Report of the State of Maine Child Death and Serious Injury Review Panel 2009

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 (DHHS) for all she does to make this work possible.

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Maine People Living
Safe, Healthy and Productive Lives

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April, 2010

To the Maine Community:

As difficult as it may be to consider that serious injury and tragic death occur for any child, the hope is that as we learn the causes and factors that contributed to those incidents we learn means to be better informed in our practices designed to help and support vulnerable families. This report identifies that as we engage in comprehensive review of these incidents, whether a result of abuse or other unfortunate circumstances, we learn strategies and approaches that can reduce the occurrence of harmful incidents and make life safer for children and families in Maine.

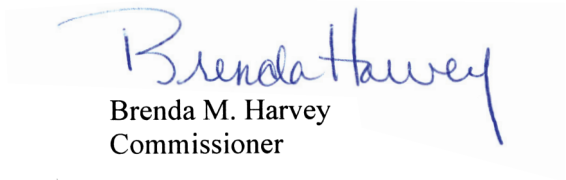
The multi-disciplinary aspect of the Child Death and Serious Injury Review Panel and their affiliation with the Child Fatality Review Teams from all of New England and with the National Child Death Review Case Reporting System continues to enhance Maine's ability to identify risk factors and patterns both in Maine and nationally that will support Maine in our efforts focused on preventing future tragedies. The Reporting System is a case report tool made available from the National Center on Child Death Review that provides standardized data elements and data definitions for the purposes of analyzing and reporting information on child deaths and injuries over time.

Each Panel member contributes their expertise and time to this difficult endeavor of examining our very most difficult cases. Their work not only enhances overall learning but provides opportunity to bring learning back to inform the work within their own discipline that will support families and will identify trends and patterns that impact the safety of children.

The Panel took on some more varied reviews over this past year and thoroughly examined home birth practices in Maine. Through interviews of professionals working in hospital-based child births and home births, an international literature review, interviews of parents who chose home birth, and review of hospital records, a comprehensive report was submitted to identify recommendations to the Department of Professional and Financial Regulation. The report valued the coordinated and collaborative system of care for birth in Maine and noted that if we want to have optimum outcomes for home birth, families and caregivers choosing to deliver at home must all be included in the system of care.

Overall, the recommendations in this report are an opportunity for all to advance our practice. I thank the panel for their investment, integrity, diversity, and, ethical approach to these issues and I respect the knowledge and expertise represented by the panel members.

Sincerely;



Brenda M. Harvey
Commissioner

A Letter from the

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

March 30, 2010

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 is not meant to be a part of the system of case investigation and criminal prosecution. We meet monthly to review cases evaluating sentinel events, patterns of injury and/or death and the effectiveness of our state programs that provide for child protection, safety and care. Through the Panel's findings and recommendations we hope to help reduce the number of preventable child fatalities and serious injuries in our state.

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

The challenges leading to case review in 2009 to help improve the system of care include:

- A review of care of former foster children that went on to commit violent crimes.
- To assess the safety of home birth, define the current state of newborn care in Maine and identify potential areas to strengthen to lower maternal/infant morbidity and mortality.

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

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 2009 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 2009

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Lt. Gary Wright	Maine State Police, CID II

Forward

Purpose of Child Death Review

The mission of the Child Death and Serious Injury Review Panel is to provide multidisciplinary, comprehensive case review of child fatalities and serious injuries to children in order to promote prevention, to improve present systems and to foster education to both professionals and the general public. Furthermore, the panel strives to collect facts and to provide opinion and articulate them in a fashion that promotes change. The final mission of the Panel is to serve as a citizen review panel for the Department of Human Services as required by the federal Child Abuse Prevention and Treatment Act, P.L. 93-247.

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

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

The Maine Child Death and Serious Injury Review Panel is comprised of representatives from many different disciplines. Its composition, which is mandated by state law, includes the following disciplines: judiciary, forensic pathology, forensic and community mental health, pediatrics, public health nursing, civil and criminal law, law enforcement, public child welfare. Doctoral candidates completing their clinical or field placements regularly participate in these case reviews as part of their education and training.

There are several unique functions of the Panel:

Some states have multiple local review panels in addition to a central state-level panel. In such cases only selected cases are reviewed by the state-level team. Because the state of Maine is less populous than other such states, all cases are reviewed by the full, central, state-level team. The centralized forensic medical examiner system and representation on the panel promotes standardized forensic child death investigations and post mortem exams.

The State of Maine has specialized medical examiner training for child death investigation units of law enforcement, which include Maine State Police, Bangor and Portland Police Departments. Representatives from this training sit on the Panel.

