

**CHILD ABUSE AND NEGLECT**

**DEATHS AND SERIOUS INJURIES  
IN MAINE  
1995-1998**

**REPORT OF THE STATE CHILD FATALITY/SERIOUS INJURY REVIEW  
PANEL**

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## CASE COMPOSITES

The police had been called to the residence around 2 A.M. by a neighbor who noticed the car lights were on, as well as most of the lights in the house but no one responded.

When the police arrived, they found the two children and their father had been shot to death. From the scene investigation and post mortem examinations, it was determined the children were fatally shot by their father, who committed suicide with the same gun. The parents had been involved in a protracted child custody dispute and the mother had just made it known she would not reconcile with her estranged spouse. There was a history of domestic violence with one Protection From Abuse Order against the father.

Mercifully, the two small children were likely asleep when they were murdered.

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Everyone who knew her said she was such a caring, concerned mother. Many still believed that, after her infant son was removed by court order to foster care where he quickly gained weight and thrived. The mother had made up false stories that her baby had seizures and had stopped breathing. Because the mother had a medical background and presented as very attentive and convincing, doctors believed her baby was very sick. In actual fact, the baby did not have a medical condition but he almost died due to actions his mother took to cut off his air supply. The attention the mother received from service providers and family and friends met her needs. The case was actually a severe form of child abuse, known as "Fictitious Illness by Proxy", or Munchausen Syndrome by Proxy.

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The little girl stood dazed amidst the chaos and filth in the apartment. She could not understand why the strange woman was in the apartment. She did not understand why the woman had to take her away. She did not understand why her little brother had cried so, or why her mother's boyfriend had shaken the baby and banged him on the floor until he stopped making any noise at all. She did not understand the confusion of the lights flashing and the loud radios and the lady who came to take her away from the only home she had. She did know she had to behave or the men with the lights might put her in jail if she told on her mother's boyfriend. She cried and wanted everyone to go away and stop asking her questions. That is all she knew.

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The Emergency Medical Technicians rushed to the apartment at 9:00 AM in response to a 911 call that an infant had stopped breathing. Upon arrival, the EMT's saw the infant's mother sitting at a table drinking a beer. The infant was found amidst several blankets that served as a bed for both the mother and her infant. As the EMT's attempted resuscitation of the infant, the mother opened another beer and continued to sit at the table. Mother reported that she returned home after a night of heavy drinking and went to bed. She awoke to find the infant not breathing. It was clear to the EMT's that the baby had been dead for some time. As the EMT's gathered their equipment and prepared to transport the infant to the hospital, the mother offered them a beer.



Angus S. King, Jr.  
Governor

STATE OF MAINE  
DEPARTMENT OF HUMAN SERVICES  
*State House Station #11  
Augusta, Maine 04333*

Kevin W. Concannon  
Commissioner

Dear Citizens of Maine:

I am pleased to issue this report of the Department of Human Services Child Death and Serious Injury Review Panel. This Panel reviews the circumstances of deaths of children known to the Department's Bureau of Child and Family Services and children whose deaths appear to be suspicious. The purpose of this comprehensive review is to see what can be learned and what action taken to make it less likely that children will die or be seriously injured under similar circumstances in the future.

The report identifies some significant improvement in Maine's response to abused and neglected children notably the increased use of a state of the art Child Maltreatment mental health evaluation and increased cooperation and collaboration between law enforcement and Child Protective Services. More remains to be done.

I want to use this report as a call to action to professionals working with children to recommit yourselves to protecting Maine's children by acquainting yourself with the findings of the report to gain new knowledge and insights that you can use to enhance your ability to carry out your child protective responsibilities. Use the report to learn about the common characteristic of abusive parents, and the increased vulnerability of infants to abuse and neglect. Be guided by the findings related to the danger posed to children by personal and professional biases. Finally, take note that a parent who loves their child may still abuse or neglect that child and fail to keep them safe from harm.

The tragedies of the children who are the subject of this report cannot fail to deeply move all of Maine's citizens. We must commit ourselves to turn our concern into specific actions to improve the system of child protection for all of Maine's children. If we do not, who will?

Kevin W. Concannon  
Commissioner  
Maine Department of Human Services

## **LETTER FROM THE CHAIR**

This is our second report since the Maine Child Death and Serious Injury Review Panel started in 1992. The Panel continues to plod along, dissecting each case in minute detail. Panel members have the difficult task of reviewing and digesting a novel's worth of history each month. Often the reading is compelling but just as often the work is mundane and tedious. Yet, in that very tedium sometimes lies the most important details for the panel to answer our few, yet weighty questions. Why did this child die? Was the death preventable? What did we do right? What did we do wrong? How can we prevent future deaths like this?

As can be seen by the analysis to follow there were far too many abusive injuries and deaths in Maine since our last report 4 years ago. We have made some progress since our first report but not nearly enough.

We have successfully joined with other New England States to form a consortium of Northern New England Child Fatality Review Teams and maintain a presence within the national network of child death teams.

We have conducted extensive educational programs for professionals inside and outside the state of Maine on child deaths. Our particular focus has been on the structure and function of our unique team and on education of professionals to better identify and intervene in high risk situations before death occurs.

The Department of Human Services, with our support, has initiated a risk assessment protocol to help them identify and intervene effectively in high risk cases.

The State Forensic Service, also with our support, has developed a Child Maltreatment Risk and Impact Evaluation procedure to determine the risk parents pose to their children and to develop intervention plans.

Collaborative case investigation involving law enforcement, child protective services, and medical providers has improved remarkably in the last 4 years thanks in large part to efforts of the panel members.

Yet we continue to struggle with inadequate data collection and analysis. Two reports in 7 years in a state of over 1 million citizens should not win us any awards. The Panel continues to need funding and support. We should be able to publish a report every year or at most two and we should, perhaps in concert with the Bureau of Health, do surveillance of all deaths and serious injuries to Maine children.

As can be seen in this report there were several instances, some involving my medical colleagues, of failure to adequately assess and report suspected abuse. This is disturbing to say the least. In many cases this failure delayed protective action such that a child was subsequently injured or killed. The burden of our children's health does not just lie in our families. We are all responsible. Must it take prosecution of those professionals who fail to report to spur us to greater action?

One case of child death resulted from co-sleeping with an intoxicated mother. Co-sleeping when appropriately applied and monitored may have some value to children and parents but in many households, particularly those with risk factors for abuse such as substance abuse, it is a recipe for disaster. Indeed one could almost argue that the risk, any risk, of death far outweighs any benefits.

Successful prosecution has been inconsistently applied both in Maine and the nation. If the twin goals of prosecution are incarceration of offenders to protect us from a criminal and warning the citizenry of the consequences of an offense to prevent a crime, and if we believe that one or both of these goals protect children, then we should be working towards a more aggressive and consistent application of prosecution

and particularly sentencing in Maine. It should be no less serious to injure or kill a child than to injure or kill an adult.

Finally, let me again offer my heartfelt thanks to all the Panel members past and present for their tireless enthusiasm and effort. As always, it has been and continues to be an honor to work with these dedicated professionals.

