease the risk of future child abuse and/or neglect? Are these factors current, frequent, or continuous? In what circumstances or situations do they occur? To what extent can these factors be predicted and controlled?

X. RISK MANAGEMENT RECOMMENDATIONS:

INDIVIDUAL:

Provide relevant clinical recommendations, such as psychotherapy interventions that target child abuse and neglect risk factors.

FAMILIAL:

Recommend referrals for appropriate mental health evaluations or therapy, public nursing or other relevant programs, etc. as well as involving appropriate extended family members as resources.

COMMUNITY:

Recommendations may include involving appropriate community members, employers, colleagues, etc., as resources, for example, as supports, supervisors, etc.

XI. ***PROGNOSIS:***

Assess the alleged/perpetrator's motivation and ability to follow and benefit from risk management recommendations. Utilize evaluation findings and relevant research to estimate the time it may take to effect behavioral change consistent with positive parenting and effective risk management.

PANEL INITIATIVE

Shaken Impact Baby Syndrome Retrospective Study

A subcommittee of the Child Death/Serious Injury Review Panel has undertaken a one year retrospective review of Shaken Impact Baby Syndrome (SIBS) cases. Depending upon the numbers of cases identified, a three to five year retrospective study will follow, with ongoing epidemiological surveillance.

Annually, an estimated 10 to 20 Maine children suffer Shaken Impact Baby Syndrome (SIBS). SIBS describes the medical results of violent shaking of infants, with or without associated impact, by caretakers. Results encompass a syndrome which includes brain injuries, skeletal injuries, eye, and skin injuries, all in a characteristic pattern.

Among the criteria for inflicted injury are: admitted abuse, witnessed abuse, injury, especially brain injury, incompatible with offered history, blood behind the eyes with brain injury, multiple fractures, especially rib and chip fractures of the growing end of a bone, and multiple bruises in inflicted patterns.

In order to better define this syndrome as it applies to Maine children, its social/situational causes, its medical presentation, and its legal repercussions, a study of this disease in Maine is necessary. Assisting in this project will be Maine State Police, the Bureau of Child and Family Services of the Department of Human Services, The Office of Chief Medical Examiner, Division of Public Health Nursing, The Child Abuse Program at the Spurwink Clinic, Maine Medical Center and Eastern Maine Medical Center.

Among the purposes of the study are: 1) identification of risk factors for SIBS, 2) outcomes of criminal investigations and prosecution, and 3) annual trends of SIBS in Maine.

PANEL INITIATIVE

Infant Feeding Management

DHS's Division of Maternal and Child Health will be working with involved service providers to new parents regarding infant feeding mismanagement and the risks of hyponatremia: water intoxication due to giving infants too much water. Any water, including bottled water, can cause serious problems because there is no salt. A less common cause of hyponatremia is due to diluting infant formula.

PANEL MEMBERS REFLECTIONS/SUGGESTIONS

JUDICIARY

The District Court is a high volume court and as a result the circumstances dictate immediate response and action. There is little time to reflect due to the emergency matters that confront the District Court on a daily basis.

The Child Death/Serious Injury Review Panel has provided me with the opportunity to reflect on these actions and responses. Learning how other agencies function in the investigation of child injury/death cases has been most enlightening and educational. It also has helped me develop a different perspective about my work and responsibility.

It is most heartening to know how dedicated our state agencies are in protecting the best interests of Maine's children.

Honorable Judge John Beliveau
Maine District Court Justice

DISTRICT ATTORNEY

As a new member of the Panel, I was immediately impressed with the interaction of members from different disciplines, each viewing problems from the perspective of their own professions. Despite the diversity of approach, the overall interaction of the group has shown a unanimity of purpose and concern. The extent to which the Panel uses its abilities to foster improvement in the system's reaction to abused children, and the people who abuse them, will be the measure of its actual success for me.

My experience in prosecuting cases of child abuse and neglect has shown that for the most part, the people within the system are what "work" best, and to the extent that the system is responsive, it is as a result of the individual efforts of such people. The major challenge that faces the legal system are the inadequate resources devoted to it. More money and resources cannot be the answer to every social problem; however, until there are sufficient numbers of trained investigators, prosecutors and judges to deal with such cases in a timely fashion, the system will undoubtedly fail numbers of abused children and their families.

Alan P. Kelley
Deputy District Attorney
Prosecutorial District IV

LAW ENFORCEMENT

Being on the Panel has meant:

1. **My awareness has increased of the cooperation that exists and is available with other agencies.**

2. **My respect for those agencies, especially DHS, willingness to self-evaluate and address areas of concern has increased significantly.**

We currently have a pretty good system, but, as with any "machine", it constantly needs adjusting for proper operation. A problem within the State Police is insufficient personnel to adequately deal with the current case load demands.

We must continuously train with DHS personnel and prosecutors, encouraging all efforts to promote the team concept, when appropriate. Dealing with child homicides (shaken baby, etc.) is especially critical and all concerned must receive and be aware of "state of the art" techniques as we deal with these increasingly difficult circumstances.

Captain Charles N. Love, Director
Criminal Investigation Division
Maine State Police

Being on the multidisciplinary Child Death/Serious Injury Review Panel has been very exciting to me. Until being on this Panel, I never realized the major role that the other disciplines played in child death/serious injury cases. This gave me a better appreciation of the roadblocks and difficulties that all agencies have in these cases.

Due to this Panel, the Maine State Police has improved child death investigations and made those investigations more consistent. Our investigators are now mandated to contact Department of Human Services on child death cases, which is improving communication between the agencies. We are also gathering more information that is useful to the Medical Examiner on child death cases.

There is always room for improvement and I feel strongly that the best way to do that is through a multidisciplinary panel.

Lt. Gerard Therrien
Criminal Investigation Division
Maine State Police

ATTORNEY GENERAL

I have been a Panel member for several years, always as the designated representative for the civil division of the Office of the Attorney General. During that time, one of the greatest personal and professional benefits of participation has been exposure to the wide spectrum of disciplines and concerns represented by the standing membership of the Panel. It is impossible to imagine what facet of community, mental health, legal, social work and law enforcement systems has not been given full voice during deliberations and discussions. Beyond the systemic balance of the Panel, the individuals who have filled those slots have, without exception, been compassionate, informed, intelligent, and thoughtful. I am convinced that the full exploration of the cases presented has never been compromised by an attempt by any Panel member to insulate their profession from critique, understanding the purpose of the work to always be constructive praise and criticism.

On a more personal note, I have enjoyed the monthly seminar, free of charge, on topics of great personal and professional interest: shaken baby syndrome, teenage suicide, SIDS, pedophilia, and assorted other seemingly morose and macabre subjects. These discussions have made me a better attorney in child protective cases and have given me a wealth of information which I have attempted to share with other lawyers in my office. I also have a ready-made panel of experts who have been generous with education and suggestions when I have raised questions about my cases.

