PROGRESS REPORT OF MINNESOTA CHILD MORTALITY REVIEW PANEL

MINNESOTA DEPARTMENT OF HUMAN SERVICES
June 1990

Child Mortality Review

Sandra Gardebring, the commissioner of the State Department of Human Services, established Minnesota's Child Mortality Review Panel in March of 1987. The 1989 Legislature statutorily mandated the child mortality review panel effective June, 1989. The panel reviews deaths of children who were recipients of public social services. It consists of representatives of various professions including medicine, health, law and human services, all appointed by the Commissioner of Human Services or the Commissioner the panel member represents. Each member of the panel represents a profession that has some responsibility for providing services to families in which children have 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 used to determine which cases will be reviewed by the panel takes into account both the status of the case and the manner of death. The panel reviews not only active social service cases but also cases open for assessment and cases closed within a year preceding the child's death. The manner of death in cases chosen for review may be homicide, suicide, accident, or Sudden Infant Death Syndrome (SIDS). Deaths that result in a maltreatment report are also reviewed, whether they are attributed to natural causes or homicide, even if the family was not known to social services prior to the receipt of the report.

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 of the professionals who have been involved with the case. Afterward, the State Child Mortality Review Panel conducts its review.

The county agency's case record is sent to the State as soon as a State review is scheduled. Members of the State panel receive a summary of the case record and the report of the local review prior to meeting to review the case. Representatives from the local agency may attend the State review to clarify possible ambiguities in the reports before the panel. The panel usually meets or review once a month.

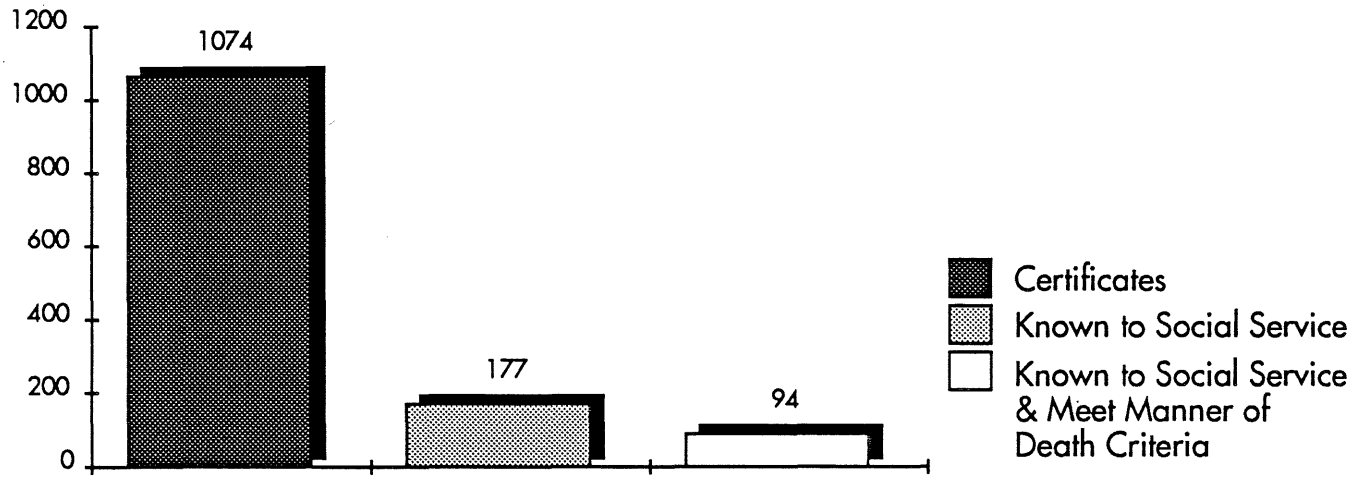
Child Deaths

From the last tabulation of the child mortality review data on January 8, 1988 through May 15, 1989 (one year and four months), 1,076 new child death certificates were received from the Minnesota Department of Health. The counties identified 177 of the 1,076 deaths as either current or former recipients of public social services or the subjects of assessment of a maltreatment report.

