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Minnesota Department of **Human Services**

Review of Minnesota Child Deaths and Near Fatalities Related to Child Maltreatment 2012 - 2013

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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 who 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, Minn. Stat., 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, subp. 5, establishes 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 2012 – 2013, the Minnesota Child Mortality Review Panel examined 127 cases: 12 involved fatal inflicted injuries, 20 near fatal inflicted injury cases, 71 sudden unexpected infant deaths, 14 fatal accidents, eight near-fatal accidents and two suicides.

Medical issues and medical neglect

Children with multiple medical issues due to chronic illness or disability often are dependent on life sustaining medications, treatment, equipment or assistance from a caregiver for activities of daily living. These children are particularly vulnerable due to their disability or health condition. Families often receive supportive services to assist in providing home care to children with disabilities. When an error or interruption of care occurs in a child with high medical needs, it may result in a medical event that leads to a near fatality or fatality; there may be a child protection response. The Child Mortality Review Panel reviewed four cases involving medical issues or medical neglect.

Accident cases reviewed

The Minnesota Child Mortality Review Panel examined 11 fatal and seven near fatal accident cases. Fifty-five percent of the cases reviewed were children under age 3 who died or were severely injured in an accident. Drowning was the leading cause of accidental deaths. Although the drowning incidents were unintentional, an observation noted in police reports documented

inadequate supervision of the child by the caregiver, given children's ages or developmental abilities. Seventeen percent of accidental injuries involved young children who accidently ingested prescription narcotics.

Unexpected infant death cases reviewed

The Minnesota Child Mortality Review Panel examined 71 unexpected infant deaths. Unexpected infant death cases are those where an infant that appeared to be healthy, died without evidence of a birth defect, illness or injury. Often, these infants were placed in an unsafe sleep position such as on their side or stomach; 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 a blanket, quilt, pillow, soft toy or other items in the crib. To reduce the risk of suffocation while sleeping, department staff promotes the American Academy of Pediatrics' (AAP) safe sleep recommendations. Infants should always be placed to sleep on their back in a crib with a firm mattress without any soft items. The AAP recommends that infants sleep in a crib in the same room as the parents for the first six months. To keep infants warm, they may wear a one-piece sleeper that allows them to move their arms freely.

The Child Mortality Review Panel examines unexpected infant death cases when a 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-three percent of sudden unexpected infant death cases reviewed occurred in licensed family daycare homes. Six percent of sudden unexpected infant death cases reviewed occurred in licensed foster care or licensed relative foster care homes.

Suicide/self-inflicted injury cases reviewed

Two 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. Often, these youth had prior involvement in the social services, mental health or juvenile probation systems. Collaboration among these systems to offer comprehensive services to address mental health and behavioral issues may be beneficial.

Homicide/inflicted near fatal injury cases reviewed

The Child Mortality Review Panel examined 12 cases involving fatal and 20 cases involving near fatal inflicted injuries. Eighty-one percent of these deaths and near fatal injuries occurred to children under age 3. Fifty-seven percent of fatal or near fatal injuries involved abusive head trauma caused by shaking or striking a child's head, resulting in traumatic brain injury or death. In the cases reviewed, 3 percent of the abuse cases involved children who also had significant injuries from sexual abuse.

The following patterns were noted among offenders who inflicted injuries:

- 72 percent were male
- 38 percent had alcohol and/or drug abuse history
- 38 percent were previously diagnosed with a mental illness
- 34 percent were unemployed
- 28 percent had a prior criminal history
- 28 percent previously maltreated children.

Minnesota hospitals are required to show a video on the dangers of shaking a baby before a mother and newborn are discharged. 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 practices, 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 2012 – 2013. 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 cases reviewed by the Minnesota Child Mortality Review Panel. The deaths or near fatal injuries reviewed for this report occurred in years prior to the year of the review.

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 community. 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); 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 a 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 review, local teams recommend improvements in community systems. 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 127 cases during 2012 – 2013. The table below shows the total number of cases reviewed during each year and types of incidents reviewed.

Table 1: Fatal cases reviewed by year and cause of death

Type of death	2012	2013	Total
Sudden unexpected infant death	41	30	71
Accident – fatal	4	10	14
Medical issue – fatal	1	0	1
Suicide	0	2	2
Inflicted injury – fatal	4	8	12
Total	50	50	100

Table 2: Near fatal cases reviewed by year

Type of near fatal injury	2012	2013	Total
Accident – serious and critical condition	3	1	4
Medical issue – serious and critical condition	0	2	2
Medical neglect – near fatal	1	0	1
Inflicted injury – serious and critical injury	3	17	20
Total	7	20	27

The state Child Mortality Review Panel examines findings from 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 responses 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 occurred. 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, medical condition, abnormal development during fetal development or Sudden Infant Death Syndrome
- 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, co-occurring factors such as a medical condition and a person's actions, or this classification is sometimes used when no anatomical cause of death is found.

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.

