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# Review of Minnesota Child Deaths and Near Fatalities Related to Child Maltreatment 2010-2011

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

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# **Review of Minnesota Child Deaths and Near Fatalities Related to Child Maltreatment 2010 – 2011**

## **Executive Summary**

The death of a child is a tragic occurrence and an immense loss for a family and community. The circumstances involved in unexpected child deaths are complex. A thorough review of these cases at both the local and state level helps professionals that work with children and families to better recognize the elements that increase risk of harm, and develop recommendations to improve the child welfare system.

In 1989, Minnesota Statute, section 256.01, subd. 12, was enacted to authorize the commissioner of the Minnesota Department of Human Services to develop a multi-disciplinary panel to review child deaths and near fatal injuries attributed to maltreatment, or where maltreatment is a contributing cause. Under the statute, the commissioner is given authority to obtain limited private data relevant to the review process. Minnesota Rule 9560.0232, subpart 5, establishes the criteria and review requirements for the state panel and local reviews. The review process is a partnership among many agencies that work to serve and protect children.

During 2010 – 2011, the Minnesota Child Mortality Review Panel examined 102 cases: 28 were homicide or near fatal inflicted injury cases, 55 sudden unexpected infant deaths, 11 accidents, and eight suicides. Of the 102 cases, 20 were near fatal cases involving accidents or inflicted injuries.

### **Accident cases reviewed**

The Minnesota Child Mortality Review Panel examined 11 accident cases which had recent history with the social service system. Forty-five percent of the cases reviewed were children 4 – 6 years old, who died or were severely injured in an accident. Twenty-seven percent of accident cases involved children diagnosed with developmental disabilities. Drowning was the leading cause of accidental deaths. Although the drowning incidents were unintentional, a significant factor in many of the cases was inadequate supervision, given a child's age and developmental ability.

### **Unexpected infant death cases reviewed**

The Minnesota Child Mortality Review Panel examined 55 unexpected infant deaths. Unexpected infant death cases are those where an otherwise healthy infant died without evidence of a medical condition, illness or injury. Often, these infants were placed in an unsafe sleep position such as on their side or stomach; or in an unsafe sleep environment, including placing an infant to sleep in an adult bed; with another person or pet; on a soft sleep surface such as a sofa, chair, quilt, rug or sheepskin; or with loose bedding, soft toys or other items in the crib. A safe sleep environment is to place infants on their backs in a crib with a firm mattress without blankets or pillows. To keep warm, they may wear a blanket sleeper.

The Child Mortality Review Panel examines unexpected infant death cases when the family was involved with social services within a year of an infant's death, or when an infant's death occurred while in the care of a licensed daycare or foster care facility. Twenty-five percent of sudden unexpected infant death cases reviewed occurred in licensed family daycare or licensed foster care homes.

### Suicide/self-inflicted injury cases reviewed

Eight suicide or self-inflicted injury cases were examined by the Child Mortality Review Panel. Mental health issues and conflicts in their relationships with family and/or friends were prevalent patterns in the cases reviewed. Many of these deaths involved youth who had prior involvement with the child protection system. Better public education and awareness is needed about how to respond when a peer threatens suicide, and whom to contact to prevent them from self-harm. The availability, access to and continuity of mental health services, especially in rural areas, are significant factors in addressing and preventing youth suicide.

### Homicide cases reviewed

The Child Mortality Review Panel examined 28 cases involving fatal or near fatal inflicted injuries. Eighty-nine percent of these deaths and near fatal injuries occurred to children under age 3. The most common cause of death or near fatal injury was abusive head trauma caused by shaking or striking a child's head, resulting in traumatic brain injury or death. In the cases reviewed, 11 percent of the head trauma cases involved infants that also had significant injuries from sexual abuse.

Patterns were noted among the offenders who inflicted injuries:

- 59 percent were male household members
- 55 percent residing with the victim were not employed
- 46 percent had alcohol and/or drug abuse history
- 38 percent had prior criminal history
- 34 percent previously maltreated children
- 31 percent were previously diagnosed with a mental illness.

Minnesota hospitals are required to show a video on the dangers of shaking a baby before a mother and newborn are discharged from the hospital. Public health and social service agencies are working to engage fathers or male household members to assess their strengths and needs in a parenting role, and provide services to educate and support them in their role as caregivers of young children.

## Minnesota Child Mortality Review Process

The state and local child mortality/near fatality review process provides a multi-disciplinary perspective to learn and better understand the factors that contribute to death and near fatal injuries. This information is used to evaluate policies and practice, recommend systemic improvements and promote initiatives to prevent future harm to children.

This report is a summary of the child death and near fatal injury cases reviewed by Minnesota's Child Mortality Review Panel during 2010 – 2011. Minn. Stat., section 256.01, subd. 12, authorizes the Minnesota Department of Human Services to convene a child mortality review panel to examine deaths and near fatal injuries due to child maltreatment or cases where maltreatment may have been a contributing factor. Data for this report was obtained from Minnesota Department of Health death certificates, and from cases reviewed by the Minnesota Child Mortality Review Panel.

