Maine Department of Health and Human Services

Report of the State of Maine Child Fatality/Serious Injury Review Panel

Child Deaths and

Serious Injuries in Maine

2004

The Child Death and Serious Injury Panel would like to thank all providers, DHHS staff and law enforcement that attended the reviews. Their attendance enriches the work of the panel. Without them, this report would not be possible. We would also like to thank Jen Ellis, Glenda Hamilton (DHHS) and Jeanine Brown (Muskie) for all they do in locating information and the numerous other things they do that make this work possible.

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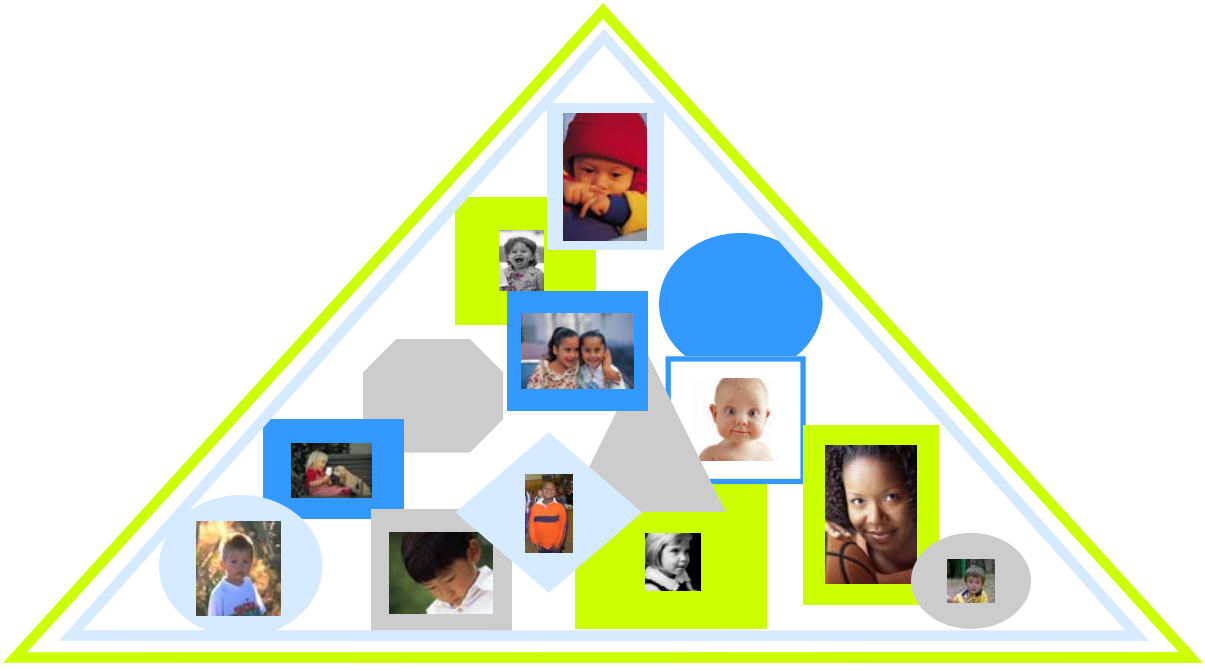

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A Letter from the Commissioner
Maine Department of Health and Human Services

Maine Department of Health and Human Services

Commissioner's Office

221 State Street
#11 State House Station
Augusta, ME 04333-0011

John Elias Baldacci
Governor

Brenda M. Harvey
Commissioner

May 31, 2006

Dear Friends of Maine Children:

On behalf of the Department, I want to thank the members of the Maine Child Fatality/Serious Injury Review Panel who worked diligently to produce this report. Seeking to learn from tragedies is often difficult and painful work and I extend my deep appreciation to the members for their contributions in promoting positive systemic change to better protect Maine's children.

Sadly child deaths occur in even the best systems of care, thus, it is critically important that we learn from these tragedies in order to continually make improvements to the system. This report will help us create a plan to implement improvements including how child deaths can be prevented in Maine.

Just as any review process brings together multiple disciplines, so must our response toward systems change. Integration of systems will be the cornerstone of any new Department service delivery initiative and is key to our current change efforts. Keeping children safe is a shared responsibility, requiring a strong public/private partnership as well as an integrated service delivery approach. This report will serve to assist policy makers in assuring attention to those requirements in the protection of Maine's children.

Sincerely,

Brenda Harvey

Brenda M. Harvey
Commissioner

BMH/klv

A Letter from the Chairman of the Child Death and Serious Injury Review Panel

Dear Citizen's of Maine:

There is probably nothing more unfortunate than the death of a child, preventable or unpreventable. The Maine Child Death and Serious Injury Review Team (CD&SI) was established by state law in 1992 to review child deaths with a focus of systems and intervention. Maine's team is unique in that we also review serious injuries. The panel meets monthly to conduct in-depth examinations of child deaths and serious injuries in hopes that the Committee's findings and recommendations can help to reduce the number of preventable child fatalities in our state. Additionally, the Committee meets annually with the Child Fatality Review Teams from Maine and Vermont, to share experiences, information and to review a case that involves services from more than one state.

The members of the multidisciplinary team are volunteers who give generously of their time and expertise and who represent both public and private agencies that have an interest in the welfare of Maine children. Through their commitment, the Panel has been able to build a collaborative network to foster teamwork and to share the recommendations with the larger community. We hope this report will be an instrument in accomplishing that.

The Panel has made great strides since its inception, but there is still work to be done. The Panel will continue to look at ways to implement our recommendations and to maximize the impact of these recommendations on the actions and policies of the agencies and individuals who advocate for our children.

In recognition of the commitment and dedication of the members of the Panel, I would like to present the 2004 Annual Report to the Honorable John Baldacci, Governor of the State of Maine.

