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OFFICE OF PROGRAM EVALUATION AND
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TO: Members, Government Oversight Committee

FROM: Peter Schleck, Director

DATE: July 20, 2022

RE: Child Fatality Reporting Details

This memo provides information and additional clarification and detail for the Government Oversight Committee (GOC) regarding Child Fatality Reporting published by the DHHS Office of Child and Family Services (OCFS).

Overview, OCFS Annual Child Fatality Reporting and the Recency of OCFS Involvement

In response to questions and concerns regarding OCFS child fatality reporting, OPEGA obtained and analyzed the relevant source data to provide some clarification as to the number of fatalities, the recency of OCFS's involvement, and specific types of fatalities.

Annual Child Fatalities

Total annual child fatalities for the last three calendar years, as obtained from the Maine CDC's Division of Data, Research, and Vital Statistics, are provided in the following table.

Table 1. Maine Annual Child Fatalities - All	
Calendar Year	Total
2019	245
2020	298
2021	256
Total	799

OCFS Reported Child Fatalities

The number of child fatalities reported by OCFS on its dashboard are only those that meet certain criteria as defined in the Child Abuse Prevention and Treatment Act (CAPTA), and do not reflect all child fatalities that occur in Maine. Of the 799 child fatalities occurring in Maine between 2019 and 2021, only 60 met one or more of the following criteria to be included in the OCFS child fatality table:

- Are due to homicide as determined by the Medical Examiner, regardless of whether there was child protective history with the family;

- Have OCFS findings of abuse and/or neglect associated with the death, regardless of whether there was a child protective history with the family or whether there are law enforcement findings; or
- Had a child protective history before or during the child's life, even when the cause of death was natural, accidental, suicide, or undetermined.

It should be noted that not every child fatality that meets one of these criteria is included in OCFS's child fatality dashboard as some (which may be known to the public and the Department) are subject to ongoing criminal investigations/proceedings. Data on child fatalities reported by OCFS on its dashboard by calendar year for the last three years are provided in the following table:

Table 2. Annual Child Fatalities – OCFS	
Calendar Year	Total
2019	19
2020	12
2021	29
Total	60

OPEGA Analysis

To perform additional analysis, OPEGA obtained child fatality data directly from OCFS and requested that the data include those fatalities that are subject to ongoing criminal investigations or otherwise withheld. The data provided to OPEGA included an additional six child fatalities which we captured in the category "Criminal Case Pending" in the following analyses. OCFS and OPEGA received approval from the Criminal Division of the Office of the Attorney General to release these figures as they are aggregate totals and include no additional identifying information. Annual child fatalities, using this additional data, is provided in the following table:

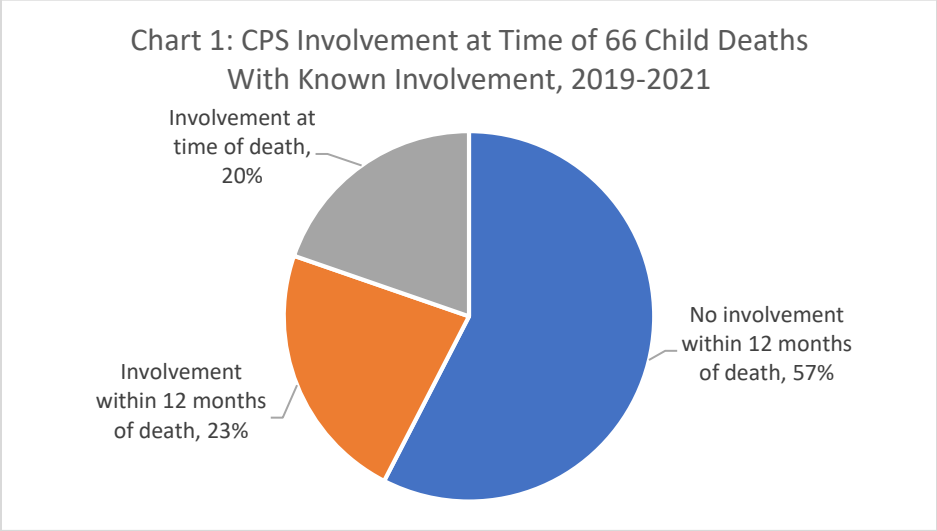
Table 3. Annual Child Fatalities - OPEGA	
Calendar Year	Total
2019	19
2020	13
2021	34
Total	66

