Report of the State of Maine Child Death and Serious Injury Review Panel 2007-2008

Maine Department of Health and Human Services

Caring…Responsive…Well-Managed…We are DHHS.

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

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Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

John E. Baldacci, Governor Brenda M. Harvey, Commissioner

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November, 2009

To the Maine Community:

It has been a difficult year as we have learned about tragic deaths of very young children, it continues to be difficult to consider that serious injury can be inflicted upon any child. Despite the difficult economic times, we must continue to work to assure our most vulnerable are still safe in their homes. While there has been progress, tragic incidents are still a part of the world in which we live.

As this report suggests, however, and as we continue to engage in vigorous oversight of these incidents, whether a result of maltreatment or other circumstances, we are learning strategies and approaches that can reduce the occurrence of harmful incidents and make life safer for children in Maine.

Staff from both the Office of Child and Family Services and the Center for Disease Control participate on the Child Death Serious Injury Review Panel and are able to bring learning back to inform the work to support families and to identify trends and patterns that can impact the safety of children. We have learned much through the in depth review of circumstances that lead up to injuries and deaths. Over the past years the rate of SIDS deaths have dramatically declined with a "Back to Sleep campaign" that promotes infants sleeping on their backs. This is just an example of what can be learned and what a change in public awareness can accomplish by careful evaluation. We have worked with partners, especially hospitals across the state, to encourage sharing of information with new parents on safe sleeping environments and on understanding the crying patterns of infants through the widely disseminated *Period of Purple Crying* Program. This has the promise of reducing the incidence of abusive head trauma to infants.

The recommendations in this report will lead to better policy and practice in all of our systems. I appreciate the integration, diversity, and, ethical approach of the panel and combined knowledge represented by the panel members. Change does not occur without comprehensive review, data analysis, and examination of practice. I continue to appreciate the dedication of the panel for its commitment to meeting monthly, using a collaborative approach, and being willing to address difficult issues facing families and staff with respect, compassion, and understanding.

Please recognize that this report serves as a valuable resource to all of us who hope to promote a safe and violence free environment for families and children.

Sincerely,

Brenda Harvey

Brenda M. Harvey
Commissioner

A Letter from the

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

November 6, 2009

To The Honorable Governor John Baldacci:

The Maine Child Death and Serious Injury Review Panel is a multidisciplinary team of professionals established by state law in 1992 to review child deaths and serious injuries with a focus on improving our systems of child safety and care. The panel meets monthly to review cases evaluating sentinel events, patterns of injury and/or death and the effectiveness of our state programs that provide for child protection, safety and care. Through the Panel's findings and recommendations we hope to help reduce the number of preventable child fatalities and serious injuries in our state. Among the questions the panel tries to address in case review are: What events and activities led to this child's death? What State of Maine systems of care were involved in the child's life before the injury or death? What did we do right? Did we do anything wrong? Is this event part of a pattern of events? Could we lower the risk of future deaths and injuries by implementing changes in our system of care? In the case of serious injuries, what kept this injury from being a death and should we have reacted sooner or differently?
Additionally, the Panel meets annually with the Child Fatality Review Teams from all of New England to share experience, information and review cases that involve services from more than one state or which represent a challenge that all of our States are trying to address.
The members of the Maine Child Death and Serious Injury Review Panel are volunteers who give generously of their time and expertise and who represent both public and private agencies with an interest in the welfare of Maine children. Through their commitment, the Panel has been able to build a collaborative network to foster teamwork and to share our recommendations with the larger community.
The challenges facing Maine identified by the panel these 2 years include:

- Increases in abusive head trauma related death and injury in children under the age of one.
- Increases in serious injury related to child maltreatment.
- Increases in the incidence of drug affected infants (165 in 2005 and 434 in 2008)

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

In recognition of the commitment and dedication of the members of the Panel and in the hope that our recommendations continue to support and improve the welfare of Maine Children we would like to present the 2007-2008 Annual Report to the Honorable John Baldacci, Governor of the State of Maine.

On behalf of the Panel,

Stephen J Meister, M.D.
Co-Chair

Karen Mosher PhD
Co-Chair

Team Members of the Child Death and Serious Injury Review Panel 2007 and 2008

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Lt. Gary Wright	Maine State Police, CID II

Forward

This report documents cases that were reviewed in 2007 and 2008 by the Maine Child Death and Serious Injury Review Panel. The mission of the Panel is to provide multidisciplinary, comprehensive case review of child fatalities and serious injuries to children in order to promote prevention, to improve present systems of child protection and care and to foster the education of professionals and the general public to enhance the safety and security of our children.

The Panel strives to collect facts and to provide opinions and articulate them in a fashion which promotes effective change. In this role, the Panel may develop, in consultation with the Commissioner of the Department of Health and Human Services, periodic reports on child abuse fatalities and major injuries, which are consistent with state and federal confidentiality requirements.

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

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

Each member of the Panel volunteers their time to review extensive case records, relevant research literature, and pertinent policy in preparation for monthly retrospective reviews. The Panel is established in state statute that permits confidentiality of the Panel's work and grants the Panel the power to subpoena relevant case documentation and testimony. The Panel's usual process of review includes an in-depth review of all relevant records, oral presentations by key, involved service providers and a review and discussion of scientific literature and evidence related to the case(s).

The State of Maine has supported staff from public child welfare, the Medical Examiner's office and Maine State Police to participate in the National Sudden Unexplained Infant Death Investigation (SUIDI) Academy. All of those trained individuals sit on the Panel and have

provided specialized training for child death investigation units of law enforcement, which include Maine State Police, Bangor, and Portland Police Departments.

