2024-2025 Annual Report

Maine Child Death and Serious Injury Review Panel

The Child Death and Serious Injury Review Panel would like to thank all providers, DHHS staff and law enforcement that supported the Panel's case reviews. Their participation adds to their complex workload, and their contributions are key to the multidisciplinary work of the Panel.

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& with the support of the Panel Coordinator.

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Introduction from the Chair and Vice Chair

It is an honor to present this Annual Report of the Child Death and Serious Injury Review Panel which describes the work undertaken by the Panel from July 1, 2024 - June 30, 2025. The mission of the Maine Child Death and Serious Injury Review Panel ("CDSIRP" or "the Panel") 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 engages in case reviews, seeking information and insight from appropriate resources to make recommendations to state and local agencies about improving the child protection system, including modifications of statutes, rules, policies and procedures.[1]

The Panel is comprised of professionals and private citizens[2] providing multidisciplinary perspectives, which are crucial for comprehensive review and analysis of child fatalities and serious injuries, and for crafting effective, sustainable, and well-informed recommendations for the State of Maine. Panel case review is confidential,[3] therefore the annual report, quarterly updates provided to the Maine State Legislature, and any other public-facing information, contains broad observations and aggregated data.

The recommendations offered in this report are formulated with the intent of supporting and improving the safety and well-being of Maine's children. Each recommendation originates from in-depth reviews of challenging and tragic circumstances. The work of translating data that reflects the complete scope of harm and/or tragedy and incorporating empathy and humanity is challenging and, at times, incongruent. The Panel extends condolences to the families and communities who have lost a child and holds solidarity with communities who support and nurture the safety and well-being of children and youth.

We urge readers to engage with this report prepared to care for themselves. This work is critical, and it is important to acknowledge its impact on all who are part of the tight-knit community that is the State of Maine.

Erika Simonson	Nicholas Miles, MD, MSc
Chair	Vice Chair

[1] Panel's authorizing statute, including purpose and membership: Title 22, §4004: Authorizations

[2] See Appendix A for full list of members.

[3] https://www.mainelegislature.org/legis/statutes/22/title22sec4008.html

About CDSIRP

The work of CDSIRP is to engage in case review, host presentations from panel members and external partners, convene subcommittees to provide additional analysis, and provide information about panel activities. The Panel met nine times during the 12-month reporting period.[4] All of those meetings were scheduled monthly and were used to engage in regular panel activities.[5] CDSIRP hosted five presentations by panel members or guests, and the Chair provided quarterly updates to the Maine State Legislature about panel activities.

Case Review

Case review is a primary activity of CDSIRP. The Panel examines data compiled by the Office of Child and Family Services[6] (OCFS) and supplemented by the Office of the Chief Medical Examiner. Reviewed cases include serious injuries reported due to suspected abuse or neglect, and fatalities that fall into several categories including those with a finding of abuse or neglect, those determined to be a homicide or suicide, unsafe sleep deaths or Sudden Unexplained Infant Death (SUID), as well as deaths categorized as accidental.[7] Case review is structured in three levels:

- **Level One** is a summary review and is the least intensive form of review. The Panel surveys basic information about individual instances of serious injury or fatality. The Panel may flag any case for further review by level two or three format.
- **Level Two** is a thematic review which explores cases that share a characteristic the Panel determines should be examined more closely. Some examples of level two reviews include serious injuries or fatalities involving a lack of water safety practices, growth faltering (previously known as failure to thrive), or cases involving a parent/caregiver operating under the influence of alcohol and/or drugs.
- **Level Three** is a comprehensive examination of an individual case including reports, records, and responses from individuals, institutions and systems connected to the family and event. Records and responses explored in the review include first responders, i.e. police and fire/rescue, medical professionals, child protective services, community-based providers, schools and educators, family supports and specialized professionals providing resources and support for substance use, mental health, and domestic and sexual violence.

Presentations to the Panel

Alongside case review, CDSIRP hosts presentations on a regular basis. Presentations enable the Panel to receive information and insight from experts across various expertise areas, to guide the feasibility and efficiency of potential recommendations. During this reporting period the panel hosted the following presentations and presenters:

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[4] The Panel does not meet in July or August. The April meeting was cancelled due to a statewide conference.
[5] The Panel participates in joint meetings with the Domestic Abuse Homicide Review Panel, on cross-over cases however no joint meetings occurred during the timeframe of this report.
[6] Child Fatality Reporting | Department of Health and Human Services
[7] Most cases coded as "accidental" are recategorized as "unintentional" by the Panel for its purposes.

