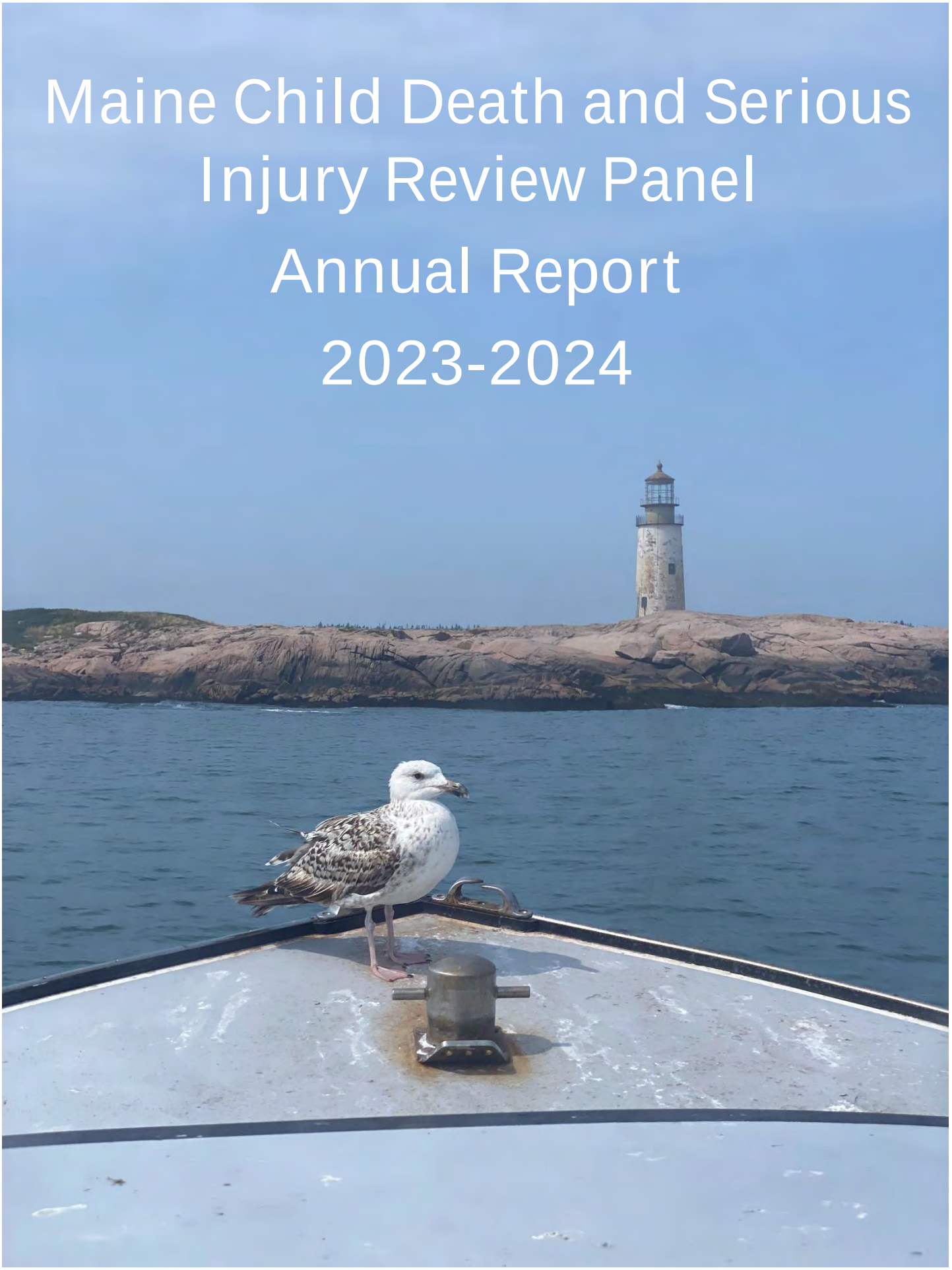
Maine Child Death and Serious Injury Review Panel

Annual Report

2023-2024



The Child Death and Serious Injury Panel would like to thank all providers, DHHS staff and law enforcement that contributed to our reviews. Their participation 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:

