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Review of Minnesota Child Mortalities in 2001



Minnesota Department of **Human Services**

Children and Family Services
Child Safety and Permanency Division



Acknowledgements

The department would like 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 the death and to seriously consider needed changes to prevent future deaths.

The department would also like to acknowledge the members of the state Child Mortality Review Panel for their dedication and leadership in seeking changes to protect children.

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 seventh report detailing Minnesota's child mortality reviews, covering the period January 1 through December 31, 2001. This document provides data on the activities of the county child mortality review teams and the state Child Mortality Review Panel. In 2001, 583 children died in Minnesota. Of those, 186 were non-natural deaths from accidents, suicides, homicides or undetermined causes. Another 22 deaths were caused by Sudden Infant Death Syndrome (SIDS). The non-natural and the SIDS deaths are the primary concern of the review teams. In 2001, 65 deaths were eligible for review by the local teams.

In 2001, accidental or unintentional deaths comprised 64 percent of all non-natural deaths. The state Child Mortality Review Panel believes that a majority of unintentional deaths were preventable or could have been avoided with a reasonable intervention. Many are caused by poor caregiver judgment or inappropriate supervision. Prevention is a major focus of the state's review efforts.

In 2001, there were 19 child homicides; 12 victims were under 12 years old.

In 19 deaths, child protection agencies made determinations of maltreatment. The majority of perpetrators in physical abuse deaths were mothers, a change from 2000, when fathers were most often responsible.

Unfortunately, the department does not have an accurate picture of the causes of children's deaths, nor an accurate count of children who die from abuse and neglect. The work of the multidisciplinary county and state child mortality reviews helps 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 goals for the reviews are to identify changes needed to prevent future deaths of children from abuse and neglect.

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Child Mortality Review 2001

Introduction


History

Minnesota established the statewide child mortality review process in 1989. Minnesota Statutes, section 256.01, subdivision 12, placed the 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 is 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 department reviews the local reports and the Child Mortality Review (CMR) Panel completes reviews of specific cases. Cases chosen for review have issues that may impact child protection policies and practice 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 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 county public health department, a county attorney's office, a county human services supervisor, a school social worker, a metro county medical examiner and a pediatrician. Membership also includes the ombudsperson from the Office of Mental Health and Mental Retardation, the ombudsperson 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 Divisions.



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.



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

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, examining the facts relevant to the case; drawing conclusions about the appropriateness of services; determining compliance with laws and recommending 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:

- Statements of facts relevant to the case being reviewed
- Circumstances that caused the agency to use non-standard protocols
- Conclusions regarding compliance with law and appropriateness of the case management or specific services
- Recommendations for change at either the 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: The Minnesota Department of Health's Vital Statistics section sends the death certificates for children to the department on a quarterly basis. The CMR coordinator reviews the death certificates and sends a copy to the social services office in the child's county of residence requesting a search for county social services records.

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

Each case reviewed by the CMR Panel will include examination of the autopsy report, 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 of the case is presented and discussed during the monthly CMR meetings. All information or material received or discussed at the meetings is confidential. The focus of the discussions is to learn as much as possible about needed changes in the local and state child protection 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 goals are 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 of the reviews is to identify changes to prevent future deaths from abuse and neglect. Part of this goal includes promoting a better understanding and greater awareness of all causes of children's deaths.

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, including:

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 determined 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).

- Non-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
- Non-natural causes (refers to homicide, suicide, accident, or cannot 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, including:

- 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
- Deaths which 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 2001

Manner of Deaths by Age

In the year 2001, 583 children died in Minnesota. Of these children, 343 were under the age of 1, 468 were under the age of 12 and 113 were aged 12 through 17. For two children, the age was not designated. The manner of death by age is indicated in the chart below:

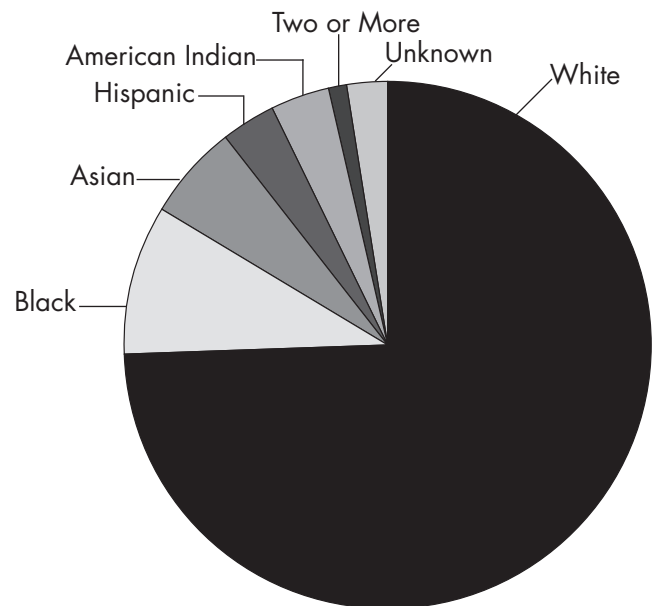
Age	Unknown	Accident	Cannot be Determined	Homicide	Natural	Suicide	Total
<1	4	20	11	5	303		343
1-4	1	20	2	6	28		57
5-8		18			15		33
9-11		14	1	1	18	1	35
12-14		9	3		13	7	32
15-17		37		7	19	18	81
Unknown		1			1		2
Total	5	119	17	19	397	26	583

Race or Ethnic Heritage

The number of deaths by race were as follows:

- 435 were white (decreased by 15 or 3 percent from 2000)
- 54 were black (decreased by 28 or 35 percent from 2000)
- 34 were Asian or Southeast Islanders (increased by eight or 31 percent from 2000)
- 18 were Hispanic (increased by one or 6 percent from 2000)
- 21 were American Indian (increased by six or 40 percent from 2000)
- 7 were of two or more races (increased by one or 5 percent from 2000)
- 14 were unknown (decreased by 11 or 46 percent from 2000).

Percentage of deaths by race:



Gender

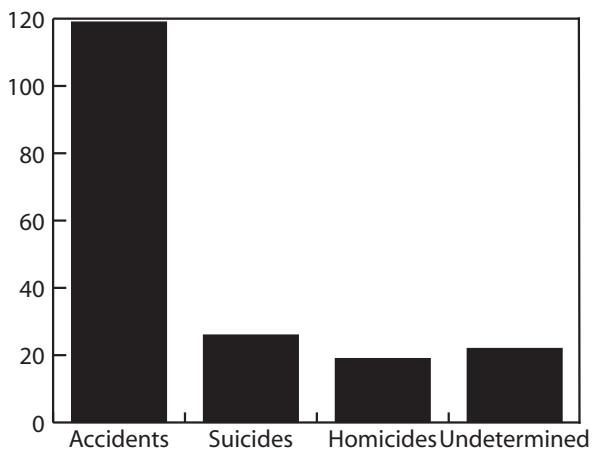
Of the child deaths, approximately 51 percent were males and 49 percent were females.

Non-Natural Deaths

Minnesota had 186 deaths from non-natural causes in 2001. These deaths, plus the 22 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 186 non-natural deaths were:

- 119 accidents
- 26 suicides
- 19 homicides
- 22 undesignated or cannot be determined.

Manner of Death



Accidents: It is clear that the 119 accidental or unintentional deaths were the greatest cause of non-natural deaths. Although homicides of children receive substantially more media attention, accidental deaths are 64 percent of all non-natural deaths. Forty-nine accidents involved motor vehicles, including 11 with pedestrians or children on bicycles or rollerblades. Ten accidents involved all terrain vehicles (ATVs) or snowmobiles. Twenty-two accidents involved asphyxiation from overlay, positional causes, collapsed bassinet, choking on food, entrapment in windows or asphyxiation from plastic bags. Seventeen accidents were from drowning, 10 in house fires and one from a car fire. Ten deaths were from various other causes, such as falls, farm machinery and hyperthermia. 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, 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 caregiver judgment or lack of appropriate supervision on the part of the parent. Deaths from poor caregiver supervision or judgment included drowning in bathtubs and lakes; over-lay while co-sleeping; unsafe bedding; hyper or hypothermia; scalding; house fires; entrapment in windows; and accidents involving vehicles, bicycles, ATVs, snowmobiles or farm equipment.

The following are examples of preventable deaths:

- A 1-year-old drowns after being left alone in the bathtub while the parent "surfs" the internet for more than an hour.
- A toddler awakes after napping on the floor and asphyxiates on a plastic bag left nearby.
- An infant is sleeping between both parents and dies of asphyxia when one of them rolls over onto the infant.
- Three 10-year-old boys die in a house fire while sleeping when the mother leaves them alone at night with candles burning.
- 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 backs up and lowers 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.
- An 8-year-old tries to get into his locked home through a window to retrieve forgotten schoolbooks after his mother leaves for work. He becomes entrapped and asphyxiates.
- 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.

