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PROGRESS REPORT  
OF  
MINNESOTA CHILD MORTALITY REVIEW PANEL

MINNESOTA DEPARTMENT OF HUMAN SERVICES

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MAY 1988

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OF  
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(APRIL 1987 THROUGH FEBRUARY 1988)**

**Introduction**

The child protection system faces numerous and complex challenges. Criticism is leveled at child protective services both from persons who state that it is overly intrusive into family life and from those who believe child protection is too timid in its approach to protecting children.

These challenges to the child protection system command greater public attention whenever a child dies as a result of abuse or neglect. National data on child deaths attributed to maltreatment are limited, but samples provide a projection of 1132 reported child abuse fatalities nationally in 1987. Further projections indicate that these fatalities increased 33% between 1985 and 1986 and declined 4% between 1986 and 1987.\* Of the available data in Minnesota, reports of deaths due to maltreatment were 9 in 1982, 5 in 1983, 11 in 1984, 6 in 1985, 10 in 1986, and 5 in 1987.

The occurrence of these child deaths due to maltreatment is alarming in and of itself. An even greater cause for alarm exists, however, at the discovery that in some cases the child is from a family that has received services from a child protection agency or another community agency. These conditions have created greater pressure to identify the weaknesses and strengths in the child protection system in an effort to improve its effectiveness.

Nationally, there has been increased attention directed to child abuse and neglect fatalities. In 1987 the National Committee for Prevention of Child Abuse hosted a national symposium and prepared a publication on these child fatalities. A bill recently passed by the United States Senate (S.1663) calls for the establishment of a national commission to study "the causes and remedies to" deaths associated with child maltreatment.

Thirty-two states have responded to child abuse and neglect fatalities by creating a system for the review of child deaths.\*

Minnesota's review system is unique in that it does not focus solely on deaths attributed to maltreatment and the investigation of the maltreatment report. Rather it applies broader criteria to focus on how public social services function to protect vulnerable children. The purpose of the review is to identify problems and make recommendations for improvements in statute, policy, interdisciplinary relationships and practice.

\* The National Committee for Prevention of Child Abuse, Child Abuse Fatalities Remain High: The Results of the 1987 Annual Fifty State Survey

## Child Mortality Review

In March 1987, Sandra Gardebring, Commissioner of the State Department of Human Services, established Minnesota's Child Mortality Review Panel. The panel reviews cases in which a child died who was a recipient of social services from a public social services agency. Commissioner Gardebring appointed the review panel which is comprised of representatives of various professions including medical, health, legal, and human services. Each member of the review panel has some professional responsibility for providing services to families where a child has been abused or neglected. (Appendix I - Panel Members) The information and recommendations included in this report are derived from the work of the review panel.

### Review Criteria

The criteria established to determine which cases will be reviewed by the Child Mortality Review Panel takes into account both the status of the case and the manner of death. The status of cases reviewed includes not only active social service cases but cases open for assessment and cases closed within a year preceding the child's death. The manner of death includes those cases where the death was attributed to homicide, suicide, accident, or Sudden Infant Death Syndrome (SIDS). Deaths attributed to natural causes that result in a maltreatment report were also reviewed.

### Review Process

Cases are reviewed at two levels. First, the case is reviewed at the local level by the county social service agency and any other professionals who have been involved with the case. The case is then reviewed by the State Child Mortality Review Panel.

The county agency's case record is sent to the State as soon as a State review is scheduled. An analysis of the case record and the report of the local review is made available to the State review panel in advance of the State review. Representatives from the local agency attend the State review and are available to clarify any ambiguities which may exist in the reports before the panel.

County participation has been excellent. This participation is noteworthy considering the review process requires that case records be opened for critical examination by representatives of other professions.

Counties have approached the review as an opportunity for both the State and the county to learn to more effectively protect vulnerable children. The counties are to be commended for their contribution to the success of the reviews.

### The Child Deaths

From the inception of the mortality review system in March 1987 through January 7, 1988, 493 death certificates were received from the Minnesota Department of Health. The counties identified 77 of the 493 deaths as either current or former recipients of public social services or the subject of the assessment of a maltreatment report.