- **McAuley Residence,** Melissa Skahan, Vice President of Mission Integration from Northern Light Health and the McAuley Residence presented an overview of the family-first approach to support families impacted by substance use disorder.
- **Maine Maternal Opioid Misuse Initiative**, Alane O'Connor, DNP, Clinical Advisor presented about the Alcohol Use Disorders Identification Test and Drug Abuse Screening Test (AUDIT/DAST) tools that Office of Child and Family Services staff are utilizing to support their work engaging with families impacted by substance use.
- **Maine CDC regarding Youth Suicide Prevention,** Sheila Nelson (MSW, MPH), Program Manager of Adolescent Health, Injury, & Suicide Prevention (panel member) presented "Trends and Updates on Youth Suicide and Self-Harm in Maine."
- **Parenting Capacity Evaluations,** Sarah Miller (PhD), Director State Forensic Service and Chrissy Young, Family Court Program Coordinator, State Forensic Service, provided an overview of changes in court ordered diagnostic evaluations.
- **Representation of Parent Voice on the Panel,** Abby Collier, Director of the National Center for Child Fatality Review and Prevention (NCFRP) gave a presentation about family voice in fatality reviews.

Panel Subcommittees

Narcan Subcommittee

The Panel convened a subcommittee examining the availability and use of Narcan[8] in childcare facilities. The subcommittee was formed after fatalities in other states[9] where children had consumed opiates. The subcommittee's work strategizes access to information, practical tools for Maine's childcare centers, and opioid awareness among childcare providers and how to respond to opioid exposure and overdose. The subcommittee collaborated with partners to strategize education and access opportunities for Opioid Overdose Prevention in childcare settings. The subcommittee explored:

- Training currently available through Substance Abuse and Mental Health Services Administration (SAMHSA) and the Heart Association and if those are sufficient to meet the needs of childcare providers,
- Exploring mandatory training for childcare providers,
- Creating a bulletin about resources available through OCFS platforms for childcare providers on the use of Narcan and childcare facilities.

Other Subcommittees

The Panel explored strategies to include family/caregiver voice in the fatality reviews. After the presentation from the NCFRP, the Panel determined to convene a subcommittee with the goal of evaluating approaches to better understand parent, family, and caregiver experience navigating

[8] Narcan (naloxone) is a medicine that rapidly reverses opioid overdose and can quickly restore normal breathing to a person if their breathing has slowed or stopped because of an opioid overdose.
[9] In September 2023, a one-year-old child ingested a fatal amount of fentanyl in childcare facility in NY. Three additional children were hospitalized due to fentanyl ingestion. Link to news story, reported by CNN: Bronx day care child death: 2 arrested after 1-year-old dies, 3 children hospitalized in suspected exposure to opioids | CNN

systems. Additional components that the subcommittee will explore considerations around the safety of families/caregivers to participate in fatality review, assessing a compensation model for participation, and utilizing individualized, trauma-informed, family-centered practices.

The Panel discussed the utility of a potential subcommittee on creating awareness and confidence among Maine's pediatric providers to screen children for suicide and self-harm. There are other groups and Panels with whom CDSIRP could partner in this endeavor, including the Domestic Abuse Homicide Review Panel (DAHRP), which routinely examines suicide threats as a tactic used by abusers to exert control over their partners and family members.[10]

Other Work of the Panel

Representatives from CDSIRP coordinate with members from Maine's citizen oversight panels[11] at least quarterly, and the Panel hears presentations from those entities summarizing their annual reports. Those entities include the Justice for Children Task Force[12] and the Maine Child Welfare Advisory Panel,[13] and from the Child Welfare Ombudsman.[14]

Panel members, usually the Chair and/or Vice Chair, present to the Maine State Legislature Joint Standing Committee on Health and Human Services (HHS), as part of the quarterly child welfare update. These updates include aggregate data, observations, and potential recommendations.

Case Reviews

During the reporting period of July 1, 2024-June 30, 2025, the panel conducted:

- 4 cases, presented as Level 3 (in depth) reviews.
- 4 cases, presented as Level 2 (thematic) reviews.
- 23 fatalities, 201 serious injuries and 449 ingestions, comprised Level 1 (summary) reviews.