*About two thirds
of all homicides
are children under the
age of 3.*

Suicides: In Minnesota, 26 suicides were committed by children 11-17 years-of-age. Eight (30 percent) were committed by children under 15, including one 11-year-old and one 12-year-old. Eighteen (69 percent) were committed by adolescents ages 15 to 17. Thirteen of the suicides were committed with firearms, 10 by hanging, two by drug overdose and one youth jumped from a highway overpass. Nine of the children who committed suicide had prior contact with the county social services system.

Homicides: Of the 19 homicides in 2001, 11 or 58 percent were age 3 or younger. One of these occurred at birth when the infant was drowned and left in a grocery store bathroom. The primary cause of death for children under age 3 was blunt force trauma, including one shaken baby death. One 10-year-old was shot. 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 those 15-17 years old where the instrument of death was some kind of firearm. In twelve of the homicides the children or their family had prior contact with county social services.

Homicides by Method/Age

Age	Method					Totals
	Asphyxia	Blunt Force	Drowning	Firearm	Sharp Force	
< 1 year	1	3	1			5
1-2 years		2			1	3
3-9 years		1		1	1	3
10-12 years				1		1
13-16 years				6		6
17 years				1		1
Totals:	1	6	1	9	2	19

Cannot be Determined: Seventeen deaths were listed in this category due to insufficient information to classify the death. When a child dies with no anatomical cause identified while sleeping in a crib, 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. It is often classified as undetermined or cannot be determined.

Deaths in Licensed Facilities: Of the seven deaths in licensed family day care homes, three were homicides, one was a drowning and three were natural deaths, including two determined to be SIDS. Five of the deaths were assessed by child protection and two homicides were

determined to be deaths caused by maltreatment. A third homicide was not determined to be maltreatment by the county child protection agency. This death has never been criminally charged. Four of the seven deaths were associated with asphyxia from unsafe bedding or other unsafe conditions.

There were six deaths in foster care. One was considered natural and four were accidental deaths. The accidental deaths included two in a house fire, one drowning and one a positional asphyxia. The manner of death for one child could not be determined.

Deaths Eligible for Child Mortality Review

For 2001, 65 of the 207 deaths (185 non-natural deaths plus the 22 SIDS deaths) were eligible for a child mortality review. In these 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 the Minnesota Department of Human Services. Counties completed 58 child mortality reviews. Six local reviews are still pending due to ongoing criminal court processes. One local review was not completed. The following table indicates the kind of county contact that made the death eligible for a review.

Deaths Eligible for Review due to:

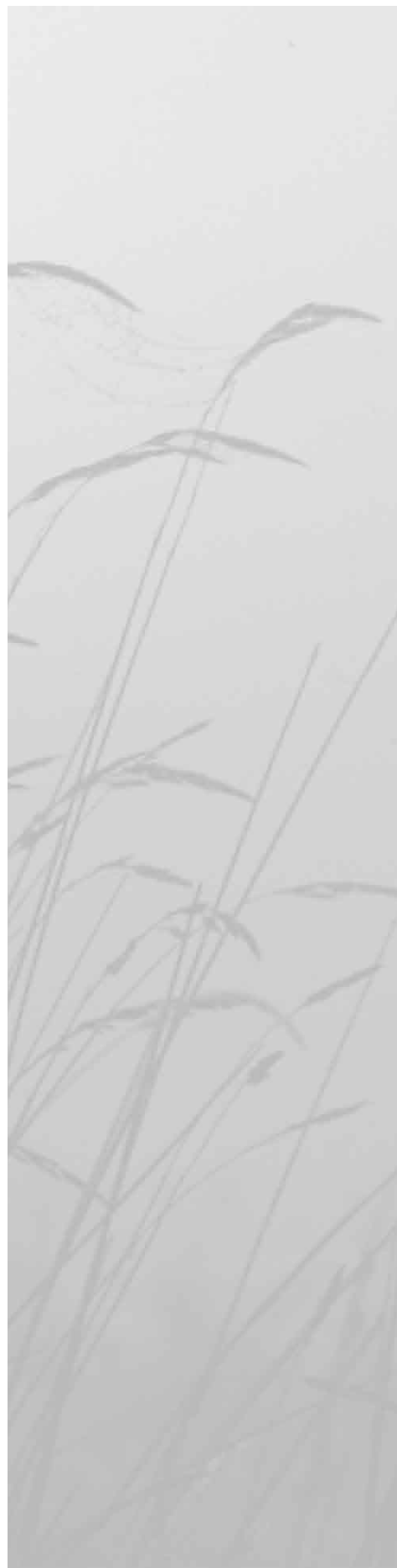
Maltreatment or suspected maltreatment	29
Prior social services contact	28
Death in a facility licensed by DHS	8*
Total	65

* There were 12 deaths in licensed facilities. However, four of the deaths were investigated for maltreatment or suspected maltreatment and counted in this category.

