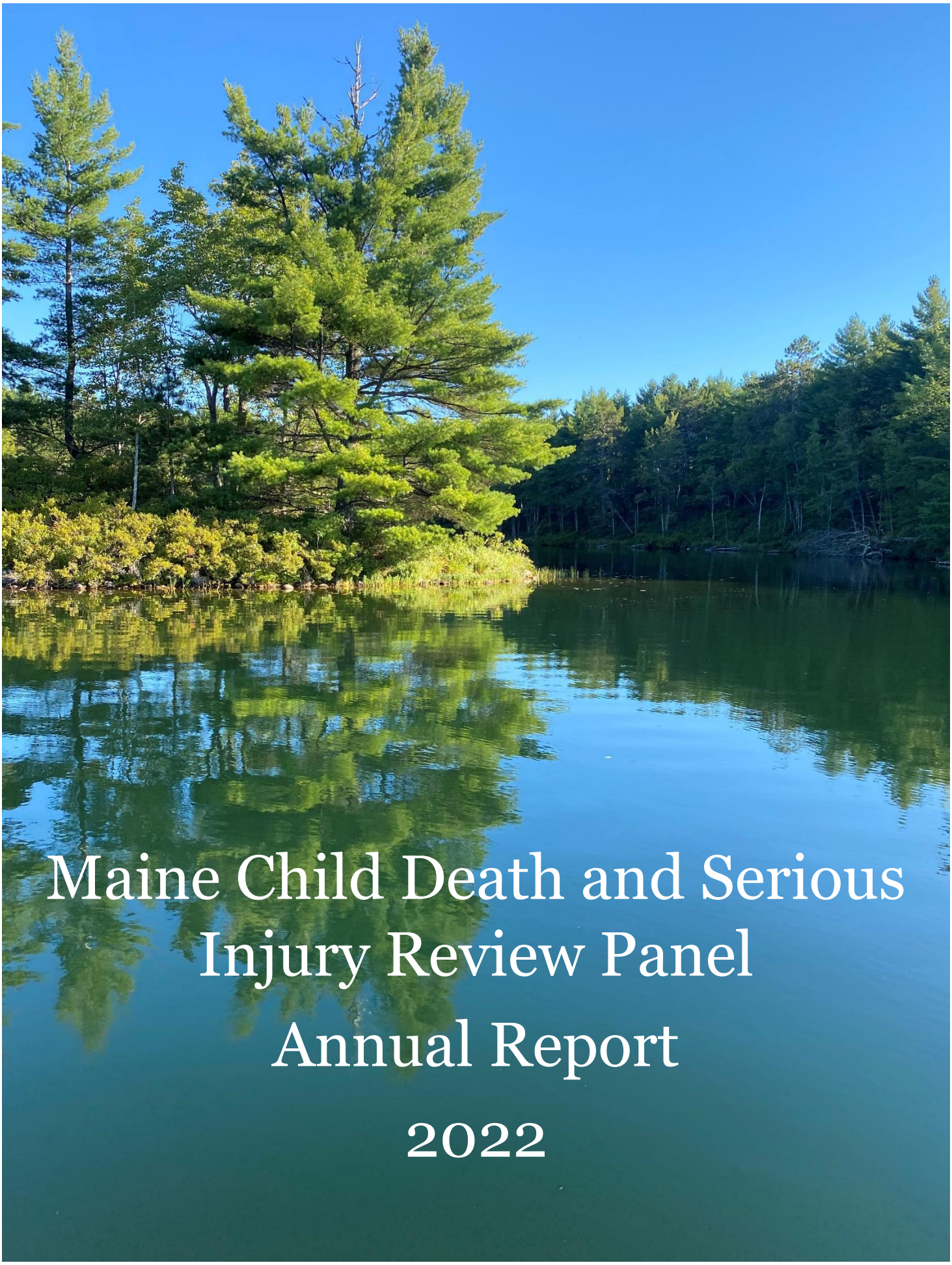

Maine Child Death and Serious Injury Review Panel Annual Report 2022

The Child Death and Serious Injury Panel would like to thank all providers, DHHS staff and law enforcement that contributed to our reviews. Their participation enriches the work of the Panel. Without them, this report would not be possible.

