

Review of Minnesota Child Mortalities in 2000

December 2003



Minnesota Department of **Human Services**
Children and Family Services Division
Child Safety and Permanency

Acknowledgements

We wish to acknowledge the excellent work of the county multi-disciplinary child mortality review teams across the state. It takes courage to do an in-depth review of the death of a child, to examine all of the circumstances that lead to a child's death and to seriously consider needed changes to prevent future deaths.

We wish to acknowledge the members of the state Child Mortality Review Panel for their dedication and leadership in seeking changes to protect children.

We wish to give special thanks to the Minnesota Department of Health's Vital Statistics Unit for providing the child death certificate data.

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Minnesota Child Mortality Review

– Executive Summary

Minnesota created a child mortality review process in 1987 to study factors that contribute to children's deaths due to maltreatment. In 1989, this process was formalized by the state legislature under the authority of the Minnesota Department of Human Services. With the enactment of Minnesota Statutes, section 256.01, subdivision 12, which established the requirements for county and state reviews, Minnesota created a partnership among the many agencies across the state that work to serve and protect children. In doing so, Minnesota became part of a national movement to strengthen the state's child protection efforts.

This is the sixth report regarding Minnesota's child mortality reviews, covering the period from January 1 through December 31, 2000. It provides data on the activities of the county child mortality review teams and the state Child Mortality Review Panel. In 2000, in Minnesota, 616 children died. Of those, 190 were non-natural deaths from accidents, suicides, homicides and undetermined causes. Another 23 deaths were caused by Sudden Infant Death Syndrome. The non-natural and the SIDS deaths are the primary concern of the review teams. In 2000, 62 deaths were eligible for review by the local teams.

In the year 2000, accidental or unintentional deaths made up 70 percent of all of the non-natural deaths. The state Child Mortality Review Panel believes that the majority of unintentional deaths are preventable or could have been avoided with a reasonable intervention. This prevention effort is a major focus of the state's review.

There were 16 deaths of children by homicide with nine, aged 12 or younger. In thirteen deaths, a child protection agency made a determination of maltreatment. The majority of perpetrators in physical abuse deaths were fathers, while mothers or both parents were most often responsible for deaths resulting from neglect.

Unfortunately, the state does not have an accurate picture of the causes of children's deaths. Nor does the state have an accurate count of children who die from

abuse and neglect. The multidisciplinary county and state child mortality reviews, help to:

- Accurately identify and document the cause of each child's death
- Collect accurate data on child deaths and near deaths
- Address the underreporting of maltreatment deaths
- Coordinate efforts and improve communication among child protection, law enforcement, county attorney, public health and other related agencies
- Generate change in legislation, rule, policy and practice
- Identify public health issues, patterns and trends
- Identify training needs for direct service social workers, public health nurses, law enforcement and medical examiners or coroners.

The most critical goal for the reviews is to identify changes needed to prevent future deaths of children from abuse and neglect.

Table of Contents

Introduction	6
History	6
Team Structure	6
Review Process.....	7
Purpose of Review	8
Eligibility for Review	8
Cause and Manner of Death.....	8
Child Mortality Data 2000	9
Manner of Deaths by Age.....	9
Race or Ethnic Heritage.....	9
Gender	10
Non-Natural Deaths.....	10
Accidents.....	10
Suicides	10
Homicides.....	11
Cannot be Determined.....	11
Deaths in Licensed Facilities.....	11
Deaths Eligible for Child Mortality Review	12
Deaths due to Maltreatment	12
Race/Age/Manner of Death	13
Perpetrators	13
Underreporting of Maltreatment	14
Child Mortality Review Recommendations	17
Table of Contents	17
Recommendations	18
Child Mortality Review Panel Members	29
Statutes	31

Child Mortality Review 2000

Introduction

History

Minnesota established the statewide child mortality review process in 1989. Minnesota Statute section 256.01, subdivision 12, put responsibility for reviewing deaths of children that occurred in the state under the Commissioner of the Minnesota Department of Human Services. The purpose of the reviews was to strengthen the state's efforts at protecting children and preventing future deaths. The law established the criteria and review requirements for state and local reviews, creating a partnership among the many agencies across the state that work to serve and protect children. The county child mortality reviews provide the backbone of the statewide system. The state reviews the local reports and the Child Mortality Review (CMR) Panel does a complete review of specific cases. Cases chosen for review have issues that may impact child protection statewide or relate to the prevention of deaths. In 1998, the statute was amended to include the review of near fatalities.

Team Structure

County Review Teams: All 87 Minnesota counties use a multidisciplinary review team to examine deaths of children in their county. Multidisciplinary review teams provide a wide range of experience and knowledge from many different disciplines/professions to help provide the broadest understanding of the causes and reasons for a child's death.

State CMR Panel Membership: Statute requires that the state Child Mortality Review Panel include a representative of the Minnesota Departments of Health, Education and Public Safety and the state Attorney General's Office. Membership also includes representatives from the Midwest Children's Resource Center, the Bureau of Criminal Apprehension, a city police department, an American Indian family services center, a local county public health department, a county attorney's office, a local county human services supervisor, a school social worker, a metro county medical examiner and a pediatrician. Membership also includes the Ombudspersons from the Office of Mental Health and Mental Retardation and for Spanish Speaking Families and representatives of the Minnesota Department of Human Services' Children's Mental Health, Children's Justice Initiative and Child Safety and Permanency Division.

Mission: To identify and understand how and why children die in Minnesota in order to make changes that will prevent future deaths from abuse and neglect.

Review Process

Local Review Process: The counties must report a death or near death of a child to the Minnesota Department of Human Services (DHS) within 48 hours. The counties must also conduct a local review of the child's death within 60 days. They examine the facts relevant to the case, draw conclusions about the appropriateness of services and compliance with the laws and make recommendations for change in county level policy, procedures or training. They may also make recommendations to be considered at the state review. A written report of the local child mortality review must be submitted to the state Child Mortality Review Coordinator within 90 days of the child's death. The report must include:

- A statement of facts relevant to the case being reviewed
- Any circumstances that caused the agency to use non-standard protocols
- Conclusions regarding compliance with law and appropriateness of the case management or specific services and
- Recommendations for change at either a local or state level.


Reviews may be delayed for pending criminal or civil action to:

- Prevent interference in local law enforcement and child protection investigations
- Allow the criminal process to be completed in order to have complete information regarding the case.

State Review Process: On a quarterly basis, DHS receives the death certificates for children from the Minnesota Department of Health's Vital Statistics Section. The CMR Coordinator reviews all of the death certificates and sends a copy to the social services office in the county where the child was a resident requesting a search for county social services records.

The CMR Coordinator uses the record search information and the local review report to choose cases that will be reviewed by the CMR panel. Cases may be chosen if maltreatment or suspected maltreatment was a factor in the case, if a child died of other than natural causes and was known to the county agency or the death occurred in a facility. Cases may also be chosen to be reviewed if there are issues for discussion that relate to a number of county human services, law enforcement or other related agencies statewide.

For each case to be reviewed by the CMR Panel, the CMR Coordinator obtains a copy of the autopsy, human services, law enforcement, hospital and clinic records and any other records, that may be pertinent to the death or near death of a child. A summary is presented and discussed at the monthly CMR meeting. All information or material received or discussed at the meeting is confidential. The focus of the discussion is to learn as much as



The county child mortality reviews are the backbone of the statewide child mortality review system.

possible about needed changes in the local and state system. Through these cooperative efforts, future deaths of children may be prevented.

Purpose of Review

The purpose of child mortality reviews is to improve the child protection system, including making needed changes in law, rule, policy and practice. The goal is to:

- Accurately identify and document the cause of every child's death
- Collect accurate data on child deaths and near deaths and address the underreporting of maltreatment deaths
- Coordinate efforts and improve communication among child protection, law enforcement, county attorneys, public health and other related agencies
- Generate change in legislation, rule, policy and practice
- Identify public health issues, patterns and trends
- Identify training needs related to direct service social workers, public health nurses, law enforcement, medical examiners or coroners.

The most critical goal for the reviews is to identify changes to prevent future deaths from abuse and neglect. A part of this goal includes promoting a better understanding and greater awareness of all causes of the deaths of children.

