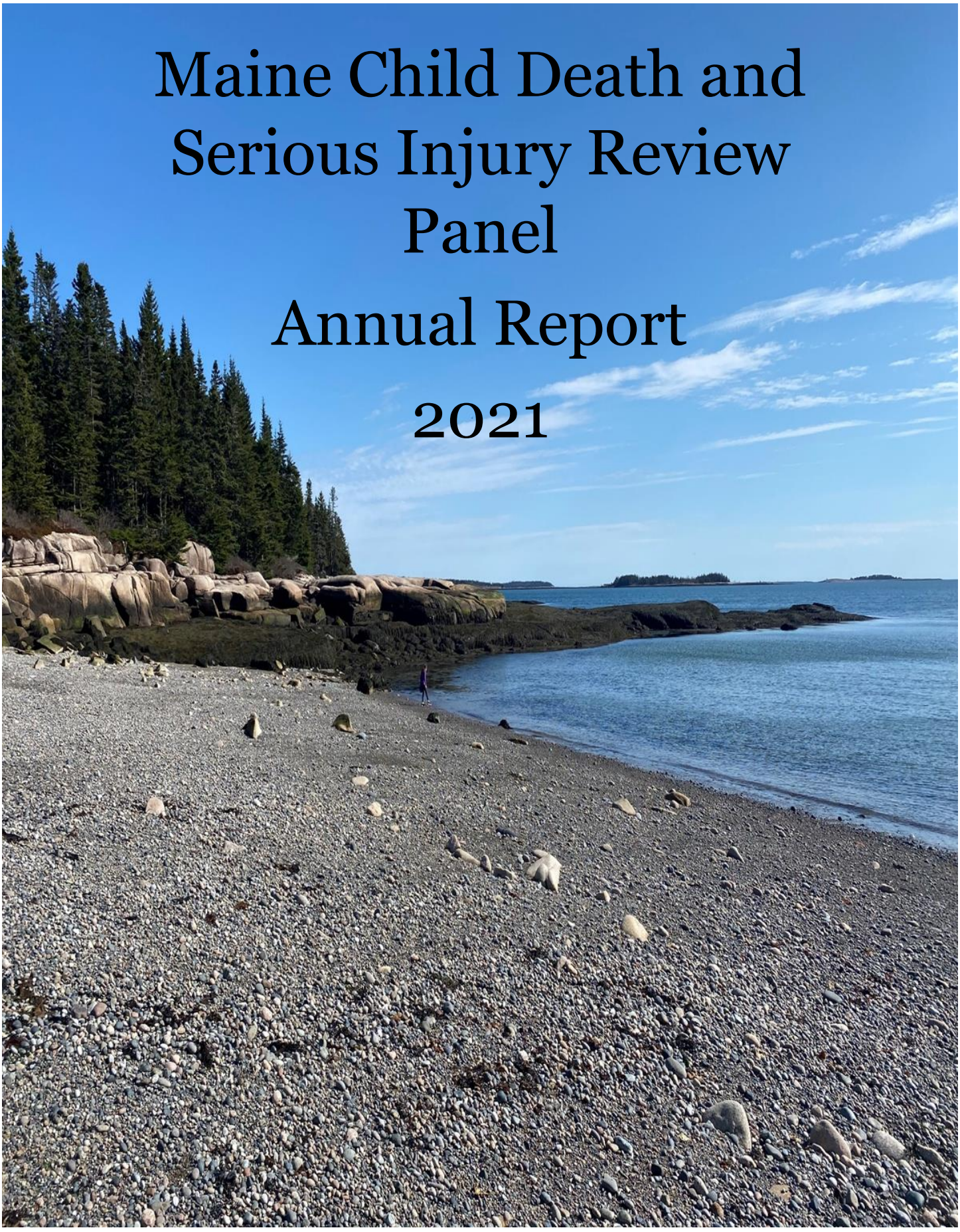
Maine Child Death and Serious Injury Review Panel

Annual Report

2021



The Child Death and Serious Injury Panel would like to thank all providers, DHHS staff and law enforcement that attended the 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:

Mark Moran, LCSW

On behalf of

Maine Child Death and Serious Injury Review Panel

With support from Kathryn Brice, MSc, LSW

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Published 2022

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207-624-7900

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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, rather than complete list of members. Recognizing that multidisciplinary perspective is crucial for comprehensive review and analysis of child deaths and serious injuries, the 2021 Panel was comprised of 31 professionals,[2] representing both public and private entities with an interest in the welfare of Maine's children. These members generously volunteer their time and expertise to examine the most tragic cases encountered by the child welfare system. Additionally, 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. In 2021, as in past years, the group met monthly in 10 of 12 months to conduct its work. The Panel receives administrative support from the Office of Child and Family Services.

Traditionally, the Panel has met 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. This regional meeting has not occurred during the Covid-19 pandemic. Finally, the Panel has also historically partnered 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. No joint reviews were completed in 2021.

The format of this report will differ somewhat from prior Panel reports, in part because of efforts undertaken by the Panel to examine and evaluate how we conduct our work and restructure to better meet our purpose and mission. Though no specific reporting interval is specified in Maine statute as of the writing of this report, the Panel's intent moving forward is to issue annual reports. The Panel is interested in maximizing the accessibility, digestibility, and usability of its report, with the ultimate goal of optimizing the impact of its work. Therefore, the Panel aims to produce an annual report that is more succinct than past reports. To this end, the annual report will no longer contain duplicative Child Protective Services data that is readily available in other

[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 in CY2021. See Appendix A.
[3] https://www.mainelegislature.org/legis/statutes/22/title22sec4008.html

reports produced by the Office of Child and Family Services (OCFS). It will also no longer contain the full text of related statutory content and instead will include links and references to the appropriate statutes. The Panel also recognizes that this annual report is being published in close proximity to a larger report covering the Panel's work from 2017-2020. Since larger systemic issues tend to be very complex, become evident over longer periods of time, and take longer periods of time to improve, the Panel anticipates there will be some repetition of content themes between not just the 2017-2020 report and the 2021 report, but also between annual reports in the future.

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 create system change in less obvious or public ways. As a result, and even prior to the publishing of this report, we are confident that our work has already contributed to case specific influence, broader policy considerations, and real-time education and alterations to practice, both within OCFS and outside it.

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 present the 2021 Child Death and Serious Injury Review Panel Report.

Mark Moran, LCSW
Chair

Amanda Brownell, MD
Vice Chair

The National Perspective

Every US state has at least one Child Fatality Review Team (CFRT). Some states, like Maine, have one team that reviews cases statewide, while other states have several local teams (for example, county-based). All CFRTs have technical assistance available to them via the National Center for Fatality Review and Prevention.[4] The National Center also maintains the National Fatality Review-Case Reporting System. This web-based tool allows local and state teams "to enter case data, summarize findings, review team recommendations, access and download data, and create standardized reports."[5] Maine does not currently contribute data to this system, but has in the past[6].

Each year, the Children's Bureau (Administration on Children, Youth and Families, Administration for Children and Families) of the U.S. Department of Health and Human Services publishes a report[7] reflecting data contributed from every state on a number of child maltreatment related measures. For FFY2020, the estimated national rate of child maltreatment related fatalities (CMRF) was 2.38 per 100,000 children, or approximately 1,730 children. Sixty-eight percent of these fatalities are in children younger than 3 years of age and 46% are in children who have not yet reached their first birthday. The CMRF rate in children under 1 year (23.03/100,000) is 3.6 times that of 1 year old children (6.49/100,000). Generally, the rate of CMRF decreases with age.[8]

In FFY2020, there were approximately 248,000 children in Maine.[9] The aforementioned report shows Maine reported the following CMRF in the past 3 years: 3 in 2018, 3 in 2019, and 1 in 2020. While there are undoubtedly intricacies involving data definitions, reporting processes, and the validity of these numbers as an accurate reflection of the true incidence, Maine is generally believed to have a lower CMRF rate than the national average. Given the relatively low number of child maltreatment fatalities in Maine, CDSIRP reviews include not only child deaths, but also serious injuries and ingestions (both of which may easily lead to a fatality) that are reported to OCFS.

[4] https://ncfrp.org/cdr/our-role/
[5] https://ncfrp.org/data/nfr-crs/
[6] Personal communication with Abby Collier, MPH, Director of NCFRP on 1/22/22
[7] https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2020.pdf
[8] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2020. Available from https://www.acf.hhs.gov/cb/data-research/child-maltreatment.
[9] https://datacenter.kidscount.org/data#ME/2/0/char/0

Panel Function, Review Protocols and Additional Activities

Maine's CDSIRP is one of three Citizen Review Panels[10], authorized under the Child Abuse Prevention and Treatment Act (CAPTA)[11] and Children's Justice Act (CJA)[12]. In 2021, leadership from CDSIRP, the Maine Child Welfare Advisory Panel (MCWAP)[13] and the Justice for Children Taskforce (JCT)[14] began meeting quarterly to enhance the working relationship among the three groups. Additional information about each of these panels can be found at https://www.mecitizenreviewpanels.com/. The CDSIRP is also one of three fatality review panels in Maine: the Domestic Abuse Homicide Review Panel[15] and the Maternal, Fetal and Infant Mortality Review Panel[16] share some overlapping members, though the panels differ in their focus. When appropriate, the panels may conduct joint case reviews or refer case reviews to one another to optimize their collective efficiency.