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

The Maine Child Death and Serious Injury Review Panel belongs to the consortium of Northern New England Child Fatality Review Teams and works closely with the National Center on Child Death Review. Our work and methods conform to the standards of our companion States. A team of Maine panel representatives have both participated in and presented at each of the past thirteen annual Northern New England Child Fatality Review Team Meetings. The Panel Coordinator attended the 2009 National Child Death Review Symposium in Washington DC.

2009 Activities

The serious injury or the death of a child is a tragic event. In communities with small populations, such events may seem rare and unpreventable. Yet, it has been shown that when a community takes a public health approach, tracking patterns of serious injury and death to children over time has led to the identification of risk factors and informed policies resulting in improved outcomes for children.

In February 2009, Teri Covington, the Director of the National Center on Child Death Review came to Maine to describe the National Child Death Review Case Reporting System. The National Child Death Review Case Reporting System is a case report tool that provides standardized data elements and data definitions for the purposes of analyzing and reporting information on child deaths and injuries over time.

Subsequently, The Maine Department of Health and Human Service’s Child Death and Serious Injury Review Panel decided to partner with the Maine Center for Disease Control, the Medical Examiners Office, Maine’s Office of Child and Family Services and the Office of Vital Statistics to enhance our State’s ability to identify risk factors and patterns for the purpose of preventing child deaths and serious injuries. We are accomplishing this by collecting comprehensive information from these multiple agencies through the use of the Child Death Review Case Reporting System from the

National Center for Child Death Review. The first cases will be entered into the Reporting System beginning January 2010.

Panel members particpated in a number of educational opportunities including a presentation by Deputy Chief Medical Examiner, Dr. Marguerite Dewitt, on deaths involving unsafe sleep practices. This, and a number of infant deaths in Maine involving bed sharing, led the Panel coordinator and several Panel members to help develop a Safe Sleep Campaign Committee. Public service announcements and other eductional materials are being developed with The Maine Children's Trust taking the lead in developing a sudden unexpected infant death (SUID) prevention program.

For the months of May, June and August, the committee became very knowledgeable about home birth practices in Maine, nationally and internationally. The committee interviewed a number of professionals working in both hospital-based child births and home births; conducted a literature review; interviewed parents and reviewed home birth records. The result was a complete report to Commissioner Anne Head, Department of Professional and Financial Regulation. The findings and recommendations from that report are included here.

In November, Joseph Riddick, panel member and Health Planner from the Injury Prevention Program at the Maine CDC, presented the findings of Maine's Youth Suicide and Injury Prevention Program. The program collected information from medical examiner, death certificates and police reports over a 4 year period of time**.** Future work will included a content analysis of suicide notes, expanding the years and age range of reviews, to inform Maine's suicide prevention and intervention strategies.

This Report

The report is a summary of the cases reviewed by the Panel in 2009 and the resulting recommendations to the Department of Health and Human Services. We present the prevention activities lead by the Maine Children's Trust to address the high rate of abusive head trauma previously identified and reported on by the Panel. This year the report also makes recommendations to the Department of Professional and Financial Regulation regarding the Panels review of and special report on home births in Maine. The 2009 Referral Report from the Office of Child and Family Services, DHHS is also included.

Violent Crimes Committed By Youth Formerly in Foster Care

This year the panel began a review of cases where young adults who were formerly foster children have committed violent crimes. Two cases have been reviewed to date.

Case Examples

Two young adult male subjects were convicted for the murder of a 62 year man.

In the first case, prior to and during his placement in DHHS custody, the subject experienced a number of Adverse Childhood Experiences (ACES) including; physical abuse, sexual abuse, substance abuse by parent, and parental divorce. By age 4 he had incurred injuries that required sutures on 5 separate occasions and had lived in 5 homes, both with and without his mother. He was placed in voluntary custody of the Department of Health and Human Services at age 4 and by the age of 5 he was in permanent state care. Although he was left with many different caregivers, he formed a strong emotional attachment to his mother who unfortunately was an inadequate caregiver. While in custody, he was placed in 10 foster homes and 7 psychiatric facilities. In foster care and residential care, he was exposed to punitive behavior modification techniques, including locking him in a room with the lights out. Throughout his time in foster care, he believed that he was in foster care as a result of his own behavior, as opposed to the behaviors of his mother. His multiple placements reinforced this belief. His placement in psychiatric facilities and his multiple moves were the result of his self injurious and assaultive behaviors and he did express homicidal and suicidal thoughts.