On behalf of the committee,

Lawrence R. Ricci

Lawrence R. Ricci, MD
Chair, Maine DHHS Child Death and Serious
Injury Review Panel

Team Members of the Child Death and Serious Injury Review Panel 2004

Richard Aronson, MD, MPH	Maine Center for Disease Control and Prevention
Lou Ann Clifford, AAG	Department of the Attorney General, Civil Division
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Lawrence Ricci, MD, CHAIR	Director - Spurwink Child Abuse Program
Diane Schetky, MD	Child, Adolescent and Adult Psychiatry
William Stokes, AAG	Deputy Attorney General , Chief of the Criminal Division
Francis Sweeney	Child Welfare, DHHS

FORWARD

This report documents cases that were reviewed in 2004 by the Maine Child Death and Serious Injury Review panel. The mission of the Panel, is to provide multidisciplinary, comprehensive case review of child fatalities and serious injuries to children in order to promote prevention, to improve present systems and to foster education of both professionals and the general public. Furthermore, the panel strives to collect facts and to provide opinions and articulate them in a fashion which promotes change. The final mission is to serve as a citizen review panel for the Department of Health and Human Services as required by the Federal Child Abuse Prevention and Treatment Act, P.L. 93-247.

When "Shari" was born to a young couple, a CPS report was made by the hospital because the baby had traces of marijuana in her urine. Her mother admitted to a history of drug and alcohol use while denying current use. Her father was in jail for OUI at the time of the birth. DHHS staff visited the home and found her parents to be nurturing and willing to address their substance abuse issues. No further assessment was done. At two months of age, "Shari" dies while sleeping with her intoxicated mother in the same bed.

The Child Abuse and Serious Injury Review Panel follows the review protocol outlined below.

1. The Panel conducts reviews of 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. The Panel conducts comprehensive, multidisciplinary reviews of any specific case. The Office of Child and Family Services, the Commissioner of the Department of Health and Human Services, or any member of the multidisciplinary review panel may initiate reviews.
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 are obtained by the Department of Health and 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 Health and Human Services.
6. The review panel may develop, in consultation with the Commissioner of the Department of Health and Human Services, periodic reports on child abuse fatalities and major injuries, which are consistent with state and federal confidentiality requirements.

The Maine Child Death and Serious Injury Review Panel is comprised of representatives from many different disciplines. Its composition includes the following disciplines.

- Judiciary
- Forensic Pathology
- Forensic and Community Mental Health
- Pediatrics
- Family Practice
- Nursing
- Public Health
- Civil and Criminal Law
- Law Enforcement
- Public Child Welfare
- Doctoral candidates completing their clinical or field placements

Each member of the Panel volunteers their time to review extensive case records in preparation for monthly retrospective reviews.

There are several unique functions of the 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. Some states have multiple local review panels in addition to a central state-level panel. In such cases, the state-level team reviews only selected cases. Because the state of Maine is less populous than other such states, the full, central, state-level team reviews all cases. The centralized forensic medical examiner system and representation on the panel promotes standardized forensic child death investigations and post mortem exams. The State of Maine has specialized medical examiner training for child death investigation units of law enforcement, which include Maine State Police, and Bangor and Portland Police Departments. Representatives from this training sit on the Panel.

The Panel is established in state statute that permits confidentiality of the Panel's work and grants the Panel the power to subpoena relevant case documentation and testimony. This latter feature allows the Panel to conduct in-depth retrospective reviews of all relevant records, supplemented by oral presentations by key, involved service providers.

"Sammy", a two-year-old boy died after ingesting a relative's prescription medicine that was left on the table near a candy dish. The family had a long Child Protective, domestic violence and poly-substance abuse history. "Sammy" was having a negative reaction to the medicine for hours before his mother called 9-1-1. By then, it was too late.

Finally, the Maine Child Death and Serious Injury Review Panel belongs to the consortium of Northern New England Child Fatality Review Teams.

Findings and Recommendations

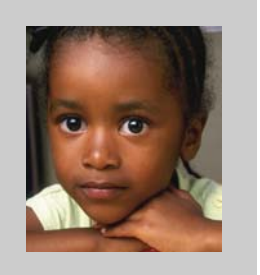
The results of reviews undertaken by the Panel in 2005 lend themselves to discussion along several lines. These parallel the evaluative processes such as information gathering followed by data synthesis and opinion development followed by treatment. Several other areas not easily categorized along these lines will be discussed such as support of high-risk mothers, prosecution, psychological evaluations, and co-sleeping.

I. Information Gathering and Sharing

The ability to make accurate, skilled decisions requires effective multidisciplinary information gathering and sharing. In these areas the Panel found case examples of some concern as well as case examples of high quality work.

Case Examples

- A positive urine drug screen on a newborn was not reported to the public health nurse working with the family.
- Child Protective Services did not access records from out of state. This may well have affected the accuracy of the final assessment of risk to the child.
- In more than one case, providers relied on self-reports with regard to substance abuse. Available objective documentation was overlooked. The impact of substance abuse on the parents' ability to care for and protect their child was therefore inaccurate, placing a child at high risk of harm.
- In one case of serious burns, photographs were not taken at the hospital prior to the burns being dressed. Scene photographs were not taken immediately by law enforcement or Child Protective Services.
- The term, "accident" was used by law enforcement to describe a case. The response from DHHS was to accept the term "accident" as ending their responsibility in the case. Police are talking about criminal culpability when using the term, "accident". DHHS has additional and different statutory responsibilities in responding to reports of suspected child abuse and neglect and must assess the role of each parent and caregiver to the child.
- In one case, the Program Administrator at DHHS was not notified immediately when a death occurred.



Recommendations

- DHHS needs to expand its training in parental substance abuse. This should include the development of specific skills for dealing with denial and minimization and in evaluating the parent's ability to protect and nurture their children while using substances. This includes the ability to document behaviors that are protective versus talk that is protective. The Panel applauds DHHS's decision to develop and offer trainings that begin to address this need. Families in the child welfare system who are experiencing problems with substance abuse should be referred to providers who use *The Substance Abuse and Child Maltreatment Screening and Assessment Guidelines* and *The Substance Abuse and Child Maltreatment Status Review Guidelines.* These are assessment protocols that were developed through a joint effort among the Office of Substance Abuse, DHHS Child and Family Services, and private mental health and substance abuse providers.

- Positive drug tests of newborns should be communicated to Public Health Nursing from the hospital. Every effort should be made to communicate other risk factors as well. Health care providers are already required by statute to notify the Department when the provider knows or has reasonable cause to suspect that a newborn has been born affected by illegal substance abuse or is suffering from withdrawal symptoms related to legal or illegal drugs.