Over the past year, CDSIRP has continued its efforts to formalize how it is structured and how it operates through the creation of by-laws. This work has been done through sub-committees and the work has happened concurrently with the Panel's primary case review activities. The first three work products of those subcommittees are nearing completion and final approval by the Panel. Areas being addressed initially include the Panel's authority and reporting protocols, how the Panel selects the content it reviews, and how those reviews are structured and conducted. The Panel has previously adopted a three-level review process, in which these newly defined protocols are beginning to be implemented[17]. Those three levels and activities under each are:

- Level 1 Reviews: The Panel reviews brief, summary reports of every child death, serious injury, and ingestion[18] that is reported to OCFS. The timeframe in which these reports are received by OCFS is >30 days prior to the start of the month in which the review by the Panel is taking place[19]. This delay is designed to allow OCFS an opportunity to complete its initial response to such a report, thus allowing more information to be available on individual cases when requested by the Panel. OCFS staff provide limited additional case details during Level 1 reviews on an as needed basis. The Panel's goal is to complete Level 1 reviews at each of its 10 monthly meetings, to maintain a current perspective of the types and circumstances of deaths, injuries, and ingestions reported.

[10] https://www.childwelfare.gov/topics/management/administration/partnerships/oversight/citizen/
[11] https://www.childwelfare.gov/pubPDFs/about.pdf
[12] https://www.childwelfare.gov/topics/systemwide/courts/reform/cja/
[13] https://www.mainelegislature.org/legis/statutes/22/title22sec4010-D.html
[14] https://www.courts.maine.gov/about/committees/justice-children.html
[15] https://legislature.maine.gov/legis/statutes/19-A/title19-Asec4013.html at 4
[16] https://www.maine.gov/dhhs/mecdc/population-health/mch/perinatal/maternal-infant/
[17] The Panel anticipates including final versions of completed sections of its by-laws in the appendices of future reports.
[18] Given the comparatively low number of ingestions reported each month, the Panel will be reviewing summary ingestion reports on an annual basis in 2022.
[19] For example, reports reviewed in the Panel's January meeting would have been received by the OCFS between November 1 and November 30 of the preceding year.

- Level 2 Reviews: If/when the Panel identifies themes or common threads among the Level 1 reviews, the Panel will select a small number of cases involving the theme for a more in-depth Level 2 review and discussion. The records provided to and examined by the Panel in such a review are generally limited to OCFS records, though selected, additional records may be included based on the individual cases or themes.

- Level 3 Reviews: If/when the Panel identifies an individual case that is particularly noteworthy, its most in-depth review is conducted. A specific case may be noteworthy for several reasons, including but not limited to a large number of child welfare system components being involved with a family, a high-profile case that has garnered the attention of the public or government officials, a case in which the family has a lengthy history with OCFS, or a case in which there is an obvious challenge that requires more extensive root cause analysis.

The Panel does not conduct Level 2 or Level 3 reviews on cases where there is a criminal prosecution pending to preserve the integrity of the important role the judicial process plays in protecting children.[20] Given the length of time criminal prosecutions can take, the Panel generally cannot review such a case until 18-24 months after a child's death, serious injury, or ingestion.

Panel meetings in 2021 have been conducted exclusively using secure video conferencing, as has been the case since the COVID-19 pandemic began. The use of this technology has been beneficial to the Panel's work, in that it has allowed for improved attendance at meetings, eliminated the additional time commitment to travel from various parts of the state to Augusta, and limited the need to cancel meetings due to inclement weather. Use of remote conferencing, however, has also adversely impacted the Panel and its members by removing some of the elements of a meeting that allow members to continue to do this important work in a healthy manner. Several known strategies to mitigate the adverse impacts of repeated exposure to traumatic content are not currently available to members because of the need to meet remotely, resulting, at times, in a sense of interpersonal disconnection, loss of informal support structures, and reduced ability to process the challenges associated with this work.

In addition to its primary case review activities, the Panel also receives education on a variety of topics throughout the year to help inform its understanding of evolving policy, best practices, and new initiatives. In 2021, the Panel heard presentations relating to pediatric ingestions and poisonings, failure to thrive, policy and practice changes at OCFS, Maine's implementation[21] of

[20] https://www.mainelegislature.org/legis/statutes/22/title22sec4004.html at "F".
[21] https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/system-improvements-initiatives/families-first-prevention-act

the Family First Prevention Services Act, the work[22] of Casey Family Services and Collaborative Safety, clinical consultation and support available to OCFS staff to address the ongoing vicarious trauma inherent to OCFS' work, and secondary traumatic stress among those conducting child fatality reviews.

The Panel provided input on two different legislative matters in 2021. In April, the Chair of the Panel submitted written testimony related to the management and regulation of Maine's marijuana programs and its potential impact on Maine's children (Appendix B). In September, the Chair also presented to the Government Oversight Committee related to the structure, function, and role of the Panel (Appendix C).

CDSIRP REVIEW DATA

The figures below reflect the total numbers of child death (CD), serious injury (SI) and ingestion (I) reports reviewed by the Panel in 2021, including those reported through OCFS' Intake unit and those that OCFS and the Panel learned about from the Office of the Chief Medical Examiner.[23] 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[24] while others meeting intake criteria are investigated.
- Investigations by OCFS may or may not have resulted in findings of abuse or neglect.
- Investigations by OCFS may have resulted in a determination that a SI or I, while suspected at the time of report, did not, in fact, occur.
- Investigations by law enforcement may have led to criminal prosecutions that may still be ongoing.[25]
- 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.
- Data reported is based on the manner in which the data point is defined. 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.

[22] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Maine%20Review%20Summary%20Report%20and%20Recommendations.pdf
[23] Not all CD/SI/I are reported to OCFS
[24] 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 assessment. Not all CD/SI/I reports result in an investigation.
[25] 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.

2021 CHILD DEATH, SERIOUS INJURY AND INGESTION REPORTS

	Serious Injuries	Ingestions	Child Fatalities	Child Fatalities Initially Reported to OCFS as a Serious Injury or Ingestion	Total
January	18	4	2	0	**24**
February	15	11	6	0	**32**
March	17	7	1	0	**25**
April	13	3	2	1	**19**
May	16	3	5	0	**24**
June	12	5	5	2	**24**
July	11	2	5	0	**18**
August	7	0	4	0	**11**
September	19	1	3	1	**24**
October	10	2	4	1	**17**
November	11	4	9	1	**25**
December	16	0	2	0	**18**
Total	**165**	**42**	**48**	**6**	**261**

These 2021 totals, as compared to 2019 data (pre-pandemic), represent increases of 4% in serious injury reports and 31.3% in ingestion reports. Annual serious injury reports to OCFS had been trending upward (131, 160, 158, and 191 per year) from 2017 to 2020. Ingestion reports to OCFS had been trending downward (51, 49, 32, and 31) over the same period.

Beginning with 2021 data, the Panel will be reporting total deaths of children under the age of 18 years that were reported to either or both OCFS and OCME. Child death numbers previously reported by the Panel had demonstrated relative stability from 2017-2020 (17, 20, 17, and 22 per year). However, these data included some, but not all child deaths reported to the OCME. By including all child deaths reported to the OCME in its reviews moving forward, the Panel hopes to gain a broader view of the causes of and contributing factors to child deaths. Because of this change, the Panel is unable to reliably compare this data point over time.

Injury Specific Observations and Recommendations

Over the course of 2021, primarily though Level 1 reviews, the Panel has noted some types of injuries or incidents that were reported with more frequency than others. This is not an exhaustive list of the injuries reported or reviewed, but rather some of those that garnered the attention of the Panel for their repetition.

Bruising in pre-mobile infants

In 2013, Maine's child abuse and neglect reporting statutes were amended, with the Panel's support, to include a new section [26] that required the reporting of several specific injuries (a fractured bone, substantial or multiple bruises, subdural hematoma, burns, poisoning, or any injury resulting in substantial bleeding, soft tissue swelling, or impairment of an organ) when present in an infant who is less than 6 months of age or otherwise non-ambulatory. This new section was noteworthy in that it did not require, for those injuries in that age range, that the mandated reporter have reasonable cause to suspect that a child has been or is likely to be abused or neglected. In a predictable and desired fashion, the numbers of these types of reports have increased since that time.

Much attention has been given to the concept of prevention and early identification of risk in the child maltreatment field. In a 2013 paper[27], Sheets et al coined the term "sentinel injuries" to describe relatively minor, yet suspicious, injuries sustained prior to more substantial and perhaps life-threatening abusive injury. The researchers retrospectively examined the records of 401 infants who had been referred to a hospital-based child protection team for evaluation of abuse. Of the 200 infants who were deemed to have a definite concern for abuse, 27.5 % had record of a prior sentinel injury. Of the 100 infants who had an intermediate concern for abuse, 8 % had a prior sentinel injury. Finally, of the 101 infants who had no concern for abuse after evaluation, none had a prior sentinel injury. The presence of a sentinel injury is not just an indicator of a potentially unsafe environment for a child, it an uncommon finding in non-abused children.