In the second case, the subject entered the Department of Health and Human Services (DHHS) custody at age 16 as the result of a Juvenile Custody Order and he remained in care till age 18. Prior to coming into the custody of the DHHS he suffered numerous Adverse Childhood Experiences (ACES) including physical abuse, sexual abuse and neglect. By age 17, he had suffered numerous closed head injuries, had a long history of requiring multiple surgical interventions, including a bicycle accident resulting in a femur fracture and a concussion prior to DHHS custody. He had poor school achievement. He was abused and terrorized by his older brother as a child. Multiple reports were made to the Department that did not result in a Child Protection Assessment. At the time of the Juvenile Custody Order, he was on probation for assault, criminal threatening, criminal mischief, and possession of tobacco. Once in DHHS custody this youth experienced 13 moves to 8 facilities, including 4 hospitalizations. While in State custody, he was treated with anti-psychotic medications which resulted in obesity**.**

These young men met in custody and reunited after reaching the age of 18. Both young men were exposed to substance abuse and domestic violence and the separation of their parents. Both had been engaged in antisocial and aggressive behavior. Both had a history of arrests for assaultive behaviors.

Findings & Recommendations
First, the Panel recognizes that numerous changes have been made in Child Welfare services in Maine since these subjects became known to the Department. Several positive findings were identified through the review of these cases.

1) The Department has made improvements by decreasing the number of children in residential treatment to 10%, down from 32%.
2) The Department has been using the Pediatric Symptom Checklist for children over 4 since 2007 and makes referrals to Child Development Services for all children under 4 in substantiated cases for screening, assessment and services as identified
3) The child in the first case was not seen by an expert in child abuse after he was molested. The Department now has a system in place for forensic sexual abuse evaluation.
4) The children in these cases had numerous placements and never had permanency or safety. The records indicated that relatives may have been a resource for these children and were not approached. The Panel is aware that the Department's current policy is to look for relatives as resources for children.
5) The Pediatric Rapid Evaluation Program (PREP) data shows that 25% of children in care over age 12 have 4 or more placements; 90% of children who come into care under age 5 have 1-2 placements. The Department makes efforts to identify children early and reduce the number of placements.

Finding & Recommendation
The youth in these cases had multiple injuries prior to coming in to custody that were identified as accidents. Their medical records were not thoroughly reviewed when they came into care. The Panel recommends that Maine continue its use of the Pediatric Rapid Evaluation Program (PREP), which is now in 6 counties; and recommend that it be implemented statewide.

Departments Response
DHHS, OCFS recognizes the benefit of a thorough review of the medical records of children who enter care and have instituted a policy to require an initial medical assessment of each child entering care within 72 hours. OCFS has also begun work to ensure that each child in foster care has a medical home, a medical practice that can gather, maintain and facilitate record retention, as well as facilitate a consistent, coordinated delivery of health care. Consistent with state procedural guidelines a process of extending Requests for Proposals (RFP) to promote expansion of the PREP model of intervention is likely.

Finding & Recommendation
Case workers and other professionals working with children would benefit from training in child behavior and development and the impact of adverse childhood experiences on a child's behavior. This training might assist in the recognition of factors that differentiate children with the potential for violent behavior from typical adolescent behaviors. We know that the earlier the onset of aggressive offending, the higher the likelihood of

criminal behavior. Earlier identification and acknowledgment of risk may lead to improved early intervention.

Departments Response
OCFS has supported training in the years since the time these individuals were in state care on the impact of Adverse Childhood Experiences (ACE's). OCFS would welcome ongoing support from the members of the CDSI Panel to identify the best practices to address aggressive behaviors in children. The OCFS work to conduct evidenced based clinical trials collaborating with Judge Baker Children's Center, Harvard University, in implementing interventions to address disruptive behavior/conduct disorder are anticipated to demonstrate effective interventions for this population.

Finding & Recommendation
In the first case the child's behavior was difficult to manage and he experienced punitive behavior management while in foster care and residential treatment. Punitive measures utilized included the use of physical restraints, physical discipline, isolation (locked in a room alone with the lights off), a lack of nurturing and the pathologizing of normal childhood behaviors. In both cases, adverse events were documented in the case record, however, not conceptualized in a way that articulated the impact of the abusive and neglectful behavior management techniques. The cumulative impact of ongoing abuse should be identified in the Department's documentation of cases. These cases require evidenced based services.

Departments Response
OCFS has worked with both the residential treatment community and foster care treatment programs to develop behavioral management guidelines that disallow punitive and restraint based behavioral management techniques. More frequent contact by workers with children in care (at least monthly), development by former youth in care of a Youth Bill of Rights, and youth driven Family Team Meetings all facilitate a mechanism for youth to be more equal partners in their own decision making.