Lawrence R. Ricci, M.D. Chair - Maine Child Death and Serious Injury Review Panel

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## **KEY POINTS FROM THE WORK OF THE PANEL**

- \* SHAKEN BABY EDUCATION PROGRAMS NEED TO PARTICULARLY TARGET THE MOST LIKELY OFFENDER, THE YOUNG ADULT MALE IN THE HOME
- \* CO-SLEEPING WITH INFANTS CAN POSE RISK OF SERIOUS INJURY OR DEATH ESPECIALLY WHEN OTHER RISK FACTORS SUCH AS SUBSTANCE ABUSE ARE PRESENT
- \* A LARGE PROPORTION OF OFFENDERS WHO TAKE A CHILD'S LIFE BY ABUSE OR NEGLECT RECEIVE MINOR LEGAL CONSEQUENCES FOR THEIR ACTIONS
- \* SEVERAL INSTANCES OF MEDICAL PROVIDER FAILURE TO REPORT CHILD ABUSE/NEGLECT DELAYED PROTECTIVE ACTION
- \* MEDICAL PROVIDERS & OTHER KEY PROFESSIONALS NEED TO CONSIDER CHILD ABUSE IN MANY CLINICAL PRESENTATIONS, E.G. BRUISING IN BABIES
- \* PRIMARY CARE PROVIDERS NEED TO GIVE MORE ATTENTION TO PRENATAL & NEWBORN PUBLIC/COMMUNITY NURSING REFERRALS
- \* EARLY, RAPID COLLABORATION BETWEEN LAW ENFORCEMENT & CHILD PROTECTIVE IS CRITICAL TO CHILD SAFETY & SUCCESSFUL PROSECUTION
- \* SAFETY ASSESSMENTS OF SURVIVING SIBLINGS IS CRITICAL
- \* DEVELOPING A COURT RECORD OF FINDINGS OF FACT MAY BE CRITICAL TO DHS'S PRESENTATION OF EVIDENCE IN SUCCESSIVE COURT CASES
- \* MAINE'S ADVOCACY SYSTEM NEEDS STANDARDS, ACCOUNTABILITY, SUPERVISION & STAFF TRAINING
- \* GOOD SUPERVISION & PEER REVIEW ARE REQUIRED FOR ALL PROFESSIONALS INVOLVED IN CHILD ABUSE & NEGLECT CASES
- \* THERE IS NO "PROFILE" OF ABUSIVE OR NEGLECTFUL PARENTS, BUT CERTAIN CHARACTERISTICS & RISK FACTORS ARE COMMON:
  - \*DOMESTIC VIOLENCE \* SUBSTANCE ABUSE \* PRIOR CPS INVOLVEMENT
  - \*TRANSIENT CHAOTIC LIFESTYLE WITH MULTIPLE UNRELATED CAREGIVERS

- \* PROFESSIONALS INVOLVED IN THESE CASES NEED TO BE ALERT TO THEIR OWN BIASES TOWARD PARENTS WHO MAY APPEAR TO BE "LIKE US".  
LIKEWISE, PARENTAL DEMONSTRATIONS OF AFFECTION & CARING FOR THE CHILD MAY SIDETRACK PROFESSIONALS FROM RECOGNIZING THE PARENT MAY ALSO BE ENDANGERING THEIR CHILD'S SAFETY
- \* DHS CASEWORKERS NEED TO OBTAIN ALL RELEVANT DOCUMENTS/RECORDS REGARDING HOUSEHOLD MEMBERS
- \* DHS CASEWORKERS NEED TO IMPROVE ANALYSIS OF THIS INFORMATION TO MAKE DECISIONS AND TAKE ACTION
- \* AWARENESS OF THE CAUSES OF CHILD ABUSE & NEGLECT, AMONG PROFESSIONALS WITH THE RESPONSIBILITY TO RESPOND TO CHILD ABUSE & NEGLECT, IS UNEVEN. INFORMATION ABOUT THE IMPACT OF CHILD ABUSE & NEGLECT ON CHILDREN APPEARS TO BE EVEN LESS WIDELY KNOWN

## **FINDINGS/RECOMMENDATIONS OF THE PANEL**

### **CASE CHARACTERISTICS**

While there is no "profile" of parents or caregivers involved in child death and serious injury cases, there are certain characteristics that are evident in a significant percentage of cases. These include:

- Domestic violence
- Substance abuse
- An inability to recognize and protect the child from sources of harm
- An inability to recognize and/or meet the child's needs
- Transient, chaotic lifestyles, which include multiple moves and multiple caregivers
- Multiple family problems (e.g. divorce, poor housing, unemployment)
- Prior CPS involvement
- Unrelated and inexperienced caregivers of infants and young children

### **CHILD ABUSE AND NEGLECT ASSESSMENTS**

- I. Child welfare caseworkers have the difficult and complex task of directing and controlling the gathering, synthesis and analysis of information about a family which is related to abuse and neglect. The sources of information are multiple, sometimes incomplete and sometimes in conflict with one another. Caseworkers and Supervisors must then make decisions and take action to protect children based on this analysis. In some cases reviewed by the Panel comprehensive, focused and relevant assessments were completed in a timely fashion. However, in a notable number of cases reviewed by the Panel, all or part of this task was not completed. The focus on child safety and risk assessment became less clear and was sometimes lost. In some of these same cases the capacity and willingness of all caregivers for the child was not assessed. As a result, some children were left in homes where harm to the child occurred. Since abuse and neglect often occur in the context of complex and intertwined family dynamics, care must be used when assessing relatives as possible placement resources for abused and neglected children. In short, safety of children must be paramount.

The ability of parents to recognize and meet the basic needs of children for food, clothing, shelter and nurturance, as well as recognize and anticipate threats of harm

to children, must be a major focus of risk assessment by the Department of Human Services and other service providers. The ability and willingness of parents to put the basic needs of children first is also a critical area for assessment. Assessing the above mentioned areas when parents have mental illness and/or mental retardation is especially difficult. In several cases reviewed by the Panel the conclusions drawn about these areas were not supported by the information contained in the case record. The actions then taken based on these conclusions did not offer sufficient protection for the involved children. In several cases information which was used to assess the safety and risk related to a deceased or seriously injured child was not then used to assess the risk to surviving or uninjured children in the same household.

The new time frames mandated by both federal and state law make it even more important that assessments be focused on risk, and comprehensive enough to provide the basis for informed decision making, service provision and more timely permanence for children in foster care. The Panel acknowledges the progress which the Department is making towards a better, more comprehensive safety and risk assessment system.

- II. Evaluations completed by mental health professionals of individuals who were receiving Child Protective Services were often not helpful to the Department of Human Services or the court in making the difficult decisions required in these cases. Many evaluations did not focus on risk to children nor on a parent's capacity and willingness to care for and protect their children.

The Panel acknowledges recent improvements by evaluations resulting from the State Forensic Service's development of assessment protocols specific to maltreating parents and maltreated children.

- III. Advances have been made in providing professional training concerning behaviors and conditions that pose threats of harm to children. Continuing education must continue. The Panel makes a specific recommendation that the Department of Human Services provide more comprehensive training and support to both new and experienced supervisors and consider instituting a supervisor apprentice program.

## **EARLY IDENTIFICATION AND PREVENTION**

- I. The Panel reviewed three cases where medical providers failed to report obvious child abuse. There were several other cases where medical providers appeared to have little knowledge of the indicators of abuse and neglect.

The panel recommended that existing child abuse and neglect medical management protocols be updated and supplied to all medical providers in Maine.

The Panel requests that the Maine Child Abuse Action Network take responsibility for this effort.

The Department of Human Services needs to undertake renewed effort to educate critical mandated professionals about their reporting responsibility under Title 22 MRSA CHAPTER 1071, The Child and Family Services and Child Protection Act. Information on recognizing abuse and neglect should also be provided in these education programs.

