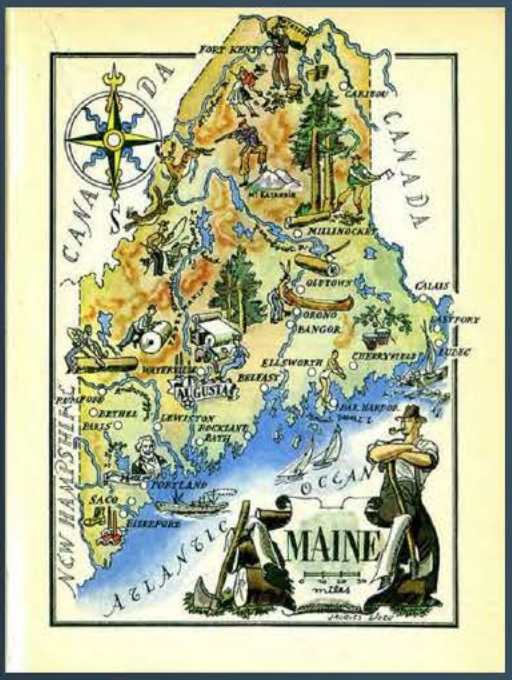
Exhibit D



2014 - 2016 Report of the Maine Child Death and Serious Injury Review Panel

The Maine Child Death and Serious Injury Review Panel are volunteers who give generously of their time and expertise and who represent both public and private agencies with an interest in the welfare of Maine children.

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

Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

The Child Death and Serious Injury Panel would like to thank all providers, DHHS staff and law enforcement that attended the reviews. Their attendance enriches the work of the panel. Without them, this report would not be possible.

All data analysis and writing for this report was completed by:

Maine Child Death and Serious Injury Review Panel and

Prepared by Jan M. Bielau-Nivus

With support from the Maine Automated Child Welfare Information System (MACWIS) Personnel

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For information about this report or to request copies, please call the Maine Department of Health and Human Services Office of Child and Family Services 207-624-7900

"Life doesn't count for much unless you're willing to do your small part to leave our children – all of our children – a better world. Even if it's difficult. Even if the work seems great. Even if we don't get very far in our lifetime."

Barack Obama

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Parents are the ultimate role models for children. Every word, movement and action has an effect. No other person or outside force has a greater influence on a child than the parent.

Bob Keeshan

"Safety and security don't just happen, they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear."

Nelson Mandela

LETTER FROM THE CHAIR AND VICE-CHAIR

March 3, 2017

To the Honorable Governor Paul LePage;

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

The members of the Maine Child Death and Serious Injury Review Team are volunteers who give generously of their time and expertise and who represent both public and private agencies with an interest in the welfare of Maine children. Through their commitment, the Panel has been able to build a collaborative network to foster teamwork and to share the recommendations with the larger community.

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

The challenges leading to case reviews from 2014 to 2016 to help improve the system of care include:

- Substance Exposed Newborns (SEN) continue to be an issue discussed and reviewed by the Panel. There were 1097 SEN reported in Maine in 2015. Through the Panel's review of the monthly OCFS intake child death and serious injury review reports, the reports repeatedly reference child abuse and neglect incidences involving substance exposed newborns. Substance exposed newborns are some of the State of Maine's most fragile citizens. The substances the newborns are exposed to in utero are not limited to illegal substances. Tobacco, alcohol and prescription opiates are also substances ingested by the infants' mothers. In 2014, Marietta D'Agostino, program manager for Maine's Medicinal Marijuana Program presented an overview of the Program. The Panel continues to review cases involving substance exposed newborns and make recommendations to improve the health and wellbeing of these newborns.

- The Panel continues to see sentinel injuries that are occurring in infants under six (6) months. In a number of cases, individuals who have come in contact with an infant have seen the sentinel injuries but have failed to address the injuries with the family and/or failed to report the injuries to DHHS. In some of the child death cases the Panel has reviewed, the deceased child was observed to have sentinel injuries prior to the incident that caused the infant's death. The Panel has made recommendations regarding a public education program for the general public regarding indicators of child abuse and neglect in children under the age of six (6) months that should be reported. The Panel also remains consistent it its support of strengthening mandated reporter laws.

- Suicide in teenage females: Adolescent suicide accounted for approximately 15% of the deaths of children under the age of 18 in 2015. In 2015, approximately half of the suicide deaths of children under the age of 18 were female. The Panel recommended providers involved with children who may be at risk of suicide use the Columbia Suicide Severity Rating Scale (C-SSRS) tool available. The Panel also recommended the Department of Education communicate the value and necessity of mandated reporter training to school districts and administrators for educators at schools, whether the school is public or private.

- Burns: and Culture barriers: In the monthly child death and serious injury intake reports that the Panel reviews, there have been a number of children that have received substantial burns. The Panel did a case review of one child that received burns but there was a language barrier between the medical providers, OCFS staff and the parents of the child. In some Maine communities the population is very diverse. The Panel discussed recommending recruiting child welfare workers to help meet the needs of the cultures that make up some Maine communities. The Panel discussed that State intervention with certain families from a different culture may not be the best idea and discussed maybe a community response through the Alternative Response Program would better serve culturally diverse families.

- Home Birth: The Panel continues to be concerned regarding certain instances of home birth, including twin births and breech births. On April 29, 2016 LD 690 "An Act to Ensure the Safety of Home Birth" was enacted into law. The Panel has been consistently supportive of legislation to regulate the safety of home births. LD 690 creates a process whereby the safety of home births will be regulated. This process and regulation in turn will serve to benefit mothers who choose to give birth at home and infants born at home. The Panel reviewed a home birth case in which a difficult home birth was not attended by a midwife. The newborn was brought to the hospital approximately five hours after delivery and then died. LD 690 includes safeguards to facilitate making home births safer for mothers and infants.

- Unsafe Sleep: Infant deaths from unsafe sleep continue to be reflected in the monthly intake child death and serious injury reports that the Panel reviews. Prior to discharge from a birthing hospital, parents are given information regarding Safe Sleep and Period of Purple Crying. The Panel reviewed an unsafe sleep death of an infant. The Panel recommended that if OCFS or any community agency has concerns regarding unsafe sleep practices between the parents and the child under one (1) year of age, the sleep environment should be observed for indications the child is sleeping in a separate and safe environment. The panel also recommended that if OCFS staff is involved, the child welfare staff should explore the issue of safe sleep behaviors with other household members in addition to the parents.

- Hospital transport: Transportation of the injured child by a parent or caregiver who might be the abuser from one hospital to another was a component of the case review. The Panel recommended that hospitals implement policies regarding transportation of children with suspected inflicted injuries from the triaging hospital to the treating hospital.

