Minnesota Department of Human Servic

Review of Minnesota Child Deaths and Near Fatalities Related to Child Maltreatment 2005-2009

Minnesota Department of **Human Services**

Children and Family Services Administration
Child Safety and Permanency Division

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Minnesota Child Mortality Review Report
2005 – 2009
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.

Department staff began working with the National Center for Child Death Review in 2005. Currently, there are 34 states using a standardized process to review and study child deaths. Minnesota collects data on the cases reviewed to help illustrate patterns and trends regarding child maltreatment. Analysis of this data will help department staff to prepare more effective child abuse and neglect prevention strategies.

From 2005 – 2009, the Minnesota Child Mortality Review Panel examined 202 cases; 71 were homicide/inflicted injury cases; 63 were unexpected infant deaths; 52 were accidents; 16 were suicides. Of the 202 cases, 34 were near fatal cases involving accidents or inflicted injuries.

Accident cases reviewed
The Minnesota Child Mortality Review Panel examined 52 accident cases which had recent history with the social service system. Fifty percent of the cases where children died or were severely injured in an accident involved children under age 4, and 33 percent of the children were 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 reviewed 63 unexpected infant deaths. Unexpected infant death cases are those where an otherwise healthy infant died without any precipitating illness or injury. Often, these infants were placed in an unsafe sleep environment which includes placing an infant to sleep on their stomach; in an adult bed; with another person or pet; with soft bedding or other items in the crib. Cases are reviewed when an infant died unexpectedly without illness or injury, and the family also had a recent history with social services, or an infant was in the care of a licensed daycare facility when the death occurred.

Suicide cases reviewed
Sixteen suicide 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. In some cases, a child's mental health treatment was discontinued due to the cost of services, high insurance co-pays, or the treatment stopped because the family moved, or a youth discontinued voluntary services. Public education and awareness is needed for adults and youth about how to respond to a peer who threatens suicide, and who to contact to prevent harm. The availability, access and continuation of mental health services, especially in rural areas, is a significant factor in addressing and preventing youth suicide.

Homicide cases reviewed
The Child Mortality Review Panel examined 71 cases involving fatal or near fatal inflicted injuries. Seventy-five 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, also known as Shaken Baby Syndrome.

Patterns were noted among the offenders who inflicted injuries, including unemployment, history of substance abuse, violent behavior, domestic abuse, criminal history or untreated mental health issues. Sixty-seven percent of the offenders were male household members. Fifty-one percent of offenders residing with the victim were not employed. Thirty percent of all offenders had a history of alcohol and/or drug abuse.

Minnesota hospitals are required to show a video on the dangers of shaking a baby before a mother and baby are discharged from the hospital. Public health and social service agencies are working to engage fathers or male household members in services to provide education and support in their role as a caregiver of a young child.

Minnesota Child Mortality Review

The state and local child mortality/near fatality review process is a multi-disciplinary perspective to learn and understand the factors that contribute to death and near fatal injuries. This information is used to evaluate policies and practice, make systemic improvements and promote initiatives to prevent future harm to children. This report is a summary of the intensive work by the state panel and local teams in reviewing child deaths and near fatalities for the years 2005 – 2009.

This report focuses on cases reviewed by the Minnesota Child Mortality Review Panel, as required by Minnesota Statutes, section 256.01, subd. 12. Data for this report was obtained from Minnesota Department of Health death certificate data and from cases reviewed by Minnesota's 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 improve services to children by examining the practices, coordination and communication among the various agencies involved with a family prior to and following the fatal or near fatal incident. The local teams and state Child Mortality Review Panel examine cases in which a child is injured or has died 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 licensed facility
- The manner of death classified as a homicide, suicide, accident, cannot be determined; and natural deaths that involve infant sleep-related deaths or neglect of a child's basic needs, along with a child or a family member receiving 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 the local agencies and within the local social service system. The response by local agencies following the 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 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 202 cases from 2005 – 2009. The table below shows the total number of cases reviewed by the panel for each year, and the types of incidents that were reviewed.