All data analysis and writing for this report was completed by:

Mark Moran, LCSW

On behalf of

Maine's Child Death and Serious Injury Review Panel

With support from OCFS staff

Cover Photo Credit: Mark Moran

Published 2023

For inquiries related to this report, please contact the

Maine Department of Health and Human Services

Office of Child and Family Services

207-624-7900

TABLE OF CONTENTS

INTRODUCTION FROM THE CHAIR AND VICE CHAIR

The Maine Child Death and Serious Injury Review Panel ("CDSIRP" or "the Panel") is a multidisciplinary team established by statute in 1992 to review child deaths and serious injuries. The statutory 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."[1] The 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.

The Panel's membership is also established by statute. The CDSIRP leadership has historically viewed that list as a minimum, rather than complete list of members. In 2022, the Legislature added Maine's Child Welfare Ombudsman to the list of required members, and representatives of that office began attending Panel meetings in September 2022. Recognizing that multidisciplinary perspective is crucial for comprehensive review and analysis of child deaths and serious injuries, the 2022 Panel was comprised of 34 professionals,[2] representing both public and private entities with an interest in the welfare of Maine's children. These members generously volunteer their time and expertise to examine the most tragic cases encountered by the child welfare system. Additionally, members may be accompanied by students from their discipline. The proceedings and records of the Panel are confidential[3] by statute, therefore all members and guests are required to sign a confidentiality agreement prior to participation in any Panel meeting. In 2022, the group met monthly in 9 of 12 months to conduct its work (the Panel does not meet during July and August and one meeting was cancelled due to weather). The Panel receives administrative support from the Office of Child and Family Services.

Traditionally, the Panel has met annually with the other Child Fatality Review Teams from New England and nearby Canada to share experience and information and review cases that involve systems from multiple states or that represent challenges faced by multiple states. After a pandemic related pause, this regional meeting was again held in Summer 2022. Finally, the Panel has also historically partnered with Maine's Domestic Abuse Homicide Review Panel when appropriate, to cooperatively review cases in which children are killed in the context of adult domestic abuse dynamics. No joint reviews were completed in 2022.

This past year also saw the statutory addition of a specific reporting requirement for the Panel. While the statute now requires a report every two years, the Panel's intent moving forward is to issue annual reports. Since larger systemic issues tend to be very complex, become evident over longer periods of time, and take longer periods of time to improve, the Panel anticipates there will be some repetition of content themes from year to year. Persistent themes may not be

[1] https://www.mainelegislature.org/legis/statutes/22/title22sec4004.html
[2] This includes any Panel member who was part of the Panel for any length of time in CY2022. See Appendix A.
[3] https://www.mainelegislature.org/legis/statutes/22/title22sec4008.html

presented in as much detail if they have been addressed in a prior Panel report. Additionally, the reader is referred to prior Panel reports for information about the Panel and its work that has not substantively changed from prior descriptions.

Finally, it is worth noting that the observations and recommendations contained in this report and future reports are not necessarily reflective of the totality of the Panel's discussions, observations, and recommendations. Aside from generating formal recommendations for system improvement, there is great value in specific-case-driven multidisciplinary conversation among those with expertise in children's welfare, particularly when such conversations include policy makers, practice influencers, and those who otherwise can create system change in less obvious or public ways. As a result, and even prior to the publishing of our annual reports, we are confident that our work has already contributed to case specific influence, broader policy considerations, and real-time education and alterations to practice, both for OCFS and other community partners.

In recognition of the commitment and dedication of the members of the Panel and in the hope that our recommendations continue to support and improve the welfare of Maine's children, we present the 2022 Child Death and Serious Injury Review Panel Report.

Mark Moran, LCSW
Chair

Amanda Brownell, MD
Vice Chair

Panel Case Reviews and Additional Activities

In 2022, the Panel conducted five Level 3 (in depth) case reviews in addition to Level 1 (summary) reviews of all child deaths and serious injuries reported to OCFS from October 2021 through September 2022. In addition to its primary case review activities, the Panel also received presentations relating to pediatric ingestions and poisonings and implementation of the Safety Science Model.

The Panel Chair presented the first two quarterly updates to the Joint Standing Committee on Health and Human Services of the 130th Legislature, pursuant to LD 1853 . Additionally, multiple Panel members attended the New England Regional Child Fatality Review meeting in Hartford, CT.