Medical issues and medical neglect

Children with medical issues due to chronic illness and/or disability often are dependent on life sustaining medications, treatment, equipment or assistance from a caregiver for activities of daily living. Some children receive care from their families, supplemented by professional or paraprofessional home care. Some children receive care in a group home facility. These children are very vulnerable due to their disability or health condition and require an extraordinary level of care compared with healthy children of the same age. Cases reviewed involving medical issues include children with high medical needs where there was an error or an interruption in their daily care requirements that resulted in a medical event that caused a child's death or to be in serious or critical condition. Children with high medical needs may have multiple health conditions that may contribute to the death, serious or critical health condition. When there is an unexpected death, or a child is in serious or critical condition due to an interruption or error in their care, there may be a child protection response.

Cases where a child protection investigation resulted in a determination of medical neglect may involve a child with chronic or acute medical issues. When there is a preponderance of evidence that a child's caregiver did not respond to their needs or medical condition by providing appropriate care, medical neglect may be determined. Social services are often provided in

these cases to support parents in the care of a child with high medical needs, and to help them access services to provide care for their child. A family may be referred to public health nursing services, respite care or services for individuals with developmental disabilities.

Table 3: Number of medical issue or medical neglect cases reviewed

Medical issue or neglect	Number of cases	
	2012	2013
Medical neglect – fatal	1	0
Medical issue – fatal	1	0
Medical issue – near fatal	0	2

Table 4: Fatal and near fatal medical issue and medical neglect cases – age of children at time of incident

Age	Number
Birth – 11 months	1
1 – 2 years	0
3 – 4 years	1
5 – 10 years	1
11 – 17 years	1
Total	**4**

Table 5: Race/ethnicity of victims of medical issue and medical neglect cases reviewed

Race	Number
Caucasian	2
African American	1
American Indian	1
Asian/Pacific Islander	0
Two or more races	0
Race unknown	0
Total	**4**
Hispanic ethnicity	0

Accident cases reviewed

The Child Mortality Review Panel examined 14 fatal and four serious or critical injury accident cases during 2012 – 2013. Drowning was the leading cause of accidental child deaths or near fatal injuries. Thirty-four percent of accident cases reviewed involved children with developmental disabilities.

Drowning incidents are often preventable through close and direct supervision when children are in or near water. Floatation vests are very effective at preventing drowning when children are playing in or near water, but careful supervision is still required. Drowning is usually quick, silent, submersion in water resulting in lack of oxygen that can cause 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. 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 water. Use of electronic devices, socializing or alcohol consumption while supervising children in a pool or open water create distractions that interfere with the vigilance required to safely supervise children in water. Pool parties involving children require multiple adults focused solely on close supervision of children in the water, without any other tasks or distractions.

In 2011, following a number of drowning deaths in Hennepin County, a public-private coalition formed the Minnesota Water Safety Coalition to educate community members about water safety and drowning prevention. Group members include law enforcement, fire and rescue, hospitals, swimming schools, city and county parks and recreation boards, apartment complex managers, Abbey's Hope, Safe Kids Minnesota and the Minnesota Department of Natural Resources. The group provided community education at local apartment complexes to raise awareness about how quickly and silently drowning can occur, the importance of using life vests, close and attentive supervision, and how to safely respond if a person is in crisis. The group also requested that buildings with pools have a phone installed in the pool room and provide rescue equipment in the pool room (life ring and shepherds hook). The public education was provided at poolside, giving participants an opportunity to practice using rescue equipment. All training materials, posters and videos prepared by the group are posted on its website and available for free to encourage other community groups to raise awareness about water safety. The drowning prevention materials are posted at: www.thinkdontsink.org

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

Another type of accidental injury is "non-sleep-related asphyxia" that often refers to choking on food, toys, or 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 6: Number of accident cases reviewed

Type of accidental injury	Number of cases reviewed			
	2012		2013	
	Fatal	Near fatal	Fatal	Near fatal
Drowning	2	1	3	0
Motor vehicle crash with intoxicated driver	0	1	2	0
Ingestion of prescription medication within child's reach	1	1	1	0
Motor vehicle/pedestrian collisions or motor vehicle/train collisions	0	0	2	0
Non-sleep related asphyxia (lack of oxygen)	1	0	0	1
Falls	0	0	1	0
Canine attack	0	0	1	0
TOTAL	**4**	**3**	**10**	**1**

Table 7: Age of victims of accident cases reviewed

Age	2012		2013	
	Fatal accidents	Near fatal accidents	Fatal accidents	Near fatal accidents
Birth – 11 months	0	0	3	0
1 – 2 years	2	2	2	1
3 – 4 years	1	0	0	0
5 – 10 years	1	1	4	0
11 – 17 years	0	0	1	0
Total	**4**	**3**	**10**	**1**

Table 8: Race/ethnicity of victims of accident cases reviewed

Race	2012		2013	
	Fatal	Near fatal	Fatal	Near fatal
Caucasian	2	1	7	0
African-American	1	1	0	0
American Indian	0	1	0	0
Asian/Pacific Islander	1	0	2	0
Two or more races	0	0	0	2
Race unknown	0	0	0	0
Total	**4**	**3**	**9**	**2**
Hispanic ethnicity	0	0	1	1

Recommendations to prevent accidents

Strengthening individual knowledge and skills by:

- Providing water safety information for parents in languages spoken by immigrant populations
- Informing parents and caregivers that when infants and toddlers are in a bathtub, they must remain within arm's reach at all times
- Encouraging parents to teach their children how to swim.

