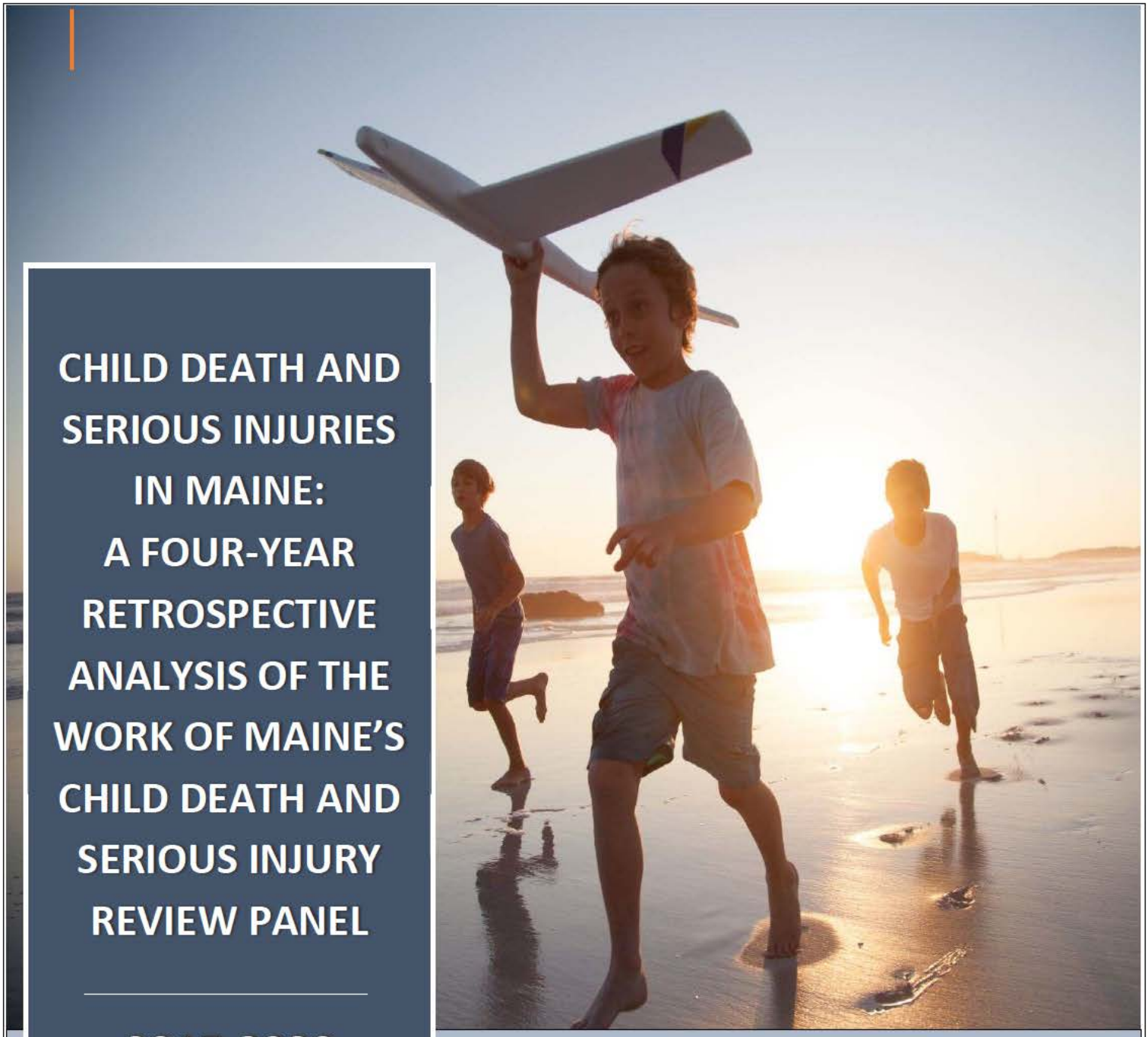

CHILD DEATH AND SERIOUS INJURIES IN MAINE: A FOUR-YEAR RETROSPECTIVE ANALYSIS OF THE WORK OF MAINE'S CHILD DEATH AND SERIOUS INJURY REVIEW PANEL

2017-2020

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

Department of Health and Human Services

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

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

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Maine Department of Health and Human Services

Office of Child and Family Services

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TABLE OF CONTENTS

LETTER FROM THE CHAIR AND VICE CHAIR

December 31, 2021

To the Honorable Governor Janet Mills:

The Maine Child Death and Serious Injury Review Panel is a multidisciplinary team 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's current mission is to promote child health and well-being, improve child protective systems, and educate the public and professionals who work with children to prevent child deaths and serious injuries. The Panel accomplishes this mission through collaborative, multidisciplinary, comprehensive case reviews, from which recommendations to state and local governments and public and private entities are developed.

The Panel's current membership is comprised of approximately 30 professionals, representing both public and private agencies with an interest in the welfare of Maine's children, who generously volunteer their time and expertise. This group meets monthly to conduct its reviews and is supported by staff from the Office of Child and Family Services. Additionally, the Panel meets annually with the other Child Fatality Review Teams from New England and nearby Canada to share experience and information and review cases that involve systems from multiple states or that represent challenges faced by multiple states. Finally, the Panel also partners with Maine's Domestic Abuse Homicide Review Panel when appropriate, to cooperatively review cases in which children are killed in the context of adult domestic abuse dynamics.