Thirty-three of the 77 deaths met the manner of death criteria for review, i.e., the death was attributed to homicide, accident, diagnosed as Sudden Infant Death Syndrome (SIDS) or the death was attributed to natural causes but it resulted in a maltreatment report. (Table I)

Nineteen cases have been reviewed by the panel to date. (Table II) The cause of death in eight of the cases reviewed was attributed to an accident, one was determined to be suicide, and one was attributed to homicide. Death in nine of the cases reviewed was attributed to natural causes including five SIDS deaths.

Of the total of nineteen deaths reviewed, one occurred in a licensed day care facility. Eleven of the children whose deaths were reviewed were one year old or younger.

### Findings And Recommendations

The findings and recommendations identify specific problems and issues that surfaced during a detailed examination of these 19 cases. The findings are expressed in general terms due to data privacy constraints and because the findings represent a consensus of the panel.

The child protection system is multi-disciplinary. Various professionals are legally charged with some responsibility for protecting children. (For example, in addition to social services there are the judicial system, law enforcement and the many professions mandated to report child maltreatment.) Although the primary focus of the review process is on the social services component, findings were also made that address the other components of the child protection system.

There were situations in which the child protection system did not function as it was intended. The panel could not determine with any degree of certainty, however, that a death would have been prevented if a report had been made earlier, or an assessment initiated sooner, or if a court would have given an agency more authority to intervene had a petition been filed.

#### **IDENTIFICATION AND REPORTING OF MALTREATMENT**

- I. FINDING: In some instances the safety of a child may be better assured by an earlier report which identifies the risks to the child instead of waiting until the child has been harmed.

Recommendations:

- a. Participate with the appropriate academies of the Minnesota Medical Association in developing criteria for assessing a parent's capacity to provide the care needed by a medically "at risk" child.
- b. Provide training to mandated reporters to help them recognize that they are required to report when parents fail to take appropriate action to provide essential care for a child who has been identified as medically at risk.
- c. Establish a statewide task force involving medical and social service personnel to study babies born addicted to drugs (including those addicted to alcohol) and make recommendations as to appropriate intervention by Child Protection Services (CPS).
- d. Seek an amendment to the child maltreatment reporting law to expand the definition of reportable neglect by cross referencing the definition of neglect in the Juvenile Code (Minnesota Statutes, section 260.015, subd. 10.)

II. FINDING: The conditions resulting in a child's death are often directly created by or are under the control of the parent and yet the death is not identified as maltreatment. It is important that a full assessment of accidental deaths be conducted in order to determine whether the circumstances surrounding the accident present a risk to surviving children.

Recommendations:

- a. Provide training designed to sensitize fire investigators and law enforcement officers to the possibility that negligence may have been a contributing factor in an accidental death.
- b. Seek legislation establishing "child endangerment" as a crime in Minnesota's criminal statutes.
- c. Recommend the Department of Health review the cause of death on death certificates to determine whether the information is internally consistent, in agreement with the current state of medical knowledge, and fully accounts for the conditions resulting in the death.
- d. Train first responders (e.g. paramedics, law enforcement) to better observe the death scene in order to improve identification of SIDS deaths, accidental deaths, and deaths from maltreatment.
- e. Obtain complete reports of law enforcement investigations pertaining to accidental deaths of children known to public social services.

## ASSESSMENT PROCESS

III. FINDING: Changes in medical technology that keep more newborns alive mean that children leaving the hospital require greater and more sophisticated care at home and place greater care demands on parents. This complicates the Child Protective Services (CPS) assessment of a parent's capacity to provide proper care.

### Recommendations:

- a. Address the parents' capacity to meet the extraordinary needs of the child. Readily available expert medical consultation is needed for the CPS worker to assist with these assessments.
- b. Develop risk assessment guides that stress the importance of obtaining information regarding the parents' utilization of prenatal care.
- c. Develop standard procedures for working with chronically ill children and define a specialized child protection function for premature infants.
- d. Provide child development training to CPS workers to better prepare them to identify "failure to thrive" and other developmental issues related to the failure of parents to provide proper care.
- e. Define "adequate medical care" so that CPS assessments will have a standard against which to determine the adequacy of care.
- f. Provide training to CPS workers that prepares them to work with children with health problems. The training needs to address the special problems posed by these children and their families so that the worker will more quickly recognize risks to which the child might be exposed, and better recognize the demands placed on the parents because of the child's health care problems.