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On behalf of

Maine's Child Death and Serious Injury Review Panel

With support from OCFS staff

Cover Photo Credit: Mark Moran

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INTRODUCTION FROM THE CHAIR AND VICE CHAIR

The Maine Child Death and Serious Injury Review Panel ("CDSIRP" or "the Panel") is a multidisciplinary team established by statute in 1992 to review child deaths and serious injuries. The statutory 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."[1] The Panel's 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 membership is also established by statute. The CDSIRP leadership has historically viewed that list as a minimum, recognizing that multidisciplinary perspectives are crucial for comprehensive review and analysis of child deaths and serious injuries, the 2023-24 Panel was comprised of 44 professionals,[2] representing both public and private entities with an interest in the health and welfare of Maine's children. These members generously volunteer their time and expertise to examine the most tragic cases encountered by child serving entities and some members may be accompanied by students from their discipline. The proceedings and records of the Panel are confidential[3] by statute, therefore all members and guests are required to sign a confidentiality agreement prior to participation in any Panel meeting. The Panel receives essential, administrative support from the Office of Child and Family Services (OCFS).

During this reporting period, between January 2023 and June 2024, the Panel met 20 times to conduct its work.[4] Those meetings included five joint case reviews, conducted with Maine's Domestic Abuse Homicide Review Panel (DAHRP). The CDSIRP and DAHRP frequently conduct cooperative reviews of cases in which children are killed by a family or household member.

To address statutory changes, the Panel has elected to adjust to a state fiscal year reporting schedule. As a result, this report will cover all of calendar year 2023 and the first six months of 2024. The next report will cover the 12 months of state fiscal year 2025. The Panel will continue to issue annual reports, recognizing several realities of addressing systemic change. Larger systemic issues tend to be very complex and are learned about over longer periods of time. Potential remedies or improvements, therefore, take longer periods of time to recommend and enact. The Panel anticipates there will be some repetition of content themes from year to year. Persistent themes may not be presented in as much detail if they have been addressed in a prior

[1] https://www.mainelegislature.org/legis/statutes/22/title22sec4004.html
[2] This includes any Panel member who was part of the Panel for any length of time from January 2023 through June 2024. See Appendix A.
[3] https://www.mainelegislature.org/legis/statutes/22/title22sec4008.html
[4] The Panel does not meet during July and August and 2 meetings were cancelled due to conflicts with statewide child welfare meetings.

Panel report. Additionally, the reader is referred to prior Panel reports for information about the Panel and its work that has not substantively changed from prior descriptions.

While the Panel's work of reviewing tragic and complex cases has historically been conducted in a confidential manner, the past two years have seen a period of intense scrutiny of Maine's Child Protective Services (CPS) in a public forum. The Joint Standing Committee on Health and Human Services (HHS) has hosted quarterly public presentations from Maine's Citizen Review Panels (CRPs) and others involved in efforts to improve CPS work and outcomes. The Panel's reports to HHS often included observed gaps in overall child welfare systems responses, opportunities missed by professionals, and the lack of resources available in our state to address families' and children's needs. The staff of the Office of Program Evaluation and Government Accountability (OPEGA), as directed by the legislature's Government Oversight Committee (GOC), conducted detailed reviews of not only topical themes/phases of CPS cases, but also of specific cases. OPEGA's presentations to the GOC and the public hearings that followed have allowed a level of insight- both for the legislature and interested members of the public- into the complexity of the work/reviews the Panel conducts regularly, as well as the difficulties inherent to child protection work. The Panel is grateful to the GOC, OPEGA, and HHS for the light they have helped shine on the safety of Maine's children.

Finally, it is worth noting that the observations and recommendations contained in this report and future reports are not necessarily reflective of the totality of the Panel's discussions, observations, and recommendations. Aside from generating formal recommendations for system improvement, there is great value in specific-case-driven multidisciplinary conversation among those with expertise in children's welfare, particularly when such conversations include policy makers, practice influencers, and those who otherwise can support efficient system change. As a result, and even prior to the publishing of our annual reports, we are confident that our work has already contributed to case specific improvement, broad policy considerations, and real-time education and positive changes in practice, both for OCFS and other community partners.

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 safety, permanency, and well-being of Maine's children, we present the 2023-24 Child Death and Serious Injury Review Panel's Annual Report.

Mark Moran, LCSW
Chair

Nicholas Miles, MD
Vice Chair

Panel Case Reviews and Additional Activities

During the 2023-24 reporting period, the Panel conducted 10 Level 3 (in depth)[5] case reviews, five of which were reviewed jointly with the DAHRP. The Panel conducted three Level 2 (thematic)[6] reviews involving a total of nine cases, in addition to Level 1 (summary)[7] reviews of all child deaths and serious injuries reported to OCFS from September 2022 through April 2024. To complement its primary case review activities, the Panel received presentations relating to pediatric trauma resulting from adults driving under the influence of intoxicants, legislation, trends in adolescent suicide, and policy and practice updates from OCFS.

