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.