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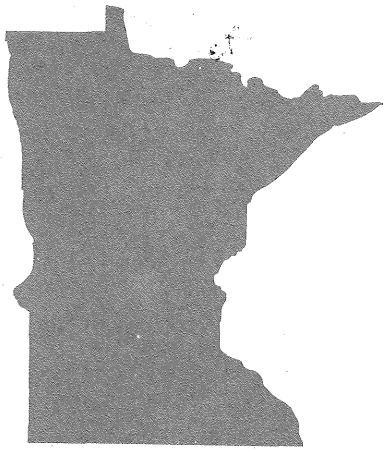
PROGRESS REPORT of

The Minnesota Child Mortality Review Panel

Cases Reviewed:
July 1, 1990 through December 31, 1992



MINNESOTA DEPARTMENT OF HUMAN SERVICES
MAY, 1994

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EXECUTIVE SUMMARY

Seldom does a family or community face greater devastation than that which accompanies the violent, unpredicted death of a child. Children represent both our most valued and vulnerable citizens. Reviews of child death reveal the fact that many children are known to professionals and agencies within our communities. However, despite our familiarity with children and families at risk, the rate of children who die each year is increasing.

The purpose of this report is to share the findings and recommendations of the systemic review of numerous child deaths to illustrate the wide array of factors which contribute to child death, particularly for those children whose families were known to Minnesota public social service agencies. It is anticipated that as a result of this review, policy makers from various disciplines will be better prepared to develop procedures and provide training that will enhance the coordination and delivery of services which will ultimately serve to reduce the number of child deaths. The period covered by this report is July 1, 1990 through December 31, 1992. During this thirty month period, 1,752 child death certificates were received from the Vital Statistics Unit at the Minnesota Department of Health.

The Minnesota Child Mortality Review Panel was established in March 1987 in recognition of the value of reviewing child deaths in order to better understand factors which contribute to child mortality. In 1989 the Minnesota legislature provided authority for the formal review of child deaths by promulgating Minnesota Statutes, Section 256.01, subdivision 12. The statute requires the Commissioner of Human Services to establish a child mortality review panel to review deaths of children in Minnesota, including deaths attributed to maltreatment or in which maltreatment may be a contributing cause. Currently the child deaths eligible for a full review by the panel are all non-natural deaths (except Sudden Infant Death Syndrome) in which the child or the child's family was receiving services from a public social service agency 1) at the time of death; 2) as a result of the death; or 3) in the year preceding the death. The statute also requires that the commissioners of Health, Education, Public Safety, and the Attorney General, designate a representative to the panel.

The purpose of the panel as set forth in the statute is to make recommendations to state and local agencies to improve the child protection system, including modifications in statute, rule, policy and procedure.

This is the fourth report regarding the progress of the child mortality review panel. Contained in the report are a host of findings and recommendations which identify deficiencies in practice, policy and coordination and gaps in services which leave children at risk. A number of the recommendations address system barriers which restrict the investigation process needed to determine how children die and what services should be provided to a family after the death of a child. The findings and recommendations are specific to professional disciplines which have a role in either providing service to families or investigating child deaths. As a result of this effort the panel strives to target populations where service efforts will prevent child fatalities, eliminate inconsistencies in practice, recommend training and underscore problems needing change.

Just as the composition of the panel is multidisciplinary, the enclosed recommendations reflect a variety of professional viewpoints. The enclosed findings and recommendations were the result of reviewing 41 child deaths between July 1, 1990 and December 31, 1992.

Findings and recommendations contained in this report encompass the following areas:

- Social Services/Child Protection
- Medical including Medical Examiners and Coroners
- Public Health
- Legal/Law Enforcement
- Chemical Dependency
- Cultural/Ethnic considerations
- Infant Death Investigation Guidelines

This report does not serve to implicate any particular discipline or imply that any individual had direct responsibility for the death of a child.

Rather, this report recognizes that as professionals we have a obligation to continuously review the quality and effectiveness of our efforts while acknowledging our limitations.

Hopefully the efforts of the Minnesota Child Mortality Review Panel in partnership with other state and local agencies will assure the most protective and healthy environment for our most innocent and vulnerable citizens, Minnesota's children.

CHILD MORTALITY REVIEW

INTRODUCTION

There is probably no single event which stirs public interest more than the violent, unpredicted death of a child, and these deaths are on the rise. A survey conducted by the National Committee for the Prevention of Child Abuse (April 1992) indicates a 54% increase in child abuse related fatalities from 1985 to 1991. There was an alarming 10.3% increase in the child fatality rate between 1990 and 1991. Based on data from 25 states, this study found that 79% of these victims were under the age of five, and 54% were one year or younger. At the same time, there is probably no circumstance that prompts public anger and cynicism more than the revelation that "the system" was providing services to the child at the time of death. It was within this context of outrage and concern that the Minnesota Child Mortality Review Panel was formed in March of 1987. Minnesota is one of 33 states that currently have some form of death review committee.