During the period of 2017 through 2020, the Panel has encountered themes similar to those highlighted in prior reports, as well as some additional themes. These themes include suicide prevention, domestic violence, managing defense experts, the selection and implementation of best practices, children traumatized or re-traumatized during court ordered visitation, ingestions, internal sentinel event reviews conducted by OCFS in high profile child fatalities, practice issues, and the availability and use of empirically supported assessment and treatment methods. While there have been improvements in the broadly defined child welfare system in Maine in recent years, there remains much work to be done. The Panel will continue to examine the intricacies of individual cases and conduct thematic analyses identified in those cases, with the ultimate goal of identifying opportunities for systemic change that will reduce the likelihood and frequency of child deaths and serious injuries.

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's children, we would like to present the 2017-2020 Child Death and Serious Injury Review Panel Report to the Honorable Janet Mills, Governor of the State of Maine.

Sincerely,

Mark Moran, LCSW
Chair

Amanda Brownell, MD
Vice Chair

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Assistant Attorney General, Criminal Division, Maine Office of the Attorney General

ENABLING LEGISLATION

General, Title 22 § 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;

F. Investigating suspicious child deaths. An investigation under this paragraph is subject to and may not interfered with the authority and responsibility of the Attorney General to investigate and prosecute homicides pursuant to Title 5, section 200-A.

Optional disclosure of records, Title 22 § 4008(2)

E. A person having the legal responsibility or authorization to evaluate, treat, educate, care for or supervise a child, parent or custody who is the subject of a record, or a member of a panel appointed by the department to review child deaths and serious injury, 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.

Confidentiality, Title 22 § 4008(3-A)

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.

Subpoenas and obtaining criminal history, Title 22 § 4021(1)

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 the 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.

STATUTORY DEFINITIONS

Abuse or neglect, 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 or deprivation of essential needs, or lack of protection from these, by a person responsible for the child. "Abuse or neglect" also means truancy under Title 20-A, section 3272, subsection 2, paragraph C or section 5051-A, subsection 1, paragraph C or D when truancy is the result of neglect by a person responsible for the child. "Abuse or neglect" also means a threat to a child's health or welfare caused by child sex trafficking by any person, regardless of whether or not the person is responsible for the child.

Jeopardy to health or welfare or jeopardy, 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;

B-1. Deprivation of necessary health care when the deprivation places the child in danger of serious harm;

B-2. Truancy under Title 20-A, section 3272, subsection 2, paragraph C or section 5051-A, subsection 1, paragraph C or D;

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, 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, Title 22 § 4002(11)

"Serious injury" means serious physical injury or impairment.

Suspicious child death, Title 22 § 4002(12)

"Suspicious child death" means the death of a child under the circumstances in which there is reasonable cause to suspect that abuse or neglect was a cause of or factor contributing to the child's death.

ABOUT THE CDSIRP

The mission of the Child Death and Serious Injury Review Panel (CDSIRP) is to promote child health and well-being, improve child protective systems, and educate the public and professionals who work with children to prevent child deaths and serious injuries. The Panel accomplishes this mission through collaborative, multidisciplinary, comprehensive case reviews, from which recommendations to state and local governments and public and private entities are developed.

The Child Death and Serious Injury Review Panel serves as one of three Citizen Review Panels for the State of Maine's Department of Health and Human Services, as required by the federal Child Abuse Prevention and Treatment Act, P.L. 93-247. The Panel follows the review protocol below to meet with purpose defined by 22 MRSA, Chapter 1071, Subsection 4004. The Panel is to recommend to state and local agencies methods of improving the child protective system, including modifications of statutes, rules, policies, and procedures.

1. The Panel will conduct reviews of cases of children up to age eighteen, who were suspected to have suffered fatal child abuse and/or neglect or to have suffered serious injury resulting from child abuse/neglect.
2. The Panel will conduct comprehensive, multidisciplinary reviews of any specific case 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 Health and Human Services staff and disseminated to the members of the review panel.
5. The review panel may develop and distribute periodic reports on child fatalities and major injuries, which are consistent with state and federal confidentiality requirements.

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.

Because the state of Maine is less populous that other states who may have multiple local review panels, all child death and serious injury cases are reviewed by the full, central, state-level team. Additionally, the centralized forensic medical examiner system and representation on the Panel promotes standardized forensic child death investigations and postmortem exams. Furthermore, the State of Maine has specialized medical examiner training for child death investigation units of law enforcement.

The Child Death and Serious Injury Review Panel is comprised of representatives from many different disciplines. Its minimum membership, which is mandated by state law, includes 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.

At times, the Panel may collaborate with other statewide panels, including the Domestic Abuse Homicide Review Panel and the Maine Center for Disease Control and Prevention's Maternal, Fetal, and Infant Mortality Review Panel (MFIMR). The Maine Child Death and Serious Injury Review Panel also belongs to the consortium of New England Child Death Review Teams and works closely with the National Center of Child Death Review. A team of Maine Panel representatives have either participated in or presented at each of the past fifteen annual New England Child Death Review Team Meetings, with the exception of 2020 and 2021.