- II. Co-sleeping has been identified by the Panel as posing a risk to infants under certain circumstances. The Panel recommended that the Bureau of Health research this issue and develop professional and public awareness educational programs.
- III. Household items and products caused serious harm to children in a number of cases reviewed by the panel. The panel urges the Bureau of Health to consider developing a method, in cooperation with the Office of Chief Medical Examiner, for issuing product alerts for parents, such as the use of walkers.
- IV. Domestic violence continues to be minimized in its important relationship to child maltreatment. Multidisciplinary training is needed for professional providers and DHS caseworkers to be exposed to current information on domestic violence.

### **CRIMINAL INVESTIGATION AND PROSECUTION**

- I. The Panel identified a number of instances in which investigations worked well to protect children and/or prosecute perpetrators. These included instances of rapid, well organized, well coordinated information gathering and evaluation. Some of these involved law enforcement and some involved joint DHS/law enforcement investigations.

There were also situations where conflicts between DHS and law enforcement interfered with the investigation. Nonetheless, the Panel is pleased with the overall improvement of the working relationship between DHS and law enforcement. The Panel concludes that joint educational experiences and conflict resolution forums and procedures should be continued and enhanced.

- II. The successful criminal prosecution of child maltreatment cases presents numerous challenges. The crimes most often occur in private and child victims are often not able to testify. Successful prosecution is enhanced by a number of factors including:
  - Rapid reporting to law enforcement
  - Legally sound interviewing
  - Careful documentation by first responders such as physicians
  - High quality photo and video documentation of the child's condition and their home.

- III. The Panel found sentencing for child homicide to be significantly more lenient than that for comparable or even lesser crimes against adults. These sentencing practices and options need to be reviewed. (see Appendix)

A premature decision about individual culpability has resulted in investigators failing to fully explore the role of each potential perpetrator.

- IV. There were a couple of cases in which evaluations of juveniles and adults conducted by the Department of Corrections were inadequate. The panel recommends increased training for Department of Corrections staff in the dynamics of domestic violence, child abuse and risk assessment. The Panel also recommends increased support to the Department of Corrections to allow probation workers adequate time to assess and monitor the individuals on their caseloads.

These findings appear to reflect years of inadequate funding to the Department of Corrections. The Department of Corrections is an important aspect of the safety net that has been chronically underfunded to the detriment of Maine's children and the Panel recommends the Department of Corrections appoint a representative to participate in the Child Death/Serious Injury Review Panel.

- V. In prosecution and sentencing of juvenile offenders, the current sentencing options available to judges are too rigid and restrictive. National studies of juvenile murderers consistently indicate good outcomes, with little recidivism, with adequate interventions.

### **CIVIL PROSECUTION**

Successful civil prosecution of child maltreatment cases is enhanced when DHS maintains focus on the following areas:

- Assessing potential risks presented by all household members when a child has been harmed, but a specific perpetrator cannot be identified.
- Documenting all facts in a child protective record, whether developed by Department of Human Services, law enforcement, mental health or other professionals; and doing so irrespective of the outcome of any criminal prosecution.
- In cooperation with the Department of Attorney General, clearly articulating and documenting all the evidence which describes the nature of the jeopardy alleged, and the risks and benefits posed by potential plans to address that jeopardy.

### **SERVICES AND TREATMENT**

- I. In formulating service plans for parents who maltreat their children, too often professionals often fail to identify the real bases of risk in the family and/or to target risk specifically in treatment. As a result, parents may be able to successfully complete treatment and still pose a risk to their children. Mental health interventions need to be specifically tied to risk assessment. Training in this area has been developed and continues to be important for providers and caseworkers alike.
- II. The Panel's reviews of situations where parents with mental illness pose risk to their children indicate that mental health providers as well as DHS caseworkers struggle with understanding what the risks are, how to assess them and how to effectively treat them. Additional training for providers and caseworkers in this area would be useful.
- III. It is common for parents, especially those with mental illness or mental retardation, to have a number of people advocating for them including providers and professional advocates. In these situations, the needs of the child are easily overshadowed by the compelling needs of the parent. The importance of advocating for children's needs in these situations needs to be stressed in training and in public policy.

The Panel found that the mental health advocacy system is in need of training, establishment of professional and ethical standards, and a system of supervision and accountability that ensures adherence to those standards.

## **THE ROLE OF PROFESSIONALS**

Professionals need to be aware of possible bias when working with persons who are similar to themselves or who present in an attractive or appealing manner. For example, professionals may overly rely on the family's self-report regarding the child's well-being, rather than seeking independent corroboration or taking appropriate protective action.

Professionals may be confused by expressions and demonstrations of caring by a parent to such a degree that they do not fully explore or correctly evaluate a parent's capacity and willingness to care for and protect their child. Good supervision and peer review are important aspects of professional practice in child abuse and neglect cases.

## **CHALLENGES**

- I. The Panel continues to see the impact on DHS staff of the increase and numbers of reports of child abuse and neglect coming to the Department, the impact of pressures relating to the needs of children in out-of-home care.
- II. Law enforcement agencies, the Department of the Attorney General, the Judiciary, The Department of Corrections, and Public Health Nursing are all significantly understaffed. Specialized mental health services for abused and neglected children and their families are not available in the number and quality required.
- III. The new federal and state law aimed at more timely permanence for children in DHS foster care and increased court oversight of the process will tax the above resources even more.
- IV. Creating and maintaining collaboration, communication and coordination between and among professionals must be continued and intensified.

## ANALYSES OF CHILD DEATH/SERIOUS INJURY DATA

### CASES REVIEWED BY THE PANEL 1995-1998

<b>Case</b>	<b>Age</b>	<b>Sex</b>	<b>Outcome</b>	<b>Panel Conclusion</b>
27.	3 yr.	Female	Lived	Munchausen Syndrome by Proxy by mother
28.	6 yr.	Female	Died	Murder/Suicide by father in custody dispute
29.	7 yr.	Male	Died	Murder/Suicide by father in custody dispute
	10 yr.	Male	Died	Murder/Suicide by father in custody dispute
30.	6 yr.	Male	Lived	Sadistic torture by mother's boyfriend
31.	0.1 yr.	Female	Lived	Non-organic failure to thrive in care of mother
32.	1 yr.	Male	Died	Heat Stroke neglect in care of mother
33.	1 yr.	Female	Lived	Shaken Baby Syndrome by father
34.	1.5 yr.	Female	Lived	Shaken Baby Syndrome by father
35.	11 yr.	Male	Lived	Sadistic torture by stepfather
36.	0.1 yr.	Male	Died	Co-sleeping with intoxicated mother
37.	0.7 yr.	Female	Died	Battered Child Syndrome by one or both parents
38.	5 yr.	Male	Died	Complications of chronic illness in care of parents
39.	0.2 yr.	Male	Died	Poisoning in care of father
40.	9 yr.	Male	Died	Battered Child Syndrome by father
41.	4 yr.	Female	Died	Battered Child Syndrome by mother's boyfriend
42.*	0.1 yr.	Male	Lived	Sibling of Case 37, protected by DHS custody
43.	1.5 yr.	Female	Lived	Munchausen Syndrome by Proxy by mother
44.	0.2 yr.	Male	Died	Asphyxiation by mother
45.	0.1 yr.	Male	Lived	Shaken Baby Syndrome by one or both parents
46.	0.1 yr.	Female	Lived	Shaken Baby Syndrome by father
47.	1.5 yr.	Female	Died	Battered Child Syndrome by mother's boyfriend
48.	2 yr.	Female	Died	Battered Child Syndrome by mother or boyfriend
49.	3 yr.	Female	Died	Asphyxiation due to neglect while in care of parents
50.	0 yr.	Female	Died	Neonatacide while in care of mother as newborn
51.	15 yr.	Male	Died	Suicide
52.	1.5 yr.	Male	Died	Poison ingestion while in care of mother