### Local county child mortality/near fatality reviews

All 87 counties and two American Indian tribes in Minnesota have multi-disciplinary Child Mortality Review teams. The purpose of a local review is to conduct a comprehensive examination of the practices, coordination and communication among the various agencies involved with a family prior to a fatal or near fatal incident. The local review may result in improved services to children and families in the local jurisdiction. The local teams and state Child Mortality Review Panel examine cases that meet criteria for reviews established in statute and rule. The criteria, briefly summarized, include:

- The death or near fatal injury of a child resulting from maltreatment or suspected maltreatment
- The death or near fatal injury of a child occurring in a facility licensed by the Minnesota Department of Human Services
- The manner of death classified as a homicide, suicide, accident, cannot be determined, natural deaths diagnosed as Sudden Infant Death Syndrome (SIDS) or Sudden Unexpected Infant Death (SUID) or Sudden Unexpected Death in Infancy (SUDI), or neglect of a child's basic needs; along with history that a child or a family member received social services within 12 months prior to the death or near fatal injury.

The local teams' comprehensive case reviews examine what was known about a family prior to the incident, services provided, as well as communication and coordination among local agencies and within the local social service system. The response by local agencies following a fatal or near fatal injury is also reviewed to evaluate the effectiveness of local response. Based on the retrospective review, the local teams recommend improvements in their community system. A report of the local review and recommendations is sent to the Minnesota Department of Human Services' Child Mortality Review Panel.

## Minnesota Child Mortality Review Panel

The Minnesota Child Mortality Review Panel examined 102 cases during 2010 – 2011. The table below shows the total number of cases reviewed by the panel for each year, and types of incidents that were reviewed.

**Table 1: Fatal or near fatal injury cases reviewed by year**

<b>Type of death or near fatal injury</b>	<b>2010</b>	<b>2011</b>	<b>Total</b>
Sudden unexpected infant death	24	31	<b>55</b>
Accident	11	0	<b>11</b>
Suicide/self-inflicted injury	5	3	<b>8</b>
Homicide/inflicted near fatal injury	16	12	<b>28</b>
<b>Total</b>	<b>56</b>	<b>46</b>	<b>102</b>

The state Child Mortality Review Panel examines findings from the local child mortality reviews and aggregate data collected from cases. By reviewing multiple cases at an aggregate level, the state panel is able to:

- Identify systemic issues and emerging patterns related to severe maltreatment
- Evaluate system response to child fatalities and near fatalities
- Develop recommendations for statewide system improvements
- Recommend child abuse prevention strategies, and professional development for social workers and other professionals involved in child abuse or neglect cases.

### Cause and manner of death

The cause and manner of death listed on a death certificate are determined by a medical examiner or coroner. The cause of death refers to the physiological reason for the death. The manner of death is a general classification regarding the circumstance in which the death happened. Determining the manner of death requires a multi-step process, including a careful review of the death scene investigation, review of the decedent's medical history and a complete autopsy. Medical examiners and coroners use five classifications to describe the manner of death, including:

- Natural – resulting from a diagnosed illness, congenital anomaly or Sudden Infant Death Syndrome (SIDS)
- Accident – resulting from an unintentional injury
- Homicide – resulting from another person's intentional action
- Suicide – resulting from a person's own intentional action
- Not classifiable, cannot be determined or pending investigation – resulting from unresolved questions about how a child died.

## Near fatal injuries

A near fatal injury is defined according to Minn. Stat. 626.556, subd. 2, as a case in which a physician determines that a child is in serious or critical condition as a result of illness or injury caused by suspected abuse, neglect or maltreatment.

**Table 2: Near fatal cases reviewed by year**

Year	2010	2011	Total
Near fatality cases – all categories	13	9	22

## Accident cases reviewed

The Child Mortality Review Panel examined 11 accident cases during 2010 – 2011. Drowning was the leading cause of accidental child deaths or near fatal injury. Drowning incidents are often preventable through close and direct supervision when children are in or near water. Drowning is usually quick, silent, and can result in permanent brain damage or death within four to six minutes. The Child Mortality Review Panel examined some cases where children were left unattended in a bathtub for a short time. It is imperative that adults remain within arm's reach of infants and toddlers in bathtubs. Adults must also be within arm's reach of young children in pools, lakes, ponds and rivers, and have constant visual contact and remain within close proximity when older children are in the water. Distractions such as use of electronic devices, socializing or alcohol consumption interfere with the high level of vigilance required to supervise children in the water to prevent drowning. Floatation vests are very effective at preventing drowning when children are playing in or near water, but careful monitoring is still required.

Very few motor vehicle accidents are examined by the Child Mortality Review Panel because maltreatment is rarely a contributing factor. The motor vehicle accidents reviewed included pedestrian/motor vehicle crashes, and crashes involving children that were passengers in vehicles driven by caregivers that were under the influence of alcohol or drugs, or in the care of a licensed daycare or foster care provider when a collision occurred.

Non-sleep-related asphyxia often refers to choking on food, toys, coins and other small items. Parents and caregivers need to exercise caution about foods that are offered to infants and young children, and keep choking hazards out of the reach of young children.