Other researchers have examined the intricacies of which injuries, in which locations, and in which children should be of greatest concern. Perhaps most noteworthy among them in recent years is the work that has produced the easily remembered mnemonic "TEN-4." Peirce et al[28] developed the TEN-4 bruising clinical decision rule to help identify which injured children should have more thorough evaluation for child abuse concerns. They found that bruising on the (T)orso, (E)ar or (N)eck in a child 4 years of age or younger or any bruising in a child less than 4 months of age was a sufficiently strong predictor of abuse to warrant more detailed examination. Pierce et

[26] https://www.mainelegislature.org/legis/statutes/22/title22sec4011-A.html at "7."
[27] Sheets, L. K., Leach, M. E., Koszewski, I. J., Lessmeier, A. M., Nugent, M., & Simpson, P. (2013). Sentinel injuries in infants evaluated for child physical abuse. Pediatrics, 131(4), 701–707. https://doi.org/10.1542/peds.2012-2780
[28] Pierce, M. C., Kaczor, K., Aldridge, S., O'Flynn, J., & Lorenz, D. J. (2010). Bruising Characteristics Discriminating Physical Child Abuse From Accidental Trauma. PEDIATRICS, 125(1), 67–74. https://doi.org/10.1542/peds.2008-3632

al further validated this decision rule and expanded it in 2021[29] when they added "FACES-P" to the mnemonic- representing bruising to the (F)renulum, (A)ngle of the jaw, (C)heek, (E)yelid, and (S)ubconjunctivae, as well as (P)atterned bruises, in the same age range. Further support and validation of the TEN-4 rule resulted from Kemp et al in 2021, who concluded that such a simple decision rule to identify children at risk for abuse "has the potential to save lives."[30]

The Panel is pleased that OCFS is receiving more reports of this type- not for the injuries sustained by these children, but for the identification of opportunities for multidisciplinary intervention before maltreatment becomes fatal; however, work remains to be done on this front. Despite more reports of sentinel injuries being made at initial presentation, the Panel has continued to see reports in which sentinel injuries are not reported by medical providers and children subsequently remain in potentially unsafe environments where they can sustain more serious injuries. This has been a point of education among members of the Maine chapter of the American Academy of Pediatrics as recently as October 2021, and the Panel strongly supports ongoing education of all professionals who have the opportunity to pro-actively identify at-risk children.

Recommendation:

1. Ongoing efforts to educate professionals who interact with young children about sentinel injuries and their significance should continue.

Abusive Head Trauma

Maine continues to see many cases of abusive head trauma (AHT), formerly known as Shaken Baby Syndrome, each year, most of which fail to reach the threshold of widespread public awareness. AHT occurs most frequently in children under 6 months of age and is fatal in approximately 25% of cases, making AHT the most lethal form of child maltreatment.[31] Among the survivors, nearly 70% "have some degree of lasting neurologic impairment."[32] In a large review of AHT-related confessions, more than 80% of cases involved shaking or shaking plus

[29] Pierce, M. C., et al. (2021). Validation of a Clinical Decision Rule to Predict Abuse in Young Children Based on Bruising Characteristics. JAMA Network Open, 4(4), e215832. https://doi.org/10.1001/jamanetworkopen.2021.5832

[30] Kemp, A. M., Maguire, S. A., Nuttall, D. E., Collins, P., Dunstan, F. D., & Farewell, D. (2021). Can TEN4 distinguish bruises from abuse, inherited bleeding disorders or accidents? Archives of Disease in Childhood, archdischild-2020-320491. https://doi.org/10.1136/archdischild-2020-320491

[31] https://www.dontshake.org/learn-more/itemlist/category/13-facts-info

[32] Narang, S. K., Fingarson, A., Lukefahr, J., & COUNCIL ON CHILD ABUSE AND NEGLECT. (2020). Abusive Head Trauma in Infants and Children. Pediatrics, 145(4), e20200203. https://doi.org/10.1542/peds.2020-0203

impact.[33] Over the last several years, the validity of the diagnosis of AHT has been challenged in legal settings by defense experts, despite the overwhelming medical evidence, supported by the professional literature, endorsing its existence.[34] Maine has begun to see this defense being put forth, which jeopardizes the health and safety of abused children.

Several years ago, Maine embarked on an effort to implement the Period of PURPLE Crying[35] programming in every birthing hospital in the state. Expert educators traveled the state to introduce and explain the program, which has been and continues to be supported by prevention-focused entities such as the Maine Children's Trust.[36] However, research that has examined the effectiveness of parent education programs at reducing hospital admissions for AHT has shown inconsistent results.[37] Additionally, concerns have arisen regarding whether Maine birthing hospitals continue to implement the PURPLE Crying program with fidelity. The Panel is not aware of any systematic evaluation or monitoring of this program's implementation or effectiveness in Maine. It does not appear to be part of any integrated injury prevention strategy within the state. To their credit, OCFS does have a policy[38] requiring staff, when evaluating the safety of children under 12 months old, to inquire about whether the caregiver has already received PURPLE Crying education and to provide that education if the caregiver has not. The degree to which this policy is both followed and effective as a prevention strategy is unclear.

Related to this, the Panel's efforts to locate information about a unifying strategy to address AHT in Maine have been disappointing. A review of the Maine Center for Disease Control and Prevention's Maine Injury Prevention Program (MIPP) primary webpage[39] contains no injury-related reports dated more recently than 2011. Other MIPP sub-pages reveal areas of absent information and additional, significantly outdated material (for example, one of three reports listed on one page, "Young Children in Motor Vehicle Crashes," reflects data from 1996-2001). Most notably, the two specific resource links listed related to AHT ("The Shaken Baby Alliance" and "Shaken Baby Syndrome Prevention Program") both direct the reader to web domains that are no longer active. The Panel readily, and gratefully, acknowledges the reality and focus of the pandemic-related work that has been conducted by the Maine CDC over the past 2 years;

[33] Edwards, G. A., Maguire, S. A., Gaither, J. R., & Leventhal, J. M. (2020). What Do Confessions Reveal about Abusive Head Trauma? A Systematic Review. Child Abuse Review, 29(3), 253–268. https://doi.org/10.1002/car.2627

[34] Choudhary, A. K., et al. (2018). Consensus statement on abusive head trauma in infants and young children. Pediatric Radiology, 48(8), 1048–1065. https://doi.org/10.1007/s00247-018-4149-1

[35] https://www.dontshake.org/purple-crying

[36] http://www.mechildrenstrust.org/purple-crying.asp

[37] Roygardner, D., Hughes, K. N., & Palusci, V. J. (2021). A Structured Review of the Literature on Abusive Head Trauma Prevention. Child Abuse Review, 30(5), 385–399. https://doi.org/10.1002/car.2717

[38] https://www.maine.gov/dhhs/ocfs/cw/policy/iv_-d-8-safe-sleep-checklist-a.html

[39] https://www.maine.gov/dhhs/mecdc/population-health/inj/index.html (Accessed 1/23/22)

however, the lack of data available through the MIPP site stands in stark contrast to what has become available through the OCFS site[40] in recent years.

The Panel has learned that the MIPP lost its state and federal funding several years ago. Between the impact of the loss of state funds and the loss of federal grant funds, which are awarded through a competitive process, Maine no longer has the resources to support staff time or infrastructure dedicated to the prevention of injuries other than those associated with suicide. The Maine CDC has applied for renewed federal funding, but without the ability to demonstrate an existing infrastructure, their applications fail to reach a competitive level. This has implications for not only AHT prevention, but also for programming related to gunshot injuries and ingestions. The mission of the MIPP is to "provide leadership and coordination to assure a statewide, comprehensive and integrated injury prevention program that serves as a resource for professionals, communities, agencies, and professional organizations in both the public and private sectors."[41] Without adequate funding, the Maine CDC, through the MIPP, will continue to fail to meet this mission.

Recommendations:

2. Abusive Head Trauma prevention should be part of a comprehensive injury prevention program and strategy focused on the health and safety of Maine's children. This strategy should include evaluation of all current efforts and consideration of any emerging strategies to reduce the incidence of AHT.
3. The Maine Legislature should appropriate adequate funding to the Maine CDC for the express purpose of re-establishing the MIPP, thus allowing pursuit of its mission.
4. If funded by the Legislature, the Maine CDC should dedicate at least one full time employee to begin the process of rebuilding the MIPP.
5. MIPP staff should convene a multidisciplinary stakeholder group to develop a workplan consistent with Recommendation 2.

Failure to Thrive

Failure to thrive (FTT), which is increasingly being called "growth faltering" in the literature[42], is "an abnormal pattern of weight gain defined by the lack of sufficient usable nutrition and

[40] https://www.maine.gov/dhhs/ocfs/data-reports-initiatives
[41] https://www.maine.gov/dhhs/mecdc/population-health/inj/index.html
[42] This report will use the term "failure to thrive" since it is the more familiar term at this point.

documented by inadequate weight gain over time."[43] FTT is not a final diagnosis but a symptom of medical disorders, developmental/behavioral concerns, nutritional neglect, and/or psychosocial difficulties. Frequently, these factors can be addressed through routine interventions and by providing support services, such as parent education, breastfeeding support, or connecting a family with WIC resources.[44]

One excellent resource to assist and support families whose child is failing to thrive is Public Health Nursing (PHN). During the prior administration, the ranks of Public Health Nurses in Maine were cut substantially. State Senator Brownie Carson subsequently led an effort in 2017 (LD 1108)[45] to require the Executive Branch to fill many vacant PHN positions. Under the current administration, progress has been made toward that goal, and the Panel strongly supports the maintenance of a robust PHN staff. PHN involvement should be considered in most FTT cases. PHNs can partner with families in their natural environments and in a non-threatening manner to maximize the likelihood of a child's successful recovery from a FTT diagnosis.

In some cases, the behavioral or psychosocial factors contributing to FTT cannot be adequately managed with routine interventions and supports, allowing a child to continue to fail to thrive. Concerns for a child with FTT, such as parental refusal to accept the diagnosis, significant parental impairment, or refusal to meaningfully participate in a treatment plan, may rise to the level of requiring OCFS involvement. Additionally, subspecialty medical care with a Child Abuse Pediatrician[46], who is trained to navigate the complex features of such cases and works with a multidisciplinary team, may be necessary. Sub-specialist involvement can lead to more consistent evaluation and management of FTT, which may benefit not only the child, but also the family. The Panel has reviewed multiple cases in which there has been a failure to recognize the need for enhanced levels of intervention by OCFS and/or a Child Abuse Pediatrician by other professionals involved with a child or family. Indeed, there have been times that the need to involve a Child Abuse Pediatrician has been missed by OCFS staff as well.