Level 1 Data Review

The figures below reflect the total occurrence of child death, serious injury, and ingestion reports received by OCFS in the last six months of 2024 (July-December) through the first half of 2025 (January to June), including those reported through the OCFS intake unit and those reported to OCFS by the Office of the Chief Medical Examiner.[15] These data may differ from data presented elsewhere, such as on the OCFS website, for reasons including but not limited to:

- Reports made to OCFS Intake may be screened out, while others may be assigned for investigation.
- OCFS investigations may result in a determination that a reported event did not occur.

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[10] Suicidality is considered a risk factor for the future use of lethal violence. Coming Together for Safety ,15th Biennial Report of the Maine Domestic Abuse Homicide Review Panel, December 2025.

[11] Citizen Oversight Panels are convened under the Child Abuse Prevention and Treatment Act (CAPTA)

[12] 2024 Annual Report, Justice for Children Task Force

[13] 2024-MCWAP-Annual-Report.pdf

[14] 2024 Child Welfare Ombudsman Annual Report.pdf

[15] Not all CD/SI/I are reported to OCFS.

- Ongoing criminal investigations and/or prosecutions may have an impact on information that is publicly available for review.[16]
- Child fatality data provided by the OCFS website reflects all fatalities reported to OCFS and may include data for families who had previous involvement with OCFS, regardless of the fatality's cause or how long ago child protective services had contact with the family.

The first chart, *2024 Child Death, Serious Injury, and Ingestion Totals,* includes data from July 1, 2024, through December 31, 2024. The second chart, *2025 Child Death, Serious Injury, and Ingestion Totals,* includes data from January 1, 2025, through June 30th, 2025.

2024 Child Death, Serious Injury, and Ingestion totals (BY LEVEL 1 REPORTS)

	Serious Injuries	Ingestions	Child Deaths	Child Deaths Initially Reported to OCFS as a Serious Injury or Ingestion	Total
July	21	16	5	0	**42**
August	25	14	4	0	**43**
September	17	19	3	0	**39**
October	15	19	1	1	**36**
November	18	23	0	0	**41**
December	18	26	3	0	**47**
Total	**114**	**117**	**16**	**1**	**248**

2025 Child Death, Serious Injury, and Ingestion totals (BY LEVEL 1 REPORTS)

	Serious Injuries	Ingestions	Child Deaths	Child Deaths Initially Reported to OCFS as a Serious Injury or Ingestion	Total
January	20	47	1	1	**69**
February	9	41	1	0	**51**
March	21	56	1	0	**78**
April	14	61	1	0	**76**
May	9	91	3	0	**103**
June	14	36	0	0	**50**
Total	**87**	**332**	**7**	**1**	**427**

[16] Aggregate data about cases with pending criminal investigation and/or prosecution is included in this data.

2024 Ingestion Data

The ingestion data for this reporting period indicates a distinct increase in the total number of ingestion reports, particularly in the latter 6 months of the reporting period. This increase is due to a change in classification and reporting practices, resulting in a broader recording of ingestion incidents. To address the impact of these changes on the data, effective January 2026, reporting has been corrected to include only ingestion cases that meet the definition of a serious injury: cases in which ingestion of a substance, whether accidental or potentially resulting from abuse or neglect, results in or is likely to result in a serious injury and/or requires medical intervention.[17]

Panel members continue to discuss several key components in relation to the risk of ingestion including the level/severity of exposure, safe storage of substances, caregiver supervision, caregivers supplying substances, and systemic responses to ingestions. There are reasonable limitations to the prevention of intentional ingestions by youth who are seeking to use substances.

Data Trends

The data from 2024-2025 Annual Report indicates a notable decrease in both serious injuries and child deaths, in comparison to the previous report.[18] The panel observed a 44% decline in the number of child deaths. This marked decline is an artifact of a change in the reporting period (12 months versus 18 months); when averaged, the number of child deaths in Maine continues a trend of slight decline.

In the 2023-2024 Annual Report, a slight increase in serious injuries was noted; in this report, the Panel observes a 42% decline in serious injuries.[19] Again, this marked change is likely an artifact of the change in reporting period.

Future reports will continue to a 12-month standard.

Observations & Recommendations

Case review processes generated a list of observations which were utilized to craft recommendations for organizations, institutions, and systems at large to improve responses, practices, policies, and statutes. Recommendations are generally tailored to address an identifiable systemic issue rather than single instances or isolated incidents. Recommendations are structured to provide meaningful input and avoid overregulated systemic responses and/or create barriers.