IV. FINDING: There were instances when a closer working relationship and prompt sharing of information among those working with the family would have resulted in a more effective response to children at risk. This is particularly critical between the child protection worker and the public health nurse in order to accurately assess and treat neglect.

### Recommendations:

- a. Require local agencies to establish standard procedures for intra-agency sharing of information so that the assessment will include risks known to non-CPS programs in the agency.

- b. Establish standard procedures for communication between the CPS agency and the local public health authority so that the assessment will include information from the nurse.
- c. Provide training to CPS workers on effective use of outside consultants and how to use interdisciplinary staffing of cases to maximize resources available for protecting children at risk.
- d. Provide dual training for public health nurses and child protection workers that identifies their respective roles with particular emphasis on the role each plays in cases of chronic neglect.
- e. Develop practice guide material which encourages the use of a police officer as a resource when CPS or Public Health Nursing is unable to gain access to a residence.
- f. Clarify Child Protective Services' access to information gathered by law enforcement in a criminal or juvenile investigation when such information may be important in assessing the need to intervene for the protection of children.

V. FINDING: In neglect cases, it is important that the agency and the court consider not just the facts in the immediate report or event, but also consider the pattern of parental care when determining whether intervention is necessary for the protection of children. However, neglect assessments are very time consuming and inadequate resources lead to a too narrow focus on the immediate report.

Recommendations:

- a. Develop a CPS risk assessment guide to aid in documenting those factors that suggest the need for stronger intervention.
- b. Develop standard procedures for neglect assessments which will improve earlier identification of a pattern of neglect. This should include such considerations as whether the children have a physician and when they were last seen by their physician, whether or not the children have been immunized, and whether or not mother received prenatal care. These procedures should emphasize the usual stages of child development.
- c. Provide training to CPS workers to improve the effectiveness of neglect assessments. The training should stress the value of obtaining information about the prenatal care the mother received and the importance of determining whether or not a child has a doctor.

- d. Establish assessment procedures which include a series of alternatives to be used when CPS is unable to make contact with a family or if the whereabouts of the family is unknown.

VI. FINDING: The volume of reports received by child protection contributes to a delay in the initial response to reports and a less thorough assessment in some cases.

#### **SERVICE PLANS AND SERVICE DELIVERY**

VII. FINDING: A higher priority needs to be given to work with families in which the maltreatment is in the form of neglect. More attention should be directed at the correlation between a parent's indifferent supervision and the death of a child, considering that 14 of the 19 deaths were from families where conditions of neglect were the reason for intervention.

#### Recommendations:

- a. Require notification of the local public health authority of all reports of child neglect to assure a fuller use of public health professionals to serve families experiencing neglect.
- b. For active CPS cases, develop practice guides and provide training that stresses the importance of evaluating the impact of the birth of another child on the parents' capacity to provide an acceptable level of care to their children.
- c. Develop a policy that CPS should not close a case when the decision to close is based on parental willingness to follow through with a particular action until the parent has demonstrated that the action is being taken.

VIII. FINDING: Deficiencies with case plans include: 1) absence of specificity as to expectations of the client and the goals to be achieved; 2) no assessment as to whether or not the services provided were accomplishing their intended purpose; and 3) the level of services provided did not seem to correspond to the severity of the problem described in the case record.

#### Recommendations:

- a. Amend Department of Human Services (DHS) rules to establish standards for service plans. Service plans should convey a clear expectation for correction of neglectful and abusive conditions, require measurable behavioral changes, and establish a reasonable time limit for accomplishing goals.



- More emphasis is needed in the case planning and case management process to hold parents accountable for correcting the conditions that necessitated the intervention of CPS.
  - The progress and usefulness of the services provided should be assessed prior to a reauthorization of services to determine whether or not the services provided result in a safer home for the child.
  - In situations where child protection is closing its case and relying on the continued activity of other professionals as a condition for terminating services, child protection should formally obtain the other professional's acceptance of the referral prior to closing and make clear the agency's interest in receiving reports of new incidents.
- b. Require the use of multi-disciplinary treatment teams, including the mandated reporter making the report, for "high risk children." Establish procedures for the team to communicate each member's expectations and experiences with the family and to coordinate activities to insure proper management of the risk.
  - c. Encourage better coordination between CPS and chemical dependency (CD) counselors and encourage the participation of CD counselors on multi-disciplinary teams.
  - d. Provide training to CPS in case management where there are multiple service providers so that children are not left vulnerable because services called for in the plan were not provided or were poorly coordinated.
  - e. Develop practice guidelines that encourage local agencies to seek stipulations in custody orders that allow the agency and foster parents to cancel parental visits when the child is ill and a visit could aggravate the illness.