Failing to recognize the need for enhanced intervention, as well as failing to be aware of the relevant resources and how to access them, allows FTT to persist. Left untreated, or inadequately treated, FTT can lead to long term growth deficits, cognitive impairments, behavioral problems, and developmental delays.[47] The Panel considers such an outcome to constitute an avoidable serious injury.

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[43] Homan, G. J. (2016). Failure to Thrive: A Practical Guide. American Family Physician, 94(4), 295–299. https://www.aafp.org/afp/2016/0815/p295.html

[44] https://www.maine.gov/dhhs/mecdc/population-health/wic/

[45] http://www.mainelegislature.org/legis/bills/display_ps.asp?ld=1108&PID=1456&snum=128

[46] This subspecialty is further described on page 19.

[47] https://www.stanfordchildrens.org/en/topic/default?id=failure-to-thrive-90-P02297 (Accessed 3/11/22)

Recommendations:

6. The provider of Child Abuse Pediatrics services in Maine should conduct outreach efforts to the pediatric medical community to ensure their awareness of the availability of FTT specific consultation and multidisciplinary co-management.
7. OCFS leadership should communicate to frontline staff and supervisors regarding the value of Child Abuse Pediatrics consultation in FTT cases and frontline OCFS staff should refer children they are evaluating who have FTT for that consultation.
8. The Maine CDC should maintain a robust PHN workforce to ensure adequate availability of services to families who are among those most in need of their support.

Gun Shot Wounds and Firearm Fatalities

The Panel continues to see reports of cases involving children sustaining serious injuries or being killed by unintentional firearm discharge. The Everytown "#NotAnAccident" data tracker [48] reflects media accounts of at least 12 unintentional firearm discharges by children in Maine since 2015, resulting in 6 deaths and 7 injuries. Thirty-three percent of those came in 2021 alone (1 death, 3 injuries). From their national database, Everytown reports that handguns account for 85% of incidents in which a firearm is unintentionally discharged by a child, and that number climbs to 93% when the child is 9 years old or younger.[49] The recent context for these incidents includes US gun sales in 2021 that were down 12.5% to 19.9 million, compared to 2020's record setting 22.8 million. The previous record high was in 2016, when 16.7 million guns were sold.[50] Research examining rates of childhood firearms injuries during the first 6 months of the COVID-19 pandemic, as compared to the same 6-month period in 2016-2019, showed an increase both in the rate of firearms injuries in children (with younger children having a higher risk) and firearms injuries inflicted by children. Both findings correlated with the increase in new firearm purchases during the same time periods of study.[51]

The Panel has observed that in cases where children are injured or killed by unintentional firearm discharges, a caregiver often mistakenly believes that the child either doesn't know where the gun is in the home or knows not to touch it. When parents and children have been surveyed about these topics, 40% of parents who reported that their child did not know where guns were

[48] https://everytownresearch.org/maps/notanaccident/#ns
[49] https://everytownresearch.org/report/notanaccident/
[50] https://www.forbes.com/sites/joewalsh/2022/01/05/us-bought-almost-20-million-guns-last-year---second-highest-year-on-record/?sh=76f30e2a13bb
[51] Cohen, J. S., Donnelly, K., Patel, S. J., Badolato, G. M., Boyle, M. D., McCarter, R., & Goyal, M. K. (2021). Firearms Injuries Involving Young Children in the United States During the COVID-19 Pandemic. Pediatrics, 148(1), e2020042697. https://doi.org/10.1542/peds.2020-042697

stored in the home and 20% who reported that their child had never handled a firearm were contradicted by the child's own report.[52]

Separate from, but equally important to, unintentional firearm discharges are intentional discharges- that is, youth firearm suicides. The rate of teenage firearm suicides increased nearly 60% between 2010 and 2019 and 20 years of research has shown that access to highly lethal means makes a substantial difference in outcome, with a 90% mortality rate when a firearm is used in a suicide attempt.[53] A 2014 metanalysis found an over 3 times greater likelihood of suicide among persons with firearm access compared to those without access[54] and a separate study found that parental decisions related to safe firearm storage were not impacted by the presence or absence of self-harm risk factors for their children.[55] The American Academy of Pediatrics (AAP) issued clear recommendations in 2012 that pediatricians "incorporate questions about the presence and availability of firearms into their patient history taking and urge parents who possess guns to prevent access to these guns by children."[56] Unfortunately, not all pediatricians are comfortable addressing firearm injury prevention with parents and a minority sampled in one study felt adequately trained in firearm safety.[57]

The best public health interventions to address this problem should be evidence based. When guns are present in a home with a young child, there is good evidence that gun storage practices that prevent child access have a direct impact on unintentional injury risk for children.[58] For that reason, the Panel applauds the Maine Legislature for passing LD 759[59] in 2021. Such negligence-based laws are the most likely to reduce unintentional injury. Further, the Panel also supports the Legislature's having passed LD 1392.[60]

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[52] Baxley, F., & Miller, M. (2006). Parental misperceptions about children and firearms. Archives of Pediatrics & Adolescent Medicine, 160(5), 542–547. https://doi.org/10.1001/archpedi.160.5.542

[53] Fleegler, E. W. (2021). Our Limited Knowledge of Youth Suicide Risk and Firearm Access. JAMA Network Open, 4(10), e2127965. https://doi.org/10.1001/jamanetworkopen.2021.27965

[54] Anglemyer, A., Horvath, T., & Rutherford, G. (2014). The Accessibility of Firearms and Risk for Suicide and Homicide Victimization Among Household Members: A Systematic Review and Meta-analysis. Annals of Internal Medicine, 160(2), 101–110. https://doi.org/10.7326/M13-1301

[55] Scott, J., Azrael, D., & Miller, M. (2018). Firearm Storage in Homes With Children With Self-Harm Risk Factors. Pediatrics, 141(3), e20172600. https://doi.org/10.1542/peds.2017-2600

[56] COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION EXECUTIVE COMMITTEE, Dowd, M. D., Sege, R. D., Gardner, H. G., Quinlan, K. P., Ewald, M. B., Ebel, B. E., Lichenstein, R., Melzer-Lange, M. D., O'Neil, J., Pomerantz, W. J., Powell, E. C., Scholer, S. J., & Smith, G. A. (2012). Firearm-Related Injuries Affecting the Pediatric Population. Pediatrics, 130(5), e1416–e1423. https://doi.org/10.1542/peds.2012-2481

[57] Cabrera, K. I., Fort, V. K., Bentson, B. H., Feldman, E. S., Guttadauria, B. C., Hartman, C. E., ... & Barone, S. R. (2021). Pediatrician Firearm Safety Screening and Counseling Practices in New York. Pediatrics, 147(3_MeetingAbstract), 108-110.

[58] Krass P et al. *Preventing Unintentional Injury & Death Among Youth: Examining the Evidence.* PolicyLab at Children's Hospital of Philadelphia; 2020. Retrieved from *http://bitly.com/Preventing-Unintentional-Firearm-Injury*

[59] https://legislature.maine.gov/legis/bills/display_ps.asp?PID=1456&snum=130&paper=&paperId=l&ld=759

[60] https://legislature.maine.gov/legis/bills/display_ps.asp?PID=1456&snum=130&paper=&paperId=l&ld=1392

Recommendations:

9. Unintentional firearm discharge and suicide by firearm prevention should be part of a comprehensive injury prevention program and strategy focused on the health and safety of Maine's children. This strategy should include evaluation of all current efforts and consideration of any emerging strategies to reduce the incidence of unintentional firearm discharges and deaths.
10. When provided with adequate staff and funding, MIPP staff should convene a multidisciplinary group of stakeholders and subject matter experts to develop a workplan consistent with Recommendation 9.
11. Pediatric healthcare providers, including family medicine providers in any setting should continue to follow AAP recommendations[61] related to firearm safety inquiries and safe storage guidance and solicit training opportunities to address their own comfort with and knowledge of this topic. Further, pediatric healthcare settings should have safe storage resources available to provide to families when a need for these resources is identified.

Ingestions

The Panel has expressed concern in 2021 regarding the frequency with which it sees reports of children ingesting various substances, including marijuana, and this concern is reflected in the data highlighted earlier in this report. While the increase in ingestion reports is not solely related to marijuana, the Panel Chair submitted testimony in April 2021 to the Joint Standing Committee on Veterans and Legal Affairs regarding marijuana ingestions in children, and the reader is referred to Appendix B. The Panel intends to examine the recent rise in ingestion reports to OCFS during 2022.

Recommendations:

12. Pediatric ingestion/poisoning prevention should be part of a comprehensive injury prevention program and strategy focused on the health and safety of Maine's children. This strategy should include evaluation of any current efforts and consideration of any emerging strategies to reduce the incidence of ingestions/poisonings in children.
13. When provided with adequate funding, MIPP staff should convene a multidisciplinary group of stakeholders and subject matter experts to develop a workplan consistent with Recommendation 12.
14. The Maine Legislature and/or the Maine Office of Marijuana Policy should prohibit the sale, marketing, or labeling of marijuana containing products in packaging that is attractive or appealing to children.