However, I remain concerned about the value of the Panel as an institution. Certainly, we all anticipate the release of the Panel's report will, for a time, focus discussion on what works and what doesn't in our society's efforts to protect children. I am pessimistic about the uses to which the report may be put; it has always appeared to me that the public is much more interested in lurid details about child death and injury than it is in any examination of the mechanisms which failed and the appropriate way to correct them. On occasion, even in the frank and open discussions of the Panel, I have at times felt that there existed an implicit agreement not to dwell on errors attributable to inadequate funding or staffing of an agency or organization. Although I firmly believe that few child protective issues can or should be resolved by simply allocating more funds, I reject the proposition that advocacy for realistic levels of financial support should be stilled by the irrefutable logic of budget charts and fiscal projections. This is true in both the public and private sectors, which both need to be accountable for the safety of children. In short, I hope the Panel will strengthen its resolve to assess all the cases presented to it in a manner not unreasonably curtailed by a perception of what we should do and what we can afford to do.

I also have, I believe, failed to adequately respond to what appears to be real conviction on the part of some Panel members that the legal system does not care about and cannot protect children. To some degree, my inarticulate defense of the statutes and procedures in that arena has been offset by the addition of Judge Beliveau to the

Panel. The Panel needs to be more attentive to what balancing of personal and governmental rights as well as child and family rights is represented by the Child and Family Services and Child Protection Act; it should be able to acknowledge the legitimacy of those interests and consider them in it's critique of the legal piece of the child protection system. In that regard, the Panel might benefit from a short session on those issues. I would like to see the Panel, in turn, be more precise in identifying those occasions in which the legal system has been inadequate and how best to address those deficiencies. This includes the possibility of requesting changes in the law or court procedures designed to make the legal system a better forum for child protective intervention.

Please do not allow my thoughts to be construed as disappointment in the Panel's efforts or dissatisfaction with its conclusions. Certainly no other program or entity has been more helpful to me professionally or interesting to me personally. I look forward to continued participation with this enterprise.

Christine Foster, Assistant Attorney General
Civil Division
Department of the Attorney General

My specific discipline is the initial investigation, in conjunction with the police authorities, and the ultimate prosecution of cases involving homicides. In the context of child abuse and neglect, this would involve child homicides. My experience in these cases is that they are very frustrating with respect to their solution and the willingness of jurors to accept the fact that parents and caretakers do, in fact, kill their children. The concept that a parent can act in such a violent way as to cause death to his or her child is so horrible to contemplate, that I believe that a jury encounters an initial resistance in wanting to believe that it could happen. From my perspective, what I hope the Panel can do for me is to give me a better understanding of the medical aspects of the injuries involved in child deaths and better equip me to present these matters to lay juries in an intelligent, common sense and understandable fashion.

Certainly I think that there is a greater public awareness, consciousness and sensitivity to the existence of child abuse and neglect. I think we have done a fairly good job, as a society, in getting the message out that child abuse exists. Nevertheless, I am not sure that that sensitivity has reached a point where people are willing to act upon their initial suspicions. There certainly remains the notion that people do not want to get involved; that a parent's method of disciplining his or her child is the family's business no one else's; and there is, of course, the remaining problem that it is fun and convenient to bash the Department of Human Services and caseworkers in general.

What is particularly frustrating in my line of work is that family members provide so little information to the authorities when an incidence of child abuse is discovered. It frequently happens that multiple members of the family simply claim a lack of

knowledge of any abuse having occurred. Clearly that is a challenge for the future, namely, impressing upon all family members in a household the importance of forthright and candid disclosures to the authorities. That, of course, is going to be a very difficult challenge since the desire for self-preservation is so strong and the willingness to take personal responsibility for one's conduct is so rare.

William R. Stokes
Assistant Attorney General
Criminal Prosecution Unit
Department of the Attorney General

FORENSIC MENTAL HEALTH

Being on the Panel has given me an expansion of consciousness that has helped me immensely in my work as Director of the State Forensic Service and as Medical Director of the Department of Mental Health and Mental Retardation. It is a unifying experience that helps to understand the cycle of violence, neglect and child abuse that infects so many people. I had previously come to the realization that in working with populations in different institutions throughout the state that I was dealing with the same individuals, but at different stages of development. The Child Death/Serious Injury Review Panel work has helped to fill in the very earliest years and sharpened the focus for my day to day work. It is experience without parallel.

As a Psychiatrist and a Forensic Psychiatrist at that, I realize increasingly that the very earliest intervention is necessary because patterns of behavior are set in place before childhood ends. We know that if patterns of behavior are set by somewhere around age 6, that the likelihood of change later diminishes rapidly. Our challenges are to discover children at risk and bring protection to them as early as possible. I would like to see early intervention with dysfunctional families become a reality in Maine.

Ulrich Jacobsohn, M.D., Director
State Forensic Service
Department of Mental Health & Mental Retardation

The personal and professional impact of my participation on the multidisciplinary Child Death/Serious Injury Review Panel is twofold. On the one hand, I am deeply saddened, angered and disgusted by the pain and suffering these children and families experience. At the same time, I am hopeful and optimistic. As illustrated by the work products included in this annual report, we can make a difference!

The multidisciplinary make-up of the Panel has enabled me to get a more thorough understanding of child abuse and neglect issues. This knowledge has been useful for the development of the preliminary Guidelines for Forensic Evaluations of Alleged or

Convicted Perpetrators of Child Abuse and Neglect; a work product of the Child Abuse Action Network's Task Force on a Multidisciplinary Decision Making Model for Child Abuse in Maine.

As a clinical and forensic psychologist, I have seen significant increases in Maine professionals' awareness and understanding of sex abuse issues. Gaps exist; especially in the area of treatment program evaluation and quality assurance. Education and training in the areas of physical abuse, and particularly emotional abuse and neglect, appear to lag behind. This is a serious concern because suspicious child deaths and serious injuries most frequently occur in neglectful situations. Hopefully, these issues will get the attention they require to assure effective intervention in the future.

Sue Righthand, Ph.D.
Clinical and Consulting Psychologist
State Forensic Service Senior Consultant

COMMUNITY MENTAL HEALTH

Participation on Maine's Child Death/Serious Injury Review Panel has provided a much clearer picture of the power of detailed record review in providing adequate assessment and understanding of questions of parental capacity in child abuse and neglect evaluations.