Level One (summary) reviews were typically conducted within a few months of the original incident report to OCFS. Level Two (thematic) and Level Three (in-depth) reviews occurred several months to years after the incident was reported. These delays occur for a variety of reasons; however, occur primarily due to restrictions around reviewing cases with pending criminal

[17] The 2025-2026 Annual Report, scheduled for release in early 2027 will reflect similar ingestion data trends for the first six months of the reporting period from July 1, 2025-December 31, 2025.
[18] Data trends evaluate the available data provided to CDSIRP and may have limitations. Limitations are outlined in the "Level One Data Review" section of this report.
[19] See footnote 18.

investigation or prosecution, or because of an intentional delay for planned thematic review. When case review is significantly delayed, the Panel explores changes that have occurred in policy, practice, statute, resource allocation, etc. from the time of the incident to the review. When a systemic change is underway and/or has been implemented, Panel recommendations are structured to support and inform current efforts.

Observations and recommendations during this reporting period fall into four broad categories; 1) supporting a multidisciplinary approach as best practice, 2) assessing the impact of bias on systemic response, 3) utilizing specialists when determining child abuse and/or neglect, and 4) addressing social determinants that create vulnerability.

Supporting Multidisciplinary Approach as Best Practice

A multidisciplinary approach to child safety and well-being that focuses on preventing and responding to risk, harm, and/or injuries and fatalities, is a cornerstone best practice. Over the last several reports, the Panel's observations have highlighted opportunities to enhance key multidisciplinary practices that provide infrastructure for Maine's child welfare system response. This infrastructure includes but is not limited to the Office of Child and Family Services, Maine's mandatory reporting structure/training, and the obligation of certain professionals to report suspected child abuse and neglect, information sharing agreements between OCFS caseworkers, medical professionals, law enforcement and first responders, and coordination with community-based providers, like mental health professionals/supports, substance use professionals/supports, domestic violence and sexual assault resources and organizations.

The Panel made the following observations:

- Mandated reporters[20] have significant practice variations in the criteria used when determining whether to make a report of possible abuse or neglect.
- Professionals from all disciplines are using Child Protective Intake as a tool to connect families to support services or resources. A vast majority of these reports are screened out as they do not contain allegations of abuse or neglect. This practice highlights the need for an alternative pathway to connect families with community resources and supports, and to engage families in abuse and neglect prevention strategies.[21]
- The lack of supervised visitation resources, in Maine, impacts individual family safety planning and in some cases reduces the ability to meet best practice standards. Barriers to accessing supervised visitation include rural/remote geography of the state, access to transportation and the non-clinical nature of programs that limit providing wider assessment of family health/stability. The Panel also observed a lack of OCFS staff to utilize natural and/or least-restrictive environments for visits.
- The Panel continues to observe difficulties in information sharing practices between medical professionals, law enforcement, and OCFS.

[20] List of professionals who are mandated reporters can be found here: Title 22, §4011-A: Reporting of suspected abuse or neglect

[21] More information about Child Protective Intake Data can be found in footnote 27 and 28 of this report.

- The Panel observed multiple examples of a disconnect between the safety threats[22] identified by OCFS staff and the implemented safety plan[23] that addressed the threat. There was also a deficit in linking the safety threat to the safety plan in documentation.
- OCFS staff would benefit from better tools and resources to articulate medical indicators of child abuse and neglect. Better tools would likely support a more efficient case process and requests for medical records if/when a family/parent/caregiver does not consent to the release of those records.[24]

There are several current efforts in Maine to both refine and reform key points of child welfare system infrastructure and response, particularly related to mandatory reporting. The Panel generated several recommendations that are important to note even as reform initiatives are already underway. Additional recommendations, in other sections of this report, provide additional input on these topics.

The following recommendations resulted from the Panel's discussion about supporting a multidisciplinary approach as best practice:

- ❖ The Panel recommends that OCFS, in collaboration with other key partners, should create specialized resources for mandated reporters from different professional disciplines, to facilitate enhanced decision making when reporting instances of suspected child abuse and/or neglect.
- ❖ The Panel recommends that OCFS staff receive information, education, and/or training to support their ability to most effectively respond to suspected abuse and neglect; specifically, by:
  - Working in collaboration with collateral contacts[25] to ensure information used to inform agency response is accurate and complete.
  - Receiving support from child abuse pediatric specialists to articulate medical indicators of child abuse and neglect and access tools, such as a skin assessment checklist.
  - Developing a strategy to enhance documentation and safety planning practices by making a clear connection between the safety threats identified and the safety plan put in place to address those risks/threats.
- ❖ The Panel recommends that the Court, OCFS, Guardians ad Litem, attorneys, and other entities recommending and/or ordering supervised visitation, in collaboration with supervised visitation providers/centers, utilize best practices established in statute and policy. These best practices should include utilizing objective visit supervisors, making