The Maine Child Death and Serious Injury Review Panel belongs to the consortium of Northern New England Child Fatality Review Teams and our work and methods conform to the standards of our companion States. A team of Maine panel representatives have both participated in and presented at each of the past eleven annual Northern New England Child Fatality Review Team Meetings.

Findings, Recommendations and the Department's Response

The following provides findings, recommendations and responses for the specific categories of reviews that have been conducted over the 2007-2008 period.

Permanency

CASE EXAMPLES

In one case reviewed because of a serious injury to a child while the family was engaged with the child welfare system, the panel review revealed that the permanency plan for the children was delayed because the children were in a temporarily safe environment. In this same case the children had been removed from a home that wanted to keep them permanently for purposes of meeting the children's therapeutic needs without full exploration of addressing their therapeutic needs within the placement environment.

RECOMMENDATIONS

The Panel recommends that permanency plans for children be implemented as quickly as possible and not delayed because the children are in a physically safe environment.

Permanency options for children must be considered early in a case with full consideration given to the long term commitment of the placement. Appropriate supports, which include recognition of cultural issues, should be given to the family with whom the children are placed that will support the long term commitment in addition to addressing the treatment needs of the children. In any case situation permanency must be paramount and services should follow the child and not be dependant on the placement type. Placement changes can be harmful to children and children should not be forced to move if their current placement can be modified to meet their needs.

DEPARTMENT'S RESPONSE:

The Department agrees with the recommendations and the following is a reflection of steps to both address these findings and to make improvement in practice in general.

The Department has embarked on an ongoing reform effort to promote permanency for all children. Timelines from TPR (Termination of Parental Rights) to adoption or permanency guardianship have been significantly reduced since 2006 with this effort. Department staff have been provided training through the "You Gotta Believe" program from New York and the Family Finding processes by national expert, Kevin Campbell, that reinforce the focus of permanency and of supporting family members to meet the needs of children both in permanency and in treatment services.

The Department staff now recognizes the importance of permanency over temporary stability. The following chart demonstrates improvement in adoption timeframes from 2005 to 2007.

Statewide	2005	2006	2007
Number of Children:	311	339	334
Average Months from Removal to TPR	22.8	22.0	19.6
Average Months from TPR to Adoption	24.3	22.3	19
Average Months from Removal to Adoption	47.1	44.3	38.7
% Exiting to Adoption w/in 24 months of Removal	12.9%	16.5%	26.0%

Over 2008 the Department worked with youth in care and graduated from care to develop a youth driven and focused, "Permanency Policy", that is now part of the Department of Child and Family Services Policy Manual. This policy provides guidance to staff to meet the above recommendations.

The Department has worked in collaboration with the Family Division of the Court to address both the issue of improved timelines in the court process and in addressing permanency in a timely manner both through direct discussion and joint training venues.

Information Sharing

CASE EXAMPLES

In one case when a child improved from a near death state, there was no recognition by the courts of the probable long-term sequelae of severe brain injury when a decision was made to return the child home. No provision for on-going supports to allow the family the opportunity to understand and address the potential long term impact was provided.

In one case, complete medical records and information from out of state were not obtained. This information could have provided a more accurate picture of the nature of the current injuries and the historical patterns of behavior of the caregivers.

In one case reviewed, DHHS did not have the prior medical records. These records were needed to clearly define the sources of risk, draw conclusions, and make decisions.

RECOMMENDATIONS

When a child is in DHHS custody, it is important that all of a child's past and current medical records be available to the caseworker. The pediatrician involved in caring for the child should be asked to help the caseworker both obtain and interpret the records. It is critical that a child's medical records follow the child regardless of placement.

There needs to be better communication between the medical community and others involved in a child's care; the courts should consult with our State's medical experts or the child's care providers when considering the seriousness of a child's injuries and long term medical outcome for the child.

The Panel recognizes that there are Departmental policies regarding interstate communication, but there are examples that other states have managed this effectively. The Department should actively explore alternatives to improve methods of communication. The panel recognizes that federal legislation supporting transfer of medical records that is pending may address this concern.

The process to review medical records should become standard procedure in cases. The Pediatric Rapid Evaluation Program (PREP) in Central Maine covers 6 counties and provides a thorough medical and mental health evaluation of children entering our child welfare system. In this program, medical and behavioral health records are obtained and reviewed by an expert evaluator. This program should be available for all children in our State's child welfare system.

DEPARTMENT'S RESPONSE:

The Department agrees with the recommendations and the following is a reflection of steps to both address these findings and to make improvement in practice in general.

The Department is working toward providing a "medical home" for each child so that a child's medical history is obtained, current medical needs are met, and there is the opportunity for consistent medical follow up on conditions that may have long term impacts.

The Department will be taking steps to improve policy that will require staff to obtain all prior medical records for children in care. The use of the Family Team Meeting will be explored to identify where records may be and to get family support as well as medical community support to obtain records.

The Department's integrated Office of Child and Family Services can now allow the Division of Child Welfare to more effectively coordinate with the Division of Children's Behavioral Health Medical Director to develop standardization of medical record review.

The Department agrees the Pediatric Rapid Evaluation Program (PREP) should be expanded statewide and despite difficult economic reality will continue to explore the feasibility of this to more adequately meet children's needs.

The Department has moved to a requirement that all children who enter foster care must be seen by a medical practitioner within 72 hours of entry into care to assess the child's acute medical and behavioral health needs. As this practice becomes fully implemented it may provide better access to records as well.