Eligibility for Review

Within 60 days of the death or near death of a child, counties must conduct a local mortality review if the death or near death is eligible for review. There are three categories of review eligibility. They are:

Death or near death resulting from maltreatment or suspected maltreatment. If the death or near death results in a child protection assessment, a local mortality review must be completed even if child protection determines that no maltreatment occurred. This is the only category that includes near deaths. An attempted suicide, which did not occur because of abuse or suspected abuse, would not be eligible for review.

Death resulting from:

- Sudden Infant Death Syndrome (SIDS) or Sudden Unexpected Death (SUD). The manner of death must be confirmed by an autopsy and listed on the death certificate (these are the only natural deaths requiring review). *or*
- Other than natural causes (refers to homicide, suicide, accident or cannot be determined. See "manner of death" definitions.) *and*
- The child or any member of the child's family received social services or a child protection assessment within one year prior to the death.

Death or incident leading to a death in a facility licensed by DHS (including daycare, foster care, group homes, etc.) and resulting from:

- SIDS or
- Other than natural causes (refers to homicide, suicide, accident, or can not be determined. See "manner of death" definitions.)

Cause and Manner of Death

The cause and manner of death listed on a death certificate are determined by the medical examiner or coroner. Cause refers to the biological or medical reason for the death. Manner refers to the circumstance in which the death happened. Determining the manner of death requires a multi-step process, including a careful death scene investigation and a complete autopsy. Medical examiners or coroners use five classifications to describe the manner of death. These include:

- Natural deaths from illness or birth defects
- Accidental death resulting from an unintentional injury
- Homicide resulting from another person's intentional action
- Suicide resulting from the child's own intentional actions
- Cannot be determined, in which there are unresolved questions about the manner in which the child died. Cannot be determined is used when there is insufficient information to classify the death as natural, homicide, suicide or accident.

Child Mortality Data 2000

Manner of Deaths by Age

In the year 2000, 616 children died in Minnesota. Of these children, 354 were under the age of 1, 478 (354 plus 124) were under the age of 12 and 138 were aged 13 through 17. The manner of death by age is indicated in the chart below:

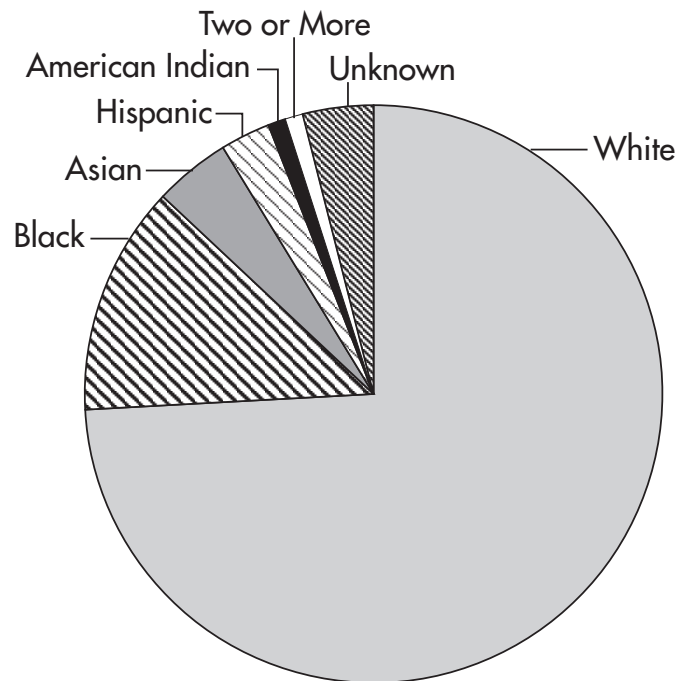
Age	Not Designated	Accident	Cannot be Determined	Homicide	Natural	Suicide	Total
<1	1	13	14	3	323		354
1-4	1	14	1	3	31		50
5-8		16	1	1	29		47
9-11		12		2	13		27
12-14	1	19		1	16	5	42
15-17		60	1	6	14	15	96
Total	3	134	17	16	426	20	616

Race or Ethnic Heritage

The number of deaths by race were as follows:

- 450 were white
- 78 were black
- 26 were Asian or Southeast Islanders
- 17 were Hispanic
- 15 were American Indian
- 6 were of two or more races
- 24 were unknown.

Percentage of deaths by race:



Gender

Of the child deaths, 375 (61 percent) were males and 239 (39 percent) were females. In two deaths, the gender was not reported.

Non-Natural Deaths

A total of 190 deaths were non-natural deaths. In Minnesota, those 190 deaths plus the 23 SIDS deaths are the cases that may be eligible for a local county child mortality review, if they fit the criteria. The manner of death for the 190 non-natural deaths were:

- 134 accidents
- 20 suicides
- 16 homicides
- 20 undesignated or cannot be determined.

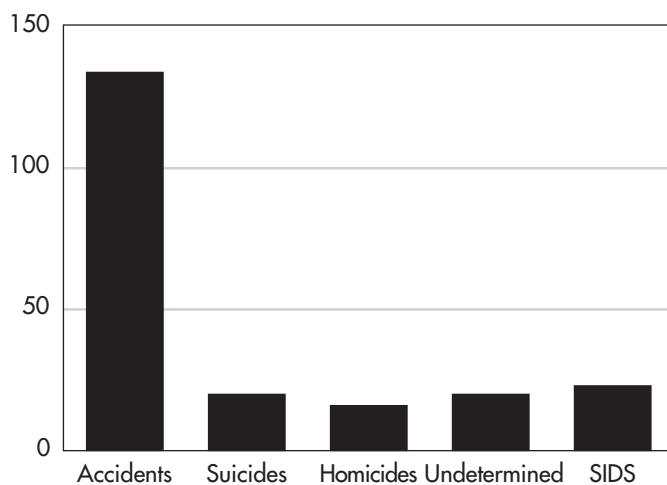
Accidents: It is clear that the 134 accidental or unintentional deaths were the greatest cause of non-natural deaths. Although homicides of children receive substantially more media attention, accidental deaths are 70.5 percent of all non-natural deaths. The majority of accidental deaths are preventable and this is where the state's attention is focused. Preventable deaths are determined, with retrospective analysis of circumstances or resources available, to be deaths that could have been avoided with a reasonable intervention. When eligible for a local review, the task of the county child mortality team is to determine what those interventions should be.

Many of these deaths resulted from poor judgement or lack of appropriate supervision or on the part of the parent. These deaths included drowning in bathtubs, toilets, drainage ditches and lakes; over-lay while co-sleeping; unsafe bedding; hyper or hypothermia; scalding; fires; entrapment in windows; accidents involving vehicles, bicycles, ATVs, firearms or farm equipment.

The following are examples of preventable deaths:

- A toddler, left alone in the yard, wanders into a drainage ditch and drowns.
- A baby is left playing in the bathtub while the parent answers the phone. The baby drowns.
- An infant is put to bed with an intoxicated parent, who rolls over on the infant while sleeping. The baby dies of asphyxia.

Manner of Death



- A 3-year-old is riding with his father on farm equipment, in a seat specially built for him between his father's feet. When the father is backing up and lowering the bucket at the same time, he does not see the child lean forward. The bucket catches the child's head, crushing it.
- A parent forgets to drop the child at daycare and instead leaves the child in a car all day. The child dies of hyperthermia.
- A child's head is trapped as she tries to get in a partially open car window and loses her footing. She dies of asphyxia.
- A child is put to sleep in an unapproved portable crib and asphyxiates after becoming tangled in the cover when it becomes unsnapped.

Children under the age of 1 are most vulnerable to asphyxia by adult overlay or becoming entangled or smothered by adult bedding. Children aged 1-to-5 are most vulnerable to drowning.

Suicides: In Minnesota, 20 suicides were committed by children 13 through 17 years of age. Fifteen (75 percent) were committed by 15-16-year-olds. The method of suicide was primarily by firearm or hanging. Only four of the children who committed suicide had prior contact with the county social services system.