Only two counties had responsibility for five or more child mortality reviews in 2001. Hennepin County had 14 reviews; Anoka County five; Washington and Mille Lacs Counties each had four; Ramsey, Dakota, Benton and McLeod Counties each completed three reviews; one county did two reviews and 16 counties did one review. Seven counties each had one review pending. One child died out of state and the review was not on the database.

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 child protection assessment was completed on 29 of the child deaths eligible for review. A determination of maltreatment was made for 19 of those deaths. Seventeen of those were children age 3 or under, including nine homicides. Fifteen 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 2001 by Race/Age/Manner of Death

Age by Manner of Death	Race					Totals
	White	Black	Asian	American Indian	Mixed*	
Less than 1 year: Homicide Accident Cannot be Determined	1	1	2		1	5
	1	2				3
	1			1		2
1 year Homicide Accident	1					1
	1					1
2 years Homicide Accident	1					1
	1					1
3 years Homicide	2		1			3
11 years Accident	1					1
16 years Accident	1					1
Totals	11	3	3	1	1	19

*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 mothers. This is a change from the 2000 data, when fathers were indicated as the primary perpetrators of physical abuse deaths. For neglect cases in 2001, mothers and fathers were each responsible for four of nine deaths. This was also a change from the 2000 data, when mothers were most often the neglecting parent.

Perpetrator by Race and Type of Maltreatment

Perpetrator:	Race		Maltreatment	Totals
		Physical Abuse	Neglect	
Mother	White	2	2	4
	Asian	2		2
	Black		1	1
	Mixed	1	1	2
Father	White		3	3
	Black	1	1	2
Both Parents	White		1	1
Mother's Boyfriend	White	2		2
Daycare Provider	White	1		1
	Asian	1		1
Totals		10	9	19

Underreporting of Maltreatment


The state does not have an accurate picture of the way children die. Furthermore, the number of children who die because of abuse or neglect is not really known. This gap in the data is caused by a number of factors, which include:

- Insufficient death scene investigations
- Inconsistent use of the Minnesota Infant Death Investigation Guidelines
- Lack of reporting by law enforcement of the death of a child to child protection for an assessment
- Screening out or not making maltreatment determinations by counties 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 after 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 at risk. Law enforcement may be primarily concerned with whether a crime was committed, which needs to be referred to the county attorney.



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.

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 judgment 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 into 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."

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 prior to the death.

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Preventable deaths are those that, with retrospective analysis of circumstances or resources, 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 Child Mortality Review Panel are shared with the commissioner of the Minnesota Department of Human Services (DHS), the county human services agency where the case originated, and other relevant agencies for possible action. County human services agencies share the state's recommendations with their multi-disciplinary review teams and take any actions deemed appropriate. The following are recommendations made by the state Child Mortality Review Panel in 2001.

Child Mortality Review Teams

Recommendations for Child Mortality Reviews – Local

The social services agency should develop a best practice protocol for completing local child mortality reviews, incorporating the procedures enumerated in Bulletin #99-68-2 and should ensure that subsequent reviews and reports follow the directives in the Bulletin. A physician familiar with emergency room protocols should be part of the local child mortality review team.

In the death of a child, the county child protection agency should make a written request for a copy of the autopsy findings from the medical examiner or county coroner and attach a copy of Minnesota Statutes, section 626.556, subdivision 9. If the local county attorney's office has the autopsy information, social services and law enforcement may obtain the information from that office. Until written findings are obtained, initial verbal information should be obtained from the medical examiner to assist in making a maltreatment determination.

Recommendations for Child Mortality Reviews – State

The local social services 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

A thorough law enforcement investigation of the death of a child should include:

- Concerted attempts to formally interview all relevant individuals in order to gather information and rule out complicity in the death; and document the interview in the law enforcement report.
- Conducting separate interviews of parents or caregivers to prevent them from exchanging information about events, and

to develop a distinct picture of each person's recollections.

- Comparing statements given by childcare providers and other parties made to each agency involved.
- Reviewing the child protection report, including one that indicates maltreatment was not determined.
- Confronting individuals regarding inconsistencies in the statements.
- Reservation of the conclusion of the investigation until all information, including the autopsy, is available.

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.