ACTIVITIES

Every year, the Panel hosts 10 monthly meetings from September-June. At each meeting, the Panel typically conducts in-depth reviews of cases where allegations of child abuse and/or neglect were made in reported child deaths and serious injuries. Members have the opportunity to review case records and are joined by frontline staff, both child protective and, oftentimes, the responding law enforcement agency, to learn more about their experiences on the case.

Moreover, the Panel also conducts summary reviews of every child death and serious injury report made to the Office of Child and Family Services (OCFS). Between 2017 and 2018, adjustments were made to the OCFS data collection system, allowing for the review of ingestion cases as well. Occasionally, the Panel will also host subject matter experts to present on issues related to the Panel's work. For example, in 2017, a guest from the Maine Center for Disease Control and Prevention (CDC) participated in the meeting to educate members on national and statewide teen suicide trends.

Over the last several years, the Panel has also collaborated with Maine's Domestic Abuse Homicide Review Panel and the Maine Maternal, Infant, and Fetal Mortality Review Panel. This partnership has allowed each panel to clarify their roles in an effort to maximize resources and reduce duplication. At times, the panels have elected to conduct joint case reviews. Typically, this involves each panel reviewing a case independently but sharing conclusions with one another or having representation from one panel at the other's meeting. When scheduling allows, the panels may opt to conduct dual reviews whereby both panels participate in the same review meeting.

In 2017, 2018, and 2019, members of the CDSIRP participated at the New England Regional Child Fatality Teams meeting. Attendance at these meetings not only provides the opportunity for members to learn from the presenting subject matter experts on a variety of topics, but also encourages state-to-state networking and the exchange of ideas with peers who serve on similar child fatality review panels. In addition, representatives from the Panel have also participated in other conferences, including the Children's Justice Act Grantees Annual Conference, and the Maine Judicial Conference.

Over the last several years, the Panel has seen many technical changes to its process as well. For example, in 2018, the Panel began to explore the possibility of electronically sharing case records in a way that maintains confidentiality of the families whose cases are reviewed. In 2019, this practice was formally established- members now have access to a secure site where case records are uploaded, and the Panel's minutes, agendas, membership and subcommittee work is stored permanently for members to view at any time.

In addition, the COVID-19 pandemic influenced changes for the Panel as well. Prior to the pandemic, the Panel met monthly in a centralized location in Maine. When it became unsafe to do so, meetings were temporarily halted (in April, May and June of 2020). Ultimately, the pandemic encouraged a new means for monthly meetings: as of September 2020, all CDSIRP meetings have been conducted over a virtual platform. Since then, many favorable outcomes have been observed, including increased participation by both members and guests

and a reduction in the number of meetings cancelled (prior to the virtual format, meetings would be canceled due to inclement weather, for example).

Lastly, the CDSIRP also works collaboratively with Maine's two additional Citizen Review Panels (CRPs), the Maine Child Welfare Advisory Panel (MCWAP) and the Justice for Children Task Force (the Task Force). In 2020, representatives from each panel worked together to develop and enhance the Maine Citizen Review Panels website (http://www.mecitizenreviewpanels.com). This updated website serves as a critical link between the public and the CRPs, connecting citizens and stakeholders to resources, ensuring the public understands the role and focus of each panel, and providing a means for communication with the panels.

Through each of the Panel activities described above, especially the in-depth case reviews, members are provided with the opportunity to provide feedback to the Department regarding policy, practice and training initiatives. In addition, findings and recommendations may also be made to the broader child welfare system, including the medical community, mental health providers, educational system and legislation. The findings and recommendations made between 2017 and 2020, along with Child Protective Services statewide data during the same timeframe, are explored below.

CHILD DEATH, SERIOUS INJURY AND INGESTION REPORTS BY MONTH

The figures outlined below reflect the total numbers of child death, ingestion and serious injury (CD/SI/I) reports received in every month of the corresponding year. These values may differ from the Maine Office of Child and Family Services data presented elsewhere for a variety of reasons: the data below reflect all reports, whether screened out or investigated and whether or not findings were made; it includes all CD/SI/I reports, including those in which it was determined through investigation that a serious injury or ingestion had not occurred; it is combined with data obtained from the Office of Chief Medical Examiner, and therefore OCFS may not have received a report with allegations of child abuse or neglect; etc. Furthermore, because there is no identifying information in the data presented below, the tables are able to include cases where criminal prosecution is pending.

2017				
	Serious Injuries	**Ingestions**	**Child Deaths**	**Total**
January	10	6	2	**18**
February	9	2	0	**11**
March	8	5	0	**13**
April	12	3	0	**15**
May	15	4	4	**23**
June	14	6	1	**21**
July	14	5	3	**22**
August	15	7	1	**23**
September	9	3	1	**13**
October	7	5	3	**15**
November	7	4	1	**12**
December	11	1	1	**13**
Total	**131**	**51**	**17**	**199**

2018				
	Serious Injuries	Ingestions	Child Deaths	Total
January	11	0	0	11
February	7	3	3	13
March	11	7	1	19
April	13	6	2	21
May	20	0	4	24
June	12	2	2	16
July	15	5	4	24
August	12	4	1	17
September	15	6	0	21
October	14	7	1	22
November	15	3	1	19
December	15	6	1	22
Total	**160**	**49**	**20**	**229**