[22] OCFS Definition of Safety Threats: Immediate risk of serious harm to a child due to the presence of parent/caregiver concerns, child behaviors, conditions, or past history.
[23] OCFS Definition of Safety Plan: A Safety Plan is a short-term, detailed set of action steps to control safety threats identified in the SDM© Safety Assessment Tool. The Safety Plan is created with a family and their supports when one or more safety threats are present and safety interventions have been planned or taken to ensure the safety of a child who will remain in the care and/or custody of their parents. A Safety Plan cannot last more than forty (40) days and an investigation or case may not be closed while a Safety Plan is in effect.
[24] This most often came up when caseworkers observed bruising or skin abrasions.
[25] OCFS Definition of Collateral Contact: A person who may have knowledge about the family, the issues identified in the report, or other factors related to child safety.

inclusive safety considerations, and mitigating the potential of traumatizing factors and environments.

Assessing the Impact of Bias on Systemic Response

Bias can become pervasive in systemic responses and have notable impacts on the effectiveness of systems, which affects the ability of families to access services and demonstrate compliance. It is important to recognize that bias is universal and influenced by an individual's experiences, belief systems, culture, and environment. Bias can be both implicit (unintentional) and explicit (intentional). Most of the instances of bias observed by the Panel were likely unintentional; however, it had a clear impact on families and children.

Some examples of how bias can be unintentional but have a negative impact includes developing professional shorthand that prioritizes some activities over others, scripting conversations with key information and failing to respond to a person's specific questions, and developing assumptions over time about who needs help or resources or who is capable of change, based on a practitioner's past experiences with "a family like that."

Specifically, within the process of determining whether to make (or not make) a mandatory report, bias can impact both over-reporting of families in the absence of suspected abuse or neglect and underreporting. In both situations, factors unrelated to evidence or indicators of abuse or neglect are considered in decisions to report. In addition, the Panel regularly encountered scenarios in which individual bias likely impacted diagnosis, treatment, offered options, support structure, and resources provided to a family. Further assessment also revealed instances where processes, systems, and resources were likely operating on assumption and/or supposition instead of facts.

The Panel made the following observations:

- Professionals who did not make a report after observing indicators named statute as factors to make a mandated report, often, but not always, did so based on factors such as a pre-existing relationship with the caregivers, or a perception of the family's ability to care for that child based on profession or socioeconomic status.
- Reports are frequently received from professionals that do not contain allegations of abuse or neglect. The reasoning behind such reports could sometimes be linked to specific conditions such as poverty, family structure, parenting judgement, cultural differences, and/or filing a report with the intention of connecting the child/family to services.[26]
- The high number of reports that are screened out for not meeting the statutory threshold of abuse or neglect reflect a significant burden on child welfare system resources.[27] They also identify the need for an alternative pathway to connect families and children to services/resource. Multi-year data indicates that the prevalence of

[26] The Help Me Grow Program is a statewide resource that connects families to resources. Additional supports are available through the Be There for ME website.

[27] In 2024, 90% of 29,658 reports of suspected child abuse or neglect did not result in findings: CSFWB Year 1 Update. In 2023, 92% of 30,556 reports of suspected child abuse or neglect did not result in findings, Child Safety and Family Well-Being Plan (2025-2030).

another report being made on families whose case was screened out, is virtually non-existent.[28]

- There are differences in OCFS screening outcomes in situations with similar facts and circumstances.
- There have been cases screened out by Child Protective Intake without making a referral or having contact with the Spurwink Center for Safe and Healthy Families as indicated and/or directed by policy.
- Decisions made by professionals across all disciplines are often based on how "appropriate" or "inappropriate" the parents/caregivers were perceived. Behaviors are often interpreted subjectively, and the interpretation differs across genders, socioeconomic status, cultures, and a variety of other factors that lead to problematic determinations.

The impact of bias on systemic responses has been recognized and informs statewide initiatives. In the last few years, Maine statute has been amended to change the definition of neglect to require more context for determining neglect for families living in poverty.[29] Further efforts have been made to revise Maine's mandatory reporter training to support professionals in examining biases potentially contributing to reporting decisions.[30] Additional resources to support first responders, medical professionals, and educators is an area of potential exploration for Maine, as new initiatives are implemented.