Ninety-four of the 177 deaths met the manner of death criteria for review, i.e., the death was attributed to homicide, suicide or accident, diagnosed as Sudden Infant Death Syndrome (SIDS), or attributed to natural causes but resulted in a maltreatment report. (See Graph I)

Graph I

Death Certificates Received Between January 8, 1988 And May 15, 1989



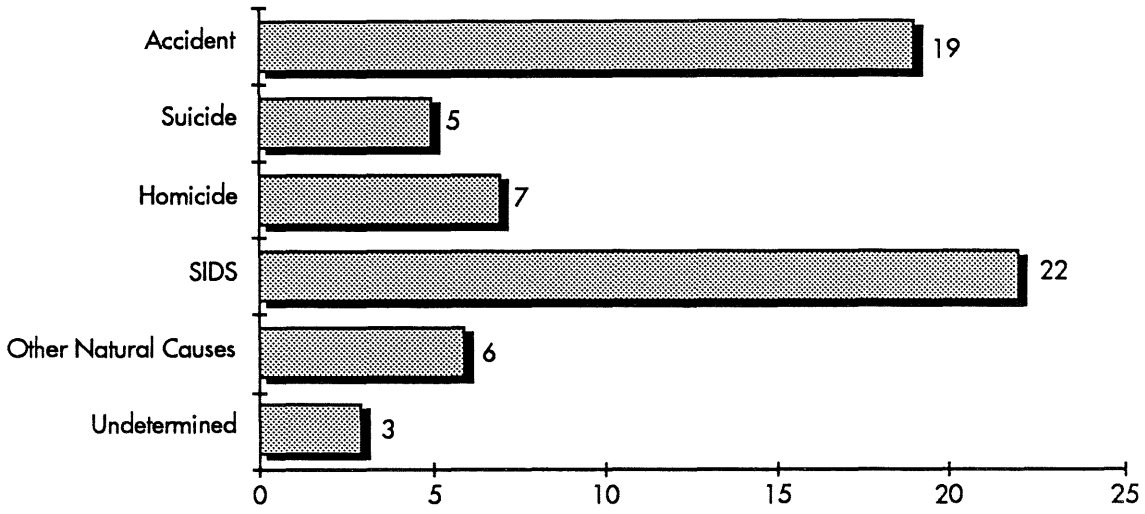
Sixty-two cases have been reviewed by the panel since the previous report.

The deaths were attributed to an accident in nineteen of the cases reviewed. Five deaths were listed as suicide, and seven as homicide. In twenty-two cases, death was attributed to SIDS. Six deaths were attributed to other natural causes, and three deaths identified the cause as "undetermined" or "unknown." (See graph II)

Of the total of sixty-two deaths reviewed, two occurred in a licensed day care facility, three occurred in foster care, two in a residential treatment facility, one in jail and one in an unlicensed daycare home. Thirty-four of the children were one-year old or younger at the time of death.

Graph II

Manner Of Death For Cases Reviewed From March 28, 1988 Through June 26, 1989



Some of the deaths reviewed were screened from a full State review, as a preliminary review determined that the deaths were not related to child protection issues. These were: nine accidental deaths, two suicides, and one homicide. Other deaths were fully reviewed, but resulted in no recommendations. These were two accidental deaths, three deaths diagnosed as SIDs that had autopsies which supported the diagnosis and there were no protection issues identified and one homicide in a family unknown to social services.

Findings and Recommendations

The following findings and recommendations address specific concerns identified during the detailed reviews of sixty-two cases. The findings are stated in general terms due to data privacy constraints. Both the findings and the recommendations were agreed upon by consensus of the panel.

The "local agency" referred to in the recommendations is the social services agency authorized by each county board to provide social services, including child protective services.

IDENTIFICATION AND REPORTING OF MALTREATMENT

I. CHEMICAL DEPENDENCY AND CHILD PROTECTION

Finding: Parental abuse of drugs and/or alcohol often contributes to the vulnerability of children. Greater recognition of this factor and greater communication between chemical dependency (CD) workers and child protection workers might aid in the identification of vulnerable children.

In particular:

- Infants in families involved with cocaine use are at a very high risk requiring more aggressive intervention.

- Children born to a mother who uses cocaine may be at a statistically higher risk of SIDS.

- The narrow focus of a traditional CD evaluation does not include information needed to determine whether or not children in the family are at risk.

- Four of the five suicide cases were known to social services only through CD evaluations and treatment provided to parents (and in one case also to the child).

Recommendations:

A. It should be mandatory for local agencies to open a case upon receipt of a report or referral concerning a baby born to a mother who is using drugs. The case should remain open until either the mother has dealt with her drug use or the child is out of the home.

B. The Department of Human Services (DHS) should seek training for mandated reporters—especially chemical dependency counselors/evaluators—to help them recognize situations which pose a risk to children in the home. The training should prepare them to assess the impact of the substance use on the children and to determine if a report should be made to the local child protection agency.

C. When child protection issues are identified, CD evaluators should consider infor mation beyond the self-reports of the client. In particular, information from the child protection social workers should be included in the CD evaluation.