**Table 3: Number of accident cases reviewed**

Type of accidental injury	Number of cases reviewed 2010 – 2011	Percent of accident cases reviewed
Drowning	4	36%
Motor vehicle or vehicle/pedestrian collisions	4	36%
Asphyxia (not sleep-related)	2	19%
Falls	1	9%
<b>TOTAL</b>	<b>11</b>	<b>100%</b>

Accident prevention recommendations include:

- Flotation vests should be worn by young children when in or near open water. Adults need to be within arm’s reach of infants, toddlers, preschoolers and children with special needs when supervising children in open water so they can respond immediately if a child becomes submerged.
- Raise public awareness that caregivers must be in close proximity to the water and have constant visual contact when their child is in the water.
- Teach caregivers that when infants and toddlers are in a bathtub, they must remain within arm’s reach at all times.
- Encourage parents to teach their children how to swim.
- Provide water safety information for parents in languages spoken by immigrant populations.
- Raise awareness about choking hazards, making safe food choices to prevent choking, and current first aid guidelines that do not recommend doing a finger sweep of the mouth when a child is choking.
- First responders must have pediatric-size resuscitation supplies, including CPR masks.
- Support public education to raise awareness and prevent driving while intoxicated.

**Table 4: Age of victims of accident cases reviewed**

<b>Age</b>	<b>Number</b>	<b>Percent</b>
Birth – 1 year	3	28%
2 – 4	2	18%
5 – 12	4	36%
Age 13 and older	2	18%
<b>Total</b>	<b>11</b>	<b>100%</b>

**Table 5: Race/ethnicity of victims of accident cases reviewed**

<b>Race</b>	<b>Number</b>	<b>Percent</b>
Caucasian	6	55%
African American	3	27%
American Indian	1	9%
Asian/Pacific Islander	0	0%
Two or more races	0	0%
Race unknown	1	9%
<b>Total</b>	<b>11</b>	<b>100%</b>
Hispanic ethnicity	0	0%

## Unexpected infant deaths

The Child Mortality Review Panel examines sudden unexpected infant deaths when a family received social services within a year of an infant's death, or when a death occurred in a facility licensed by the Minnesota Department of Human Services.

The medical definition for Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant under 1 year of age that remains unexplained after a thorough case investigation, including a complete autopsy, examination of the death scene and review of medical history. According to the Centers for Disease Control and Prevention, SIDS is the leading cause of death among infants aged 1-12 months, and is the third leading overall cause of infant deaths in the United States. Data from the Centers for Disease Control and Prevention reveal that although the overall rate of SIDS in the United States has declined by more than 50 percent since 1990, rates for non-Hispanic, African American and American Indian/Alaska Native infants remain disproportionately higher than for the rest of the population. Preventing SIDS remains an important public health priority.

Sudden Unexpected Infant Death, Sudden Unexpected Death in Infancy, and Sudden Infant Death Syndrome are cause of death diagnoses that may be classified on the death certificate as natural, accident or cannot be determined. For consistency and clarity in this report, all sudden infant deaths involving a child without an illness, injury or congenital anomaly that caused the death are identified as unexpected infant deaths.

In many of the unexpected infant death cases reviewed by the Child Mortality Review Panel, infants were found in an unsafe sleep environment. In some cases, the cause of death was diagnosed as positional asphyxia, a condition that occurs when an infant's airway becomes occluded by an object in their sleep environment such as a blanket, pillow, soft bedding, toys, a soft sleep surface or inadvertent compression by a sleeping adult, child or pet. Sudden unexpected infant death can also occur when an infant becomes entrapped in a bed frame, between a wall and mattress of an adult bed, or between broken crib railings. For medical examiners and coroners to determine the manner of death accurately, the Centers for Disease Control recommend the following best practices:

- Investigators, under the direction of medical examiners and coroners, be trained in forensic methods and dispatched to a death scene immediately to re-create the conditions in which a child died
- Investigators use an investigation tool developed by the Centers for Disease Control to gather accurate data about a death scene to help coroners or medical examiners accurately diagnose the cause of death
- The medical examiner or coroner reports their findings to a local Child Mortality Review team that considers whether each fatality was adequately investigated.

During 2010 - 2011, the Minnesota Child Mortality Review Panel examined 55 cases involving unexpected infant deaths. In 2005, the American Academy of Pediatrics (AAP) released a policy statement about safe sleep environments for infants, due to the number of unexpected infant deaths. In 2011, the AAP expanded its recommendations to focus on a safe sleep environment that can reduce the risk of all sleep-related deaths. The expanded safe sleep recommendations

describe a safe sleep environment, as well as recommendations for health care providers, manufacturers of products marketed to prevent sudden infant death, and research regarding cause and prevention of sudden infant death. The AAP recommends that infants be placed on their back in a separate but proximate sleeping surface to sleep, such as a crib in the parents' bedroom. There should be no soft objects or loose bedding in the crib. Infants should sleep on a firm surface with a comfortable room temperature so they are not overheated. The AAP policy statement and its complete recommendations can be found at:

<http://pediatrics.aappublications.org/content/early/2011/10/12/peds.2011-2284>

The Minnesota Department of Human Services has partnered with the Minnesota Department of Health and the Minnesota Sudden Infant Death Center to promote public awareness of a safe infant sleep environment to prevent these tragic deaths. Child protection workers and public health nurses are encouraged to ask families with an infant, or who are expecting a baby, about an infant's sleep environment, and offer information and guidance about safe sleep.