Standard mental health evaluations do not traditionally cover the areas required by children, families, mental health providers, DHS or the courts to adequately clarify parental capacities and deficits in caring for children. Nor do they adequately delineate treatment needs, capacity for various modalities of treatment, or reasonable time lines in which progress in treatment, relating specifically to the care and safety of children, might be expected.

Adequate mental health assessment and treatment of these families requires the development of new technologies. My own practice, which involves programmatic responsibility for the development and provision of these services, has been affected. The agency assessment and treatment teams for which I have responsibility are actively involved in modifying the focus, depth and complexity of assessments, treatment plans and interventions offered in order to better serve the needs of abused and neglected children and their families.

In regard to mental health assessments of parental capacity, in cases of child abuse and neglect, it appears that very little is actually working well. Standard mental health evaluation procedures do not meet the needs of these children, their families, DHS or the courts. Only scattered mental health professionals have developed an adequate focus with, and understanding of, these families, their lives, histories and capabilities.

Meaningful assessments of parental capacity and risks to children appear to be the exception rather than the rule. Treatment programs that can meaningfully address the special needs of this population are rare as well.

Currently, the Burden Foundation Grant offers the possibility that protocols for meaningful assessment and treatment for abused and neglected children and their families can be developed and promulgated in the State of Maine.

Karen K. Mosher, Ph.D.
Clinical Director for Adult Services
Kennebec Valley Mental Health Center

TRAINING OPPORTUNITIES FOR PH.D. CANDIDATES

To date, I have sponsored the participation of two doctoral level interns in psychology and one third year psychology Ph.D. candidate on the Child Death/Serious Injury Review Panel. My interest and hope in encouraging student participation on the Panel has been to add to the insight and training of new psychologists in the area of child abuse and neglect.

The students have gained a better understanding of the complex problems involved in this area. They have developed a clear picture of what child abuse and neglect evaluations need to involve, if they are to meet the needs of the Department of Human Services and the courts.

The provision of child abuse and neglect evaluations is a complex sub-specialty of professional training and practice. The use of the Panel to expose students to the concepts and intricacies of this area provides a broadening of their training that has proven valuable to the students as well as to their potential usefulness as experts. One student has graduated, remained in Maine, and is currently providing child abuse and neglect assessments for the Department of Human Services.

The experience of reviewing these cases, and of realizing what in our system works, and what is inadequate, is unforgettably powerful. It provides an unparalleled training experience that leaves students with insights and understandings that are not available to them in other settings. As a result, I would like to see students in medicine, nursing, social work, and law, as well as those in psychology, have an opportunity to participate on the Panel. The Panel might also consider creating more formal inroads into the state's professional schools to broaden opportunities for the training of Maine students in this critical area.

Karen Mosher, Ph.D.
Clinical Director for Adult Services
Kennebec Valley Mental Health Center

As a third year doctoral candidate at the University of Maine, I obtained a practicum with Kennebec County Crisis and Stabilization Program in Waterville, and the Kennebec Valley Mental Health Center in Augusta. Through my supervision with Dr. Karen Mosher I have obtained permission to attend the monthly meetings of the DHS Child Death/Serious Injury Review Panel.

I feel that participation in this panel is potentially very useful, in general, for individuals studying within the field of clinical psychology and, in particular, for those who specialize in clinical psychology with a focus on children. Through my attendance on this panel I hope to gain knowledge of the issues surrounding child mistreatment in Maine and to learn the psychologists' role in the prosecution of perpetrators of child abuse. In addition, I hope to gain exposure to the different agencies and professions that are responsible for working with this difficult issue, and to determine psychologists' role within the interdisciplinary framework.

It is inevitable that there will be some areas which are not covered in the coursework used to train doctoral level psychologists. The topics of child abuse and neglect, and the complex problems which accompany them, are two such areas which are absent from my current academic training. As a result, I feel that the time spent on the panel will be profitable for my professional growth. I welcome the opportunity to work with a panel dedicated to dealing with the difficult and challenging issues raised by the problem of child abuse and neglect deaths and serious injury.

Peter C. Trask, B.A.
Doctoral Candidate
Department of Psychology
University of Maine

FORENSIC PATHOLOGY

Since Forensic pathology is a small part of the panel's concerns, yet it is essential that the Office of Chief Medical Examiner be represented on child fatality review panels.

It is clear that there is a need for the multidisciplinary nature of the panel so that many different, but involved agencies, can exchange information and become aware of the problems each has in dealing with the cases considered. There is no substitute for such exchange by experienced persons.

It is clear that there are special needs in this area. Expertise in general law enforcement, prosecution, forensic pathology, etc. must be supplemented by specific attention to the matter of child injury and death.

Though the root problems are societal and cultural and do not have easy solutions, these root problems can be identified even if alteration is not simple. Nevertheless, it is gratifying to note that, for each case considered, some specific recommendations always seemed possible.

Personal contact with other concerned individuals outside my own specialty has proven extremely helpful, not only towards general understanding but also toward more effective on-going communication and problem resolving. It is now possible to work with other specific persons, not just other agencies.

The requirements of the panel for specific and general information has stimulated use of our medical examiner data files for mini-reports. Impressions have been replaced by hard data. Similarly we now probe deeper into certain areas of concern, especially the general background of the victim.

Partially, as a result of our experience with the panel, my department has focused on certain problems and changes have been made, though the most important innovation (II below) was in place prior to the panel, as the result of internal agency action in cooperation with the Maine State Police and the Department of Attorney General.

A. We have become more aware of environmental concerns that shed light upon the cause and manner of child deaths. Toward the end of acquiring better information the following have been instituted.

   I. There is immediate contact through the investigators with the Department of Human Services to determine relevant past history that might direct attention to a problem.

   II. A special set of investigators, of the Maine State Police, Bangor and Portland police departments, incorporated within the suspicious death investigation units, had been formed to respond to child deaths, not only with concern for possible abuse but also to advance understanding of medical, environmental and peri-terminal factors that might suggest specific accidental or natural causation. These officers have training sessions with the Office of Chief Medical Examiner and are provided with inquiry protocols. This has proven extremely effective as opposed to having no quality scene and background investigation, or one done by an officer without training, who may see one such case in his/her career.

   While the above was instituted prior to the existence of the panel and cannot be ascribed to its efforts, the panel clearly profits by this system, affirms the need for same and supports the effort which might prove valuable should an attempt be made to reduce the role of law

enforcement personnel in non-criminal investigations of child death or to decentralize the authority to conduct these investigations.

B. The experience of the panel physician, who sees non-fatal abuse, and hence a greater number of cases, has proven advantageous. On-going communication with such a person, involving general and specific case matters, is more valuable to us than periodic seminars or programs.