Educating providers by:

- Including information on nutrition and feeding practices that are appropriate for children's age and developmental abilities in training for licensed family child care providers
- Including information on behavior management techniques and stress management in training for child care providers
- Ensuring that staff employed in facilities that provide care for individuals who require skilled nursing care are trained by nursing professionals to provide safe and appropriate care, and trained in safe and appropriate feeding for children with developmental disabilities or illnesses.

Promoting community education by:

- Promoting water safety messages through public service announcements, websites, and incorporating into training of licensed child care and foster care providers
- Supporting public education to raise awareness to prevent driving while intoxicated.

Fostering coalitions and networks by:

- Initiating community efforts to reduce drowning by implementing public awareness campaigns, ensuring that public pools (apartments, hotels, schools, recreation centers and health clubs) have essential rescue equipment, training citizens to recognize potential drowning and how to respond, and teaching community members to safely supervise children in and near water to prevent drowning. Resources are available at www.thinkdontsink.org
- Encouraging hotel managers who rent out hotel pools for children's parties to ask renters to meet certain safety and adult-to-child supervision ratio requirements while children are in or near the pool. Some hotels require hiring a lifeguard. Restrict food from being served in the pool room so that children are away from water when food is served; adults may be distracted from supervising children in the water.
- Developing community-based programs to enable families to obtain free or low cost respite child care when they are experiencing a crisis.

Changing organizational practices by:

- Informing law enforcement agencies in the state that when children are injured or killed in a vehicle driven by a person intoxicated by alcohol or drugs, of the mandate to notify the child protection agency in the jurisdiction where a child resides.
- Inviting a State Patrol officer to participate in local child mortality review meetings.
- Encouraging use of a home safety checklist, available from the Minnesota Department of Health, for child protection assessments and services provided to children with developmental disabilities. The Home Safety Checklist may identify safety concerns, given a child's age or developmental abilities.
- Encouraging hospitals to develop a crisis response team to assist families after a family member has been brought to the hospital for emergency treatment after a critical incident.
- Ensuring low income parents be made aware of quality and safe child care resources and subsidy programs.
- Employing the Family Group Decision Making process when relatives provide foster care to encourage collaboration among a child's parents, relatives and social service agency.
- Increasing the frequency of licensed family child care home inspections from once every two years to annually.

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.

In 2005, the American Academy of Pediatrics released a policy statement about safe sleep environments for infants, due to the number of unexpected infant deaths. In 2011, the American Academy of Pediatrics 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 American Academy of Pediatrics recommends that infants be placed on their back in a separate but nearby sleeping surface, such as a crib in the parents' bedroom. There should be no soft objects such as crib bumpers, toys, or loose bedding in the crib. Infants should sleep on a firm surface with a comfortable room temperature so they are not overheated. The American Academy of Pediatrics policy statement and its complete recommendations are available at the American Pediatrics website.

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, Sudden Infant Death Syndrome is the leading cause of death among infants ages 1–12 months in the United States. Data from the Centers for Disease Control and Prevention reveal that although the overall rate of Sudden Infant Death Syndrome in the United States has declined by more than 50 percent since 1990, death rates for non-Hispanic, African-American and American Indian/Alaska Native infants remain disproportionately higher than for the rest of the population. Preventing Sudden Infant Death Syndrome remains an important public health priority.

The Child Mortality Review Panel examined 71 cases of unexpected infant death; in many of the cases reviewed, 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 blocked by a soft mattress, sleep surface, or an object in their sleep area such as a blanket, pillow, quilt, bumper pads, toys or accidental compression by a sleeping adult, child or pet. Accidental suffocation or strangulation can also occur when an infant sleeping in an adult bed becomes entrapped in a bed frame, between a wall and mattress, or between broken crib railings.

Table 9: Age of victims of unexpected infant death cases reviewed

Age	2012	2013	Total	Percent
Birth – 3 months	28	20	48	68%
4 – 6 months	11	4	15	21%
7 – 9 months	2	4	6	8%
10 – 11 months	0	2	2	3%
Total	**41**	**30**	**71**	**100%**

Table 10: Race/ethnicity of victims of unexpected infant death for cases reviewed

Race	Number
Caucasian	41
African-American	13
American Indian	9
Asian/Pacific Islander	0
Two or more races	8
Race not reported/unknown	0
Total	**71**
Hispanic ethnicity – any race	7

To help medical examiners and coroners to determine the cause and manner of death, accurate death scene documentation is needed. The Minnesota Department of Health, in partnership with medical examiners, the Bureau of Criminal Apprehension and the Minnesota Department of Human Services, adopted the Centers for Disease Control and Prevention's Sudden Unexpected Infant Death Investigation Form. Implementation of the form is expected Sept. 1, 2014. It is used to assist first responder and medical examiner investigators in documenting the death scene and medical history.