The Panel Chair presented six[8] quarterly updates to the Joint Standing Committee on Health and Human Services and addressed the GOC in multiple public hearings.

CDSIRP Level 1 Review Data

The figures below reflect the total numbers of child death (CD), serious injury (SI) and ingestion (I) reports received by OCFS in 2023 and the first half of 2024, including those reported through OCFS' Intake unit and those that OCFS and the Panel learned about from the Office of the Chief Medical Examiner.[9] These values may differ from data presented elsewhere, such as on the OCFS website, for a variety of reasons that include, but are not necessarily limited to, the following:

- Some reports to OCFS are screened out[10] while others that meet criteria are assigned for investigation.
- OCFS investigations may or may not have resulted in findings[11] of abuse or neglect.
- OCFS investigations may have resulted in a determination that a SI or I, while suspected to have happened at the time of report, did not, in fact, occur.
- Criminal investigations by law enforcement may have led to prosecutions that may be ongoing.[12]

[5] Level 3 reviews include a formal presentation by OCFS staff and law enforcement and full access to all relevant case records.
[6] Level 2 reviews include multiple cases being reviewed in tandem, including access to selected case records.
[7] Level 1 reviews include discussion of summaries of every death, serious injury, and ingestion reported to OCFS. Future Level 2/3 case reviews are selected from these summaries.
[8] The Panel's July 31, 2024 presentation is included in this count since it reflected the Panel's work from April through June 2024.
[9] Not all CD/SI/I are reported to OCFS
[10] All reports are screened by Intake using a Structured Decision Making (SDM) tool and a determination is made regarding whether the report is appropriate for investigation. Not all CD/SI/I reports result in an investigation.
[11] A "finding" is a decision reached by a social worker based on the facts and evidence gathered during an assessment to support a decision that a person responsible for a child has, by a preponderance of the evidence, abused or neglected a child.
[12] Normally, data related to ongoing or pending prosecution would be withheld. It is included here in aggregate because no case specific or otherwise identifying information is included.

- In some cases, the OCFS website may reflect deaths that were not referred to CDSIRP because they had been reported earlier to CDSIRP as serious injuries.
- Child fatality data published on the OCFS website reflects all fatalities reported to OCFS during a given year if the family had previous involvement with child protective services, regardless of the cause of the fatality and regardless of the level of involvement the family had with child protective services or how long ago that involvement occurred.
- Serious injuries or ingestions that happen in one month but are reported in a subsequent month are counted in the month in which they are reported.

Figure 1: 2023 Child Death, Serious Injury, and Ingestion totals

	Serious Injuries	Ingestions	Child Deaths	Child Deaths Initially Reported to OCFS as a Serious Injury or Ingestion	Total
January	25	10	1	2	**38**
February	18	5	3	1	**27**
March	11	7	2	0	**20**
April	15	8	1	1	**25**
May	17	5	1	1	**24**
June	24	9	2	0	**35**
July	23	11	3	0	**37**
August	24	8	2	0	**34**
September	24	13	3	1	**41**
October	18	7	5	0	**30**
November	8	3	1	0	**12**
December	23	8	1	0	**32**
Total	**230**	**94**	**25**	**6**	**355**

Figure 2: 2024 Child Death, Serious Injury, and Ingestion totals

	Serious Injuries	Ingestions	Child Deaths	Child Deaths Initially Reported to OCFS as a Serious Injury or Ingestion	Total
January	15	12	2	0	**29**
February	14	4	1	2	**21**
March	15	11	1	0	**27**

April	9	6	0	0	**15**
May	30	3	3	0	**36**
June	28	15	2	2	**47**
Total	**111**	**51**	**9**	**4**	**175**

Annual Data Trends

These 2023 and 2024 (annualized) totals, as compared to 2022 data, represent slight increases in serious injury and ingestion reports. Serious injury reports have continued their overall, upward, multiyear trend.[13] Ingestion reports have continued to increase as well, though far below the 114% increase observed from 2021 to 2022.[14] Thirty-one child deaths in 2023 and 13 through the first six months of 2024 reflect an overall decreasing trend compared to 2021 and 2022.[15]

Systemic Observations

The Panel's Level 3 and Level 2 case reviews are often conducted 6-24 months after the initial report to OCFS. Timing and other factors related to the cases result in the reality that reviews may sometimes highlight areas for improvement that have already been addressed by the time of the Panel's review. In some situations, the Panel foregoes making formal recommendations when the concern has already been addressed. If a systemic change or remedy has been enacted, the Panel will often engage in discussion about whether the improvement has had the desired impact. If it has not, or insufficient time has passed to determine the impact of a change, additional recommendations may be considered.