C. The court hearings within 10 days of filing an emergency child protection petition, while mandated by statute, make it impossible for the Office of Chief Medical Examiner to have a complete report within such a short time span. Since there are only 2 pathologists in the office and these cases are heard in scattered district courts, on short notice, this is a serious concern for our staff. Further, these hearings allow discovery when all the medical facts have not been ascertained and opinions must be deferred. This is an example of how we are assisted by the opportunity the Panel provides to air and explain our limitations.

D. We also have been able to explain two other problems that are recurrent in the prosecution of cases and which may lead to criticism of the medical examiner's efforts by other involved parties. The two problems are:

I. The dating of injuries so as to focus on a caregiver who was present at the time. The typical rapid change of caregivers and large number of parties, who may have had access to the child, often call for timing of injuries that is beyond our science.

II. The fact that most young children are killed by mechanical trauma other than gunshot, manual strangulation, gross impact injuries from a weapon or cuts and stabs, makes it more difficult to distinguish between possible accidental injury and inflicted injury.

Both of the above are not always appreciated by others working in child abuse, but they are now well understood by panel members.

E. We have been enabled, as a result of the above, to more clearly define the causes or possible causes of death in sudden and unexpected infant deaths. This has led to a narrowing of what we term Sudden Infant Death Syndrome (SIDS). Further, SIDS is a substitute term for "undetermined" when the autopsy, scene investigation, background and laboratory studies show no specific cause of death in infants between two weeks and one year of age. SIDS is not a specific cause of death. An understanding of this, and the fact that infant homicides can be very subtle and difficult to detect, may prove very helpful to others involved with child welfare and protection. Analysis of cases in which one or more previous SIDS deaths have

occurred in the family is improved by this understanding and leads to deeper scrutiny, which is another example of the value of a multidisciplinary panel, which taps the expertise of all members.

Henry F. Ryan, M.D.
Chief Medical Examiner
Office of Chief Medical Examiner

Since I am one of the two forensic pathologists in the state and the pathologist who performs the majority of the pediatric cases, including the child abuse and neglect cases, being on the panel has meant an increased amount of work for me in preparation for discussion of these cases. In addition, there is occasionally some pressure (though not much, due to the lag time between death and the Panel's review of the case) to rush and finish the cases, which are frequently very complicated. I find these meetings by far the most depressing of any I participate in, as the multigenerational social pathology exhibited by most of these families seems to me to be beyond hope for successful intervention.

Several changes in the investigation of deaths of infants and children had already been instituted before the existence of the Panel, but it is helpful to have the Panel's approval and support of these changes and any future innovations. The single greatest change I have seen come about as a result of the Panel is vastly increased cooperation from Child Protective Services, particularly the release of information in a timely manner.

Kristin G. Sweeney, M.D.
Deputy Chief Medical Examiner
Office of Chief Medical Examiner

PUBLIC HEALTH

The Child Death/Serious Injury Review Panel fulfills an essential function by reviewing tragic events occurring to children. By contributing the highest professional acumen available in Maine, the Panel dissects these cases and provides diagnosis, systems analysis and recommendations to prevent recurrence of these situations.

I am truly impressed by the honesty, caring and passionate dedication of all my colleagues on the panel to elucidate the problems and to propose solutions and preventive measures. Each one of us brings many years of experience in our field to these meetings, nevertheless nobody has become cynical or disaffected. We all seem to feel that "we are our little brothers' keeper". Each meeting is a tremendous emotional drain on me, and from my observations, on my colleagues too.

From a professional standpoint, I have been able to implement several recommendations from the Panel's recommendations in the Division of Maternal and

Child Health's (DMC)programs, especially in training areas for public and community health nurses and primary care providers.

I also have incorporated the needs uncovered during our deliberations into a federal MCHB grant, to coordinate health services with the Family Preservation and Support Group.

Zsolt Koppanyi, M.D., Director
Division of Maternal & Child Health
Bureau of Health
Department of Human Services

PUBLIC HEALTH NURSING

Since being asked to join the Panel nearly 3 years ago, the monthly meetings with other dedicated professionals, whose expertise in various fields concerning the struggle for the well-being of Maine's children, has been an invaluable learning experience. I always feel that I come away with more knowledge and understanding than I could ever hope to contribute to the Panel. However, I realize that because everyone's expertise is vital in the interpretation of the findings, sound recommendations based on the whole picture can be made.

Since my daily work is involved in directing Public Health Nurses,as well as my doing direct home visitation to families myself, I know the importance of this front-line intervention as a necessary prevention measure in preventing child abuse/neglect.

The home environmental assessments, the parent/child interaction assessments, the health assessments of mother and children, the identification of developmentally delayed children followed by appropriate referral for intervention, the anticipatory guidance and parenting education, the on-going support and understanding are some of the skills offered by the nurse, and are vital to helping families care for, and protect their children.

I value the day-to-day work that our home visiting nurses program is doing in Bangor. I know that their being involved with families makes a difference in promoting environments to rear healthy, safe, and happy children.

From reviewing very complicated family case histories of the victims, it is my professional opinion that nursing intervention, at the prenatal stage to high-risk Maine women, is crucial in preparation for a child to be brought into a family. As suggested in the Healthy Families Maine initiative, a trained home visitor, such as the nurse, could serve as an important first step in reducing child abuse.

This service could enable early detection of family problems and reduce the undesirable behaviors of at-risk pregnant women, thus promoting healthier birth outcomes. The second most important entry level for home visitation by nurses and/or para-professionals is at birth, when this service could be offered indiscriminately to all Maine parents.

In our experience, we have found many families function in isolation without support and many are unable or unknowing to request needed services. By reducing the isolation and offering parents the opportunities of having a knowledgeable, caring home visitor capable of identifying needs of families and helping to secure needed resources through the pre-school years, would enhance positive parenting to provide homes for safe children.

From the fatal outcome cases discussed by the Panel, it is clear that very few families had consistent on-going support services which were acceptable to the parents involved. By history, public health nursing intervention is usually non-threatening and received as a helping service. Several cases could have used referrals to Public Health Nursing and yet this was obviously not done. Public Health Nursing is a resource which needs to be utilized in early intervention to families. By addressing health issues of the family first, the family becomes more comfortable in revealing other needs for which the nurse helps the family seek help. As realists, the Public Health Nurse knows that not all families are successful and some children must be removed from unsafe households. It is critical that the Public Health Nurse advocate for the well-being of children in whatever the family situation.

Home visiting nurses provide a vital link in child abuse prevention services. An increase in Public Health Nurses must be strongly considered for future home visitor programs because of their abilities to provide comprehensive care.