CDSIRP Review Data

The figures below reflect the total numbers of child death (CD), serious injury (SI) and ingestion (I) reports received by OCFS in 2022, including those reported through OCFS' Intake unit and those that OCFS and the Panel learned about from the Office of the Chief Medical Examiner.[4] These values may differ from data presented elsewhere, such as on the OCFS website, for a variety of reasons that include, but are not necessarily limited to, the following:

- Some reports to OCFS are screened out[5] while others meeting intake criteria are assigned for investigation.
- Investigations by OCFS may or may not have resulted in findings of abuse or neglect.
- Investigations by OCFS may have resulted in a determination that a SI or I, while suspected at the time of report, did not, in fact, occur.
- Investigations by law enforcement may have led to criminal prosecutions that may still be ongoing.[6]
- In some cases, the OCFS website may reflect deaths that were not referred to CDSIRP because they had been reported earlier to CDSIRP as serious injuries.
- Data reported is based on the manner in which the data point is defined. Fatality data published on the OCFS website reflects all fatalities reported to OCFS during a given year if the family had previous involvement with child protective services, regardless of the cause of the fatality and regardless of the level of involvement the family had with child protective services or how long ago that involvement occurred.

[4] Not all CD/SI/I are reported to OCFS

[5] All reports are screened by Intake using a Structured Decision Making (SDM) tool and a determination is made regarding whether the report is appropriate for assessment. Not all CD/SI/I reports result in an investigation.

[6] Normally, data related to ongoing or pending prosecution would be withheld. It is included here in aggregate because no case specific or otherwise identifying information is included.

2022 Child Fatality, Serious Injury, and Ingestion Totals

	Serious Injuries	Ingestions	Child Fatalities	Child Fatalities Initially Reported to OCFS as a Serious Injury or Ingestion	Total
January	12	5	3		**20**
February	9	4	2		**15**
March	23	9	5		**37**
April	11	9	3		**23**
May	23	9	7		**39**
June	11	9	7	1	**28**
July	18	4	2		**24**
August	15	10	2		**27**
September	24	6	6		**36**
October	26	7	6		**39**
November	19	13	6		**38**
December	12	5	4		**21**
Total	**203**	**90**	**53**	**1**	**347**

***Please note: Serious injuries or ingestions that happen in one month but are reported in a subsequent month are counted in the month in which they are reported.**

Annual Trends

These 2022 totals, as compared to 2021 data (presented in the Panel's 2021 report), represent increases of 23% in serious injury reports and 114% in ingestion reports. Annual serious injury reports to OCFS had been trending upward (131, 160, 158, and 191 per year) from 2017 to 2020, but dropped in 2021 to 165. The 2022 total resumes the multiyear increase seen prior to that drop. Ingestion reports to OCFS had been trending downward (51, 49, 32, and 31) over the same period, however increased to 42 in 2021 and have more than doubled in 2022.

Beginning with 2021 data, the Panel has reported total number of deaths of children under the age of 18 years that were reported to either or both OCFS and OCME. Child death numbers previously reported by the Panel had demonstrated relative stability from 2017-2020 (17, 20, 17, and 22 per year). However, these data included some, but not all child deaths reported to the OCME. The 2022 total child deaths (54) can only be viewed in comparison to 2021's total (54).

By including all child deaths reported to the OCME in its reviews moving forward, the Panel hopes to gain a broader view of the causes of and contributing factors to child deaths.

Injury Specific Observations

Over the course of 2022, primarily though Level 1 reviews, the Panel has noted some types of injuries or incidents that were reported with more frequency than others. This is not an exhaustive list of what has been reported or reviewed, but rather some of those that garnered the attention of the Panel for their repetition. Also, the absence of specific types of injuries or incidents, particularly when identified in prior reports, should neither be interpreted to mean that those injuries or incidents were absent from the Panel's reviews this year nor that adequate systemic changes have necessarily been made to address those concerns.

Ingestions

Of the 90 ingestion reports received by OCFS in 2022, marijuana/THC accounted for 42. Sources of marijuana ingested by Maine children include, but are not necessarily limited to, cookies, brownies, butter, batter, chocolate bars, gummy bears, lemonade, lozenges, ice cream, dabs, and elements of marijuana plants. The Panel presented legislative testimony in April 2021 outlining concerns related to pediatric marijuana ingestions. That testimony was included as an appendix in the Panel's 2021 report. The Panel also offered recommendations related to marijuana ingestions in that report (p18).