Central themes encountered by the Panel in its reviews and selected for further discussion in this report have included sentinel injury awareness, recognition, reporting, and evaluation; the use and management of multidisciplinary teams in the investigation and evaluation of serious injury, ingestion, and fatality cases; the adequacy of information sharing between OCFS and community partners; and efforts to prevent serious injuries, ingestions, and fatalities.

[13] Serious injury reports: 165 in 2021, 203 in 2022
[14] Ingestion reports: 42 in 2021, 90 in 2022
[15] Child death reports: 54 in 2021, 54 in 2022

Sentinel injuries

In the Panel's 2021 report,[16] the topic of sentinel injuries[17] was explored in some depth. Enhanced awareness of the importance of sentinel injuries as potential indicators of unrecognized current injuries or the likelihood of future, potentially life-threatening, inflicted injury may be contributing to the ongoing increase in serious injury reports. The Panel continues to see several cases a year in which obvious sentinel injuries are not recognized as such or responded to appropriately by various types of professionals, including medical and OCFS personnel most frequently. This is not to say that every young child with a sentinel injury is or will be an abuse victim. Rather, every young child with a sentinel injury should receive a careful, multidisciplinary evaluation that includes consultation with a board-certified child abuse pediatrician, looking for additional and/or occult injuries and safety or risk factors that may inform appropriate, effective safety planning.

Some examples encountered by the Panel include:

- an infant with an unexplained joint fracture who was neither referred for Child Abuse Pediatrics[18] consultation nor reported to OCFS or law enforcement;
- an infant with bruising who was reported to OCFS appropriately by a primary care provider, yet not prioritized as a potential emergency by OCFS;
- an Emergency Medicine physician who refused the explicit recommendations of a child abuse pediatrics provider for more thorough evaluation of an infant with a sentinel injury;
- an evaluation of a sentinel injury by OCFS staff without seeking consultation from a child abuse pediatrics provider.

While these examples reflect a minority of cases examined by the Panel, they each represent a missed opportunity, in which a known indicator of risk was not properly assessed. These failures hinder the response and ability of protective systems to ensure a child's safety and well-being.

Multidisciplinary teams

The core members involved in a multidisciplinary team evaluation of sentinel injuries include OCFS staff, medical personnel (including a Child Abuse Pediatrician), and law enforcement. When such teams operate most effectively, each team member both provides and receives necessary information to/from other team members, with the result being a well-rounded, well-informed

[16] Pages 11-12

[17] Sentinel injuries are relatively minor, yet suspicious, injuries sustained prior to more substantial and perhaps life-threatening abusive injury.

[18] https://www.healthychildren.org/English/family-life/health-management/pediatric-specialists/Pages/What-is-a-Child-Abuse-Pediatrician.aspx

assessment of each case with resulting intervention (or non-intervention) specific to each discipline. The Panel has observed that these teams do not always function at peak effectiveness. Like the examples above regarding sentinel injuries, issues that contribute to under-functioning include, though are not necessarily limited to, inadequate understanding of the roles/needs of other team members, prioritization of one member's goals/outcomes without consideration of the impact on the ability of other members to effectively achieve their goals, team members not recognizing the value of including other members, and the availability of individual members to participate on a team in a timely manner.

Some examples observed by the Panel include:

- OCFS staff preparing/sharing legal documents with a family that contain sensitive investigative data without considering the impact that sharing such data could have on law enforcement actions or processes;
- Medical or OCFS staff failing to seek child abuse pediatrics guidance on the evaluation of a seemingly well/healthy sibling of a seriously injured or deceased child;
- OCFS failure to systematically provide feedback to mandated reporters and their organizations when mandatory reports are not made as required;
- Lack of coordination between law enforcement and OCFS in responding to a potential crime scene.

Information Sharing

The Panel has consistently recognized and supported the importance of confidentiality in child protective services work. The details of an OCFS case have significant implications for both the children and the adults involved. The Panel also believes that the safety net of child protection (i.e., the child welfare system) in our society is comprised of more entities than simply OCFS alone. Medical providers and educators are two of the most frequent sources of reports[19] to child protection agencies nationwide. They often have ongoing relationships with the children and families who are the subject of those reports, and yet the Panel notes that these groups often lack information, readily known to OCFS, about their patients/students. More open sharing of such information would better position these professionals to participate in the ongoing protection of children involved with the child welfare system.