- DHHS needs to be diligent in pursuing and utilizing all available sources of information about risk and mitigating factors including records from other states early in the case history.

- Policies and procedures should be developed in Maine hospitals regarding photographing serious injuries immediately before the application of dressings that might hide the injuries. DHHS, Office of Child and Family Services should explore the use of other entities within the agency, such as hospital licensing to accomplish this goal.

- DHHS needs to assure prompt reporting of all death and serious injury cases and develop mutually acceptable protocols for joint intervention by DHHS and Law Enforcement. Response should be prompt and thorough as well as compassionate. DHHS should assure that protocols for after hour coverage are consistently followed throughout the state. Reports of serious injury or death of a child with surviving siblings should require an immediate response. Reports of suspicious serious inflicted injuries to young children should always go to the District Attorney.

- There needs to be a procedure in place whereby Program Administrators are immediately made aware of a death or serious injury.

DHHS Response

The Department agrees with the Panel's finding with respect to effective multidisciplinary information gathering and sharing. As the Panel notes in its recommendation, DHHS has already developed and provided training to staff and supervisors regarding parental substance abuse. The Office of Child and Family Services (OCFS) has incorporated the screening tool into the Child Protection Assessment and trained all staff in the entire assessment process.

The Department recognizes that more needs to be done in educating and training staff in the area of parental substance abuse. OCFS will work with the Office of Substance Abuse in the coming year to expand education and training in this area. Currently, training is being developed regarding the child welfare response for children found in clandestine meth-amphetamine labs. With respect to positive drug tests on newborns, OCFS will convene a team to review compliance with the relatively new drug affected infant policy and law.

Regarding the recommendations for prompt reporting of and response to child death and serious injury cases the Department has taken the following steps: The OCFS protocol for internal reviews of all child death and serious injury cases has been amended to create a more immediate process for sharing of information as well as the review itself. This includes immediate notification of the Program Administrator. The protocol also now involves selected members of the Child Death and Serious Injury Review Panel in the internal review.

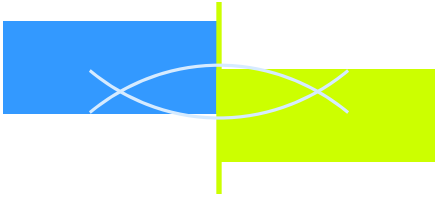
Finally, through the Child Abuse Action Network, training was provided to both OCFS staff and law enforcement personnel at the Cops and Caseworkers Conference. This Conference is planned to be an annual event. DHHS has not yet taken action on the Panel's recommendation for developing policies and procedures for Maine hospitals to photograph serious injuries immediately before the application of dressings that might hide the injuries. DHHS will need to receive consultation from Dr. Lawrence Ricci, Director of Spurwink, before further exploring this recommendation.

II. Supervision and Decision Making

Once adequate data has been gathered, it is critical that responders develop a clear and comprehensive opinion and plan. Regularly scheduled, planned, purposeful supervision that addresses both the situation under discussion as well as the responses of the person receiving supervision is essential to this task. The panel saw various instances of decisions being made where it did not appear that supervisory oversight had the desired effect.

Case Examples

- In one case the DHHS involvement was only around the immediate circumstances of the death rather than all of the factors related to the child and did not appear to integrate the family history into ongoing safety and case management decisions.
- In more than one case, extensive information was gathered, but the analysis appeared flawed seemingly due to lack of adequate supervision incorporating both theoretical and practical considerations especially as they pertain to the dynamics of abuse and neglect and maintaining a focus on the real risk to children.
- In the absence of a clear understanding of "how" a child was injured, in one case, there was still enough evidence of serious harm to a child to file a petition for a protective order. The child's condition and circumstances taken as a whole rather than individual incidents make it clear that physical abuse was taking place.
- There was a problem with DHHS staff, law enforcement and medical personnel drawing conclusions and making assumptions just from speaking with emergency staff at the scene. A thorough investigation should be done immediately after an injury regardless of whether the event is initially designated an accident by emergency or law enforcement personnel.
- In more than one case, attention was focused on the details of the case rather than looking at the picture as a whole. As a result, the most significant source of harm and risk to a child was not identified resulting in an inaccurate assessment and the provision of services that do not target the actual harm and risk to the child.



Recommendations

- Assistant Attorneys General should have the opportunity to review a case if they are trying to determine if there is enough evidence to go to court.

- There is a policy in DHHS for the review of cases in which repeat maltreatment occurs. There needs to be an analysis of historical interventions and reports. Intervention is based on the analysis of that history in relationship to the current circumstances.

- Decisions should be made relying on multiple sources of information rather than initial impressions or single sources of information. A thorough investigation should be done immediately after an injury regardless of whether the event is initially designated an accident.

- Supervisory training and support could be productively focused on learning to step back and recognize patterns of behavior as well as the meaning they carry. This is in contrast to seeing them as separate and isolated issues.

DHHS Response

The Department agrees with the Panel's finding regarding supervision and decision-making. OCFS has expanded the Supervisory Enhancement Initiative that began in 2003 and provides consultation and mentoring to all casework supervisors and Program Administrators. Current plans call for even further expansion of this initiative by adding two more consultants in the coming year. Regarding the analysis of repeat maltreatment, OCFS recently received consultation on this matter from Linda Mitchell of The Administration for Children and Families and will begin implementing her suggested guidelines for review of repeat maltreatment cases.

Regarding the Panel's recommendation that Assistant Attorneys General review cases to determine if there is enough evidence to petition the court, we believe this is already standard practice in our District Offices. To improve consistency of practice OCFS will work with Janice Stuver, Child Protection Division Chief to better communicate and implement this expectation.

III. Intervention

Once information gathering and analysis have occurred the next step is effective intervention planning. Again both good and bad practice were evident to the panel.