[61] https://www.aap.org/en/patient-care/gun-safety-and-injury-prevention/

15. The Maine Legislature and/or the Maine Office of Marijuana Policy should require that marijuana containing products be sold in child-proof packaging.
16. The Maine Legislature should consider an additional amendment (see footnote 47) to 17-A MRS 23, §554,[62] establishing that endangering the welfare of a child also includes failure to properly secure or otherwise prohibit a child's access to marijuana containing products.

Unsafe Sleep Related Deaths

The Panel has, for many years, been aware of the reality in Maine that an average of 1 infant dies per month in circumstances that involve some manner of an unsafe sleep environment. The American Academy of Pediatrics has offered clear guidance[63] on what constitutes a safe infant sleep environment and has made this information accessible to parents.[64] Specific efforts by the Maine CDC's Maternal and Child Health (MCH) Program in recent years have included a public awareness and education campaign.[65] Additionally, the DHHS Commissioner asked all Maine birthing hospitals[66] to become Safe Sleep Certified[67]in 2019. This was accomplished by April 2021. The MCH Program and Perinatal Quality Collaborative for ME (PQC4ME) also supported hospitals doing a quality improvement project to educate on safe sleep environments in the hospital and support families when they get discharged home. Based on data reviewed by the Panel, these activities correlated with a 50% reduction in unsafe infant sleep related deaths in 2020. Data and cases for 2021 are still being reviewed and investigated, but provisional numbers suggest that 50 % reduction was maintained during 2021. The MCH Program intends to continue its public awareness and education activities on this topic. The Panel supports these ongoing efforts to intervene by the MCH Program as well as the efforts of all Maine birthing hospitals to continue to meet Safe Sleep Certification standards. Additionally, the Panel supports ongoing efforts by OCFS staff to educate families with whom they are involved about infant safe sleep and encourages all care/service providers in all settings to do the same.

Recommendations:

17. The Maine CDC Maternal and Child Health Program should continue its focus on unsafe infant sleep related deaths, including public awareness and education messaging.

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[62] https://legislature.maine.gov/statutes/17-A/title17-Asec554.html
[63] Moon, R. Y. & TASK FORCE ON SUDDEN INFANT DEATH SYNDROME. (2016). SIDS and Other Sleep-Related Infant Deaths: Evidence Base for 2016 Updated Recommendations for a Safe Infant Sleeping Environment. Pediatrics, 138(5), e20162940. https://doi.org/10.1542/peds.2016-2940
[64] https://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx
[65] https://safesleepforme.org/
[66] https://www.maine.gov/dhhs/mecdc/population-health/mch/perinatal/documents/Maine-Birthing-Hospitals-Map-2018.pdf
[67] https://cribsforkids.org/hospitalcertification/

18. All service providers (medical, social services, childcare, etc.) in all settings should reinforce infant safe sleep messaging when working with caregivers of children under 1 year of age.

Systemic Observations and Recommendations

Beyond specific injury types, over the course of its 2021 reviews, the Panel has also noted several larger systemic challenges that highlight opportunities for improvement. These opportunities exist not just among Maine's OCFS, but also among the broader child welfare system. It is worth noting the issues mentioned below are rarely, if ever, able to be isolated as the single factor leading to a child's death or serious injury.

Failure to consult with Child Abuse Pediatrics subspecialty services

In 2006, the American Board of Pediatrics granted formal subspecialty status in Child Abuse Pediatrics (previously known informally as "Forensic Pediatrics") in 2006, offering their first board certification exam in 2009.[68] One hundred ninety-one physicians passed that initial exam and 394 Child Abuse Pediatricians (CAPs) are board certified in the US as of December 2021.[69] While the total number of CAPs has increased, the number of certifications granted with each exam offering has fallen consistently since 2009.[70] In 2018, Child Abuse Pediatrics had the fewest number of first year fellows among all the pediatric subspecialties, filling just 67% of available first year fellowship openings,[71] and the average age of CAPs is the sixth oldest among 21 pediatric subspecialties which portends a serious shortage of practicing CAPs.[72] Most CAPs practice through affiliation with academic teaching hospitals, while Maine's CAP presence is housed in and supported entirely by Spurwink Services, a non-profit organization that provides behavioral health and education services to children, adults and families.[73] Maine has been fortunate to have had the services[74] of a CAP without interruption for 35 years and the availability of this subspecialty care has been a crucial component of the broad child welfare system. Most recently, the staffing realities of these services have proven inconsistent with a sustainable model of

[68] Jenny, C. (2008). Medicine Discovers Child Abuse. JAMA, 300(23), 2796. https://doi.org/10.1001/jama.2008.842
[69] Angelo P. Giardino, Nancy Hanson, Karen Seaver Hill, John M. Leventhal; Child Abuse Pediatrics: New Specialty, Renewed Mission. Pediatrics July 2011; 128 (1): 156–159. 10.1542/peds.2011-0363
[70] https://www.abp.org/content/pediatric-subspecialists-ever-certified
[71] Macy, M. L., Leslie, L. K., Turner, A., & Freed, G. L. (2021). Growth and changes in the pediatric medical subspecialty workforce pipeline. Pediatric Research, 89(5), 1297–1303. https://doi.org/10.1038/s41390-020-01311-7
[72] https://www.abp.org/content/age-comparison-pediatric-subspecialists
[73] https://spurwink.org/about/#mission
[74] https://spurwink.org/youth-and-family/youthbehavioralhealth/spurwink-center-for-safe-healthy-families/

practice; one physician cannot reasonably be available to an entire state, around the clock, every day of the year, even with existing nurse practitioner support.

In its 2021 reviews, the Panel has found several examples of cases in which the involvement of and consultation with a CAP was not sought by either OCFS or medical staff[75] or was sought but then had a case disposition while that consultation was still pending. Such examples include:

- cases in which Failure to Thrive was a concern and there were notable psychosocial factors impacting the case trajectory

- cases in which young children in Emergency Departments had inappropriate screening criteria [76] for head imaging studies applied, resulting in a lack of appropriate imaging studies being performed, and thus potentially missing clinically minor but forensically significant injuries

- cases in which sentinel injuries were not properly identified by medical providers and therefore not reported, resulting in children being left in potentially unsafe circumstances

- cases in which a forensic opinion[77] is offered by a non-forensic medical provider, resulting in inappropriate case management decisions by OCFS staff

- cases in which non-CAP medical providers report subjective case information[78] to OCFS, potentially influencing the objectivity of a related assessment

- cases in which OCFS staff referred a child/family for CAP evaluation but then closed an investigation while that evaluation was still pending

- cases in which medical staff referred a child/family for CAP consultation but then discharged a patient from their care prior to the evaluation being completed

- cases in which medical staff completed a report to OCFS, followed by OCFS requesting a CAP evaluation, but the medical staff discharge a patient from their care while that evaluation is pending

The importance of CAP evaluation or consultation in cases that are psychosocially complex or in which there is (or should be) doubt about the cause or origin of an apparent injury cannot be overstated. While it would be easy to assume that CAPs would be most likely to diagnose abuse in most of the cases referred to them, the Panel has found that CAP consultation often results in a non-abuse diagnosis, thus preventing inappropriate OCFS, law enforcement, or even medical

[75] "Medical staff" as used in this report refers to physicians, physician assistants, nurses, nurse practitioners or any other professional in any medical setting.
[76] https://californiaacep.org/page/PECARN
[77] "Forensic" as used in this report means "relating to or dealing with the application of scientific knowledge to legal problems." https://www.merriam-webster.com/dictionary/forensic
[78] "Subjective case information" refers to observations by medical staff or other professionals such as whether a caregiver is "appropriately concerned" about their child or is "loving and attentive." Such information may be accurate but has no diagnostic relevance in the assessment of a concerning injury.

intervention. The value of CAP consultation, as well as the degree to which that consultation results in an opinion different from that of a primary medical or Child Protective Services staff member, has been noted in the relevant literature.[79, 80] Like other subspecialties, CAP services should ideally be available to the medical, child protective, and law enforcement professionals in Maine at any time of the day or night.

Recommendations:

19. The provider of Child Abuse Pediatrics sub-specialty services in Maine should maintain its efforts to provide appropriate training to the medical and social services community.
20. The provider of Child Abuse Pediatrics sub-specialty services in Maine should maintain its efforts to recruit and retain at least two board-eligible or board-certified Child Abuse Pediatricians.
21. The major healthcare organizations who provide pediatric care in Maine, as well as OCFS, should collaborate with Spurwink Services to support at least two Child Abuse Pediatricians as well as the sustainability of their services.
22. OCFS staff who request Child Abuse Pediatrics evaluation as part of a child protection investigation should not end their investigation until the results of the CAP evaluation are available to be incorporated into the OCFS case analysis.