This is the fourth report on the progress of the Child Mortality Review Panel since its beginning in March 1987. The purpose of this report is to share the findings and recommendations of the systemic review of numerous child deaths to illustrate the wide array of factors which contribute to child death, particularly for those children whose families were known to Minnesota public social service agencies. The panel is guided by the authority of Minnesota Statutes, Section 256.01, subdivision 12 and is administered by the Department of Human Services. The panel reviews deaths of children who have come to the attention of public social service agencies. While the deaths of children are limited to recipients of public social services, the panel recognizes that the protection of children is the responsibility of many varied professional agencies and disciplines. Moreover, the protection of an individual child rests in the ability of professionals and agencies to understand their roles within the child protection network and to coordinate a comprehensive response. The purpose of child death reviews is to improve the quality of the system's response to protecting children by examining how various disciplines met their professional responsibility. The review process serves to identify deficiencies in statute, policy, administration, interagency cooperation and gaps in training and resources which serve as barriers to effective intervention.

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 of the agency 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 cases for review considers both the manner of death and whether the family was receiving services from the county social service agency. The panel reviews deaths of children whose cases are active with social services and deaths which came to the attention of the agency for a child protection assessment. The panel also reviews cases which were active with social services in the year preceding the child's death. The case status criteria is considered to be met if the family was involved with the social service agency even though the deceased may not have been a recipient of services or a maltreatment report.

The manner of death for cases eligible for review is limited to:

- Homicide
- Accidents
- Suicide
- Sudden Infant Death Syndrome (SIDS)
- Deaths where the manner of death is listed as, "could not be determined"

In addition to having representation on the Child Mortality Review Panel the Minnesota Department of Health also studies child deaths through a program called the Infant Mortality Reduction Initiative (IMRI). The goal of this program is to identify preventable causes of infant mortality and to respond promptly to improve the likelihood of infant survival. The IMRI administers five contracts for this purpose and also conducts an ongoing review of all maternal, infant, child, and fetal death records for Minnesota residents and for non-Minnesota residents when the death occurred in Minnesota.

For more information regarding the Department of Health programs contact:

- Junie Svenson, Infant Mortality Consultant
  Minnesota Department of Health
  717 Delaware Street S.E.
  Minneapolis, MN 55404
  (612) 623-5411

REVIEW PROCESS

The review process begins with a joint review of every child death certificate by the Department of Human Services and a pediatric forensic pathologist to determine if the manner of death criteria is met. Basic identifying information is then recorded into a data base. Information as to whether the death certificate was incomplete or inadequate is also recorded. Next, the death certificates are sent to the county social service agency where the decedent resided. The local agencies determine if the child was a member of a family receiving social services at the time of death or within one year preceding the death. The county agency then returns the determinations back to the Department of Human Services and the information is added to the data base. Cases meeting the review criteria are either screened out after further information is received or are scheduled for review by the state review panel.

When a case is selected for state review the local social service agency is notified that they are required to convene a local review of the death. The local agency generally uses the county child protection team required by Minnesota Statutes, Section 626.556 to conduct the review and additional invited professionals who have knowledge of the case. The county team then prepares a comprehensive report which includes findings, conclusions, and recommendations. The county sends a copy of its report and the social service case file to the Department of Human Services and a summary is prepared for the state review panel.

The state panel is comprised of professionals with a high level of expertise, who examine each death from the viewpoint of contemporary professional practice. Local representatives also participate in the state review allowing panel members to ask questions regarding barriers and problems that exist in the community. Finally, the panel makes recommendations based on the conclusions of each case reviewed. The scope of panel recommendations may vary from endorsing the recommendations of