Despite the requirement for training on safe infant sleep for licensed foster care and child care providers, 25 percent of sudden unexpected infant death cases reviewed occurred in licensed family child care or foster care homes. Disturbing practices were noted in the unexpected infant deaths that occurred in licensed family child care homes. Often, the infants were placed to sleep on their side or stomach, contrary to requirements that licensed providers place infants on their back to sleep. Several cases involved infants placed on a firm crib mattress, covered with a folded quilt to soften the surface of the crib mattress. In some cases, infants were placed to sleep but the provider did not check on them at frequent intervals.

When an infant dies in the care of a licensed family child care provider while in an unsafe sleep environment, the license is immediately suspended to permit time to investigate the death and any possible maltreatment or licensing violations. When maltreatment or licensing violations are substantiated, licensing sanctions are issued, including fines, a conditional license, suspension or revocation of the license.

Minn. Stat., section 245A.144, requires licensed foster care providers, staff persons and caregivers to complete training on reducing the risk of sudden infant death syndrome before caring for infants.

Minn. Stat. 245A.50, subd. 5, requires the same training for family child care license holders, staff persons, caregivers, and helpers.

Minn. Stat., section 245A.1435, requires that all licensed providers caring for children place an infant on their back to sleep in an approved crib.

In addition, Minn. Stat., section 245A.146, requires that all licensed child care providers maintain documentation of annual checks to determine if a manufacturer has issued a recall on equipment in use by the license holder, and monthly safety inspections of each crib used by or accessible to children in care. Child safety in licensed child care settings and compliance with licensing requirements is essential to reduce the risk of sudden infant death.

In some cases reviewed, the licensed provider failed to contact 9-1-1 promptly when an infant was found unresponsive. Minnesota Statute 245A.50 requires family child care providers to be trained in Cardio Pulmonary Resuscitation (CPR) training every three years. The statute permits video CPR training, reviewed and approved by the local social services agency to satisfy the training requirement. The training requirement does not require license holders to demonstrate their skills through testing, and certified to administer CPR. The Red Cross provides the national standard for CPR training, including pediatric CPR. Red Cross CPR certification training includes hands-on training and testing to determine that the learner can demonstrate the skills to administer CPR.

Data was gathered from the Minnesota Sudden Infant Death Center, Minnesota Department of Human Services Licensing Division and Child Mortality Review Panel on deaths in licensed child care facilities. The data indicates that there has been an increase in the number of deaths in licensed child care since 2007.

**Table 6: Deaths in licensed child care facilities**

<b>Year</b>	<b>Deaths in licensed family daycare homes</b>	<b>Deaths in licensed child care centers</b>	<b>Total death by year</b>
<b>2002</b>	3	0	<b>3</b>
<b>2003</b>	5	0	<b>5</b>
<b>2004</b>	3	0	<b>3</b>
<b>2005</b>	5	1	<b>6</b>
<b>2006</b>	8	0	<b>8</b>
<b>2007</b>	8	0	<b>8</b>
<b>2008</b>	12	1	<b>13</b>
<b>2009</b>	8	0	<b>8</b>
<b>2010</b>	10	1	<b>11</b>
<b>2011</b>	11	0	<b>11</b>
<b>2012 (first quarter)</b>	6	0	<b>6</b>
<b>TOTAL</b>	79	3	<b>82</b>

A variety of factors may contribute to unexpected infant deaths. The general public has not been aware of the dangers of suffocation, entrapment or compression injuries that can occur when sharing an adult bed with an infant. The Centers for Disease Control and Prevention, public health agencies, hospitals and medical providers are increasing efforts to inform parents and the general public about the American Academy of Pediatrics' *Recommendations for a Safe Infant Sleeping Environment*. Poverty may be a factor that interferes with parents' ability to purchase a safe crib. Second-hand cribs may be unsafe because they may be worn or faulty. When parents and infants are away from home, there may not be a crib available so infants may be placed to sleep in an unsafe environment such as a sofa, car seat, stroller or on the floor.

Unexpected infant death prevention recommendations include:

- Promote and practice the American Academy of Pediatrics *Recommendations for a Safe Infant Sleeping Environment*.
- Place infants to sleep on their back, in a crib that meets the safety standards of the Consumer Product Safety Commission, on a firm mattress, without any loose bedding, pillows, toys or other items in the crib.
- Ensure that all licensed child care and foster care providers are informed of and comply with the American Academy of Pediatrics' *Recommendations for a Safe Infant Sleeping Environment*.
- Develop stronger consequences when licensing violations occur to help improve provider compliance with regulations.
- Provide outreach and education to various cultural and community groups by engaging community leaders, parents and health care providers to promote safe infant sleep.
- Develop public or private resources within communities to provide cribs to families that are unable to purchase a safe crib for their infant.
- Increase the frequency of training for licensed child care and foster care providers on safe infant sleep and Sudden Infant Death Syndrome prevention, from once every five years to every one to two years.
- Require licensed family child care providers to complete American Red Cross classroom training on pediatric Cardio Pulmonary resuscitation (CPR) training and to pass testing to be certified by the Red Cross to administer CPR. Require that the Red Cross pediatric CPR certification refresher course be completed every two years to maintain certification.
- Make information about licensing requirements readily available for parents, including those related to safe infant sleep, so they can help ensure that the provider is in compliance with licensing requirements, including those related to safe infant sleep.
- Reach out to parents and the general population to promote safe sleep and other safety practices for young children using the following tools:
  - Internet, YouTube, Facebook and other social media sites.
  - Broadcasts on Minnesota Public Radio and local radio programs.
  - Cable television programs.
  - News media.
  - Flyers, brochures in Laundromats; grocery stores; food banks; libraries; places of worship; Women Infant and Children clinics; social service offices; unemployment offices; community corrections; medical and dental offices; hospital waiting rooms and admission offices.
- Encourage child protection workers and public health nurses to ask parents of infants about the infant's sleep environment, and offer guidance if the environment is unsafe.