OCFS staff- workforce

The Panel has long noted the complexity and difficulty of child welfare work conducted by OCFS staff. Recent efforts[81] by OCFS administrators, spurred in part by legislative directive,[82] to properly evaluate the various dimensions of workload should be commended. The Panel recognizes that achieving optimal outcomes for children and families requires a strong, well-trained, supported, and resilient workforce. While workload analysis and management is certainly one aspect of creating and maintaining that workforce, another component that must be considered is the impact the nature of child welfare work has on the workforce. Issues of primary and secondary trauma, post-traumatic stress, burnout, and turnover are critically

[79] McGuire, L., Martin, K. D., & Leventhal, J. M. (2011). Child Abuse Consultations Initiated by Child Protective Services: The Role of Expert Opinions. Academic Pediatrics, 11(6), 467–473. https://doi.org/10.1016/j.acap.2011.06.005

[80] Anderst, J., Kellogg, N., & Jung, I. (2009). Is the diagnosis of physical abuse changed when Child Protective Services consults a Child Abuse Pediatrics subspecialty group as a second opinion? Child Abuse & Neglect, 33(8), 481–489. https://doi.org/10.1016/j.chiabu.2009.05.001

[81] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/2021%20OCFS%20Workload%20Report.pdf

[82] https://legislature.maine.gov/legis/bills/getPDF.asp?paper=HP0595&item=3&snum=129

important.[83] To its credit, OCFS has engaged Spurwink Services to provide clinical support for its staff to mitigate the adverse impact [84]of child welfare work. Unfortunately, the services available through this support program do not include any evaluation of its effectiveness in meeting its goals. The Panel reasonably hopes that such services could have significant positive influence on not only individual well-being, but also workforce metrics, such as decreased rate of turnover, lower number of vacancies, decreased absenteeism, increased length of service, and increased productivity. The absence of an evaluation component may make it difficult to justify the continuation of what is likely a very valuable service being provided to OCFS staff, particularly if/when funding priorities change.

After-hours or "standby" coverage is another workforce management topic that has received attention[85] over the past year and one that the Panel has noted as a challenge. OCFS has tried various methods of providing coverage outside the standard workday over the course of many years. Such coverage is necessary in one form or another, since OCFS staff are as much first responders as law enforcement, firefighters, and EMS professionals and child maltreatment neither begins at 8 AM nor ends at 5 PM. The Panel is aware that OCFS is actively considering alternatives for after-hours coverage, including the Governor's proposal/request to fund 16 new caseworker and 3 new supervisor positions to cover night and weekend shifts.[86] The Panel welcomes these efforts as a method of both enhancing the quality of after-hours services and enhancing the well-being of OCFS staff.

Recommendations:

23. OCFS administrators should continue their regular analysis of workload metrics to ensure Maine's workforce management practices are consistent with accepted standards for best practice in child welfare.

24. OCFS administrators should continue to contract for services that provide for the clinical support of OCFS staff and those contracts should include an evaluation component for the services being provided.

25. OCFS administrators should continue their evaluation of best practice standards for the provision of after-hours coverage and request any necessary funding or support to meet those standards.

[83] https://www.childwelfare.gov/topics/management/workforce/workforcewellbeing/burnout/secondary/
[84] https://www.acf.hhs.gov/trauma-toolkit/secondary-traumatic-stress
[85] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Maine%20Review%20Summary%20Report%20and%20Recommendations.pdf at p17-18
[86] https://www.maine.gov/governor/mills/news/governor-mills-unveils-bipartisan-legislation-budget-initiatives-strengthen-child-welfare

26. The Maine Legislature should appropriate adequate funding to support OCFS' provision of after-hours coverage.

OCFS staff- practice

As stated earlier, the Panel has long recognized the complexity of child welfare casework and supervision. During its 2021 reviews, the Panel noted several persistent themes related to child welfare casework and supervision. Those include:

- Proper identification and use of child maltreatment risk factors for case planning, service referral, and evaluation of adequacy of services, including both failure to recognize known risk factors and failure to solicit information from collateral sources related to those risk factors
- Inability or unwillingness to challenge or otherwise address instances of parents and caregivers being found to not be truthful in their communication with OCFS staff, adversely impacting OCFS ability to accurately determine a child's level of risk
- The potential to view moderate severity cases as lower risk than they may truly be, because of more frequent exposure to higher severity cases
- Failure to acknowledge and appropriately attend to the totality and complexity of factors or dynamics involved in a case, including past incidents and involvements with OCFS, instead focusing a limited scope of inquiry on just the specific incident reported, particularly in cases involving failure to thrive and firearm injuries
- The consideration of complex domestic violence dynamics when developing plans for safety, such as allowing one parent to supervise the other despite a history of domestic violence concerns
- Characterization of a firearm related injury or fatality as an "accidental" firing of a weapon, rather than focusing on the caregiver action, inaction or behaviors that created the conditions in which the injury or fatality occurred
- The inefficiency and increased workload of documentation requirements including duplication of identical notes when more than one case member is part of a single conversation, as well as the need to manually enter e-mail or text message exchanges with a case member into the MACWIS[87] system
- The value of Family Team Meetings being convened at points of critical case decisions and resulting deficiency in practice when those meetings are not held

[87] Maine Automated Child Welfare Information System

- Inconsistent findings of child maltreatment in fatality cases with similar circumstances due to a focus on avoiding compounding of a tragic event for the caregivers
- Involvement of Regional Associate Directors (RADs) in the management of and decision making for serious injury and death cases during the initial OCFS response, but not at the conclusion of the response, perhaps contributing to inconsistent findings and decision making
- Reliance upon opinions of professionals to guide case decisions, even when those professionals lack subject matter expertise
- The importance of providing high quality supervision to assist caseworkers with adequate case analysis, identification of risk and protective factors, consideration of relevant history a family has with OCFS, and appropriate case planning
- The reality that newer caseworkers require substantially more supervisory attention, support, and education than longer serving workers and that the workload associated with supervising a unit of several experienced workers is substantially different than that of a unit with several relatively new workers.

These complex issues reflect just some of the reasons why child welfare work is so challenging. Recognizing that sole focus on OCFS caseworker and supervisor practice will not solve the problem of child maltreatment, the Panel makes the following recommendations.

Recommendations:

27. OCFS should continue to look for ways to increase the efficiency of its staff and reduce the need for duplicative work, while maintaining an appropriate focus on safety, permanency, and well-being for children and families.
28. OCFS should, in addition to its continued attention to caseworker workload, consider the complexity of the supervisory role and include analysis of supervisor level metrics in its ongoing workload analysis.
29. OCFS should continue to make use of the resources available through the Maine Coalition to End Domestic Violence Child Protective Services initiative[88] and ensure that caseworkers and supervisors have access to the co-located DV/CPS liaisons provided through that initiative.
30. OCFS should include RADs in decisions related to investigation outcomes, findings of child maltreatment, and case closure when those cases include child deaths and serious injuries.

[88] https://www.mcedv.org/initiatives/

31. OCFS should review both its initial training and continuing education curriculum at regular intervals, to ensure that OCFS staff have the most up to date information in the field to optimize their casework and decision making.

32. OCFS should ensure that its staff have awareness of and access to the services of professionals with subject matter expertise in areas including, but not necessarily limited to, Child Abuse Pediatrics and adult and child psychopathology.

Multidisciplinary child welfare system

When a child is injured or killed, particularly if child abuse and/or neglect is involved, there are often understandable calls for accountability, program review, and the need for change. Too often, these calls are focused solely on the state agency whose charge is to protect children from such abuse or neglect. The deaths and injuries of children related to child maltreatment reflect a much broader systemic failure in our society. The label "child welfare system" in Maine is frequently understood to apply only to OCFS; however, the Panel has long recognized that OCFS is merely one piece of a larger system. Accordingly, and in addition to observations and recommendations noted earlier in this report, the Panel has identified several elements of and examples in the child welfare system that warrant attention and improvement. These include:

- The frequent lack of existing or accessible mental health services for families, particularly in more rural areas of Maine
- When services do exist, the providers of those services are infrequently trained in the complexities of working with maltreating families who are referred for intervention by OCFS staff
- The absence of such specialized, forensic training results in an inability to adequately assess and communicate a caregiver's progress in necessary services, as that progress specifically relates to the safety, permanency, and well-being of the child/ren in question
- The tendency of a parent's or family's service provider to align themselves with the interests of the parent or to focus their clinical work on issues identified by the parent, rather than focusing on factors that prioritize the child or would ultimately allow the parent to safely care for the child
- The provision of long-term case management or clinical services to families with no apparent change in baseline functioning of the family or its members and thus no change in baseline safety for children
- The lack of service provider understanding of risk and safety factors in a family that may have prompted OCFS involvement, resulting in a deficient approach to the provision of services

- The absence of a well-coordinated, public health focused, injury prevention program
- The inadequacy of the existing Court Ordered Diagnostic Evaluation (CODE) system to meet the ongoing need for clinical, child maltreatment focused evaluation of parents and caregivers in all areas of the state

Ultimately, it is the duty of a society's child welfare system, defined broadly and beyond the systems identified in this Panel report, to ensure children's safety and well-being. The Panel supports efforts to enhance that system, such as ongoing work among hospitals, law enforcement and OCFS to enhance their collaboration in child maltreatment cases, efforts to expand the pool of TF-CBT[89] clinicians available in the state,[90] and implementation of the Family First Prevention Services Act.[91] As was noted in the Panel's 2017-2020 report, the Panel also continues to recognize that universal approaches to enhancing family wellbeing and functioning, or even somewhat more targeted interventions (such as in the aftermath of trauma), may be helpful to most families, but they will continue to be inadequate to meet the needs of those families with the highest levels of complexity.

Recommendations:

33. OCFS and Office of Behavioral Health (OBH) administrators and providers of community based behavioral health services should continue to collaborate to build the capacity and skill set of the behavioral health workforce in Maine, as it relates to child and family health and wellness.
34. OCFS, OBH (including but not limited to the State Forensic Service[92]), and the Office of the Attorney General (OAG) should convene a workgroup whose purpose is to develop recommendations, including legislative funding requests, for the creation of a functional system of evaluators with expertise in complex child maltreatment cases who are available in all areas of the state.
35. The Legislature should strongly consider any funding requests for program development consistent with recommendation 34.