Table 1: Inflicted fatal or near fatal injury cases reviewed by year

Type of death or near fatal injury	2005	2006	2007	2008	2009	Total
Sudden unexpected infant death	21	3	7	21	11	**63**
Accident	4	9	6	13	20	**52**
Suicide	0	3	4	6	3	**16**
Homicide/inflicted near fatal injury	6	6	14	19	26	**71**
Total	**31**	**21**	**31**	**59**	**60**	**202**

The state Child Mortality Review Panel studies 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; and develop recommendations for statewide system improvements; strategies for child abuse prevention; and implement 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 is determined by the medical examiner or coroner. The cause of death refers to the physiological reason for the death, and 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 documentation, 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 actions
- Not classifiable, cannot be determined or pending investigation – resulting from unresolved questions about how a child died.

Near fatal injuries

A near fatality is defined according to Minnesota Statute 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. During the years 2005 – 2009, there were 61 near fatalities reported to the Minnesota Department of Human Services. The increase in number of near fatalities indicates better reporting by the counties rather than an increase in the number of incidents.

Table 2: Near fatal cases by year

Year	2005	2006	2007	2008	2009	Total
Near fatality cases – all categories	4	7	8	10	32	**61**

Accident cases reviewed
The Child Mortality Review Panel examined 52 accident cases from 2005 – 2009. The three leading causes of accidental child deaths included drowning, asphyxia from airway obstruction and car/pedestrian accidents.

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 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 or any water. Adults must maintain constant visual contact with older children in pools, lakes, ponds and rivers. Floatation devices are very effective at preventing drowning when children are playing in or near water, but careful monitoring is still required.

Nineteen percent of accident cases involved asphyxia from obstruction to a child's airway. Often, these cases involved choking on food or a small object, or a child's face had prolonged contact with a plastic bag.

Very few motor vehicle accidents are examined by the Child Mortality Review Panel because maltreatment is rarely a contributing factor. The motor vehicle accidents that were reviewed involved children that were injured or killed when a vehicle backed over them; children that were passengers in vehicles driven by caregivers that were under the influence of alcohol or drugs; or children were in the care of a licensed daycare or foster care provider when a collision occurred.

Table 3: Number of accident cases reviewed

Type of accidental injury	Number of cases reviewed 2005 – 2009	Percent of accident cases reviewed
Drowning	16	31%
Asphyxia (not sleep-related)	10	19%
Motor vehicle or vehicle/pedestrian collision	8	15%
Fire	6	11%
Drug overdose	3	6%
Compression from falling object	3	6%
Medical neglect by caregiver	3	6%
Hyperthermia	1	2%
Gunshot wound	1	2%
Poisoning	1	2%
Total	**52**	**100%**

Accident prevention strategies include:

- Raise public awareness that caregivers must have constant visual contact with a child in water and be in close proximity to the water. Flotation devices should be worn by young children when in or near open 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.
- Raise awareness about choking hazards, making safe food choices to prevent choking, and of current first aid guidelines that do not recommend doing a finger sweep of the mouth when a child is choking.
- Raise public awareness that firearms and ammunition need to be securely stored to prevent access by children.
- Raise public awareness about the potential harm of misuse of over-the-counter medications, as well as prescription medications; and the importance of storing medications where children will not have access to them.

Accident prevention accomplishments:

- The Minnesota Department of Natural Resources aired radio public service announcements during the summer months to raise awareness of drowning prevention
- The Minnesota Department of Health home safety checklist, used by public health nurses, includes reminders to instruct parents on a variety of safety issues based on a child's age and developmental ability, including bath and water safety, choking prevention, safe storage of medications and securing furniture that could fall if a child climbs on it
- One community launched a public education campaign on water safety aimed at immigrant populations to raise awareness of the seasonal changes in moving water, and also developed a program to provide swimming lessons to immigrant youth.