- Child deaths and serious injuries can occur during incidents of adult domestic violence. The Panel has participated in dual case reviews with Maine's Domestic Abuse Homicide Review Panel. It is the hope that the collaborative case reviews and collaborative recommendations will

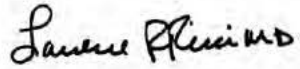
reduce child deaths and serious injuries that occur during incidents of domestic violence. The Panel's recommendations are incorporated in Maine's Domestic Abuse Homicide Review Panel report.

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 2014-2016 Child Death and Serious Injury Review Panel Report to the Honorable Paul LePage, Governor of the State of Maine.

Sincerely

Mark Moran, LCSW
Chair



Lawrence Ricci, M.D.
Vice Chair

CHILD DEATH AND SERIOUS INJURY REVIEW PANEL MEMBERS 2016

Mark Moran, LCSW, *CHAIR*	Family Service & Support Team Coordinator, EMMC
Lawrence Ricci, MD, *VICE CHAIR*	Medical Director, Spurwink Child Abuse Program
Tessa Mosher	Director of Victims Services, Maine DOC
Ann LeBlanc, PhD	Director of State Forensic Service
Stephen Meister, MD	Medical Director, Edmund Ervin Pediatric Center
Karen Mosher, PhD	Psychologist Public Mental Health, Retired
Hannah Pressler, DNP, PNP	Simmons College, School of Nursing
Valerie Ricker, RN, MS	Director, Division of Family Health, Maine CDC
Nora Sosnoff, Esq.	Chief, Child Protection Division, Office of the Attorney General
Mark Flomenbaum, MD	Chief Medical Examiner, Medical Examiner's Office
Lyn Carter	Coordinator, Maine Coalition to End Domestic Violence
Elizabeth McCullum, Esq.	Children's GAL Services Coordinator, State of Maine Judicial Branch
Christopher Gardner	Special Agent, Maine Drug Enforcement Agency
Jeffery Love	Lieutenant, Maine State Police, Major Crimes Unit
Christopher Pezzullo, DO	State Health Officer, DHHS, Maine CDC
Christine Theriault	Program Manager, Division of Disease Prevention/ Tobacco and Substance Use Prevention and Control, Maine CDC
Julia Gillespie	Medicolegal Death Investigator, Medical Examiner's Office

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Lauren Edstrom	Detective, Maine State Police
Maura Keaveney, Esq.	Assistant Attorney General, Child Protection Division, Office of the Attorney General
Richard Fein, DO	Hospitalist, MaineGeneral Medical Center
Leane Zainea, Esq.	Assistant Attorney General, Criminal Division, Office of the Attorney General
Jan Bielau-Nivus	CDSI Panel Coordinator, DHHS

MISSION AND PURPOSE

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

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

1. The Panel will conduct reviews of cases of children up to age eighteen, who were suspected to have suffered fatal child abuse and/or neglect or to have suffered serious injury resulting from child abuse/neglect.
2. The Panel will conduct comprehensive, multidisciplinary reviews of any specific case as requested by the Office of Child and Family Services, by the Commissioner of the Department of Health and 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 Health and Human Services.
6. The review panel may develop, in consultation with the Commissioner of the Department of Health and Human Services, periodic reports on child fatalities and major injuries, which are consistent with state and federal confidentiality requirements.

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

MALTREATMENT

Abuse or neglect, Citation: Ann. Stat. Title 22, § 4002(1)
“Abuse or neglect" means a threat to a child's health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation including under Title 17-A, sections 282, 852, 853 and 855, deprivation of essential needs or lack of protection from these or failure to ensure compliance with school attendance requirements under Title 20-A, section 3272, subsection 2, paragraph B or section 5051-A, subsection 1, paragraph C, by a person responsible for the child.”

Jeopardy to health or welfare or jeopardy, Citation: Ann. Stat. Title 22, § 4002(6)

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

A. Serious harm or threat of serious harm;
B. Deprivation of adequate food, clothing, shelter, supervision or care or education when the child is at least 7 years of age and has not completed grade 6;
B-1. Deprivation of necessary health care when the deprivation places the child in danger of serious harm;
C. Abandonment of the child or absence of any person responsible for the child, which creates a threat of serious harm; or
D. The end of voluntary placement, when the imminent return of the child to his custodian causes a threat of serious harm.

Serious harm, Citation: Ann. Stat. Title 22 § 4002(10)

"Serious harm" means:
A. Serious injury;
B. Serious mental or emotional injury or impairment which now or in the future is likely to be evidenced by serious mental, behavioral or personality disorder, including severe anxiety, depression or withdrawal, untoward aggressive behavior, seriously delayed development or similar serious dysfunctional behavior; or
C. Sexual abuse or exploitation.

Serious injury, Citation: Ann. Stat. Title 22 § 4002(11)

'Serious injury' means serious physical injury or impairment.

UNIQUE FUNCTIONS

Some states have multiple local review panels in addition to a central state-level panel. In such circumstances only selected cases are reviewed by the state-level team. Because the state of Maine is less populous than other states, all cases are reviewed by the full, central, state-level team. The centralized forensic medical examiner system and representation on the panel promotes standardized forensic child death investigations and post mortem exams and the State of Maine has specialized medical examiner training for child death investigation units of law enforcement. The Panel is established by a state statute that mandates confidentiality of the Panel's work and grants the Panel the power to subpoena relevant case documentation and testimony. This latter feature allows the Panel to conduct in-depth retrospective reviews of all relevant records, supplemented by oral presentations by key, involved service providers.

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

"Teamwork is the secret that makes common people achieve uncommon results."

Ifeanyi Enoch Onuoha

ACTIVITIES

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

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

In 2013, then-Chair Stephen Meister, MD, MHSA, FAAP wrote a letter to Commissioner Mary Mayhew setting forth concerns the Child Death and Serious Injury Review Panel (CDSIRP) had regarding home births. The CDSIRP had an opportunity to review several home birth cases. The cases the CDSIRP reviewed were cases that had good outcomes and bad outcomes. Based partly on the work of the Panel and its recommendations and case reviews, LD 690 "An Act to Ensure the Safety of Home Birth" was introduced into the Maine Legislature as a concept bill in December, 2014. Introducing LD 690 as a concept bill and holding it over in the Legislature allowed time for all stakeholders invested in the home birth issue to meet, discuss and write meaningful legislation. LD 690 became law on April 29, 2016.

