Progress Report of Minnesota Child Mortality Review Panel

Minnesota Department of Human Services
1991

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CHILD MORTALITY REVIEW

This report is the third report on the progress of the Child Mortality Review Panel since its beginning in March of 1987. The panel operates under the authority of Minnesota Statutes 1989 Supplement 256.01, Subdivision 12. The panel reviews deaths of children who have come to the attention of the public social service agencies. While the deaths reviewed may be limited to recipients of social services, the panel recognizes that the protection of children depends on the collective work of all the agencies or disciplines with some responsibility for serving children at risk; thus, as a death is reviewed the panel examines the role played by other professionals who were involved with the family of the deceased child. The purpose of the review is to assess the adequacy of Minnesota's system for protecting vulnerable children and to recommend changes in the system if deficiencies are found.

The panel 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. (See Appendix II for list of 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 are appropriate for review takes into account both the status of the case and the manner and cause 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 case status criteria is considered to be met if the family was involved with the agency even though the deceased may not have been a recipient of services or the subject of a maltreatment report. The manner of death of cases chosen for review is limited to those deaths that were identified as due to: an accident; a homicide; or a suicide. Deaths due to natural causes are also reviewed if it appears neglect may have been a factor in the death or if the death was diagnosed as SIDS.

Review Process

Cases are reviewed at two levels. First the case is reviewed at the local level by the local social services agency and other professionals who have been involved with the case.

In addition to mandating the review of child deaths, the legislation enacted by the Minnesota Legislature in 1989 strengthened the review process in two ways. First, it made the expectation for a local review very explicit and, second, the law is specific in its expectation that all professionals with knowledge of the case participate in the local review. Thus, the reviews covered in this report are enhanced by a fuller participation on the part of local social service agencies and other professionals involved in the case or with some responsibility in the child protection system.

The review by the State Child Mortality Review Panel follows the local 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 attend the state review to clarify possible ambiguities in the reports and to participate in assessing how the system for protecting children functioned in the particular case. The panel generally meets to review cases once a month.

The number of cases meeting the review criteria strained the ability of the panel to review all of them and prompted the panel to consider and try various options for managing the volume of cases coming to its attention. An early effort to manage the volume was to drop the expectation for local participation as the case was reviewed by the state panel. This option allowed for the review of more cases at each meeting but the value of the review was diminished by the lack of county participation and it was not considered an acceptable option.

Two actions were taken this past year in order to reduce the backlog of cases waiting to be reviewed and to handle the volume of new cases. First, the waiting list was reduced by dropping 42 cases from the list. Second, in order to avoid the accumulation of another backlog of cases waiting for review, a system for screening out some cases from a full review was established by conducting a preliminary abbreviated review. The abbreviated review consists of obtaining summary information from one or more of the following: the local social services agency, public health, the medical provider and law enforcement. In some instances an autopsy report is also obtained. The information obtained from the above sources is reviewed with the pediatric forensic pathologist serving on the panel. If it appears the death does not raise protection issues, the case is not further reviewed. Specifically as the screening criteria applies to a SIDS death, a death attributed to SIDS is screened out if: there was an autopsy and its findings supported a SIDS diagnosis; the death was certified by a coroner or medical examiner; there was a death scene investigation; and there were no indications of maltreatment.