**Table 7: Age of victims of unexpected infant death cases reviewed**

<b>Age</b>	<b>Number</b>	<b>Percent</b>
<b>Birth - 3 months</b>	26	47%
<b>4 – 6 months</b>	23	42%
<b>Over 6 months</b>	6	11%
<b>Total</b>	<b>55</b>	<b>100%</b>

**Table 8: Race/ethnicity of victims of unexpected infant death for cases reviewed**

<b>Race</b>	<b>Number</b>	<b>Percent</b>
Caucasian	25	45%
African American	16	29%
American Indian	6	11%
Asian/Pacific Islander	1	2%
Two or more races	5	9%
Race not reported/unknown	2	4%
<b>Total</b>	<b>55</b>	<b>100%</b>
Hispanic ethnicity –any race	2	4%

## Suicide/self-inflicted harm

According to death certificate data provided by the Minnesota Department of Health, 49 youth committed suicide during the years 2010 – 2011. Forty-five percent of adolescent suicides in Minnesota occurred in rural areas where there is often limited access to mental health treatment.

The Minnesota Child Mortality Review Panel examined seven suicide cases and one self-inflicted harm case that involved significant mental health issues. The majority of youth received mental health services prior to their death. In 71 percent of the suicide cases reviewed, victims had previously threatened or attempted suicide. Prompt intervention was viewed as crucial for youth experiencing stress, depression or suicidal thoughts.

Data from the cases reviewed by the Child Mortality Review Panel found that 37 percent of the youth had substance abuse issues, and 62 percent had histories of trauma related to prior physical or sexual abuse. None of the youth in the cases reviewed had histories of delinquent behavior.

In rural Minnesota communities, there is very limited access to child psychiatrists or psychologists. Currently, the Ambit Network, with support from the University of Minnesota and the Minnesota Department of Human Services, has provided training on evidence-based trauma treatment approaches to more than 100 mental health practitioners throughout Minnesota. The training is intended to improve the quality of care to children, and provide better continuity of care when children move to another community or return home from a treatment center.

Some patterns identified from the review of suicide and self-inflicted injury cases noted that family practice physicians appear to have prescribed psychotropic medications for children without a thorough mental health evaluation. The cost of mental health services is a barrier for some families that cannot afford continued treatment for their child. When a family moves to another community, the mental health treatment for a child can be disrupted or discontinued. All of these factors may increase the risk of suicide for a youth with mental health issues.

Suicide prevention is a shared responsibility among agencies that serve children, including social services, public health, schools, mental health providers and other child-servicing jurisdictions. Effective communication and collaboration across and among jurisdictions is important; coordinated and integrated services are needed to effectively reduce child suicides.

In 1999, the Minnesota Legislature and the Minnesota Department of Health, in consultation with many community agencies, developed a suicide prevention plan that is reviewed annually. The Minnesota Department of Health awards \$200,000 annually to local organizations and service providers throughout Minnesota to reduce suicides. In the fall of 2012, Suicide Awareness Voices of Education (SAVE) will sponsor a youth summit for suicide prevention. Youth from around the state will attend a one and a half day training that will provide them with skills and information to bring to their communities.

**Gender of victims of suicide/self-inflicted injury cases reviewed**

Male: 6

Female: 2

**Table 9: Age of victims of suicide/self-inflicted injury cases reviewed**

Age	Number	Percent
Under 11	0	0%
11 – 14	3	37%
15 – 17	5	63%
<b>Total</b>	<b>8</b>	<b>100%</b>

**Table 10: Race/ethnicity of victims of suicide/self-inflicted injury cases reviewed**

Race	Number	Percent
Caucasian	6	75%
African American	1	12.5%
American Indian	0	0%
Asian/Pacific Islander	0	0%
Two or more races	1	12.5%
Race unknown	0	0%
<b>Total</b>	<b>8</b>	<b>100%</b>
Hispanic ethnicity – any race	0	0%

Suicide prevention recommendations include:

- Increase availability, access to and continuity of mental health care for children, especially in rural areas.
- Provide standardized mental health care to ensure appropriate monitoring of quality

of care.