In May, 2015, Maine hosted the New England Child Death Review Regional Meeting. The meeting was held at the Portland Harbor Hotel in Portland, Maine. Child Death Review team members from Connecticut, Rhode Island, Massachusetts, New Hampshire, and Vermont were joined by colleagues from Michigan, Georgia, and Nova Scotia. Dr. Stephen Meister presented several years of Abusive Head Trauma (AHT) data for Maine. This data led to the statewide implementation of the Period of Purple Crying program. Dr. Lawrence Ricci presented recent AHT data and Det. Lauren Edstrom presented information regarding the death investigation of Ethan Henderson, who was a victim of fatal AHT. Dr. Tom Andrew from New Hampshire presented photos of head injuries, bruises and broken bones associated with AHT. Dr. Meister also presented information regarding the neurodevelopmental outcome of a child that had suffered AHT and survived. Dr. Robert Sege from Massachusetts spoke in detail about the lack of reporting as well as research he has done on AHT. Dr. Ricci also presented information regarding Maine's new mandatory reporting law.

In September, 2016, Dr. Chris Pezzullo, Medical Director of Maine's Center for Disease Control and Prevention, brought to the Panel's attention a recent upward trend of Maine's Infant Mortality Rate from 2011-2014. The Panel voted to form a subcommittee to investigate and analyze the data to determine the causes of the recent rise in Maine's Infant Mortality Rate. The subcommittee has sought the advice of the National Institute for Children's Health Quality (NICHQ). The subcommittee is also anticipating receiving up to date linked birth certificate and death certificate data. One of the strategies being discussed by the subcommittee to determine the reasons behind the rise in Maine's Infant Mortality Rate is to do an in depth chart review at the Medical Examiner's office.

ABUSIVE HEAD TRAUMA

Severe inflicted head injury in infancy, such as may be caused by shaking an infant held by the arms or trunk or forcefully striking an infant's head against a surface, is responsible for significant and devastating injuries to young children.

The effects for children and families of Abusive Head Trauma (AHT) are far reaching. The effects include acute and chronic health concerns for the child as well as ongoing costs of medical care. A study published in 2014 found AHT diagnosis was associated with significantly greater medical service use and higher inpatient, outpatient, drug, and total costs for multiple years after the diagnosis.

A recent analysis of Maine AHT data showed 16 cases of AHT in 16 months.

The average age of the children was 5 months. 54% were males and 46% were females.

Substance abuse was present in 45% of the cases.

Domestic violence was present in 37% of the cases.

Twelve percent of the cases involved a substance exposed baby.

Child abuse was present in the parents' childhood in 25% of the cases.

Thirty-one percent of the families had previous law enforcement involvement.

Forty-three percent of the families had previous child protective services involvement.

An unrelated male was residing in the home in 31% of the cases.

Seventy-five percent of the infants sustained significant head trauma.

Prior injuries were found in 37% of the infants.

Fathers were identified as the alleged perpetrator in 59% of the cases, while an unrelated male represented the alleged perpetrator in an additional 31% of the cases.

CONCLUSIONS/RECOMMENDATIONS:

- Abusive head trauma in Maine infants is on the rise both because of increasing rates and better surveillance.
- Sentinel injuries (prior injuries) are often present.
- For every infant with AHT there is one infant with severe injuries without AHT and at least one infant shaken without injuries.

- All caretakers should be exposed to PURPLE information. PURPLE is a caretaker education program to decrease incidences of Abusive Head Trauma.

- Identifiable risk factors are almost always present and should guide more aggressive prevention strategies.

- PURPLE alone is not enough. Expanded prevention services for high risk families are required.

- It is particularly important for any male caretakers to be exposed to PURPLE.

UNEXPECTED INFANT DEATH – UNSAFE SLEEP

Infant unsafe sleep related fatalities and sudden unexpected infant deaths account for a large number of the deaths of children each year throughout the nation. Maine is no exception. In 2015, this category of death accounted for almost 45 percent of the child fatalities that were reported to Maine's child protective services; more than any other single accidental cause of death. Unsafe sleep practices involved in those instances included bed-sharing, sleeping on a couch or chair, and having soft objects in the infant's sleeping area.

Nearly 55 percent of U.S. infants are placed to sleep with bedding that increases the risk of sudden infant death syndrome, or SIDS, despite recommendations against the practice.[1] Sleep environment risk factors for infants may be different for different age groups. The predominant risk factor for younger infants (0-3 months of age) is bed-sharing, whereas rolling to prone with objects in the sleep area, is the predominant risk factor for older infants (4 months to 364 days).[2]

CASE COMPOSITES

Age at death: 4 weeks

A member of the home tried to get the mother up, the mother was screaming that the infant was dead. The mother had the infant in the bed with her. The mother reported that the infant woke up crying and she put him in bed with her and when she woke up he was not breathing.

Age at death: 11 weeks

Reported to intake that baby died at home. A member of the home put baby to bed. Mother reported a scenario that was developmentally impossible. She said the 11 week old baby was rolling back to front, rolled off the bed, onto the floor and suffocated on a plastic bag that fell of the washing machine and onto the floor by the bed.

Age at death: 3 months
A previously substance exposed infant died when his mother, who was taking Methadone, bed shared with him.

Age at death: 25 weeks

The infant had been sick recently with a cold and a fever, and had been seen by a medical provider. No drug affected report was made for this baby at birth. The child's grandmother reported that she heard a thump on the floor and she assumed that that baby must have fallen out of bed.

CONCLUSIONS/RECOMMENDATIONS:

1. **This is an area in which the development of useful, workable recommendations that are acceptable to and manageable by parents has presented an ongoing challenge. Simply recommending against bed sharing, sleeping on a couch with a baby, or having soft objects in the baby's crib does not appear to provide adequate motivation for many high risk parents to change their behavior.**

2. High risk families must be identified in the hospital. Drug affected babies are high risk. We should tailor a more aggressive approach to these high risk families. It is important that prior to discharge, everyone concerned is able to talk together and develop a concerted plan to make sure this child stays safe during the very vulnerable first few months of life.

3. Efforts have been made to educate staff at the methadone clinics as well as substance abuse providers. It may be fruitful to have discussions with Mental Health and Substance Abuse Licensing regarding making assessment and intervention around this issue a required element of services families regularly access.

4. Bed sharing occurs in private, but family members may be aware bed sharing is going. Reaching out to educate grandparents, aunts, uncles, and friends of the parents may be helpful in changing the behavior.

   The reality of having a crying, screaming baby and the parents being sleep deprived cannot be ignored. High risk families often struggle with distress tolerance and with problem solving under the best of circumstances. Working intensely with the parents as well as the extended families in this situation may provide additional impact.

5. Relative to the above concerns, the panel applauds the joint efforts of Maine DHHS, CDC and OCFS, to provide effective services to families with more complicated needs. Intensive prenatal interventions have been added to already existing postnatal interventions.