Patricia Bond, R.N., Director
Public Health Nursing Program
City of Bangor, Maine

With Public Health Nursing as my background, I have found serving on the Child Death/Serious Injury Review Panel a painful and angry experience. Painful as the case reviews reinforces what we already know as risk factors for children. I have felt anger because as professionals the process of intervention is so difficult and complicated with methods that make us appear as intruders to families rather than facilitators for positive change and growth.

What works now is interventions with families coordinated by qualified and compassionate professionals working in close collaboration. Collaboration must continue to exist and strengthen. Methods for needed interventions must be developed

and respected by all Maine's citizens. Maine must value and support all our children that they may live, grow in a healthy way and be valued as individuals.

Kathleen Jewett, R.N., M.S.
Department of Human Services
Bureau of Health
Division of Public Health Nursing

CHILD WELFARE

The panel offers the most in-depth, relevant continuing education I receive. The panel's multidisciplinary composition offers a unique opportunity for cross-disciplinary training and team building while providing useful, specific feedback and suggestions for improving our practice to better protect children. The enormous commitment demonstrated by each professional on the panel is an inspiration.

A personal goal for the future work of the panel is to better integrate the panel's findings into casework practice in a timely and consistent manner. Specifically, the panel needs to be known to the Bureau of Child and Family Services staff at all levels of our agency and must be viewed as a positive, constructive resource.

Kathy Howley, Deputy Director
Bureau of Child & Family Services
Department of Human Services

Personally, being on the Panel has been a very painful experience. I realize that we are never going to prevent all child abuse and neglect deaths, but it is still very frustrating that some service wasn't able to intervene and protect these children.

It's been an educational experience, and I have made some changes in the way I review the work we do; it's been an incentive to make changes and to recognize the good work that is done. It's also a good opportunity to get input from all disciplines and to share work that can and cannot be done by the Bureau of Child and Family Services.

Many excellent recommendations have been made but many have not been implemented; that is frustrating and I think we need to find a vehicle to address this.

Mary Dionne, Regional Program Manager
Bureau of Child and Family Services
Department of Human Services

Being a member of the panel has been one of the most educational and powerful, professional experiences of my career. The opportunity to have the time to methodically review and analyze the most tragic of cases in order to better protect

children in the future feels like I have been given a priceless gift. A good part of this gift's value comes from conducting the reviews with an amazing group of skilled, knowledgeable, dedicated and passionate professionals, who create both energy and synergy in the search for a greater understanding of the etiology of abuse and neglect and therefore, an improved response to its occurrence.

Engaging in the struggle that each review requires, with professionals from other disciplines, has enabled me to increase my knowledge and understanding about child abuse and neglect and reinforce my view that collaboration must occur if we have even a chance to protect children from harm.

What works now are collaborative efforts by professionals, who follow accepted standardized protocols for evaluation and intervention in child abuse and neglect situations. This requires well-trained, knowledgeable, and skilled professionals who respect and value the skills and knowledge their colleagues in other professions are able to bring to our response to child abuse and neglect. We must all be able to reflect on our practice individually and collaboratively.

The biggest challenge facing child protective services at this time is a society that:

- to a large extent still views children as the property of their parents
- is in denial about the prevalence of abuse and neglect and the damage and pain it inflicts upon children
- demonizes and belittles the adults who intervene on behalf of abused and neglected children
- is not willing to spend the dollars or energy it would take to even begin to have an impact on the incidence and severity of child abuse and neglect.

To affect any real change in our response to child abuse and neglect, professionals and state agencies, and individual citizens must make child abuse and neglect their responsibility and their priority.

Sandra Hodge, Director, Div. of Child Welfare
Bureau of Child and Family Services
Department of Human Services

ADOLESCENT SUICIDES - SUMMARY INFORMATION

1995 is, so far, a troublesome and atypical year for Maine adolescent suicides: in 4 months there have already been 7 adolescent suicides (1 of whom was actually pre-teen), all males, most of whom died by gunshot, and one case considered undetermined, but suspicious for suicide (one pre-teen).

Maine is a small state and the incidences of suicide are small compared to more populated states. Nevertheless, all suicides nationally and in Maine are increasing, including the rate of teen suicide.

Due to the level of impulsivity in normal adolescent development, and the degree of impulsivity involved in adolescent suicides, predictability is therefore more difficult. Some studies suggest that the availability of guns has an effect on the overall suicide rate. The availability of guns in Maine homes is a factor, at least concerning the choice of suicide method. The use of guns in female suicides is now about the same for male suicides. While restricting availability of guns may reduce suicide rates, that would not eliminate incidences of suicides, as other, accessible methods are available.

Some common factors in adolescent suicides in Maine are: family discord, OUI charges with threat of jail or loss of license; failure at school; loss of a girlfriend or boyfriend.

In large, highly populated states, and where drug abuse is a factor in adolescent suicides, those deaths tend to be classified as undetermined or accidental, whereas in actuality many are suicides. The result is a relatively lower number of suicides in the overall count. Since the suicide rate for African Americans is much lower than for whites, the rate for states with more racially mixed populations tends to be lower per 100,000 population.

Maine's Medical Examiner Act has a specific legal standard to determine deaths, including suicide: "preponderance of the evidence", whereas other states often have the higher legal standard of "a great preponderance" or "clear and convincing" to meet.

Because Maine has a centralized medical examiner system, accuracy of data, including determinations of causes of deaths in M.E. cases, is better. There is less local/political/"humanitarian" influence on decision making in Maine, which is helpful because unless we know the truth of the problem, we cannot make constructive changes.

The notion of "psychological autopsies" of Maine's 1995 adolescent suicides would be a useful process, but is way beyond the capabilities of the Office of Chief Medical Examiner and law enforcement. Such a study could be undertaken by a multidisciplinary team. Alternatively, the DHS Multidisciplinary Child Death/Serious Injury Review Panel is more than capable of doing this and, in effect does, during its monthly review of cases.

What follows is a more detailed study by the Office of Chief Medical Examiner of suicides in Maine, including adolescent suicides.

Maine's Child Death/Serious Injury Review Panel recommends: 1.) Governor Angus King's task force on adolescent suicide promote the review and adoption of a statute similar to Oregon's statute on suicide attempts by minors, and 2.) involve Maine's Office of Chief Medical Examiner in the governor's task force.

SUICIDE ATTEMPTS BY MINORS

441.750 Suicide attempts by minors; referral; report; disclosure of information; limitation of liability. (1) Any hospital which treats as a patient a person under 18 years of age because the person has attempted to commit suicide:

(a) Shall cause that person to be provided with information and referral to in-patient or out-patient community resources, crisis intervention or other appropriate intervention by the patient's attending physician, hospital social work staff or other appropriate staff.

(b) Shall report statistical information to the Health Division of the Department of Human Resources about the person described in this subsection but is not required to report the name of the person.