Coordinated Investigations

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

CASE EXAMPLES

As in reviews in the past, the panel reviewed a case where law enforcement involved stated that the early determinations were that the events leading to the child's death were due to an "accident."

In a co-sleeping case, the Medical Examiners office reported that the manner of death was "accidental", this finding altered the child welfare investigation and had an impact on the ongoing safety of other children in the home. The District Attorney did not get a referral on this case in regard to the child's injury that would have allowed for a coordinated law enforcement investigation.

In one case of a death resulting in a child welfare system referral, the first intake report was referred to the standby worker. The record indicated no evidence of follow-up with law enforcement.

In one case reviewed the AAG was not contacted and/or consulted.

In one case of a child death, the police investigation was inadequate as only the mother was interviewed.

RECOMMENDATIONS

When professionals on the scene term a death an "accident," the system of evaluation and care tends to be less thorough and complete. Responsible investigators and decision makers should avoid premature judgment, moving instead to identify causes and factors related to the injury. Injuries should be classified as either intentional or nonintentional. We should avoid using the term, "accident," as it suggests that an investigation is not necessary.

Departmental Staff, the Attorney Generals office and the Medical Examiner should communicate in cases determined accidental by the Medical Examiner, to learn the circumstances of the child death, and risk factors involved. It is important to recognize that the death might be nonintentional, but also avoidable. It is also recommended that the multidisciplinary team be convened to review such cases of unexplained or unclear fatalities.

A medical finding of plausible accidental cause of the injury should be concluded only as a result of a thorough investigation. Severe, unexplained injuries require a DA referral. Plausible explanations for such injuries do not need to rule out referrals to the DA.

When a serious report is referred to a standby caseworker an onsite co-investigation with law enforcement should take place.

The Panel acknowledges that contacting and consulting the Attorney General is now part of the Department's standard practice.

In the case of possible inflicted injury, it is prudent that thorough investigations are always completed.

DEPARTMENT'S RESPONSE:

The Department agrees with the recommendations and the following is a reflection of steps to both address these findings and to make improvement in practice in general.

As noted previously, the State of Maine has supported staff from public child welfare, the Medical Examiner's office and Maine State Police to participate in the National Sudden Unexplained Infant Death Investigation (SUIDI) Academy. All of those trained individuals sit on the Panel and have provided specialized training for child death investigation units of law enforcement. Additional training and compliance with procedures in compliance with the national SUIDI guidelines need to occur.

The Department has plans in place to improve staff skills in forensic interviewing that can support the exploration of using alternate hypothesis in cases where there are questions regarding the injury or behaviors of a caregiver. The Child Protective Services (CPS) Program Specialist has worked with specific CPS assessment units to improve assessment practices that include interviews of all critical case members as well as other individuals who have information relative to the case.

The Department will need to take additional steps to reinforce policy related to coordination with the District Attorney's Office and the Attorney General's Office.

The Department, while needing to reduce the number of after-hours on-call staff, has taken steps to clarify expectations and establish more consistent practice statewide of after hour services.

The Department supported the 2007 Cops and Caseworkers conference and will work collaboratively with the Child Abuse Action Network to plan a 2009 conference to continue to improve the process of coordinated investigations.

Date: October 1, 2007
Re: Annual Cops and Caseworkers Training Agenda
Date: October 16th and 17th, 2007

"An opportunity for interactive learning between DHHS caseworkers and law enforcement involved in the assessment and investigation of child abuse and neglect"

"Invest Early", presentation by Attorney General G. Steven Rowe and Lauren Sterling
Developmentally Based Child Interviews, presentation by Ms. Joyce Wientzen
Child Death and Serious Injury Review Team Findings, presentation by Dr. Lawrence Ricci
Sudden Unexplained Infant Death investigation, presentation by Dr. Marguerite Dewitt, Lt. Brian T. McDonough and Virginia Mariner, DHHS

Resources and Referrals

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

CASE EXAMPLES

In one case the first referral to the Community Intervention Program (CIP) [now called the Alternative Response Program – ARP] was not an appropriate referral as it was alleged to be High Severity Neglect. In this same case there was no follow up by the Department after the case was closed by CIP (ARP) because they could not locate the child's mother.

In one case reviewed, the worker noted on several occasions that the child was developmentally delayed but had not been seen or evaluated by Child Development Services (CDS).

In one case, the surviving sibling had an injury that could have future health risks but was not addressed in the assessment.

In one case that we reviewed, the link between the Department and the Maine Office of Multicultural Affairs was very good. In this same case, it was determined that the parent was from a cultural and language background that was alien to the community and she was socially isolated, lacking resources for assistance and support. The isolation, as well as the dynamics contributing to it, was a risk factor relative to the safety of the child.

RECOMMENDATIONS

According to departmental policy, high severity allegations shall not be referred to the Alternative Response Program (ARP), therefore steps should be in place to improve compliance with this policy.

When an ARP agency is unable to locate clients, they should always verbally notify and seek assistance from the Department and contract provisions should clarify this expectation.

A broader focus on children being assessed by Child Protective Services will often result in a better assessment and appropriate referrals.

The treatment community needs to be sensitive to the needs of children who were harmed as infants and have evidenced based skills to address these needs.

When a parent, particularly one who is from a different culture, is identified as being isolated and without social supports, it is important to develop a clear understanding of both the personal and social dynamics that contribute to their isolation. Meaningful attempts to address isolation or offer resources must be made in a manner that understands, acknowledges, and respects the cultural aspects of the situation. Generally, it will be necessary to seek consultation to best accomplish this goal.