Case Examples

- DHHS did an outstanding job of assuring the well being of a child when it came to implementation of a visitation plan. The psychologist did an excellent job laying out the risks and benefits of visitation with family members. This helped lay the basis of the DHHS visitation plan and played an important part in keeping a child safe.
- In more than one case, anger management classes were ordered as a response to domestic violence. Anger management does not address battering. Anger management is often incorrectly used interchangeably with Batterer's Intervention.
- In general mothers were not always assessed as a possible source of harm or risk to a child. The assessments were not always comprehensive when they were conducted. In one case the mother was identified by the family and law enforcement as a victim of domestic violence and not reported to Child Protective Services though she was a significant source of harm and risk to her children.
- One case highlighted the complexities of serving the sometimes competing interests of parents with mental health issues and the welfare of children in need of protection.

Recommendation

Each case requires careful behavioral and historical analysis resulting in a comprehensive, specific, risk oriented plan with well-articulated, measurable goals and outcomes.

DHHS Response

OCFS has revised the policies for assessment, case planning, and working with families experiencing domestic violence, all in an effort to improve interventions.

Policies now reflect that child protective interventions must be specifically targeted to decrease signs of danger and risk and enhance signs of safety. Case management activities must have a specific reference to the family service plan. The revised policy for working with families experiencing domestic

IV. Services for High Risk Mothers and Their Babies

violence clearly states that anger management counseling is an inappropriate intervention for these situations.

The Panel recognized a need for shelters of mothers and babies, but also recognized the difficulty in assessing women served by these programs and the support staff needed to serve these homes. The Panel reviewed two cases where babies died in these shelters.

Case Examples

- There is a lack of knowledge by professionals, including DHHS, about what shelters or homes for at-risk mothers and their babies are able to do. There is an assumption that there is a higher level of care and protection than the homes can actually provide.
- In the cases reviewed, there was a breakdown in communication between medical care, the homes and DHHS.

Recommendations

- Determine the type and level of care each home or shelter can provide. The needs of the mother should be assessed before a home for her is chosen. Guardian-ad-litems and DHHS caseworkers should be educated on the resources that these homes can provide.
- A HIPPA *Authorization to Release Confidential Information* should be signed at the time of admission so that staff may communicate with the physicians for the young mothers and babies. The Panel recommends that the DHHS licensing division review both the licensing and programming of the shelters/ homes for single mothers and their infants. The purpose of this review is to identify any needed changes in order to assure the safe care of mothers and their infants.
- Appropriate licensing standards for these homes are needed, fitting the level of care they can provide.
- Consider the development of foster “Family Care Homes” where high risk

mothers and their babies or young children can stay together and receive professional monitoring, teaching, modeling and support.

DHHS Response

OCFS recently completed a statewide analysis of current and projected needs for residential services. This process involved OCFS staff and provider agency staff in a full discussion of the residential services currently offered in each District. These forums served to better explain to OCFS staff just what residential programs for high-risk mothers and their babies can and cannot provide. Treatment Foster Care agencies also attended these forums and heard OCFS staff articulate a need for foster homes that can serve high risk mothers and their babies. Work is underway to develop homes to meet that need. With respect to the release of confidential information, DHHS is currently receiving assistance from the Office of the Attorney General to develop appropriate forms and protocols for authorizing the release of this information.

Finally, as recommended by the Children's Services Reform Workgroup DHHS will be developing program standards for all residential services and will implement these standards through licensing regulations and performance based contracts.

V. Psychological Evaluations

In cases that the Panel reviewed, it was noted that psychological assessments could make a tremendous difference for the better or worse. It is important that the level of assessment is correct and the level of expertise of the examiner matches the assessment being done. In one case reviewed, it was noted that the psychological evaluation on the mother was thorough and well done. The provider was skilled at getting to the real issues. This illustrates the importance of having specifically trained providers to do these assessments.

Recommendation

The Panel recommends that the general level of expertise among professionals in regards to testing instruments should be increased.

DHHS Response

OCFS has worked with the Family Division of the District Court to expand the Child Abuse and Neglect Evaluators Project to most Districts in our State. This project recruits and trains psychologists to utilize an evidence-based protocol for evaluating both parents and children involved in complex child maltreatment cases. As CANEP has expanded, the use of other types of evaluations has decreased. OCFS is beginning work with Dr. Sue Righthand to develop a handbook for deci-

VI. Prosecution

sion-making regarding psychological evaluations. This handbook will aid caseworkers and those in the legal community to know when to access the right type of evaluation.
The Panel noted that prosecution is difficult in child abuse and neglect cases and sentences are generally light. Maine has been working to change this and the panel applauds these efforts. In many areas of the state there are few prosecutions for child endangerment.

Recommendation

The Panel supports gathering information from law enforcement and prosecution in regards to factors and barriers to prosecution. It is recommended that DHHS and the Maine Prosecutors assume the lead responsibility for this effort.

DHHS Response

Child Protective Services has no influences over prosecutorial decisions.

VII. Co-Sleeping

Co-sleeping has been a problem that the Panel has addressed for several years. The Panel reviewed several cases in which co-sleeping was a factor. In the shelter cases, there was one co-sleeping death and another incident where co-sleeping was present. Yet, there remains significant misinformation in the professional community about the risks associated with co-sleeping despite the recent cautions about those risks from the American Academy of Pediatrics and other professional associations.

Recommendation

Members from DHHS have met and are reviewing public health messages that can be used with families on the risk of co-sleeping. The Panel encourages a public health campaign regarding co-sleeping.

DHHS Response

The Department continues education efforts regarding the risks associated with co-sleeping.