(2) Any disclosure authorized by this section or any unauthorized disclosure of information or communications made privileged and confidential by this section shall not in any way abridge or destroy the confidential or privileged character thereof except for the purposes for which any authorized disclosure is made. Any person making a disclosure authorized by this section shall not be liable therefore, notwithstanding any contrary provisions of law.

(3) No physician, hospital or hospital employee shall be held criminally or civilly liable for action pursuant to this section, provided the physician, hospital or hospital employee acts in good faith or probable cause and without malice. [1987 c.189 §1]

Note: 441.750 and 441.755 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 441 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

441.755 Report form; contents. (1) The Health Division of the Department of Human Resources shall prescribe a form to be used by hospitals to make the report required by ORS 441.750 (1)(b) and shall prescribe the frequency of such reports.

(2) The report form may include the name of the hospital reporting, the date of birth, race and sex of person described in subsection (1) of this section, the suicide method used by the person and known prior attempts in the past 12 months.

3) The Health Division shall compile the results from the reports and report the results to the public. [1987 c.189 §2]

Note: See note under 441.750.

441.810 (Formerly 441.510; repealed by 1979 c.284 §199]

SUICIDES IN MAINE

Office of Chief Medical Examiner - May 1995

A presentation and analysis of suicide data for the State of Maine from the records of the Office of Chief Medical Examiner.

It has been said that Maine has more suicides per capita than elsewhere; that "cabin fever" plays a significant role; that the December holiday season is a particularly bad time; that availability of guns plays a significant role in the number of suicides; that suicide rates have been rising in recent years; that many suicides are missed or misclassified deliberately, that Aroostook County is especially high in suicide rate and that females almost never shoot themselves. Despite a great amount of literature on suicides, undocumented concepts persist, are publicized by the media and set government agendas through political leaders.

The data reported are for the years 1983-7 and 1992-4 as these are the years for which Office of Chief Medical Examiner computerized records are complete. 1992 has been chosen as a comparison year because that is the year for which the most recent annual reports from other jurisdictions are available.

CABIN FEVER AND HOLIDAY SUICIDE SURGES:

SUICIDES BY MONTH:
Maine 1983-7 + 1992-4. King Co. Washington 1992. State of New Mexico 1992.

MONTH	MAINE 8 yrs.	KING CO 1992	N.M. 1992
JAN	115	19	23
FEB	91	19	27
MAR	121	17	22
APR	132	17	24
MAY	123	12	29
JUN	111	21	30
JUL	102	18	36
AUG	119	18	25
SEP	114	10	28
OCT	111	21	24
NOV	114	20	24
DEC	103	16	20

The fairly consistent peak month for suicides in Maine is April with March and May next. December is the lowest month in the two others and next to the lowest in Maine.

N.B. There is slight inaccuracy caused by the fact that the date, and even year, of death in Maine medical examiner records is when the body was found. In the spring bodies that over-wintered under the ice, in cold water and under the snow are found and in the fall the hunters find bodies from previous months and even years. However, these case are few and have little

affect on the data.

IS THE SITUATION IN AROOSTOOK COUNTY SO BAD?

HAS THE RATE OF SUICIDES IN MAINE INCREASED DRAMATICALLY?

SUICIDES BY COUNTY: Maine 1983-7 + 1992-4.

Average for each period per year and rate per 100,000 population based upon 1992 population. Though not a true rate it is somewhat useful for intercounty comparison.

COUNTY	83-87	92-94	ALL	RATE	POPULATION	CASES
Androscoggin	14.0	12.0	13.3	12.8	104,000	106
Aroostook	9.2	11.7	10.1	11.6	87,000	81
Cumberland	32.0	26.0	29.8	12.2	244,000	238
Franklin	3.8	3.3	3.6	12.4	29,000	29
Hancock	6.4	11.0	8.1	16.9	48,000	65
Kennebec	18.2	19.3	18.6	15.9	117,000	149
Knox	5.0	9.0	6.5	17.6	37,000	52
Lincoln	4.0	5.3	4.5	14.5	31,000	36
Oxford	9.4	8.0	8.9	16.8	53,000	71
Penobscot	23.2	22.3	22.9	15.7	146,000	183
Piscataquis	1.8	4.7	2.9	15.3	19,000	23
Sagadahoc	3.4	2.7	3.1	9.1	34,000	25
Somerset	5.6	8.3	6.3	12.4	51,000	53
Waldo	6.2	6.0	6.1	17.9	34,000	49
Washington	4.2	8.3	5.8	16.1	36,000	46
York	18.6	19.0	18.8	11.3	167,000	150
STATE	165.0	177.0	169.5	13.7	1,236,000	1356

Maine medical examiner records are for the county where <u>death</u> has occurred. This is not the same as where the person lived or where the incident took place. There are major medical centers in Cumberland, Penobscot and Androscoggin counties that take the seriously injured from elsewhere. Scattered crossing of county lines can occur whenever a victim is taken to a hospital, even DOA. The numbers involved are small.

1983-87 Total suicides residents 805, non-residents 20.

1992-94 Cumberland County: Total 78, Hospital Death 16, Incident not in county 4.

Penobscot County: Total 67, Hospital Deaths 9, Incident not in county 4.

It would appear that there is some spread amongst the counties in rate of suicide per 100,000. 7 of the 16 counties are below the state rate. The range is from 9.1 to 17.9. Aroostook county has an undeserved bad reputation falling well below the state rate despite opinions to the contrary. Of the larger counties, over 100,000 population, 3 show a drop in average suicides per year and 2 show a rise when the 83-7 period is compared with the 92-94 period. Some small counties show a significant rise but small numbers must be viewed cautiously.

The Maine average has risen slightly, 7% from the first to the second period. The Maine population for the period 1983-87 averaged 1,164,923 and the 1992 population, used for the 1992-4 rate was 1,236,348, a 6% increase. Thus little to no increase in the suicide rate is demonstrated in this study period.

HOW IMPORTANT IS THE AVAILABILITY OF HANDGUNS?

IS IT TRUE THAT WOMEN ALMOST NEVER USE GUNS, ESPECIALLY LONG GUNS, TO KILL THEMSELVES?

MAINE SUICIDES, 1992 & 8 YEAR AVERAGE, VERSUS SAMPLE JURISDICTIONS 1992:

(The year 1992, atypical for Maine, was selected because other jurisdiction reports were readily available for that year. N.B. = New Brunswick, Canada, KING CO. = King County Washington, including Seattle.) N.M. = New Mexico.)