DEPARTMENT'S RESPONSE:

The Department agrees with the recommendations and the following is a reflection of steps to both address these findings and to make improvement in practice in general.

Through the Department's Performance and Quality Improvement (PQI) Unit steps have been made to complete an analysis of the use of Alternative Response Programs and their coordination with the Department. A new process of contract responsibility has been developed to ensure ARP compliance with contract provisions and to increase cross training opportunities for ARP agency staff.

The Department has a Community Partnerships for Protecting Children (CPPC) program that began in two neighborhoods in Portland and has now expanded to an additional Portland neighborhood, a site in south Portland and potential sites in Westbrook and Biddeford with an expectation to expand statewide over the next two years. This project specifically addresses community inclusion in supporting families with a focus on important cultural aspects of care.

The Department has greatly expanded a network of evidenced based services and interventions to support families in a wide range of communities across the state. These are evidenced by the THRIVE Initiative in the Lewiston area, Wraparound Maine services in all districts and Child STEPS collaboration in three districts. The Child STEPS project provides clinicians with training and supervision in evidenced based treatment approaches through Harvard's Judge Baker Children's Center.

The Department continues to improve and enhance the practice of Family Team Meetings that are a process to ensure the family is part of their own case planning and that have an opportunity to utilize their own family and cultural supports.

Supervision and Decision Making

CASE EXAMPLES

In one case reviewed, a holiday weekend played a role in decisions regarding the case, delaying intervention and decision making.

In one case reviewed, the case was so time-consuming that the caseworker was in a position of neglect of her other cases and it was not clear if steps could have been made to identify this and address it.

In one case reviewed, there was a breakdown in communication between the caseworker and Program Administrator.

In more than one case reviewed, the signs of safety were not clearly defined in the Safety Plan. In one case the Safety Plan was not written in a way that was understandable for the clients; the meanings were vague and documentation did not articulate the risks or analyze how those risks made the children unsafe.

In many cases reviewed we found a pattern of frequent caseworker transitions. In one case the numerous caseworker transitions caused information about the child to be inadequately passed on, which had an eventual safety impact on the child.

In one case reviewed, the Department failed to provide adequate supervision to an inexperienced caseworker.

In one case reviewed, it appeared that the risk of emotional abuse and jeopardy was not adequately recognized. There was enough information (if formulated and well articulated) that could have warranted a petition to be filed. The decision making was incident based, rather than looking at the greater context in which maltreatment occurred.

In reviewing the basis of decision making in one case, it was apparent that there was confusion between the parent's intent and her need and ability to assume responsibility for the child.

RECOMMENDATIONS

A thorough investigation by Child Protection Services per Department policy needs to be completed regardless of the timing of the referral.

A process should be put in place so that supervisors are aware of how much time is being spent by a caseworker on one case so that adjustments could be made if necessary.

The Panel recommends that the Department continue to use the team decision making model.

The Department should work with caseworkers to develop achievable and measurable goals with parents that include a framework for consequences of violating the Safety Plan. These goals should reflect changes the parents can make that will materially improve the safety and wellbeing of their children.

Both caseworkers and supervisors carry responsibility for ensuring information transfer.

It is the responsibility of supervisors to ensure all cases receive supervision appropriate to the caseworkers experience and competencies.

The Panel recognizes that the Department already has a Repeat Maltreatment policy in place. This policy calls for staffing if there is another substantiated case within the year.

The Panel recognizes that in cases where there is a pattern of maltreatment, but one event does not rise to the level of jeopardy, it would be useful to bring all parties together including the AAG for input and consultation.

When there is repeat maltreatment, it is useful to bring in outside experts to look at the case. A closer evaluation of the client's parenting capacity may have been helpful.

In assessing the safety of a child within the context of a family where the child has been harmed, it is not productive to speculate as to "intent" or lack thereof. It is reasonable to assume that most maltreating families do not start out intending to harm their children. Safety can be established by the systematic and carefully focused addressing of risk factors. A sense of accountability provides a necessary basis for that work.

DEPARTMENT'S RESPONSE:

The Department agrees with the recommendations and the following is a reflection of steps to both address these findings and to make improvement in practice in general.

The Department has fully implemented the Family Team Meeting model that supports a process that allows the caseworker and family to jointly develop achievable and measurable goals that include a framework for consequences of not following the Safety Plan. These goals are to be designed to enhance changes the parents can make that will materially improve the safety and well being of their children.

The Department is more closely monitoring the process where new reports are received both on open cases or recently closed cases. The Department also supports the recommendation of utilizing outside experts where critical to the case and within fiscal limits.

The Department has planned over the past year to implement a new data support system, Results Oriented Management (ROM), that allows supervisors to review data down to each individual caseworker level and the expectation for supervisors is to use this data in supervision sessions.

The Department has had a number of supervisory initiatives over the years to strengthen the skills of supervisors. Supervisors have used a peer review system of doing a PQI analysis of caseworker's cases from another unit in the office. This has been enlightening and led to supervisors being able to see the work of their staff in a different context.

Review Process

CASE EXAMPLE

In several of the cases reviewed, the Districts had also reviewed the case and identified a number of the same concerns as the Panel had. The effectiveness of the DHHS internal review process was used in ways that were beneficial to the system.

In one case reviewed by the Child Death & Serious Injury Review Panel, representation from the Department was minimal and there was no law enforcement representation.

RECOMMENDATIONS

The Panel recommends continuation of the internal reviews now being conducted.

The Panel recommends that Districts prioritize participation in the Child Death & Serious Injury Review Panel reviews by sending workers and supervisors who are best able to speak to the case.