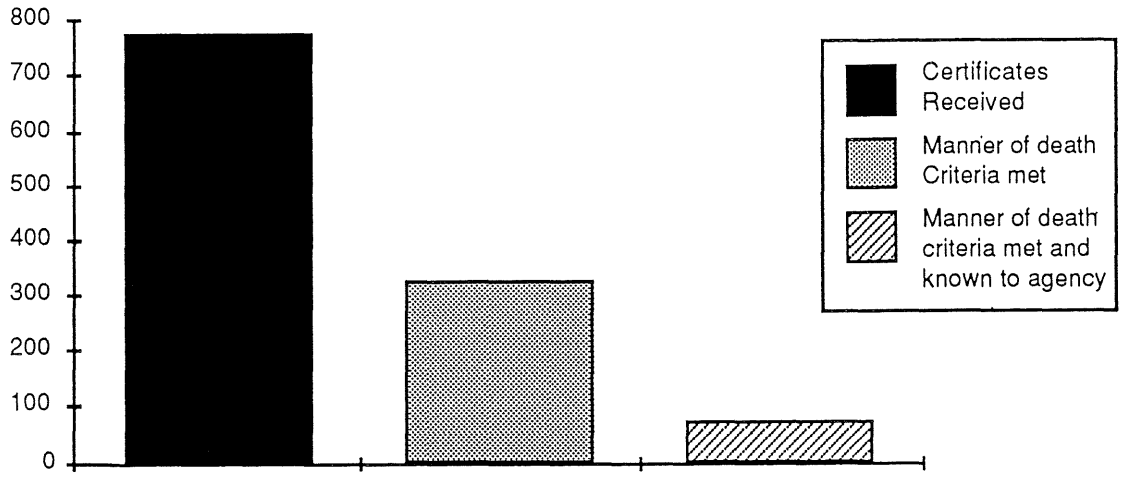
Child Deaths

From the last tabulation of the child mortality review data on May 15, 1989 through June 30, 1990 (thirteen months), 777 new child death certificates were received from the

Minnesota Department of Health. Three hundred and twenty-seven (42%) of these deaths met the manner of death criteria for review. There were an additional eleven cases that lacked sufficient information to permit a determination with regard to meeting the review criteria.

Seventy-two of the three hundred and twenty-seven deaths that met the manner of death criteria for review were known to a local public social services agency; i.e., the family was a current recipient of services, had been a recipient within the year preceding the death, or the subject of a maltreatment report. Whether or not a child was known to a local agency could not be established in one case. Thus, there were at least 254 deaths that met the manner of death criteria that will not be reviewed as the family was not known to the social services agency; i.e., better than 77% of the deaths meeting the manner of death criteria.

Graph I
Death Certificates Received Between May 15, 1989 and June 30, 1990



CASES REVIEWED BETWEEN 7-1-89 AND 6-30-90

During the period covered in this report sixty-one cases were reviewed. Nineteen cases were fully reviewed with only an abbreviated review for the remaining forty-two cases. The chart below provides a breakdown by manner of death for the cases reviewed.

CASES REVIEWED BETWEEN JULY 1, 1989 AND JUNE 30, 1990

MANNER/CAUSE OF DEATH	ABBREVIATED REVIEWED	FULL REVIEW	TOTAL REVIEWED
Accident	12	3	15
Homicide	4	9	13
SIDS	16	4	20
Suicide	1	1	2
Natural other than SIDS	8	1	9
Undetermined	1	0	1
Pending investigation	0	1	1
TOTALS	42	19	61

See appendix I for information identifying the age, sex, and manner of death of the child for the 19 cases that were brought to the panel for a full review.

In addition due to the backlog there were forty-two cases mentioned earlier that were waived from the waiting list of cases that met the criteria for review. The chart below shows the manner of death for the cases that were waived.

CASES WAIVED FROM CONSIDERATION
IN ORDER TO
ELIMINATE THE WAITING LIST

MANNER OF DEATH	NUMBER OF CASES
Accident	16
Homicide	3
SIDS	14
SUICIDE	5
Natural causes other than SIDS	3
Undetermined (accident or suicide)	1
Total	42

It should be noted that the cases that were reviewed (either abbreviated or full review) and those that were waived do not comprise the universe of certificates received during the period covered by this report; i.e., some of the cases reviewed or dropped came from certificates received prior to May 15, 1989. Also some of the 72 death certificates identified earlier as meeting both the manner of death and case status criteria were yet to be reviewed as of June 30, 1990.

Findings and Recommendations

The following findings and recommendations address specific concerns identified during the detailed reviews of the nineteen cases that had a full review. The findings are stated in general terms due to data privacy constraints. Both the findings and recommendations were agreed upon by consensus of the panel.

IDENTIFICATION AND REPORTING

I. Medical Practitioners/Hospital Emergency Rooms

The reviews provided considerable evidence of prompt reporting of maltreatment and examples of aggressive probing to understand how a child came to be injured. However, there were also examples of maltreatment not being reported (or reported after a lapse of valuable time) with the result that the deceased and/or the deceased's siblings were left at risk. Although there were some instances of not reporting maltreatment even after identifying the injury as such, most of the failure to report appeared to be due to not recognizing maltreatment due to a lack of questioning as to how the injury occurred, a misinterpretation of the medical findings or a reluctance to believe the parent(s) capable of inflicting the injury.