CATEGORY	MAINE 1992	MAINE AVG.	N.B. 1992	KING CO. '92	N.M. 1992
POP.	1236000		725000	1564000	1578077
RATE	12.86	13.75	15.86	13.30	19.77
TOTAL	159	170	115	208	312
MALE	137	136	106	162	256
FEMALE	21	34	9	46	56
% FEMALE	13%	20%	8%	22%	18%
GSW	102	96	69	96	203
" % ALL	64%	56%	60%	46%	65%
HANDGUN	55	46	7	70	NA
" % GSW	54%	48%	10%	73%	
SHOTGUN	21	21	12	11	NA
" % GSW	21%	22%	17%	11%	
RIFLE	26	28	50	15	NA
" % GSW	25%	29%	72%	16%	
DRUGS	12	19	5	40	35
" % ALL	8%	11%	4%	19%	11%
HANGING	22	23	25	27	37
" % ALL	14%	14%	22%	13%	12%
CARB MONO	4	14	8	15	NA
" % ALL	3%	8%	7%	7%	
OTHER	19	18	8	15	
" % ALL	12%	18%	7%	7%	

The above shows that Maine and King County, Washington have similar rates of suicides per 100,000 population. New Brunswick, Canada and New Nexico are distinctly higher.

The male:female ratio is similar in all but New Brunswick where it is much lower.

While Maine approaches New Brunswick in GSW deaths, the type of gun used is different. Rifles predominate in N.B. with shotguns second. In King Co. handguns predominate to about the same extent that rifles do in N.B. Maine

fits between the two with a wider spread amongst the gun types. New Mexico has the highest percentage of GSW deaths compared to other methods of suicide. It is interesting to note that the scarcity of handguns in N.B. has not affected the total GSW rate which is higher than in Maine and K.C.

The situation is similar to the above with respect to drug overdose, with Maine and N.M. fitting between a low rate in N.B. and high rate in K.C.

The hanging rate is higher in N.B. The others have about equal rates.

The three reporting same have similar rates for carbon monoxide suicide deaths. Maine stands out for the percent of other methods used.

This raises some important points about regional/cultural differences in choice of method. Total suicide rates were generally more alike than percent for each of the methods chosen. Some studies claim that banning handguns will reduce suicide. Perhaps, but the affect of reduced availability may not be as great as one might be led to believe.

The racial mix of suicides in K.C. is interesting but no figures were supplied concerning the mix in the population - White 190, Asian 8, Hispanic 7 and Black 3. Nevertheless the low rate in Blacks, especially females, is well documented elsewhere.

SUICIDES RATE BY RACE - NATIONAL - 1979-87 - AGE 15-24:
(Source YOUTH SUICIDE CDC surveillance 1986 - uses VR data)

RACE	RANGE
ALL	11.2-12.9
WHITE	12.7-14.3
BLACK	6.6-8.5
OTHER	11.7-17.7

The rate for blacks is a bit more than 1/2 that for whites.

From 1979-1989 the national suicide rate for all ages dropped by 3.4%.

WHAT ARE THE PITFALLS IN INTERPRETING DATA FROM MAINE WITH ELSEWHERE?

FACTORS RELATING TO DATA COLLECTION:

How accurate are the figures used for comparison? What do these figures mean? There are some biases that tend to make the Maine figures higher than other jurisdictions. They are:

- Maine has a centrally supervised statewide medical examiner system. When systems are local, especially in small communities, and when the officials are politically appointed or elected there is more of a tendency to not report a death as suicide especially in children.

- Maine has physician medical examiners and the system is under the overall control of a forensic pathologist. This not only helps overcome local pressures but also means that every case is reviewed by an experienced person well trained in recognizing suicide who deals with about 150 cases per year

In general the more experience and expertise a person has the less reluctance there is to rule suicide as the manner in difficult cases.

- In Maine the methods used are more obvious than in communities where prescription drug overdose is more common. It is easier to miss and harder to classify a suicide by prescription drugs and where this method is common more suicides pass undetected or may not be classified as such even if the cause of death is recognized.

- Where the rate of drug abuse is higher some suicides may be misclassified. The common practice when a death is due to abused drugs is to classify such a death as "undetermined" or "accident." Some so classified are certainly suicide since, when other methods have been used by a drug abuser, it is not uncommon to learn that the person expressed that drug abuse was the reason for suicide. The bias against using suicide in drugs of abuse deaths diminishes the true suicide rate and the underestimate is greater where drug abuse is common. In Maine deaths from drug abuse are not nearly as common as in many other parts of the country and are uncommon in teen-agers.

- Maine uses, by law, "preponderance of the evidence" as the standard for classifying deaths. Many other jurisdictions have no specific statute. Even where a statute exists how it is applied is variable. In Maine we use the statute strictly. Many, if not most, other jurisdictions use a higher standard in practice. In Oregon the Chief Medical Examiner states he uses "a great preponderance" and in Cook County, Illinois, the chief states he uses "clear and convincing" a higher standard indeed. Some jurisdictions hedge on cases using "unclassified" although this does not appear as a choice on the standard death certificate.

- Maine has a very small black population. The rate of suicide in blacks is about 1/2 that of whites. Thus in states with large numbers of blacks the overall rates will be lowered. Comparison should be made with like populations, white vs. white or black vs black - see above table.

FACTORS RELATING TO DATA SOURCE:

OCME VERSUS VITAL RECORDS DATA 1992:

MANNER	OCME	VR
SUICIDE	159	152
MVACC	221	208
ACC.	161	191
HOMICIDE	36	27

It is apparent that the numbers will be different depending upon whether they are obtained from Vital Records or from the Office of Chief Medical Examiner. Still other numbers will be given by police and safety agencies. There are several reasons as follows:

Completion Deadline - highway safety officials will cut off at a certain date and not consider the death to be caused by the automobile accident after that date. Vital Records will code and enter to a certain date and pending or

changed certificates after that date may not be included. The OCME continues to revise and finalize cases after these deadlines and will ascribe deaths to accident/suicide/homicide long after the incident provided they are causally connected.

Who Is Included - Some records only include deaths of state residents and may incorporate same even if the death occurs elsewhere. Medical examiner jurisdiction is where the death occurs and OCME statistics will include in state deaths caused by an out of state incident but may not include out of state deaths caused by an in state incident. Even if the death has occurred in state, if the body has been transported out of state before discovery, it may not be included in the medical examiner office numbers.

Year of Death - Sometimes the death has occurred a year or more before the body is found. These deaths may appear in the medical examiner's report for the year the body was discovered.

Coding Differences - OCME data is coded differently than other data. Police do not consider some cases classified as homicides by the medical examiner to be homicides for police purposes. Vital Records, before about 1979, did not code suicide deaths in young children (below 14) as suicides regardless the entry on the certificate. Some deaths that might be considered natural by the medical examiner may be considered accident by Vital Records such as when a hip fracture is only a contributing cause to a natural death, cases certified as aspiration and therapeutic misadventures. These may have never been referred to the medical examiner.