Table 4: Age of victims of accident cases reviewed

Age	**Number**	**Percent**
Infant to 4	29	56%
5 – 12	15	29%
Age 13 and older	8	15%
Total	**52**	**100%**

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

Race	**Number**	**Percent**
Caucasian	34	65%
African American	12	23%
American Indian	5	10%
Asian/Pacific Islander	1	2%
Two or more races	0	0%
Race unknown	0	0%
Total	**52**	**100%**
Hispanic ethnicity	2	4%

Unexpected infant deaths

The medical definition for Sudden Infant Death Syndrome is the sudden death of an infant under 1 year of age that remains unexplained after a thorough case investigation, a complete autopsy, examination of the death scene and review of clinical history. According to the Centers for Disease Control and Prevention, 57 percent of all infant deaths are officially diagnosed as Sudden Infant Death Syndrome, even though many of these deaths may have been due to positional asphyxia, when an infant's airway was occluded by soft bedding or toys, soft sleep surface or inadvertent compression by a sleeping adult or child. Also included in this category are situations where an infant has been entrapped in parts of a bed frame, between a wall and bed or between broken crib railings. For medical examiners and coroners to determine an accurate manner of death, the Centers for Disease Control recommend the following best practices:

- Investigators for 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 the coroner or medical examiner 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.

Sudden Unexpected Infant Death 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.

From 2005 – 2009, the state mortality review panel examined 63 cases involving unexpected infant death. 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. The AAP made 12 recommendations regarding safe sleep that, in brief, 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 their complete recommendations can be found at: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;116/5/1245.pdf

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 for infants.

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. Poverty may interfere with parents' ability to purchase a safe crib. Second-hand cribs may be unsafe because they may be worn or faulty. When the parents

and infant are away from home, there may not be a crib available; the infant may be placed to sleep in an unsafe environment such as a sofa, bean bag chair, stroller or floor.

Unexpected infant death prevention strategies

Safe sleep practices that can save an infant's life include:

- Utilizing and promoting the recommendations from the American Academy of Pediatrics on safe infant sleep practices by informing parents, licensed daycare and foster care providers, medical practitioners and social services staff of these recommendations.
- Encouraging 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.

Accomplishments in preventing unexpected infant deaths include:

- A collaborative effort including the Minnesota Coroners and Medical Examiners Association, Minnesota Sudden Infant Death Center, Minnesota Departments of Health and Human Services sending a letter to all licensed family practice physicians, pediatricians, obstetricians and hospitals, requesting that they educate parents and expectant parents about the American Academy of Pediatrics' recommendations for safe infant sleep. The letter generated requests for more than 20,000 brochures about safe sleep.
- Minnesota Statutes, section 245A.1444, requires licensed foster care providers and their assistants to obtain training on reducing the risk of unexpected infant deaths.
- Minnesota Statutes, section 245A.1435, requires that licensed child care providers place an infant on their back to sleep in an approved crib.
- The Minnesota Departments of Health and Human Services jointly presented a training for local child mortality review teams about preventing sudden infant death by placing infants to sleep in a safe sleep environment.
- Two public health and social service agencies obtained private funds to purchase a few safe portable cribs to loan to families with infants.

Table 6: Age of victims of unexpected infant death cases reviewed

Age	Number	Percent
Birth to 3 months	40	64%
4 – 6 months	12	19%
Over 6 months	11	17%
Total	**63**	**100%**

Table 7: Race/ethnicity of victims of unexpected infant death for cases reviewed

Race	Number	Percent
Caucasian	27	43%
African American	26	41%
American Indian	3	5%
Asian/Pacific Islander	2	3%
Two or more races	3	5%
Race not reported/unknown	2	3%
Total	**63**	**100%**
Hispanic ethnicity – any race	4	6%

Suicide

According to death certificate data provided by the Minnesota Department of Health, 117 youth committed suicide during the years 2005 – 2009. The Minnesota Child Mortality Review Panel examined 16 of the suicide cases. More than 50 percent of adolescent suicides in Minnesota occurred in rural areas where there is often limited access to mental health treatment.

The majority of youth in the cases reviewed received mental health services prior to their death. However, lack of access, availability of mental health services, or the interruptions of a child's treatment were often significant factors in many of the cases reviewed, especially in rural areas. Some patterns noted included that youth had a history of delinquent behavior, substance abuse, or history of trauma related to prior physical or sexual abuse.

In more than 50 percent of the suicide cases reviewed, victims had previously indicated to friends or family that they had thoughts of suicide. Often, the family member or friend did not seek professional help for the youth. Many of the youth committing suicide had conflicted relationships with their parents, and almost 70 percent had experienced a recent personal crisis. Prompt intervention was viewed as crucial for youth experiencing stress, depression, or suicidal thoughts.