Recency of OCFS Involvement

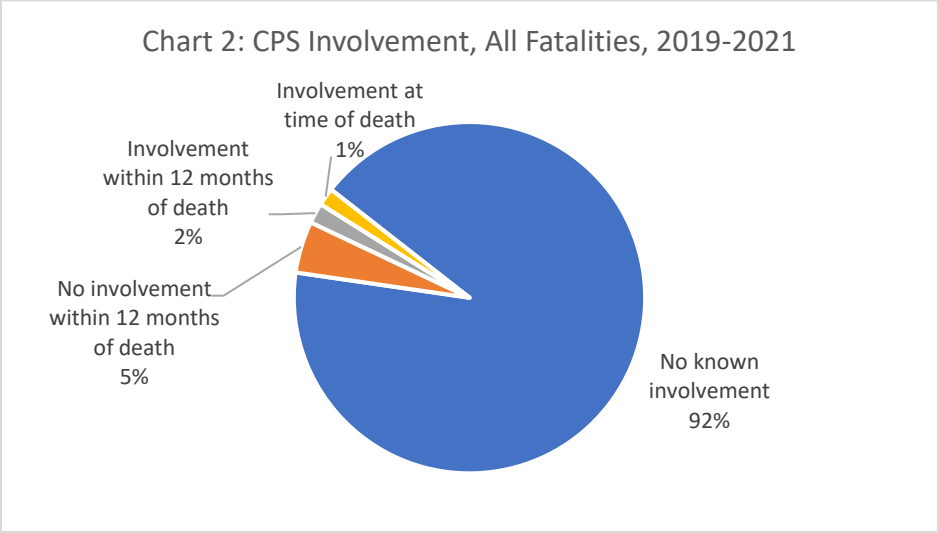
As the child fatality totals include deaths of children whose families had a CPS history during the child's life—regardless of how long ago that might have been or even if it occurred before the child was born—it appears useful to consider the recency of CPS involvement in these cases. Such an approach acknowledges that not all reports are deemed appropriate for CPS involvement, and that CPS involvement is not permanent nor indefinite as families may achieve outcomes or goals, parental rights may be terminated or the family may refuse voluntary CPS involvement and there is no legal basis for

the court to compel participation. As a result, two measures of recency were selected—having an open involvement at the time of the child death and having had an open involvement within 12 months of the time of the child death.

Of the 66 child fatalities, 38 had no CPS involvement at the time of death nor within 12 months prior to the death. The remaining 28 child fatalities had either CPS involvement at the time of death (13) or CPS involvement within 12 months prior to the death (15). CPS involvement at the time of death by percentages is provided in the following chart:



Including the child fatalities that are not captured in OCFS's child fatality dashboard, it is apparent that the vast majority of families that experience a child fatality have no prior CPS involvement, as seen in the following chart:



Manner of Death and Findings Related to Death

Fatalities captured in OCFS's child fatality dashboard are classified into one of six categories related to the manner of death as identified by the Office of the Chief Medical Examiner:

- Accidental (includes causes such as motor vehicle accidents, drowning, fire, etc.)
- Natural (includes fatalities caused by medical conditions)
- Sudden Unexplained Infant Death (SUID)
- Unsafe Sleep
- Homicide
- Other (includes suicides and undetermined causes)

Along with the manner of death, the data we obtained also indicated whether there was an OCFS finding of abuse and/or neglect associated with the death. For the 28 child fatalities in which there was CPS involvement at either the time of the death or within the 12 months prior, the following table provides the manner of death and whether there were OCFS findings associated with the death are:

Table 4. Manner of Death and Findings – CPS Involvement at Time of Death or Within 12 Months Prior (2019-2021)

Manner of Death	Number of Deaths	Number with Findings Related to Death
Accidental	7	4
Natural	5	1
SUID	4	0
Unsafe Sleep	4	3
Other (Suicide & Undetermined)	3	0
Criminal Case Pending[1]	5	5
Total	28	13

Additionally, we noted some areas of interest during committee discussions related to some specific scenarios:

Open CPS Case at Time of Death

From 2019 to 2021, there were 13 child fatalities in which OCFS had an open case at the time of the death. The manners of death for these children varied and are summarized in the table below—as well as a count of those fatalities that had OCFS findings related to the death:

[1] This OPEGA-created category captures those fatalities subject to a criminal investigation.

Table 5. Manner of Death and Findings – CPS Involvement at Time of Death (2019-2021)		
Manner of Death	Number of Deaths	Number with Findings Related to Death
Accidental	0	0
Natural	4	0
SUID	2	0
Unsafe Sleep	3	2
Other (Suicide &Undetermined)	2	0
Criminal Case Pending	2	2
Total	13	4

Child Fatalities Attributed to Unsafe Sleep

From 2019 to 2021, nine child fatalities attributed to unsafe sleep were captured in OCFS's Child Fatality Table. Of these nine, only three had OCFS findings of abuse and/or neglect associated with the death. For these three, we followed up with OCFS to learn that while substance use may have been a factor in the families' lives, substance use did not contribute to the fatalities.