[89] https://tfcbt.org/
[90] https://content.govdelivery.com/accounts/MEHHS/bulletins/28f16dd
[91] https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/system-improvements-initiatives/families-first-prevention-act
[92] https://legislature.maine.gov/statutes/34-B/title34-Bsec1212.html

COVID-19 impact

There have been myriad ways in which the impact of the COVID-19 pandemic has been experienced in Maine and the child welfare system has not been immune. During its 2021 reviews, the panel has noted several concerns related to the pandemic's influence.

- Child and family service systems that traditionally relied on in-person contact were forced to either pivot to virtual services or cease operation, at least temporarily
- Telehealth services became the norm, however the lack of reliable broadband internet access in many areas in rural Maine adversely impacted the ability of children and families to access those services
- Despite the proliferation of telehealth service availability, there was also an increase in children and families in need of behavioral health care services concurrent with significant workforce shortages, leading to long waiting lists and help not being available to families when it was needed
- Families became reluctant to bring their children to medical providers for recommended well-child visits in their primary care offices, a setting in which many needs can be addressed proactively, and acute problems can be identified
- Families were resistant to allowing the few remaining community-based service providers offering in-home services into their homes, for fear that they would bring coronavirus with them
- Public health nursing staff, a critical component of the support and intervention system for not just families at risk, but all families, were nearly all assigned to contact tracing or other public health duties, again leaving gaps akin to the primary care setting
- Court ordered or OCFS recommended service availability changed, undoubtedly influencing the timeliness of progress to permanency for children whose cases were subject to judicial oversight
- Housing shortages resulted in some families allowing unsafe individuals, who had nowhere else to go, back into their homes, creating significant adverse impacts to children's safety
- Truancy and other school-based reporting of abuse and/or neglect decreased as children transitioned to remote schooling alternatives
- Primary caregivers were unable to care for their children while ill, leaving them instead in the unsafe care of other overwhelmed and ill-equipped substitutes

Certainly, Maine is not unique in its experience. An Associated Press (AP) analysis of child welfare data from 36 states published in March 2021 found double digit decreases in the total number

of child maltreatment reports and investigations early in the pandemic, yet also found evidence of increased case severity, complexity, and urgency to respond, as well as increased numbers of child maltreatment fatalities and near fatalities in the states whose data was reviewed.[93] Some in the field have attempted to strike a more positive, hopeful tone related to the decreased number of maltreatment reports, including the Colorado Office of Children, Youth and Families Director, who told the AP when interviewed for the same article, "It's possible that families and communities came together and weathered this storm together." This view has been shared by others in the child welfare field since, including Drs. Sege and Stephens from Tufts Children's Hospital. An article they published in December 2021 acknowledged that while some medical centers around the country had seen an increase in child abuse related admissions, there remained a "missing epidemic of child abuse" in the pandemic context at the population level. They hypothesize various reasons, including the possibility that government assistance to families in financial distress may be protective, that increased parental presence at home may improve attachment, that parent/child collaboration on schoolwork may build stronger relationships, and that survey data reflecting widespread positive parenting practices reduces corporal punishment- a substantial physical abuse risk factor.[94]

The true role of the pandemic in child abuse and neglect trends likely won't be fully understood for some time. The Panel's ability to evaluate pandemic influence in specific cases in which Maine children have died or been seriously injured will also be delayed, given limitations on the Panel's ability to conduct timely case reviews.

Conclusion

The underlying causes of and contributing factors to the deaths and serious injuries of Maine's children in recent years, as they are whenever such events take place, are complex. Simple solutions and kneejerk reactions are rarely, if ever, effective, and Maine's children deserve the protection and advocacy of their entire communities. There are things that can be done and steps that can be taken to improve current systems. The Panel is committed to continuing its work as one of Maine's Citizen Review Panels to examine these most challenging cases with the goal of identifying additional opportunities for improvement. We do so with the hope and belief that whatever lessons may be learned from one child or family's tragic outcome can inform improvements to the broad child welfare system that will prevent similar tragedy for others. We do so with gratitude to those who choose to work to improve the lives of Maine's children and families, both within the Maine OCFS and outside of it. And we do so to honor those whose lives could not be adequately impacted in time to prevent their serious injury or death.

[93] https://apnews.com/article/coronavirus-children-safety-welfare-checks-decline-62877b94ec68d47bfe285d4f9aa962e6

[94] Sege R, Stephens A. Child Physical Abuse Did Not Increase During the Pandemic. JAMA Pediatr. Published online December 20, 2021. doi:10.1001/jamapediatrics.2021.5476

Appendix A: 2021 Panel Membership

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

Amanda Brownell, MD, Vice Chair
Medical Director, Spurwink Center for Safe and Health Families

Kathryn Brice, MSc, LSW, Panel Coordinator
Panel Coordinator, Maine Office of Child and Family Services

Elsie-Kay Banks
Medicolegal Death Investigator, Office of Chief Medical Examiner

Amy Belisle, MD, MBA, MPH
Chief Child Health Officer, Maine Department of Health and Human Services

Betsy Boardman, Esq.
Child Protective and Juvenile Process Specialist, State of Maine Judicial Branch

Adrienne Carmack, MD
Medical Director, Maine Office of Child and Family Services

Lyn Carter
Rural Grant Program Coordinator, Maine Coalition to End Domestic Violence

Lauren Edstrom
Detective, Maine State Police, Major Crimes Unit- South

Matthew Foster, Esq.
District Attorney, Hancock and Washington Counties

Brieanna Gutierrez
Communications and Compliance Manager, Maine Office of Child and Family Services

Julie Hardacker, BSN
Public Health Nurse II, Maine Center for Disease Control and Prevention

Sandi Hodge
Retired child welfare professional

Tracy Jacques, Esq.
Director of Licensing, Maine Office of Marijuana Policy

Bobbi Johnson, LMSW
Associate Director of Child Welfare Services, Maine Office of Child and Family Services

Todd Landry, Ed.D.
Director, Maine Office of Child and Family Services

Jeffrey Love
Lieutenant, Maine State Police, Major Crimes Unit- North

Marianne Lynch, Esq.
District Attorney, Penobscot and Piscataquis Counties

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

Tessa Mosher
Director of Victim Services, Maine Department of Corrections

Karen Mosher, PhD
Retired community mental health professional

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

Geoff Parkin, Esq.
Assistant Attorney General, Child Protection Division Office of the Attorney General

Hannah Pressler, DNP
Pediatric Nurse Practitioner

Lawrence Ricci, MD
Child Abuse Pediatrician

Tammy Roy, LSW
Child Welfare Project Manager, Maine Office of Child and Family Services

Kaela Scott, Esq.
GAL Services Coordinator, State of Maine Judicial Branch

Nora Sosnoff, Esq.
Chief, Child Protection Division, Maine Office of the Attorney General

Christine Theriault, LMSW
Family First Prevention Services Manager, Maine Office of Child and Family Services

Briana White, Esq.
Assistant Attorney General, Child Protection Division, Maine Office of the Attorney General

Leane Zainea, Esq.
Assistant Attorney General, Criminal Division, Maine Office of the Attorney General

Appendix B:

Testimony of
Mark W. Moran, LCSW
Chair, Maine Child Death and Serious Injury Review Panel
Before the Joint Standing Committee on Veterans and Legal Affairs

LD 1319- An Act Regarding Registered Dispensaries and Rules under the Maine Medical Use of Marijuana Act and the Definition of "Resident" in the Marijuana Legalization Act

LD 1242- An Act to Ensure Appropriate Oversight of Maine's Medical Marijuana Program

Hearing Date: April 23, 2021

Senator Luchini, Representative Caiazzo, and members of the Joint Standing Committee on Veterans and Legal Affairs:

My name is Mark Moran. I am a Licensed Clinical Social Worker and the Chair of Maine's Child Death and Serious Injury Review Panel (CDSIRP)* and I am submitting this testimony relative to your work on the above referenced legislation. The mission of the Panel is to promote child health and well-being, improve child protective systems, and educate the public and professionals who work with children in order 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, as well as public and private entities, are developed. As you consider these bills and any other related matters, I, as Chair of the Panel, ask that you consider the implications for Maine's children of how Maine's marijuana programs are managed and regulated.

As medicinal and recreational marijuana laws have evolved across the United States over the past several years, the incidence of reports to poison control centers and encounters with medical services related to unintended pediatric ingestions of marijuana have increased significantly. The unintentional ingestion of cannabis by children is a serious public health concern and is well-documented in the medical literature.[1] While much of the published research on this topic originates in the western half of the country, this problem has also been noted closer to home. A study conducted in Massachusetts in 2019 revealed a 137% increase in the number of cases of pediatric cannabis ingestions and unintended cannabis-related consequences called to the Regional Center for Poison Control and Prevention during the four years following medical marijuana legalization, as compared to the four years preceding legalization. The same study also showed a significant increase in ingestions of edible cannabis products by children 0-4 years of age during the same time periods.[2] In Maine, calls to the Northern New England Poison Control Center for pediatric marijuana exposures rose from 2014 to 2020 among children of all ages. The largest increase was seen in children 0-5 years of age, from 4 to 23 calls in 2014 and 2020, respectively, reaching a peak of 28 calls in 2019. Nearly all these exposures involved ingestions. In that same age group, 40% of the children experienced moderate or greater clinical effect from the exposure, while the overall rate of moderate or greater clinical effect in this age group for all substance exposures is only 1%.[3] Maine's children, like others around the country, have experienced cannabis ingestions from a variety of sources, including (but not limited to) baked goods, hard candy, gummies, oil, and beverages.