D. The relationship between child suicide and alcoholism should be studied.

II. SCREENED-OUT REPORTS

Finding: By rule, some reports of child maltreatment are "screened out" by local agencies prior to assessment. In some instances, unfortunately, a report may be "screened out" due to the quality of the report and not the seriousness of the alleged maltreatment.

Recommendations:

A. Since medical professionals are usually reluctant to report maltreatment, it is especially important that local agencies follow up on reports received from them.

B. Physicians should be educated about the kind of referral information the agencies need to initiate a child protection assessment.

C. Agency intake workers should always talk with reporters of maltreatment directly to determine what their suspicions are and why.

D. The reporter should be informed when reports are "screened out" and should also be encouraged to contact the agency with more specific information which clarifies the authority or responsibility of the agency to intervene.

E. Child protective services (CPS) could consider liaison workers to the hospitals, police and schools, to help professionals understand the human services system and what is needed to activate cases.

III. INTERPRETERS

Finding: Language and cultural barriers can limit a family's access to social services and an investigator's access to information later on, as well as a host of other vital communication.

Recommendations:

A. In order to serve immigrant families effectively social service agencies need to employ workers of Southeast Asian backgrounds. If this is not possible, agencies should hire workers with some knowledge of Southeast Asian language and culture.

B. The Department of Human Services should ensure the availability of trained interpreters to families using social services.

ASSESSMENT AND SERVICES: COORDINATION

I. ATTENTION TO CASES OF NEGLECT

Finding: The Review Panel found that neglect or negligence was present in at least twelve of the sixty-two deaths reviewed (or at least twenty percent). It is imperative that cases of neglect receive more attention from both social service agencies and the legal system.

Recommendations:

A. Human service agencies should establish a protocol for child protection team work in neglect cases.

B. More attention should be given to new reports of maltreatment in cases involving chronic neglect. A new report must re-energize the agency's activity with the family.

C. Local agencies who serve families experiencing neglect should include public health workers in their child protection teams. In addition, nursing services should be provided by experienced public health nurses, if at all possible, rather than private nursing services which may not be familiar with the issues of neglect and abuse.

D. Early intervention to remove a child is indicated in situations which involve low weight babies, failure to thrive, and a lack of cooperation on the part of the parents.

E. Children born into a family already active with CPS need to be evaluated on a case by case basis. Such evaluation needs to begin during pregnancy. If the situation is serious, the possibility of removing the child at birth should be considered.

F. First responders should receive training on the possibility that negligence might be a contributing factor to an accidental death.

G. The Department of Human Services should identify high social risk variables that may impair normal infant growth and development, for child protection workers.

II. COORDINATED RESPONSES TO DANGEROUS CASES

Findings: A system that defines or relegates the role of child protective services (CPS) to only monitoring the provision of services by various other groups cannot effectively protect vulnerable children. Someone must be responsible for checking on the safety of vulnerable or surviving children, and the involved professionals must cooperate fully. In one case, the local police had not shared their criminal investigation with child protection by the time of the state review, one full year after the child's death.

Recommendations:

A. Checking on the safety of the child should be part of a Human Services service plan. In order to keep on top of the family's progress or lack of progress, the local agency should require formal periodic reports from the service providers.

B. A systematic way of involving social services, police and county attorneys as soon as possible in all serious or potentially serious cases should be established.

C. The local agency and the local police should work out protocols for responding to abuse complaints that may result in criminal charges. Hospitals should be alerted to the need to report suspected abuse immediately.

D. When more than one program is involved in a case, the various program responsibilities must be made explicit. The child protection worker should always keep a sharp focus on the well-being of the child and not become involved in the mental health needs of the parents to the detriment of the safety of the child.

III. INTERNAL PROBLEMS THAT ALLOW DRIFT

Finding: In some instances, internal practices allow child protection cases to drift, unmonitored, for periods of time. Some such problematic practices are a focus on the parent/caretaker and not the child, a lack of supervision for problem families, incomplete reports and unrecorded case plans, and finally, protracted judicial processes.

Recommendations:

A. **Parent caretakers must be held accountable for the actions or failures in pursuing case plan objectives in order to achieve more effective intervention to protect children.**

B. **The ability of parents to hide their children should be seen as a "red flag." A child who is the subject of a maltreatment report must be seen before the report is marked "unsubstantiated."**

C. **CPS should make greater use of protective supervision as a disposition.**

D. **When a report of maltreatment is substantiated, the perpetrator should be identified, so that specific behavioral changes can be required before the child returns home. While the perpetrator remains unknown, both parents should be identified as such.**

E. **The Department of Human Services should clarify for county child protection workers whether a written case plan separate from the narrative recording is required. The written case plan must be distinguished from the DHS 2140, "Application for and Initial Service Plan".**

F. **The Department of Human Services should clarify the need for both a "Tenneson" and a "Miranda Warning" in cases requiring joint investigations by agency and law enforcement.**

G. **The judicial process should be sped up, in the interest of both parents and child.**

H. **The number of county child protective services staff should be increased, to improve the provision of services on behalf of vulnerable children.**

IV. LICENSING

Finding: In one case, the county allowed a day care provider's license to simply expire without taking the appropriate negative licensing action required when neglect is substantiated in a day care facility. The Department of Human Services, in turn, did not connect the county's report of substantiated institutional maltreatment to the licensing action report.