In particular:

- **There were injuries attributed to actions of the injured child that the age and condition of the child would suggest the child was not capable of the behavior attributed to him (her).**

- **It was assumed by the attending physician that because the bruises were small they must not have been inflicted by a parent.**

- **In one instance a child received care in a hospital emergency room for suspicious injuries but the matter was not reported to child protective services nor to the child's physician who would have been able to place the fact of the injury into a broader context.**

- **An injury which eventually caused a child's death was not reported until the death occurred, making it impossible to conduct a meaningful investigation as the possible evidence of maltreatment was no longer available and the family had left the community.**

- **The initial report by the attending physician was mailed rather than telephoned to the social service agency causing a delay in the agency getting the report and conveying a false sense that the matter was not at all urgent.**

- **There was concern about how little is known about the staffing of hospital emergency rooms throughout the state. If the staffing pattern consists of rotating physicians representing a variety of specialties, a maltreated child might well be seen by a physician who is not aware of the general health issues of children or prepared to recognize and deal with child abuse or child fatalities emanating from abuse or neglect.**

The County Attorney's Office in one county attempted to deal with the problem of failure to report by sending a letter to persons mandated to report who fail to report, reminding them of their responsibility to report.

Recommendations:

A. Send a letter on behalf of the panel to the hospital that had failed to report child maltreatment alerting the hospital of the fact that an incident of maltreatment was found but not reported.

B. Send a letter to the county attorney who has made some attempt to contact persons mandated to report who failed to report encouraging the responsibility for the practice be fixed so that the reporters will consistently receive the reminders.

C. The Department of Health should canvass all hospitals in Minnesota to determine their emergency room practice with regard to processing cases in which the injury or death may have been caused by maltreatment. It was suggested the canvassing be done by asking the hospitals to respond to hypothetical cases. The purpose of the study is to learn more about the state of the art and to be in a position to offer help so that instances of maltreatment are more fully identified.

D. Physician training should be provided which encourages a team approach to maltreatment or suspected maltreatment. The panel further recommended to the Academy of Family Practice that their curriculum stress the importance of obtaining a complete history of the events leading up to an injury unless the cause is self-evident.

II. Law Enforcement and Reporting of Maltreatment

The cross reporting between law enforcement and child protection services is improving and the case files reviewed contain documentation of this improvement. There are however two issues that indicate a need for further attention.

First, the retrospective review of cases identified instances when law enforcement had prior contact with the family as a result of domestic violence complaints. Repeated calls to the police in response to domestic violence were seen by the panel as a red flag signaling that children are at risk. Consideration was given to recommending that police report all domestic violence to child protective services when there are children in the home. It was concluded that such a requirement would burden the child protective services system with many reports in which the intervention of child protective services was not indicated and the proposal was dropped.

A second matter relates to situations in which law enforcement receives a report of maltreatment but delays notifying child protective services while criminal charges are contemplated (a violation of the child maltreatment reporting statute) and/or child

protective services defers to law enforcement during the consideration of criminal charges--in either case leaving surviving children at risk.

Recommendations:

A. The training curriculum for law enforcement officers should include information sensitizing law enforcement officers to the impact of domestic abuse on children residing in the family.

ASSESSMENT AND SERVICES: COORDINATION

The experience of reviewing the cases contained in this report affirms the importance of interdisciplinary cooperation and coordination in protecting children experiencing maltreatment or at risk of maltreatment. Rarely is the harm or risk such that it can be fully appreciated from the perspective of a single discipline. It truly takes the combined knowledge and understanding of all the disciplines in order to arrive at an appreciation of the level of risk and to arrive at a determination as to the need to intervene to protect children and a plan for intervention to provide for safety of the child and treatment of the family.

Again, while there were many examples of fine teamwork among the various disciplines, there are also areas and instances that suggest that better coordination and cooperation can more effectively protect vulnerable children.

Included among the considerations pertaining to coordination raised in the reviews were:

- A prompt and aggressive interview of the parents by the medical staff can play an important role in cutting through the denial and establishing that a death was a homicide.

- Thorough death scene investigations are important in order to determine the manner of death with certainty and to act to protect surviving children when such action is indicated. Although there appears to be some reluctance on the part of law enforcement to pursue a death scene investigation once the possibility of SIDS is suggested, the panel believes a thorough investigation will strengthen a SIDS determination and enhance the integrity of the diagnosis. Similarly a thorough investigation will aid in identifying those cases for which SIDS is not an appropriate diagnosis, where neglect or abuse may have contributed to the cause of death.