Homicides: Of 16 homicides committed in the state in 2000, nine children were 12 or younger. According to the Minnesota Department of Health Data Brief: Child Maltreatment, 30 percent of children who died from shaken baby injuries were seen previously in the emergency room or local clinic for vomiting, bruises or other related symptoms. The other seven deaths were 17-year-olds. The major instrument of death for 17-year-olds is some kind of firearm. In nine of the homicides, the children or their family had prior contact with county social services.

About one third of all homicides are children under the age of 3.

Homicides by Method/Age

Age	Method			Totals
	Firearm	Blunt Force	Shaken Baby	
< 1 year	1	1	1	3
1-2 years		1	1	2
3-9 years		2		2
10-12 years	1	1		2
13-16 years				
17 years	5	2		7
Totals:	7	7	2	16

Cannot be Determined: 20 deaths were listed in this category due to insufficient information to classify the death. An example is a child dies with no anatomical cause identified, while sleeping in a crib, and it is listed as Sudden Infant Death Syndrome (SIDS). The manner of death is considered natural. However, if the death scene information indicates that the child was sleeping with an adult or another child in an adult bed or with pillows or other soft bedding, it may be more difficult to make a definitive diagnosis. The death may have been caused by over-lay by the adult or child. It may be asphyxia from the pillows or blankets.

Deaths in Licensed Facilities: Of 11 deaths in licensed family day care homes, six were determined to be SIDS, two were caused by asphyxia from unsafe bedding or other conditions and two were natural deaths. Only three of the deaths were assessed by child protection and none were determined to be deaths caused by maltreatment.

There were seven deaths in foster care. Six were considered natural, including one SIDS, one possible SIDS, one from unsafe bedding and three from medical conditions. The seventh death was a suicide.



Deaths Eligible for Child Mortality Review

In Minnesota, in 2000, 62 of the 213 deaths (190 non-natural deaths plus the 23 SIDS deaths) were eligible for a child mortality review. In those cases, the child or family had prior contact with county human or social services agencies. Contact may have been through a child protection assessment, the provision of social services or the death occurred in a facility licensed by DHS. The counties completed 61 child mortality reviews. One local review is still pending due to an ongoing criminal court process. The following table indicates the kind of county contact that made the death eligible for a review.

Deaths Eligible for Review due to:

Maltreatment or Suspected Maltreatment	23
Prior Social Services Contact	23
Death in a Facility Licensed by DHS	16*
Total	62

* There were 22 deaths in licensed facilities. However, six of the deaths were investigated for maltreatment or suspected maltreatment and counted in that category.

Only three counties had responsibility for four or more child mortality reviews in 2000. Hennepin County had 14 reviews, Anoka County had 10, Dakota County had five, Stearns and Ramsey County each had four. Rice County completed three reviews. Seven counties each did two during the year and eight counties each did one.

Deaths Due to Maltreatment

Child maltreatment includes physical or sexual abuse or neglect of a child by a person responsible for the child’s care. Maltreatment determinations are made by the county child protection agency as a result of an assessment of the family. This information is reported to the state in the Social Services Information System (SSIS) and required in the report of the local review. A maltreatment determination was made for 13 of the 62 deaths eligible for review. Twelve of those were children age 3 or under, including five homicides. Nine were less than 1 year old. The following table provides a breakdown of maltreatment deaths by race, age and manner of death.

Maltreatment Determinations in 2000 by Race/Age/Manner of Death


Age	Race					Totals
	White	Black	Asian	American Indian	Mixed*	
Less than 1 year Homicide	3					3
Accident	1		1	1	1	4
Cannot be Determined	1	1				2
1 year Homicide	1					1
2 years Homicide	1					1
3 years Cannot be Determined	1					1
16 years Accident	1					1
Totals	9	1	1	1	1	13

*Mixed race refers to persons who designated two or more races, but were not American Indian.

Perpetrators

The majority of perpetrators in physical abuse deaths were fathers. In neglect cases, mothers or both parents were responsible for five of seven deaths.

	Maltreatment	Abuse	Neglect	Totals
Perpetrator:	Mother		3	3
	Father	4	1	5
	Both Parents		2	2
	Mother's Boyfriend	1		1
	Daycare Provider		1	1
	Relative Caregiver	1		1
Totals		6	7	13



We do not have an accurate picture of the causes of children's deaths. We do not really know the number of children who die because of abuse or neglect.

Underreporting of Maltreatment

We do not have an accurate picture of the way children die. Furthermore, we do not really know the number of children who die because of abuse or neglect. This gap in our data is caused by a number of factors, which include:

- Insufficient death scene investigations
- Inconsistent use of the Minnesota Infant Death Investigation Guidelines
- Law enforcement not reporting the death to child protection for an assessment
- Counties screening out or not making a maltreatment determinations on cases deemed accidents, homicides or when there are no siblings
- Lack of cooperative relationships between child protection and law enforcement
- Inconsistent classification by the medical examiner or coroner
- Inconsistent standards for child autopsies throughout the state
- Lack of a requirement for a review for legal non-licensed daycare homes.

Death Scene Investigation: Law enforcement is usually the first emergency personnel on the scene of the death of a child. It is law enforcement's responsibility to secure the death scene, preserve evidence and obtain accurate information about what happened. Because the death scene may be chaotic and family members are extremely distraught, securing the scene and getting information is often challenging. The family may have moved the child. In rural areas, law enforcement may have to assist the ambulance driver taking the child to the hospital, leaving the death scene without retaining the evidence. Grieving family members may attempt to help by washing bedding, dismantling and getting rid of the bassinet or crib or otherwise cleaning up the scene. These actions may eliminate critical evidence, which may help to establish the cause and manner of death.

Minnesota Infant Death Scene Investigation Guide: For children under the age of 2, the Minnesota Infant Death Scene Investigation Guide should be used. This is not done consistently.

Lack of Report to Child Protection: Law enforcement may not refer the death for a child protection assessment, if they consider the death an accident or if the medical examiner or coroner has classified it as one. They may not make a referral, if there are no surviving siblings, since they consider no other child is at risk. Law enforcement may be primarily concerned with whether a crime has been committed, which needs to be referred to the county attorney.

Child Protection Screens out the Law Enforcement Report: Accident: If law enforcement does make a referral, the child


protection agency may screen out the report. They may accept the law enforcement decision that the death was an accident and not consider that an assessment is needed regarding whether the parent's inappropriate supervision or judgement contributed to the death. Because no assessment is completed, the death is not included in the state's statistics as a maltreatment death even when neglect may have been an issue.

No Siblings: Some county child protection agencies may screen out law enforcement reports of a child's death when there are no surviving siblings. They may decide that since there is no risk to another child, no assessment is required. However, if the death is caused by the caregiver's neglect or maltreatment, no record of this behavior will be established without a child protection assessment and determination. The parents may later have children who might be at risk. In addition, in the future, the parents may wish to provide day care or foster care. Without a maltreatment determination, no record of the neglect or abuse would be available in a licensing background check.

Homicides: In the death of a child, a county child protection assessment and maltreatment determination may be completed based solely on the law enforcement investigation. When the person who committed the homicide has been convicted, counties often will not consider it necessary to complete an assessment. This death is never documented as maltreatment at the county level, is never entered in SSIS and does not become a part of the state's required reporting of child maltreatment to the federal government.

Interagency Relationships: The investigation of a death where maltreatment may have occurred is not always done jointly between child protection and law enforcement. Critical information may not be shared, leading to inaccurate conclusions. The county may determine that no maltreatment occurred without including input from law enforcement and vice versa.

Inconsistent Classification of Manner of Death: Medical examiners or coroners who are inexperienced with infant deaths may mislabel the manner of death. Some death certificates indicate that the death was caused by Sudden Infant Death Syndrome (SIDS) because the autopsy revealed no anatomical cause of death. The manner of death is listed as natural. However, some of those death certificates may list under "Other Significant Conditions," co-sleeping or unsafe bedding. The child may have been sleeping with adults or siblings. The child may be sleeping on an adult bed with pillows or heavy blankets or on a sofa. Any of these factors may mean that the medical examiner could not rule out asphyxia. According to medical experts, it is almost impossible to distinguish between accidental or intentional asphyxia and SIDS. In cases where the child is not sleeping in a crib with safe bedding, the manner of death should be designated "cannot be determined."