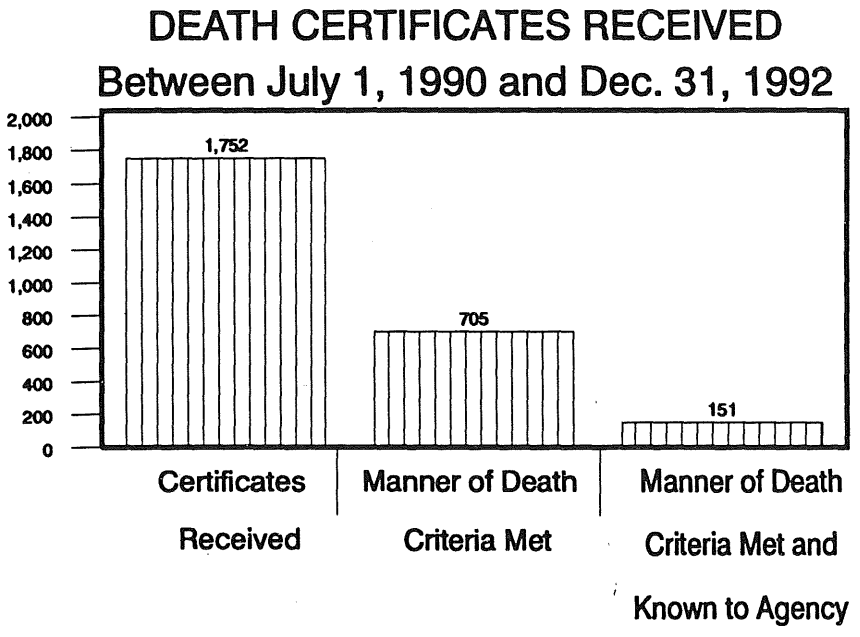
recommendations based on the conclusions of each case reviewed. The scope of panel recommendations may vary from endorsing the recommendations of the local review to suggesting changes in state policy. The panel's final report containing conclusions and recommendations is sent to the local social service agency.

CHILD DEATHS

The period covered by this report is July 1, 1990 through December 31, 1992. During this thirty month period, 1,752 child death certificates were received from the Vital Statistics Unit at the Minnesota Department of Health. Of these deaths, 705 (40%) met the manner of death criteria for review.

Of the total 705 deaths meeting the manner of death criteria 48 were flagged for review due to incomplete or inadequate death certificates, 151 were also known to a local public social service agency. Therefore, 554 deaths (79%) which met the manner of death review criteria were not eligible for review as the family was not known to the social services agency.

GRAPH 1



CASES REVIEWED BETWEEN JULY 1, 1990 AND DECEMBER 31, 1992

During the period covered by this report 41 cases were reviewed by the panel. Another 91 cases received an "abbreviated review" which involved obtaining additional data and consulting with a pediatric forensic pathologist. The "abbreviated review" generally consists of obtaining a brief summary of the local social service agency's involvement along with the autopsy and death certificate. Currently 19 cases are pending an "abbreviated review" as further information is sought. Cases are screened out from a full panel review in this manner when it appears that the death was thoroughly investigated and appropriate procedures were followed.

The following chart illustrates the number of deaths which met the manner of death criteria for review and whether the child or the child's family was known to the local social service agency at the time of death or within a year of the child's death:

CASES MEETING THE MANNER OF DEATH REVIEW CRITERIA BY STATUS WITH SOCIAL SERVICES July 1, 1990 through December 31, 1992

MANNER OF DEATH	KNOWN TO SOCIAL SERVICES	NOT KNOWN TO SOCIAL SERVICES
HOMICIDE	**18**	**29**
SUICIDE	**10**	**47**
ACCIDENT	**53**	**247**
SIDS	**44**	**188**
UNDETERMINED	**6**	**15**

FINDINGS AND RECOMMENDATIONS

The following findings and recommendations address specific concerns identified during the detailed reviews of the 41 cases receiving a full panel review:

I. SOCIAL SERVICES/CHILD PROTECTION

The experience of reviewing deaths generally serves to underscore the fact that most social workers/child protection workers are responding appropriately to situations involving children at risk of maltreatment. However, the reviews did reveal findings and recommendations which address deficiencies in social work practice and adherence to accepted standards.

The review of deaths known to local social service agencies has consistently demonstrated the vulnerability of young children. The risk for significant harm to a child increases proportionally with the stresses placed on a caretaker. Children of young single mothers are particularly vulnerable especially when poverty, substance abuse, and domestic violence are factors within the family.

The complex societal forces which contribute to the increasing instability of the family unit challenge the child protection system's ability to respond. This challenge is compounded by increasing child protection caseloads and diminishing resources.

Findings arrived at by the panel in relation to social services/child protection were:

A. Chemical Abuse Issues

- One social service file contained numerous references to parental substance abuse. Neglect associated with binge drinking episodes accounted for numerous shelter placements of the children and domestic abuse calls to law enforcement. Despite the documentation regarding chemical abuse, the county never referred the caretakers for a chemical dependency assessment.

- In another case, the social service file contained a psychological evaluation which indicated that in-patient chemical dependency treatment was needed. However, neither the court or social service agency sought a chemical dependency evaluation.

- The decedent in another case was the third consecutive child born "cocaine positive". Although the county acknowledges that chemical abuse was a problem for the mother, they could not document that this had an adverse impact on the children despite weekly home visits by professionals. Children cannot be removed from the home based on chemical use of a caretaker alone.