Table 1
Number of Child Deaths by County 2004

Androscoggin: 9	Hancock: 3	Oxford: 4	Somerset: 4
Aroostook: 6	Kennebec: 3	Penobscot: 13	Waldo: 1
Cumberland: 20	Knox: 2	Piscataquis: 2	Washington: 4
Franklin: 0	Lincoln: 1	Sagadahoc: 1	York: 8

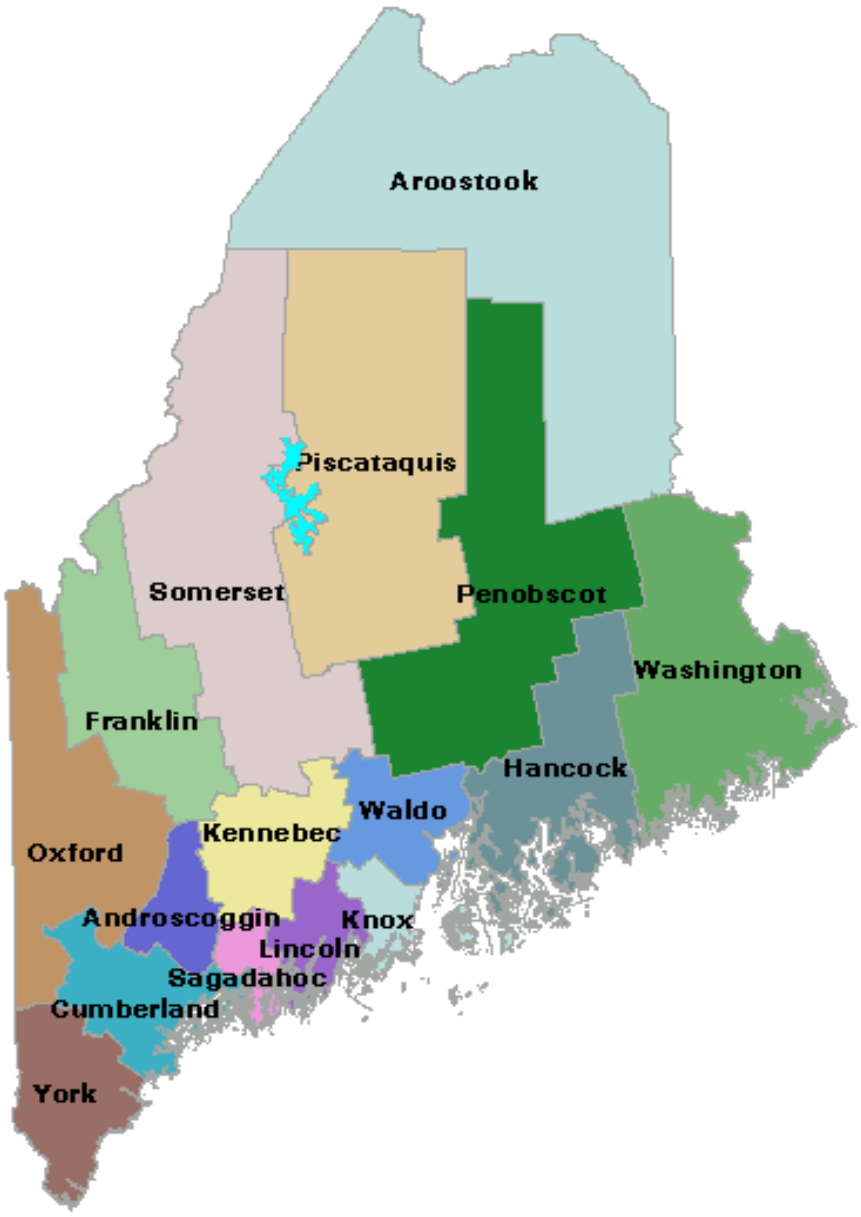


Table 2
Manner of Deaths of Maine Children 2004

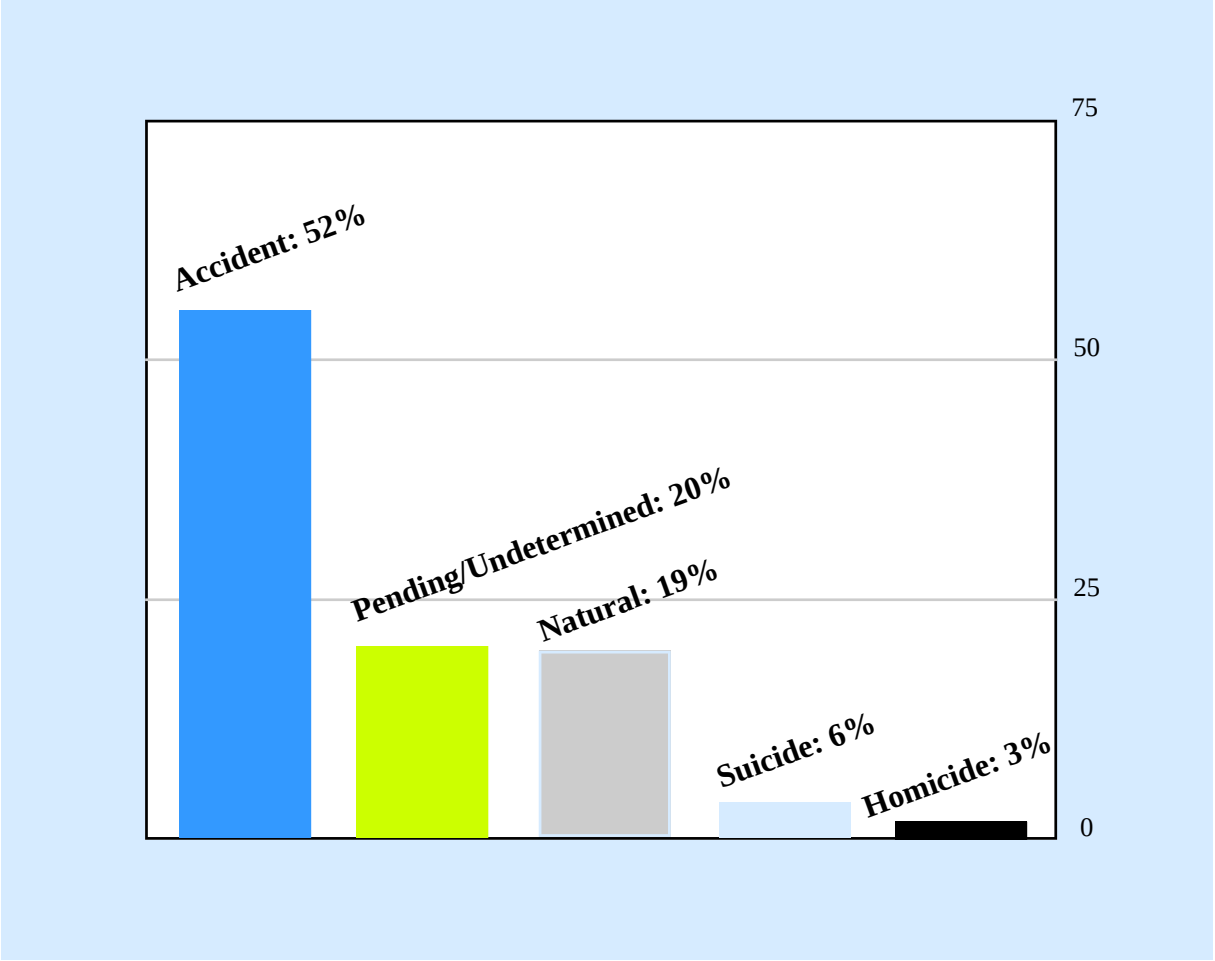


Table 3-A
Causes of Deaths in Cases Reviewed 2004

Victim Age	Cause of Injury	Perpetrator - Relation to Victim	Perpetrator Age
Newborn	Unknown	Mother	28
8 Weeks	SIDS/co-sleeping present	Unknown	—
8 Weeks	Undetermined SIDS death, alcohol and co-sleeping involved	Mother	22
5 1/2 Months	SIDS, respiratory problems	Mother	23
20 Months	Strangulation: mini-blinds	None	—
23 Months	Poisoning by swallowing grandmother's medication	None	—
3 Years	Strangulation: hanging by rope	None	—
10 Years, 8 Months	Suicide, hanging	None	—

Table 3-B
Causes of Serious Injuries in Cases Reviewed 2004

Victim Age	Cause of Injury	Perpetrator - Relation to Victim	Perpetrator Age
1-3 Months	Failure to thrive, Neglect	Mother	22
9 Months	Fall/unknown	Unknown	—
19 Months	Severe burns	Unknown	—
3 Years	Severe abuse	Mother, Mother's Girlfriend	29 , 23

