Child Death and Serious Injury Review Panel Quarterly Report

Report to the Joint Standing Committee on Health and Human Services

Presented by Mark Moran, LCSW, Panel Chair

March 27, 2024

Public Law 2023, chapter 261: "... 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.... Any presentation of the report 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 Office of Child and Family Services to improve the child welfare system;

2. A summary of the collaboration between the child welfare advisory panel and serious injury review panel as well as any judicial branch task force or panel with a focus on the child welfare system or child protective proceedings; and

3. Any recommendations on how to further protect the State's children through department policy and rulemaking and through legislation."

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.

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

Jan 2024:L2 reviews of 5 cases involving serious injuries sustained on snowmobiles;L1 reviews of serious injuries and fatalities for Sept, Oct, Nov; Joint review with DAHRP

Panel Observations: 12 MRS §13106-A (25) only requires headgear for <18y.o. operators and passengers if on a trail funded by the Snowmobile Trail Fund (as identified by DACF); cases in which Spurwink was not consulted due to lack of 24/7 service availability; fentanyl not included in hospital testing; no universal referral for Cradle ME

OCFS Efforts: Panel is in communication with MWS rep for assistance engaging the right group/groups to discuss potential recommendations; OCFS more attentive to drug testing protocols and related systemic deficits

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

Feb 2024: Presentation of work on Child Safety and Family Well-Being Plan v.2; follow up discussion from joint review; membership discussion; 2023 ingestion review; L1 Dec ’23

Panel Observations: Inconsistent practice in proper medical evaluation of siblings following a death or serious injury to another child in the home; 46(↑4) of 94(↑4) ingestion reports for marijuana, 5(↓2) fentanyl, increases in cocaine/buprenorphine; additional examples of Spurwink not being consulted – both by OCFS and by medical providers

OCFS Efforts: ongoing effort to clarify process and protocols for Spurwink consultation within current limitations; safe storage discussions with families

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

March 2024:L2 reviews of 3 cases involving window falls; L1 reviews Jan ’24; membership addition; MCWAP/ JCTF/ Ombudsman reports; Joint review with DAHRP

Panel Observations: increased vigilance/ education is required as weather warms; access to safe and affordable housing is a child welfare issue; repeated themes- missed well child visits, many incident-based involvements (multi-gen) without bigger picture perspective, many services over a long time, inadequate services for the complexity of deficits in parental capacity; inadequate conceptualization of safety/risk

OCFS Efforts: work with CDC on seasonal messaging; ongoing efforts to revamp CODE system; ongoing work with HHS and GOC to examine many existing system deficits; new leadership

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

- MCWAP/JCTF annual presentations to CDSIRP 3/1/24
- Quarterly leadership meeting 3/4/24
- CDSIRP Chair attended JCTF meeting 3/12/24

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

-Protective headgear should be worn by children when operating or passengers on snowmobiles, regardless of location of operation (pending)

-Better process needed at OCFS to holistically review full case history to identify themes related to safety and risk over time (2022)

-OCFS should increase information sharing with key community partners who are part of our children's safety net, as is allowed in existing statute (pending)

-Cradle ME referrals should be made universally for all birthing families (pending)

-Well child visits should be viewed as sufficient red flags for OCFS investigation in SELECTED circumstances (2022)

-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 (2021)

-OCFS and Spurwink should continue to examine barriers to effective collaboration (2021)

-OCFS and Spurwink should collaborate to develop short guide for emergency departments statewide on proper evaluation of kids in the immediate aftermath of a sibling's death or serious injury (pending)

-OCFS should continue to collaborate with CDC on relevant public health messaging (2022)

-OCFS should continue to collaborate with OBH to revamp CODE system (2021)

Acronym Glossary

CDC: Maine Center for Disease Control and Prevention

CODE: Court Ordered Diagnostic Evaluation

DACF: Dept of Agriculture, Conservation, and Forestry

DAHRP: Domestic Abuse Homicide Review Panel

JCTF: Justice for Children Task Force

MCWAP: Maine Child Welfare Advisory Panel

MWS: Maine Warden Service

OBH: Office of Behavioral Health

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