In the death of a child, a county child protection assessment and maltreatment determination may be completed based on the law enforcement investigative report.



Since SIDS is not considered a preventable death, the medical examiner or coroner may categorize a death as SIDS to reassure the parents that they were not to blame. However, deaths from overlay or asphyxia from unsafe bedding or co-sleeping are preventable. It is important to have an accurate count of these deaths to focus attention on prevention efforts.

In some cases, an infant may be found at home not responsive and revived at the hospital. If the child then develops pneumonia and dies, the medical examiner or coroner may list the death as pneumonia. However, it may first have been a SIDS incident (if no other anatomical cause of death is found). If the manner of death is listed as SIDS or undetermined, the death is eligible for a local child mortality review. Natural deaths, other than SIDS, are not eligible for review.

Legal Non-licensed Daycare: Minnesota has about 7,000 legal non-licensed family daycare homes. No on-site inspection of the home is required. There are many more uncounted and unregulated relative caregivers. No mortality review is required for deaths of children occurring in those homes unless there has been maltreatment or suspected maltreatment or a member of the family has received social services in the year before the death.

Table of Contents for Recommendations

Recommendations for:

Child Mortality Review Teams	18
Child Mortality Review – Local.....	18
Child Mortality Review – State.....	18
Death Scene Investigations	18
Law Enforcement Investigations	18
Minnesota Infant Death Investigation Guidelines.....	19
Medical Examiner.....	19
Minnesota Department of Human Services	19
Other Topics	20
Child Protection	20
Child Protection Teams	21
Child Safety	21
Collaboration Between County Departments and Agencies	22
Consumer Product Safety	22
Court Procedures.....	22
Data Privacy	22
Developmental Disabilities	22
Domestic Violence.....	23
Grief.....	23
Mandated Reporters	23
Medical Evaluations.....	23
Mental Health	24
Minor Parent	26
Public Education – Hyperthermia	26
Public Health’s Home Visitor Program	26
Prenatal Exposure to Alcohol	27
Relative Placements	27
Social Services.....	28

Preventable deaths are those that, with retrospective analysis of circumstances or resources available, are determined to be deaths that could have been avoided with a reasonable intervention.

Child Mortality Review Recommendations

Recommendations made by the local review teams are reviewed by the state child mortality review Coordinator. Recommendations made by the state CMR Panel are shared with the commissioner of DHS, the county human service agency where the case originated, and other relevant agencies for possible action. County human service agencies share the state's recommendations with their multidisciplinary review teams and take any actions deemed appropriate. The following recommendations were made by the state child mortality review panel:

Child Mortality Review Teams

Recommendations for Child Mortality Review — Local

As required by statute, the local review team must review an eligible death within 60 days of the death and submit a report to the state.

- The local review team should review the case history and provide recommendations reflecting the entire scope of the case.
- A local review of the death of an American Indian child should involve the child's tribe and other agencies that shared responsibility for the case.

Recommendations for Child Mortality Review — State

The local social service agency should ensure that a staff person with direct knowledge of the case attends the Minnesota Child Mortality Review (CMR) Panel meeting to discuss the death and the Panel's recommendations.

Death Scene Investigations

Recommendations for Law Enforcement Investigations

Law enforcement officers, who specialize in the investigation of child maltreatment crimes, should be available by a paging device and should be notified immediately of any serious child injury or fatality to avoid a delay in the investigation.

Law enforcement investigations should not end when the coroner or medical examiner makes a determination that the manner of death was an accident or could not be determined. Through investigation, law enforcement may discover additional information that clarifies the cause of death. In addition, information may be obtained that will establish whether maltreatment occurred.

In suspected child maltreatment, law enforcement should interview parents or caregivers separately to prevent them from

exchanging information about events and to develop a distinct picture of each person's recollections.

When financial problems and significant debt are primary factors in a death, gambling habits should be explored as part of the law enforcement investigation.

The law enforcement officers at the scene should secure all evidence related to a child's death, by request or through a search warrant. Accurate measurements, such as the depth of water in a bathtub, location of objects and other important information should be recorded. If a tool for measurement is not available, a photographic record should be made using a common object for comparison.

The law enforcement investigation into allegations of sexual abuse must be initiated within 24 hours to prevent exposing a child to continued abuse. An investigative interview should not be delayed, even so the child can obtain sexual abuse counseling, which may influence the child's statement and hinder the criminal prosecution. A significant delay between the time of the child's disclosure and the investigative interview could result in a child altering or forgetting details of the abuse.

Local law enforcement should work together with hospitals to develop a protocol when a child dies. Physical evidence should not be disturbed, taking into consideration the parents' desire to grieve and law enforcement's need to preserve evidence.

Recommendations for Minnesota Infant Death Investigation Guidelines

The Minnesota Infant Death Investigation Guidelines (MIDIG) were developed in 1990 to investigate and document the death scene of a child under the age of 2. The MIDIG help discern if cases require a homicide investigation, assist the coroner or medical examiner in making a determination of the cause and manner of death, and support a county attorney's decision to criminally charge a case. Without a comprehensive investigation of the death scene, critical evidence and information may be lost. The MIDIG have not been updated since being developed.

- The Minnesota Departments of Health, Human Services, Bureau of Criminal Apprehension and the Minnesota Coroners and Medical Examiners Association should collaborate to revise the MIDIG.

- After the guidelines are revised, training should be implemented statewide for law enforcement officers, first responders, coroners, medical examiners, county attorneys and emergency room physicians.
- The MIDIG should be used to do a thorough investigation, including documenting the death scene. It should be completed by the law enforcement agency and the coroner's investigator for all unexpected deaths of children under 2.
- There should be a statutory requirement that the MIDIG must be followed in the investigation of all unexpected deaths of children under 2.
- The Minnesota Bureau of Criminal Apprehension should include the MIDIG on their Web site, so it is readily available to investigators.

Recommendations for Medical Examiner

- When an expert in child abuse is consulted about injuries to a child found during the autopsy, all medical and autopsy reports should be available to determine if the injuries were inflicted or accidental. If the consult was obtained without all reports, a new consult should be obtained.
- For a child who died unexpectedly, the medical examiner (ME) or coroner conducting the autopsy examination should review past medical records and the death scene investigation.
- A protocol for autopsies of infants and young children should be established as a reference for coroners and pathologists.
- A coroner or ME should report all cases of suspected child maltreatment to the child protection agency.

Minnesota Department of Human Services

- Both the Minnesota Departments of Health and of Human Services (DHS) should continue funding for programs that provide treatment and long-term support for chemically dependent women who are pregnant as well as for those women who

delivered a baby with prenatal exposure to alcohol or drugs. Funding should be expanded to under-served areas of Minnesota.

- DHS, in partnership with other agencies in the medical community, should develop and implement training on recognizing child abuse and neglect. The training may use interactive video to enable physicians to participate with minimal travel time or the video could be viewed at their convenience. The training should include information on the legal mandate to report suspected maltreatment to the local social services agency or law enforcement agency.
- DHS should develop a more comprehensive definition of neglect and incorporate the language into Minnesota Statutes, section 626.556.
- DHS should develop training to educate child welfare workers about recognizing and working with clients with cognitive impairments.

Other Topics

Recommendations for Child Protection

Intake: When suspected child maltreatment is reported, the case should be assigned to a child protection worker promptly, so the assessment is begun within 24 hours as required in rule. Decisions regarding child protection intake, or assignment of maltreatment reports to child welfare services, should consider risk factors such as family size, age of the parent, support from the extended family, history of domestic abuse, housing, and disabling conditions such as developmental disability or mental illness. All of these factors elevate the stress level, interfere with the ability to care for the children, and increase the risk of child maltreatment.

Assessment: A county child protection assessment should be completed regarding the death of a child is caused by being left unattended in a vehicle and any maltreatment determination documented in the child protection system. The assessment should consider a child's developmental age and whether the parents neglected to provide basic needs for the child, including supervision, nourishment, liquids, exercise, play or hygiene, while the child was in the car. The assessment should consider that many accidental

deaths of children are the result of parental neglect and may be maltreatment.