DEPARTMENT'S RESPONSE:

The Department agrees with the recommendations and the following are steps to address these findings.

The Department will inform staff that their participation in a child death or serious injury review is a priority when they are requested to be present. The Department will reinforce that workers and supervisors who have direct knowledge of the case should be present for reviews by the Child Death and Serious Injury Review Panel.

Mandated Reporting/Intake

CASE EXAMPLE

In one case reviewed any one of the risk factors present might not reasonably have met the criteria for reporting by a mandated reporter or for substantiation of abuse or neglect. However, the combination and cumulative effect of risk factors put the children at significant risk.

In one case reviewed, the report to Central Intake about bruising of a child was deemed inappropriate. This was a repeat bruising, but did not rise to the level of assessment.

In one case reviewed even though a professional made the first intake referral, the case was not assessed.

RECOMMENDATIONS

When combinations of risk factors are present, it is important that they be considered as a whole. This would allow cases to be reported earlier and not closed so quickly.

The Panel would encourage ongoing performance and quality review on intake decisions in each district.

New reports on open cases need to be identified as a new report and not incorporated into the prior report/case.

It is often difficult to judge the relationship of a current injury to a past serious injury of a child. The Panel recommends that when the report of a trained mental health, medical, or public safety professional is rejected, those reports be given a second review by a supervisor.

The practice of requiring significantly less paperwork when a referral is rejected should be reviewed due to the concern that cases may be more likely to be rejected when it substantively reduces the caseworker's workload.

DEPARTMENT'S RESPONSE:

The Department agrees with all of the above recommendations with the exception of both the finding and recommendation related to the amount of paperwork required when an intake report is deemed inappropriate (or rejected as the language in the recommendation states). The intake process is the same for both appropriate (accepted for CPS assessment) or inappropriate (not accepted for CPS assessment). At intake the same amount of questions, exploration of circumstances and review by a supervisor takes place regardless of the outcome. All intake decisions are reviewed by a supervisor as there is a supervisor available at intake 24 hours a day and 7 days a week. The Department has changed practice so that all decisions are done at intake and a case is then transferred to the district for assignment.

The following is a reflection of steps to both address the other findings and to make improvement in practice in general.

A Performance and Quality Improvement of Review is now done periodically of intake decisions and has shown to improve the quality of information gather at intake and the quality of decision making.

Infant Deaths, SIDS and Bedsharing

Unsafe infant sleep practices as a cause of infant death is a pressing public health problem. Sudden Unexpected Infant Deaths (SUID) have doubled during the last decade in the United States, with many being attributed to accidental asphyxiation. There are 4600 infant deaths per year due to Sudden Unexpected Infant Death Syndrome. Education for families about bedsharing risks and safe-sleep is virtually non-existent in Maine. Leadership from the child welfare system in Maine is urgently required to both identify how often babies die when co-sleeping and how to educate families about the risk.

RECOMMENDATIONS

The Child Death and Serious Injury Review Panel should work with the Department of Health and Human Services and the Child Abuse Action Network to develop and implement a safe sleep campaign.

DEPARTMENT'S RESPONSE:

The Department is in strong agreement with the above recommendations and has worked closely with the members of the Child Abuse Action Network to support a public awareness campaign about safe sleeping guidelines. This work is also coordinated with both the Division of Child Welfare, the Division of Early Childhood, and the Maine CDC. The Maine

Children's Alliance has been a supporter of the distribution of educational materials on safe sleeping.

"Back to Sleep" Campaign The Back to Sleep campaign promotes placing babies on their backs to sleep. This reduces the risk of Sudden Infant Death Syndrome (SIDS), also known as "crib death." This campaign has been successful in promoting infant back sleeping to all caretakers: parents, family members, child care providers, and, health professionals. The campaign is sponsored by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development, the Maternal and Child Health Bureau, the American Academy of Pediatrics, the SIDS Alliance, and the Association of SIDS and Infant Mortality Programs.

The Maine Child Abuse Action Network is now a distribution center for the Safe Sleep for Your Baby Brochures published by the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD).

What is SIDS?

SIDS stands for sudden infant death syndrome. This term describes the sudden, unexplained death of an infant younger than 1 year of age.

Some people call SIDS "crib death" because many babies who die of SIDS are found in their cribs. But, cribs don't cause SIDS.

What Should I Know About SIDS?

Health care providers don't know exactly what causes SIDS, but they do know:

- *Babies sleep safer on their backs.* Babies who sleep on their stomachs are much more likely to die of SIDS than babies who sleep on their backs.
- *Sleep surface matters.* Babies who sleep on or under soft bedding are more likely to die of SIDS.
- *Every sleep time counts.* Babies who usually sleep on their backs but who are then placed on their stomachs, like for a nap, are at very high risk for SIDS. So it's important for everyone who cares for your baby to use the back sleep position for naps and at night.
- *Communities across the nation have made great progress in reducing SIDS!* Since the *Back to Sleep* campaign began in 1994, the SIDS rate in the United States has declined by more than 50 percent.

http://www.nichd.nih.gov/SIDS

Always place your baby on his or her back to sleep.

What Can I Do to Lower My Baby's Risk of SIDS?

Here are 10 ways that you and others who care for your baby can reduce the risk of SIDS.

Safe Sleep Top 10

1. *Always place your baby on his or her back to sleep, for naps and at night.* The back sleep position is the safest, and every sleep time counts.
2. *Place your baby on a firm sleep surface, such as on a safety-approved* crib mattress, covered by a fitted sheet.* Never place your baby to sleep on pillows, quilts, sheepskins, or other soft surfaces.