\* Not included in data analysis

## **CASE SUMMARIES**

- Since the last report in 1995, the Panel has reviewed an additional 25 cases involving 26 children from 1996, 1997 and 1998. 13 (50%) were female and 13 (50%) were male. The average age was 3 1/2 but 8 (30%) children were under 1 year of age and 12 (46%) were under 2 years of age. As can be seen in the accompanying bar graph, the majority of the children were under the age of 5.
- 17 Children Died (65%) from the following causes:
  - Neglect 7
  - Battered Child Syndrome 5
  - Murder/Suicide 3
  - Neonatacide 1
  - Suicide 1
- 9 Children Lived (34%) but experienced the following:
  - Shaken Baby Syndrome 4
  - Munchausen Syndrome by Proxy 2
  - Torture 2
  - Failure to thrive 1
- 14 cases - had 2 adult caregivers in the home
- 5 cases - biological father was identified abuser
- 3 cases - boyfriend was identified abuser
- 5 cases - biological mother was identified abuser
- 17 cases - involved domestic violence
- 8 cases - involved substance abuse

This was the first time the Panel had an opportunity to review a particularly troubling form of child abuse, that of the predatory sadist. Both cases involved a boyfriend/stepfather who chose to discipline an older boy via sadistic torture, in one case while a hapless mother stood by and watched.

Three children in two families were murdered by their father in a murder/suicide and in both cases a divorce/custody conflict was present.

The Panel continues to frequently review cases of Shaken Baby Syndrome (see separate discussion) and cases of severe battering of older children. The most common perpetrator was the male figure in the home although we did see a case of Neonatacide and two cases of Munchausen Syndrome by Proxy, both forms of abuse almost always perpetrated by the mother.

## **REFLECTIONS FROM THE PANEL**

### **FORENSIC MENTAL HEALTH**

Forensic Mental Health has made some significant advances in the area of child maltreatment assessment and interventions. In Maine, the State Forensic Service's Child Abuse and Neglect Evaluation Program (described in another section of this report) provides empirically based evaluations to assist the courts in child maltreatment cases. Furthermore, the State Forensic Service, the Departments of Human Services and Corrections, and the Maine Child Abuse Action Network have worked, often collaboratively, to provide professional training based on current research studies, develop empirically based assessment protocols, and identify clinicians throughout the state who can provide needed evaluations and interventions.

In spite of this important progress, this is only a beginning. The need for timely forensic evaluations is acute. Problems that interfere with timely assessments, (such as "no shows" for evaluation appointments) must be identified and resolved. Additional evaluators and evaluation teams need to be identified or developed to facilitate assessments that are tailored to the developmental needs of children. Because the assessment of issues related to child maltreatment is a specialized and developing area, continuing education and training is required.

Maine's efforts are well ahead of the nation in delivering meaningful and reliable input to the courts in this highly complex field, largely the result of extensive forensic training.

Lastly, but very importantly, risk assessment research that identifies the factors that best predict increases and decreases in the risk of maltreatment is required. This area of research is receiving increasing attention in the sex offender field, but has not been developed in other areas of child maltreatment. Reliable and validated risk assessment protocols facilitate more accurate and timely assessments and can be used to implement interventions that more effectively meet the needs of children and families.

Sue Righthand, Ph.D.

Ulrich Jacobsohn, M.D.

Ann LeBlanc, Ph.D.

## **FORENSIC PATHOLOGY**

As the new Chief Medical Examiner who was appointed to succeed the 22 year tenure of Dr. Henry Ryan, it has been very helpful for me and my Deputy Chief, Dr. Michael Ferenc, to participate as members of the Multidisciplinary Child Death and Serious Injury Review Panel. The enhanced ability to meet and develop working relationships with individuals in each of the disciplines has been invaluable. Within the scope of the committee's reviews, the primary function of the Medical Examiner is to provide information and opinions to those who protect, investigate, prosecute, and treat the effects of child abuse and neglect. While we act only in very specific instances, the information we develop may have far-reaching effects. Participation on the Panel has sharpened our awareness of the need to make that information available as efficiently as possible to the individuals and agencies who depend upon it for their function.

During the next year, our office will focus on becoming networked to the Maine state system and implementing a computer software system which will allow efficient data organization and more rapid retrieval of information. This will enhance our ability to follow child fatality trends and pinpoint specific areas of public interest. In turn, this improved database may allow our multidisciplinary Panel to recognize and predict those children at risk of abuse.

Margaret S. Greenwald M.D.  
Chief Medical Examiner

Michael J. Ferenc, M.D.  
Deputy Chief Medical Examiner

## **LAW ENFORCEMENT**

It is an honor to participate in the writing of the second public report of the multidisciplinary Child Death/Serious Injury Review Panel. For Major Love and I, representing the Panel has been both interesting and rewarding. The hard work and dedication of the professionals assigned to these cases, especially from the Department of Human Services and Law Enforcement agencies from across the state, has been inspiring. While much is currently being done to protect Maine's children, it is clear that we can and must do better.

While collaboration is a "buzzword" for the 1990's, it is absolutely critical when it comes to working to protect our children, or investigating the incidents where our children were injured or killed. The Department of Human Services and Law Enforcement generally have a good working relationship, but more needs to be done to strengthen it. Sandra Hodge, Director of child protective services, has always been a proponent of joint trainings and has launched efforts to continue in this vein. Any training which increases the awareness of each others role and responsibility is important, and we stand ready to cooperate in any way we can. Public Health Nursing this year also sponsored training and invited DHS, Law Enforcement, and the Medical Examiner to speak. This was an excellent opportunity to share with each other what it is we do.

The work of the panel has been important in demonstrating areas for improvement within the disciplines represented. While we feel that Law Enforcement has generally done a superb job at investigating these cases, it is important to be mindful of the lessons learned from mistakes made, or areas for improvement. Presenting cases to the panel has also been of great benefit to our staff. It has served to foster a greater appreciation for the other disciplines involved. The input from the experienced professionals involved in the review has always been welcomed and has served to make our people better detectives.

Finally, we would like to extend our thanks to Phyllis Merriam, staff assistant to the panel. Without her, the important work of the panel would not be possible.

Major Charles Love, Commanding Officer  
Operations & Field Troops  
Maine State Police

Lt. Timothy Doyle  
Maine State Police, CID II

## **FAMILY MEDICINE**

Understanding the complexity of familial dynamics is at the very basis of family practice. Without this insight one can only treat symptoms and the persons behind the diagnosis or treatment can be forgotten.

In reviewing the many and disturbing cases of Maine's children who have been killed or maimed as the result of a possible breakdown in the very systems designed to protect them, I see the need for and the role of family medicine much more clearly. Primary care providers are often the first to see or hear of signs of abuse or neglect that subsequently goes unreported. People may feel that by reporting to a doctor's office suspicious bruises or alleged domestic violence that they have done their societal duty. However, all too often the report goes no further or is not legitimized.