A child protection assessment should include interviews with all adult caretakers in the household, an evaluation of parenting skills, observation of the interactions between the children and adult caretakers who live in the home, and a thorough review of prior child protection records concerning the family.

A child protection assessment should include a check on the criminal history of all adult members of the household to reveal prior maltreatment, domestic abuse, felony and misdemeanor offenses and probationary status, which may indicate a pattern of criminal or unhealthy behavior.

Particularly when young children have suspicious injuries and are unable to speak for themselves, interviews with people who have informal contact with the family, such as neighbors, relatives or child care providers should be conducted.

When the child protection report includes allegations of physical abuse or severe neglect to an infant, the assessment should include a medical exam and a skeletal survey to determine if the child has injuries that are not apparent through simple observation.

Assessment After the Death of a Child: A child maltreatment assessment is required when suspicious injuries are found during the autopsy or concerns arise during the death scene investigation, even though the child is dead. Minnesota Statutes, section 626.556, subdivision 10 states that, "in cases which result in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred." The statute requires that the local social service agency prepare a separate report of their findings and determination of maltreatment.

In the death of a child without siblings, the child protection agency should assess the risk of future harm and provide appropriate services to the family. If the couple have more children, social services could be offered to the family to provide education and other resources deemed necessary. If the child's death resulted from the parents' poor judgement, that should be documented in the child protection records, in the event that the parents apply for a child care or foster care license.

In the death of a child, the alleged maltreater should be interviewed by law enforcement or child protection about the allegations whenever possible, as required in Minnesota Statute, section 626.556, subdivision 10(i). If the offender declines to be interviewed, that should be documented in the assessment report and the maltreatment determination made based on the other evidence collected during the assessment or investigation.

Assessment for Chronic Abuse and Neglect: Children are damaged by chronic abuse and neglect because their physical, medical and emotional needs are consistently unmet. Children in neglectful environments are at just as high a risk for illness or injury as children who reside in abusive environments.

Each report made to child protection should be screened and assigned based on all the information available, including chronic neglect cases where an accumulation of events elevates the level of risk. A risk assessment tool and safety assessment tool should be used to help determine whether child protection services are required. The county attorney should be consulted to ensure that the level of response is supported by the statute.

The assessment tool used in child welfare cases should consider the severity, chronicity, and pattern of neglect in the family, to assess the level of risk and make a decision regarding intervention and the assignment of the case to child protection services.

The child protection system must pay attention to significant evidence of chronic neglect and abuse of children to prevent death, emotional or behavioral problems. This evidence may involve second or third degree burns, long bone fractures or facial trauma inflicted on infants, medical neglect or abandonment.

When evidence of abuse and neglect is accumulating despite the intervention efforts of the child protection system, the entire case history should be presented to the county attorney to determine if a CHIPS petition is appropriate. The chronicity of the maltreatment should be considered rather than each report as an isolated incident.

Ongoing Child Protection Services: When a family moves from the address given in a child abuse report, efforts should be made to locate them including re-contacting the person who made the

report; searching the county financial assistance records; contacting local law enforcement, former landlords, the telephone company and the post office. These efforts should be documented in the case record.

When a family flees from a county where a maltreatment determination has been made, the new county of residence should consider the prior determination as valid, if the family comes to its attention. The entire case record from the prior county should be requested.

Recommendations for Child Protection Teams

The child protection agency should utilize the child protection team to strengthen the working relationships of agencies involved in the protection of children. These agencies include child protection, law enforcement, courts, probation, public health, schools, the county attorney's office and other agencies providing services to a family. The agencies should work together to accomplish planned goals and to communicate consistent messages to the family.

In one example, the law enforcement agency knew that a mother had limited intellectual capacity and that an offender was back in the home. The child protection agency did not have this information and did not request an evaluation of the mother's intellectual functioning level to determine her ability to protect her children.

Recommendations for Child Safety

A detailed case plan describing services should be developed with the client, so the client understands what is expected.

If the parent is unable or unwilling to comply with the case plan and to provide a safe environment for their children, the children should be placed in a safe environment.

When a parent is unable or unwilling to provide required medical care for a child with a serious injury or illness, or suffering second and third degree burns resulting in a permanent disfigurement, the county attorney should be consulted about filing a CHIPS petition. If the parent is still unable or unwilling, then out-of-home placement should be pursued.

A written statement from a physician that a child, who sustained a serious abusive injury, remains at risk

for life-threatening events, should be immediately shared with the county attorney. The county attorney should be informed of all the facts regarding the family's history with child protection and law enforcement to evaluate whether a CHIPS petition would help to protect the child.

The entire child protection history should be a factor in the decisions made by all levels of the social services and judicial system. Relevant history includes information about the safety of the children, such as medical, legal or educational abuse or neglect; the progress made toward accomplishing the goals of the case plans; level of cooperation of the parents and other information specific to the case. The information is important because past behavior is a predictor of future behavior.

The court must be informed of the entire scope of a family's child protection history, including criminal history, dysfunctional family dynamics or licensing denials, at the earliest opportunity, not just when a termination of parental rights petition is filed.

Recommendations for Collaboration Among County Agencies

When mandated reporters contact child protection intake with information on an open child protection case, that information should always be sent to the child protection worker. The child protection worker should contact the mandated reporter for additional information and to acknowledge that the information was received.

County work groups from child protection and adult services should discuss the need to notify each other about "crossover" families with open cases in developmental disabilities, adult mental health, children's mental health. The group should develop working guidelines for reporting and handling child protection information on families with open cases.

Recommendation for Consumer Products Safety

Medical examiners should contact the Consumer Product Safety Commission to report any unsafe objects related to the death of a child. An example is a bassinet with a snap-on cover that came off, causing a child to suffocate while entangled in it.

Recommendations for Court Procedures

A guardian ad litem, who offers an objective opinion and recommendations to the court concerning the best interests of children, should be appointed on every case petitioned through a CHIPS action, including educational neglect and abandonment.

Recommendations for Data Privacy

The federal data privacy statute allows for the release of information regarding chemical dependency when it is necessary to make a report of suspected child maltreatment. Minnesota Statutes, section 626.556 permits the release of child protection, but not child welfare records, to another jurisdiction. Minnesota Statutes, section 626.556, subdivision 10g should be revised to share child welfare records with another jurisdiction, particularly with the development of the child protection Alternative Response system. Cases may be referred for a traditional investigation, after an initial Alternative Response.

The laws that relate to public information in police reports should be modified to protect the identity of the reporter, regardless of the nature of the crime. Although this information is protected under Minnesota Statutes, section 626.556 and 626.557 for people who report abuse to children or adults, the same standard does not apply to other types of crimes.

Recommendations for Developmental Disabilities Services

Parents in the moderate range of mental retardation, who have young children, may benefit from developmental disability services. Special programs are available to parents with limited cognitive ability to teach them parenting skills and assess their ability to provide for a child's physical, emotional and safety needs.

- A parent who appears to be cognitively impaired should have an evaluation by a psychologist of their ability to care for children.
- A parent with an intelligence quotient score below 70 should be referred for an evaluation designed for persons who have a developmental disability.

Recommendations for Domestic Violence

Domestic abuse offenders often have court ordered visitation with their children after they are excluded from the home by an order for protection. Orders for protection are frequently violated. Despite the offender being excluded from the home, there is a high probability that the offender will return to the family and continue to inflict abuse, if child protection intervention services are not provided to the offender.

Minnesota Statute 626.556 requires an investigation of alleged abuse to children. Allegations of abuse to children related to domestic abuse should be thoroughly assessed. The assessment must include direct observation of the child with the alleged injuries, and may include interviews with collateral contacts. Interviews with witnesses and collateral contacts must be recorded by audiotape whenever possible, according to 626.556, subdivision 10.

When a parent with children in the home requests that an order for protection be amended to allow the offender to return to the home, the family court staff should forward a copy of the petition and any subsequent orders to child protection. This is particularly important when the request for an amendment to the petition is made soon after the order for protection was issued.