OCFS has also facilitated two evidenced based models of service to high risk families that include, Multisystemic Treatment Foster Care (MST) and High Fidelity Wraparound.

Recommendation
Multi-disciplinary and parental/foster parent involvement in the planning and pre-planning process should begin at the onset of the case.

Departments Response
OCFS continues to utilize Family Team Meetings (FTM) that are family focused and in 2008/2009 has emphasized the need to hold FTMs prior to a child's entry into care.

Finding & Recommendation
Children need healthy attachments to adults and need to feel safe in order to progress developmentally. PREP data shows that 25% of Maine children in care over age 12 have 4 or more placements; 90% of Maine children who come into care under age 5 have 1-2

placements. The Department may want to consider developing a comprehensive review, recommendation, and support option for children who experience disruption of their placement a third time.

Department Response
OCFS has been tracking the number of placement changes a child has and has instituted policy to support more pro-active work with caregivers to support placement and prevent disruption. OCFS is very interested in the recommendation to complete a comprehensive review of children who disrupt for a third time and will look at the feasibility of this process.

Finding & Recommendation
In the first case, a voluntary placement was used and resulted in the failure to establish findings of abuse or neglect. This coupled with the child's belief that being in custody was his fault, may have adversely impacted his long term outcome. In the second case, the child came into custody through a juvenile action; also resulting in a failure to establish findings of abuse or neglect. Whenever warranted, the Department should determine if there is a substantiated finding of abuse or neglect, even in cases where children are placed voluntarily.

Departments Response
OCFS has clarified the substantiation and indication process of findings and have developed rules that support consistency in this process, including client's rights to appeal finding decisions.

Finding & Recommendation
In the first case the record depicts a child who was grieving for many years and who blamed himself for the loss of his family. Those working with him did not take actions that would dispel his belief that he was at fault. The Department should utilize evidenced based practices to address the effects of trauma and promote resiliency.

Departments Response
OCFS has incorporated training through many venues to address trauma and its effects and the support of resiliency in children.

Recommendation
In the first case, the system of care interpreted the child's desire to be with his mother as "attachment", rather than an anxious, trauma-based response. It is recommended that home visitors and caseworkers receive training in the important differences between child-centered relationships versus parent or self-centered relationships.

Department Response
OCFS agrees to actively pursue opportunities to both 1) Identify training that will address a child's trauma-based responses and variances in child-centered versus parent centered relationships which has the most current research supporting the training model and 2) To then make that training available to staff.

Serious Injury Review

Case Example

The Panel reviewed the serious injury of a two year old boy who suffered severe burns to his thighs and perineum while in the care of his mother's live-in boyfriend. In addition to burns, the child presented with numerous inflicted bruises. The review of the medical records for the subject and his two siblings depicted young children with multiple injuries and hospitalizations. In particular, the child had one emergency room visit with the chief complaint being right shoulder pain where the explanation was not consistent with his age or ability. At that visit he was found to have a severe right shoulder fracture. The severity of this injury coupled with the inadequate explanation should have triggered a child protective referral and a skeletal survey. A follow-up skeletal survey showed a healing fracture to the right humorous and clavicle resulting in significant limitation of motion of the right elbow. There was a question of healed fractures of both proximal radii.

Recommendations

Finding & Recommendation
Over the years the Panel has found a pattern of failure to report to the Department of Health and Human Services in cases where mandated child abuse reports should be made. A subcommittee was formed to make recommendations to the committee regarding an appropriate set of responses to this issue. The subcommittee developed a template letter and recommends that the Department of Health and Human Services use the letter in cases where there was failure to make a mandated child abuse and neglect report.

Departments Response
OCFS agrees there is a need to have a consistent response to providers who fail to report under the mandated reporter statute. OCFS will utilize the template where needed.

Finding & Recommendation
The Panel found that water temperature over 120 degrees is a public health issue. The Panel researched national data and found that in Washington State the incidence of injury to children under 5 and the elderly dropped significantly after legislation was passed addressing this public health concern. The legislation required landlords to set the water heater limit at 120 degrees Fahrenheit before each new tenant moved in; that utility companies send an annual warning of the dangers of hot water to all of its customers; and that manufacturers preset the water temperature at 120 degrees F. The CDSIRP recommends that the State of Maine adopt similar legislation.

The panel also recommends that the Department of Health and Human Service's Foster Home Licensing unit check the residential water temperature during the licensing process and that warnings about the dangers of tap water temperature above 120 degrees be added to the foster parent newsletter annually.