Only by educating our doctors, physician assistants and nurse practitioners, who are on the frontlines hearing many of these reports, can we hope to begin halting these tragedies before they occur. Nurses too have and continue to play a critical role here from home visits to simply hearing a concerning story through a telephone call. Only by raising awareness of when to act and who to call will we be able to further the fight to end the senseless abuse, neglect and death of our children. Furthermore, a more collaborative effort in these situations would not only expedite intervention, but also allow professional cooperation that would cut through much of the bureaucracy that impedes current reporting and subsequent action.

This committee has been tremendously rewarding and educational on both a personal and professional level. I feel very fortunate to work with such a dedicated and caring group of professionals as we work toward a common goal of eradicating the need for such a committee. Until that time, we shall continue our work to promote critical thinking with regard to the many cases of child deaths and serious injury.

Douglas J. Jorgensen, D.O.

## **PUBLIC HEALTH NURSING**

As we review the cases of children who have died or been seriously injured, we find that many of these children have not had a Public Health Nurse or Community Health Nurse working with the family. We would suggest a closer working relationship with primary health care providers, encouraging referrals to Public Health Nursing and Community Health Nursing, particularly in the prenatal and newborn period.

We have also noted that families are often transient, and often get “lost” in the system. We would recommend better communication between all service providers in support of the family.

Continuing education on Child Protective Services, as well as programs specific to mental illness, would be beneficial in updating Public Health Nurses and Community Health Nurses. Continuing education programs bringing together Child Protective Services and Public Health Nurses/Community Health Nurses is essential for the development of effective communication between these service providers. This will facilitate both disciplines in understanding the roles and boundaries of one another to best serve the families. Continued community placement of persons with mental illness requires regular updating of service providers, such as Public Health Nurses. It is important for service providers to recognize the signs and symptoms that may not be recognized as mental illness as well as what referrals need to be made based upon these symptoms.

Pat Bond, R.N., Director  
City of Bangor Public Health Nursing

Luanne Crinion, R.N., M.S.  
Public Health Nurse Supervisor  
Division of Community & Family Health  
Department of Human Services

## **PUBLIC CHILD WELFARE**

Providing child protective services is a critical and complex process which occurs in the context of legal mandates, professional standards of good practice and conflicting community values and expectations. Recent additional pressures on the field of child protection in Maine include Federal incentives to incorporate computer technology by creating a Child Welfare Information System, and significant changes in Federal and State laws governing how child welfare services must be delivered, including significant court oversight.

The review of cases by the Child Death/Serious Injury Review Panel points to the need for Child Protective Services and Children's Services staff to emphasize the basics:

1. Gathering information (including past and current records) relevant to child safety and child maltreatment.
2. Synthesizing the information within a valid theoretical framework of child maltreatment.
3. Analyzing the information to determine what type of abuse and neglect is present, if the child is safe, what is the overall level of risk to the child, what are the underlying causes of risk and what are the family's protective capacities.
4. Taking action necessary to protect the child, that seeks to control, manage or mitigate the threats of harm to a child. This could include:
  - Petitioning the court for custody or court ordered services.
  - A family service plan including referrals to appropriate community agencies.

Sandra Hodge, Director, Division of Child Welfare

Phyllis Merriam, Manager, Child Protective Intake

Mary Dionne, (Retired) District Program Administrator

## **COMMUNITY MENTAL HEALTH**

The case reviews carried out by the Child Death and Serious Injury Review Panel provide a rich opportunity for understanding what our profession does well in the areas of assessing and treating children and their families. It also highlights areas that require additional training and development. It is clear that the profession has made progress in the past four years, since the last report of the Panel. However, mental health practitioners in the community are still in need of additional training. This is particularly true in the specialized area of assessing the risk to children in maltreating families. Here, our field needs to dedicate itself to developing more reliable and valid measures of maltreatment, which can be efficiently and effectively employed with diverse children and adult clients. In addition, the mental health community must continue to design and implement new treatment strategies which protect children and stabilize families.

Karen K. Mosher, Ph.D.

Neil Colan, Ed.D.

## **ASSISTANT ATTORNEY GENERAL**

I am very honored to be a member of this important Panel. I have benefited professionally from the knowledge acquired through the Panel's comprehensive case reviews and particularly from the Panel's deliberations of these troubling and important cases. However, we could not accomplish our mission without Phyllis Merriam's able assistance. She deserves a great deal of credit for enhancing the quality of the Panel's work and for helping us get through the voluminous documents provided for our consideration.

I have been representing the Department of Human Services in civil child protective matters for several years. I cannot think of a field of work more important, more challenging, or more rewarding. To work in this field requires specialized knowledge in an ever changing field. It also requires dedication, compassion and a great deal of emotional strength. The public is outraged when a child is killed or seriously injured by a parent or caretaker and is quick to blame the Department of Human Services when tragedy strikes. My hope is that the work of this Panel will provide the public with a better understanding of the dynamics of child abuse and neglect and will lead the public to support all of our efforts to protect children at risk.

Over the years, the Panel has made many recommendations to improve the Department's efforts to protect children. In my work, I have seen positive changes made by the Department in response to the Panel's recommendations. Nevertheless, we can always do more. Child protective caseworkers need better training, better supervision, better pay, more support services, and access to more community resources. The public should demand this, and the children deserve this even more.

Recent changes in the law and court procedures have been initiated to make the civil legal system more responsive to the needs of children in child protective proceedings. While preserving the integrity of families remains an important goal, children removed from abusive/neglectful homes will no longer have to wait unreasonable lengths of time for their cases to be resolved. Unless the "system" is provided the resources needed to carry out the statutory mandates, my fear is that we will not achieve the results desired. Good legislative intentions without adequate fiscal support are meaningless. This situation needs to be carefully monitored.

On occasion, the Panel has expressed frustration with the legal system's response to a particular child protective matter. In my opinion, the legal system is not the best forum to address these matters. The adversarial process is not the most productive way to resolve complicated family matters, especially when child protective services are involved. In my experience, the most successful cases, from the child's best interests standpoint, occur when the parties involved, including treatment and services providers, cooperate with each other to achieve the desired outcomes. I am encouraged that efforts have been made to implement alternative resolution procedures to resolve child protective matters. The Panel should be kept informed of these efforts.

With the benefit of hindsight, the Panel has the unique opportunity to gain a better understanding of the circumstances surrounding a child's death or serious injury. It is important that we continue to use the knowledge we gain to encourage improvements in the field of child protection. While the Panel is careful about public criticism of an agency, organization, or individual who may have played a role in failing to prevent a child's death or serious injury, it is important for the Panel to take firm stands when addressing identified system failures. By identifying failures in the system which culminated in the death or serious injury of a child, the Panel can make recommendations which may spare another child a similar and horrible fate. Although we need to be careful not to misplace blame, I am committed to doing my part to ensure that the Panel carries out this responsibility.

Lou Ann Clifford  
Assistant Attorney General

## **APPENDIX**

## **Abusive Head Trauma in Maine Infants 1991-1994 A Medical, Child Protective, and Law Enforcement Analysis**

Detective Lieutenant Timothy Doyle  
Phyllis Merriam, L.M.S.W.  
Lawrence R. Ricci, M.D.