INGESTIONS

An estimated 71,000 children (18 years old or younger) are seen in emergency departments each year because of unintentional medication poisonings (excluding recreational drug use). Most of these visits (over 80%) were because an unsupervised child found and consumed the medication without adult supervision. Children less than 5 years old are twice as likely as older children to be taken to the emergency department for an adverse drug event, and one out of every 180 two-year-olds visits an emergency department for a medication poisoning annually.[3]

Finding and eating or drinking medicines on their own, without adult supervision, is the #1 cause of emergency visits for adverse drug events among children less than 5 years old. Nationally, an estimated 53,000 children less than 5 years old are brought to emergency departments each year because of unsupervised ingestions.[4]

EXAMPLES OF INGESTION REPORTS

"2 yo female ingested 8 mg strip of Suboxone, brought to Emergency Room."

"2 yo male ingested marijuana. The child's father was supposed to be watching child while the mother took a shower. The father fell asleep and at some point they discovered the child had eaten a cannabis brownie."

"1 yo female may have ingested Trazadone while in care of her parents. The parents brought the child to Emergency Room because the child was lethargic and not acting like herself."

"It was reported that 5 yo ingested Kerosene."

"Reported that 2 yo ingested Dextromethorphan cough syrup while mother napped for two hours."

"2 yo male ingested 60 mg extended release morphine tablets."

"13 mo male ingested laundry detergent after the mother opened the laundry detergent pod and smelled it. The mother then put it in the cart with the child. The mother looked away and when the mother looked back and the 13 mo had a half-eaten pod in his mouth."

"1 yo female was transported to the hospital for possible ingestion. The mother is prescribed Suboxone. The 1 yo was on the floor and the mother saw her licking her lips and shaking her head back and forth."

"2 yo admitted to the hospital for possible marijuana ingestion."

"1 yo female ingested mother's psychotropic medication. The 1 yo and her father were playing in the living room. When the father left the room, the child went up to the top of the tv where mother's pill box was. When father returned, pill box was open and not all the pills could be accounted for."

CONCLUSIONS/ RECOMMENDATIONS: The Maine CDC, Office of Child and Family Services, and Substance Abuse and Mental Health Services have partnered in developing and making available recommendations to prevent ingestions. These recommendations should be coupled with other prevention efforts. In spite of these efforts we continue to see a problem with child ingestions. As a result, it is recommended that the involved agencies meet to develop a work plan to further analyze some of these situations to determine what is and isn't working and to obtain and/or develop concrete recommendations that may offer the opportunity for meaningful change.

DUAL CASE REVIEWS WITH DOMESTIC ABUSE HOMICIDE REVIEW PANEL

An important part of the work of the CDSIRP is collaboration with Maine's Domestic Abuse Homicide Review Panel (DAHRP). The CDSIRP and DAHRP participated in two dual case reviews. Collaborating on cases that involve domestic violence, homicide and/or child abuse and neglect give both panels an opportunity to collaborate with other professionals. This collaboration adds to the value of the work that both panels perform.

CASE COMPOSITE:

Homicide of 2 ½ month old

A 2 ½ month old infant's head was squeezed by his father and then the infant was thrown hard in to a living room chair. The father admitted to breaking the 2 ½ month old's arm in a fit of rage when the infant was 4 weeks old.

CASE COMPOSITE:

Homicide of mother and her three children

A husband shot and killed his wife and his children. The children were shot at close range; the wife was shot in the head.

Recommendations of the CDSIRP were incorporated in the Domestic Abuse Homicide Review Panel's report.

HOME BIRTH

Since 2011, the CDSIRP has actively reviewed, debated, discussed, developed reports on and made recommendations regarding the issue of home births in Maine. Previous reports of the panel have outlined these efforts and recommendations in detail. In the Spring of 2016, the Maine Legislature passed LD 690 "An Act to Ensure the Safety of Home Birth." LD 690 contains many of the recommendations of the Panel. The bill became law on April 29, 2016 and is slated to take effect January, 2020.

Below please see the link for the full text of LD 690 "An Act to Ensure the Safety of Home Birth."

http://www.mainelegislature.org/legis/bills/display_ps.asp?ld=690&PID=1456&snum=127

This legislation clearly states the practice limitations for home birth and the qualifications for licensure. It also clearly defines the membership of the oversight board for homebirth practitioners.

MANDATED REPORTER LAW UPDATES

Over the past three years, the CDSIRP has had a number of discussions after case reviews regarding the non-reporting of injuries by people statutorily tasked with reporting child abuse and neglect. It is vitally important to the health and safety of Maine children that people designated as mandated reporters continue to be educated regarding their responsibilities under the mandated reporting statute because non-reporting has far reaching repercussions. The work of the CDSIRP as well as other groups has contributed to various changes in the mandated reporting law, the more recent of which are highlighted below.

On March 27, 2016 LD 622 became law, adding a requirement that all mandated reporters complete, at least once every 4 years, a mandated reporter training approved by DHHS.

Maine's mandated reporter law was also strengthened in 2015.

§4011-A(1) was amended to read:

Whenever a person is required to report in a capacity as a member of the staff of a medical or public or private institution, agency or facility, that person immediately shall notify either the person in charge of the institution, agency or facility or a designated agent who then shall cause a report to be made. The staff also may make a report directly to the department.

If a person required to report notifies either the person in charge of the institution, agency or facility or the designated agent, the notifying person shall acknowledge in writing that the institution, agency or facility has provided confirmation to the notifying person that another individual from the institution, agency or facility has made a report to the department. The confirmation must include, at a minimum, the name of the individual making the report to the department, the date and time of the report and a summary of the information conveyed. If the notifying person does not receive the confirmation from the institution, agency or facility within 24 hours of the notification, the notifying person immediately shall make a report directly to the department.

An employer may not take any action to prevent or discourage an employee from making a report.

§4011-A(2) was amended to read:

2. Required report to district attorney.

When, while acting in a professional capacity, any person required to report under this section knows or has reasonable cause to suspect that a child has been abused or neglected by a person not responsible for the child or that a suspicious child death has been caused by a person not responsible for the child, the person immediately shall report or cause a report to be made to the appropriate district attorney's office.

Whenever a person is required to report in a capacity as a member of the staff of a medical or public or private institution, agency or facility, that person immediately shall notify either the person in charge of the institution, agency or facility or a designated agent who then shall cause a report to be made. The staff also may make a report directly to the appropriate district attorney's office.

If a person required to report notifies either the person in charge of the institution, agency or facility or the designated agent, the notifying person shall acknowledge in writing that the institution, agency or facility has provided confirmation to the notifying person that another individual from the institution, agency or facility has made a report to the appropriate district attorney's office. The confirmation must include, at a minimum, the name of the individual making the report to the appropriate district attorney's office, the date and time of the report and a summary of the information conveyed. If the notifying person does not receive the confirmation from the institution, agency or facility within 24 hours of the notification, the notifying person immediately shall make a report directly to the appropriate district attorney's office.