Departments Response
DHHS is in full agreement that steps should be taken to ensure that in foster and kinship homes the water temperature be set no higher than 120 degrees and that steps must be taken to work with the plumbing and heating industries to establish guidelines and determine the feasibility of legislation to address this need.

Recommendation
When a case worker is faced with a child with fractures, the caseworker should reserve the right to contact the child abuse pediatric specialist

Departments Response
OCFS has worked closely with child abuse experts in the state and caseworkers more consistently contact the child abuse pediatric specialist to obtain an experienced opinion on the etiology of fractures or other serious injuries. The expectation to seek this opinion will continue to be reinforced with OCFS staff.

Special Report
Home Birth Review
Reviewed May, June & August 2009

Summary of Home Birth Review:

The Child Death and Serious Injury Review Panel, a review panel authorized under the federal Child Abuse Prevention and Treatment Act (CAPTA) and Title 22, MRS was asked by the Department of Health and Human Services to consider the safety of Home Birth care in Maine. This request was based on anecdotal reports concerning serious adverse events necessitating transfer of mother and child from home to a hospital either during or immediately after birth.

In Maine, approximately 30% of hospital births are by cesarean section. Medical liability for Obstetricians and Hospitals is one significant reason for the rise in surgical deliveries in Maine. Some Hospitals and Obstetricians in Maine will not offer a trial of vaginal birth after cesarean to their pregnant patients.

Home birth in England and Canada is reported to be as safe as hospital births when pregnancies are carefully followed by an experienced, certified practitioner enabling a problem to be identified early and resulting in transfer to a higher level of care. Australia

experienced a very high rate of untoward outcomes in their home births as there was poor differentiation between high and low risk pregnancy by their home birth midwives and no system of care to enable safe early transfer of care to higher levels of service. As a result of their findings, South Australia developed and implemented a system of care to improve home birth outcomes for their pregnant women and newborn infants.

In Maine, there is currently a well developed and reliable system of care to assure that at risk infants, expectant mothers and postpartum women receive high quality care. Home birth is often excluded from this traditional system of care based upon the profoundly differing definitions, focus and values expressed by the two sides resulting in mutual and self feeding fear, mistrust, and anger. Generally speaking, both sides recognize that the state's system needs to be structured to minimize risk and to ensure the best possible global outcome for all births in Maine. Barriers include the attitudes of some hospitals and medical providers toward home birth providers. There is also fear regarding a perceived increase in physician and hospital liability if the home birth providers are included.

Direct entry midwifery has a long and honored history in Maine. As the health care environment changes, midwives seek to both remain and to become a meaningful part of the system of maternity care in Maine. The Certified Professional Midwives (CPMs) the Panel interviewed currently transfer very few intended home births (5%) to more specialized providers; systems of care identifying low rates of complication for their home births (England, Canada) show a rate of transfer between 15% and 22%. Panel members remained unclear on the CPM's process and standard for classifying low, moderate and high risk pregnancy. What was clear was that their process and standards differ from those of medically trained providers.

The parents that were interviewed described the importance of childbirth to their family and their positive experience giving birth at home. The mother described concern over the risk of hospital birth and her informed belief that for her, home birth may be safer than hospital birth.

The record review reaffirms the Panel's findings from the interviews that there is an absence of planned inclusion of home birth in the system of maternity care in Maine. Though the Panel was unable to obtain complete data, it appears that Maine has a low rate of planned transfer of intended home births to hospital care. Case selection by CPMs led to high and moderate risk pregnancies being attempted at home. When present, the informed consent provided by home birth caregivers did not appear to be balanced or carefully grounded. There was a significant lack of preventative public health screening in the intended home births. Mother's that delivered at home were 400 times more likely to refuse blood spot screening for congenital disorders than mother's that delivered in a hospital.

The 2 years of records that were reviewed identified 1 infant death and a single intrauterine fetal demise at term for 291 home births. This number of births and untoward outcomes is so small that a projected rate from this statistical sample may not be

predictive from one year to the next. Our State of Maine Maternal Child Health epidemiologists report that from 1999 to 2005, Maine hospital's registered 93,627 births and neonatal mortality rate for all except very premature births and congenital anomalies was 0.7/1000.

Findings for Maine Homebirth Review
The Child Death and Serious Injury Review Panel's findings include evidence that suggests the following:

Birth, while a natural process, involves a level of preventable risk that could be partially mitigated through some degree of regulation.

Home birth is a part of our culture. Some women and families will choose home birth with or without regulation.

Hospitals and health care providers have in some cases increased the number of cesarean sections due to fear of liability, especially in the case of vaginal delivery after cesarean section. The issue of physician and hospital malpractice and liability needs to be addressed.