If child protection services are being provided, the worker assigned to the case should be informed if an offender has returned home in order to assess the situation and take any necessary steps to ensure the safety of the children.

Minnesota Statutes, section 626.556 should be expanded to include a definition of chronic and severe domestic abuse that would enable child protection or the police to intervene to protect the children. The condition would be defined as children living in an environment of chronic or severe domestic abuse, who are at great risk of being victims of physical and emotional abuse.

Recommendations Regarding Grief

Children who had a sibling die, due to abuse in the home, should be informed of the death in a manner that respects their need to grieve and they should be allowed to participate in the family rituals.

When law enforcement does not want children to have contact with other relatives until they have been interviewed, the county child protection system should take responsibility for advocating for the children's needs and plan for their participation in the funeral. They should use creative problem solving to:

- Have the children interviewed before the funeral
- Hold a special service for the children when relatives are not present
- Request that the family delay the funeral so the children can participate.

When a child is separated from the parent after the death of the sibling, and has previously experienced separation, the local social services agency should request mental health services to assess the child's attachment issues, grief and coping reaction to the death, and separation from the parent. The primary caregiver should be advised to initiate a mental health evaluation of the child and follow any recommendations for therapeutic intervention. If the primary caregiver is not cooperative with social services, then a CHIPS petition should be filed to request that a court order recommend the services.

The agency should assess the parents' grief reaction, discuss mental health services and make a referral for a public health nurse to visit the family. Counseling may help the parents cope with the death of their child and prevent the development of, or provide early intervention for, mental health problems.

Recommendations Regarding Mandated Reporters

Mandated reporters should be encouraged to call child protection to consult about suspicious injuries.

Mandated reporter training is needed for physicians, hospital emergency room staff and other medical personnel, due to the number of serious injuries not reported to child protection.

Recommendations for Medical Evaluations

Physicians, who may be reluctant to report suspicious injuries, should contact the Midwest Children's Resource Center 24-hour child abuse consultation line. The physician should describe the

medical findings, provide digital photographs and ask for an opinion from specialists about suspected maltreatment. The Midwest Children's Resource Center also has a list of physicians with expertise in diagnosis of child abuse injuries so the physician may obtain a local consult.

When medical practitioners document injuries to a child, which in retrospect appear to be suspicious, a report should be made to the police or child protection.

When a physician observes that the infant's fontanel is swollen and the parent reports that the baby had seizures, a complete medical assessment of the conditions should be done to determine if the conditions are a sign of infection or trauma and to prevent possible developmental delays and cortical blindness. Medical care for the conditions must be provided.

Recommendations Regarding Mental Health

Children Living With Parents who have Mental Illness: Mental health services are a voluntary program unless the person is considered to be a danger to themselves or others. A parent who is seriously and persistently mentally ill may decline mental health treatment or services. Refusing mental health services may impact the care and safety of the children who reside with that parent. It is well established in social work and psychiatric research that there is a significant relationship between parents who are neglectful and mental illness (including depression). When the mental health is deteriorating and the person is not compliant with treatment, it is necessary to ensure that mental health treatment is obtained and to ensure the safety of the parent, children and the community.

The Maltreatment of Minors Reporting Law does not address the risk of harm to children, who are in the care of a parent with an untreated mental illness. The definition of neglect should be modified to include assessing the safety of children when parents have untreated symptoms of serious mental illness or have been diagnosed with a serious and persistent mental illness and are not compliant with their treatment plan.

Parents, who are seriously and persistently mentally ill and are chronically overwhelmed and

unable to provide adequate care and supervision to their children, should be:

- Referred for a mental health evaluation
- Evaluated in terms of a pattern of neglect of the children over the time that services are provided.

The community mental health system should assist parents, who are seriously and persistently mentally ill by:

- Engaging the client through greater use of the early intervention strategies detailed in Minnesota Statutes, section 253B.065, the Mental Health Commitment Act.
- Having case managers routinely visit parents to establish a supportive relationship.
- Assessing parents with children differently than those without children. Risk factors that, combined with other factors, elevate the risk of harm to a child, include non-compliance with prescribed medications; drug/alcohol abuse; and domestic abuse within the home.
- Transferring a case to child protection if mental health services do not result in improved parental functioning or the parent declines to accept mental health services.

Data Privacy: Due to data privacy laws, therapists have a dilemma when patients are a danger to themselves or others. When a patient threatens to harm a specific person, the therapist or other mental health professional has a duty to warn that person. This is an ethical obligation to exercise professional judgement to violate confidentiality when it is critical to protect the patient or their family.

Emergency Hospital Evaluations: Good communication among the therapist, police, hospital and family would help to ensure accurate mental health evaluations in an emergency mental health situation.

When a patient has been referred to a hospital for mental health evaluation, the referring therapist should follow up with the hospital to ensure that the patient arrived. If the patient did not arrive, the therapist should contact local law enforcement to transport the patient to the hospital.

When a law enforcement officer, responding to a person with erratic behavior, is not the person who provides transportation to the hospital emergency room, the officer needs to ensure that information about the circumstances is given to hospital staff to facilitate their assessment.

The hospital should do a thorough assessment, including getting information from the referring therapist and the family or household members, on whether there are children in the home, and whether the patient is responsible for the childcare at any time. The assessment should include inquiry about suicidal and homicidal thoughts. The evaluator should interview family members about behavioral indicators that may be signs of suicidal intent.

A thorough mental health assessment should be done on every person who presents in a hospital emergency room with non-accidental self-inflicted injuries or a suicide attempt. Part of the thorough assessment is to inquire if the patient has homicidal ideation. It is standard protocol for a patient to be admitted to the hospital for psychiatric care for at least 24 hours after a suicide attempt. If a patient has been suicidal, a referral should be made to the county mental health services. The county should develop a crisis response team to assess suicidal or homicidal patients in the hospital or at the patient's home. When the patient is a parent, the assessment should include evaluating the ability to care for the children and the risk of harm to the children.

Family Members: Family and friends of a person with mental illness may not recognize the signs of suicide or depression or know what to do with the information.

- Public health education regarding depression and suicide prevention should be directed at the community at large so that family members and peers would be more likely to recognize signs of possible suicidal or homicidal intent. The education should advise the public about behavioral indicators of depression and suicidal ideation.
- Family members of a person with a serious mental illness should be offered family therapy to support and educate them about mental illness. It is particularly important for family members to understand the seriousness of

noncompliance regarding medication, threats of harm and indicators of suicidal and homicidal thoughts, risk factors that should be assessed by a mental health professional. A safety plan should be established for children who reside with a parent with a serious mental illness.

Suicidal ideation is a symptom requiring assessment or intervention by a mental health practitioner. Family members of a person with a serious mental illness should be offered family therapy to support and educate them about mental illness, including:

- The seriousness of any threats that the mentally ill person might make to harm self or others
- Behaviors and thoughts that may be risk factors that should be assessed
- Need for a safety plan for children if they believe their parent is threatening harm to self or others.

Interpreter: A hospital may decide not to complete a psychiatric evaluation after a suicide attempt and may not want to hospitalize the patient if the language and cultural differences were the basis for the behavior rather than mental illness. When a language interpreter is needed because the patient is not fluent in English, one can be located through the AT&T Telephone Language Interpreter Service. Although these interpreters are not necessarily certified in medical translation, they are readily available in emergency situations.

Religious Resources: Although people may seek counseling from religious leaders when they need psychological or psychiatric care, religious leaders are not typically trained to treat people with mental health conditions. Religious organizations should discuss the need for better training regarding mental health issues and work together to implement training.

Religious leaders, who may have limited expertise in dealing with the mental health needs of parishioners, should make a referral for professional counseling as soon as they are aware that the mental health issues are at a crisis level.

Support Resources for Men: The emotional trauma of divorce may create a downward spiral of events for men, which could include fractured family relationships, unemployment, debt resulting in foreclosure on the home, and in rare cases the murder of household members and suicide of the man. In most communities, men do not have support groups as readily available as women. In addition, when a petition for an order for protection is filed, men often do not have advocacy comparable to women's support systems. Men often feel victimized by the system, a sense that inhibits their compliance with court orders.