Recommendations:

A. The Department of Human Services should stress the importance of including reports of substantiated neglect in county licensing recommendations.

B. The Department of Human Services should establish an internal mechanism to make sure a license is not reissued to a provider who has been found to be negligent.

RECOGNIZING DEATHS FROM MALTREATMENT

I. SUDDEN INFANT DEATH SYNDROME (SIDS)

Finding: Panel members expressed concern that an autopsy and a death investigation had not been done in six cases diagnosed as SIDS, since there was reason to think that harmful circumstances might have contributed to the deaths. Some of the harmful circumstances were: parental use of drugs, failure to thrive, and toxic substances near the child. It is impossible to determine whether a SIDS diagnosis is proper or not without all of the relevant information: case history, death scene investigation and autopsy.

Recommendations:

A. A death scene investigation of all infant deaths should be mandatory.

B. The Department of Health should not accept any death certificate which diagnoses SIDS without performing an autopsy.

C. The Department of Human Services should work with the SIDS Center to establish criteria by which typical SIDS cases may be differentiated from infant deaths in which neglect may be a contributing cause of death.

D. Toxicology screening should be performed as part of the autopsy in cases in which a family history of drug or alcohol use is known or suspected.

II. AUTOPSIES, DEATH INVESTIGATIONS AND DEATH CERTIFICATES

Finding: In two cases of "natural" and "undetermined" cause of death as well as in several of the SIDS cases, the death certificates were inadequate. Autopsies were incomplete or insufficient, the explanations of the events and the medical examiner's findings were in conflict, and the death certificates were inaccurate or uncertain.

Recommendations:

A. Medical Examiners need more training on the essential matter of completing death certificates properly.

B. We support the creation of a system to provide expert consultation to Medical Examiners in greater Minnesota.

C. The state should support funding for centralized autopsies, to ensure consistency in the determinations of cause of death.

D. The Panel supports the development of guidelines for infant death investigation that can be used statewide.

MORTALITY REVIEW PROCESS

I. BETTER INFORMATION

Finding: The mortality review was limited at times by insufficent information, either because the review came too late (and confidential documents had already been destroyed) or because the local review did not collect all of the necessary information prior to the state review.

Recommendations:

A. The Department of Human Services should develop a check list for the local review or for the assessment process, describing the kind of information the panel needs to understand the circumstances surrounding the death, and to determine whether the death was preventable.

B. DHS should clarify which cases will require a review, so that counties can conduct earlier local reviews. The earlier review will elicit fresher information, and include the professionals who worked with the child or family (rather than their successors). In addition, an early review will not cause undue concern in the community by bringing up old cases.

II. SIDS TERMS AND RISK FACTORS

Findings: As the panel continues to explore the uncertainties pertaining to infant death, it needs to consolidate and make use of what it has discovered to this point.

Recommendations:

A. The panel should re-examine all SIDs cases reviewed to date for the purpose of identifying common concerns.

B. The Department of Human Services should provide counties with guidelines for what local review teams should look for in SIDS deaths (i.e., are there special risk factors that are documented in SIDS research?)

C. The panel should define for itself the various terms associated with a SIDS diagnosis: "unexplained" and "unexpected", "adequate autopsy", "adequate case review" and "normal growth and development".

Update: Changes in Statute and Policy

Since the publication of the original "Progress Report of the Child Mortality Review Panel" in May 1988, many of its recomendations have been implemented by changes in state statute and policy, some of which were proposed by the Department of Human Services. The following is an abbreviated listing of some of the most important changes.

Mandate for the Panel and Data Sharing:

(Laws of Minnesota 1989, chapter 282, article 2, section 112)

- The 1989 Laws require the Commissioner of Human Services to establish the mortality review panel.

- The commissioner may require local reviews and the participation of involved professionals.

- The review panels have access to the pertinent data of police, medical professionals, coroners, and social service agencies. This data is classified "confidential" (not accessible to the public or to the subject of the data).