DNA and genetic testing/matching should have been completed regarding the unidentified infant found in the river in order to eliminate the teenager as the mother of that child. In the deaths of all unidentified infants, or where the lineage of the parents is not known, proper sampling from the autopsy should be sent to the Bureau of Criminal Apprehension as a standard procedure. Tissue samples should be maintained for matching when an individual who may be the mother is identified.

Recommendations for Minnesota Infant Death Investigation Guidelines

Background: The Minnesota Infant Death Investigation Guidelines (MIDIG) were developed in 1990 to improve investigations and document the death scene of a child under the age of 2. The MIDIG help to 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.

- A statute should be sought requiring that the MIDIG be followed in the investigation of all unexpected deaths of children under age 2.

- Law enforcement agencies should forward the results of the Minnesota Infant Death Investigation to the county attorney for review.

Recommendations for Medical Examiner

A coroner or medical examiner should report all cases of suspected child maltreatment to the child protection agency.

Minnesota Department of Human Services

The Minnesota Department of Human Services (DHS) should emphasize to county agencies the need to evaluate the knowledge and skills of the child protection social workers about the intake and assessment process.

The department should encourage counties to require child protection workers who lack intake and assessment skill and are providing direct services to complete the Minnesota Child Welfare Training System's course CORE 101; Family-Centered Child Protective Services and/or Advanced Intake and the Assessment of Risk training or equivalent training.

The department should clarify that, in the death of a child, under Minnesota Statutes, section 626.556, subdivision 9, local law enforcement and social services agencies have the right to receive a copy of autopsy findings from the medical examiner or coroner as soon as the findings are available.

The department should review the provisions of Minnesota Statutes, section 626.556, subd.10 and any related regulations that apply to a county or agency responsible for assessing a report of child maltreatment resulting in the death of a child. The focus of the review should be on the provisions that permit the county or agency to rely on the fact-finding efforts of law enforcement to make a determination of whether or not maltreatment occurred. The department should clarify policy and practice standards relating to safety, risk and the need for child protective services for any surviving children in the household or facility where the death occurred; or when deaths are considered "egregious harm" as defined in Minnesota Statutes, section 260C.007, subd. 26.

Other Topics

Recommendations for Alternative Response

The department should:

- Encourage county social services to make the Alternative Response protocol the preferred intervention in cases of co-occurrence of child maltreatment or domestic abuse when imminent harm is not alleged.
- Use positive outcome data from the longitudinal study on the effectiveness of Alternative Response to seek appropriations for support services for families involved in the program.

Recommendations for Child Care

The Minnesota Department of Education, DHS Licensing Division, county social services and the Child Care Resource and Referral Center (CCRRC) should strongly recommend that childcare providers complete cardio-pulmonary resuscitation (CPR) and child related safety training prior to becoming licensed or shortly thereafter. This should be implemented as rapidly as possible.

The Department of Education and the CCRRC should establish first year training priorities for childcare providers, which emphasize best practices regarding the physical and social development of children. This training should enhance the quality of childcare by addressing age appropriate supervision and care of children. The department's Licensing Division, the Department of Education and the CCRRC should emphasize with county social services the need to sufficiently orient and train childcare providers on the supervision requirements of licensed childcare. This training should have a focus on accident prevention and preferably be completed prior to taking on the care of children.

The Department of Education and the CCRRC should emphasize when orienting and training childcare providers the need for the provider to obtain relevant information about the unique needs of each child in their care, and to maintain written records of this information.

Minnesota Rules, part 9502.0385, subpart 2, should be revised to incorporate the new shortened timeline for providers to complete CPR and child related safety training prior to becoming licensed or shortly thereafter.

The CCRRC should inform parents of the licensure requirements of childcare providers and continue to remind them that they have a vested interest in ensuring quality childcare.

Public and private social service agencies should pursue funding for the development of childcare programs (i.e. more centers, night time childcare, etc.) as childcare options are greatly needed and the supply is inadequate.

Recommendations for Child Protection

Intake: The counties should require child protection workers who lack intake and assessment skills and are providing direct services to complete the Minnesota Child Welfare Training System's course CORE 101, Family-Centered Child Protective Services, or Advanced Intake, the Assessment of Risk training, or equivalent training.

When suspected child maltreatment is reported, the case should be assigned to a child protection worker promptly so the assessment is started within 24 hours as required in rule. When making decisions regarding child protection intake, or assignment of maltreatment reports to child welfare services, risk factors that should be considered include family size, age of the parent, support from the extended family, history of domestic abuse, housing, and disabling conditions such as developmental disabilities or mental health issues. All of these factors elevate stress levels, interfere with the ability to care for children, and increase the risk of maltreatment.