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 stroller, sofa, car seat, or on the floor.

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. The Minnesota Departments of Health and Human Services have partnered to participate in a study of Sudden Unexpected Infant Death funded by the Centers for Disease Control and Prevention. This partnership enables a comprehensive review of all sudden unexpected infant death cases,

rather than only those that met the criteria for review by the Minnesota Department of Human Services. This partnership will improve public health awareness about infant sleep safety and reduce the incidence of deaths attributed to suffocation or strangulation.

Several community organizations have initiated prevention efforts to raise awareness about infant safety in their communities. The Brooklyn Center Police Department's Multi-Cultural Advisor Group invited Kathleen Fernbach, director of the Minnesota Sudden Infant Death Center, to speak about preventing infant death. The presentation was taped for cable television. There were also articles in local newspapers about Brooklyn Center Police Department's efforts to promote safe infant sleep. In May 2014, several Brooklyn Center community organizations worked together to host the first "Celebrate Babies" health fair. Information was presented on safe infant sleep and post-partum depression. Several organizations provided information to parents of infants.

Citizen Review Panels in Washington and Winona counties also promoted infant safety. Members of the Washington County Citizen Review Panel wrote three articles about infant sleep safety that were published in several local newspapers. The Winona County Citizen Review Panel addressed its concern about infant abandonment by raising awareness of the Safe Place for Newborns law that permits a person to anonymously place an unharmed infant less than seven days old in the care of a hospital staff person, or first responder. This message was promoted through ongoing public safety messages on the local cable television station, and placing flyers throughout the community. The messages were distributed in English, Spanish and Hmong.

In 2012, the Minnesota Department of Human Services released "Review of Child Deaths in Minnesota Licensed Family Child Care Homes; January 2002-Augist 2012." Beginning in 2006, infant deaths that occurred in licensed family child care homes began to increase. As a result, a number of recommendations from the report were proposed to the Minnesota Legislature and resulted in amendments to statutes that encourage compliance with licensing regulations that included:

- Increased training on safe infant sleep practices for providers and licensing workers
- Standardized training on cardio-pulmonary resuscitation (CPR), and requiring CPR skills demonstration testing to complete training, and
- Closer monitoring of sleeping infants while in a child care home.

The "Minnesota Department of Human Services Licensing Division Year-end Report 2013" stated:

> "The number of infant deaths in licensed child care settings fell dramatically in 2013 from the prior two years. In 2013, there were three infant deaths in these settings, compared to nine deaths in 2012 and 11 in 2011. The decrease was likely the result of a heightened awareness of family child care safety issues that

resulted from the publication of information on compliance histories of child care providers on the DHS website, media coverage of infant deaths, and the high profile violations of licensing standards played a role in these deaths, and the high profile nature of the Office of Inspector General's "Safe Sleep Initiative" proposed to the 2013 Legislature."

Table 11: Deaths in licensed child care facilities

Year	Deaths in licensed family daycare homes	Deaths in licensed child care centers	Total deaths by year
2012	9	0	**9**
2013	3	0	**3**
TOTAL	12	0	**12**

Recommendations to prevent unexpected infant death

Strengthening individual knowledge and skills by:

- Promoting the American Academy of Pediatrics "Recommendations for a Safe Infant Sleeping Environment"
- Placing infants to sleep on their back, in a crib that meets safety standards of the Consumer Product Safety Commission, on a firm mattress, without loose bedding, pillows, toys or other items in the crib for every sleep
- Discussing safe infant sleep during prenatal and post-partum health care visits.

Promoting community education by:

- Exploring innovative ways to inform parents of the importance of safe infant sleep and the dangers of sharing an adult bed with an infant, such as:
    - Advising parents how to create a safe sleep environment when they are away from home and a crib is not available
    - Including safe infant sleep in high school family life education curriculum and community-level parenting education programs
    - Informing community members at health fairs, county fairs and car seat clinics
    - Showing videos about safe infant sleep in waiting rooms at public health, social services and medical clinics
    - Placing advertisements promoting safe infant sleep in public transportation vehicles and on billboards
    - Placing advertisements for safe infant sleep in baby changing stations in hospitals, government buildings, and other buildings frequented by families with infants

- Posting safe infant sleep promotions on You-tube, Facebook and other social media sites
- Encouraging local radio and television programs to include safe infant sleep in broadcast programming
- Placing brochures on safe infant sleep in laundromats, grocery stores, food banks, libraries, places of worship, unemployment offices, community corrections, medical and dental offices.