B. Minor Parent Plan

- The purpose of the Minor Parent Plan is to address services to minor parents and their children. However, in practice the plan tends to focus these services only to the mother. Often, under age fathers' or the mothers' boyfriends are left in a primary caretaker role with the child and are not considered for services.

- Because of limited resources, a large county metropolitan social service agency employed only one worker to handle minor parent referrals. The worker was only able to do a "bare bones" assessment and services were not offered unless the assessment resulted in a maltreatment report to child protection.

- Social service agencies generally do not receive a referral for minor parent services until the child is born. This results in the agency having limited background information on the mother and an inability to help the client with a decision regarding parenting prior to the birth. In one particular case, the family of a pregnant adolescent was in so much denial regarding the impending birth that the minor did not know whether her parents supported her decision to keep the baby.

C. Practice Issues

- In one case, the local review of the death reported that "the systems involved responded appropriately" yet the assessment of maltreatment on two reports were not initiated within 72 hours, contrary to Minnesota Rule 9560.0216, subpart 5. When the CPS assessment was concluded, the risk was determined to be high. Despite this finding and the fact that the child was under age one, the case was closed in less then three months with no indication that the risks had diminished.

- Child protection assessment and of service delivery is very difficult when clients move from one county to another county without notifying their social worker. In one county the worker was able to track the frequent moves of a client through changes to the financial assistance file.

- In a case where a female adolescent was in a foster home, the county social worker and foster parents were unaware of the foster care licensing rule which requires that prescribed medicine be dispensed by an adult. The adolescent, who had a history of depression and suicide attempts, was able to store enough medicine to take a lethal dose.

- In one case of homicide the perpetrator was successfully prosecuted because the siblings of the deceased were able to trust the child protection workers enough to disclose details of the death.

- One county identified a caseload size of 32 cases as a factor which affected the delivery of service to a family. Frequently, large caseloads are cited as a factor in service delivery.

SOCIAL SERVICE/CHILD PROTECTION RECOMMENDATIONS:

1) County child protection workers should vigorously pursue chemical dependency evaluations for clients whose history suggests extensive chemical abuse.

2) The Department of Human Services should develop guidelines and training regarding the authority of local agencies to intervene in cases where children are exposed to domestic violence.

3) County child protection workers should routinely refer families to Public Health Nursing services for home health safety education when a "lack of supervision" is the issue.

4) County child protection workers should aggressively pursue protective intervention of surviving minors when discrepancies and questions remain surrounding the death of a sibling.

5) Foster parents should be informed and the county should comply with licensing rule part, Minnesota Rule 9545.0180, subpart 1.A., requiring foster parents to administer prescribed medications to foster children.

6) In a case where a mother's boyfriend murdered a child the panel recommended that the county make a child protection referral to the state where the mother moved because she had given birth to another child and had a history of relationships with abusive men. The panel also recommended that the county conduct a child protection assessment for neglect by the mother in order to create a file regarding the mother's role in the death and to serve as documentation if background information is sought by another jurisdiction.

7) Child protection and public health (if they are involved) should determine whether the planned sleeping space for an infant is safe prior to releasing the child from the hospital.

II. MEDICAL

Reviews of child deaths underscore the importance of thorough medical evaluations and concise reporting to appropriate authorities in cases where maltreatment is suspected. It is clear that the ability of the system to protect children is often guided by the competence of medical providers to identify maltreatment and their willingness to commit to a diagnosis of abuse or neglect. Medical personnel who feel uncomfortable with diagnosing abuse or neglect should seek consultation from colleagues who specialize in the recognition of child maltreatment.

The panel also noted what appears to be a diminishing ability for medical professionals to provide care and respond to children at risk as more families are moved from traditional medical services to managed health care.

A. Practice

- In a case where a 2 month, 23 day old female died of sudden infant death syndrome (SIDS), the panel was concerned about the ambivalence a physician expressed to the mother regarding the importance of using an apnea monitor. Although there was no consensus as to the importance of using the monitor, it seemed the monitor should have either been withdrawn or clear expectations should have been discussed with the parent to use the monitor.

- In a case of a second SIDS death within one family, the social service agency would have been in a better position to intervene had the physician who made a child protection report labeled the injuries as caused by maltreatment. The nature of the injuries suggested that abuse had occurred; i.e., bruises on a two month old child, bruises of different ages, and a "pattern bruise".

- A child protection report from one hospital was ambiguous. It would be helpful to child protection agencies if there were a standard practice used by physicians to indicate in their written report whether maltreatment was "clinically suspected" or "clinically certain."

- A telephone medical consultation yielded a recommendation that a baby be bundled up to raise its temperature. This suggested that the medical staff believed the mother's report that the baby's temperature was 94.5. If that assessment of temperature was accurate, the child should have been seen immediately by a physician or in an emergency room for medical care.