2019				
	Serious Injuries	Ingestions	Child Deaths	Total
January	22	7	1	30
February	4	7	1	12
March	9	4	4	17
April	9	0	2	11
May	15	0	3	18
June	14	1	0	15
July	14	3	2	19
August	11	5	1	17
September	8	0	0	8
October	26	1	2	29
November	10	2	1	13
December	16	2	0	18
Total	**158**	**32**	**17**	**207**

2020				
	Serious Injuries	Ingestions	Child Deaths	Total
January	8	0	2	**10**
February	15	3	1	**19**
March	14	1	1	**16**
April	12	6	3	**21**
May	26	1	2	**29**
June	20	2	2	**24**
July	17	6	3	**26**
August	20	3	0	**23**
September	19	2	0	**21**
October	18	3	4	**25**
November	11	1	3	**15**
December	11	3	1	**15**
Total	**191**	**31**	**22**	**244**

PRACTICE ISSUES

The findings and observations noted below are based upon the Panel's reviews and are those that apply to the Department of Health and Human Services, Office of Child and Family Services, at all levels. This includes the work carried out by caseworkers and supervisors with clients and community service providers. This work can be considered to be the result of decisions, actions and supervision carried out by management personnel.

It must be noted that for over a year, the already difficult work of Child Protective Services has been made more difficult by the COVID pandemic. The staff have continued their substantial efforts in the service of the protection of children and services to their families in the face of the pandemic's significant challenges.

Findings

The majority of cases reviewed by the Panel involve families with prior history with the Department. It was noted that many families had multiple referrals that spanned more than one generation. Some of this history involved prior removals of children from their parents' care or custody prior to the current incident of serious injury or death. These, and other cases reviewed, did not reflect a clear, consistent framework for determining if abuse and/or neglect is present; the severity of the abuse and neglect and its impact on a child; risk factors; and required intervention.

During Panel reviews, practice inconsistencies were noted, including the length of time between home visits by a Department caseworker, and the type of information collected during investigations. It was common to note a failure to assess, or to accurately assess, the nature of the parent/child relationship either directly by the caseworker or through other collaterals sources of information. For example, evaluations by a licensed professional with expertise in parent/child attachment were rarely seen or documented.

When confronted with parents or caregivers that are not providing consistent reports of issues or behaviors that are directly related to the safety or well-being of their child, there was often no noted attempt to explore or resolve these inconsistencies. There were also instances where a parent's lack of truthfulness did not appear to affect the Department's assessment of a parent's ability to care for or protect their child. This occurred in situations where the inconsistencies should have had an impact on the analysis, the safety plan and the reunification plan. As a result, there were times where this failure appeared to contribute to the harm a child experienced.

In some cases, there seemed to be no consequences for parent/caregiver failure to abide by a case plan. There were a small number of cases where very specific, documented information and professional opinions did not appear to be given sufficient weight in making child safety decisions, to the detriment of the child. Most cases involving law enforcement with shared responsibilities were successfully managed; however, there were some cases which highlighted minor shortcomings in Department/law enforcement case coordination and information sharing.

Case reviews showed instances of inadequate information gathering and a lack of clear fact finding on issues including:

- Did child abuse and neglect occur? If so, what was the severity of the abuse/neglect, and the impact on the child?
- What risk factors were identified and what is the current level of risk to the child?
- What are the protective capacities of each parent/guardian/caregiver identified and how do they relate to and mitigate the identified risk factors?

The above-mentioned failures to have clear fact-supported decisions in cases often resulted in unfocused and/or ineffective plans and interventions.

There was little information contained in many case records regarding observations and interviews with children. The fact that child interviews are recorded and stored separately limited the information available in the Child Death and Serious Injury record reviews.

There were multiple cases reviewed in which the families were referred for supportive services out of the Department's direct supervision, such as the Alternative Response Program. These programs are voluntary and many of the families rejected the referral. In other cases, the services provided were ineffective and did not address the underlying issues leading to child abuse/neglect. In these cases, the panel observed that referrals to ineffective services or third-party service agencies often left the child(ren) in the unsafe environment without effective oversight and appropriate services. The Panel opines that in some of these cases an evaluation by a relevant expert or the filing a formal Child Protective Proceeding would have been far more effective at ensuring child safety.

An additional practice issue involves values and practices regarding family preservation. The Panel is aware that there has been significant discussion in the past decades about the damage caused to children when they are removed from their families and that these beliefs appear to have material consequences on the decisions made about safety, removal, and reunification. While removing a child from their family is not without consequence, it is also true that there are children whose circumstances are such that they will face trauma regardless of whether they stay with their family or are removed. For these children the decision is not between harming them or not. It must be a decision made to minimize harm and optimize their opportunity for positive change.

The term, "Families First" and the focus on family preservation has gained a significant level of stature and importance in the field. It has become a nationally accepted standard for child welfare practice. It is commonly understood that it promotes the value of being supportive of families and avoiding foster care. Beyond that, it's meaning is often unclear. The phrase itself appears to have become a "general truth" and expectation that is relied upon as basic guidance for the work when issues surrounding child risk and safety are unclear. The optics of the family preservation approach are very positive. It is easy to sound progressive and humane when talking about it, while questioning it often places an individual in a defensive position. Nevertheless, as with any set of assumptions that are no longer widely questioned, it is important to look at both sides of their implementation in the lives of real families.