Assessment: When there is serious injury to a child or a pattern of injuries, child protection should obtain as much information as possible in order to accurately assess the risk of maltreatment; the use of a risk assessment tool approved by the department to decide if there is significant risk to the child will be helpful.

For all child protection assessments, each adult in the household should be interviewed to determine if the abuser is in the home and has continued access to the child. If the abuser is unidentified, child protection should provide services to support the family and assess the parenting skills. If necessary, the child protection worker can educate adults about appropriate parenting techniques.

The county child protection agency may rely on law enforcement information to complete a child protection assessment in the fatal injury of a child, but must make an independent determination of whether maltreatment occurred and whether services are needed; the agency must issue a separate report describing the basis for the determination.

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 “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 services agency prepare a separate report of their findings and determination of maltreatment.

The department should review the provisions of Minnesota Statutes, section 626.556, subd.10, and any related regulations that apply to a county or agency responsible for assessing a report of child maltreatment resulting in the death of a child. The focus should be on the provisions that permit the county or agency to rely on the fact-finding efforts of law enforcement to make a determination of whether or not maltreatment occurred, and to clarify policy and practice standards relating to safety, risk, and the need for child protective services for any surviving children in the household or facility where the death occurred. The department should clarify when deaths of children are considered cases of “egregious harm” as defined in Minnesota Statutes, section 260C.007, subd. 26.

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 judgment, that should be documented in the child protection records in the event that the parents apply for a child care or foster care license.

The county social services agency should send a written request for autopsy findings to the medical examiner citing the law. A request should be made for verbal and written results of the autopsy as soon as the information is available. With some initial autopsy information obtained verbally, a joint law enforcement and county interview with the family could be completed prior to receiving the full autopsy report. This would allow the child protection staff to complete their responsibility to do an assessment in a timely manner.

The law enforcement report and the autopsy findings should be reviewed prior to a maltreatment determination being made. A determination may be delayed until critical information is obtained.

In all deaths of children where maltreatment has been determined, the county should send the child protection assessment information to the county attorney for review.

Assessment for Chronic Abuse and Neglect

Background: 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.

Chronic neglect reports, where an accumulation of events elevates the level of risk should be screened by child protection and assigned based on all the information available. 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 statute.

When a child dies suddenly, the local social services agency should make a referral to public health for a home visit to the family.

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.

- The child protection team should include childcare and foster care licensing social workers.
- The county child protection and licensing workers, law enforcement and other agencies involved with the family, should function jointly in maltreatment investigation activities.
- All child protection assessment/investigative and other service information should be shared with the child protection team to ensure that decisions are based on all relevant information.

- County social services agencies, mental health and chemical dependency service providers, law enforcement and probation personnel need to communicate regularly with the local child protection team to ensure that relevant information and important decisions are shared with others involved with a child.

The county should accurately report the number of children who died as a result of maltreatment (due to parents' poor judgment about their child's safety) on SSIS (for statistics that will reach the state Legislature) and to county commissioners to demonstrate the need for adequate financial resources for child protection services.

Recommendations for Collaboration Among County Agencies and Departments

The county social services agency should coordinate discussions with the local hospital to develop a written protocol and provide training to emergency room personnel regarding types of injuries, or circumstances that the emergency room personnel should report to child protection. A written protocol would help determine when incidents involving children should be reported to the local child protection agency.

Hospital emergency room staff should call the local child protection agency for consultation if they are unsure whether to report an incident.

Recommendations for Court Procedures

The judicial system's response to domestic abuse situations should include requiring the respondent to participate in specific appropriate treatment programs which may limit further domestic violence.

The justice system should consider sanctions for domestic abusers, including incarceration for a substantially increased amount of time, or bail set at a significantly increased amount. Each time a violation occurs, a hearing should be expedited and the time in jail and/or the amount of bail should increase.

Recommendations for Domestic Violence

Background: 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.

The department should provide clarification that the current language in the maltreatment statute might include situations where a child is at risk of threatened physical harm or emotional harm due to domestic abuse. Disseminate statewide the Guidelines for Responding to the Co-occurrence of Child Maltreatment and Domestic Violence to county social services.

Although enforcement of court orders for domestic abuse treatment is difficult without a criminal charge, a recommendation for treatment services, which would ameliorate risk to children, should be made to the court.

When orders for protection are violated, it should result in vigorous enforcement by the entire justice system. Violators should be arrested by law enforcement and incarcerated.