- Engage a child psychiatrist to monitor children's medications for those with complex diagnoses.
- Inform parents of youth diagnosed with depression of the heightened risk of suicide, warning signs, and developing a response plan in the event that a child threatens or attempts suicide.
- Inform youth how to respond and whom to notify when a peer threatens or discusses thoughts of suicide.
- Integrate care with increased communication and coordination among mental health providers and the family.
- Raise awareness among the general public, as well as professionals working with families, of Minn. Stat. 609.666, Negligent Storage of Firearms. Concern about the safety of children or youth with easy access to firearms should be reported to child protection or local law enforcement.
- Ensure that families have knowledge of and access to mental health services in their communities for children.
- Include suicide response protocols in Cardio Pulmonary Resuscitation training for staff of mental health, chemical health and corrections treatment facilities. The response protocol should be developed in consultation with medical, mental health, law enforcement and legal professionals.
- Promote effective communication between school staff, parents, mental health or medical providers and local social service agency staff when a child or youth has expressed suicidal thoughts.
- Encourage facilities that provide in-patient treatment to youth to secure furniture so that it is less likely to be moved to use in a suicide attempt.

## Homicide/inflicted near fatal injury due to maltreatment

During the years 2010 – 2011, the Minnesota Child Mortality Review Panel examined 28 cases involving the death or near fatal inflicted injuries due to abuse or neglect. Eighty-five percent of the children that died or suffered near fatal injuries were under age 3.

Fatal and near fatal child abuse is often caused by a forceful assault. Most child maltreatment deaths occurred as a result of physical abuse by a person responsible for the children. Sixty-eight percent of the fatal and near fatal inflicted injuries were due to abusive head trauma caused by forceful shaking or blunt force trauma to the child's head. Eleven percent of infants with head trauma also had severe injuries from sexual abuse. Explanations given by offenders that inflicted fatal or near fatal injuries involved frustration and anger about a child's crying, feeding, sleeping or toileting problems. Fatal and near fatal conditions caused by neglect occurred when a caregiver failed to adequately provide for a child's basic needs, including appropriate supervision for a child's age and developmental ability, failure to provide adequate nourishment, lack of necessary medical care for a treatable condition, or failing to protect a child from a person known to be violent.

Forty-three percent of children who suffered a fatal or near fatal injury had previously been a subject of a child protection Family Assessment or investigation. Only 4 percent of the children’s families were receiving child protection services at the time of the fatal or near fatal incident.

**Table 11: Age of victims of homicide/near fatal inflicted injury cases**

<b>Age of Child</b>	<b>2010</b>	<b>2011</b>	<b>Total</b>	<b>Percent of total</b>
Birth – 3 months	7	3	10	36%
4 – 7 months	3	3	6	21%
8 – 11 months	0	2	2	7%
1 – 2 years	3	3	6	21%
3 – 4 years	0	1	1	4%
5 – 10 years	1	0	1	4%
11 – 17 years	2	0	2	7%
<b>Total</b>	<b>16</b>	<b>12</b>	<b>28</b>	<b>100%</b>

**Table 12: Race/ethnicity of victims of homicide/near fatal inflicted injury cases**

<b>Race of child</b>	<b>2010</b>	<b>2011</b>	<b>2010-2011 Total</b>	<b>2010-2011 Percent of total</b>
Caucasian	12	10	22	78%
African American	3	1	4	14%
American Indian	1	0	1	4%
Asian/Pacific Islander	0	0	0	0%
Two or more races	0	1	1	4%
Race unknown	0	0	0	0
<b>TOTAL</b>	<b>16</b>	<b>12</b>	<b>28</b>	<b>100%</b>
Hispanic ethnicity – any race	3	1	4	14%

### Relationship of offenders to child victims

Fifty-nine percent of the cases reviewed identified a male household member as the offender of a fatal or near fatal child abuse injury. Male offenders were often responsible for the child’s care while the mother was working or away from the home. Forty-five percent of offenders were the biological father of the victim. Mothers inflicted fatal or near fatal harm in 24 percent of cases reviewed. Often, the mother’s actions were less violent, but caused fatal or near fatal harm by failing to provide a child with nourishment, or failed to protect a child from a violent person in the home. Women were most often the offenders in severe neglect resulting in death or near fatal injury due to neglect of a child’s basic needs.

Relationship between offenders and children for cases reviewed in 2010 – 2011 included:

- 45 percent of offenders were biological fathers
  - 24 percent of offenders were biological mothers
  - 14 percent of offenders were mother’s male companions
  - 3 percent of offenders were relatives or friends
  - 3 percent of offenders were licensed daycare providers
  - 11 percent of offenders were unknown.
- (There were 29 offenders responsible for fatal and near fatal incidents)

**Factors noted in fatal and near fatal inflicted injury cases**

The Minnesota Child Mortality Review Panel identified common factors noted in the 28 child homicide/near fatal inflicted injury cases reviewed. Employment data is collected on adults residing in a child’s household. Data collected on the cases reviewed revealed that 55 percent of offenders residing in a child’s household were unemployed. The circumstances often involve a working mother who leaves a child in the care of the child’s father or other male household member, because he is unemployed. Policies permit the approval of child care assistance for low income families when an unemployed adult residing in the household displays behavior or a history that suggests that they may be unable to safely care for a child. When a parent requests child care assistance because of concern for a child’s safety while in the care of the other adult in the home, a determination must be made by a licensed physician, psychologist or local social service agency staff that the other adult in the home is unable to care for a child.

Other factors that were noted in the homicide/near fatal inflicted injury cases included 46 percent of offenders had histories of drug or alcohol abuse; 38 percent had prior criminal convictions as a juvenile or adult; 34 percent had previously maltreated a child in the offender’s current home or in another household; and 21 percent had perpetrated domestic abuse.