Recommendations

There is a need for the development and maintenance of strong relationships with community-based assessment and treatment professionals who understand and have expertise working with at-risk families and families where child abuse and/or neglect has been found. Child safety and family integrity would benefit from improved relationships and information sharing between existing community resources, including all branches and levels of law enforcement, school personnel, medical providers, pediatricians, substance use professionals, mental health processions and family service providers.

Meaningful action on this recommendation would be measured by the creation of a workplan outlining legislative, budgetary, management and personnel strategies to accomplish these goals.

OCFS should consider working with law enforcement to create a position for an OCFS staff person who could become a certified trainer at the Criminal Justice Academy. This person would provide, along with a law enforcement professional, a class at the Academy on child abuse and neglect.

Positive working relationships require continued purposeful interaction to first establish and then to maintain them. All levels of organizations that are critical to crafting an effective response to child abuse and neglect must actively support these relationships for them to be successful.

DHHS should continue ongoing review of community treatment reimbursement levels. Attention should be given to creating the availability of consultation from subject matter experts on the issues identified as needing assessment within a family. Finally, staff should be provided with policies as well as a training program to ensure they are aware of the best practices and most current knowledge in the field of child abuse and neglect and the field of Child Protective Services.

Many practice issues are best addressed through the supervisory relationship. However, as there is no documentation of supervisory meetings available to the Panel, it is not possible to review this critical function. Given the identified challenges found in the cases reviewed, it is recommended that OCFS develop standards for supervision, including strategies to measure the effectiveness of supervision provided to staff.

DHHS is in a unique position to provide leadership and funding to create a coordinated, multi-disciplinary team of community providers with specialized expertise in child abuse and neglect to enhance the identification, treatment and prevention of child abuse and neglect and should endeavor to do so.

It is recommended that reviews of child deaths and serious injuries by all reviewing bodies include specifically, the impact of child welfare staff's understanding and interpretation of the prioritization of family preservation and their understanding of and decision making around the balance between family preservation and child safety.

SELECTION AND IMPLEMENTATION OF BEST PRACTICES

Over the years, concerted efforts have been made to use program funds to identify, develop and support the most effective services possible to meet the needs of families and children. However, this effort is not as helpful as it might be as there are instances where the effectiveness of a particular program changes depending upon the characteristics of the individuals or families to which the program is applied. Without the help of a research psychologist or a research assistant who understands how to analyze and interpret studies, look at inclusion criteria, failure rates and the reasons for failure, these efforts are subject to error in what studies are considered and how they are interpreted.

Recommendations

The Maine Department of Health and Human Services would benefit from the ability to access a professional with expertise in identifying, categorizing, analyzing and summarizing research literature into a format that is accessible to staff responsible for integrating this information into selection, training, practice, contracting and licensing of programs, particularly those targeting individuals and families with specific needs.

DHHS should consider hiring such an individual with expertise in identifying best practices. This professional should provide research data to managers responsible for developing proposals for programs designed to meet specific needs for specific populations.

THE AVAILABILITY AND USE OF EMPIRICALLY SUPPORTED ASSESSMENT AND TREATMENT STANDARDS

Assessment Standards

Parenting and risk assessments for families involved with the child welfare system require specialized training. The State of Maine is experiencing a critical lack of evaluating psychologists trained and willing to provide state of the art parental risk assessments and parental capacity evaluations. At the time of this writing, there are only three evaluators in the State with current contracts with the State Forensic Service who conduct Court Ordered Evaluations for this purpose. Furthermore, a family must have a pending child protection action to access this critically important tool. This leaves the Department without an effective evaluation option during the investigation state which is a crucial time in the process to identify the issues and what services would be effective to address them.

These evaluations require specific expertise that requires training that is not easily available to evaluators. The evaluations are often extraordinarily time consuming and thus, expensive. The current payment structures fall drastically short of covering the time and work required to complete each evaluation. Further complicating the situation is that these individuals are more likely than other types of evaluators to be the subject of litigation, either malpractice suits or licensing complaints. Even though these suits are not often successful, they consume the time, money, and most importantly the enthusiasm and motivation of the evaluator to continue this important work.

Without the availability and expertise of professionals trained and qualified to assess child abuse and/or neglect, risk factors for child maltreatment, and parental capacity, and who can provide consultation to Department staff and formal evaluation when needed, the Department caseworkers' ability to make well-informed decisions regarding the children at risk in these dangerous cases is seriously impaired.

Recommendations

Rebuilding the capacity for evidence-based evaluations specifically tailored to the requirements of these families requires a complex array of support and expertise. The development and ongoing monitoring of assessment capacity requires a "home base" that is capable of recruiting, training, monitoring, and supporting assessors and their work. The State currently maintains such a resource in the State Forensic Service for evaluations for criminal matters.

Consideration should be given to the development of an expert consultation service being made available to Department OCFS staff. This consultation service could also be housed within the State Forensic Service. There are many instances where a full evaluation is not necessary, parents might not cooperate with an evaluation, or in emergency situations there may not be time to wait for a full evaluation. A consultation service could aid with the development of treatment recommendations that would maximize parents' opportunity to safely and successfully care for their children. It could also provide guidance to caseworkers and their supervisors in understanding and processing risk factors in any given case. A consultation model, where the services of a psychologist with expertise in child maltreatment assessment and treatment are available to caseworkers and their supervisors but decision making remains in the hands of OCFS and of the

community clinicians who are providing treatment services may offer mitigation of some factors that limit the availability of the service.