Fentanyl accounted for another 7 ingestions in 2022. All of these were because of the presence of illicit (not prescribed) fentanyl in a child's home. Statistics documenting the substantial impact of fentanyl in Maine are plentiful. Maine children are being significantly impacted as well, and Maine has seen related criminal prosecutions in the past year for incidents involving children's ingestion of fentanyl[7, 8]. Despite the increased presence of fentanyl in Maine over the last several years, the Panel has learned during its reviews that not all healthcare facilities or providers of laboratory services employ urine toxicology testing that includes an assay for fentanyl. This can be extremely important, not just for the ability of medical personnel to provide optimal care, but also for investigative and protective entities' ability to ensure the safety of the child in the future, by accurately identifying a child's substance ingestion or exposure. Additionally, accurate testing of caregivers can result in critical data being available to assist OCFS staff as they make both safety planning and reunification decisions.

In the setting of increased opioid exposure among Maine youth, the availability of naloxone in the community has taken on new importance. Overdose reversal should no longer be considered

a remedy reserved for adults with opioid use disorder (OUD). Rather, the presence of naloxone in proximity to a pediatric patient with opioid ingestion could save a child's life. Maine EMS protocols (p112) include guidance for the provision of naloxone to pediatric patients with suspected opioid ingestions and the FDA has said that naloxone can be used by patients of any age, including children. Additionally, the FDA issued new recommendations to healthcare providers in 2020 that a naloxone prescription be considered not only for those prescribed an opioid pain reliever, those receiving medication for OUD, or those otherwise at risk for opioid overdose (such as having a current or past diagnosis of OUD), but also for patients who meet those criteria and have children in their homes. Naloxone is available through several community-based resources and the Panel encourages continued efforts to increase that availability throughout the state, consistent with FDA recommendations.[9,10,11]

The Panel has observed a tendency among OCFS staff to be more focused on whether an ingestion (regardless of type) was "accidental/unintentional" or "intentional," rather than on the context in which the ingestion occurs. This is the same dynamic the Panel has previously observed when examining firearm related injuries. A child is not necessarily safe in the care of an individual if the individual maintains an environment in which the child has easy access to firearms, drugs, or other mechanisms through which the child could suffer significant harm or be killed. Continuing to focus on a distinction based upon a caregiver's intention to harm or not harm a child, to the exclusion of the contextual caregiver behaviors that contributed to an ingestion or injury, risks missing important opportunities for secondary and tertiary prevention.

Finally, it is important to note that even with the increase in ingestion reports, not all injuries due to pediatric ingestions are reported to OCFS or to the Northern New England Poison Center (NNEPC). There is no specific standard mandated reporting requirement when a child presents with an ingestion. The Panel is unaware of any mechanism being used in Maine to monitor emerging trends in pediatric ingestions from the numerous entities who have this information, including, but not limited to, NNEPC, hospitals, medical providers, law enforcement, emergency medical providers, community-based service providers, and OCFS. The Panel expects that more complete data tracking would bolster the work of a well-structured, well-funded injury prevention program. Maine's lack of such a program was addressed in the Panel's 2021 report (p13-14).

Unsafe Sleep

The Panel, in its 2021 report, commented on an apparent decrease in unsafe sleep related deaths, which appeared to correlate with multiple efforts at both state and local levels to push preventive messaging into the community. In 2022, preliminary data suggests that improvement may have been temporary, as at least 9 Maine infants died in circumstances involving some

[9] https://getmainenaloxone.org/
[10] https://knowyouroptions.me/
[11] https://mainedrugdata.org/find-naloxone-in-maine/

element of an unsafe sleep environment. Given the relatively small numbers, these may not be statistically significant changes from year to year. Regardless, an unsafe sleep environment is an entirely modifiable circumstance that could save an infant's life, and even one preventable death is one too many. Public statements on the topic from high-ranking Maine officials have, in the past, sparked statewide conversation and raised awareness of the problem. The American Academy of Pediatrics (AAP) issued updated recommendations in 2022 for reducing infant deaths in the sleep environment, and ongoing public health messaging remains a critical component of prevention. The Panel recommends that Maine CDC, in partnership with the Office of the Attorney General (OAG) and Office of the Chief Medical Examiner (OCME), resume its efforts to disseminate public health messaging on safe infant sleep, incorporating guidance and recommendations from the AAP.