The Panel reviewed 12 cases in 2004. Three were SIDS deaths, two with co-sleeping involved and one with both co-sleeping and alcohol involved. There were also three hanging cases reviewed, two accidental and one a suicide.

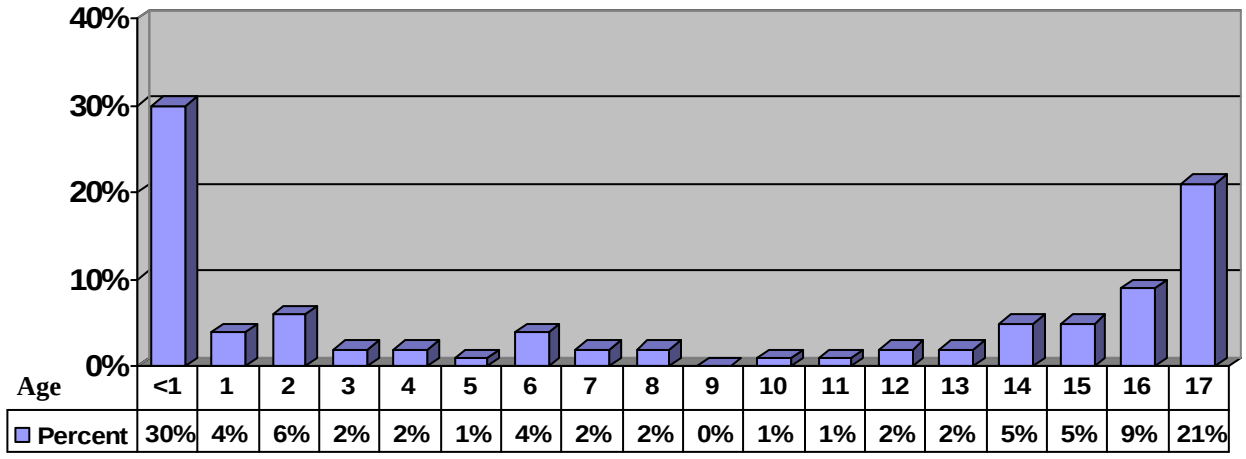
In 58% of the cases, the event which caused a serious injury or death was witnessed by at least one person. Of these cases 8% were inflicted injuries. The Panel determined that 42% of the time the injuries or deaths could have been prevented.

Child Deaths Reported to the State of Maine
Office of Chief Medical Examiner 2004

Total Deaths In 2004

81 child deaths were reported to the State of Maine Office of the Chief Medical Examiner in 2004. 30% of these children were under the age of one, and 21% were 17 years of age. 52% of the deaths were the result of accidents; while 3% were homicides. 63% of the children were male. More deaths occurred in Cumberland County than any other region; followed by Penobscot County.

Table 4
Ages of Child Deaths Reported to the
Maine State Medical Examiner's Office 2004



Age	<1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Percent	30%	4%	6%	2%	2%	1%	4%	2%	2%	0%	1%	1%	2%	2%	5%	5%	9%	21%

Note: Percentages equal 99% due to rounding

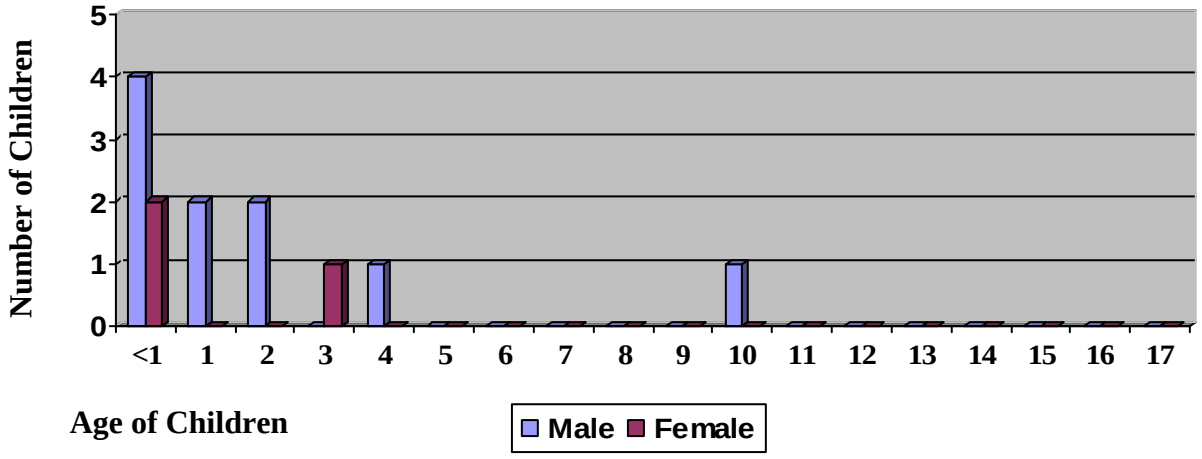
Case Demographics: Cases Reviewed by the Maine Child Death And Serious Injury Review Panel 2004