It is recommended that a work group be formed that includes at minimum the State Forensic Service, the Office of the Attorney General, Child Protection Division, the Administrative Office of the Courts, and OCFS. Funding must be made available to allow the State Forensic Service to identify and contract with an expert in the provision of these evaluations to participate in this workgroup.

This workgroup would report to the Commissioner of DHHS, the Attorney General, the Chief Judge of the District Court and the Ombudsman, providing written recommendations for structure, funding, recruitment, training and support of expert evaluators. The entities receiving those recommendations would jointly prepare any funding requests and proposed legislation necessary to put the plan in place. Once funding and an organizational structure are in place, recruitment and training should begin as soon as is practicable.

Treatment Standards

Children's Behavioral Health Services is to be applauded for its ongoing efforts to bring evidence based and empirically supported treatments to the state including supports for training treatment staff and paying for services at a level that is adequate to their maintenance.

Unfortunately, many of these services are not specifically focused on the needs of families who cannot safely care for their children. It appears that within the provider community in the State there is little understanding of the unique treatment needs of families who experience child abuse and/or neglect.

It has been evident in the literature since the late 1980's that maltreating parents do not reliably became more able to care for, nurture, or protect their children by participating in traditional client-driven psychotherapy (Azar, 1989; Azar & Siegel, 1990; Cohen, 1979; Cohen & Daro, 1987). The findings of these seminal works continue to be supported by more recent work on the effectiveness of child maltreatment intervention (Asawa et al., 2008; Douglas, 2017.) When families have been unable to successfully utilize generally available prevention services it is necessary to provide effective and accurate identification of the family's specific risk factors for abuse. Then support and interventions must be provided on a very basic and concrete level, focused on addressing deficits in empathic and developmental understanding and the development of the capacity to put their children's needs in front of their own. Also requiring specifically tailored intervention are the parents' cognitive, emotional, behavioral, and social skills, problem solving and decision-making skills, and practical self and home organization skills which must all be addressed. When this level of intensity is required, services are, of necessity, provided by a team including a licensed mental health professional and a specifically trained paraprofessional member.

Neither therapists nor paraprofessionals are traditionally taught these methodologies as a part of their academic preparation. This leaves many therapists unprepared to provide the necessary interventions, vulnerable to inappropriately aligning with parents in placing their own needs first and ultimately providing unhelpful or even damaging services. The difficulty and expense of providing effective services ultimately leads many providers to either refuse these clients or to provide them with ineffective, traditional services.

The combined efforts of the Office of Behavioral Health Services and OCFS could provide expertise and leadership in identifying evidence-based treatments specific to the unique needs of maltreating families. They could then provide training and assist in the development of adequate reimbursement rates for community based mental health and addictions treatment staff. Training would be most effective if it included child welfare staff so that they could develop a clearer idea of how to formulate appropriate, child safety-oriented goals for parents and caregivers to work on in their treatment.

Recommendations

Meaningful action on this recommendation would be measured by the creation of a workplan outlining how the identification of state-of-the-art assessment and treatment services would be accomplished as well as any required legislative, budgetary, management and personnel strategies.

OCFS and the Office of Behavioral Health Services should develop and implement joint, multidisciplinary, empirically supported trainings for key community-based professionals and child welfare staff. Participants should include, but not be limited to, school-based professionals, law enforcement, Public Health Nurses, visitation supervisors, social workers, psychologists, therapists, and addictions professionals. A process of fidelity monitoring should also be considered. Additionally, a plan to provide adequate reimbursement for these interventions should be developed.

Training materials should be identified or developed using the highest standards of outcome data available. The training materials should be based on the assessment of and interventions specific to child safety.

Resources identified in the section above, *The Selection and Implementation of Best Practices,* would be useful in identifying appropriate research studies, assessment, and treatment approaches to be included in such training.

Finally, this training should be ongoing, for the benefit of both the professionals who would have already been trained and for new professionals entering the field.

CHILDREN TRAUMATIZED OR RETRAUMATIZED DURING COURT-ORDERED VISITATION

Value is placed upon keeping families together or reunifying them when they are separated. By statute, absent a compelling reason, visitation is ordered by the courts to provide parents the opportunity to maintain and improve attachment with their children, as well as to learn or demonstrate their ability to provide safe, nurturing parenting. “Compelling” is not legally defined, so there is often a lack of understanding of the options that might be available to protect a child in regard to visitation.

Unfortunately, it is not unusual for children to be re-traumatized or experience new trauma when visiting with their parents in these cases. Repeated exposure of children to parents who have not resolved their parental deficits and who have not developed or are unable to develop a healthy attachment to their child(ren) has a long-term emotional impact on the child(ren) that can be devastating and difficult for them to recover from.

It is also of note that visitation and/or reunification plans that we reviewed were not noted to document potential harm that might be done to a child as the plan is carried out.