Recommendations Regarding Foster Care

New county social workers and experienced workers who will have responsibility for placement decisions need information on separation/placement related to special needs children from the social workers' supervisor to provide appropriate case management. They should attend Minnesota Child Welfare Training System's CORE 104 training which includes issues related to separation and placement of children and special needs children.

- Social workers must inform, advise and prepare foster parents who provide care for children with cognitive impairments, developmental delays or emotional disturbances about the increased risk of harm due to impaired judgment regarding personal safety and the inability to recognize danger or to protect themselves. Foster parents should be oriented to the need for heightened vigilance in supervision and assisted to think through activities, looking at the potential risk to a child.

- Foster parents need a written guide for water safety and emergency response when supervising foster children. The guide should include information on how to gauge a child's swimming abilities; when personal floatation devices are needed; what to do in case a child disappears; and when to notify emergency responders.
- Any foster parent who will be supervising a foster child in or near water should be able to demonstrate to the county social worker awareness of appropriate protocols for water safety/emergency response, and knowledge of the foster child's swimming ability.
- Foster parents should be strongly encouraged by counties to obtain training in Cardio-pulmonary Resuscitation to be able to appropriately intervene in emergencies.
- Foster parent providers who care for special needs children need to attend the Foster, Adoptive and Kinship Care training (FAK), which includes issues related to separation and placement of special needs children.

Recommendations Regarding Mental Health

Therapists should inquire about children in the home and ask who is responsible for childcare. If the patient is not functioning at a level sufficient to make reasonable judgments about the care of the children, then the family should be advised that alternate childcare arrangements should be made.

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

- When a family member is severely depressed, mental health practitioners should advise the family that there is a potential risk of suicide or homicidal behavior; and, if any firearms are stored in the home, strongly advise family members to remove the firearms from the home until the patient's condition has stabilized.
- In case of an emergency, mental health practitioners should give family members information regarding mental health resources such as hotlines and standing appointments at mental health centers; and also law enforce-

ment's authority to take a person into custody and transport them to a hospital if it appears that they are a danger to self or others.

Recommendations for Methamphetamines

The Minnesota Child Welfare Training System should take a lead role in planning and implementing state-wide training directed at county social services staff about the dangers of manufacturing, possession and use of methamphetamines as it relates to children. Guidance and assistance in planning the training should be sought from the Children's Justice Task Force and the Bureau of Criminal Apprehension.

The department should clarify its policy regarding child endangerment and determinations of child maltreatment to include methamphetamine manufacturing, possession or use as a risk factor. The policy should clarify that persons mandated to report child protection issues to the county agency must report when a child is exposed to methamphetamine manufacturing, possession or use. The policy clarification should be disseminated statewide.

The Minnesota Departments of Health, Natural Resources and Transportation should jointly clarify who is responsible for cleaning up methamphetamine manufacturing sites and assuring that the sites are safe, since there is so much contamination, including land, water and vehicles used in methamphetamine manufacturing.

The Minnesota Department of Health should clarify the emergency room medical procedures and required tests to be administered when children are exposed to methamphetamine manufacturing sites.

The department should clarify with counties that uncontaminated clothing should be available as standard procedure for children removed from methamphetamine manufacturing sites.

Recommendations for Minor Parents

To lower the very high risk level for infant mortality of children of minor parents, substantial support should be provided for pregnant teenagers through programs that recognize the effectiveness of peer groups in obtaining needed information, providing support and connecting with available resources.

Information regarding birth control, pregnancy, the importance of prenatal care, the birth process, and resources for counseling for adoption or other options, should be mandated as part of the public school sex education curriculum for all students.

Recommendations for Public Education — Hyperthermia

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

- Hospital education for parents of newborns
- Regular articles in newspapers about child safety
- Passenger safety information when cars are sold. The state coordinator for passenger safety may have materials that could be distributed to car dealers.

Physicians and nurses who see children for well baby care should educate parents about the need for adequate hydration, because a young child can become severely dehydrated quickly.

Education should also be provided for the parent who shares child care responsibility, but does not take the child to the clinic. This can be done through pamphlets or videos.

Recommendations for Public Health's Home Visitor Program

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

Recommendations Regarding Safe Place for Newborns

To provide a lifesaving alternative to leaving infants in trashcans, dumpsters, rivers, parking lots and shallow graves, the local social services agency should send information about the Safe Place For Newborns to schools, including the middle, junior and high schools, tribal schools and alternative schools in their county and other agencies that provide social, educational and recreational activities to youth.

The Safe Place for Newborns program should modify their brochure for better readability for adolescents, making it more likely to be read.

