Office of Child and Family Services Fatality Data Update

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Director

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OCFS' Fatality Dashboard

https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/child-fatality-reporting

How are fatalities categorized?

The categories of fatalities as identified by the Office of the Child Medical Examiner are:

- **Accidental** (includes causes such as motor vehicle accidents, drowning, fire, etc.)
- **Homicide**
- **Natural** (includes fatalities caused by medical conditions)
- **Other** (includes those fatalities identified by the Office of the Chief Medical Examiner as due to undetermined causes or by suicide)
- **Unsafe Sleep**
- **Sudden Unexplained Infant Death (SUID)**

Quarterly and annual data is available by fatality type, calendar year, age and gender.

What is and is not included on the Dashboard?

What <u>is</u> included in the dashboard?

- Any child fatality that is determined to be a homicide by the Office of the Chief Medical Examiner (OCME) – regardless of whether there is child protective history
- Any child fatality that has a finding of abuse or neglect associated with the death – regardless of whether there is child protective history
- Any child fatality where the family has prior history with the Department – this includes history before or after the child's birth and includes all types of death (including natural, accidental, suicide, and those where the cause of death has been found to be undetermined by OCME)

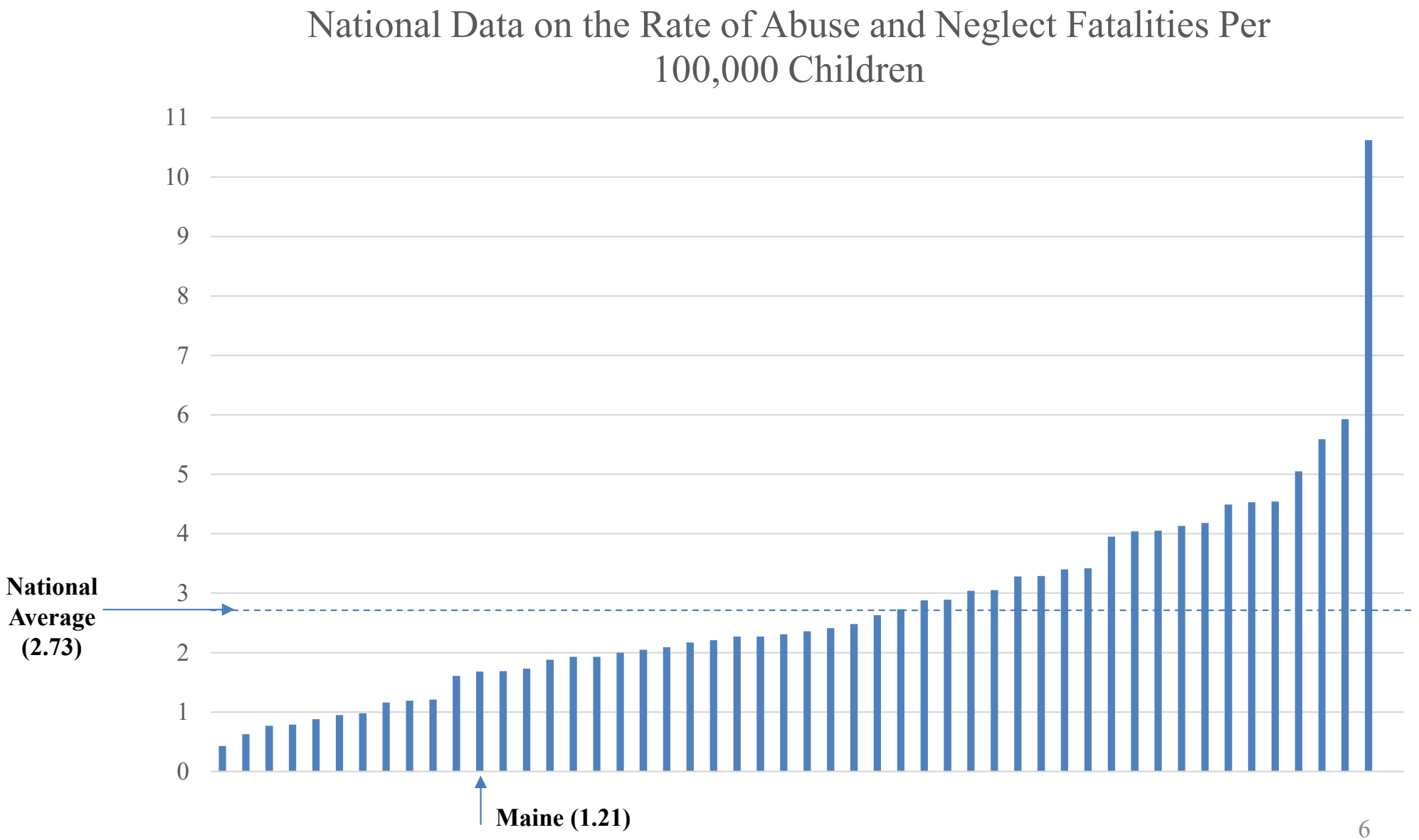
What <u>is not</u> included in the dashboard?