- Third parties who bid to provide medical care need to be aware that part of the cost of providing services to families with children at risk is the cost of networking with other community agencies. Medical staff employed by entrepreneur hospital-based programs are not as accustomed to working with child protective services as are public health nurses.

- There is a clash between the push for cost containment of medical care and the needs of children at risk requiring intensive services. The down side of cost containment is that some "at risk" children may die if comprehensive service coordination is not provided.

- In the review of a case in which Munchausen's Syndrome by Proxy was suspected, the panel was informed that this syndrome represents a spectrum of dynamics which is both broad and complex and requires a thorough review of <u>all</u> data to arrive at a differential diagnosis. Munchausen Syndrome by Proxy is a form of child abuse in which a disorder of the child is fabricated by the parent. This syndrome should be considered whenever the circumstances of a death cannot be explained.

- In the suspected Munchausen Syndrome by Proxy death, the findings of a pathologist who reviewed slides of the lung tissue concluded that there was pneumonia present that could have been a cause of the death. However, it did not appear that this finding was weighed against the other historical and medical data which could not be explained.

- In the suicide death of an adolescent, there was a concern that the amount of prescribed medication was far in excess of what would be prudent for an adolescent with a history of hospitalizations for suicide attempts and ideation.

- In a case where a pregnant woman was reported for "injecting drugs" (October 1989), there was concern that as a matter of standard practice, the physician did not test for substance abuse. It was noted that the law requiring the reporting of pregnant women using drugs was relatively new in 1989. It was hoped that the physician confronting a similar situation today would initiate testing for the use of controlled substances.

- The panel questioned the findings in the autopsy report of a one month old child whose manner of death was "probable natural". The autopsy indicated the serum screen tested positive for benzoic acid. If the information was correct, it was considered insignificant but the possibility of a misprint seemed likely. The substance may have been a cocaine derivative rather than benzoic acid. The panel requested clarification of this finding and determined that the lab finding of benzoic acid was accurate and not a typing error in the report. The pathologist stated that they have found benzoic acid in a number of infant deaths including SIDS. The panel was not sure what importance to attach to this finding but are noting it in the reports in the event it turns out to be significant in the future.

B. Sudden Infant Death Syndrome (SIDS)

In 1989, the National Institute of Child Health and Human Development promulgated the following definition of SIDS:

> "The sudden death of an infant under one year of age which remains unexplained after the performance of a complete postmortem investigation, including an autopsy, an examination of the scene of death and review of the case history".

To conclude that a child died of SIDS requires the physician to rule out all other possible factors including child maltreatment. While the panel has noted that scene investigations and autopsies are frequently obtained prior to a SIDS determination, there remains a concern that SIDS is too frequently listed as the cause of death at the expense of more thorough scene and postmortem investigations.

The findings listed below were made in reference to cases where SIDS was determined as the cause of death:

- A death certificate indicated death was due to SIDS prior to the availability of the autopsy report. As a result, the SIDS diagnosis brought to a halt any further investigation or assessment of the death. This particular family had a similar SIDS death a few years earlier and it was felt by the panel that it would have been more appropriate to classify the death as "unexplained infant death".

- The panel was concerned that the autopsy of a SIDS death did not indicate that there had been a toxicological test nor a test for electrolytes or glucose. Without a toxicological examination and a thorough death scene investigation, a diagnosis of SIDS cannot be made with confidence.

MEDICAL RECOMMENDATIONS:

1) A death certificate should not be completed until the process for establishing the manner of death has been completed; i.e., the death scene investigation, medical history and a complete autopsy. The final determination of death should be made following a consultation among those with information relevant to a determination as to the cause and manner of death.

2) A quality review process should be developed for determining compliance with the recommended autopsy protocol developed by the Department of Health ad hoc group which designed the Minnesota Infant Death Investigation Guidelines.

3) The panel supported a local review team recommendation that major medical providers should be required to establish service sites in the counties they serve. It is difficult for many rural families to travel significant distances to receive medical care for their children. Rural families with children should be referred back to rural providers for primary care.

4) Training should be provided to county child protection teams regarding the dynamics of SIDS deaths.

5) As medical personnel are often the first to arrive at the death scene they should alert law enforcement of the details of the death scene after life saving efforts are completed.

6) Organizations representing pathologists should develop minimum standards for conducting autopsies when child abuse is suspected.

7) The Director of Health Care Management Services at the Department of Human Services should be invited to speak at a panel meeting to provide background on the differences between traditional public health nursing services and managed health care services.

8) Information regarding crisis nursery services should routinely be distributed to parents upon discharge of a newborn from the hospital. Crisis nursery services allow the parent(s) a often needed respite from the stress of a newborn in the home.