This retrospective study analyzed 20 cases of abusive head trauma in Maine infants under the age of 2 over a 4 year period. The study was conducted with the collaboration of the Office of Chief Medical Examiner, the Maine Child Death and Serious Injury Review Panel, the Maine State Police, the Spurwink Child Abuse Program, the Maine Department of Human Services Bureau of Child and Family Services, and the Childhood Injury Prevention Program and Community Health Nursing. The review had grant support from the Maine Department of Human Services, Bureau of Health, Division of Community and Family Health.

This study identified 20 cases involving 19 children who were hospitalized over the 4 years 1991-1994 with inflicted intracranial trauma. The criteria for inclusion in the study were children under the age of 24 months with brain trauma, plus one or more of the following: admitted or witnessed assault, inconsistent history, unexplained suspicious bruises, unexplained serious suspicious fractures, and retinal hemorrhages. There were 95 children admitted to Maine hospitals, specifically Maine Medical Center and Eastern Maine Medical Center, during the study period for head trauma. Of these 95, 20 (21%) met the study criteria indicating that when a child under the age of 2 is hospitalized there is a 1 in 5 chance that that child's injuries were inflicted.

There were 20 hospital admissions, involving 19 children (one child was hospitalized twice). The mean age of the children was 7.5 months, with a range of 2 weeks to 17 months. Of the 19, 11 (58%) were males, and 8 (42%) were females. This slight preponderance of males has been described in other studies and remains an interesting but unexplained finding. The presenting complaint in 40% of the cases was acute unexplained illness and in 60% of the cases, acute injury. In all cases of injury, however, the force described was minor, such as a fall of less than four feet. In addition, 30% of the cases had a history that changed with each telling; 25% had a delay in seeking treatment; 30% had a history of past injury; 45% had a history of prior symptoms suspicious for prior injury; and 65% had a history of prior medical evaluations for symptoms also suspicious for prior injury.

Although often considered a hallmark of inflicted trauma, a changing history and delay in seeking treatment were not frequently found.

Of particular interest was the fact that 13 (65%) of these children had prior medical evaluations for symptoms that could have been related to prior head injuries. One child had a bruise at age 6 weeks. The literature is clear that any bruising in infancy is of

concern. One child had two visits for crying, if not a symptom of abuse certainly a risk factor for abuse. One child had a fractured leg at 2 months of age, again highly suspicious. Two children had seizures. Three children had symptoms of irritability and lethargy.

On physical examination, 12 (60%) had bruises that were suspicious for inflicted trauma, whereas 15 (75%) had physical evidence of prior injury, either in the form of old bruises, old fractures, old retinal hemorrhages, or old brain injuries.

The presentations for all these children were generally quite severe, with 50% presenting with seizures, 45% presenting in coma, 30% presenting with apnea, 40% with a tense anterior fontanel, and 35% with enlargements in head circumference. Indeed, 55% had either a tense anterior fontanel or enlarged head circumference, findings that medical providers should be on the alert for.

Nineteen (95%) had retinal hemorrhages, and nine (45%) had bloody cerebral spinal fluid on lumbar puncture, suggesting the presence of subarachnoid hemorrhage.

Bone surveys were done in 90% of children, and fractures were present in 10 of the 18 who had these studies done. Bone scans were done in 13 children, of which two revealed new findings that were otherwise unsuspected on the bone survey. The data indicates that screening radiologic studies are being done in the two major medical centers in Maine and that bone scans are useful. Nine of 20 children had skull fractures indicating that at least half the children who have inflicted head trauma in infancy sustain impact in addition to shaking.

In terms of disposition, three children died; eight went into foster care; five went home without the alleged perpetrator in the home; and four, surprisingly, went home with the alleged perpetrator still in the home, primarily because of lack of clarity in the medical diagnosis. The three children who died presented little differently from the children who did not die except that one child had diffuse axonal injury to the brain.

CT scans were done in 19 of the 20 children. The only exception was a child who died prior to CT scan. MRI scans were done in three. All 19 had subdural hematomas, of which six were posterior, a particularly important finding in inflicted trauma. Cerebral edema was present in 10 of the 19, and parenchymal injury, a marker for later disability, was present in 6 of the 19.

Of the 20 cases, hospitals diagnosed 16 as abused. Two were children who died and were subsequently diagnosed as abused by the medical examiner. The other two were not diagnosed as abused primarily because hospital personnel believed the initial history. Child Protective Services was notified fairly immediately in all cases although law enforcement was rarely notified probably due to confusion about law enforcement reporting.

Of the 16 survivors, eight had moderate to severe neurologic impairment.

Parental risk factors were often, although not uniformly present. Substance abuse was present in 53% of the cases; domestic violence in 42%; unrealistic expectations of the child in 42%; parents who were abused as children in 37%; attachment concerns in 32%; and prior criminal history in 32%. Single parentage was only present in 10%; mental health history only present in 16%; and unemployment only present in 5%. The average age of the mother was 24.7 years and the average age of the father was 27.5 years. There were only two teenage mothers and only two teenage father figures. We noted that risk factors were poorly assessed and/or documented by child welfare personnel in 50% of the cases. Most interestingly, there were no apparent risk factors present in four cases and only one risk factor present in three cases. Family composition was also interesting, with mother and father both being in the home in 73% of the cases and married in 53%.

In reviewing child risk factors and triggers, five children were identified as difficult for the father to manage, and four children were identified as crying persistently. Indeed, when trigger for inflicted injury was identified, most commonly it was crying.

A perpetrator was identified by law enforcement in 15 of 19 cases. The most likely perpetrator was biological father in 10 cases, baby-sitter in 2, stepfather in 1, boyfriend in 1, and mother in 1. Males were identified as the most likely perpetrator in 13 cases, with the average age of the perpetrator being 26. Of these males, 40% had a prior criminal history.

The caretaker at symptom onset was the father in 10 of 20 cases and stepfather in 2 of 20 cases. Indeed, the data strongly indicated that the person alone with the child at the time of symptom onset may be the most likely suspect.

Of 19 cases, 13 were prosecuted. Two were found guilty; seven pled; three were acquitted; and one did not go to trial. Confessions occurred in four cases. We had information on nine cases regarding sentencing. In two fatal cases one individual pled and received a 15-year sentence and another went to trial and received an 8-year sentence following conviction. In the seven non-fatal cases, one case went to trial and the convicted perpetrator received a 10-year sentence while six pled and received minimal sentences, e.g., two years, one year, 90 days, 30 days.

This review arrived at the following conclusions and recommendations:

1. Multidisciplinary case reviews were useful and should be ongoing.
2. Early multidisciplinary notification and case collaboration between law enforcement, Child Protective Services, and medicine is crucial to identification, protection and prosecution.

3. Medical providers should consider child abuse in many clinical presentations in infancy, particularly any infant with bruising.
4. Child Protective risk assessment should look very closely at underlying risk factors.
5. Shaken baby community education programs should aggressively target male caretakers, including those seemingly at low risk.