The weight of the legal system sides heavily with the rights of parents, which is appropriate when the interests of parents and their children can be brought into alignment with one another. However, it can be damaging when children’s best interests are not aligned with their parent’s interests. Grieving children can be sad, angry or both, resulting in difficult behaviors. These children are far more likely to be abused than children who feel safe and nurtured (Chance & Scannapieco, 2002).

Programs such as Family Visit Coaching provide clinically based, attachment sensitive parent training in the context of supervised visitation where children remain relatively safe and secure, and parents receive individualized opportunities to learn and incrementally demonstrate that they have mastered nurturing parenting behaviors which are necessary to keep their child safe. Unfortunately, these services are expensive and difficult to maintain.

Recommendations

It is recommended that as a part of developing a reunification/ visitation plan for a child, the potential harm that may be done to the child as the plan moves forward be documented as well as the efforts to be taken to minimize that harm.

The Panel recommends that caseworkers contact their AAG to discuss the facts of a case if there is concern that visitation may be harmful to a child after a PPO is filed.

As a part of identifying subject matter experts, discussed in the previous section, the Department should identify and develop subject matter experts who can, and would be willing to testify as to why visitation may be harmful to a particular child.

As the case progresses, subject matter experts who are willing to testify as to what accommodations would be required to ensure that children are not further traumatized during visitation should also be identified and/or developed.

It is recommended that consideration be given to resurrecting professional, clinically driven visitation services that are focused on the needs of the child and include ongoing assessment of parental capacity and progress through the demonstration of increased capacity to meet the needs of their children and ensure their safety.

Meaningful action on these recommendations could be measured by the creation of a workplan outlining legislative, budgetary, management and personnel strategy.

Ideally, DHHS would establish evidence-based clinical family visitation services in all regions of the state. Using evidence-based models, families would follow a transition plan that would either increase or decrease their level of supervision during visits depending on their progress developing the necessary skills and making progress on their reunification plan. Ideally, reunification efforts in all regions of the state will ultimately follow an evidence-based model.

DOMESTIC VIOLENCE INTERVENTION SERVICES

Domestic Violence Intervention programs across the state provide a major opportunity to protect parents and children against domestic violence. While intervention into domestic violence and abusive behavior is a rapidly changing area of study, it remains clear that effective intervention in this area is critical to both the physical and the emotional well-being of Maine children.

Findings

Children continue to suffer from violent and abusive behaviors perpetrated by their parents and other caretakers. It is not unusual for this behavior to continue even after it has been identified and efforts have been made to intervene. Perpetrators find many opportunities to avoid meaningful participation in domestic violence intervention services and do so without consequence.

There seems to be a lack of training and understanding amongst the Courts of not only risk to children, but the harm caused, by exposure to domestic violence in their home.

In reviewing the efforts of child welfare staff to assess and intervene with families where domestic violence exists, it frequently happens that perpetrators of domestic violence maintain control over family members through isolating them. To that point, families have been able to avoid CPS investigations by refusing to participate. Families have also been able to limit the access of Guardians *ad litem* to the child, not allowing them to be interviewed alone.

During the same period that the Child Death and Serious Injury Review Panel was identifying these shortcomings, the Maine Department of Corrections and the Maine Coalition to End Domestic Violence were partnering to identify the same and similar issues. They developed, promulgated, and carried out legislative, funding, development, training, monitoring, and research initiatives.

Recommendations

When deciding cases of child abuse and/or neglect, special attention should be paid to not labeling domestic violence as "a family law matter" but rather as a child protection matter.

Both the Panel and the Maine Coalition to End Domestic Violence have identified areas in which the courts could more reliably and effectively support offenders' participation in meaningful and effective interventions. It is recommended that the Maine Coalition to End Domestic Violence establish an ongoing collaboration with the Administrative Office of the Court to problem solve the issue and develop solutions that are acceptable to the courts and serve to more reliably protect victims of domestic violence and most specifically, their children.

The Judicial Branch should hold a training on the specific intersection of domestic violence and the impact exposure to domestic violence has on children.

Regarding families avoiding child welfare investigation and intervention, it is recommended that OCFS establish a process for ongoing meetings that would include Child Welfare staff, an Assistant Attorney General from the Child Protection Division, and a representative of the Maine Coalition to End Domestic Violence.

Meetings would focus on problem solving the most difficult situations where suspected or adjudicated violent or abusive offenders are effectively blocking assessment of and services to their families.

The Panel recommends continued support for the efforts of the Department of Corrections and the Maine Coalition to End Domestic Violence through funding for evidence based and research supported efforts to address domestic violence and abuse.

SUICIDE PREVENTION

Teen and pre-teen suicide is a growing problem in Maine as well as across the country. It has been exacerbated by the social and emotional isolation caused by the COVID-19 pandemic.

Historically, the Maine Youth Suicide Prevention program has been a model for the country having developed numerous evidence-based, effective, state-of-the-art educational and reference resources. These resources are used widely throughout Maine and the United States.

Under the previous administration, the Maine Center for Disease Control saw defunding and a significant downsizing of resources, including Public Health Nursing and those related to suicide prevention.

Under the current administration, the Maine CDC is rebuilding from those losses, though presently a large percentage of those resources have been diverted into management of the COVID pandemic.