IX. FINDING: Some practices were identified in the reviews that illustrate the general need for the provision of additional training to CPS workers and supervisors in order to improve service delivery.

Recommendations:

- a. Provide training to CPS supervisors to prepare them to meet their responsibilities as trainer, case consultant and manager.
- b. Provide training that sensitizes CPS workers to the importance of assessing the impact of the added stress on a family following the death of a child. The training should include grief counseling.

- c. Provide statewide training to licensing workers as well as other direct service workers in dealing with clients' serious injuries and/or death.

**INTERVENTION: CPS AUTHORITY AND COURT JURISDICTION**

- X. FINDING: The current system for classifying child maltreatment reports focuses on record retention and provides little direction as to practice or the need for protection services.

Recommendation:

Seek an amendment to Minnesota Statutes setting out the determinations made in the assessment in terms which make clear both the responsibility and the authority for protective intervention.

- XI. FINDING: There is a need to expand court jurisdiction and strengthen the court's intervention to protect vulnerable children.

Recommendations:

- a. Seek legislation which defines "lack of supervision" in the Juvenile Code.
  - b. Seek legislation which amends the Juvenile Code to allow the court to consider prior occurrences of maltreatment when hearing a petition on a child currently before the court.
  - c. Clarify and coordinate the responsibilities of Juvenile and Family Courts when both courts are involved in the same case through amendments to court rules. Designate the guardian ad litem as the vehicle for insuring coordination between the two courts.
- XII. FINDING: There were cases in which the apparent risk to the children appeared to warrant a juvenile court petition but a petition was not brought either because a county attorney was reluctant to file or the agency did not attempt to file out of a belief their request for a petition would not be accepted.

The reluctance of some county attorneys to fully consider evidence of neglect that occurred in another jurisdiction was also identified as a problem in securing the intervention of the juvenile court.

## PREVENTION

XIII. FINDING: The entire system "comes to a halt" when a death is attributed to an accident, yet it appears not all accidents are equally "accidental." Many accidents which occur to children living with chronic neglect and lack of supervision appear to be "accidents waiting to happen." Some form of harm would seem likely even though the specific accident could not be predicted.

### Recommendations:

- a. Develop a paradigm for establishing the "preventability" of deaths so that accidents in which neglect or indifferent supervision was a factor can be differentiated from those accidents that might be considered "an act of God."
- b. Review research to determine characteristics of "fire deaths" families.

XIV. FINDING: More attention and resources need to be focused on infants who are identified as "at risk."

### Recommendation:

Support the efforts of the Department of Health to change the release of information requirements on birth certificates to allow a freer sharing of information on infants at risk with the local public health authority.

XV. FINDING: Licensed day care facilities present specialized needs and considerations in assuring a safe environment for children in day care. The lack of authority to suspend a license during an appeal of a revocation action may be an impediment.

### Recommendations:

- a. Provide periodic training to day care providers to better recognize conditions which may pose a hazard to children in care.
- b. Seek legislation which supports the retention of records on child protection investigations of facilities licensed by DHS irrespective of the determinations made in the investigation.

## RESOURCE DEVELOPMENT

### Recommendations:

- a. Assure that there is a statewide network of regional medical consultants which makes available expert medical consultation to CPS agencies as well as commentary on risk issues.

The creation of the Midwest Children's Resource Center addresses the needs identified in this recommendation. However, there is a need for DHS to publicize the existence of the Center as a resource providing expert medical consultation to CPS agencies.

- b. The Departments of Human Services and Health should develop a joint application for federal discretionary grants made available by the National Center on Child Abuse and Neglect to further study child mortality and make improvements to the CPS system.

## MORTALITY REVIEW PROCESS

### Recommendations:

- a. Seek legislation which makes medical examiner findings available without parental consent for the purpose of child mortality reviews.
- b. Require all professionals who have knowledge of a child mortality case to participate in the local review.
- c. Seek legislation to obtain authority for access to whatever information is needed to complete this review.
- d. Seek specific statutory authority for the conduct of child mortality reviews and for protection of information generated by the review process. The information to be protected will be limited to that information generated by the review and would not include information otherwise subject to discovery.