Local communities should be encouraged to develop a support system for men that complements the support available for women. An informal support and advocacy system should be developed to help men make a healthy adjustment when they face separation or divorce and are struggling with issues of relationship, domestic violence and parenting. Members of the group would be most effective at encouraging other men to participate in the program.

Treatment Funding: The child protection system is designed to intervene only when there is evidence of the parent's inability to care for the children's basic needs and there is a risk of harm or harm has occurred. The child protection system must see a clear connection between the parent's mental health status and their inability to care for their children before child protection is likely to intervene.

The Minnesota Legislature should allocate funding to develop a more comprehensive community based mental health delivery system.

The mental health or child welfare system should be funded to provide children, who reside with a seriously and persistently mentally ill parent, with supportive services. Service models should be specifically designed for parents who have a serious mental illness and need assistance with parenting skills.

Recommendations for Minor Parent

Foster care should be an option for minor parents and their children when the minor parent does not have support or guidance from her parents or guardians. It is expected that many minor parents would be opposed to the concept of foster care, but they may consider the option if it is presented as a

mentor home, where the minor parent would learn how to care for her children.

When the minor parent feels overwhelmed, the foster parents would assist with the care of the children for a few hours or days, to ensure the safety of the children.

A minor parent in foster care should work on independent living skills such as money management, meal preparation and parenting skills.

Recommendations for Public Education — Hyperthermia

The public in rural areas of the state may not be aware of the dangers of leaving infants and children unattended in cars. Infants and small children can quickly become seriously dehydrated, which may contribute to hyperthermia and the child's death. Efforts should be continued to educate the public about the risks of leaving a child unattended in a vehicle. Information about the risk should be included in:

- Hospital education for parents of newborn infants
- Regular articles in the local newspaper about child safety
- Passenger safety information when new and used cars are sold. The state coordinator for passenger safety may have materials that could be distributed to car dealers.

Physicians and nurses who see infants and children for well baby care should teach parents about the need for adequate hydration and that an infant or young child can become severely dehydrated very quickly.

Education should be provided for the parent who does not bring the child to the clinic, but may share significantly in the childcare responsibility through pamphlets or videos.

Recommendations for Public Health's Home Visitor Program

The Minnesota Public Health Department's Family Home Visitor Program is extremely beneficial in preventing child abuse and neglect and should be continued and expanded. Public health nurses can provide ongoing health, safety and parental assessments, education and referrals.

Recommendations Regarding Prenatal Exposure to Alcohol

The Minnesota Department of Human Services' Chemical Dependency Division distributed Informational Bulletin 98-51-2 clarified terms in Part 9530.6605 of the Minnesota Rules, which were essential to a finding of chemical abuse including "inappropriate and harmful use" and "pathological use." This clarification should assist pregnant women, who are in need of chemical dependency treatment, to meet the guidelines for the treatment. The terms are clarified as follows:

- Inappropriate and harmful use means "chemical use that prohibits one from meeting work, school, family or social obligations." Use of alcohol or drugs, knowing that it puts one's unborn child at risk meets this definition.
- Pathological use means "continuing use despite a serious physical disorder that the individual knows is exacerbated by continued use". This provision identifies individuals who are risking serious physical damage by continuing to use.

When a medical provider suspects that chemical abuse was alleged to have occurred during pregnancy, or when a baby has prenatal exposure to alcohol or drugs, the mother should be referred to public health nursing services for ongoing health, safety and parenting assessment and education.

If there appears to be a need for additional services, such as a chemical dependency evaluation, a referral should be made to appropriate agencies.

There should be a wide range of approaches available to address individual issues of prenatal exposure to alcohol and drugs in order to reduce or prevent harm to the baby. The preferred approach would encourage a mother to obtain medical and prenatal care, along with chemical dependency services.

For chemically dependent women, who are not responsive to a less intrusive protective response, an alternative that will protect the mother and unborn baby from further medical crisis and potential harm should be available.

Minnesota Department of Human Services' Children and Family Services and the Chemical Dependency Divisions should provide training for professionals, that includes alternative approaches to preventing further prenatal exposure to alcohol and drugs when a pregnant woman has refused treatment and when it is appropriate to utilize the chemical dependency commitment process.

Recommendations for Relative Placements

Standards for Approval: Children who have experienced neglect, physical abuse or sexual abuse need a structured but nurturing environment. DHS Informational Bulletin 94-68-F clarifies the requirement for relatives to meet the licensing standards established in Minnesota Statute 245A.03 to provide care for children. The safety of children should be of paramount consideration when decisions are made about their placement, even with relatives.

The licensing standards must be met before a placement is made or legal custody received.

Adults with a criminal history or unhealthy family dynamics, such as being involved in an incestuous relationship or prostitution, may be unable to teach children appropriate sexual boundaries and put children at risk for child maltreatment.

The court should be informed when the history of potential relative care providers includes criminal history and family dynamics that raise the level of risk of harm.

The county should defer to the tribes on placement decisions of American Indian children unless there are significant safety concerns. When the county objects to a relative for placement based on information obtained during the foster care licensing process or home study, the objection of the county staff should be a part of the court record.

Relative searches should include the relatives of all the parents of the children in the family.

Monitoring: Minnesota Statute, section 260C.201, subdivision 6, requires that the social services agency monitor the case after a child is reunited with their parents, but does not address the need for monitoring when the legal custody of a child is transferred to a relative. The relative caregivers may need support and guidance about caring for

children who have experienced trauma, or have emotional and behavioral problems, to reduce the risk of additional maltreatment.

Minnesota Statute, section 260C.201 should be modified to enable the court to order continued monitoring for a minimum of six months after a change in legal custody to ensure that the children are safe and that the relatives have community resources to deal with potential emotional and behavioral problems.

It is highly recommended that relative caregivers with a personal or family history, which may predict that they could have difficulty coping with children's behavior or difficulty accessing supportive or therapeutic resources for the children in their care, should be the highest priority for monitoring.

For cases involving American Indian children, the responsibility for case monitoring and home visitation could be shared by the county and tribal agencies and funding options explored to assist in implementation.

Monitoring a case should include regular contact with each of the children placed in the home, including occasional unannounced home visits.

A transfer of legal custody should be stayed for six months in cases where the children have not lived with the relatives for at least six months prior to the transfer of legal custody. A stay in the transfer of legal custody will enable the agency to monitor the placement and provide any necessary services. If the placement is not successful, an alternative placement can be made for the children.

Recommendations for Social Services

County contracts for services with private agencies should identify specific tasks that are the private agency's responsibility.

When counties contract for services with private agencies, the county agency should maintain responsibility for child protection by continuing to monitor the case, visiting the family regularly and assessing the risk of harm to the children.