Many families, especially in rural Minnesota, have very limited access to child psychiatrists or psychologists. A child may be prescribed psychotropic medication by a family practice physician 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 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 awarded $200,000 annually to local organizations and service providers throughout Minnesota to reduce suicides.

Gender of victims of suicide cases reviewed
Male: 14
Female: 2

Table 8: Age of victims of suicide cases reviewed

Age	Number	Percent
Under 11	2	12.5%
11 – 14	2	12.5%
15 – 17	12	75%
Total	**16**	**100%**

Table 9: Race/ethnicity of victims of suicide cases reviewed

Race	Number	Percent
Caucasian	14	88%
African American	2	12%
American Indian	0	0%
Asian/Pacific Islander	0	0%
Two or more races	0	0%
Race unknown	0	0%
Total	**16**	**100%**
Hispanic ethnicity – any race	0	0%

Suicide prevention strategies include:

- Increasing availability, access and continuity of mental health care for children, especially in rural areas
- Providing standardized mental health care to ensure appropriate monitoring of quality of care
- Engaging a child psychiatrist to monitor children's medications for those with complex diagnoses
- Informing 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
- Informing youth how to respond and who to notify when a peer threatens or discusses thoughts of suicide
- Integrating care with increased communication with the family and coordination among mental health providers.

Homicide/inflicted near fatal injury due to maltreatment

During the years 2005 – 2009, the Minnesota Child Mortality Review Panel examined 71 cases involving the death or near fatal inflicted injuries due to abuse or neglect. Seventy-five percent of these deaths occurred in children under age 4. Fatal child abuse is often caused by a forceful assault. Men residing in a victim's household were most often the offenders in deaths or near fatal inflicted injuries caused by abuse. Women were most often the offenders in deaths and near fatal injuries caused by neglect of a child's basic needs. Fifty percent of offenders were the child's parent.

Most child maltreatment deaths occurred from physical abuse by a person responsible for the child. The most common fatal and near fatal injuries were due to abusive head trauma, also known as Shaken Baby Syndrome. These injuries occur through blunt force trauma to the head and/or shaking of an infant or toddler. 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.

The Minnesota Child Mortality Review Panel identified common risk factors in the 71 child homicide/near fatal inflicted injury cases reviewed. Although these risk factors may be present in many families that never harm their children, they were consistently present in the cases the panel reviewed where a homicide or near fatal injury occurred. The risk factors included:

- Child under age 3 or has special needs
- Unrelated adult residing in the victim's household
- Unemployment of one or more adult household members
- Male household member providing child care when mother is not home
- Previous involvement by the parent and/or other adult in the household with child protection
- Frequent moves between counties and/or states
- Parent or caretaker has history of substance abuse
- Parent or caretaker has history of violence
- Parent or caretaker has mental health issues.

Table 10: Age of victims of maltreatment cases reviewed

Age of Child	2005	2006	2007	2008	2009	Total
Under 1	4	4	7	9	10	34
1 – 2	1	2	4	6	6	19
3 – 4	1	0	2	1	2	6
5 – 10	0	0	1	0	4	5
11 – 17	0	0	0	3	4	7
Total	**6**	**6**	**14**	**19**	**26**	**71**

Table 11: Race/ethnicity of victims of maltreatment cases reviewed

Race of child	2005	2006	2007	2008	2009	Total	Percent of total
Caucasian	3	3	6	9	14	**35**	50%
African American	0	3	2	8	7	**20**	28%
American Indian	0	0	1	2	0	**3**	4%
Asian/Pacific Islander	1	0	0	0	3	**4**	6%
Two or more races	1	0	3	0	2	**6**	8%
Race unknown	1	0	2	0	0	**3**	4%
Total	**6**	**6**	**14**	**19**	**26**	**71**	**100%**
Hispanic ethnicity – any race	2	0	5	0	2	**9**	13%

Relationship of offenders to child victims

Male household members were more often identified as the offender when a child suffered a fatal or near fatal inflicted injury. Sixty-seven percent of offenders were male household members. Some of these offenders were the father, step-father, adoptive father or the mother's male companion. Mothers inflicted fatal or near fatal harm in 19 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, poisoned a child, or failed to protect a child from a violent person in the home.