Existing statutes[20] allow for either optional or mandatory disclosure of otherwise confidential information to selected entities. OCFS "may disclose relevant information in the records to…. A person having the legal responsibility or authorization to evaluate, treat, educate, care for, or

[19] https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf
[20] https://www.mainelegislature.org/legis/statutes/22/title22sec4008.html

supervise a child, parent or custodian who is the subject of a record…" (22 MRS § 4008-2-E). OCFS "shall disclose relevant information in the records to the following persons: Upon written request, a person having the legal authorization to evaluate or treat a child, parent, or custodian who is the subject of a record..." (22 MRS § 4008-3-H). The legislature seems to have contemplated a reality in which the statutes are operationalized, ideally creating a better-informed safety net for our children, and providing additional opportunities for the broad child welfare system to prevent harm or additional harm. It may be time for OCFS to revisit their policy and practice in this area to better equip other, non-OCFS, frontline, child-serving professionals to participate in these efforts more effectively.

Prevention

As the Panel has stated several times previously, the work and responsibility of protecting our children and preventing child abuse/neglect (and, more directly, serious injuries and deaths) falls on a far broader group than a single state agency, organization, or professional group. Prevention efforts that are currently deployed are often secondary or tertiary efforts in response to the identification of risk or in response to a harm event. While essential, these responses continue to dominate child welfare system efforts.

The Panel has observed multiple opportunities to enhance prevention efforts, including:

- Consistent public health/injury prevention messaging on topics such as safe sleep for infants, the dangers for small children in homes with unsecured/inadequately protected windows, and the risks of children riding on/in recreational vehicles without helmets and/or other protective gear;
- Universal referral from birthing hospitals to Maine's Cradle ME program for all families of infants;
- Ongoing education for primary care providers and emergency department clinicians on sentinel injury awareness, identification, and proper evaluation;
- Enhanced information sharing with other system partners.

One of the more salient prevention opportunities noted by the Panel involves information contained in screened out reports of alleged child abuse/neglect. When a report is received by OCFS' Intake Unit, the report data is subjected to a Structured Decision Making (SDM) protocol. While there are intricacies to the protocol, the essential result is a decision to screen in (deem appropriate to assign for investigation) or screen out (deem to not contain an allegation of abuse/neglect and thus not assign for investigation) the report. When a report is screened out, there is no further action taken regarding the information reported. Of note, when a report is screened in, but no findings of maltreatment are made after investigation (i.e., the allegations

are unsubstantiated), there is similarly no further action taken, despite the risk factors that may still be present.

The Panel encountered a specific example that highlighted this system gap. A law enforcement officer received a report from an extended family member, saying they were concerned about the household members' safety due to adult mental health concerns. The officer visited the family home and ultimately determined there was no acute mental health crisis that warranted protective custody/involuntary psychiatric evaluation. While making that determination, the officer learned other information that caused independent concern for the children in the home, though that information was not actionable for law enforcement. As a mandated reporter, the officer contacted OCFS, reported the concerning information, and thus met the statutory requirement. The report was screened out by OCFS. While there may not have been an immediate and clear allegation of abuse/neglect in the report, there were ample risk factors for child maltreatment. Those risk factors remained unaddressed by any known entity, until one of the children sustained a life-threatening injury several weeks later. The Panel views this as a missed opportunity to either share information with other professionals involved with the family (with the hope those professionals could address the risk factors in the context of their existing working relationship) or to have routed the family to another pathway for other community-based prevention and support services. Maine currently lacks such a pathway, and this example highlights what can happen when protective and preventive efforts are limited to OCFS or law enforcement.

Recommendations:

1. OCFS and the Spurwink Center for Safe and Healthy Families (SCSHF) should partner to develop an education plan for primary care providers and emergency department clinicians to be trained on the importance, identification, reporting, and evaluation of sentinel injuries in pre-mobile children.

2. OCFS and the SCSHF should partner to develop a document/poster that can be displayed in medical settings to provide ongoing, evidence-based guidance on the evaluation of sentinel injuries and the evaluation of children who are members of a household in which a child has been seriously injured or killed and there is concern for child maltreatment as a cause of that injury or fatality.

3. OCFS and the SCSHF should continue to partner regularly to examine barriers to effective case-specific collaboration and consultation.