- Quick access by child protective services to medical records can assist the agency in making an earlier identification of the pattern of maltreatment and allow the agency to act more decisively.

- In two instances surviving children were left at risk by the inability to resolve the discrepancy between the police department perceiving the death as accidental and the medical examiner's determination that the death was a homicide. Because of the discrepancy there was no referral for criminal prosecution and in at least one case the lack of a determination inhibited child protective services from aggressively intervening to protect the surviving children.

- When the medical facts of the case clearly contradict important historical statements regarding the child's condition made by the caretaker, then one should presume a non-accidental cause of death (homicide/child abuse) until proven otherwise.

- Social workers should not be expected to medically evaluate bruises but should have medical resources available to them to evaluate bruises.

There was also a concern for the safety of children when parents keep them unavailable to the worker. The panel concluded that it should be considered a potentially high risk situation, triggering an aggressive assessment, when children disappear; i.e., when parents keep the location of their children a secret. A court order to gain access to the children should be sought when the parents will not allow the child protection worker to see the children.

The need for more effective intervention and coordination in neglect cases continues to be a matter of concern. The more cases of chronic neglect that are reviewed the more it becomes apparent that the risk posed by chronic neglect, characterized by indifferent supervision and a lack of attention to a child's basic developmental needs, can not be fully appreciated if one treats each episode of indifferent supervision or improper care as a separate or isolated event. Cases were reviewed that contained numerous reports of lack of supervision or improper care which were dealt with by focusing exclusively on the presenting incident, which resulted in a determination that either the children were not at risk or the degree of risk was not fully appreciated. The sum of the individual reports suggested a pattern of behavior that left the children at considerable risk. The panel concluded that a pattern of indifferent supervision needs to be evaluated and should be considered to constitute substantiated maltreatment.

Clearly the increase in the volume and severity of child maltreatment reports received by Child Protection Services far exceed the increase in staff and other resources devoted to the problem. One agency reported that the case under review did not receive the same level of service as it would have received several years earlier and that the same case coming into the system today would not receive as much attention as the case under review received. The county reported a shift in caseload sizes from fifteen to thirty-one over the past few years and that the thirty-one cases are more difficult and more time consuming than were cases in an earlier time.

The discrepancy between the problem of child maltreatment and agency resources is manifested in a number of ways. The cases reviewed found instances in which there was a delay in initiating an assessment as the agency found it necessary to prioritize incoming reports and there is reason to speculate that the assessment once commenced was less thorough than might have been the case with a more manageable workload. There was also evidence of the volume of cases creating a pressure for an earlier closure of a case.

Large caseloads result in pressure to close cases early and thus are an obstacle in providing the long-term commitment required to protect children growing up in families in which neglect is a way of life. There appeared to be some families that did not seem amenable to help no matter the array of services that might be offered. Yet, there was some reason to believe that child protective services just being there to monitor until the children reached the age of majority seemed to provide some measure of protection.

The panel proposed that the most feasible and effective intervention for some families experiencing chronic neglect may be an on-going monitoring to assure the children are not being harmed while other families may be amenable to more intensive services. The need for a differential diagnosis was considered important in order to target treatment resources to those families in which such an effort would be most appropriate. There was interest expressed by local agencies in being a part of any initiative to address the problems in working with chronic neglect families.

The panel recognized that a change in statute would be required before such on-going monitoring could be effected.

<u>Recommendations</u>:

A. **A delegation from the panel meet with the police chiefs in both Minneapolis and St. Paul to solicit their support for a more aggressive investigation of child maltreatment reports.**

B. **DHS reinforce a practice expectation that child protective services workers utilize physicians to evaluate injuries and act to secure medical coverage for such examinations.**

C. **Make medical expertise available to local communities to better identify non-accidental injuries that are presented as accidental.**

D. **A letter should be sent to the local social services agency, the local police chief and the county attorney stressing the importance of recognizing the parallel role child protective services must play in assessing the risk to children even when a criminal investigation is in progress.**

E. The Department of Human Services take the initiative in establishing a protocol for making differential assessment of neglect families and suggest treatment modalities.

F. In situations in which families periodically disappear, child protective services should be given the authority to access information as to who is providing the primary medical care, growth records of the children, immunization records, health visits and the birth records of the children so that it will be possible to determine whether conditions exist that suggest the children may be a risk.