The patterns noted in the fatal and near fatal inflicted injury cases raised questions about whether the family dynamics and social history factors found were also present in moderate and low severity cases. Two supplementary questions were added to the Structured Decision Making Risk Assessment Tool to gather data to determine if these factors are evident in the spectrum of severity among child protection cases. The questions seek to identify the number of cases where the father, stepfather, boyfriend or male roommate provides unsupervised child care to a child under age 3 and whether the male caregiver is employed. The answers to these questions do not impact the risk level, but are used to collect data for further study. Data collection began during the spring of 2012.

**Table 13: Offender history in fatal and near fatal inflicted injury cases reviewed**

<b>Factors</b>	<b>Total</b>
Offender unemployed	55%
Offender had history of alcohol or drug abuse	46%
Offender had history of criminal conviction	38%
Offender had diagnosis of mental illness	31%
Offender had history of perpetrating child maltreatment	34%
Offender had history of perpetrating domestic abuse	21%

## Criminal prosecution

Child maltreatment cases involving fatal or near fatal injuries are investigated by child protection and law enforcement. In some cases, a child's injuries are clearly due to severe physical abuse, with the only suspects being the adults residing in the child's household, but investigators cannot determine which individual(s) harmed the child. For that reason, not every case reviewed resulted in criminal charges. In some cases, a person was criminally charged for contributing to a child's fatal or near fatal injury because they knew of the severe abuse, but failed to stop the abuse or take action to protect the child from future abuse. Appropriate action would include contacting the police, social services or obtaining medical care for a child's injuries following abuse. The Child Mortality Review Panel examines cases when criminal proceedings have concluded. In 34 percent of the cases reviewed, an offender pleaded guilty to charges that they caused the fatal or near fatal injury. In 31 percent of the cases, the offender was found guilty of causing the child's fatal or near fatal injury in a trial.

Minnesota laws aimed at preventing abusive head trauma include:

- Minnesota hospitals are required to make a video available for parents of newborns to view while they are in the hospital, informing them of the dangers of shaking infants and young children. [Minn. Stat., section 144.574, subd. 1]
- The commissioner of the Minnesota Department of Health must establish protocols for health care providers to educate parents and primary caregivers about the dangers associated with shaking infants and young children. The commissioner must request family practice physicians, pediatricians, and other pediatric health care providers, to review these dangers with parents and primary caregivers of infants and children, up to age 3 at each well-baby visit. [Minn. Stat., section. 144.574, subd. 2]
- Licensed foster care providers and their assistants that care for infants or children through age 5, must receive training on reducing the risk of Sudden Infant Death Syndrome and Shaken Baby Syndrome. Licensed family daycare providers also receive this training. [Minn. Stat., section 245A.1444]

Recommendations to prevent child severe maltreatment:

- Raise awareness among child protection workers, public health, in-home visitors and the general public about the importance of careful selection of a caregiver when the parent is away from home. Factors that may increase risk of harm to a child include:
  - Past violent behavior.
  - Alcohol and/or drug abuse.
  - Untreated mental illness.
  - Lack of experience in caring for infants and young children.
- Include male household members in public health home visits, family assessments and child welfare/child protection services to provide information and support about caring for an infant or child.
- Raise awareness among county and tribal social service workers that children with disabilities are at greater risk for maltreatment.

- Encourage effective collaborative working relationships among professionals involved in assessing and providing services in response to reports of child abuse and neglect. Positive working relationships between law enforcement, social services, public health, prosecuting attorney and medical professionals strengthens the overall effectiveness of services that reduce the risk of child maltreatment and benefits families.
- Enhance community awareness about the importance of reporting suspected child maltreatment. In several cases reviewed, neighbors or family members had concerns that a child was being neglected or abused, but did not notify child protection or law enforcement of their concerns.
- Provide culturally appropriate services in the community aimed at supporting families and providing safety for children.
- Provide shaken baby prevention education for parents and household members.
- Provide home visiting programs for families with infants and toddlers.
- Offer community-based initiatives aimed at preventing child abuse and neglect.
- Explore child care assistance policies that may inadvertently limit safe child care options for low income families, with the goal of improving policies to permit safe child care options.

## Conclusion

The information learned from the reviews of these tragic deaths and near fatal injuries has helped to identify factors that may elevate risk of severe harm due to maltreatment. This information is being integrated into training provided to child protection workers to better serve families and protect children. The Child Mortality Review Panel members often bring recommendations for improvement by professions represented on the panel. The local child mortality reviews identify practice or local systems issues that are improved as a result of the local review. The goal of the mortality review process is to reduce and eliminate preventable child deaths. The Minnesota Department of Human Services has developed, implemented, and administered a number of programs and initiatives aimed at strengthening and supporting families to reduce and prevent child maltreatment. The programs and initiatives include:

- **Children’s Trust Fund**  
Administered by the Minnesota Department of Human Services, the Children’s Trust Fund (CTF) supports public and private non-profit community-based programs to develop, operate and/or expand community-based family support programs. The goal is to reduce the risk of child abuse and neglect by promoting protective factors that strengthen and support families.
- **Parent Support Outreach Program**  
The Parent Support Outreach Program (PSOP) is an early intervention child and family welfare program developed to offer services for families with younger children that were reported to child protection services for child abuse and neglect, but whose reports did not meet criteria for child maltreatment.