An employer may not take any action to prevent or discourage an employee from making a report.

§4011-A(7) was amended to read::

This subsection does not require the reporting of injuries occurring as a result of the delivery of a child attended by a licensed medical practitioner or the reporting of burns or other injuries occurring as a result of medical treatment following the delivery of the child while the child remains hospitalized following the delivery.

§4011-A(8) was amended to read:

7. Required report of residence with nonfamily.

A person required to make a report under subsection 1 shall report to the department if the person knows or has reasonable cause to suspect that a child is not living with the child's family. Although a report may be made at any time, a report must be made immediately if there is reason to suspect that a child has been living with someone other than the child's family for more than 6 months or if there is reason to suspect that a child has been living with someone other than the child's family for more than 12 months pursuant to a power of attorney or other non-judicial authorization.

MONTHLY CHILD PROTECTIVE SERVICE INTAKE REPORTS

Each month the CDSIRP reviews a summary of all the death, serious injury and ingestion reports that are received by Child Protective Service (CPS) intake caseworkers, though not all of these reports ultimately result in a finding of child maltreatment. From this review, the Panel is able to identify trends of injuries to children, cases about which the panel members would like more information or a case for which the Panel would like to complete a full review.

2015 CHILD DEATH, SERIOUS INJURIES AND INGESTIONS

	Serious Injuries	Ingestions	Deaths	Total
Jan	10	3	4	17
Feb	12	3	3	18
Mar	12	3	0	15
Apr	8	5	1	14
May	9	2	3	14
June	14	6	0	20
July	14	5	2	21
Aug	7	1	2	10
Sept	14	8	1	23
Oct	15	4	3	22
Nov	18	0	1	19
Dec	20	1	1	22
Total	**153**	**41**	**21**	**215**

2015 CHILD DEATHS

	Unsafe Sleep	SIDS/SUID	Medical	Homicide	Suicide	Other	Total
Jan	2	0	1	0	1	0	4
Feb	0	3	0	0	0	0	3
Mar	0	0	0	0	0	0	0
April	0	0	1	0	0	0	1
May	1	0	1	0	0	1	3
June	0	0	0	0	0	0	0
July	1	0	0	0	0	1	2
Aug	0	0	1	0	0	1	2
Sept	0	0	0	0	0	1	1
Oct	1	1	0	1	0	0	3
Nov	0	0	1	0	0	0	1
Dec	0	0	1	0	0	0	1
Total	5	4	6	1	1	4	**21**

2015 SERIOUS INJURIES

	Injury	Head Injury	Inflicted	Unknown	Total
Jan	3	4	2	1	10
Feb	4	0	8	0	12
Mar	4	3	5	0	12
Apr	4	3	1	0	8
May	3	1	5	0	9
June	5	3	5	1	14
July	10	2	2	0	14
Aug	6	1	0	0	7
Sept	4	5	3	2	14
Oct	6	6	3	0	15
Nov	7	6	4	1	18
Dec	10	0	8	2	20
Total	66	34	46	7	**153**

2015 INGESTIONS

	Prescribed Non-Opiate	Illegal	Other	Prescribed Opiate	Total
Jan	1	1	0	1	3
Feb	1	1	0	1	3
Mar	2	0	0	1	3
April	4	1	0	0	5
May	0	0	1	1	2
June	4	0	1	1	6
July	3	0	0	2	5
Aug	0	0	0	1	1
Sept	0	2	2	4	8
Oct	2	2	0	0	4
Nov	0	0	0	0	0
Dec	1	0	0	0	1
Total	18	7	4	12	**41**

Examples of medications and drugs for the categories mentioned:

Prescribed Non-Opiate – Abilify, Aspirin, Clonidine

Illegal – Cocaine, Heroin, Marijuana, Methamphetamine

Other - Gasoline, Kerosene, Laundry Detergent

Prescribed Opiate – Subutex, Suboxone, Methadone

2014 CHILD DEATH, SERIOUS INJURIES AND INGESTIONS

	Serious Injuries	Ingestions	Deaths	Total
Jan	9	2	0	11
Feb	6	7	4	17
Mar	9	2	2	13
April	8	4	2	14
May	13	8	3	24
June	8	6	2	16
July	9	2	4	15
Aug	16	3	1	20
Sept	11	6	5	22
Oct	13	3	1	17
Nov	15	6	2	23
Dec	9	3	4	16
Total	**126**	**52**	**30**	**208**

2014 CHILD DEATHS

	Unsafe Sleep	SIDS/SUID	Medical	Homicide	Suicide	Other	Total
Jan	0	0	0	0	0	0	0
Feb	0	1	2	0	0	1	4
Mar	1	0	0	1	0	0	2
Apr	1	1	0	0	0	0	2
May	1	1	1	0	0	0	3
June	0	1	1	0	0	0	2
July	0	0	0	3	1	0	4
Aug	0	1	0	0	0	0	1
Sept	3	1	0	0	0	1	5
Oct	0	0	0	1	0	0	1
Nov	0	2	0	0	0	0	2
Dec	1	0	0	3	0	0	4
Total	7	8	4	8	1	2	**30**

2014 SERIOUS INJURIES

	Injury	Head Injury	Inflicted	Unknown	Total
Jan	4	3	2	0	9
Feb	5	1	0	0	6
Mar	5	4	0	0	9
Apr	2	2	2	2	8
May	7	1	5	0	13
June	7	1	0	0	8
July	3	4	2	0	9
Aug	7	5	4	0	16
Sept	9	1	0	1	11
Oct	6	2	5	0	13
Nov	10	2	3	0	15
Dec	5	1	3	0	9
Total	70	27	26	3	**126**

2014 INGESTIONS

	Prescribed Non-Opiate	Illegal	Other	Prescribed Opiate	Total
Jan	1	0	1	0	2
Feb	5	0	0	2	7
Mar	0	0	2	0	2
Apr	1	1	2	0	4
May	2	2	2	2	8
June	0	2	0	4	6
July	2	0	0	0	2
Aug	0	1	1	1	3
Sept	4	1	1	0	6
Oct	3	0	0	0	3
Nov	2	1	0	3	6
Dec	1	1	0	1	3
Total	21	9	9	13	**52**

Examples of medications and drugs for the categories mentioned:

Prescribed Non-Opiate – Abilify, Aspirin, Clonidine

Illegal – Cocaine, Heroin, Marijuana, Methamphetamine

Other - Gasoline, Kerosene, Laundry Detergent

Prescribed Opiate – Subutex, Suboxone, Methadone

WHO REPORTS IN MAINE*

REFERRAL SOURCE – REPORTS ASSIGNED FOR CHILD PROTECTIVE ASSESSMENT			
REFERRAL SOURCE	**2013**	**2014**	**2015**
Anonymous	11%	9%	8%
Child Care Personnel	0%	0%	1%
Law Enforcement Personnel	17%	18%	19%
Medical Personnel	15%	15%	16%
Mental Health Personnel	10%	10%	11%
Neighbor/Friend	4%	5%	4%
Other	1%	1%	1%
Relative	6%	6%	6%
School Personnel	17%	18%	18%
Self/Family	8%	8%	7%
Social Services Personnel	10%	9%	9%

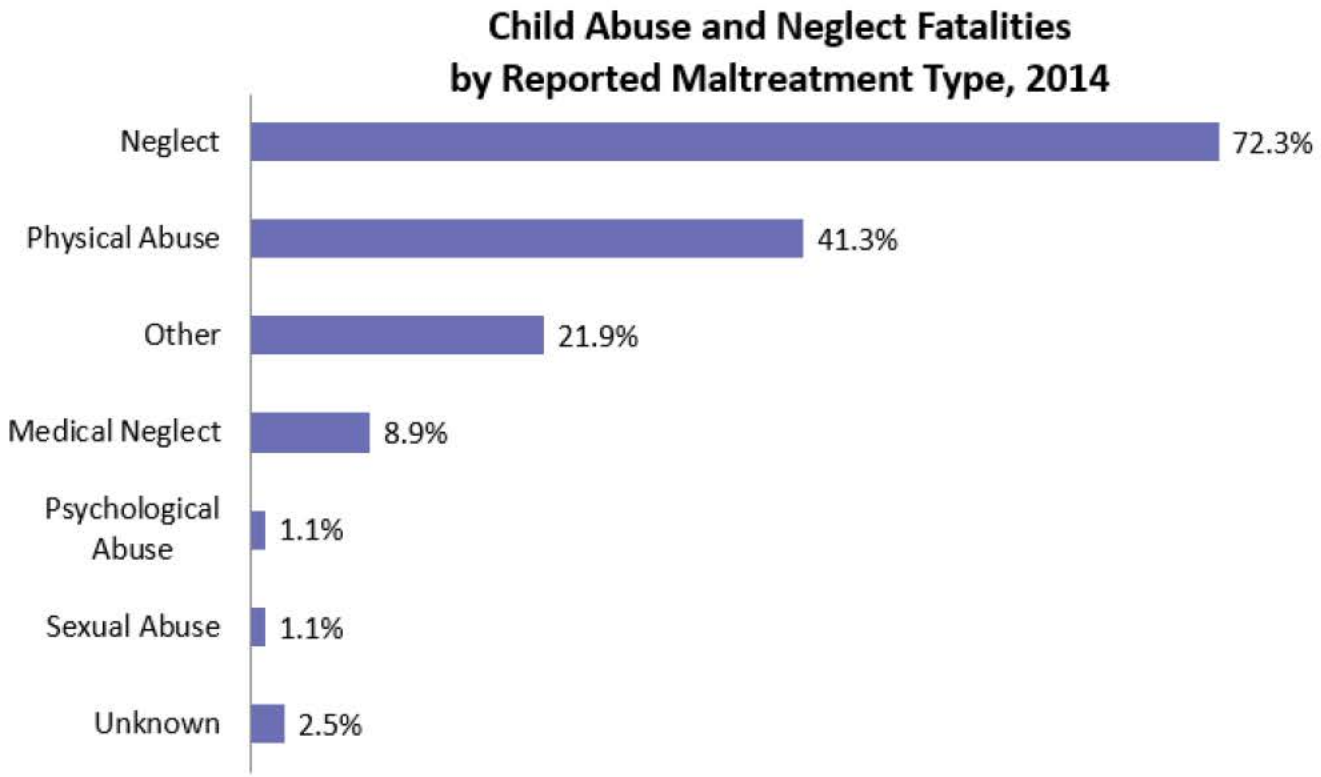
**Excludes reports referred to Licensing, Out of Home Investigations, Service Requests, and reports received where a case was already open and the information was not a new incident.*

* Information provided by Maine Automated Child Welfare Information System

COLLABORATIVE RELATIONSHIPS WITH OTHER GROUPS

The Child Death and Serious Injury Review Panel understands that there are many effective ways to acquire knowledge and understanding; the relationships that the panel shares with the National Center for the Review and Prevention of Child Death (NCRPCD), the American Academy of Pediatrics Section on Child Death Review and Prevention (AAP SOCDRP), and the New England Child Death Review (NNE CDR) demonstrates the panels desire to join other organizational entities in an effort to increase awareness of and eliminate factors that contribute to serious injuries and deaths of children in Maine communities and across the nation. Focusing on finding more effective ways to prevent the serious injuries and deaths of children, these long-standing advocacy forces meet annually to discuss new trends and emerging issues in the abuse and/or neglect of children.

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



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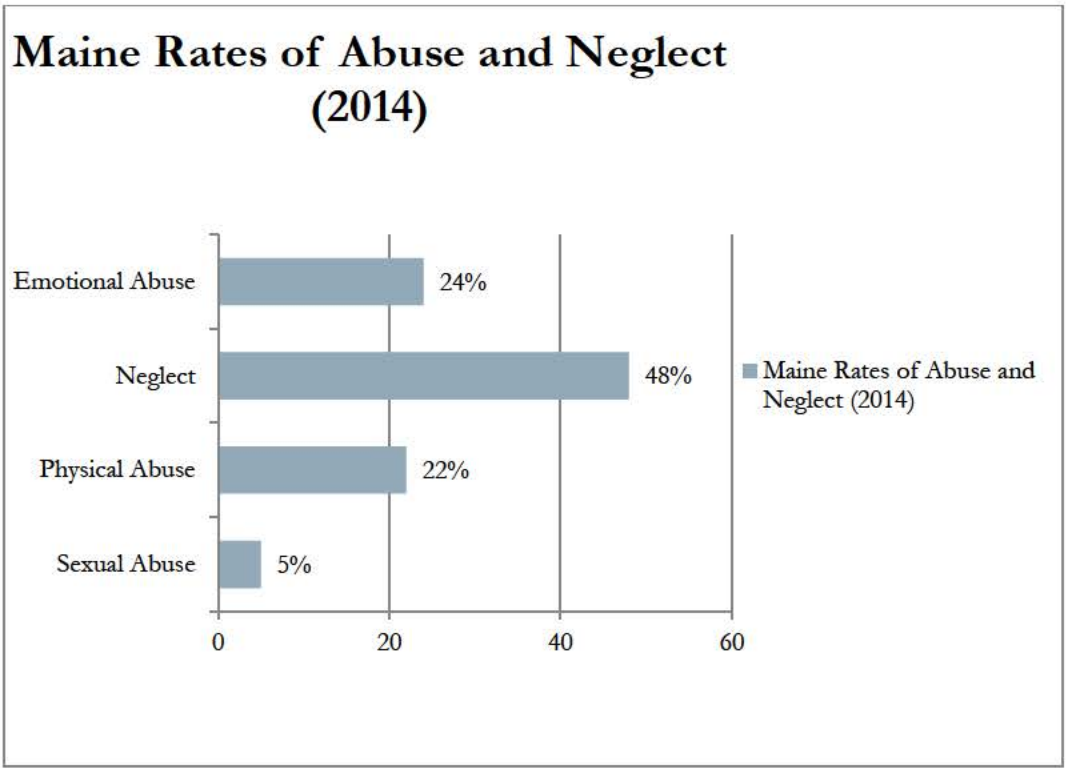