DEATH CERTIFICATES

The information on the death certificates does not distinguish accidents that are pure accidents; i.e. acts of God, and those accidents in which neglect was directly or indirectly a contributing cause of the death. A full and accurate determination of not only the cause of the death but of the contributing conditions as well can be important in order for child protective services to take appropriate steps to protect surviving children and for the county attorney to initiate criminal proceedings. There were a number of instances when it would have been appropriate to indicate that the child was exposed to conditions of neglect.

The desired identification could be made either by adding another item on the death certificate to indicate if neglect was a factor contributing to the death or by providing training to medical examiners to utilize "Part II - OTHER SIGNIFICANT CONDITIONS" on the death certificate to further categorize accidental deaths.

Some of the specific findings which prompted an interest in including more information on the death certificate were:

- In at least one instances the supervision provided was inadequate to the developmental age of the child and could have been considered to have been a contributing cause to the death.

- A case in which a house fire was the instrument of death but the conditions of neglect in which the child lived were considered by the panel to have contributed to the cause of the accidental fire.

<u>Recommendations</u>:

A. A letter should be sent to the Coroner's Association asking that the matter of identifying accidents in which neglect was a contributing factor be a seminar topic at the Coroner's Conference and that the County Attorney's Association be invited to participate on the panel. The Coroner's Association should also be asked to modify the manner of death category "accident" to facilitate the identification of accidental deaths that involved some degree of neglect--consideration should be given to terms

such as "unintentional injury," "reckless disregard" and "placing or leaving a child at peril."

AUTOPSIES

The reviews continue to indicate the need for guidelines as to which cases should be referred to a coroner, which cases require an autopsy and a protocol for autopsies that are performed on children. Unless systematic autopsy procedures for children are followed some of the evidence of a physical condition causing a death could be lost as standard adult autopsy procedures could destroy such evidence.

Minnesota statutes provide counties with an option to establish either a coroner's or medical examiner's system for determining the cause and manner of death in certain situations. Hennepin County operates under a separate statute that established the office of medical examiner and requires that the office be staffed by a forensic pathologist. In either option open to the rest of the state the person must generally be a physician. The law does not require that either the coroner or medical examiner be a pathologist but in practice medical examiners are often pathologists and coroners often are not. Coroners engage the services of a pathologist when considered necessary in determining the cause or manner of death.

The types of deaths that are to be reported to the coroner or medical examiner are similar no matter which system the county has chosen. The criteria most relevant to this report for determining the jurisdiction of the medical examiner or coroner are: 1) violent deaths and 2) deaths under unusual or mysterious circumstances. Although the latter is subject to various interpretations in practice it is assumed to include all deaths not attended by a physician.

The particular concerns that underscore the need for standardized procedures for autopsies include:

- A lack of an autopsy in some SIDS cases.
- Problems in getting an accurate diagnosis as to the cause of the death as the autopsy was initiated after preparation of the body for burial was commenced.
- An inconsistent use of toxicological tests.
- Potential dehydration was not determined.
- Instances when the medical findings did not clearly support the conclusions of the autopsy.

There was also a case of an "unattended" SIDS death not referred to the coroner that all panel members agreed a referral was indicated. There was also a consensus that the current coroner's statute is not sufficiently clear that the matter was to be referred.

Recommendations:

A. The Minnesota Department of Health work group responsible for establishing guidelines for investigation of deaths of children under two be advised of the panel's continued concern about the lack of standard operating procedures for determining SIDS deaths.

   There was also a recommendation to a particular community, where the matter of conducting an autopsy had been a problem, that it develop a protocol for when autopsies should be performed and share the results with the Department of Health work group.

B. All deaths of children unattended by a physician should be coroner's or medical examiner's cases.

C. Dual investigation by law enforcement and the coroner should be required when there is an unattended death and the results of the death scene investigation should be included in the autopsy report.

D. The child's birth weight should be obtained and included in an autopsy report.

E. Seek legislation making it explicit that all child deaths for which there is no anatomic cause of death must be certified by a coroner or medical examiner.

MEDICAL EXAMINER AND CHILD PROTECTIVE SERVICES

Conflicting interpretations of data privacy requirements serves as an impediment to the sharing of information between the medical examiner's office and child protection services. The result was the medical examiner was deprived of information potentially valuable in determining the manner of death and Child Protective Services was deprived of information from the medical examiner important to the protection of surviving children.