* For information on crib safety guidelines, contact the Consumer Product Safety Commission at 1-800-638-2772 or http://www.cpsc.gov.

3. *Keep soft objects, toys, and loose bedding out of your baby's sleep area.* Don't use pillows, blankets, quilts, sheepskins, or pillow-like crib bumpers in your baby's sleep area, and keep all items away from your baby's face.
4. *Do not allow smoking around your baby.* Don't smoke before or after the birth of your baby, and don't let others smoke around your baby.
5. *Keep your baby's sleep area close to, but separate from, where you and others sleep.* Your baby should not sleep in a bed or on a couch or armchair with adults or other children, but he or she can sleep in the same room as you. If you bring your baby into bed with you to breastfeed, put him or her back in a separate sleep area, such as a bassinet, crib, cradle, or a bedside cosleeper (infant bed that attaches to an adult bed) when finished.
6. *Think about using a clean, dry pacifier when placing your infant down to sleep,* but don't force the baby to take it. (If you are breastfeeding your baby, wait until your child is 1 month old or is used to breastfeeding before using a pacifier.)
7. *Do not let your baby overheat during sleep.* Dress your baby in light sleep clothing, and keep the room at a temperature that is comfortable for an adult.
8. *Avoid products that claim to reduce the risk of SIDS* because most have not been tested for effectiveness or safety.
9. *Do not use home monitors to reduce the risk of SIDS.* If you have questions about using monitors for other conditions talk to your health care provider.
10. *Reduce the chance that flat spots will develop on your baby's head:* provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers.

Your baby needs Tummy Time! Place babies on their stomachs when they are awake and someone is watching. Tummy Time helps your baby's head, neck, and shoulder muscles get stronger and helps to prevent flat spots on the head.

The 2008 Referral Report

Prepared by Robert Pronovost
Manager, Child Protective Intake Unit

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

The Department of Human Services has contracts with private agencies to provide an alternative response to reports of child abuse and neglect when the allegations are considered to be low to moderate severity. There were **2,325** appropriate reports involving **4,980** children which were assigned to a Contract Agency for Alternative Response in 2008.

There were 6,178 reports involving 12,141 children assigned to a caseworker for a Child Protective Assessment in 2008.

New Reports Assigned for Assessment

Families		Children involved by age group				
Office	**Reports**	**0-4**	**5-8**	**9-12**	**13-15**	**16-17**
Portland	960	745	384	284	226	119
Sanford	315	224	184	124	95	40
Biddeford	553	389	217	241	162	84
Lewiston	1014	879	503	380	230	119
Augusta	762	584	369	282	193	80
Rockland	560	462	273	178	119	64
Skowhegan	420	304	227	164	113	49
Bangor	876	778	341	284	161	96
Ellsworth	219	147	91	73	46	16
Machias	161	116	68	55	40	17
Houlton	62	54	32	18	11	5
Caribou/FK	256	232	148	93	60	38
Statewide	6178	4929	2839	2183	1461	729

Source of Reports Assigned for Assessment

School Personnel	966
Social Services Personnel	771
Law Enforcement Personnel	958
Medical Personnel	658
Anonymous	611
Neighbor/Friend	456
Relative	489
Other	194
Mental Health Personnel	489
Self/Family	486
Child Care Personnel	100

Household Type/Living Arrangement of Reports Assigned for Assessment

Two Parent Married	1341
Two Parent Unmarried	1491
One Parent Female	2556
One Parent Male	420
Adoptive Home	29
Relative	198
Non Relative	35
Other	108

Family Stress Factors Identified During Assessment

Family Violence	1352
Alcohol/Drug Misuse by Parent/Caretaker	2066
Mental/Physical Health Problem	3501
Severe Parent/Child Conflict	740
Severe Acting Out Behavior of Child	668
School Problems	767
Divorce Conflict	597
Emotionally Disturbed Child	545
Runaway	92
Alcohol/Drug Misuse by Child	183
Failure To Thrive Child	32

Completed Assessments

Office	Completed	Child Abuse/Neglect Found	Unsubstantiated	Findings Rate
Portland	986	445	541	45%
Sanford	319	114	205	36%
Biddeford	578	238	340	41%
Lewiston	1045	429	616	41%
Augusta	764	220	544	29%
Rockland	576	196	380	34%
Skowhegan	408	182	226	45%
Bangor	897	365	532	41%
Ellsworth	233	120	103	56%
Machias	166	78	88	47%
Houlton	89	31	58	35%
Caribou	193	66	127	34%
Fort Kent	59	33	26	56%
CPS Total	6313	2527	3786	40%
Institutional Abuse	198	13	185	.07%

Data compiled on Assessments begun during calendar year.

Child Abuse & Neglect Victims by Age and Sex

2007

Male	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
0-4	30	163	673	245
5-8	25	90	312	224
9-12	28	72	220	210
13-15	15	34	129	91
16-17	2	12	37	34
Total	100	371	1371	804

2008

Female	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
0-4	42	119	633	268
5-8	37	68	283	195
9-12	59	46	208	121
13-15	51	60	158	133
16-17	20	22	55	59
Total	209	315	1337	776

Drug Affected Babies

Neonatal Abstinence Syndrome (NAS) "is a generalized disorder characterized by signs and symptoms indicating dysfunction of the automatic nervous system, gastrointestinal tract, and respiratory system" (Johnson et al [2003]) and is often exhibited by neonates of heroin and methadone-maintained mothers.