Maine Rates of Abuse and Neglect (2014)
Emotional Abuse
24%
Neglect
48%
Physical Abuse
22%
Sexual Abuse
5%
0
20
40
60
Maine Rates of Abuse and Neglect (2014)

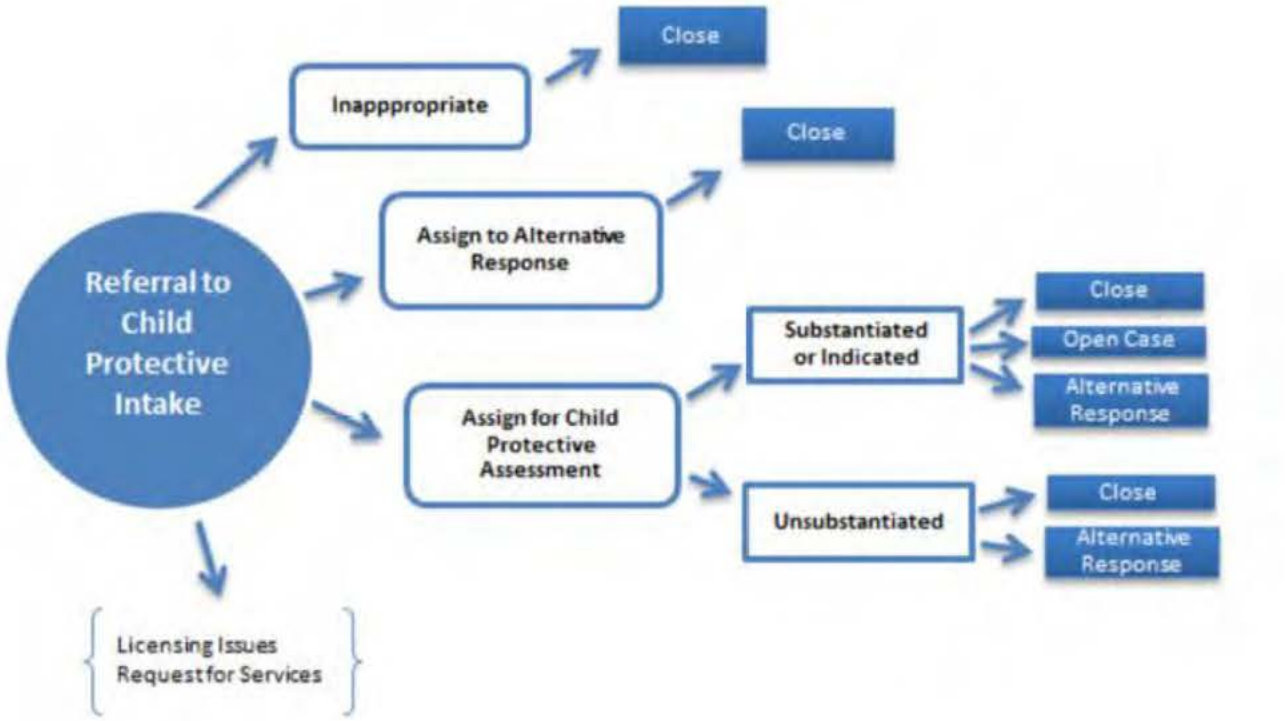
REFERRAL REPORTS

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

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

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

During calendar years 2014 through 2016 the Department of Health and Human Services received a large number of referrals for Child Protective Services intervention in a family situation. The following reports provide a summary of the number of referrals to Child Protective Services and the number of unassigned (inappropriate) referrals that were screened out.



TOTAL REFERRALS†

NUMBER OF REFERRALS BY CALENDAR YEAR			
Year	**2013**	**2014**	**2015**
TOTAL REPORTS	**19236**	**19239**	**18615**

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

APPROPRIATE REFERRALS*

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

NUMBER OF APPROPRIATE REPORTS			
Year	**2013**	**2014**	**2015**
Total Reports	**8757**	**8945**	**8446**

ALTERNATIVE RESPONSE*

The Department of Health and Human Services has contracts with private agencies to provide an alternative response to reports of child abuse and neglect when the allegations are considered to be of low to moderate severity. Between 2013 and 2015 there were **5244** reports which were assigned to a contracted agency for alternative response at the time of the initial report. Referrals were also made to Alternative Response Programs at the conclusion of a child protective assessment or case with a family, when ongoing services and support were deemed necessary.

† Information provided by Maine Automated Child Welfare Information System

	NUMBER OF REPORTS ASSIGNED FOR ALTERNATIVE RESPONSE		
Year	**2013**	**2014**	**2015**
Total Reports	**1159**	**1908**	**2177**

INAPPROPRIATE REFERRALS

Some examples of reports that would be deemed inappropriate include:

- **Parent/child conflict:** Children and parents in conflict over family, school, friends, or behaviors, with no allegations of abuse or neglect. Includes adolescents who are runaways or who are exhibiting acting out behaviors that parents have been unable to control.
- **Non-specific allegations** or allegations of marginal physical or emotional care, which may be poor parenting practice, but is not considered abuse or neglect under Maine Law.
- **Conflicts over custody** and/or visitation of children which may include allegations of marginal/poor care.
- **Families in crisis** due to financial, physical, mental health, or interpersonal problems, but there are no allegations of abuse or neglect.

