Child Death and Serious Injury Review Panel Quarterly Report

Report to the Joint Standing Committee on Health and Human Services

September 19, 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:

- 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
- 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
- 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

June 2022: MCWAP and JCTF updates, presentation from NNEPC, L1 Ingestion reviews (3/2021-3/2022), L1 Fatalities review (2/2022-4/2022)

Panel Observations: Currently no statewide comprehensive data collection on pediatric ingestions; Avg 7 reports/month to OCFS; 65% <5y old; 74% had CPS history; 77% investigated by OCFS; 37% of investigations had findings; Avg 3 marijuana and 1 non-Rx (illicit) ingestion reports/month; fentanyl ingestions of increasing concern

OCFS Efforts: Partners with CDC to have lockboxes available for distribution in all district offices

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

June 2022: New England Regional Meeting of Child Death Review Teams

Panel Observations: NH's safe sleep focus groups (child welfare involved families who chose bed-sharing despite education); National Fatality Review Case Reporting System- Maine only New England state not contributing data

OCFS Efforts: Currently considering potential avenues to support use of Case Reporting System

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

September 2022: CW Ombudsman's office represented on Panel (per LD 1960); L1 reviews beginning 2/2022

Panel Observations: Preliminarily 5 unsafe sleep related deaths through 7/2022 with 3 near misses; injury themes: outdoor recreational vehicles, parental OUI with child in vehicle, dog bites; cases selected for subsequent L2/L3 reviews

OCFS Efforts: Continuing practice of providing safe sleep education in all cases with children <1y old

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

- Joint CRP leadership meetings quarterly
- 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 2021 annual report at JCTF meeting on 6/14/22
- MCWAP and JCTF presented annual reports at CDSIRP meeting on 6/3/22

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

-Focus on context of ingestion, not simply whether accidental

-Addition of fentanyl to UDS's in all medical settings

-Multiprogram messaging re: safe storage in general, and of marijuana products in particular

-Increase access to lockboxes

-Consider proactive provision of lockboxes to CPS involved families of children <5y old

-Maine should pursue all potential avenues to participation in the National Fatality Review Case Reporting 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