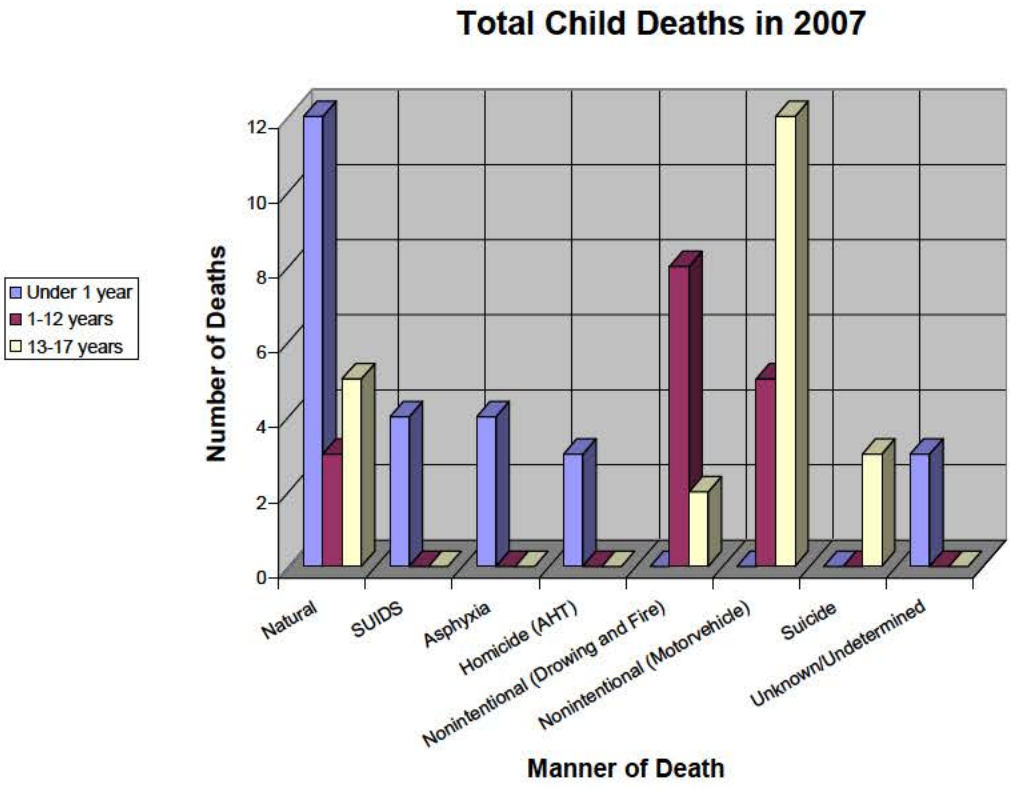
Number of Drug Affected Babies Reported to CPS

Year	Number of Reports	Comments
2005	165	Highest concentrations in Bangor, Lewiston and Auburn
2006	201	Highest concentrations coincide with 2005, with a rise in Ellsworth
2007	274	Bangor and Augusta experienced greatest increase
2008	343	Caribou, Lewiston and Rockland experienced significant increase

Child Deaths Reported to the State of Maine Office of Chief Medical Examiner 2007

Total Deaths in 2007

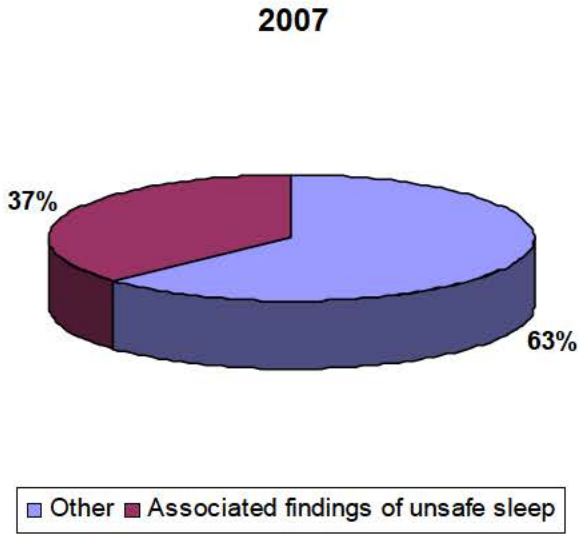
64 child deaths were reported to the State of Maine Office of the Chief Medical Examiner in 2007. 26 of these deaths were in children 1 year and younger. 16 deaths occurred in children ages 2-12 years, and 22 deaths were of children 13-17 years of age.



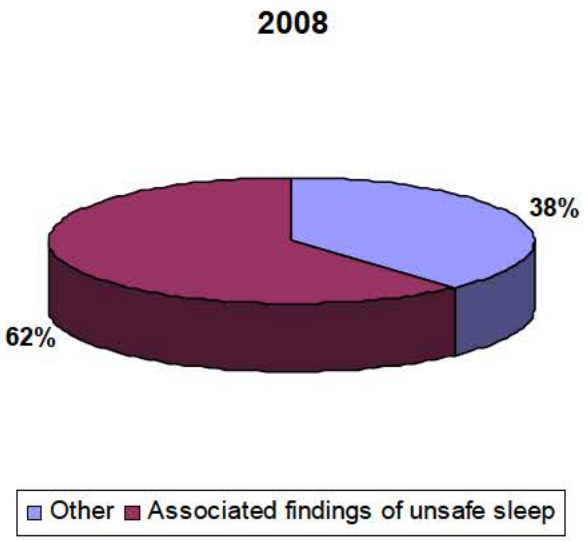
Deaths Associated with Unsafe Sleep 2007-2008

According to the American Academy of Pediatrics, unsafe sleeping practices include the sharing of sleeping surfaces (bedsharing), cluttered sleeping surfaces, soft bedding and prone positioning. These practices are risk factors for Sudden Unexplained Infant Death, and are associated with a number of infant deaths each year.