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

	NUMBER OF INAPPROPRIATE REPORTS		
Year	**2013**	**2014**	**2015**
Total Reports	**8889**	**7997**	**7534**

CHILD ABUSE AND NEGLECT VICTIMS BY ABUSE TYPE‡

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

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

2014				
AGE	**Sexual Abuse**	**Physical Abuse**	**Neglect**	**Emotional Abuse**
0-4	69	436	1237	235
5-9	86	305	729	506
10-14	82	159	427	387
15-17	28	49	126	128
Total	**265**	**949**	**2519**	**1256**

‡ Information provided by Maine Automated Child Welfare Information System

2015				
AGE	**Sexual Abuse**	**Physical Abuse**	**Neglect**	**Emotional Abuse**
0-4	64	491	1044	228
5-9	72	282	654	407
10-14	72	180	388	338
15-17	25	60	110	114
Total	**233**	**1013**	**2196**	**1087**

CHILD MALTREATMENT RELATED DEATHS

Across the nation, an estimated 1,520 children died from abuse and/or neglect in 2013. This translates into a rate of 2.04 children per 100,000 children in the general population and an average of four children dying every day from abuse and neglect.[5]

In 2014 and 2015, 10 children died at the hands of a parent or person responsible for their care.

In addition to the case composites referenced previously in the Abusive Head Trauma section and the Dual Case Review with the Domestic Abuse Homicide Review Panel, below please find details regarding the other child maltreatment deaths in 2014 and 2015:

An 8 year old boy and a 10 year old girl were strangled to death by their mother's boyfriend. The boyfriend has been arrested and charged with three counts of murder.

An 11 month old boy drowned in his parents' apartment. The boy's father had put the 11 mo boy in the bathtub. The father then left the bathroom. When he returned, the 11 mo was unresponsive. The father has been arrested and charged with manslaughter.

A 3 mo old boy was found unresponsive in a bassinet by his father. The father allegedly told police he was frustrated that the 3 mo wouldn't stop crying in the morning because the father had been using marijuana and heroin the previous evening. The father has been arrested and charged with murder.

A 3 mo boy was brought to the hospital with significant injuries. The 3 mo boy and his sister were born prematurely. The 3 mo girl was still a patient in the hospital at the time of the 3 mo boy's death. The father of the 3 mo boy indicated he shook the 3 mo and pushed on his chest to get him to stop crying. The father has been arrested and charged with murder.

FAMILY STRESS FACTORS INDENTIFIED[§]

RISK FACTOR	2013	2014	2015
Prior History with CPS	72%	75%	74%
Mental Health Problems	44%	45%	44%
Involved with Court	21%	23%	22%
Spouse Abuse/Family Violence	21%	20%	21%
Drug Misuse by Parent	19%	19%	18%
Pregnancy/New Child	19%	18%	18%
Heavy Child Care Responsibility	14%	13%	13%
Unstable Living Conditions	14%	13%	11%
School Related Problems	12%	12%	11%
Parent / Child Conflict	12%	12%	11%
ADD/ADHD	12%	11%	11%
Alcohol Misuse by Parent	11%	10%	11%
Physical Health Problems	11%	10%	9%
Severe Acting Out Behavior by Child	10%	10%	8%
Emotionally Disturbed Child	9%	9%	7%
Divorce Conflict	8%	9%	8%
Former Foster Child	8%	9%	10%
Learning Disability	8%	8%	8%
Inadequate Housing	5%	5%	5%
Social Isolation	4%	3%	3%
Physical Disability	3%	2%	2%
Drug Misuse by Child	2%	2%	2%

[§] Information provided by Maine Automated Child Welfare Information System

Premature Birth	1%	1%	1%
Runaway	1%	1%	1%
Alcohol Misuse by Child	1%	1%	1%
Abuse to Animals	1%	<1%	<1%
Visual/Hearing Impairment	1%	1%	<1%
Previous Child Death	1%	<1%	<1%
Failure to Thrive Child	<1%	<1%	<1%
Fire Setting	<1%	<1%	<1%
Fetal Alcohol Syndrome	<1%	<1%	<1%

*Totals will exceed 100% due to each assessment having multiple risk factors identified during the assessment.

ENABLING LEGISLATION

22 MRSA 4004 (1)
E. Establishing a child death and serious injury review panel for reviewing deaths and serious injuries to children. The panel consists of the following members: the Chief Medical Examiner, a pediatrician, a public health nurse, forensic and community mental health clinicians, law enforcement officers, departmental child welfare staff, district attorneys and criminal or civil assistant attorneys general.
The purpose of the panel is to recommend to state and local agencies methods of improving the child protection system, including modifications of statutes, rules, policies and procedures ; and [2007, c. 586, §3 (AMD).]

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

22 MRSA 4008 (2)
E. A person having the legal responsibility or authorization to evaluate, treat, educate, care for or supervise a child, parent or custodian who is the subject of a record, or a member of a panel appointed by the department to review child deaths and serious injuries, or a member of the Domestic Abuse Homicide Review Panel established under Title 19-A, section 4013, subsection 4. This includes a member of a treatment team or group convened to plan for or treat a child or family that is the subject of a record. This may also include a member of a support team for foster parents, if that team has been reviewed and approved by the department; [2005, c. 300, §5 (AMD).]
3-A. Confidentiality, The proceedings and records of the child death and serious injury review panel created in accordance with section 4004, subsection 1, paragraph E are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The commissioner shall disclose conclusions of the review panel upon request, but may not disclose data that is otherwise classified as confidential. [1993, c. 294, §4 (NEW) .]

22 MRSA 4021 (1)
Subpoenas and obtaining criminal history, the commissioner, his delegate or the legal counsel for the department may:

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

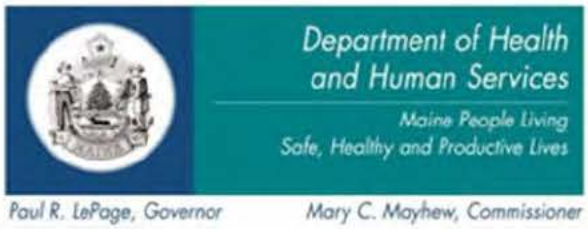
B. Obtain confidential criminal history record information and other criminal history record information under Title 16, chapter 7 that the commissioner, the commissioner's delegate or the legal counsel for the department considers relevant to an abuse or neglect case or the investigation of a suspicious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

REFERENCES

1. https://www.nih.gov/news-events/news-releases/nearly-55-percent-us-infants-sleep-potentially-unsafe-bedding
2. http://pediatrics.aappublications.org/content/pediatrics/early/2014/07/09/peds.2014-0401.full.pdf
3. http://www.careandcomfort.com/pdf/newsletter/2015.11.pdf
4. https://www.childwelfare.gov/pubPDFs/fatality.pdf
5. Ibid

Individual commitment to a group effort - that is what makes a team work, a company work, a society work, a civilization work.

Vince Lombardi



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