## **BACKGROUND OF MAINE'S CHILD DEATH/SERIOUS INJURY REVIEW PANELS**

- HISTORICALLY THE DEPARTMENT OF HUMAN SERVICE'S BUREAU OF CHILD AND FAMILY SERVICES HAS, AND CONTINUES TO, CONDUCT INTERNAL REVIEWS OF DEATHS AND SERIOUS INJURIES TO CHILDREN KNOWN TO THE BUREAU OF CHILD AND FAMILY SERVICES
- MULTIDISCIPLINARY REVIEWS OF CHILD ABUSE AND NEGLECT DEATHS AND SERIOUS INJURIES WERE INITIATED BY THE DEPARTMENT OF HUMAN SERVICES COMMISSIONER MICHAEL PETIT IN THE MID-1980'S
- IN APRIL 1992 THE DEPARTMENT OF HUMAN SERVICES REVIVED MULTIDISCIPLINARY CHILD FATALITY/SERIOUS INJURY REVIEWS WITH AN EXPANDED PANEL WHICH ON 5-1-92 BEGAN MONTHLY REVIEWS OF THESE CASES
- MAINE'S PANEL BELONGS TO THE CONSORTIUM OF NORTHERN NEW ENGLAND CHILD FATALITY REVIEW TEAMS

# CHILD PROTECTIVE SERVICES DATA 1995, 1996 AND 1997

## SUBSTANTIATED CASES

### Number of Families with a Substantiated Case

<u>1995</u>	<u>1996</u>	<u>1997</u>
2,286	2,183	2,792

### Numbers of Children in Substantiated Cases

#### 1995

<u>Ages</u>	<u>Sexual Abuse</u>	<u>Physical Abuse</u>	<u>Neglect</u>	<u>Emotional Abuse</u>
0-4	55	141	610	524
5-8	130	205	438	503
9-12	118	193	300	456
13-15	77	122	203	264
16-17	46	60	83	100
Total	426	721	1,634	1,847

#### 1996

<u>Ages</u>	<u>Sexual Abuse</u>	<u>Physical Abuse</u>	<u>Neglect</u>	<u>Emotional Abuse</u>
0-4	43	150	633	566
5-8	109	197	435	532
9-12	115	201	318	476
13-15	82	119	172	262
16-17	28	45	71	102
Total	377	712	1,629	1,938

#### 1997

<u>Ages</u>	<u>Sexual Abuse</u>	<u>Physical Abuse</u>	<u>Neglect</u>	<u>Emotional Abuse</u>
0-4	47	173	641	657
5-8	130	105	540	708
9-12	107	194	399	657
13-15	84	154	225	399
16-17	56	70	89	171
Total	424	696	1,894	2,592

## **FAMILY STRESS FACTORS**

For the years 1995, 1996 and 1997 the family stress factors listed below with the most frequently identified factor listed first, remained the same as the three preceding years.

The Department's ability to respond to all appropriate reports of child abuse and neglect was strengthened in 1997 as a result of a new pilot program. This program was set up in three counties to assess and provide services to low risk cases from the Department which allowed Child Protective Services caseworkers time to focus on moderate and high risk cases. The program was successful and was expanded into twelve counties by 1998 and will be operating in all 16 counties by late 1999.

**Family Violence/Assaultive Behavior**  
**Alcohol/Drug Misuse by Parent/Caretaker**  
**Mental/Physical Health Problem of Parent**  
**Parent/Child Conflict**  
**Mental/Physical Health Problem of Child**  
**Severe Acting Out Behavior of Child**  
**School Problems**  
**Divorce Conflict**  
**Child Withdrawn/Depression**

## **ENABLING LEGISLATION**

During the 1993 legislative session, the panel and its functions were established in an amendment to 22 MRSA Chapter 1071 Child and Family Services and Child Protection Act.

### **Pertinent Statutory Provisions**

#### **22 M.R.S.A. § 4004 (1):**

E. Establishing a child death and serious injury review panel for reviewing deaths and serious injuries to children. The panel consists of the following members: the Chief Medical Examiner, a pediatrician, a public health nurse, forensic and community mental health clinicians, law enforcement officers, departmental child welfare staff, district attorneys and criminal or civil assistant attorneys general.

The purpose of the panel is to recommend to state and local agencies methods of improving the child protection system, including modifications of statutes, rules, policies and procedures.

#### **22 M.R.S.A. §4008 (2):**

E. A person having the legal responsibility or authorization to educate, care for, evaluate, treat or supervise a child, parent or custodian who is the subject of a record, or a member of a panel appointed by the department to review child deaths and serious injuries. This includes a member of a treatment team or group convened to plan for or treat a child or family that is the subject of a record. This may also include a member of a support team for foster parents, if that team has been reviewed and approved by the department;

#### **22 M.R.S.A. § 4008 (3-A):**

Confidentiality. The proceedings and records of the child death and serious injury review panel created in accordance with section 4004, subsection 1, paragraph E are confidential and are not subject to subpoena, discovery or introduction into evidence in a civil or criminal action. The commissioner shall disclose conclusions of the review\_panel upon request, but may not disclose data that is otherwise classified as confidential.

#### **22 M.R.S.A. § 4021. Investigations**

1. Subpoenas and obtaining criminal history. The Commissioner, his delegate or the legal counsel for the Department may:
  - A. Issue subpoenas requiring persons to disclose or provide to the department information or records in their possession that are necessary and relevant to an investigation of a report of suspected abuse or neglect to a subsequent child protection proceeding or to a panel appointed by the department to review child deaths and serious injuries.

## MEDICAL EXAMINER DATA

### CHILD DEATHS BY TYPE - 1996

	Under 1	1 thru 12	13 thru 17	Total
Homicide	1		1	2
Suicide		1	5	6
SIDS	5			5
Natural (other than SIDS)		6	1	7
Accidental	1	7	4	12
Motor Vehicle		12	19	31
Undetermined	1	1		2
Total	8	27	30	65

### CHILD DEATHS BY TYPE - 1997

	Under 1	1 thru 12	13 thru 17	Total
Homicide	1	3	1	5
Suicide			10	10
SIDS	2			2
Natural (other than SIDS)		1	2	3
Accidental		15	2	17
Motor Vehicle		6	9	15
Undetermined		2		2
Total	3	28	23	54

## 1996 CHILD HOMICIDES

<u>VICTIM</u>	<u>MANNER</u>
4 mos. female	Blunt Head Trauma
13 yrs. female	Gunshot

## 1996 CHILD ABUSE/NEGLECT DEATHS

<u>VICTIM</u>	<u>MANNER</u>
9 wks. male	Poisoning
8 yrs. female	Hypothermia

## **1997 CHILD HOMICIDES**

<b><u>VICTIM</u></b>	<b><u>MANNER</u></b>
<b>4 mos. old female</b>	<b>Blunt Head Trauma (Shaken Baby Syndrome)</b>
<b>4 yr. old female</b>	<b>Blunt Head Trauma</b>
<b>16 yr. old male</b>	<b>Stabbed</b>
<b>12 yr. old male</b>	<b>Gunshot to Head/Face</b>
<b>Newborn Female</b>	<b>Asphyxiation</b>

## 1997 CHILD ABUSE/NEGLECT DEATHS

<u>VICTIM</u>	<u>MANNER</u>
35 mos. old female	Asphyxiation

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## 1997 UNDETERMINED DEATHS

2yr. Female	Found Dead
2mos. male	Found Dead
8 yr. male	Asphyxiation

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OF THE 13 VICTIMS OF CHILD HOMICIDES, CHILD ABUSE/NEGLECT DEATHS AND UNDETERMINED CAUSE OF DEATH IN 1996 AND 1997:

- 6 VICTIMS WERE KNOWN TO CHILD PROTECTIVE SERVICES
- 8 VICTIMS WERE FEMALE
- 5 VICTIMS WERE MALE
- 7 VICTIMS WERE FROM TWO PARENT FAMILIES
- 16 SURVIVING SIBLINGS/HALF-SIBLINGS
- 8 VICTIMS DIED IN THE SUMMER
- 8 VICTIMS DIED FROM FAMILY MEMBERS OR FRIENDS ACTIONS OR INACTION
- 5 VICTIMS CRIMINAL CASES HAVE PROSECUTION PROBLEMS

# **MULTIDISCIPLINARY CHILD DEATH AND SERIOUS INJURY REVIEW PANEL**

## **MISSION STATEMENT**

To provide multidisciplinary, comprehensive case review of child fatalities and serious injuries to children in order to promote prevention, to improve present systems and foster education to both professionals and the general public.