- The proceedings and records of the panel are not subject to discovery or introduction into certain civil or criminal actions. (Laws of Minnesota 1989, chapter 17)

- Inactive law enforcement data on child abuse is "private" (not accessible to the public, yet accessible to the subject) and not subject to the record destruction schedule in the Reporting of Maltreatment of Minors Act.

Legal Prevention, Assessment and Enforcement:

Prenatal Exposure to Controlled Substances

(Laws of Minnesota, chapter 290, article 5, sections 2-6)

- A pregnant woman who habitually or excessively uses cocaine, heroin, PCP or amphetamines for nonmedical purposes is a "chemically dependent person" under the Commitment Act.

- Prenatal exposure to a controlled substance, as evidenced at birth or by certain symptoms in a child's first year, constitutes neglect.

- Mandated reporters must report prenatal exposure to controlled substances to a local social service agency, which must conduct the appropriate assessment.

- If a pregnant woman has complications which indicate use of a controlled substance, the physician must administer a toxicology test, and must report positive test results or other evidence of controlled substance use.

Medical Neglect

(Laws of Minnesota, chapter 282, article 2, sections 200-201)

- If lack of medical care may cause serious and imminent danger to a child's health, professionals must report any failure to provide that care.

- In this case, the local social service agency can intervene to ensure the provision of necessary medical services.

Child Endangerment

(Laws of Minnesota, chapter 282, article 2, section 199)

- "Child Endangerment", the intentional placement of a child in a situation likely to substantially harm the child's physical or mental health or cause the child's death, by the parent/guardian/caretaker, is a gross misdemeanor.

CHIPS Jurisdiction

(Laws of Minnesota, chapter 113)

- Children who reside with another abused child or with a perpetrator of abuse are under the juvenile court's jurisdiction as "Children in need of Protective Services" (CHIPS), (Laws of Minnesota, chapter 285, sections 5-6)

- Children who are victims of "emotional maltreatment" are also under the juvenile court's CHIPS jurisdiction.

Malicious Punishment

(Laws of Minnesota, chapter 282, article 6, section 16)

- The maximum penalty for Malicious Punishment of a child is increased to five years in prison or a fine of up to $10,000 or both.

Child Protection Oversight

(Laws of Minnesota, chapter 235)

- The duty of the juvenile court to prevent placement and to reunify the family when possible, the "reasonable efforts" the agency must make to do so, and the criteria for court review of those efforts are all made explicit.

(Laws of Minnesota, chapter 282, article 6, section 203)

- The commissioner must establish a pilot program for peer review of local agency responses to child maltreatment reports by January 2, 1991.

(Laws of Minnesota, chapter 290, article 4, section 20)

- A legislative child protection system study commission is reviewing the child protection system, the reporting act and handling of sexual abuse cases.

Grants and Projects

- The Department of Human Services' Children's Division has obtained an Infant Medical Neglect Grant from the National Center on Child Abuse and Neglect, which will provide funding for improved service to infants with extraordinary medical needs. The DHS hopes to:

  (a) develop risk assessment guides for high risk infants and families;

(b) provide training for child protective services staff to prepare them for work with such families; and

(c) gather and disseminate information on supportive services available for parents of disabled infants with life-threatening conditions and children with extraordinary health problems.

- $900,000 allocated by the 1989 legislature to Hennepin and Ramsey Counties for projects related to prenatal exposure to drugs.

- The Chronic Neglect Project, funded by the 1989 Legislature, will develop standard procedures for neglect assessments, and training for CPS workers.

- The Minnesota Department of Health has established a task force for the purpose of developing investigative guidelines, including autopsy protocol for child deaths under the age of two.

DHS Training

- Joint training was provided for public health nurses and child protection social workers.

- Three training sessions were held for social workers on the investigation of licensed facilities.

DHS Rules

- A Risk Assessment Guide was developed in a pilot project, for the use by social workers in determining whether protective intervention or services are called for in each instance.

- DHS Rules require a written case plan for each case. The rule also delineates the authority and the responsibility of the social worker to provide protective intervention.

- DHS also developed a new "categorization of child mortality" guide to aid the mortality review.

Goals Identified in the DHS Grant Proposal

- DHS will develop a Child Protective Services handbook.

- DHS will define the recommended Child Protective Services workload.

- DHS will work to strengthen the multidisciplinary approach to child protection.

APPENDIX
CURRENT MEMBERSHIP ON CHILD MORTALITY REVIEW PANEL

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PERSONS NO LONGER ON THE PANEL BUT PARTICIPATED DURING THE REVIEW OF SOME OF THE CASES INCLUDED IN THE REPORT

Norman Coleman
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