III. MEDICAL EXAMINERS AND CORONERS

Medical Examiners/Coroners have the responsibility of determining the cause and manner of death when there is a violent death or a death under unusual or mysterious circumstances. Medical Examiners/Coroners play a pivotal role in detecting and/or determining whether maltreatment contributed or caused the death of a child. Often the focus of law enforcement investigations and child protection assessments are determined by the findings of the postmortem and investigation conducted by the Medical Examiner/Coroner.

- It is the responsibility of local coroners or medical examiners to recognize the limits of their expertise and local resources. They should consult with specialists when confronted with deaths which exceed these limits.

- In one case, an investigation was not conducted as a possible homicide when the preliminary cause of death was SIDS. This particular child had a diagnosis of Galactosemia (genetic disorder resulting from defective galactose metabolism) and evidence of traumatic injuries to the head. It did not appear that the autopsy considered the medical history of the child. When traumatic injury is suspected as a cause of death, the investigation should rule out homicide prior to making another determination of death.

- In another case a 20 month old child was diagnosed as having cerebral edema and brain stem herniation - etiology uncertain. The manner of death was listed as natural. The autopsy failed to recognize the importance of a recent history of fractured ribs in various stages of healing. The child was noted to be energetic and healthy on the day of death, which is inconsistent with a diagnosis of viral meningitis as listed on the autopsy report.

- The panel noted that, although referral and consultation between medical providers occurs frequently for a variety of medical reasons, it occurs less frequently when child abuse is an issue.

- In the case of the teenager who committed suicide by using prescription medication, the local coroner did not conduct an autopsy. This rendered it impossible to determine the amount and type of drug used to overdose and if the prescription refills were illegally obtained.

- In another case, a five year old died from asphyxia after being found locked in a chest. Social services determined that drug abuse and neglect of the caregiver contributed to the child's death. The death certificate stated the manner of death was

an accident. The panel felt strongly that neglect should have been listed on the death certificate under "Other Significant Conditions".

- In another review, the death certificate of a nine month old child listed death due to asphyxia (tissue paper found lodged in the child's upper aerodigestive tract) with the manner of death being an accident. However, the panel questioned the size of the tissue paper described in the autopsy versus the size needed to asphyxiate an infant and suggested the manner of death be changed to "could not be determined" instead of "accident". The autopsy also revealed that the pathologist had estimated the child's weight and height and did not obtain exact measures. Criminal charges were later brought in this death as the mother admitted stuffing the tissue paper in the child's throat.

MEDICAL EXAMINER AND CORONER RECOMMENDATIONS:

The following panel recommendations involved actions taken by the panel in response to specific child deaths:

1) In the death where the genetic disorder and traumatic injuries were not fully examined, the panel recommended that a letter be sent to the local coroner and requested that the death certificate be amended to remove SIDS as the cause of death.

2) In another case, the panel recommended that a letter be sent to the coroner suggesting that he seek expert consultation when doing an autopsy on a minor when child abuse is a concern. The panel also recommended that the coroner be requested to amend the death certificate to remove "natural" as the manner of death.

3) The panel recommended that a letter be sent to a local coroner with a copy of the Minnesota Infant Death Investigation Guidelines and suggested that there should have been an autopsy of a death by suicide.

4) In a review of a suspicious death, the panel recommended that a letter be sent on behalf of the panel to the coroner suggesting that he complete the death certificate as the manner of death had been left blank.

5) In the death of the child where tissue paper was found lodged in the throat, the panel recommended that a letter be sent to the coroner suggesting the manner of death be changed from "accident" to "could not be determined". In the same case, the panel recommended that a letter be written on behalf of the panel and sent to the pathologist who conducted the autopsy expressing concern regarding his practice of estimating the weight and height of the decedent.

6) In a case where a child died due to drowning in a bathtub with his intoxicated mother, the panel recommended that a letter be sent to the coroner and suggested that this data be mentioned in the "other significant conditions" space on the death certificate.

IV. PUBLIC HEALTH AND HOME VISITING

The review of child deaths has affirmed that the use of home visiting programs and traditional public heath nursing services to reduces the risk to children. Families under stress who are isolated from services and community supports appear to experience a greater likelihood of injury or death.

- Because a mother did not obtain prenatal care until late in the pregnancy should have served as a red flag that her baby should be considered "high risk".

- The treatment plan for a young mother who killed her child should include helping her to develop the ability to tell medical providers (if she becomes pregnant) of her experience of killing her child so that appropriate services can be delivered.

PUBLIC HEALTH AND HOME VISITING RECOMMENDATIONS:

1) The panel recommended that the state initiate a program for universal home visiting for families with newborn children in order to provide support, increase parents' awareness of their baby's developmental needs and to help in addressing situations that pose a risk to children.