In 2007, there were 19 deaths reported in children under the age of one. 7 of the deaths had associated findings of unsafe sleeping practices.



In 2008, there were 13 deaths reported in children under the age of one. 8 of these cases had associated findings of unsafe sleeping practices.



Risk Factors 2006-2008

- The Child Death and Serious Injury Review Panel collected data from 2,008 cases of Abuse/Neglect that were reported during 2006 and 2008.
- There were 10,033 risk factors identified (5 factors per case on average)
- 868 cases (43.2%) were rated Physical Abuse, High Severity
- 1,140 cases (56.8%) were rated Physical Abuse, Low/ Moderate Severity
- If any of the following risk factors are present, there is a significant increase of severe child abuse.
  - Substance Abuse by Parent
  - Parental Mental Health Problems
  - Domestic Violence History
  - Parent is Former Foster Care Child
  - Prior Child Protection System History

Conclusions

- A child's age is a very strong predictor of the severity of abuse; younger children suffer higher severity abuse than older children.
- Among younger children, elevated parental behavior problems, environmental factors and prior CPS history are strong predictors of severe abuse.
- Among older children, elevated child behavior problems and prior Child Protection System history are strong predictors of severe abuse.

Risk Factor Frequencies and Categorization

Risk Category	Frequency	%
Parental Problems	1,874	93.3
Child Problems	917	45.7
Environmental Problems	814	40.5
Previous CPS History	1,493	74.0

Activities and Outcomes, 2006, 2007, 2008

Changes as a result of the CDSIRP 2006 Report

A copy of the 2006 report was submitted to the Commissioner of the Department of Health and Human Services and the Health & Human Services Committee of the 123rd Maine State Legislature. The following changes occurred as a result of the 2006 report.

- The DHHS made a change in the Family Visitation Policy that supported more effective communication and open disclosure of observed parenting patterns and feedback to parents participating in supervised visitation.
- The Abusive Head Trauma Workgroup was formed to research evidenced based models to address and reduce the incidents of abusive head trauma to children.
- There is an active revision of the DHHS's assessment policy to address the recommendations of the Child Death and Serious Injury Review Panel to have an improved investigation and assessment protocol which will reduce the harm to child victims and family members, and ensure fairness to the accused perpetrator.
- CDSIRP supported the enhanced mandated reporter training between the Child Abuse and Neglect Councils and the Department's Central Intake. In addition, the Child Death and Serious Injury Review Panel developed a response to mandated reporters who fail to make a mandated report in cases of abuse and neglect.
- The Pediatric Symptom Checklist was adopted by the Department as a psychosocial screening instrument to reduce additional trauma to child victims by more appropriately identifying symptoms that interfere with healthy development.

Activities and Outcomes for 2007 and 2008

- Law Enforcement, the Medical Examiners Office and the Department of Health and Human Services (DHHS) collaborated on developing a protocol for investigating Maine's cases of Sudden Unexplained Infant Deaths (SUID) using the national SUIDI protocol; developed by the US Department of Health and Human Services and the Center for Disease Control. Lt. Brian McDonough, from the Maine State Police, Margurite Dewitt, M.D. from the Maine Medical Examiners Office and Virginia Marriner, Director of Child Welfare Policy and Practice at the Maine DHHS attended training on the national protocol in Boston, MA in 2008. Subsequent trainings have been presented in Maine utilizing this protocol.
- CDSIRP supported the development of the Abusive Head Trauma Workgroup. The Workgroup is made up of several members of the Child Death and Serious Injury Review Panel, the Child Abuse Action Network in addition to other critical members of the community. The Workgroup adopted the Period of Purple Crying program, an educational and evidenced-based program for parents aimed at reducing incidents of abusive head trauma. To date all home visitors and public health nurses have been trained in the program and 29 out of 31 Maine hospitals have been trained to provide the Period of Purple Crying program to all new parents. The program has been implemented in nearly every hospital in the state!
- Historically Maine's Federally Mandated (CAPTA) Citizen Review Panel is operated under the auspices of the CDSIRP. In collaboration with Casey Family Services, the

University of Maine, the DHHS, local Clergy, Adoptive and Foster Families of Maine, the Bangor Police Department, private service providers, and Domestic Violence advocates, the Network formed a development committee to form an independent Citizen Review Panel. The Panel had its orientation meeting in October 2008 and is currently developing long and short term goals for the next year. The development group met for one year to develop bi-laws and establish a membership plan.

- The Panel has begun reviewing cases in clusters, by abuse type, which has provided an opportunity for more reviews each year, but also more focused reviews with more concise recommendations and implications for prevention.

Proposed Activities for 2009

- The Child Death and Serious Injury Review Panel (CDSIRP) will conduct more focused reviews of patterns of deaths and serious injuries with more concise and systematic recommendations, rather than individual and case specific reviews. These reviews will focus more directly on issue of public health and prevention of childhood deaths and serious injuries. Recommendations will be evidenced based and practical as to the needs of children and families in Maine.

- The Child Welfare Coordinator is acting as a liaison between the National Center on Child Death Review and our local and State review teams to develop a new model for review, data collection and reporting.

- The Child Welfare Coordinator in her role as coordinator of the CAAN, CDSIRP and the CRP will utilize the resources of all three committees to develop and implement a plan for the dissemination of recommendations for improved practice in child welfare.

A special thanks for all the hours that our volunteer panel members commit to making this report a reality.