Educating providers by:

- Ensuring that all licensed child care and foster care providers are informed of and comply with the American Academy of Pediatrics' recommendations for safe infant sleep. The recommendations are published on the American Pediatric website.
- Including safe infant sleep information in the Minnesota Child Welfare Training System curriculum.
- Training law enforcement, fire fighters and social service workers about safe infant sleep, and encouraging them to offer brochures or information about the importance of infant sleep safety. Raise awareness of resources for families that cannot afford to purchase a crib.
- Training staff at chemical dependency treatment programs to advise pregnant women or parents in the program about safe infant sleep.
- Training staff at homeless shelters for families so that they provide a crib for infants and teach parents about the importance of using the crib for every sleep.
- Informing judges and administrative hearing examiners to better understand the licensing standards for safe infant sleep.

Changing organizational practices by:

- Reviewing Minnesota Department of Health death certificate data to identify the birth hospital of infants that died while in an unsafe sleep environment or unsafe position. On a quarterly basis, the Minnesota Department of Health could send aggregate data to hospitals to advise them of the number of babies that were born in their hospital that died while in an unsafe sleep environment. Encourage the hospital to include safe sleep discussions and practice in their hospitals to reduce deaths.
- Equipping all law enforcement and first responder vehicles with infant size resuscitation masks.
- Documenting a death scene by using the Center for Disease Control and Prevention's "Sudden Unexpected Infant Death Investigation Reporting Form" as part of law enforcement investigations of infant deaths.
- Providing training for law enforcement officers on techniques to conduct death scene re-enactment using a doll.

- Reporting to child protection when law enforcement is called to a child care or foster care home where there was an unexpected infant death.
- Increasing the frequency of family child care licensing inspection visits to at least annually.
- 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.
- Practicing safe infant sleep in the hospital newborn nursery.
- Discussing safe infant sleep during well-baby medical visits.
- Discussing safe infant sleep during Women, Infants and Children (WIC) clinic visits.

Suicide/self-inflicted harm

According to death certificate data provided by the Minnesota Department of Health, 57 youth committed suicide during 2012 – 2013. Sixty percent of adolescent suicides in Minnesota occurred in rural areas where there is often limited access to mental health treatment.

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.

The Minnesota Child Mortality Review Panel examined two suicide cases that involved significant mental health issues and history of mental health treatment. Prompt intervention was viewed as crucial for youth experiencing stress, depression or suicidal thoughts. Due to the small number of suicide cases reviewed, demographic information is not included in this report.

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.

The Minnesota Department of Human Services', Children's Mental Health Division, guides numerous strategic initiatives to successfully meet and treat the needs of children and youth struggling with or at risk for mental health issues. Mental health services need to provide an integrated continuum of services ranging from prevention to recovery. Efforts have been made to improve availability of mental health treatment for children and youth in rural areas. The following three initiatives were implemented by the Children's Mental Health Division in 2013:

- Developed strategies for hospital discharge and transition of youth to the next level of treatment in the community. A full report of its recommendations is available at: http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs16_183007.pdf
- Entered into a two-year contract with the Mayo Clinic to develop and provide statewide collaborative psychiatric consultation services for use by medical providers, psychiatrists and other practitioners. The consultation service will improve mental health services available for children and youth in rural areas.
- Provided training for mental health providers on administering and interpreting the "Child and Adolescent Service Intensity Instrument" (CASII) and the "Strengths and Difficulties Questionnaire" (SDQ). These instruments are outcome measures to be used with all children ages 6 – 21 who receive mental health services through Minnesota health care programs and Children's Mental Health Infrastructure Grants.

Recommendations to prevent suicide

Strengthening individual knowledge and skills by:

- Providing information to parents of children diagnosed with a mental health condition regarding behavioral indicators that suggest additional treatment is needed; the importance of a safety plan among the child, parents and mental health provider; and raising awareness of medication benefits, as well as potential side effects.

Educating providers by:

- Developing a crisis plan with youth, their family and friends to identify behaviors that require prompt communication and action to provide for the safety of the youth or others.
- Encouraging community professionals to obtain training on post-partum depression and other mental health issues often experienced by young parents served through the social services and public health systems.

Changing organizational practices by:

- Encouraging communication among professionals providing community services with professionals providing in-patient psychiatric care when a shared client is hospitalized due to risk of suicide.

- Improving communication among juvenile probation officers and children's mental health case managers to ensure that youth on probation who exhibit mental health issues are referred for children's mental health case management services.

Fatal and near fatal injury due to maltreatment

During 2012 – 2013, the Minnesota Child Mortality Review Panel examined 12 fatal and 20 near fatal cases involving inflicted injuries due to abuse or neglect. Eighty-four percent of the children that died or suffered near fatal injuries were under age 3. Of the fatal maltreatment cases, 25 percent of the households received child protection services prior to the death. All of the cases were closed at the time of the deaths. Of the near fatal inflicted injury cases, 45 percent had prior child protection involvement.