The following recommendations resulted from the Panel's discussion about the impact of bias on systemic response:

- ❖ The Panel recommends that OCFS ensure mandatory reporting training material provides practical tools for documenting observations objectively. This recommendation should be implemented in core training for all mandated reporters and reinforced in additional resources tailored for professional disciplines, such as medical providers, educators and/or law enforcement.
- ❖ The Panel recommends that OCFS create a structured mechanism to provide feedback to organizations/entities when they or their employees have failed to meet mandatory reporting requirements, as indicated by examining CPS Intake data. The Panel does not recommend follow-up with individual reporters, rather providing feedback at the institutional level to promote systemic change.
- ❖ The Panel recommends that OCFS collaborate with the Spurwink Center for Safe and Healthy Families to identify and/or create resources to help medical providers, particularly hospital emergency departments, manage protocols when an injury is identified in a child who is less than six months old.
- ❖ The Panel recommends that the Spurwink Center for Safe and Healthy Families and other key medical partners, in consultation with OCFS, communicate with the various boards of

[28] Maine's Child Safety and Family Well-Being Plan (2025-2030) and Year 1 Update, report that in 2023 and 2024, less than 1% of screened out cases, at child protective intake, later resulted in a report with findings.
[29] Statutory Definition of Abuse and Neglect: Title 22, §4002: Definitions
[30] LD 2105: An Act to Update Maine's Mandated Reporting Laws, pending legislation in Maine's 2nd session of the 132nd Legislature

medicine, in Maine, about the impact of bias on reporting practices. Communication should specifically include resources to assist in objective decision-making and documentation and avoiding subjective assessments of parents/caregivers as indicators of risk.

Utilizing Specialists When Determining Abuse & Neglect

The Panel continues to observe a lack of consistent utilization of subspecialty services available to support medical providers in making critical determinations about abuse and/or neglect. Specialists are a critical part of Maine's coordinated community response to child abuse and neglect. Utilizing specialists supports accurate, unbiased determinations in difficult circumstances. Expert Child Abuse Pediatricians can help address challenges in identifying inflicted injuries and avoid confusion from multiple forensic opinions, which could put children at risk. The distinction between a clinical and forensic opinion is significant and allows for diagnoses that better inform child welfare professionals when formulating responses.

Child abuse specialists can also provide improved responses to support safe and/or non-offending parents and caregivers to access services and resources needed for their child's health and well-being. Some of these resources may not be available to general practitioners or local medical institutions.

The Panel made the following observations:

- Specialized pediatricians may have a different assessment about the likelihood of abuse than the medical provider that first saw a child. Normalizing consultations with specialized providers is a critical component to ensure that medical determinations are as accurate as possible. Accurate diagnoses better inform law enforcement and OCFS caseworkers, allowing them to provide an appropriate, informed response.[31]
- Utilizing pediatric specialists can support caregivers in meeting a child's medical needs and can reduce conflicting medical guidance from becoming a barrier to resolution.
- Dedicated medical reports, specifically addressing the concern for possible abuse or neglect, are an invaluable tool to inform case investigations and/or case closure determinations.
- Child Protective Intake has been making increased efforts to utilize the Spurwink Center Safe and Healthy Families for consultation to inform case screening decisions.
- One of Maine's largest hospital systems has made a notable practice shift, where two medical professionals assess diagnostic results to increase the accuracy of medical determinations.

The following recommendations resulted from the Panel's discussion about utilizing specialists when determining child abuse and/or neglect:

[31] A common example observed by Spurwink Pediatricians: spiral fractures, caused by severe twisting, do not have high specificity for abuse indications, as they were once thought to have. Bucket handle fractures, also sometimes called corner fractures or classic metaphyseal lesions/CMLs, have a high specificity for abuse/inflicted trauma, as they are caused by violent twisting, shaking or pulling on a limb.

- ❖ The Panel recommends that OCFS utilize the Spurwink Center for Safe and Healthy Families to provide medical evaluations for serious pediatric injuries and continue to implement practices that appreciate the assessments of specialized medical providers.
- ❖ The Panel recommends that medical professionals utilize the Spurwink Center for Safe and Healthy Families to provide medical evaluation when they observe serious injuries in children. Medical professionals should receive regular notifications about the resources and services available through Spurwink.
- ❖ The Panel recommends that the Spurwink Center for Safe and Healthy Families continue their efforts to increase the availability and accessibility of high-quality skeletal surveys in Maine.