4. The Department of Health and Human Services (DHHS), in collaboration with appropriate state and federal funding sources and Maine's hospital/healthcare systems, must ensure

that Child Abuse Pediatrics services in Maine are sufficiently funded to allow for urgent consultations, timely in-person evaluations, and timely communication of evaluation results for all children throughout the state.

5. OCFS and law enforcement entities should include their respective Assistant Attorneys General (civil and criminal) and/or county-based prosecutors when crafting legal documents whose content may serve to adversely impact the other party's ongoing investigative or prosecutorial work.
6. OCFS and law enforcement entities should continue their efforts to collaborate on joint training sessions.
7. OCFS and the Office of the Attorney General (OAG) should collaborate to develop a form letter that can be sent from the OAG or OCFS to both mandated reporters and their organizational leadership or legal counsel when the mandated reporter has failed to meet their statutory reporting requirement.
8. OCFS should develop a workgroup, including medical providers and education staff, to examine opportunities for improvement in policy and practice related to sharing of OCFS data with other key professionals specified in statute, with a goal of optimizing the ability of those professionals to participate more meaningfully in the protection of Maine's children.
9. OCFS and Maine Center for Disease Control and Prevention (CDC) should continue to partner on consistent public health messaging on topics such as safe sleep for infants, use of protective headgear for children on/in recreational vehicles such as snowmobiles and ATVs, and child falls from improperly secured windows.
10. The Maine Legislature should propose and pass a bill requiring children to wear helmets when riding or operating motorized recreational vehicles, regardless of whether the recreational vehicle is being operated on public or private property.
11. The Maine CDC should develop a workgroup including representation from the Division of Public Health Nursing and the Maternal Child Health (MCH) Program to examine barriers to universal referral of all birthing families to Maine's MCH home visiting program, Cradle ME.
12. OCFS should convene a multidisciplinary stakeholder group and/or continue and enhance existing efforts to develop a statewide service pathway for families at risk of OCFS involvement who do not yet meet the necessary criteria for OCFS investigation or intervention. The goal of such a pathway should be to provide supportive, non-punitive services in whatever form is necessary to mitigate identified risk factors for child maltreatment.

Conclusion

The Panel continues to be grateful for the opportunity to be part of a system of review and oversight that contributes to enhanced learning and practice improvement, with the ultimate goal of ensuring all families receive the support they need to remain safe, stable, and healthy. Children being hurt or killed because of their caregivers' actions or inactions should be a continual warning to us all that much work remains to be done. We look forward to a day when all families have what they need to survive and thrive while maximizing their children's safety, and we hope our continued work contributes positively toward that end.

Appendix A: 2023-24 Panel Membership

Mark Moran, LCSW, Chair
Social Services Manager, Northern Light Eastern Maine Medical Center
CASA Guardian ad Litem, Maine CASA

Amanda Brownell, MD, Vice Chair (through 5/2024)
Child Abuse Pediatrician, Medical Director, Spurwink Center for Safe and Health Families

Nicholas Miles, MD, MSc, Vice Chair (beginning 6/2024)
Child Abuse Pediatrician, Spurwink Center for Safe and Healthy Families

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Child Protective and Juvenile Process Specialist, State of Maine Judicial Branch

Katherine Bozeman, Esq.
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Kathryn Brice
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Alice Briones, DO
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Psychologist, Edmund N. Ervin Pediatric Center

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Shannon Craig-McDaniel, BSN, RN
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Communications and Compliance Manager, Maine Office of Child and Family Services

Sandi Hodge
Retired Child Welfare Professional

Julie Hunter
Manager of Field Operations, Maine Office of Child and Family Services

Bobbi Johnson, LMSW
Associate Director of Child Welfare, Maine Office of Child and Family Services (ending 1/2024)
Director, Maine Office of Child and Family Services (beginning 1/2024)

Todd Landry, Ed.D.
Director, Maine Office of Child and Family Services (ending 11/2023)

Jeffrey Love
Captain, Maine State Police, Office of Professional Standards

Sarah Miller, PhD, ABPP
Director, Maine State Forensic Service

Ashley McAllister, LMSW
Associate Child Welfare Ombudsman

Marc Minkler, BS, NRP, I/C
Program Manager, EMS for Children, Maine EMS

Tessa Mosher
Director of Victim Services, Maine Department of Corrections

Sheila Nelson, MSW, MPH
Suicide Prevention Program Manager, Maine Centers for Disease Control and Prevention

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Geoff Parkin, Esq.
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Pediatric Nurse Practitioner

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