- **Statewide Child Protection Screening Criteria**  
 In September 2007, the Minnesota Department of Human Services developed and implemented Minnesota Child Maltreatment Screening Guidelines to promote statewide consistency in definition and practice for reporting maltreatment of children.
- **Children’s Justice Act**  
 The Minnesota Children’s Justice Act (CJA) Task Force was established in 1993 as a provision of the Child Abuse Prevention and Treatment Act. This task force is required to review and assess the systems that handle child maltreatment cases, and make recommendations for systemic improvement.
- **Minnesota Citizen Review Panels**  
 Citizen Review Panels provide opportunities for community members to play an integral role in ensuring that the child protection system is protecting children from abuse and neglect and/or finding permanent homes for them. There are five Citizen Review Panels operating in Minnesota: Chisago, Hennepin, Ramsey, Winona and Washington counties.
- **Children’s Mental Health**  
 The Minnesota Comprehensive Children’s Mental Health Act, Minn. Stat. 245.487 through 245.4887, establishes a comprehensive, unified mental health service delivery system that effectively and efficiently meets the mental health needs of its target populations. These initiatives help clients attain the maximum degree of self-sufficiency consistent with their individual capabilities.
- **American Indian Child Welfare Initiative**  
 Legislation passed in 2005 provided the Minnesota Department of Human Services commissioner with the ability to fund programs intended to enhance the capacity of federally recognized tribes to provide tribal child welfare services. This initiative transfers authority and responsibility for responding to reports of child abuse and neglect from neighboring counties to the tribes, with the tribes providing a full continuum of services that conform to tribal customs and traditions. In 2007, the Leech Lake and White Earth Bands of Ojibwe entered into contractual agreements with the state to provide child welfare services to American Indian families living on the two reservations.

## Child Mortality Review Panel Members

**Ann Ahlstrom, J.D.**

Children's Justice Initiative  
Minnesota State Court Administration

**Nan Beman, M.S.W.**

Social Service Information System  
Minnesota Department of Human Services

**Joanne Boogaard, M.P.H.**

Planning, Policy and Quality Assurance  
Hennepin County Human Services

**Mary Jo Chippendale, M.S., P.H.N.**

Family and Women's Health Supervisor  
Minnesota Department of Health

**Jackie Crow Shoe**

Children's Justice Act Consultant  
Minnesota Department of Human Services

**Kathy Eilers, J.D.**

Assistant County Attorney  
Ramsey County Human Services

**Kathleen Fernbach P.H.N.**

Minnesota Sudden Infant Death Center  
Children's Hospitals and Clinics of Minnesota

**Victor Froloff, M.D.**

Forensic Pathologist  
Ramsey Co Medical Examiner's Office

**Butch Huston, M.D.**

Forensic Pathologist  
Ramsey County Medical Examiner's Office

**Mark Kinde, M.P.H.**

Injury and Violence Prevention Unit Leader  
Minnesota Department of Health

**William Martinez,**

Senior Commander  
St. Paul Police Department

**Amelia Ortega**

**Jennifer Alexander, L.I.S.W.**

Student Maltreatment Program Supervisor  
Minnesota Department of Education

**Terry Besaw, M.S.W.**

Child Protection Consultant  
Minnesota Department of Human Services

**Christeen Borsheim, M.P.A.**

Child Safety and Permanency Division  
Minnesota Department of Human Services

**Ruth Clinard**

Child Mortality Review Consultant  
Minnesota Department of Human Services

**Marvin Davis**

Adoption Supervisor  
Minnesota Department of Human Services

**Drew Evans, J.D.**

Senior Special Agent  
Minnesota Bureau of Criminal Apprehension

**Matthew Frank, J.D.**

Manager, Public Protection/Criminal Appeals  
Minnesota Attorney General's Office

**Mark Hudson, M.D., F.A.A.P.**

Child Abuse Pediatrician  
Children's Hospitals and Clinics of MN

**Anita Keyes**

Citizen Review and Child Mortality Review  
Minnesota Department of Human Services

**Carolyn Levitt, M.D., F.A.A.P.**

Midwest Children's Resource Center  
Children's Hospitals and Clinics of MN

**Joanne Mooney, M.A.**

Children's Trust Fund Consultant  
Minnesota Department of Human Services

**Don Pelton**

Children's Mental Health Parent Liaison  
Minnesota Department of Human Services

**Karen Pitts**

Child Development Services Supervisor  
Minnesota Department of Human

**Erin Sullivan Sutton, J.D.**

Children and Family Services Administration  
Minnesota Department of Human Services

**Jo Zillhardt, R.N.-B.C., P.H.N.**

Office of Ombudsman for Persons with  
Developmental Disabilities and Mental Illness

Child Protection Supervisor  
Washington County Community Services

**Janet Spatafore, P.H.N., M.S.N.**

Public Health Nurse  
Wright County Health Department

**Esther Wattenberg, M.A.**

Center for Urban and Regional Affairs  
University of Minnesota



Minnesota Department of **Human Services**