For the above reasons most of the time the medical examiner statistics will have higher numbers for each non-natural category, except accidents.

WHERE DOES MAINE STAND NATIONALLY:

The figures given below are from Vital Records data. Some comparison figures are entered from OCME data. Taken from INJURY MORTALITY ATLAS OF THE UNITED STATES, 1979-1987. CDC.

Rates are per 100,000 population. Excess is number of deaths per year higher than national average adjusted for population.

1979-1987 UNITED STATES X MAINE:

TYPE	MAINE		NH		VERMONT		NATION	EXCESS ME.
	RATE-	#	RATE-	#	RATE-	#	#	
GSW	8.7	105	13.6	82	11.1	61	13.6	
HOM	2.4	27	1.9	19	2.5	13	9.2	
SUI	12.8	155	11.8	121	14.6	81	11.6	14 DEATHS PER YR.
MVA	19.2	225	17.9	178	20.4	110	20.2	

19 States had higher suicide rates than Maine's 12.8 age adjusted rate during this 1979-87 period. The range was from 7.1 in New Jersey to 23.2 in Nevada.

SUICIDE RATE NATIONALLY - AGE X YEAR:

AGE	1983	1984	1985	1986	1987
0-14	0.4	0.4	0.5	0.5	0.5
15-24	11.9	12.5	12.9	13.1	12.9
25-34	15.8	15.5	15.2	15.7	15.4
35-44	14.6	15.1	14.6	15.2	15.0
45-54	16.2	16.2	15.6	16.4	15.9
55-64	16.5	17.3	16.7	17.0	16.6
65-74	17.7	18.8	18.5	19.7	19.4
75-84	22.3	22.0	24.1	25.2	25.8
85+	19.0	18.4	19.1	20.8	22.1
TOTAL	12.1	12.4	12.3	12.8	12.6

- From 1952-92 the suicide rate tripled for those under 25 years of age.*

- CHANGES 1980 TO 1992:
  SUICIDE RATE X AGE:*
Less than 25 - decline 5.7 to 5.4
20-24 years - decline 16.1 to 14.9
15-19 years - increase 8.5 to 10.9
10-14 years - increase 0.8 to 1.4
*(Per Morbidity and Mortality Weekly Report 4/21/95 Vol 44 #15)

SUICIDES MAINE TOTAL AND TEEN-AGE:

YEAR	TOTAL	TEEN	% OF SUI	COMMENT
1969	119	NA		To 1978 figures 15-19 thereafter < 19
1970	119	7		
1971	136	8		
1972	150	14		
1973	159	10		
1974	155	3		
1975	NA	9		
1976	155	6		
1977	152	11		
1978	160	9		
1979	154	5	3.2%	15-19 = 11
1980	147	6	4.1%	15-19 = 10
1981	165	NA		15-19 = 20
1982	154	6	3.9%	0-18 for all following years.
1983	167	10	6.0%	
1984	172	14	8.1%	
1985	180	4	2.2%	
1986	133	8	6.0%	
1987	173	7	4.0%	
1988				Vital Records has 13 for <19
1989	176	10	5.7%	
1990				Vital Records has 11 for <19
1991				Vital Records has 10 for <19
1992	159	10	6.3%	
1993	197	9	4.6%	
1994	174	9	5.2%	
1995				

The above shows no indication of a major increase through the years. The numbers of cases are small and the scattering indicates the hazard of drawing conclusions from small numbers, e.g. 1984 was the peak year with 14 and 1985 was the lowest year since 1975 with 4.

The CDC publication YOUTH SUICIDE states ages 20-24 had about twice the rate as ages 15-19.

MAINE SUICIDES PER AGE PER YEAR - TEEN-AGE:

YR	<15	15	16	17	18	TOTAL
83	0	1	3	2	4	10
84	1	0	4	4	5	14
85	0	0	0	2	2	4
86	1	0	2	2	3	8
87	1	1	0	2	3	7
SUM	3	2	9	12	17	43
AVG	<1	<1	1.8	2.4	3.4	8.6
92	3	2	2	2	1	10
93	3	0	4	2	0	9
94	0	1	0	5	3	9
SUM	6	3	6	9	4	28
AVG	2	1	2	3	1.3	9.3

YRS	19	20	21	22	23	24	TOTAL
83-87	16	20	18	23	18	17	112
AVG	3.2	4.0	3.6	4.6	3.6	3.4	22.4
92-94	11	3	13	13	9	8	57
AVG	3.7	1	4.3	4.3	3.0	2.7	19

Even without consideration of population increase the 19-24 age group has shown a drop in suicides.

The above shows a very mild increase in suicides under the age of 19 which might be compensated for by population increase though age specific population figures have not been used. There is a problem calculating rates for the age groups in question especially for the between census years when estimates are used. For this reason we have simply given counts of cases. The following table illustrates age distribution changes by year.

MAINE POPULATION X AGE AND YEAR: (Maine Vital Records Annual Reports)

YEAR	TOTAL	UNDER 5	5-17	18-44	45-65	65+
1970	993722					
1980	1125027	78531	242919	443122	219494	140961
1981		80560	235694	452738	218527	145330

YEAR	TOTAL	UNDER 1	1-14	15-24	25-34
1983	1145825	16850	236080	185990	183650
1984	1154200	16424	235776	182000	186550
1986	1172200	16721	235675	175206	192151
1987	1186350	17302	237698	190100	192900
1988	1206580	17714	241206	186510	197150
1990	1227928	14567	244240	173967	205235
1991	1234597	16728	244152	172832	200174
1992	1236348	16167	241759	170826	194589

The year 1991 represents a final census figure. The others are estimates

or incomplete census data. There has apparently been some drop in the population in the 15-24 age group that might, if accurate, mean that the suicide rate picture is a bit worse than the count of case suggests.

SUICIDE ATTEMPTS:

Oregon studied suicide attempts from 88-93 in the 15-19 age group. The suicide rate was 15.5 in this age group for the span of years 1988-1991 - 39.6% higher than the nation.

75.5% of the suicide attenpts were with drugs and almost 1/2 of these were analgesics like ASA and acetominophen. 0.4% of these drug attempts were fatal but 78.2% of the GSW attempts and 35.7% of the carbon monoxide attempts were fatal. Attempts were 31 times more common than fatalities. (Morbidity and Mortality Weekly Report 4/28/95 Vol 44 #16)

CONCLUSION:

The facts concerning suicides in Maine are not as gloomy as many people believe. However Maine ranks fairly high nationally in suicide rate whereas in the rates of other non-natural deaths it ranks fairly low.