Seasonal-pattern injuries

As in prior years, the Panel has noted multiple deaths by drowning. The circumstances of these deaths vary, though their outcomes are all equally tragic. The American Academy of Pediatrics issued its most recent policy statement on the prevention of drowning in 2019.

Each year, the Panel observes multiple reports of injuries sustained involving the use of outdoor recreational vehicles, such as four-wheelers/ATVs and snowmobiles. The American Academy of Pediatrics, as with other injury types, provides guidance for parents and caregivers on the safe use of such machines.

Window falls are another common injury the Panel has come to expect each year as the temperature warms. To their credit, OCFS also anticipated this seasonal trend in 2022 and solicited the assistance of the Maine CDC to issue public health messaging on the topic. Various child-serving or injury prevention organizations offer recommendations to minimize the risk of such injuries.

Systemic Observations

Beyond specific injury types, over the course of its 2022 reviews, the Panel also noted larger systemic challenges that highlight opportunities for improvement. These improvement opportunities are not limited to Maine's OCFS, as they exist among the broader child welfare system. It is worth noting the issues mentioned below are rarely, if ever, able to be isolated as the single factor leading to a child's death or serious injury. Also, the absence of specific observations or recommendations, particularly when identified in prior reports, should neither be interpreted to mean that those observations were absent from the Panel's reviews this year or that the recommendations are no longer valid, nor that adequate systemic changes have necessarily been made to address previously cited concerns.

OCFS staff- workforce

Again in 2022, the Panel noted a difference in quality of investigatory casework conducted outside normal business hours. The Panel recognizes that this likely reflects the acquired skill sets of individual OCFS employees (caseworkers and supervisors) who may not work primarily in roles that involve much, if any, investigation work. OCFS recognized the need to restructure the after-hours caseworker response system. The Governor proposed and the Legislature appropriated adequate funding in 2022 for 16 after-hours Children's Emergency Services positions. The Panel supports the establishment of these positions both as a method to build and maintain strong investigative skills among after-hours staff and as a mechanism through which to improve employee retention by eliminating mandatory after-hours coverage in addition to the standard 40-hour regular work week.

OCFS staff- practice

During summer 2021, Maine OCFS, with the assistance of Collaborative Safety and Casey Family Services, began using the Safety Science Model in individual case reviews. The use of safety science is now integrated in the standard review processes OCFS leadership utilizes to analyze adverse case outcomes. Essentially, safety science focuses on the systemic conditions in which decisions are made rather than seeking to find fault with an individual or assign blame. The feedback from OCFS staff who have participated in reviews using the safety science approach has been very positive. The Panel applauds OCFS' application of safety science to case reviews, particularly since it is consistent with the Panel's historical approach to case review. The Panel looks forward to having the input of OCFS safety science analysts as we review future cases for which a safety science review has already been completed.

Over many years, the Panel has seen repeated examples of the challenge in handling cases involving families that maintain only marginally safe and/or functional environments. Such environments may exist in the context of poverty, trauma, domestic violence, substance use disorders, cognitive challenges, and untreated or under treated mental health needs. These contextual features, when present, can be multigenerational. For these families, some degree of risk and safety concerns are frequently present. Those concerns are often of sufficiently low severity that OCFS involvement and legal intervention would be an inappropriately strong response, particularly considering that CPS intervention in a family is not a purely benign intervention[12]. Periodically, a family's circumstances change in a manner that escalates the concerns to a higher severity in which OCFS or legal intervention is warranted. Typically, in response to such an escalation of risk, a report is made to OCFS, who investigates and provides services or referrals to services to hopefully mitigate the concerns. While services are in place,

[12] The degree to which CPS intervention may contribute to or exacerbate existing dysfunction within a family is not clearly delineated in the literature and requires further research.