To collect facts and provide opinion and articulate them in a fashion which promotes change.

To serve as a citizen review panel for the Department of Human Services as required by the federal Child Abuse Prevention and Treatment Act P.L. 93-247.

## **REVIEW PROTOCOL**

1. The Panel will review cases of children up to age eighteen, who were suspected to have suffered fatal child abuse/neglect or to have suffered serious injury resulting from child abuse/neglect.
2. Comprehensive, multidisciplinary review of any specific case can be initiated by the Bureau of Child and Family Services, by the Commissioner of the Department of Human Services or by any member of the multidisciplinary review panel.
3. Cases may be selected from a monthly report that includes major injuries and deaths in the preceding month, as well as a summary of deaths and major injuries from the preceding year.
4. All relevant case materials will be accumulated by the Department of Human Services staff and disseminated to the members of the review panel.
5. After review of all confidential material, the review panel will provide a confidential summary report of its findings and recommendations to the Commissioner of the Department of Human Services.
6. The review panel may develop, in consultation with the Commissioner of the Department of Human Services, periodic reports on child abuse fatalities and major injuries, which are consistent with state and federal confidentiality requirements.

## **PANEL CONFIGURATION**

- REPRESENTATIVE LEADERS OF THE JUDICIARY, FORENSIC PATHOLOGY, FORENSIC AND COMMUNITY MENTAL HEALTH, PEDIATRICS, FAMILY PRACTICE, NURSING, PUBLIC HEALTH, CIVIL AND CRIMINAL LAW, LAW ENFORCEMENT, AND PUBLIC CHILD WELFARE WHO VOLUNTEER THEIR TIME REVIEW EXTENSIVE CASE RECORDS IN PREPARATION FOR MONTHLY RETROSPECTIVE CASE REVIEWS
- DOCTORAL CANDIDATES COMPLETING THEIR CLINICAL OR FIELD PLACEMENTS REGULARLY PARTICIPATE IN THESE CASE REVIEWS AS PART OF THEIR EDUCATION AND TRAINING

## **UNIQUE FUNCTIONS OF MAINE'S REVIEW PANEL**

- MOST STATES REVIEW CHILD FATALITIES; MAINE'S PANEL REVIEWS SERIOUS CHILD ABUSE AND NEGLECT INJURIES, AS WELL AS CHILD ABUSE AND NEGLECT FATALITIES, OR SUSPICIOUS DEATHS
- CENTRALIZED REVIEW OF THESE CASES BY OUR STATE TEAM. (MORE POPULOUS STATES USUALLY HAVE LOCAL TEAMS, AS WELL)
- CENTRALIZED FORENSIC MEDICAL EXAMINER SYSTEM AND REPRESENTATION ON PANEL PROMOTES STANDARDIZED FORENSIC CHILD DEATH INVESTIGATIONS AND POST MORTEMES
- SPECIALIZED MEDICAL EXAMINER TRAINING FOR CHILD DEATH INVESTIGATION UNITS OF LAW ENFORCEMENT: MAINE STATE POLICE, BANGOR AND PORTLAND POLICE DEPARTMENTS
- ESTABLISHMENT OF PANEL IN STATUTE, CONFIDENTIALITY OF PANEL'S WORK AND SUBPOENA POWERS
- IN-DEPTH RETROSPECTIVE REVIEWS OF ALL RELEVANT RECORDS, SUPPLEMENTED BY ORAL PRESENTATIONS BY KEY, INVOLVED SERVICE PROVIDERS

# STATE FORENSIC CHILD ABUSE AND NEGLECT EVALUATION PROJECT REPORT

Project Director: Sue Righthand, Ph.D.

## Introduction:

During 1998, the State Forensic Service Child Abuse and Neglect Evaluation Project, directed by Dr. Sue Righthand, completed a number of important projects including the *Child Maltreatment Risk, Impact and Intervention Annotated Bibliography* and the *State Forensic Service Child Maltreatment Risk and Impact Evaluation Guide*. The annotated bibliography provides summaries of research relevant for clinical assessments in child maltreatment cases. The evaluation guide provides a research based theoretical framework of factors and issues that need to be considered during assessments and , when relevant, addressed in evaluation reports. The *Child Maltreatment Risk, Impact and Intervention Annotated Bibliography* has been published by the Family Violence and Sexual Assault Institute (dwforkids@earthlink.net). Copies of the *State Forensic Service Child Maltreatment Risk and Impact Evaluation Guide* are available from the National Clearinghouse on Child Abuse and Neglect ([www.calib.com/nccanch](http://www.calib.com/nccanch)).

## Training:

Since the 1995 Child Death and Serious Injury Panel Report, the State Forensic Services (SFS) also co-sponsored and provided training programs relevant to child maltreatment evaluations. The programs included:

- Causes and Consequences of Child Maltreatment: Implications for Prevention and Intervention (1999) By Byron Egeland, Ph.D.
- Empirically-based Treatment Interventions for Juvenile Sex Offenders (1998), By Mark Weinrott, Ph.D.
- Assessing Sexually Coercive Juveniles and Adults (1998), By Ray Knight, Ph.D.
- Assessing Violence Risk in Juveniles and Adults (1998), By Thomas Grisso, Ph.D.
- Multi-systemic Therapy: A Clinically Effective and Cost-Effective approach for Treating Serious Clinical Behavioral Problems in Youth (1998), By Scott Henggeler, Ph.D.
- As Good As It Gets? Conducting High Quality Forensic Evaluations in Child Maltreatment Cases (1998), By the SFSCAN project consultants.
- Intimate Violence: Breaking the Cycle (1997), By Donald Dutton, Ph.D. and Jacquelyn Campbell, Ph.D., R.N.
- Juvenile Sex Offenders: Assessment, Classification, Treatment and Needs (1997), By Robert Prentky, Ph.D.

- Termination of Parental Rights: Evaluations in Child Abuse and Neglect Cases (1996), By Sandy Azar, Ph.D.
- Child Physical Abuse Risk Factors: A Review of Theoretical and Empirical Literature, (1995), by Joel Milner, Ph.D.

#### Evaluators:

Currently, there are now 24 clinicians who are qualified to receive SFSCAN evaluation referrals. Five additional clinicians are involved in the training program. The SFS will continue to recruit new evaluators, provide training opportunities, and continuing education.

#### Referrals:

In 1997, during the first year the State Forensic Services began providing child maltreatment evaluations, 12 referrals were received. Referrals to the program increased during 1998, with the program serving 27 families and 61 individuals. It is expected that 1999 referrals will exceed the 1998 rate.

#### Goals:

Future goals involve evaluating how effectiveness the SFSCAN program is at providing timely and useful state of the research evaluations in child maltreatment cases and working to resolve identified difficulties, such as by facilitating more timely evaluations whenever possible. Additional goals include completing the Child Maltreatment Evaluation Manual, as well as updating the annotated bibliography and the evaluation protocol consistent with the evolving professional and research literature.

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