- OCFS' dashboard is not a comprehensive list of all child deaths in Maine
- Not all child fatalities are referred to the OCME (for example, a death of a child from a known medical condition where the child's physician certifies the death)
- Some child fatalities known to the public and the Department are not included due to pending criminal investigation/prosecution (these are added to the dashboard once prosecution is complete

Common Misconceptions

- Data only includes children who died while in DHHS custody
- Data only includes fatalities due to abuse and/or neglect
- There is a clear direct or proximate cause between the family's history with OCFS and the fatality

Data on Abuse and Neglect Fatalities



2024 Annual Data

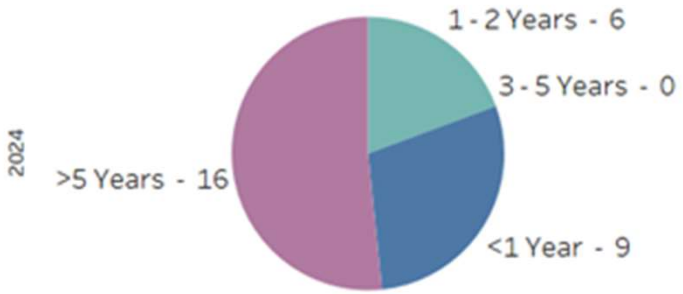
CHILD FATALITIES BY TYPE

CALENDAR YEAR	Accident	Homicide	Natural	Other	Sudden Unexpected Infant Death	Unsafe Sleep	Total
2007	0	2	0	1	3	1	7
2008	0	4	0	0	3	0	7
2009	2	1	1	1	2	1	8
2010	2	2	0	0	6	2	12
2011	1	3	0	2	1	1	8
2012	0	3	0	0	0	3	6
2013	2	1	3	2	1	2	11
2014	3	8	0	3	1	0	15
2015	2	1	1	2	1	1	8
2016	1	0	2	1	1	4	9
2017	2	4	0	3	1	4	14
2018	3	1	1	0	2	4	11
2019	4	2	3	4	2	4	19
2020	4	1	3	2	2	1	13
2021	11	5	4	7	3	4	34
2022	11	4	6	2	3	6	32
2023	10	0	7	7	0	2	26
2024	10	3	8	5	1	4	31

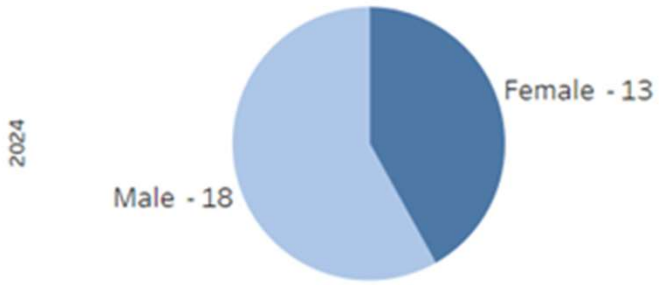
Select Calendar Year

2024

BY AGE



BY GENDER

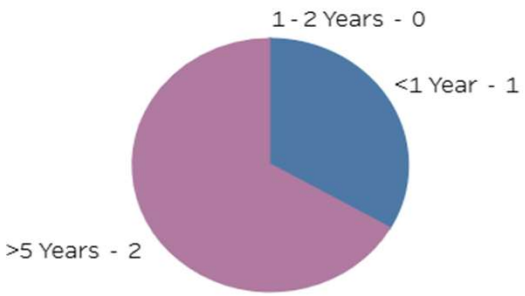


2025 Quarterly Data

CHILD FATALITIES BY TYPE

Type	2025 YTD
Accident	1
Homicide	0
Natural	1
Other	2
Sudden Unexpected Infant Death	0
Unsafe Sleep	0
Total	**4**

BY AGE



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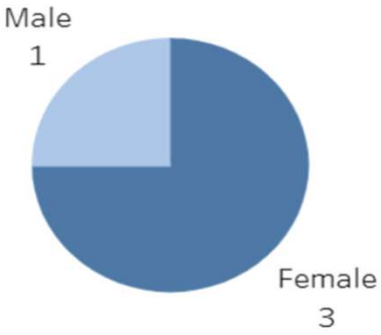

National Partnership for Child Safety

Quality improvement collaborative with a mission to improve child safety and prevent child maltreatment fatalities

Nationally, 38 jurisdictions are a part of the partnership, representing nearly 70% of all families involved with child welfare nationwide

Focused on implementing safety science principals to promote child and family safety/well-being

NPCS NATIONAL PARTNERSHIP FOR CHILD SAFETY

National Center for Fatality Review and Prevention (CFRP) Case Reporting System

https://ncfrp.org/data/nfr-crs/

"The National Fatality Review-Case Reporting System (NFR-CRS), developed and managed by the National Center for Fatality Review and Prevention (NCFRP) in collaboration with state programs, is a web-based system used by local and state Child Death Review (CDR) and Fetal and Infant Mortality Review (FIMR) teams. This system is used by all 50 states, the District of Columbia, and Puerto Rico to enter fatality review data for analysis at local, state, and national levels."

National Center for Fatality Review and Prevention (CFRP) Case Reporting System

- Provides a common repository for child fatality data for participating jurisdictions
- Data points collected are comprehensive to strengthen the data analysis and trend identification capabilities of the system
- Child welfare organizations as well as public health organizations (with a focus on fetal and infant mortality) participate
- Allows for better standardization and tracking of data, resulting in improvements in the ability to use data to improve outcomes
- Provides national context related to fatality information
- It was a recommendation of the Maine's Child Death and Serious Injury Review Panel to join the CRFP
  - Maine joined last year and recently finalized the required data use agreement with the CFRP.
  - Maine has a meeting scheduled with CFRP later this month to discuss next steps for implementation
- Data from the CFRP will ultimately replace OCFS' current fatality dashboard

Questions

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Office of Child and Family Services