the family may make some small functional improvements. These improvements may be sufficient to reduce the immediacy of the concern, and the level of risk and safety returns to a minimally tolerable level. The Panel has observed that in some cases, when OCFS closes their investigation and the services come to an end, the family returns to its precarious baseline. This pattern repeats cyclically over many years, sometimes over multiple generations, within a family. Circumstances infrequently escalate to "immediate risk of serious harm," necessitating immediate judicial intervention. If OCFS staff take an incident-based approach, the determination that no further intervention is appropriate is often made and the cycle continues. However, when viewed in the context of many years of simmering safety and risk concerns that periodically reach a high boil, an argument exists that the children may be in circumstances of "jeopardy" to their health and welfare. Herein lies the challenge: for families that are repeatedly involved with OCFS over multiple years, case files easily become hundreds, if not thousands of pages long. Going through a large volume of records, noting and extracting subtle themes, and tracking behavior and abilities of caregivers over time is difficult, time-consuming, and extremely detailed work. Caseworkers simply do not have the time, resources, and sometimes the skill and experience, to conduct a full review of this caliber.

Making lasting enhancements to a child's safety in complex, multigenerational situations even more difficult is the lack of an adequate system for clinical evaluation of OCFS-involved families. There have been different names for such a system over the years, though the most recent has been "CODE"- Court Ordered Diagnostic Evaluations. The current state of the CODE system in Maine is inadequate and ineffective. The Panel is currently aware of 3 CODE evaluators around the state. CODEs can take 6-9 months to secure, the questions posed to the evaluator often must be negotiated by the parties via their lawyers, and they are only an option once there is a pending PC (protective custody) case with the Court. If the results of such an evaluation include a recommendation for a more thorough evaluation, such as a neuropsychological evaluation of a parent, those can take another 12-14 months to secure. Ultimately, the clinician/provider the parent chooses to see to address the concerns identified in the CODE is under no obligation to follow the recommendations of the CODE evaluator or to even agree that the concerns identified are concerns at all. Maine needs a better system- one in which a reasonably available and skilled clinician can evaluate parental capacity, family functioning, and the clinical needs of the family to effectively drive the necessary reunification or removal-preventing services.

The Panel has observed that cultural barriers sometimes exist between OCFS staff and the families OCFS is seeking to serve. These barriers exist for many reasons, including language, trauma, mistrust and fear of authorities, and a limited understanding of important cultural components in a family system. These factors stand in the way of effective engagement with a family, which ultimately can impact the degree to which a family benefits from or even accepts an intervention or service being offered to assist them in enhancing a child's safety. The Panel is aware that OCFS partners with multiple cultural liaisons to build bridges with various communities and encourages the continuation of that work.

Multidisciplinary child welfare system

Law enforcement

In some cases, the Panel has observed what seems to be an increased tension between law enforcement (LE) and OCFS staff. Depending on the area of the state and the nature of a case, OCFS staff from a single district may need to coordinate their work with different units of the Maine State Police, the local sheriff's department, or any number of municipal police departments. During an investigation involving child maltreatment, LE and OCFS staff have different roles. Stated most simply, part of the role of LE is to determine whether a child has been a victim of a crime and if so, to seek appropriate consequences for the offender. Part of the role of OCFS staff is to determine if a child has been abused and/or neglected by a caregiver, and if so, to act to protect the child(ren) in question in the most appropriate manner. While these roles are performed most often in tandem and are frequently complementary, that is not always the case. Typically, challenges arise when the required protocols of one partner are inconsistent with the protocols or best practices of the other. These circumstances can frequently be managed through good planning, a shared understanding of each other's needs, and a level of familiarity that encourages open communication. The Panel has noted that these conditions frequently exist at the highest organizational levels of the Maine State Police and OCFS, however the quality of those conditions can change as one progresses down the chain of command to regional, local, and case specific front-line staff in various agencies. One way to improve those conditions throughout the hierarchy of each agency is through joint training programs. Historically, OCFS and its LE partners have offered a "Cops and Caseworkers" training in various regions of the state. This afforded both parties an opportunity to get to know their counterpart in a non-crisis situation, to learn about the rationales behind policies and protocols on both sides, to observe the techniques and practices used by both groups, and to troubleshoot common points of conflict that arise in joint investigations. This training has not been offered for many years, and the Panel believes it could positively impact what appears to be a growing issue. There may be additional benefit to including State's attorneys, such as staff from local District Attorney's offices and Assistant Attorneys General from both the Criminal and Child Protection Divisions.