Recommendation:

The Department of Health include in its legislative recommendations amendments to the data privacy act and the reporting of maltreatment of minors act to clarify the expectation that information is to be shared between the medical examiner's or coroner's office and Child Protective Services.

CHEMICAL DEPENDENCY AND CHILD PROTECTIVE SERVICES

We need to be more effective in protecting children from neglect in families where drug abuse is present. As long as the parent is using illegal drugs the children remain at risk and agencies may be attempting to achieve the impossible in trying to keep the family together unless the parent(s) have dealt with their drug usage.

How best to handle cases involving maternal use of cocaine is a particular concern that requires further study.

The panel concludes that from the perspective of risk to the child, in families experiencing maltreatment, chemical dependency is not the sole issue; chemical use in itself is an issue and may pose a risk to the child. Thus, it is the belief of the panel that the scope of a chemical dependency assessment must be defined in such a way as to encompass a determination and/or testing for chemical use not just addiction/dependency.

A number of factors were identified as contributing to a problem in obtaining a meaningful chemical dependency assessment. It was not always possible to determine the qualifications of the person conducting the assessment. A failure to obtain collateral information on the subject, collaterals denying or not recognizing the dependency and the reluctance of the parent subject of the report of maltreatment to submit to tests for the presence of a controlled substance in their system also posed problems in obtaining accurate assessments. There were cases that reflected a pattern of chemical use that left the parent ill prepared to meet the needs of the children in the family. However, because the parent denied using, a diagnosis of chemical dependency was not established.

Hennepin County has initiated Project Child that in part involves obtaining a juvenile court ordered chemical dependency evaluation if a parent refuses to cooperate in a CD evaluation or if the history makes it evident the parent will not cooperate. It is too early to assess the effectiveness of the project.

There was also a case in which unrecognized fetal alcohol syndrome was a factor in a child's behavior. The panel recognized that fetal alcohol syndrome is difficult to diagnose but had it been diagnosed there might have been less emphasis on reunification and more attention on the child's individual needs related to fetal alcohol syndrome and the chemical dependency treatment more responsive to the child's capabilities.

Recommendations:

A. When Department of Human Services Rule 25, the Department of Human Services Rule for the assessment for chemical use, is revised in January 1991, consideration should be given to defining assessment in terms which will better serve the need to protect children. Specifically the panel recommends the definition include assessing for "use", require collateral contacts and include testing.

B. Cross training should be provided to CD assessors, CD counselors and mental health professionals in the identification and treatment of children experiencing fetal alcohol syndrome.

C. The panel re-examine the matter of maternal use of cocaine by reviewing the results of the Hennepin County's Project Child after the county has had more experience in using the court to order chemical dependency evaluations.

JUDICIAL SYSTEM AND CHILD PROTECTIVE SERVICES

A number of issues surfaced relating to the role of the judicial systems (juvenile, family and criminal) in dealing with families involved in the protection system. There were perpetrators that the panel believed should have been criminally charged. There was a particular concern about the lack of attention to the perpetrator when the perpetrator was mother's boy friend. He was generally not offered remedial services and not consistently charged with a crime even though prosecution would appear to have been appropriate.

There was also concern about the system's ability to provide for the protection of the surviving children in a case in which a mother whose behavior contributed to her child's death was not prosecuted and, as the custodial parent, had continued access to the surviving children. Although the children's father was encouraged to seek custody he was deterred from doing so by the cost of the legal proceedings.

In another case the concern was about the system's ability to protect a mother and her surviving children from the children's father when he was released from prison. The only available mechanism appears to be an order for protection.

The panel believed that a more aggressive use of the court should be pursued to resolve differences between the coroner and law enforcement as to the manner of death; e.g., accident or homicide.

Recommendations:

A. Abuse that leaves a child severely and permanently damaged should be treated the same as a homicide.

B. Define the types of cases that could be better served by the Juvenile Court than by the Family Court and amend the Juvenile Code, Chapter 260, to give the Juvenile Court jurisdiction over such cases.

PREVENTION

The cases reviewed prompted several prevention observations.