Some women will logically choose to deliver their babies in a place where they feel they have a lower risk of requiring a surgical birth.

The available data reviewed from Maine were not complete; however it suggested that the rate of transfer of intended home births is lower in Maine than in Canada or England where home birth is reported to be safest. Of the years reviewed, there was a higher rate of infant mortality in home births in Maine than in hospital births; we did not test the level of statistical significance of this finding. We also found an extraordinarily high rate of refusal of preventive screening services in the home birth setting.

We have a coordinated and collaborative system of care for birth in Maine that works very well but does not include home birth services. If we want to have optimum outcomes for home birth, families and caregivers choosing to deliver at home must be included in the system of care.

The Panel finds that a full range of technical and relational expertise has material impact on the best public health outcomes; that care is better when there is a system of delivery that does not exclude or deride those in need or the people who have been trying to care for them.

Standardized evidence based informed consent would facilitate the best public health outcomes.

Recommendations
That specific areas in home birth need to be addressed including:

- A consistent definition of level of risk with only low risk birth or pregnancy related procedures delivered in the home setting
- A protocol should be developed for safe and efficient transference of cases from one provider to another
- Documentation standards need to be developed and followed by all providers
- An agreement should be arranged with the emergency transport system in case rescue services are needed
- Improvement in the understanding of the value of screening for early identification of newborn disorders
- Informed consent must be codified so that families understand the risks, benefits and possible events (including likelihood of transfer to a hospital) that may occur during the pregnancy and delivery

It must be acknowledged that a polarized relationship between the medical community and midwives negatively impacts everyone involved in the process, including most importantly families and babies. Families, midwives and medical providers all need to be treated with respect and kindness.

There should be a respectful and competent continuum of care choice for births in Maine, the development of which will require a shared responsibility of the medical community, midwives and families. The development of a smooth continuum will require that all sides of the debate work to understand, respect, and support the strengths of one another and to respectfully acknowledge and problem solve differences of opinion.

In order to facilitate a cooperative system of care for women that choose home birth, transference of care cannot include transference of liability from the Certified Professional Midwife to the hospital, the physician and/or the Certified Nurse Midwife (CNM). This is a very significant issue that needs to be addressed. Similarly, transference of care cannot involve anger or denigration expressed toward the midwives, the mothers, or the choices they have made.

The CDSIR Panel will continue to track home birth outcomes over the next two years. The full home birth report was forwarded to The Department of Health and Human Services Commissioner Brenda M. Harvey in the fall of 2009.

2009 Referral Report
by Robert Pronovost

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

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

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

During calendar year 2009 the Department of Human Services received **17,256** referrals for Child Protective Services intervention in a family situation. **9,408** referrals presented situations with evidence of serious family problems or dysfunction but did not contain allegations of child abuse or neglect.

Inappropriate Referrals Received:

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

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

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

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

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

The Department of Health and Human Services has contracts with private agencies to provide an alternative response to reports of child abuse and neglect when the allegations are considered to be low to moderate severity. **There were 1,707 Appropriate reports involving 3,554 children which were assigned to a Contract Agency for Alternative Response.**

There were 6,141 reports involving 12,171 children assigned to a caseworker for a Child Protective Assessment.

New Reports Assigned for Assessment

Families		Children involved by age group				
Office	**Reports**	**0-4**	**5-8**	**9-12**	**13-15**	**16-17**
Portland	881	678	414	309	200	120
Sanford	247	188	134	97	79	40
Biddeford	562	431	217	215	135	73
Lewiston	1111	1001	572	408	222	122
Augusta	708	598	332	242	148	64
Rockland	530	439	229	212	113	57
Skowhegan	324	261	161	108	81	42
Bangor	1025	907	431	313	205	114
Ellsworth	213	155	95	84	39	22
Machias	150	122	59	48	27	23
Houlton/ Caribou/FK	370	325	180	118	78	38
Central	20	15	18	7	3	3
Statewide	6141	5120	2842	2161	1330	718

Source of Reports Assigned for Assessment

Law Enforcement Personnel	1003
School Personnel	919
Medical Personnel	723
Anonymous	685
Social Services Personnel	646
Relative	533
Mental Health Personnel	493
Self/Family	491
Neighbor/Friend	411
Other	160
Child Care Personnel	77

Household Type/Living Arrangement of Reports Assigned for Assessment

One Parent Female	2430
Two Parent Unmarried	1716
Two Parent Married	1417
One Parent Male	380
Relative	154
Adoptive Home	28
Non Relative	21