Table 12: Age of victims of fatal and near fatal inflicted injury cases

	2012		2013	
Age of Child	**Fatal**	**Near fatal**	**Fatal**	**Near Fatal**
Birth – 3 months	0	0	2	9
4 – 6 months	0	1	4	1
7 – 9 months	0	0	0	3
10 – 11 months	1	1	0	1
1 – 2 years	1	0	2	0
3 – 4 years	0	0	0	2
5 – 10 years	1	1	0	1
11 – 17 years	1	0	0	0
Total	**4**	**3**	**8**	**17**

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 parent, household member or friend responsible for care of the children. Fifty-seven percent of fatal and near fatal inflicted injuries were due to abusive head trauma caused by forceful shaking or blunt force trauma to a child's head. Three percent of infants with severe inflicted injuries also had 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
- Failure to protect a child from a person known to be violent.

Table 13: Fatal and near fatal inflicted injury cases known to child protection system prior to injury

2012		2013	
Fatal	**Near Fatal**	**Fatal**	**Near Fatal**
3	2	2	6

Table 14: Race/ethnicity of victims of homicide/near fatal inflicted injury cases

Race of child	**2012**		**2013**	
	Fatal	**Near fatal**	**Fatal**	**Near fatal**
Caucasian	2	3	7	16
African-American	1	0	1	0
American Indian	1	0	0	0
Asian/Pacific Islander	0	0	0	0
Two or more races	0	0	0	1
Race unknown	0	0	0	0
TOTAL	**4**	**3**	**8**	**17**
Hispanic ethnicity – any race	1	0	2	4

Relationship of offenders to child victims

Seventy-two percent of inflicted injury cases reviewed identified a male as the offender. Male offenders were often responsible for the child's care while the mother was working or away from the home, although some did not reside in the child's household. Forty-one percent of offenders were the biological father of the victim. Mothers inflicted fatal or near fatal harm in 16 percent of cases reviewed. Often, the mother's actions causing fatal or near fatal harm by failing to provide a child with basic needs or failed to protect a child from a violent person in the home.

Table 15: Relationship of offender to victims of inflicted injuries

Relationship of offender	2012		2013	
	Fatal	**Near fatal**	**Fatal**	**Near fatal**
Mother	0	1	0	4
Father	1	1	5	6
Mother's male partner	1	0	3	4
Friend or neighbor	2	0	0	0
Unlicensed child care provider	0	1	0	0
Licensed child care provider	0	0	0	1
Unknown	0	0	0	2
Total	**4**	**3**	**8**	**17**

The cases reviewed involved offenders who were most often in their mid-20s to mid-30s. Adolescent parents are often offered social services or public health services, and many have significant family support. Six percent of the inflicted injury cases involved a fatal injury inflicted by a parent or caregiver under age 20. Thirty-one percent of the fatal injury cases reviewed involved an offender between the ages of 20 to 49. Sixty-three percent of the cases reviewed involved a near fatal injury inflicted by a parent or caregiver between the ages of 20 to 49. There are a variety of services available for adolescent parents, but parents in their 20s and 30s seem to have fewer resources available to guide them to learn to care for an infant or toddler. Community-based parenting education programs need to offer programming to meet the needs of all parents. Some parents that may need the most help may require more outreach or recruitment efforts. Programs need to be offered at different times to accommodate parents who work evenings, or that would interest fathers or male partners who are primary caregivers while the mother works.

Table 16: Age of offender in fatal and near fatal inflicted injury cases

Age of offender	Number				Total	
	2012		2013		2012 and 2013	
	Fatal	Near fatal	Fatal	Near fatal	Fatal	Near fatal
17 – 19 years	1	0	1	0	2	0
20 – 29 years	0	1	4	9	4	10
30 – 39 years	3	2	3	5	6	7
40 – 49 years	0	0	0	1	0	1
Unknown	0	0	0	2	0	2
TOTAL	**4**	**3**	**8**	**17**	**12**	**20**

Factors noted in fatal and near fatal inflicted injury cases

The Minnesota Child Mortality Review Panel identified common factors noted in the 12 child fatal and 20 near fatal inflicted injury cases reviewed. Employment data is collected on adults residing in a child's household. Data collected on cases reviewed revealed that 12 percent of offenders that inflicted fatal harm and 22 percent of offenders that inflicted near fatal injuries were unemployed. Nineteen percent of offenders that inflicted fatal harm were employed. Twenty-five percent of offenders that inflicted near fatal harm were employed. Eighteen percent of offenders' employment status was unknown. The circumstances preceding a fatal or near fatal injury often involved a working mother who left a child in the care of the child's father or other male household member because he was unemployed or worked a different shift than the mother. Social service 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 fatal and near fatal inflicted injury cases included offenders of near fatal harm had histories of untreated mental illness; drug or alcohol abuse; prior criminal convictions as a juvenile or adult; previously maltreated a child in the offender's current home or in another household; or perpetrated domestic abuse.