Addressing Social Determinants that Create Vulnerability

There were numerous social determinants identified by the Panel that impacted the health, safety, and vulnerability of children and adolescents in Maine. These factors include, but are not limited, to mental and behavioral health challenges, domestic abuse and violence, access to healthcare options and information, access to and utilization of firearms, and bullying.[32] In most instances, factors were adversely amplified by poverty. Provider and professional bias influenced both systemic response, and consequently, a family's willingness to seek support, significantly contributing to a family's ongoing vulnerability.

The Panel made the following observations:

- Multidisciplinary collaborations within child welfare systems are valuable and there are opportunities to utilize existing successful frameworks for coordinated community responses[33] to increase engagement with medical professionals, including Primary Care Providers (PCPs) and Emergency Medical Services (EMS) personnel.
- Distrust of medical providers impacts the decisions families make about their health and how they access medical services. Past interactions where families experience disparate treatment due to bias was a common reason for distrust.
- Emergency medical responders have limited resources, tools, and guidance to assess concerning factors when responding to planned and unplanned home births and/or families planning to stay home for births. Challenges and needs were also identified for tools to determine whether to make a report for suspected abuse and/or neglect.
- There is a lack of knowledge and access to resources for families where a child has challenging behaviors. These situations are more complex when children with special and/or additional needs have been violent with caregivers.
- Schools/educational institutions were often aware of bullying and had varied responses within their institutional framework. Online platforms and social media were often used to continue bullying behavior that originated somewhere else.[34]

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[32] The observations of the Panel found that specific instances of bullying mostly originated from educational settings and may have continued to be perpetuated through technology and social media.

[33] Examples of this work include a collaborative training/conference between OCFS casework & supervisor staff and law enforcement called "Cops and Caseworkers," and formalized partnership with domestic violence advocacy organizations to embed specialized CPS systems DV advocates in each district.

[34] The Panel additionally noted that "Aiding or soliciting suicide" is a Class D crime in Maine.

- Prevention and intervention in educational settings is key to identifying and responding to instances of suicidality.
- Providers are often uncomfortable asking screening questions to identify suicidality, or are fearful of not appropriately responding to disclosures, which impedes effective screening and therefore reduces opportunities for prevention and intervention.
- Suicide threats and suicide/self-harm attempts for youth receive disparate responses depending on the gender of the individual. Female youth are often labeled as "dramatic" or "trying to get attention." Female youth are more likely to contemplate suicide, while males accounted for 74% of Maine youth suicides in 2024.[35]
- Key resources or interventions for other social factors were not provided when youth suicidality was identified. Providers did not consistently link the existence of suicidality to other safety planning considerations. For example, if domestic violence was experienced by the child or another family member, or if there was access to firearms.[36]
- Understanding youth access to firearms in the home is important in bullying cases and when other factors bring youth into contact with child welfare systems. In 2023, firearms were the mechanism used in 59% of Maine youth suicides. In 2024, 71.4% of youth suicide deaths (ages 10-24) involved the use of a firearm.[37]
- Emergency response to youth can be hindered or complicated if there are locks on bedroom doors, if youth have access to unsecured firearms, and if other safety issues are not properly identified as risk factors such as domestic violence or substance use.
- Additional resources for prevention and harm reduction would likely be helpful to professionals to support youth in safety planning and harm reduction during institutional experiences, particularly when transitioning out of incarceration.
- Options for supporting children/youth after the death of a sibling are key, particularly because suicides and other child deaths often take place in the home where siblings are present and/or will continue to live. Sibling evaluation and services are paramount for safety and well-being.
- There has been an increase in the number of serious injury/fatality cases involving firearms, including injuries related to unintentional discharge of firearms.

Several observations demonstrated the importance of exploring the holistic support that is available or could be structured to support families and to address the frequent co-occurrence of trauma histories and other factors impacting their ability to access support and resources. The Panel reflected on similar observations that have been made by the Domestic Abuse Homicide Review Panel.

The following recommendations resulted from the Panel's discussion about addressing social determinants that create vulnerability:

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[35] Additional data for both suicide deaths and attempts/ideation and emergency department data can be found here: https://www.maine.gov/suicide/data-and-statistics.shtml

[36] DAHRP Reports highlight the link between suicidality and homicidal ideation which are considered indicators of the potential use of future violence. 13th Biennial Report: 20 Year Lookback

[37] Maine Data, Research and Vital Statistics (DRVS), 2024

Healthcare

- The Panel recommends that the Maine CDC, OCFS, and other partners continue to work to distribute information about the safety and efficacy of vaccination for preventable diseases, which may be accomplished by increasing the frequency of public service announcements or other public information sharing campaigns/strategies.
- The Panel recommends that education and training resources about premature births be identified and made available to Emergency Medical Services, along with tools to assist EMS to direct families to support and resources.