In 2004, the Maine Child Death and Serious Injury Review Panel reviewed twelve cases. Below is a summary of these cases, including demographic information about the children and families reviewed, causes of the deaths and injuries and summaries of findings and recommendations of the Panel.

Demographic Information

The ages of the children in the cases reviewed by the Panel ranged from newborn to ten years. Six cases involved children under the age of one and three involved children two years of age. Nine of the cases, or seventy-five percent focused on male children.

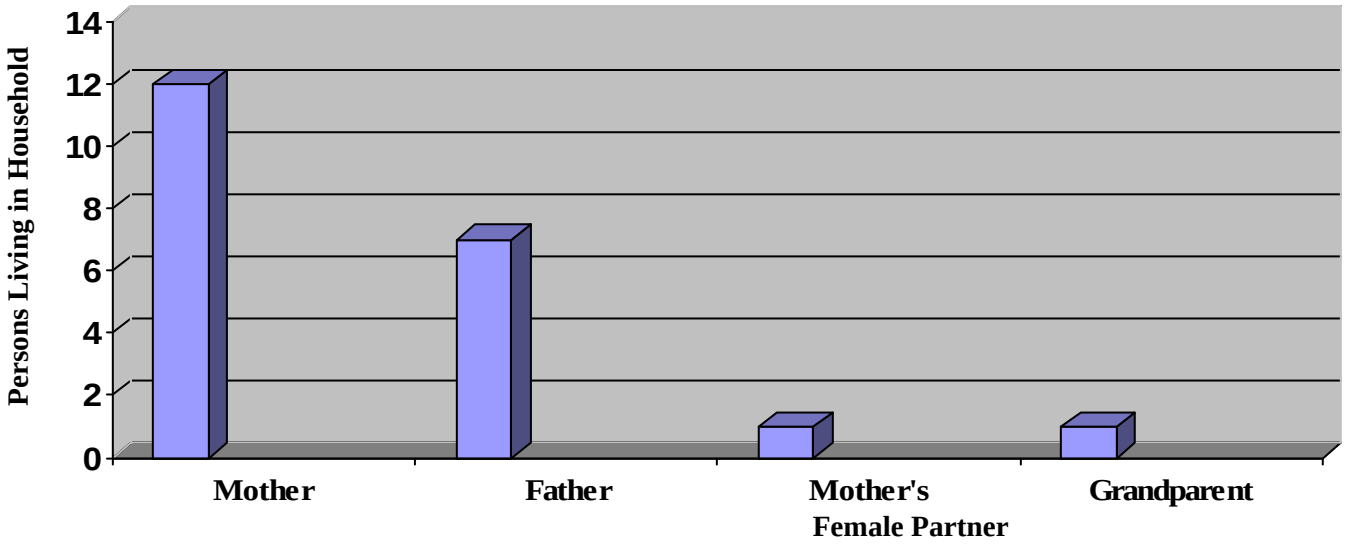
Table 5
Age and Sex of Children in Cases Reviewed 2004



Most of the children from the cases that the Panel reviewed lived in homes with two caregivers. In the majority of cases the caregivers were the biological mother and father. In 98% of the cases reviewed, children lived with their biological or adoptive mothers; 51% of the time, children lived with their biological or adoptive fathers. Eleven children resided with their parents' partners. More

specifically, 8% of children lived with a stepfather; 2% lived with the father's female partner; and 13% lived with their mother's male partner. In 11% of cases reviewed, there were other non-related persons residing with their family. (Note that these percentages do not total 100%; there is considerable overlap among these categories.)

Table 6
Members of Household in Cases Reviewed 2004

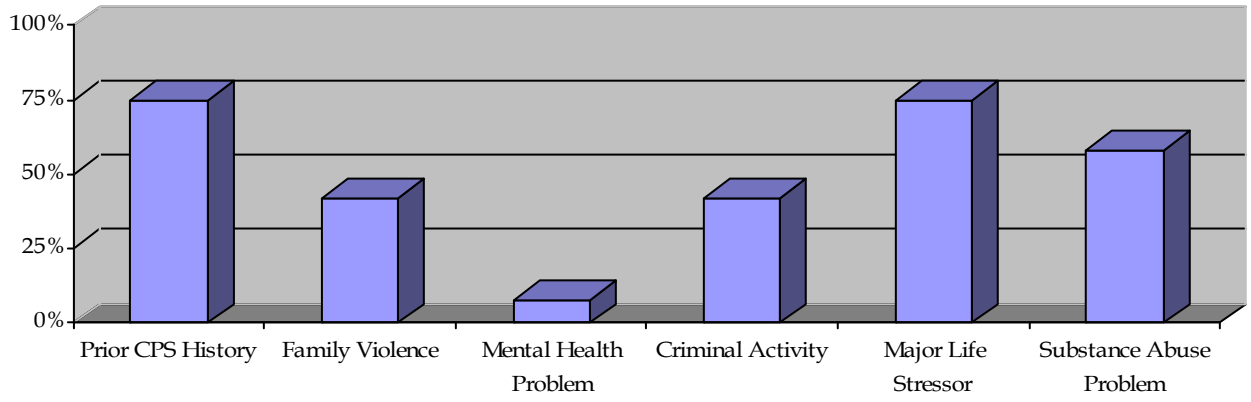


There was an average of four people living in the households (other than shelters) of cases that the Panel reviewed. In 3 of the cases, the mother and child were living in a shelter. In 89% of cases, there were other children living in the home. The average age of these children was 6 years. The average age of caregivers in the cases that were reviewed was 27 years. The caregivers who held legal custody of the children were most often married (50%); followed by parents who were never, or not married (42%) and parents who were divorced (8%).