Table 17: Offender history in fatal and near fatal inflicted injury cases

Factors	Percent of inflicted injury cases	
	2012 & 2013 Fatal	2012 & 2013 Near fatal
Offender had history of alcohol or drug abuse	22%	16%
Offender had diagnosis of mental illness	16%	22%
Offender unemployed	12%	22%
Offender employed	19%	25%
Offender had history of criminal conviction	16%	12%
Offender had history of perpetrating child maltreatment	3%	25%
Offender had history of perpetrating domestic abuse	12%	12%

Criminal prosecution

Inflicted fatal and near fatal injury cases have similar offender characteristics, relationship between offender and victim, and age of the victim. There is a slight difference in the degree of force and severity of an injury that results in a child's ability to survive abusive injuries. Fatal and near fatal inflicted 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 prosecutors did not have enough evidence to file criminal charges. 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. Of the fatal inflicted injury cases reviewed, 83 percent resulted in an offender convicted of criminal charges for having caused a child's death. In 17 percent of fatal inflicted injury cases, an offender was acquitted of charges that they caused the child's death.

Of the near fatal inflicted injury cases reviewed, 55 percent of the cases resulted in an offender convicted of causing critical injuries to a child. In 45 percent of the near fatal inflicted injury cases reviewed, no criminal charges were filed.

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 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. [Minn. Stat., section 245A.1444]

Recommendations to prevent severe child maltreatment

Strengthening individual knowledge and skills by:

- Encouraging parenting support and guidance for fathers and acting-fathers, particularly for those who are the primary caregiver of an infant or young child while the mother is at work.
- Providing basic parenting education, including prevention of child abuse and domestic abuse, to adolescents receiving children's mental health case management.
- Assessing a parent's support system when conducting a child protection assessment or investigation. If the parent or caregiver does not have family or friends to assist in stressful times, offer guidance to help them establish a support system.
- Referring parents of newborns to the Parent Support Outreach Program (PSOP) when a parent has a significant mental health history, chemical abuse, the court removed older children due to maltreatment, or lost a child from fatal maltreatment.
- Encouraging public health nurses to discuss family planning when they are involved with a family whose parental rights were terminated following child maltreatment. If a couple plans to have more children, the nurse could offer public health nursing services to help them learn to care for a baby and be successful as parents.

Promoting community education by:

- Identifying resources available for fathers and acting-fathers through Early Childhood Family Education, and other community parenting education programs. If no programs are available aimed at fathers or acting fathers who are primary caregivers, encourage community organizations to develop programs that young men will find informative and supportive of their family circumstances.

- Developing community-based supportive services for parents demonstrating poor ability to manage stress or anger, do not have family support, or have unstable relationships that impact a child's care.

Educating providers by:

- Raising awareness among child protection workers, public health, in-home visitors and the general public about the importance of careful selection of a caregiver when a parent is away from home. Factors that may increase risk of harm to a child include:
    - Past or present violent behavior.
    - Alcohol and/or drug abuse.
    - Mental illness.
    - Lack of knowledge of child development or lack of experience in caring for infants and young children.
    - No previous employment or history of poor job retention.
- Providing training to law enforcement officers who may be the first to arrive at the scene of a child death, or called to the hospital following a near fatal inflicted injury regarding securing and documenting a death scene or crime scene.
- Providing training to child protection workers on the importance of arranging for a medical examination of siblings of a child that suffered a critical abusive injury.
- Providing training to hospital emergency department staff on the mandate to report suspected child abuse or neglect.
- Providing periodic training to financial assistance workers on the mandate to report to child protection suspected child maltreatment and services provided to families to reduce risk of maltreatment.
- Supporting the medical profession in increasing training for pediatric and family practice residents on recognizing and treating injuries or conditions resulting from child maltreatment.
- Improving training for medical providers, child protection workers, law enforcement officers and prosecutors, to help explain the physiology and mechanism of injury that occurs when a rotational force injury (such as shaking) is inflicted on an infant or toddler.
- Including mental illness risk assessment as a standard of care for primary care physicians who prescribe medication to treat a mental health condition.

Fostering coalitions and networks by:

- Including parenting support and coaching for fathers and acting fathers participating in a county or tribal Work Force program as part of their employment preparation requirements and a child maltreatment prevention program
- Encouraging community agencies to use creative approaches to identify high-risk families during a pregnancy, and engage a couple to participate in public health or community services to prepare to care for their infant

- Exploring whether the Bureau of Criminal Apprehension's five-day training for law enforcement officers and child protection workers on investigating child maltreatment can be offered again

Changing organizational practices by:

- Encouraging social workers from child protection, adult mental health and developmental disabilities services to work as a team on cases involving a parent diagnosed with a developmental disability or serious and persistent mental illness. Collaborating on assessments or investigations will combine the expertise of the professionals to conduct a more thorough assessment of the parents' ability to care for their children and to refer them to the most appropriate services.
- Developing a process for the Minnesota Department of Human Services to share recommendations from the state review panel meetings with the local review teams.
- Engaging high risk parents in public health nursing services during the prenatal period when they are eager to learn, rather than in the hospital when they may be overwhelmed from a birth. This approach will begin a supportive relationship, prepare parents to provide safe baby care, and teach about child development before and after the baby is born. Parents with mental illness, chemical dependency, and history of violent behavior, as well as parents of an infant with health or developmental issues, and multiple births, should be offered public health nursing services and be referred for additional community services, as needed.
- Encouraging home visiting nurses to follow-up with new parents when the baby is about a month old, if the parents initially decline home visits.
- Expanding training provided by hospitals to new parents on preventing Shaken Baby Syndrome beyond showing a video, including a discussion about coping with stressors, managing sleep deprivation, teaching techniques to calm a crying baby, and building a support system.
- Increasing licensing inspections of family child care homes by local child care licensing staff, to be conducted annually.
- Increasing child care options that are affordable and flexible for low-income families.
- Providing culturally appropriate services aimed at supporting families and providing safety for children.