Family Stress Factors Identified During Assessment

Mental/Physical Health Problem	3834
Alcohol/Drug Misuse by Parent/Caretaker	2102
Family Violence	1365
School Problems	770
Severe Parent/Child Conflict	716
Severe Acting Out Behavior of Child	654
Emotionally Disturbed Child	592
Divorce Conflict	570
Alcohol/Drug Misuse by Child	191
Runaway	101
Failure To Thrive Child	32

Completed Assessments

Office	Completed	Child Abuse/Neglect Found	Unsubstantiated	Findings Rate
Portland	913	317	596	35%
Sanford	237	101	136	43%
Biddeford	613	271	342	44%
Lewiston	1131	452	679	40%
Augusta	708	231	477	33%
Rockland	547	150	397	27%
Skowhegan	330	165	165	50%
Bangor	1042	438	604	42%
Ellsworth	221	111	110	50%
Machias	153	73	80	48%
Caribou	313	109	204	35%
Fort Kent	73	33	40	45%
CPS Total	6281	2451	3830	39%
Institutional Abuse	179	35	144	20%

Data compiled on Assessments begun during calendar year.

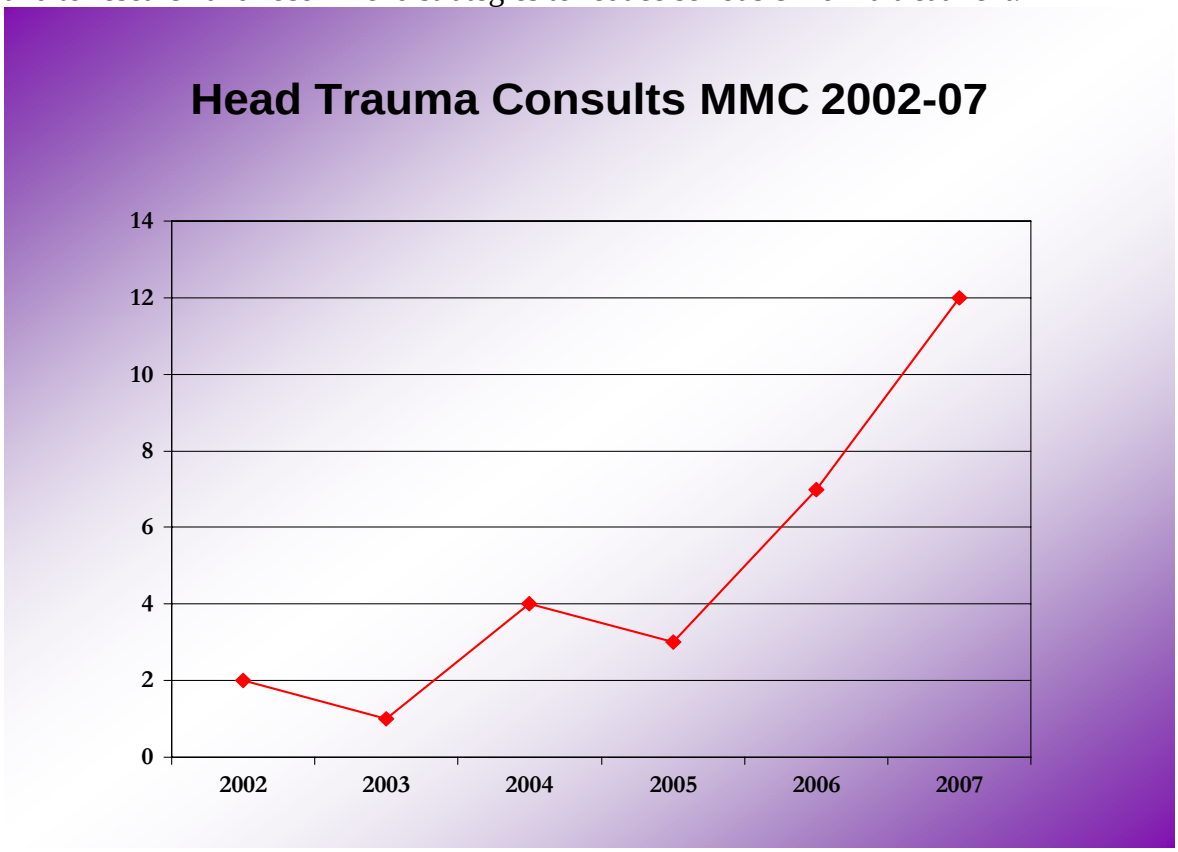
Child Abuse & Neglect Victims by Age and Sex