- **The availability of community supports such as affordable child care could have made a significant contribution to reducing the stress level the family was experiencing preceding a death attributed to maltreatment.**

- **There is a need to reach potential child abuse perpetrators earlier. There is a need for a prevention program targeted at potential physical abusers similar to SHARP (Sexual Health and Responsibility Program) which is targeted to prevent sexual abuse.**

- **Develop computer or video games for teaching child care and development.**

- **A person should be placed in the home to facilitate bonding in situations posing a risk to the newborn.**

- **Develop a strategy to create interest at the federal level in requiring a warning on smoking material (cigarettes and lighters) to caution that it is hazardous to leave the materials where children have access to the items.**

UPDATE: CHANGES IN STATUTE, POLICY AND INITIATIVES

A. **The Department of Human Services initiated a project to determine work load standards for child protective services. The standards will objectively define the amount of time it should take a case manager to deliver a service/task. The standards will be used primarily to determine the resources necessary to deliver child protective services in a given county. The standards are to be determined by September, 1991.**

B. **The Panel requested that the Coroner's Association devote a seminar at their conference to the matter of identifying accidents in which neglect was a contributing cause. The panel further requested that the Coroner's Association give consideration to modifying the death certificate to facilitate the identification of accidental deaths that involved some degree of neglect.**

C. **A delegation from the panel met with representatives from the Minneapolis Police Department concerning the role of law enforcement in the investigation of neglect reports.**

D. **The Department of Human Services is working with public and private social service agencies to develop at least four new crisis nursery programs--two in the seven county**

metro area and two in greater Minnesota. In addition the Department will assist with the expansion of the existing crisis nurseries.

E. The Department has awarded a grant to Hennepin County Community Services to develop a demonstration project working with chronically neglectful families. Chronic neglect is defined as those families in the child protection system for over eighteen months and a case has been opened and/or closed repeatedly during this period. The project will utilize clinical group work services with these family's with follow-up in the families home by a homebased paraprofessional. The project is scheduled to be completed by June of 1992.

F. The Department of Human Services has initiated a project to enhance the coordination between law enforcement, child protection services, and the county attorney's office in the investigation, assessment and in the adjudication/prosecution of child maltreatment cases.

G. The Department of Human Services has funded family based programs which will serve children at risk of maltreatment due to parental substance abuse and whose parent(s) is(are) on probation.

H. The 1990 session of the Minnesota Legislature enacted an omnibus child protection bill, Minnesota 1990 Sessions Law, Chapter 542, that addressed a number of issues raised by the Child Mortality Review Panel. The omnibus bill:

- Requires the Departments of Human Services and Public Safety to develop training which includes recognizing domestic abuse and preparation of case plans to coordinate services for the alleged child abuse victim with services for parents who are victims of domestic abuse.

- Requires the Department of Health to encourage the display of posters informing pregnant women of the dangers of alcohol in establishments selling liquor.

- Allows for the use of maternal and child health block grant money for services to women and children who are at risk due to chemical abuse by the mother during pregnancy.

- Expands the Juvenile Court's CHIPS jurisdiction to include a child whose parent's parental rights to another child have been terminated within the past five years.

- Amended the grounds for termination of parental rights statute to include as grounds for termination of parental rights--

a. **parental rights were involuntarily terminated on another child due to maltreatment.**

b. **a parent diagnosed as chemically dependent who refused treatment or failed two or more times to complete treatment required by a case plan.**

c. **the parent has been convicted of causing the death of another of the parent's children.**

- **Requires mandated reporters to report mental injury and threatened injury.**

- **Clarifies the authority for a physician to administer a toxicology test to a pregnant woman or to a woman within eight hours after delivery, and testing of the infant if the physician has reason to believe that the mother used a controlled substance during the pregnancy.**

APPENDIX I

CHILD DEATHS IN CASES REVIEWED				
	AGE		SEX	MANNER OF DEATH
1	17 years	8 months	M	Suicide
2	8 years	1 month	M	Accident
3	5 years	8 months	M	Accident
4	3 years	4 months	F	Homicide
5	3 years	3 months	M	Natural
6	3 years	1 month	M	Homicide
7	2 years	9 months	F	Homicide
8	2 years	3 months	F	Homicide
9	1 year	5 months	M	Homicide
10	1 year	3 months	M	Accident
11		5 months	M	Homicide
12		4 months	M	Pending
13		2 months	M	Homicide
14		2 months	F	Natural (SIDS)
15		2 months	M	Homicide
16		2 months	M	Natural (SIDS)
17		1 month	M	Homicide
18		1 month	M	Homicide
19		0 months	F	Natural (SIDS) No autopsy

APPENDIX II

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

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