Medical care

The Panel has encountered several topics over the past year that fall squarely within the bounds of the anticipatory guidance that is provided by pediatricians and other primary care providers during well child visits. These visits are crucial opportunities to provide timely, relevant information to parents and caregivers in a non-threatening context. The education offered is an excellent example of primary prevention, and the Panel strongly supports children's attendance at these visits. However, the Panel has also noted that high risk families- those most in need of guidance and support- sometimes fail to regularly attend well child visits. Reasons for repeated missed appointments are, of course, quite variable. Some families will simply choose to not receive any traditional medical care in favor of a more naturopathic or homeopathic approach.

Others may not want to have further discussion about their immunization choices. Of greater concern to the Panel are those situations in which failure to attend regular well child visits is a red flag for more complex problems. Such problems might include substantial resource deficits, family violence, substance use disorders, or mental health challenges. These problems tend to be frequent findings in cases reviewed by the Panel and any opportunity to intervene prior to a child's death or serious injury is a good opportunity. Because of the importance of these visits, not just from a medical perspective, but also from a developmental, psychosocial, and prevention perspective, the Panel believes primary care providers should develop protocols for the review of frequently missed well child appointments and consider what outreach options exist to engage the family more effectively. Such options could include a social worker, care manager, or other similar professional situated within the primary care practice, as well as Public Health Nurses, who would be optimally positioned to attempt to engage the family at home or in the community. In circumstances in which reasonable efforts to re-establish the patient-provider relationship have been exhausted, the primary care provider must then consider whether extended absence from well child visits is sufficient cause to make a report to OCFS. Additionally, the Panel encourages OCFS to view frequently missed well child visits, particularly in the context of additional risk factors, as sufficient cause to investigate a child's safety more thoroughly in response to reported concerns.

Recommendations- Injury Specific:

1. All healthcare facilities and providers of laboratory services performing urine toxicology screening/testing should ensure the specific screens/tests being used can detect the presence of fentanyl and other synthetic opioids.
2. Maine's Director of Opioid Response should evaluate options for increasing the availability of naloxone in homes where children and opioids are present and make recommendations to the appropriate entities to affect such an increase.
3. The Panel's Executive Committee should work with members of Maine's Opioid Clinical Advisory Committee to develop recommendations for strategies to optimally address toxicology testing inadequacies in healthcare settings.
4. DHHS/CDC should develop a data tracking or monitoring mechanism to adequately collect data on all pediatric ingestions in Maine, to inform a more complete understanding of the current state of ingestion injuries.
5. DHHS/CDC, in partnership with OAG/OCME when appropriate, should resume its public health messaging on safe infant sleep, incorporating recent guidance and recommendations from the American Academy of Pediatrics.

Recommendations- Systemic:

6. OCFS should continue to train staff to view incidents of potential or actual harm not simply from an intent perspective, but also from a negligence perspective, and in the larger context of a family's actions, capabilities, and protective capacities over time.
7. OCFS and Maine CDC should partner more regularly to highlight various seasonal or otherwise trending injury patterns via public health messaging.
8. OCFS should continue its provision of lockboxes to families with whom they are involved who have a need to secure potentially dangerous substances in the home. This should be offered both as a secondary and tertiary prevention measure.
9. The Governor should propose, and the Legislature should appropriate, adequate funding to the Maine CDC for the express purpose of re-establishing the Maine Injury Prevention Program, thus allowing pursuit of its mission.
10. OCFS should continue its use of safety science in its review of adverse case outcomes.
11. DHHS should develop a comprehensive, statewide, interdepartmental child abuse and neglect prevention plan that includes data monitoring and outcome measures, to ensure prevention activities are achieving the desired goals.
12. OCFS should continue efforts to recruit and retain after-hours investigators.
13. OCFS and its law enforcement partners should continue efforts to develop/deliver interdisciplinary training to law enforcement and OCFS staff around the state.
14. OCFS should develop a protocol for in depth review and assessment of chronically maltreating families who repeatedly come to the attention of OCFS over a long period of time.
15. OCFS, OBH, and OAG should work together to develop a functional system of evaluators for complex child maltreatment cases in all areas of the state.
16. Pediatric primary care providers should develop protocols within their practices for the review of cases in which children frequently or repeatedly miss scheduled well child visits and consider within those protocols what resources could be employed to engage a patient/family more effectively and whether a report to OCFS is appropriate when those resources have been exhausted.
17. OCFS should view repeated missed well child appointments as sufficient cause to investigate a child's safety more thoroughly, particularly in the context of additional risk factors.