Male	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
0-4	25	146	749	254
5-8	24	73		196
9-12	19	64	207	199
13-15	8	29	121	99
16-17	2	16	46	44
Total	78	328	1437	792

Female	Sexual Abuse	Physical Abuse	Neglect	Emotional Abuse
0-4	42	95	629	228
5-8	32	62	284	218
9-12	43	50	201	207
13-15	41	47	125	132
16-17	15	20	45	53
Total	173	274	1284	838

Special Recognition

In 2007, Maine Department of Health and Human Service professionals and the medical community noted an increase in the incidence of serious physical abuse and in particular abusive head trauma (shaken baby syndrome). The increase in suspected abusive head trauma evaluated at the Maine Medical Center is graphically depicted below. Maine's Center for Disease Control and Prevention in conjunction with the Office of Child and Family Services convened a group of state and community partners to discuss this issue, and to research and recommend strategies to reduce serious child maltreatment.



This group came together because they all cared about a problem: a dramatic rise in Shaken Baby Syndrome. Simply stated, they had a goal, a mission and very passionate volunteers. The group selected the Period of PURPLE crying as their evidence based program to introduce on a statewide bases. This program was developed and is offered by the National Center on Shaken Baby Syndrome; PURPLE stands for: there is a **P**EAK to the crying. The baby cries more and more each week, until it reaches a peak at around 2 months of age, and then it decreases over the following months. The crying is **U**NEXPECTED. You don't know when or where it will start or stop. The child tends to **R**ESIST soothing. No matter what you do, the baby doesn't stop crying. The child may have a **P**AIN-LIKE face while crying. The baby may look like it is in pain, although it is not. The crying may be very **L**ONG LASTING. It can last as much as five hours a day or more (oh god!). The crying increases in the **E**VENING or late afternoon.

The Maine abusive head trauma prevention workgroup connected with the National Center, which immediately became a full partner in supporting this work, and the Center offered professional guidance, expertise, services and materials. The program utilizes three levels of information and communication. Phase I is the initial delivery of the information and materials. The goal is to have every new birth family in the state receive a short presentation on the normalcy of infant crying, and the importance of both never shaking their infant and insuring other caretakers have this same information. A PURPLE DVD is shown to the new parents, and is given to them to take home. Phase II involves professionals reinforcing the original message received at the hospital to insure the parents and caretakers remember and understand the information. This group includes primary care medical providers, public health nurses, and home visitors. Phase III involves general messaging to the public and other community partners.

An implementation team of caring professionals and advocates came together to begin training and implementing this program. This group is diverse and includes parents, child welfare, public health, pediatricians, perinatal nurses, home visitors, public health nurses, child abuse prevention councils, State Troopers and many other child advocates. The implementation has been coordinated by the Maine Children's Trust. Training teams, supported in part by Maine's CDC provided training of medical staff all across Maine. Everyone had something to offer and a role to play, and readily partnered to get the task done.

So where is the program today? 100% of Maine's 30 birthing facilities have materials and have signed agreements to deliver the information and a DVD to the caregiver's of every infant born in their facility. Maine's home visitors and Public Health nurses are fully trained and are working with new parents to reinforce the information received at the hospital. The program is educating pediatricians all across the state about this program so that they can reinforce this message in their offices. Other community partners are learning about infant crying and coping techniques.

Finally, the program has a variety of information for the general public including radio Public Service Announcements, brochures and posters all reminding us about the dangers of shaking a baby.

In December, 2009, the National Center for Shaken Baby Syndrome came to Maine to award the implementation team with a national award for excellence in implementation of the Period of PURPLE crying at a statewide event at the Hall of Flags.

The abusive head trauma prevention workgroup continues to meet and explore further expansion of this training, to include Maine's school systems and other community organizations.

The Child Death and Serious Injury Review Team would like to thank the members of the implementation team for their commitment Maine's children:

Richard Aronson, MD	Human Worlds Center for Maternal and Child Health
Pam Belisle	Parent Resource Center
Angela Blodgett	Maine State Police
Kelly Bowden	Maine Medical Center
Ellen Bridge	Public Health Nursing
Jan Clarkin	Maine Children's Trust
Lanelle Freeman	KVCAP
Pam LeHaye	University of Maine, Cooperative Extension
Brian McDonough	Maine State Police
Mary McPherson	Maine Children's Alliance
Stephen Meister, MD	Family Health Maine CDC
Amy Movius, MD	Eastern Maine Medical Center
Sheryl Peavey	Early Childhood Initiative
Larry Ricci, MD	Spurwink Child Abuse Clinic
Valerie Ricker	Maine CDC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