Parental Risk Factors

The caregivers in the cases that were reviewed often presented with more than one significant risk factor as noted below. Seventy-five percent of the cases had prior histories or open cases with child protective services. 42% of the cases had a history of, or a current problem with violence in the household and 75% had experienced a major life stressor within the twelve months prior to the child's death or serious injury. Fifty-eight percent of cases had parental caregivers with substance abuse problems, 42% had a history of criminal activity and finally, 8% of the cases involved at least one caregiver with a mental health problem.

Table 7
Risk Factors 2004



State of Maine Child Protective Activities 2004
Department of Health and Human Services

Activities Based on Reports

In 2004, The State of Maine child protective system received over 17,017 reports about the well-being of Maine children. Over that period of time, 8,212 of the reports presented situations with evidence of serious family problems or dysfunction but did not contain allegations of abuse or neglect. Beginning in 1998, The Department of Health and Human Services began referring low to moderately low risk cases, for which there was insufficient staff, to Community Intervention Programs. Although these agencies do not perform child protective assessments on families, agency caseworkers have regular contact with families and therefore are able to monitor family functioning. They are also able to assist in finding appropriate services, such as housing, parenting classes, medical and mental-health treatment and so forth. In 2004, there were 3,421 appropriate reports assigned to a contract agency; 29 reports not assigned for assessment and 5,278 reports involving 10,567 children assigned to a DHHS caseworker for a safety assessment.

Table 8
State of Maine New Reports Assigned For Assessment 2004

Families	Children Involved By Age Groups					
Office	**Reports**	**0-4**	**5-8**	**9-12**	**13-15**	**16-17**
Portland	724	542	317	274	171	75
Sanford	285	176	145	163	98	47
Biddeford	576	386	268	246	177	70
Lewiston	841	616	395	369	288	110
Augusta	758	546	373	323	221	82
Rockland	370	253	187	141	92	40
Skowhegan	239	177	129	97	63	28
Bangor	764	560	353	269	185	85
Ellsworth	207	141	103	100	48	19
Machias	182	122	68	81	49	16
Houlton	96	81	43	44	26	8
Caribou/Fort Kent	220	168	98	89	72	37
STATEWIDE	**5278**	**3764**	**2476**	**2193**	**1488**	**616**

Family Assessments and Findings

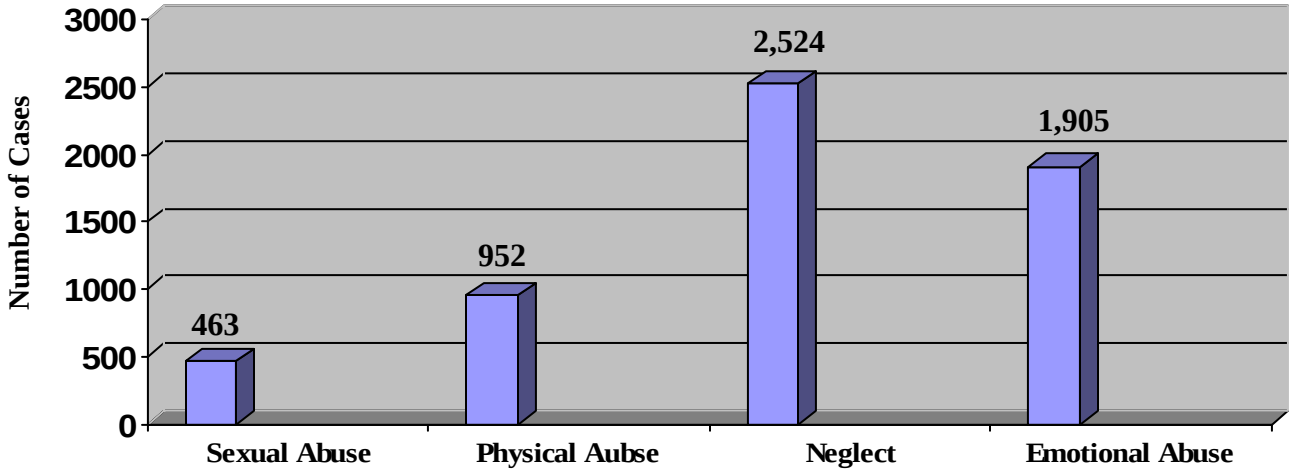
In 2004, The Department of Health and Human Services completed 5,555 assessments on Maine families/institutions suspected of abusing or neglecting children. Through these assessments, the Department substantiated that maltreatment occurred an average of 41.21% of the time. See the following table for rate of substantiation by office.

Table 9
Department of Health and Human Services
Child Maltreatment Substantiation Rate 2004

Office	Completed	Substantiated	Unsubstantiated	Substantiation Rate
Portland	751	358	393	47.67%
Sanford	275	83	192	30.18%
Biddeford	601	223	378	37.10%
Lewiston	872	391	481	44.84%
Augusta	776	262	514	33.76%
Rockland	386	157	229	40.67%
Skowhegan	240	125	115	52.08%
Bangor	780	373	407	47.82%
Ellsworth	212	102	110	48.11%
Machias	186	77	109	41.40%
Houlton	100	46	54	46.00%
Caribou	196	63	133	32.14%
Fort Kent	29	14	15	48.28%
Institution Abuse	151	15	136	9.93%
CPS TOTAL	**5,555**	**2,289**	**3,266**	**41.21%**

Maine state law defines child abuse as ‘a threat to a child’s health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these by a person responsible for the child’ (Title 22, MRSA, Chapter 1071§4002). With this in mind, the Department assesses for several different kinds of abuse when interviewing families, including sexual abuse, physical abuse, neglect and emotional maltreatment.

Table 10
Types of Substantiated Cases of Child Maltreatment 2004



A special thanks to the many
volunteer hours
that Panel Members
dedicated to make
this report
a reality.

Maine Department of Health and Human Services