Conclusion

As has always been the case, child deaths and serious injuries frequently follow earlier opportunities for prevention. A well-functioning child welfare system must be able to take advantage of those opportunities when they are present and create opportunities where none exist. Many of the recommendations presented in this year's report are related to maximizing

the likelihood that prevention activities are well-timed, relevant, and effective. The Panel is committed to continuing its work as one of Maine's Citizen Review Panels to examine these most challenging cases with the goal of identifying additional opportunities for systemic improvement. We are grateful to all those who are part of the child welfare system, both within OCFS and outside of it, who join us in this endeavor, and we look forward to a day when our work may no longer be necessary.

Appendix A: 2022 Panel Membership

Mark Moran, LCSW, Chair
Social Services Manager, Northern Light Eastern Maine Medical Center
CASA Guardian ad Litem, Maine CASA

Amanda Brownell, MD, Vice Chair
Medical Director, Spurwink Center for Safe and Health Families

Jenna Joeckel, LMSW-CC, Panel Coordinator
Maine Office of Child and Family Services

Christine Alberi, Esq.
Child Welfare Ombudsman

Jason Andrews
Detective Sergeant, Major Crimes Unit- Central, Maine State Police

Amy Belisle, MD, MBA, MPH
Chief Child Health Officer, Maine Department of Health and Human Services

Betsy Boardman, Esq.
Child Protective and Juvenile Process Specialist, State of Maine Judicial Branch

Rachel Burrows, PhD
Psychologist, Edmund N. Ervin Pediatric Center

Adrienne Carmack, MD
Medical Director, Maine Office of Child and Family Services

Lauren Edstrom
Detective, Maine State Police, Major Crimes Unit- South

Matthew Foster, Esq.
District Attorney, Hancock and Washington Counties

Liam Funte, MD
Deputy Chief Medical Examiner, Office of Chief Medical Examiner

Ariel Gannon, Esq.

Chief, Child Protection Division, Maine Office of the Attorney General

Brieanna Gutierrez
Communications and Compliance Manager, Maine Office of Child and Family Services

Sandi Hodge
Retired Child Welfare Professional

Bobbi Johnson, LMSW
Associate Director of Child Welfare Services, Maine Office of Child and Family Services

Todd Landry, Ed.D.
Director, Maine Office of Child and Family Services

Jeffrey Love
Lieutenant, Maine State Police, Major Crimes Unit- North

Marianne Lynch, Esq.
District Attorney, Penobscot and Piscataquis Counties

Nicholas Miles, MD, MSc
Child Abuse Pediatrician, Spurwink Center for Safe and Healthy Families

Sarah Miller, PhD, ABPP
Director, Maine State Forensic Service

Ashley Morrell, LMSW
Associate Child Welfare Ombudsman

Tessa Mosher
Director of Victim Services, Maine Department of Corrections

Karen Mosher, PhD
Retired community mental health professional

Sheila Nelson, MSW, MPH
Suicide Prevention Program Manager, Maine Centers for Disease Control and Prevention

Geoff Parkin, Esq.
Assistant Attorney General, Child Protection Division, Office of the Attorney General

Hannah Pressler, DNP
Pediatric Nurse Practitioner

Tammy Roy, LSW
Child Welfare Project Manager, Maine Office of Child and Family Services

Kaela Scott, Esq.
GAL Services Coordinator, State of Maine Judicial Branch

Erika Simonson
Child and Family Programs Coordinator, Maine Coalition to End Domestic Violence

Nora Sosnoff, Esq.
Chief, Child Protection Division, Maine Office of the Attorney General

Christine Theriault, LMSW
Family First Prevention Services Manager, Maine Office of Child and Family Services

Briana White, Esq.
Assistant Attorney General, Child Protection Division, Maine Office of the Attorney General

Leane Zainea, Esq.
Assistant Attorney General, Criminal Division, Maine Office of the Attorney General