## APPENDIX I

### MEMBERS OF CHILD MORTALITY REVIEW PANEL

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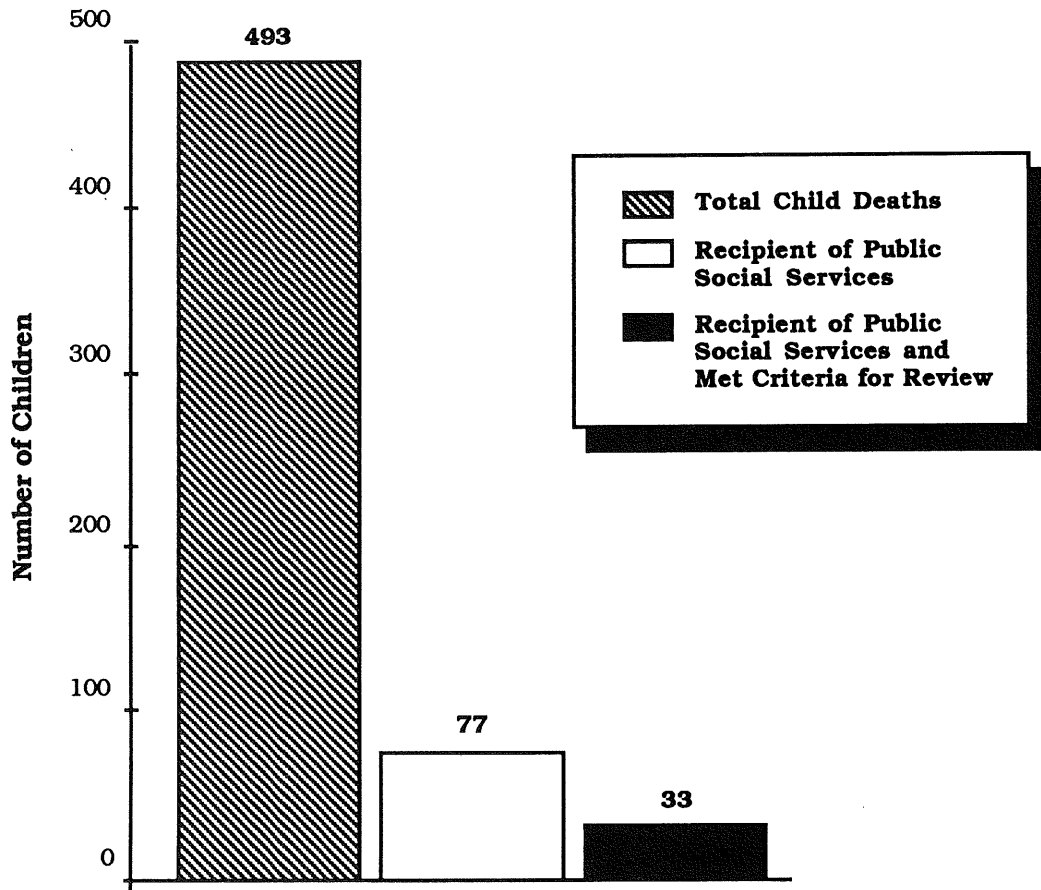
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**Table I**



**Table II**  
**Child Deaths in Cases Reviewed**

	<u>Age</u>	<u>Sex</u>	<u>Manner of Death</u>
1.	17 years 8 months	M	Accident
2.	16 years 11 months	M	Suicide
3.	12 years 8 months	F	Natural
4.	7 years 7 months	M	Accident
5.	7 years 4 months	M	Accident
6.	5 years 8 months	M	Natural
7.	5 years 5 months	F	Accident
8.	2 years 4 months	F	Accident
9.	1 year 8 months	F	Accident
10.	11 months	F	Natural
11.	9 months	M	Accident
12.	8 months	F	Natural - SIDS
13.	5 months	M	Homicide
14.	4 months	M	Accident
15.	2 months	M	Natural
16.	2 months	F	Natural - SIDS
17.	2 months	F	Natural - SIDS
18.	2 months	F	Natural - SIDS
19.	1 month	F	Natural - SIDS