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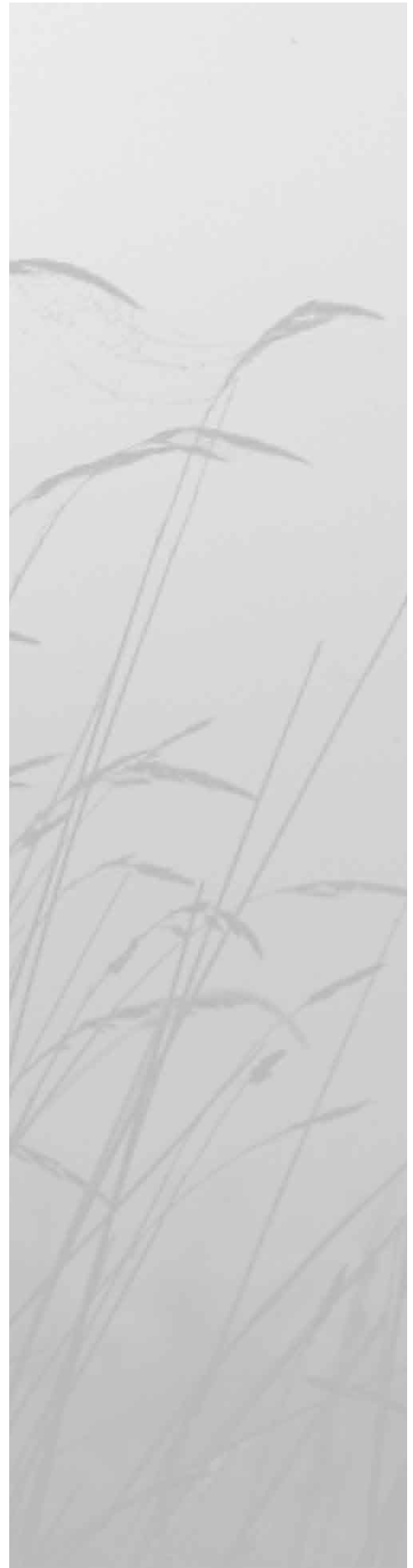
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Statutes

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





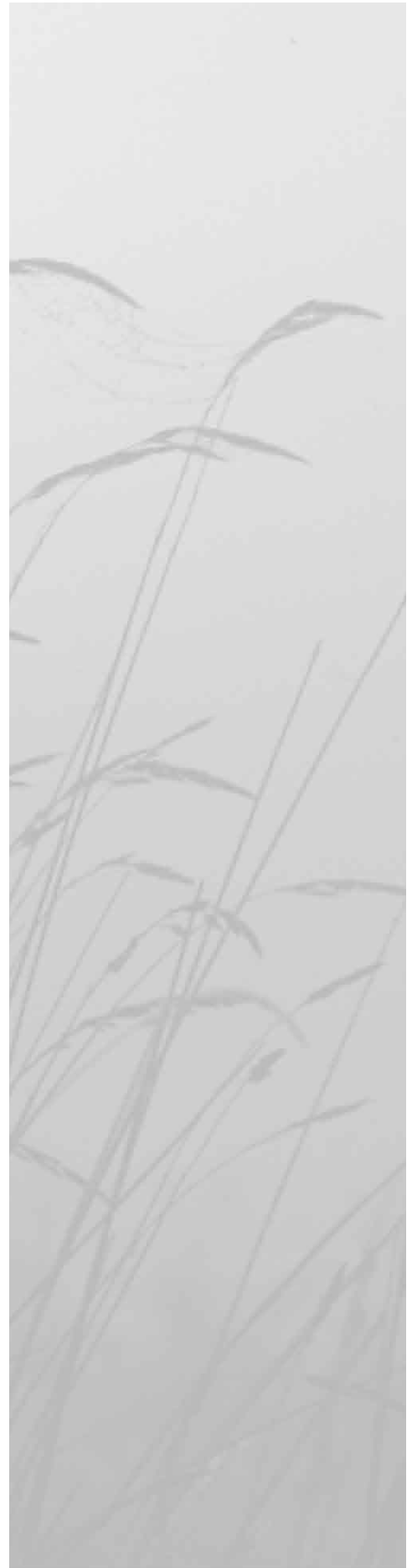
data is not subject to subpoena or discovery. The commissioner may disclose conclusions of the review panel, but shall not disclose data that was classified as confidential or private data on decedents, under section **13.10**, or private, confidential, or protected nonpublic data in the disseminating 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.





Minnesota Department of **Human Services**