Relationship of offenders to children for cases reviewed in 2005 – 2009 included:

- 34 offenders were biological fathers
- 14 offenders were biological mothers
- 11 offenders were mother's male companions
- 2 offenders were step-fathers
- 2 offenders were adoptive parents
- 2 offenders were relatives or friends
- 6 offenders were daycare providers.

Factors noted in fatal and near fatal inflicted injury cases

Employment data is only collected on adults residing in a child's household. This data revealed that of the offenders residing in a child's household, 51 percent were unemployed, 6 percent were on disability, and 4 percent were stay-at-home caregivers.

Other factors that were noted in cases of fatal or near fatal injury included history of drug or alcohol abuse, prior criminal convictions for any kind of delinquent or criminal activity, and history of perpetrating domestic abuse. Seventeen percent of offenders had maltreated a child in the home or a child in another household. Some of the prior maltreatment determinations involved infants or young children with severe multiple injuries.

Table 12: Offender history in fatal and near fatal inflicted injury cases

Factors	Percentage
Offender had history of alcohol or drug abuse	30%
Offender had history of criminal conviction	24%
Offender had history of perpetrating domestic abuse	21%
Offender had history of perpetrating child maltreatment	17%
Offender had diagnosis of mental illness	14%

Child maltreatment cases involving fatal or near fatal injuries are investigated by child protection as well as law enforcement. In some cases, a child's injuries are clearly due to severe physical abuse and the only suspects are the adults in the household, but investigators cannot determine which person 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. The adult could have contacted the police, social services or obtained medical care for a child following the injuries. In 45 percent of the cases, an offender pled guilty to charges that they caused the fatal or near fatal injury. In 29 percent of the cases, the offender was found guilty of causing the child's fatal or near fatal injury in a trial. In 8 percent of the cases, a person was found guilty or pled guilty to charges that they contributed to a child's fatal or near fatal injury.

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. [Minnesota Statutes, 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 the parents and primary caregivers of infants and children up to age 3 at each well-baby visit. [Minnesota Statutes, section. 144.574, subd. 2]

- Licensed foster care providers and their assistants who 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. [Minnesota Statutes, section 245A.1444]

Prevention efforts for child homicides include:

- Ensuring 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 strengthen the overall effectiveness of the system and benefits families.
- Enhanced 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.
- Greater emphasis by child protection social workers and public health nurses on engaging fathers and male caregivers in services to educate and support them to be safe and nurturing caregivers.
- Providing culturally appropriate services in the community aimed at supporting families and providing safety for children.
- Providing shaken baby prevention education for parents and household members.
- Providing home visiting programs for families with infants and toddlers.
- Offering community-based initiatives aimed at preventing child abuse and neglect.
- Providing children's crisis nurseries and helplines accessible to parents feeling stressed by parenting.
- Exploring 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.

Maltreatment prevention accomplishments include:

- Developed the Minnesota Department of Human Services statewide screening criteria for assessing child maltreatment reports.
- Provided statewide training for local child mortality review teams on child mortality review and prevention and homicide investigations.
- Expanded training for physicians who may see signs of physical abuse or neglect when a child is brought to a clinic or hospital. Early intervention may prevent more serious harm.
- Included supplemental questions on the Risk Assessment Tool to assess whether male household members who are providing unsupervised child care pose a child maltreatment risk.

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. Child Mortality Review Panel members often bring recommendations for improvement by those professionals represented on the panel. 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 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 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.

- **Minnesota Family Investment Program Family Connections Program**
  A three-year pilot program of voluntary family support services and coordinated case management for families receiving Minnesota Family Investment Program (MFIP) or Food Support. The pilot program was initiated in 2007 with eight participating counties.

- **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 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 in Chisago, Hennepin, Ramsey, Winona and Washington counties.

- **Children's Mental Health**
  The Minnesota Comprehensive Children's Mental Health Act, Minnesota Statute 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 of Minnesota to provide child welfare services to American Indian families living on the two reservations.

- **African American Disparity Initiatives**
  In 2005, the Minnesota Department of Human Services conducted a study examining the disparity of African American families in the child protection system. The projects involved reviewing key decision-making points and subsequent outcomes for African American children in the child protection system. The goal of the disparity project is to improve child welfare practices addressing disparity issues.

Child Mortality Review Panel Members

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