Suicide and Bullying

- The Panel recommends that the Maine CDC identify or develop an accessible tool(s) to screen for bullying, suicidal ideation/attempts, and adolescent/youth safety that can be used by a variety of professionals including first responders, medical professionals, substance use providers, corrections professionals, and educators, to support better screening and intervention in youth suicidality. MCDC should also provide technical assistance for implementation of any tool(s).

Substance Use

- The Panel recommends that OCFS continue to develop or enhance training, education, policies and tools to support OCFS staff to recognize and respond to environmental indicators of substance use in the home. This includes collaborating with community partners, such as substance use supports/providers and treatment and recovery services.
- The Panel recommends that OCFS and medical professionals collaborate to ensure that children who are present and/or live in a home where an overdose occurred are evaluated to determine if medical or mental health services are needed.

Internal – CDSIRP

- The Panel will continue the work of the Parent Voice Subcommittee to explore incorporating the perspective of individuals with lived experience into the Panel's work.

Conclusion

The Panel respects the complicated dynamics and practical logistics of ensuring all families receive the support and resources they need to remain safe, stable, and healthy. The data and recommendations in this report place deep value on the existence of helpful and effective practices, resources, and responses that currently attend to the safety and well-being of children in Maine. We hope this Annual Report contributes to those efforts by providing additional information and perspective.

Appendix A: 2024-2025 Panel Membership

Mark Moran, LCSW, Chair (2014-June 2025)
Social Services Manager, Northern Light Eastern Maine Medical Center
CASA Guardian ad Litem, Maine CASA

Erika Simonson, MPPM, Chair (beginning 06/2025)
Family Services Director, Maine Coalition to End Domestic Violence

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

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

Jenna Joeckel, LCSW, LADC, **CCS, MHRT-c,** Panel Coordinator
Maine Office of Child and Family Services

Christine Alberi, Esq.
Child Welfare Ombudsman

Jason Andrews
Detective Sergeant, Major Crimes Unit- Central, Maine State Police

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

Shannon Blosser (Resigned from the Panel in August 2024)
Medicolegal Death Investigator, Maine Office of the Chief Medical Examiner

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

Katherine Bozeman, Esq.
Assistant Attorney General, Criminal Division (beginning 10/2024)
Deputy District Attorney (ending 10/2024)

Kathryn Brice
Assistant Child Welfare Ombudsman

Alice Briones, DO (Joined the Panel in August 2024)
Chief Medical Examiner

Rachel Burrows, PhD
Psychologist, Edmund N. Ervin Pediatric Center

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

Shannon Craig-McDaniel, BSN, RN
Supervisor, Division of Public Health Nursing, Maine CDC

Liam Funte, MD
Deputy Chief Medical Examiner, Office of Chief Medical Examiner

Ariel Piers-Gamble, Esq.
Chief, Child Protection Division, Maine Office of the Attorney General

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

Sandi Hodge
Retired Child Welfare Professional

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

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

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

Ashley Morrell, LMSW
Associate Child Welfare Ombudsman

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

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

Erin O'Reilly Jakan, Esq.
Assistant Attorney General, Child Protection Division, Office of the Attorney General

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

Hannah Pressler, DNP
Pediatric Nurse Practitioner, Retired

Lawrence Ricci, MD
Child Abuse Pediatrician, Retired

Abbie Rohde, LCSW, CCS
Substance Use Disorder Counselor, Private Practice

Tammy Roy, LSW (Resigned from the Panel September 2024)
Child Welfare Project Manager, Maine Office of Child and Family Services

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

S. Taylor Slemmer
Medicolegal Death Investigator, Maine Office of the Chief Medical Examiner

Craig Smith
Assistant Child Welfare Ombudsman

Amanda Taisey
Health Systems Engagement Coordinator, Maine Coalition to End Domestic Violence

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

Christine Thibeault
Associate Commissioner of Juvenile Services, Maine Department of Corrections

Christopher Turner, MD, MPH, FACS
Attending Surgeon, Maine Medical Center

Leane Zainea, Esq. (Resigned from Panel in August 2024)
Assistant Attorney General, Criminal Division, Maine Office of the Attorney General

Chrissy Young Psy.D. (Joined the Panel in February 2025)
Family Court Program Coordinator, State Forensic Service