

CHILD DEATH AND SERIOUS INJURY REVIEW PANEL QUARTERLY REPORT

Report to the Joint Standing Committee on Health and Human Services
June 8, 2022



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."

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

March 2022: Case review-Level 3, Ingestion, Level 1 for 12/2021 reports

Panel Observations: Parent self-selected BH services often underinformed about treatment needs related to CA/N; successful completion may have no impact on child safety; currently an inadequate system for child maltreatment focused clinical evaluation; responsibility for child safety inappropriately placed on the child by the parent; thematic topic for future L2 review (child maltreatment in context of adult DV)

OCFS Efforts: 3/6/22 memo to BH Providers

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April 2022: Case Review- Level 3, Death, Level 1 for 1/2022 reports

Panel Observations: Parental caregiving capacity was severely limited; voluntary support/education services refused by parents; safe sleep education either not offered by perinatal providers or not retained by parents; OCFS ability to intervene is limited

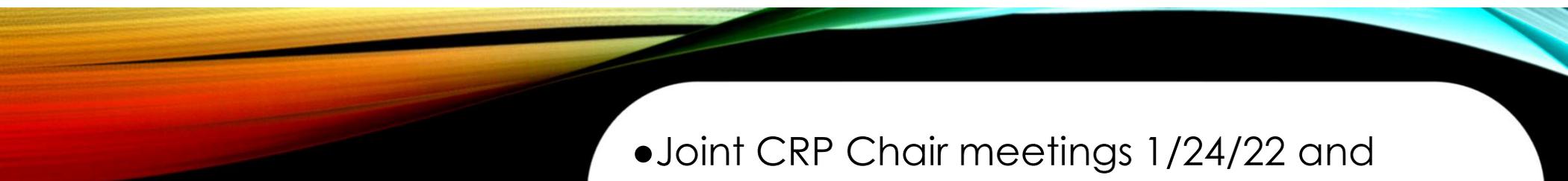
OCFS Efforts: Frequent referrals to Maine Families home visiting and/or PHN for at risk families; OCFS policy re: safe sleep education

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May 2022: Training- Safety Science

Panel Observations: Promising new approach (for OCFS) to identifying underlying systemic issues that lead to adverse outcomes; may result in improved info provision to the Panel; may impact focus or recommendations of the Panel*

OCFS Efforts: OCFS hired 1.5 FTE to conduct Safety Science analysis of serious injury/death cases

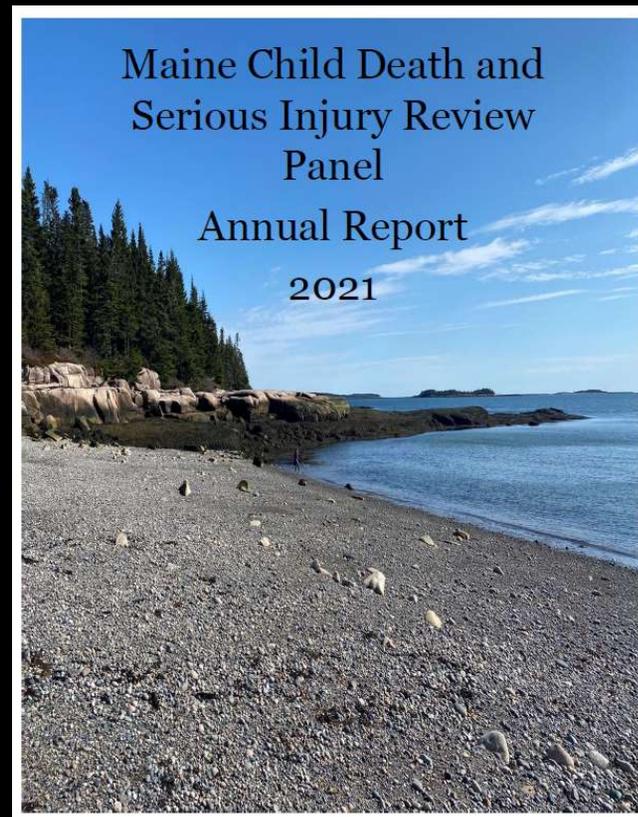


SUMMARY OF
THE
COLLABORATION
BETWEEN
MCWAP, CDSIRP,
AND THE JCTF

- Joint CRP Chair meetings 1/24/22 and 4/25/22
- Shared reports via email across CRPs with all members as they were released
- CDSIRP presented 2021 annual report at MCWAP meeting on 5/6/22
- CDSIRP presented brief update to JCTF 3/15/22, will present 2021 annual report 6/14/22
- MCWAP and JCTF presented annual reports at CDSIRP meeting on 6/3/22

<https://www.mecitizenreviewpanels.com/child-death-and-serious-injury-review-panel/>

RECOMMENDATIONS
ON HOW TO FURTHER
PROTECT THE STATE'S
CHILDREN THROUGH
DHHS POLICY AND
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Injury specific observations and recommendations (1-18)

- Bruising in pre-mobile infants
- Abusive head trauma
- Failure to thrive
- Gun shot wounds and firearm fatalities
- Ingestions
- Unsafe sleep related deaths



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Systemic observations and recommendations (19-35)

- Failure to consult with Child Abuse Pediatrics specialty services
- OCFS staff (workforce)
- OCFS staff (practice)
- Multidisciplinary Child Welfare system

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