2) Due to the number of cases reviewed where death was the result of overlaying, the panel contacted the Department of Health and requested that information regarding the dangers of bed-sharing be incorporated into their educational materials. The panel also recommended that a public service announcement be developed to address this issue.

V. LEGAL/LAW ENFORCEMENT

The review of child deaths reveals the complex relationship between statutes, law enforcement investigation, and ultimately, judicial decisions. Statutes which are broad in their authority enable law enforcement to thoroughly pursue allegations. Similarly, the thoroughness of an investigation directly impacts the prosecutor's ability to charge persons with crimes and prevail in court. Further, the greater the ability of law enforcement and social services to share information the greater the "systems" ability to protect surviving siblings and future children of a caretaker.

- In a case where a suspicious death was ultimately ruled as SIDS, the juvenile court had established jurisdiction and received information from social services. However, the court would not accept the information from social services and viewed the social service agency intervention as "the problem". The jurisdiction in which this case occurred is one in which there are rotating judges. Dependency/neglect issues are not given priority and some judges may not be knowledgeable and/or sensitive to children's issues.

- In the same case, there was a concern about the lack of sharing of information when the mother moved to another county. There is a difference in the way individual counties interpret the statutes governing the sharing of information with another county. In some counties the staff, as mandated reporters, share information with a family's new county of residence. It was recognized that there was a problem in applying the statute in this case as the court ruled the child was not at risk.

- The panel reviewed a case which they thought was appropriate for the mother to have been charged with criminal neglect. Primary considerations in believing criminal charges were appropriate were evidence of her smoking around a respiratory-impaired child and her failure to provide medically required care. Charging the mother would have underscored the seriousness of her child's medical needs and her lack of attention for the child's care. It also would have strengthened the subsequent CHIPS petition.

- In a case where a child died due to shaken baby syndrome, the alleged father was indicted for first degree murder. First degree murder charges were possible due to a change in the law which considers a past pattern of injuries.

- In one case, the public health nurse had weighed a baby five days prior to the death and found the child to be in the 75th percentile for weight. The autopsy revealed that the baby's weight was in the 25th percentile which represented a significant weight loss in the five days prior to death. Although law enforcement did investigate the death when it occurred, there did not appear to be any further investigation to eliminate criminal neglect or child endangerment. Due to this lack of investigation and the history relating to the medical condition of the infant in the days prior to the death, the medical examiner could not state that the child died as a result of neglect. However, the medical examiner was clear that the child did not die as a result of natural causes.

- In one case, the city law enforcement personnel initially arrived at the death scene (10:33 a.m.), assumed the death was due to natural causes, and did not preserve the scene. Several hours later (5:00 p.m.), when the county sheriff became aware of the death, a death scene investigation did occur and photos were taken. The death was ruled an accident. Subsequent aggressive follow-up by law enforcement occurred when a sibling developed suspicious injuries resulting in a confession by the mother to homicide.

LEGAL/LAW ENFORCEMENT RECOMMENDATIONS:

1) The Department of Human Services should seek to amend Minnesota Statutes, section 260.015, subdivision 24, to include the concept of "exposure" to domestic violence in the definition of "domestic child abuse".

2) Minnesota criminal statutes should be amended to make willful neglect a felony which matches the severity of penalty with the degree of harm or injury incurred.

3) The panel supports efforts to amend the juvenile code to extend the juvenile courts' ability to maintain delinquency jurisdiction beyond age nineteen for those delinquents in need of treatment. The panel recognizes the need for more facilities to house alleged juvenile sex offenders for secure treatment.

4) In the case where an alleged father was charged with first degree murder, the panel recommends that parent education be made part of his sentence. This recommendation was shared with the county prosecutor and the worker doing the presentence investigation.

5) The panel should study the issue of and examine mechanisms for allowing health care professionals access to children determined to be at risk beyond the current standard of "imminent danger" which is currently provided for in statute.

6) The definition of neglect should be expanded to include parental failure to respond to services when children are determined to be maltreated or in need of child protective services.

7) When the manner of death is undetermined and a child dies from other than natural causes, a law enforcement investigation should occur.

8) Law enforcement at a death scene should preserve the scene by calling in a backup if the child needs emergency transportation.

9) The panel recommended that a meeting be scheduled with the local medical examiner, police representative and county attorney to discuss the problems associated with the investigation of deaths where the manner of death is undetermined and the cause is something other than natural.

VI. CHEMICAL DEPENDENCY

There is probably no greater risk to young children than the presence of an impaired caretaker. Chemical abuse/dependency issues were the single most common factor in the majority of deaths reviewed by the panel. While it appears that professionals were consistently able to identify substance abuse problems within families, "the system" appeared unequipped to respond with effective interventions. The following conclusions and recommendations only begin to address what appears to be the number one health problem faced by present day society:

- There is concern about the inability to effectively intervene to protect children in situations involving drug- or alcohol-dependent women. From a medical perspective, being pregnant and intoxicated is as threatening as a suspicious bruise, yet the system is unable to effectively respond to the former.