The Maine Suicide Prevention Program provides significant support to community members and youth-serving professionals to promote evidence-based suicide prevention interventions. However, much of the funding for these initiatives relies on federal grants, which are time-limited and not a guaranteed resource for the future. State-level funding has not significantly increased in the past 20 years, despite rising rates of suicide deaths and attempts among youth and young adults.

Recommendations

The importance of this program to the safety of Maine children calls for an infusion of reoccurring funding adequate to the tasks of assessing, developing, and disseminating state of the art suicide prevention information and resources.

Meaningful action on this recommendation would be measured by the creation of a workplan outlining legislative, budgetary, management and personnel strategies required to accomplish this goal.

It is recommended that program funding be established at pre-2019 levels and that funding not be primarily grant based.

It is recommended that the program will work to identify additional evidence-based methodologies to lower the number of youth suicides in Maine, and to develop and disseminate programming consistent with those methodologies.

MANAGING DEFENSE EXPERTS

Occasionally, defense experts who are brought into the state to testify in child death or serious injury criminal cases promote theories that are not based upon accepted best practices or evidence-based medicine.

Recommendations

In these situations, consultation with local experts who are known for their use and understanding of evidence-based best practices can assist with prosecutorial strategy. Resources to accomplish this goal already exist within the State, for example, through collaboration with child abuse pediatricians.

Success in implementing this recommendation would be measured by increasing the knowledge of prosecutorial staff of these resources within the state and how to access them.

This recommendation could be accomplished through the development of a memorandum from the Attorney General's Office to Assistant Attorneys General and District Attorneys informing them of the availability of these resources, including contact information. OCFS could assist in identifying these resources.

INGESTIONS

Ingestions involving opiates, buprenorphine, methadone, and marijuana continue to be a significant risk to children in Maine. As legislative changes take effect and marijuana consumables become more commonly available, the risk to children will increase if the experience of other states holds true in Maine.

Recommendations

It is recommended that the State authorities responsible for oversight of the prescription and recreational sale of these substances consider the following steps:

- Include that as a requirement of licensure, information is provided to the recipient of the marijuana product regarding the safe storage of substances, including risks to children in the home.
- Introduce legislation or promulgate rules barring sellers of marijuana or marijuana derivative products from packaging or selling those products in forms or packages designed to appeal to children. This is similar to limitations placed on tobacco products.

Meaningful action on this recommendation would be measured by the creation of a workplan outlining legislative, budgetary, management and personnel strategies to accomplish these goals.

The Panel recommends an increased focus by Maine's Department of Administrative and Financial Services and/or the Maine Office of Marijuana Policy regarding the safe storage of these substances and the risks to children. The legislature should remain attentive to these issues and propose and pass changes to the statutes to protect children most effectively. This legislative work should include the prohibition of marijuana consumables being sold in forms or packaging attractive to children. Ongoing review of ingestion data from DHHS or the Northern New England Poison Control Center would inform legislation. Licensing assessment of any changes as new legislation is enacted will also assist in measuring its impact.

HIGH PROFILE CHILD FATALITIES: INTERNAL SENTINEL EVENT REVIEWS CARRIED OUT BY OCFS

It is the practice of the CDSIRP to only review cases where criminal matters have been resolved. In these cases, which are often high profile, there are multiple and justifiable calls for accountability, including reviews of the work of the Department and other stakeholders.

The reality of the situation, as all of these conflicting factors are weighed, is that the responsibility for careful, unbiased review will initially fall upon OCFS staff. These reviews can only then be reviewed and assessed by outside subject matter experts as access to case materials becomes available at a later time.

Maine's Child Death and Serious Injury Review Panel has completed review of a number of these cases, including information provided from OCFS internal case reviews after prosecution of the cases was complete.

Recommendations

It is critical to ensure that:

- There is a thorough and unbiased consideration of the facts of the case.
- The review includes the development and implementation of steps designed to improve processes that can better support frontline staff in preventing similar tragedies in the future.
- There is a balance of accountability and support for staff who provide complex services and are coping with tragic outcomes, which can be compounded by the process of public scrutiny and blaming that often follows these incidents.

The Panel would like to applaud the staff of OCFS for the manner in which they undertook and completed these reviews.

OCFS has, within the past few years, updated their internal sentinel event review processes in line with documented best practices in the field. The resulting reviews were thorough, balanced, fair and useful in improving internal processes.

The Findings and Recommendations arising out of these reviews were designed to create meaningful, measurable, positive change, and provide accountability, as well as preserve a work environment that adequately supports, trains and supervises the staff whose job it is to carry out the responsibilities of the Department to protect the children in its care, as well as those who remain with their families.

The Panel applauds OCFS on the expertise, commitment, and professionalism that formed the basis of these reviews.

A NOTE ON FOLLOW-UP TO THE PANEL'S RECOMMENDATIONS

The Panel has attempted to formulate Recommendations that are directly related to the Review Findings, that will meaningfully address issues that have been identified by the Panel as being related to the death or serious injury of children, and that are actionable and measurable.

Given the importance of meaningful progress in this area, the Panel respectfully requests that DHHS, the Administrative Office of the Court, the Attorney General's Office, Maine Coalition to End Domestic Violence and the Maine Criminal Justice Academy provide the Panel with written reports on actions taken and progress made in relation to these recommendations by December 31, 2022.

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