Young children who have ingested marijuana or marijuana containing products can present with a variety of symptoms, though the overwhelming majority are neurological in nature. Those symptoms can include tremors, difficulty walking, extreme lethargy, or coma. Some children may experience respiratory depression and require a breathing tube and a ventilator to support their recovery. Others may experience symptoms such as decreased heart rate, low blood pressure, electrolyte abnormalities, agitation, and, rarely, seizures.[4] Medical care may include outpatient, emergency department, or inpatient management, including transfer or admission to a Pediatric Intensive Care Unit, with length of stay ranging from hours to days.

In October 2020, the American Public Health Association (APHA) published an updated policy statement advocating for a public health approach to regulating commercially legalized cannabis.[5] In that statement, they call for policy actions that protect children, by careful regulation of the availability and access to cannabis products. Such protections would include advertising restrictions, regulations governing characteristics of cannabis products that may appeal to children (flavors, shapes, forms, names, imagery, etc), and regulations governing packaging (plain, opaque, child resistant, use of a universal symbol, etc). Additionally, the APHA recommends the monitoring of related public health and safety outcomes. Certainly, pediatric ingestions are an important safety outcome to monitor.

The Medical Marijuana Program Rule currently being proposed by the Maine Office of Marijuana Policy contains several of the APHA recommended protections. The existing professional literature suggests the problem of pediatric ingestions is only going to continue to increase. I encourage both the Committee and the OMP to be attentive to the downstream impact of the rules governing Maine's marijuana programs on Maine's children and to the opportunities that exist to help protect and enhance safety for Maine's children. Thank you for your consideration and for the opportunity to provide this testimony.

References

1. Richards, J. S. (2017). Unintentional Cannabis Ingestion in Children: A Systematic Review. *The Journal of Pediatrics*, 142-152.

2. Whitehill, J. e. (2019). Incidence of Pediatric Cannabis Exposure Among Children and Teenagers Aged 0 to 19 Before and After Medical Marijuana Legalization in Massachusetts. *JAMA Network Open*, 1-10.

3. Northern New England Poison Control Center (2021, April 21). Personal Communication.

4. Wong, K. (2019). Acute Cannabis Toxicity. *Pediatric Emergency Care*, 799-804.

5. American Public Health Association (2020, October 24). A Public Health Approach to Regulating Commercially Legalized Cannabis.

**While the CDSIRP includes representatives from Maine's Office of Child and Family Services, this testimony does not necessarily reflect the official opinion of OCFS.*

Appendix C:

Presentation of
Mark W. Moran, LCSW
Chair, Maine Child Death and Serious Injury Review Panel
Before the Government Oversight Committee
September 8, 2021

Senator Libby, Representative McDonald, and members of the Government Oversight Committee:

My name is Mark Moran and I am the Chair of the Maine Child Death and Serious Injury Review Panel. I have served in this role since 2014 and I have been a panel member since 2008. I was a Child Protective Services Caseworker in Bangor for 5 years and I have been a hospital-based Women's and Children's Services social worker since 2006. Additionally, I have been a volunteer Guardian ad Litem in child protection cases for the Maine Court Appointed Special Advocate program since 2009. I'm here today to provide you with an overview of the structure and function of the Panel, after which I would be happy to try to answer any questions you may have.

Multidisciplinary child abuse and neglect fatality reviews in Maine began in the early to mid-1980's under former Department of Human Services Commissioner Michael Petit, who I believe you heard from at your August 11 meeting. The review panel was re-activated in the early 1990's under former DHS Commissioner Jane Sheehan and eventually codified in Maine statutes in 1993. To the best of my knowledge, these statutes, as they relate to our Panel, have not been substantively amended since their adoption.

The current 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.

Maine's Panel is authorized specifically in Title 22, section 4004. Under this statute, our purpose is "to recommend to state and local agencies methods of improving the child protection system, including modifications of statutes, rules, policies, and procedures." The Panel's membership is established in this same section, and the Panel has historically viewed the members or disciplines specifically referenced in the statute as the minimum membership, rather than an exhaustive list. Accordingly, our Panel currently has 29 members, including multiple OCFS senior administrators and representing a variety of disciplines.

The Panel typically meets for 3 hours on the first Friday afternoon of the month, 10 months per year. Under Title 22 section 4008, "the proceedings and records of the Panel created in accordance with section 4004 subsection 1 paragraph E are confidential and not subject to subpoena, discovery, or introduction into evidence in a civil or criminal action." The statute further states "The Commissioner shall disclose conclusions of the review panel upon request but may not disclose data that is otherwise classified as confidential." Pursuant to Title 22 section 4021, the Department may issue subpoenas for information relevant to the Panel's work.

The Panel reviews cases in one of three ways. First, the panel periodically reviews and discusses brief summary reports of all child deaths and serious injuries that are reported to OCFS. We refer to these as Level 1 reviews, and our intention here is to take a broad view of the kinds of cases, injuries, and deaths being reported, looking for themes or commonalities that would provide good opportunity for further

review and for the generation of recommendations. Second, if a theme is identified, the Panel may conduct what we call Level 2 reviews, or cluster reviews. The Panel would select 2-4 cases that involve some common thread and over the course of a meeting, dig deeper into those specific cases. The Panel is provided with OCFS records of all the selected cases to inform our review. Third, if an individual case is particularly noteworthy, the Panel may decide to conduct a Level 3 review, our most in depth review. In addition to being provided OCFS records for the specific case under review, we also are provided with other related records, such as law enforcement reports, mental health records, medical records, or educational records. Some of these may already be contained within the OCFS file for a given case or may need to be obtained via subpoena. Additionally, in a Level 3 review, the Panel invites selected professionals who have been involved in a case to attend a portion of the review meeting. Such professionals might include the OCFS caseworker and supervisor, a detective, school personnel, a Public Health Nurse, a child's pediatrician, or others. This gives the Panel an opportunity to ask questions directly to those who were most closely involved with the family or child. It is worth noting that quality case review requires a substantial time commitment of Panel members not only to attend meetings, but also to review the hundreds of pages of records and documentation associated with these cases prior to the Panel's monthly meeting. Additionally, some Panel members jointly review cases with Maine's Domestic Abuse Homicide Review Panel as standing members of that Panel or at the case specific invitation of that Panel's Chair, Ms. Marchese.

Beyond the inclusion of a case in a summary report of all child deaths and serious injuries, the Panel is prohibited from reviewing a case in depth if there is a pending prosecution. This is based on guidance from the Office of the Attorney General pursuant to Title 22 sections 4004 and 4008. The effect of this restriction, well-reasoned though it may be, is ultimately to delay the Panel's review of most child death and serious injury cases for months or years, thus limiting our ability to help influence change in a timely fashion.

In addition to our case review work, the Panel periodically participates in multiple other activities to inform our primary role. For example, the Panel might request a presentation by a subject matter expert on a specific topic related to a recent or upcoming review or might be educated about a new OCFS policy or practice change. The Panel also participates in annual meetings with other similar review teams from the New England states and New Brunswick. Such regional meetings usually involve an educational topic, updates from each state, updates from the National Center for Fatality Review and Prevention, networking opportunities, and sometimes case reviews that involve multiple states' jurisdictions.

Regarding the Panel's reporting, Maine's relevant statutes do not explicitly require the Panel to report at any particular interval or to any particular entity. Historically, the Panel has submitted its periodic reports through OCFS to the office of the Commissioner of Health and Human Services. The Panel's influence, however, is quite minimally tied to its formal reporting. Given the multidisciplinary nature of our membership, the recommendations generated by the Panel directly and indirectly influence real-time policy and practice decisions in several arenas, including, but not limited to, OCFS. Some additional examples of more recent ways the Panel has attempted to influence children's welfare in Maine include sending a letter from the Panel to the Board of Licensure in Medicine about mandatory reporting requirements, submitting legislative testimony on behalf of the Panel, and working with the Maine Chapter of the American Academy of Pediatrics to further educate medical providers about recognition of child abuse and neglect. The Panel is currently in the process of finalizing a report summarizing its work over the past five years and has developed a process and timeline to support the publication of annual reports moving forward.

In closing, I would like to impress upon you a few key points related to the Panel's work. First, the welfare of Maine's children is everyone's job, not just that of OCFS. The child welfare system is far more broad than OCFS caseworkers, supervisors, and administrators. It includes not just professionals who have direct contact with children and families, such as law enforcement, educators, the medical community, counselor types, and judicial system members (among many others), but also every other citizen in our communities- including our elected officials- who directly or indirectly help create, sustain, or alter the environments in which children are being raised.

Second, these now 5 publicly reported child homicides since June 1, 2021 may be the current focus of the media, the legislature, and our communities, but please understand that these recent high-profile cases are but a small fraction of the bad outcomes and experiences children have at the hands of their caregivers. It is easy, perhaps even natural, to want to place blame on a person or a group or an agency when something bad happens to a child. Finding a target for our emotion may make us feel better, but it ultimately does little or nothing to improve the next child's chances. Where did and where do we, the broad child welfare system, fail not only these deceased children, but also the many others you won't hear about? What needs to change systemically to prevent such failures in the future? These are incredibly complex cases that warrant very complex considerations. None of us is smart enough to do this work alone. Timely case reviews conducted by broadly experienced, multidisciplinary groups are critical.

Third, and finally, the current attention garnered by these recent cases creates an opportunity to examine and improve not just the factors that contributed to bad outcomes for children and families, but also to examine and improve the ways in which the system responds to such events. I, on behalf of my fellow Panel members, appreciate the opportunity to address the Committee today, and I look forward to being able to provide whatever assistance I can as we all work together to improve our broad child welfare system.

Thank you for your time and attention. I'm happy to try to answer any questions you may have.