Child Death and Serious Injury Review Panel Quarterly Report

REPORT TO THE JOINT STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

SEPTEMBER 20, 2023

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Resolve 2021, Chapter 142:

"… the child death and serious injury review panel…shall submit reports to the joint standing committee of the Legislature having jurisdiction over health and human services matters at least every 3 months beginning in June 2022 and until June 30, 2024.… Any presentations of the reports to the committee must be presented by the citizen members of the panels to the extent possible. Each quarterly report must contain, at minimum, the following:

1. A summary of generalized and anonymized observations in the prior 3-month period regarding efforts by the Department of Health and Human Services, Office of Child and Family Services to improve the child welfare system

2. A summary of the collaboration between the advisory panel and the review panel as well as the Justice for Children Task Force established in 2006 that reports to the Supreme Judicial Court; and

3. Any recommendations on how to further protect the State's children through Department of Health and Human Services policy and rulemaking and through legislation."

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Reminders

Cases reviewed by CDSIRP are often 6-24+ months post-critical-incident.
Level 1, 2, or 3 reviews

CDSIRP does not solely focus on OCFS role, decisions, and actions. We recognize the Child Welfare System is far broader than OCFS alone.

CDSIRP focuses on system improvement, not blame or fault finding.

Much of the value of the Panel's work is in its "behind the scenes" ability to influence practice. The Panel's multidisciplinary membership is often able to influence policy and/or practice changes in real time, rather than waiting for periodic, formal, public reports and recommendations.

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Summary of observations in the prior 3-month period regarding efforts by DHHS-OCFS to improve the child welfare system

May 2023: L3 case review, addition of DOC Associate Commissioner Thibeault, L1 reviews Mar 2023

Panel Observations: inconsistent practice re: consulting Spurwink; timeliness of reports from Spurwink; timeliness and accessibility of Spurwink appointments; multiple risk factors not assessed (DV, SUD, housing instability); inconsistent response from LE following DA referral from OCFS; interviewing challenges in kids with dev delay, behavior challenges, MH needs; inadequate consideration of mom's partner as potential abuser; conflicting medical opinions- false equivalence; are enough high risk cases brought to court/ is OCFS maximizing their protective efforts?

OCFS Efforts: Ongoing work to ensure Spurwink is consulted when appropriate; advanced forensic interview training after 2 yrs casework

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Summary of observations in the prior 3-month period regarding efforts by DHHS-OCFS to improve the child welfare system

June 2023: Presentation on Ped Motor Vehicle Injuries; planned L2 review of 2 cases postponed due to pending criminal charges; updates on legislation, Exec Comm activities (COAC, GORWS, media interviews); L1 reviews Apr 2023

Panel Observations: Impaired drivers of fatally injured children less likely to use child restraints properly, more likely to be male, have an OUI in prior 3yrs, have single vehicle crash, have nighttime crash, have invalid/no license; statutory interpretation of restriction on case reviews impedes timely review; case flagged for L3 (conflicting med opinions, delayed reporting, injury to non-amb child with history of sentinel injuries to other children in fam, complications with Spurwink consult and legal case)

OCFS Efforts: ongoing work to improve Spurwink collaboration

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Summary of observations in the prior 3-month period regarding efforts by DHHS-OCFS to improve the child welfare system

Sept 2023: Panel discussion re: plan for upcoming meetings/topics; presentation on youth suicide rates; L1 May, Jun, Jul 2023; AHT Grant- Dr Brownell- data limitations

Panel Observations: 2022 lowest number of ME youth (10y-24y) suicide deaths in prior 6 yrs; > half firearms, 40% hang/suff; MIYHS: depress symptoms and SI ↑over time; girls > boys, LGB+ > heterosexual, Trans/other > cisgender; girls > boys ED visits for suicide attempt with ↑ disparity; ME will soon be the only state NOT participating in the National Fatality Review Case Reporting System (currently 1 of 3)

OCFS Efforts: Policy revisions- Child Protection Investigation among several others

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Summary of the collaboration between MCWAP, CDSIRP, and the JCTF

Quarterly leadership meeting 8/7/23

CDSIRP Co-Chair attended JCTF meeting 9/12/23 and MCWAP annual retreat 9/15/23

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Recommendations on how to further protect the State's children through DHHS policy and rulemaking and through legislation

- OCFS should examine whether there are enough caseworkers with advanced forensic interviewing training to effectively evaluate child maltreatment allegations in families with complex pediatric diagnoses

- Maine should participate in the National Fatality Review Case Reporting System to allow for more consistent, complete data collection that would make data driven policy and practice decisions possible

- Child Abuse Pediatrics services in Maine should be fully supported and adequately funded/staffed to make access to urgent consultation, timely evaluation, and timely communication of evaluation results possible for children throughout the state

- OCFS and Spurwink should continue to examine barriers to effective collaboration

- OCFS should continue its policy reviews and updates, including specifically Policy 2.9 “The use of expert consultation when assessing child abuse/neglect”

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Thank you for your interest in and attention to our children's welfare

Mark W. Moran, LCSW
Chair, Maine Child Death and Serious Injury Review Panel

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