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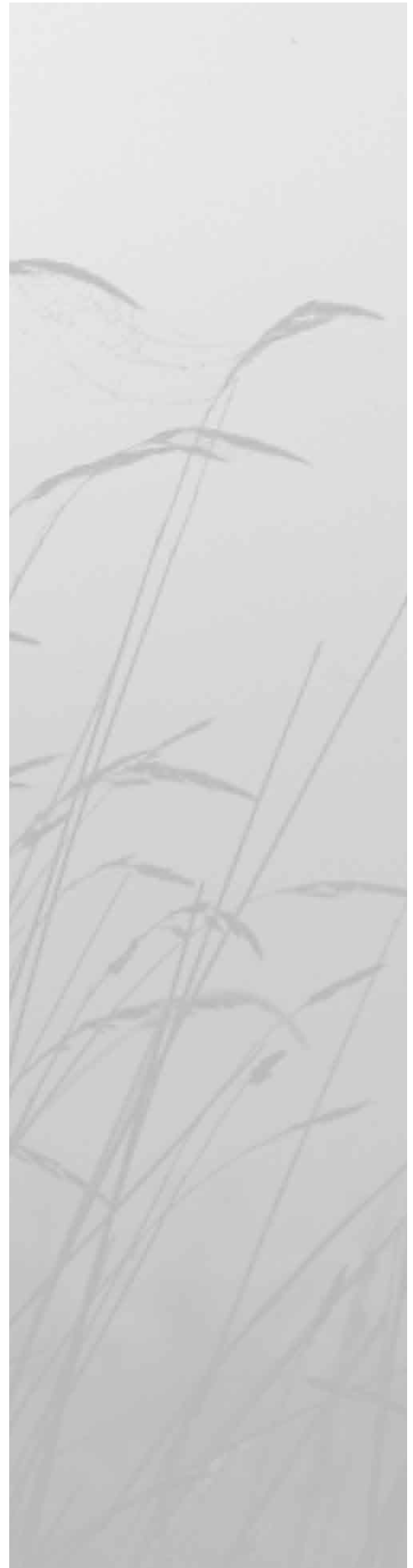
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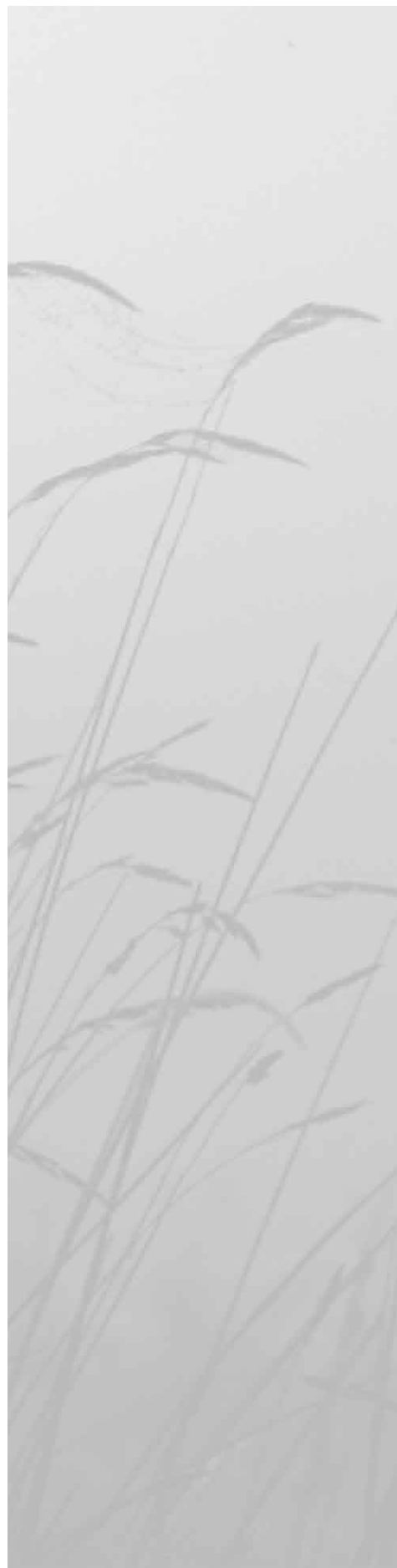
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Statutes

Child Mortality Review Panel, Minnesota Statutes, section 256.01, subdivision 12

- (a) The commissioner shall establish a child mortality review panel to review deaths of children in Minnesota, including deaths attributed to maltreatment or in which maltreatment may be a contributing cause and to review near fatalities as defined in section 626.556, subdivision 11d. The commissioners of health, education, and public safety and the attorney general shall each designate a representative to the child mortality review panel. Other panel members shall be appointed by the commissioner, including a board-certified pathologist and a physician who is a coroner or a medical examiner. The purpose of the panel shall be to make recommendations to the state and to county agencies for improving the child protection system, including modifications in statute, rule, policy, and procedure.
- (b) The commissioner may require a county agency to establish a local child mortality review panel. The commissioner may establish procedures for conducting local reviews and may require that all professionals with knowledge of a child mortality case participate in the local review. In this section, “professional” means a person licensed to perform or a person performing a specific service in the child protective service system. “Professional” includes law enforcement personnel, social service agency attorneys, educators, and social service, health care, and mental health care providers.
- (c) If the commissioner of human services has reason to believe that a child’s death was caused by maltreatment or that maltreatment was a contributing cause, the commissioner has access to not public data under chapter 13 maintained by state agencies, statewide systems, or political subdivisions that are related to the child’s death or circumstances surrounding the care of the child. The commissioner shall also have access to records of private hospitals as necessary to carry out the duties prescribed by this section. Access to data under this paragraph is limited to police investigative data; autopsy records and coroner or medical examiner investigative data; hospital, public health, or other medical records of the child; hospital and other medical records of the child’s parent that relate to prenatal care; and records created by social service agencies that provided services to the child or family within three years preceding the child’s death. A state agency, statewide system, or political subdivision shall provide the data upon request of the commissioner. Not public data may be shared with members of the state or local child mortality review panel in connection with an individual case.





- (d) Notwithstanding the data's classification in the possession of any other agency, data acquired by a local or state child mortality review panel in the exercise of its duties is protected nonpublic or confidential data as defined in section **13.02**, but may be disclosed as necessary to carry out the purposes of the review panel. The data is not subject to subpoena or discovery. The commissioner may disclose conclusions of the review panel, but shall not disclose data that was classified as confidential or private data on decedents, under section **13.10**, or private, confidential, or protected nonpublic data in the disseminating agency, except that the commissioner may disclose local social service agency data as provided in section **626.556**, subdivision 11d, on individual cases involving a fatality or near fatality of a person served by the local social service agency prior to the date of death.
- (e) A person attending a child mortality review panel meeting shall not disclose what transpired at the meeting, except to carry out the purposes of the mortality review panel. The proceedings and records of the mortality review panel are protected nonpublic data as defined in section **13.02**, subdivision 13, and are not subject to discovery or introduction into evidence in a civil or criminal action against a professional, the state or a county agency, arising out of the matters the panel is reviewing. Information, documents, and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because they were presented during proceedings of the review panel. A person who presented information before the review panel or who is a member of the panel shall not be prevented from testifying about matters within the person's knowledge. However, in a civil or criminal proceeding a person shall not be questioned about the person's presentation of information to the review panel or opinions formed by the person as a result of the review meetings.

Disclosure in Child Fatality or Near Fatality Cases, Minnesota Statutes, section 626.556, subdivision 11d

- (a) The definitions in this paragraph apply to this section.
- (1) "Child fatality" means the death of a child from suspected abuse, neglect, or maltreatment.
 - (2) "Near fatality" means a case in which a physician determines that a child is in serious or critical condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment.
 - (3) "Findings and information" means a written summary described in paragraph (c) of actions taken or services rendered by a local social services agency following receipt of a report.

- (b) Notwithstanding any other provision of law and subject to this subdivision, a public agency shall disclose to the public, upon request, the findings and information related to a child fatality or near fatality if:
- (1) a person is criminally charged with having caused the child fatality or near fatality; or
 - (2) a county attorney certifies that a person would have been charged with having caused the child fatality or near fatality but for that person's death.
- (c) Findings and information disclosed under this subdivision consist of a written summary that includes any of the following information the agency is able to provide:
- (1) the dates, outcomes, and results of any actions taken or services rendered;
 - (2) the results of any review of the state child mortality review panel, a local child mortality review panel, a local community child protection team, or any public agency; and
 - (3) confirmation of the receipt of all reports, accepted or not accepted, by the local welfare agency for assessment of suspected child abuse, neglect, or maltreatment, including confirmation that investigations were conducted, the results of the investigations, a description of the conduct of the most recent investigation and the services rendered, and a statement of the basis for the agency's determination.
- (d) Nothing in this subdivision authorizes access to the private data in the custody of a local social services agency, or the disclosure to the public of the records or content of any psychiatric, psychological, or therapeutic evaluations, or the disclosure of information that would reveal the identities of persons who provided information related to suspected abuse, neglect, or maltreatment of the child.
- (e) A person whose request is denied may apply to the appropriate court for an order compelling disclosure of all or part of the findings and information of the public agency. The application must set forth, with reasonable particularity, factors supporting the application. The court has jurisdiction to issue these orders. Actions under this section must be set down for immediate hearing, and subsequent proceedings in those actions must be given priority by the appellate courts.
- (f) A public agency or its employees acting in good faith in disclosing or declining to disclose information under this section are immune from criminal or civil liability that might otherwise be incurred or imposed for that action.