Influencing policy and legislation by:

- Supporting universal public health home visits for all first-time parents and those identified as needing additional supports.

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, such as

chemical abuse, untreated mental illness, criminal behavior and violent behavior. 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 local reviews. 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 nonprofit 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 Leadership for Child Safety and Permanency**

  Parent Leadership for Child Safety and Permanency is a partnership among the Children's Trust Fund, Child Safety and Permanency Division, Minnesota Department of Human Services, and Prevent Child Abuse Minnesota. Evidence-based practice demonstrates families are best served when government and parents work together to promote healthy families and communities. The Children's Trust Fund and Prevent Child Abuse Minnesota began collaboration in spring 2008 to promote and support the parent voice in the child welfare system through policy, program and practice enhancement. Currently, a team of 20 parent leader consultants who serve a minimum term of three years assist the department in:

  - Achieving goals of connecting parents to policy and practice initiatives
  - Developing and promoting strategies for child maltreatment prevention, and public awareness about child safety
  - Promoting the protective factors that help keep parents and their families strong
  - Addressing systemic and programmatic issues around race/ethnicity and culture.

- **Parent Support Outreach Program**

  The Parent Support Outreach Program is an early intervention child and family welfare program developed to offer outreach and supportive services to families with at least one child under age 10, who are "screened-out" from the child protection system or are otherwise at risk. Parents can request help when they find themselves in tough situations. Community agencies and others who work with children can also request

help for a family. The program works to help children and their families, and to prevent child maltreatment.

- **Statewide Child Protection Screening Criteria**

  The Minnesota Department of Human Services' Child Maltreatment Screening Guidelines promote statewide uniformity in definition and practice for reporting maltreatment of children. Child maltreatment screening statutes and guidelines are currently under review by Governor Mark Dayton's Task Force on the Protection of Children. Final recommendations for improvement were due to the governor and the legislature in March 2015.

- **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. Task force members are committed to ensuring that maltreated children are not victimized again by the systems designed to protect them. Meeting quarterly, the task force reviews and assesses how Minnesota's child protection and criminal justice systems handle child protection cases, and makes 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, Washington and Winona 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

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

Joanne Boogaard, M.P.H.
Planning, Policy and Quality Assurance
Hennepin County Public Health / Human Services

Rick E. Carlson, M.A., C.P.H.
Epidemiologist
Minnesota Department of Health

Mary Jo Chippendale, M.S., P.H.N.
Family and Women's Health Supervisor
Minnesota Department of Health

Ruth Clinard
Child Mortality Review Consultant
Minnesota Department of Human Services

Brian Coyle
Senior Commander
St. Paul Police Department

Marvin Davis
Northstar Care for Children Manager
Minnesota Department of Human Services

Kathy Eilers, J.D.
Assistant County Attorney
Ramsey County Attorney's Office

Kathleen Fernbach, P.H.N.
Minnesota Sudden Infant Death Center
Children's Hospitals and Clinics of Minnesota

Matthew Frank, J.D.
Manager, Public Protection/Criminal Appeals
Minnesota Attorney General's Office

Victor Froloff, M.D.
Forensic Pathologist
Ramsey Co. Medical Examiner's Office

Stephanie Graves
Maternal Child Health Coordinator
Minneapolis Department of Health

Mark Hudson, M.D., F.A.A.P.
Pediatrician
Children's Hospitals and Clinics of MN

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

Amy Lembcke, M.S.W.
Social Service Information System Policy Specialist
Minnesota Information Technology Agency

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

Scott Mueller
Senior Special Agent
Minnesota Bureau of Criminal Apprehension

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

Karen Pitts
Child Development Services Supervisor
Minnesota Department of Human Services

Janet Reiter, J.D.
County Attorney
Chisago County

Jamie Sorensen
Child Safety and Permanency Division, Director
Minnesota Department of Human Services

Janet Spatafore, P.H.N., M.S.N.
Public Health Nurse
Wright County Health Department

Erin Sullivan Sutton, J.D.
Children and Family Services Administration
Minnesota Department of Human Services

Esther Wattenberg, M.A.
Center for Urban and Regional Affairs
University of Minnesota

Jo Zillhardt, R.N.-B.C., P.H.N.
Office of Ombudsman for Persons with
Developmental Disabilities and Mental Illness