- The lack of follow-up on a case plan requirement for a client to receive a chemical health assessment was a concern and noted in a number of social service cases.

- The panel considered a surviving child and any subsequent children born to be at risk until the mother deals with her chemical use problem.

- Although there was a court order for a chemical dependency evaluation of the father in one case, it did not appear that this ever occurred nor did it appear that the county pursued this to resolution.

- In the accidental death of a 14 year old female due to smoke inhalation, the deceased's blood alcohol content of .275 was considered a contributing cause of death. In the same case, there was a concern about the number of other youngsters in the extended family who may exhibit fetal alcohol syndrome/effects symptoms and the

likelihood that numerous others will be born to the extended family who may be diagnosed as having fetal alcohol syndrome/effects.

- The need for fetal alcohol prevention programs was identified.

- There is confusion throughout the state about chemical dependency (Rule 25) assessments. Some workers mistakenly believe that a Rule 25 assessment should be conducted only after chemical dependency is established and funding for treatment is needed.

CHEMICAL DEPENDENCY RECOMMENDATIONS:

1) County agencies should vigorously pursue court ordered chemical dependency evaluations for clients whose history indicates problems associated with chemical abuse combined with child neglect.

2) Chemical abuse/dependency problems of parents should be sufficiently resolved prior to returning children to from county custody.

3) Due to the overlying death of an infant by an intoxicated parent receiving chemical dependency treatment in a licensed facility, the Chemical Dependency Division of the Department of Human Services will require the provision of cribs in facilities they fund.

4) More chemical dependency treatment resources should be developed where parents and children can be together.

5) The process for entering treatment should be streamlined in order to achieve more immediate access to treatment resources. More immediate access will result in greater utilization and successful intervention.

6) The panel recommends that the Department of Human Services include training on the appropriate use of Rule 25 chemical dependency assessments in the development of a comprehensive training system for child welfare workers.

VII. CULTURAL/ETHNIC CONSIDERATIONS

The panel recognized a growing need for culturally appropriate services to families involved in the human service system. Over half of the deaths reviewed during this review period were children of color. The child protection "system" is challenged by the increasing number of diverse client populations.

- In a case involving the death of an Native American child, the family was viewed by tribal social services as very traditional regarding Native American customs. Therefore it was not felt to be unusual that they did not want an autopsy performed. However, the death certificate did not adequately explain the cause of death and without an autopsy there was insufficient information to provide an accurate explanation of the death.

- On the Minnesota reservation judges are appointed by the tribal council. If social workers want to petition the court, they must go to the tribal court judge instead of a county attorney as in non-reservation cases.

- In one case, the panel and the local agency agreed that the grandmother was the primary decision maker in the family and that any effort to provide services would meet with defeat unless the mistrust of that grandmother could be overcome. There was considerable discussion as to how much the mistrust was rooted in cultural differences and how much the mistrust served to mask the role of a classic enabler in an alcoholic system. It was pointed out that although grandmother spoke excellent English, it was her second language and her understanding of English may not be on a par with her ability to speak it. It was suggested that someone who could speak Ojibwa should translate and interpret concepts such as the case plan to the grandmother.

- There was an interest in exploring the possibility of tapping into the concerns within the Native American community about what is happening to children so that their community can become a resource in protecting the surviving children in extended families.

- A case brought a great deal of attention to the implementation of the Indian Child Welfare Act, with particular attention to those elements which may impede the common goal of protecting children at risk. Considerable discussion focused on the different standards for removal of a child between Minnesota Statutes and the Indian Child Welfare Act. The many questions boiled down to the following core question: Does the Indian Child Welfare Act as it is implemented, leave Native American children at greater risk than children the county agency is serving under the authority of more general protection statutes?

- In a case involving a Hmong family, the county public health nurse had difficulty meeting with the family due to the parents not being available. It is not unusual for Hmong families to be gone in the summer as they are often gardening.

- Traditional Hmong people generally do not trust the attempts by government to intervene in their lives. It is impossible for non-Hmong social workers to make intuitive inferences about the motivations of Hmong parents given the chasm of cultural differences.

CULTURAL/ETHNIC RECOMMENDATIONS:

1) The panel endorsed a county's effort to continue meeting with the Native American community to ensure that Indian Child Welfare Act standards are met.

2) The panel encourages county social services agencies to employ persons of color to conduct child maltreatment assessments with families of color in the community.

3) Native American reservations in the state should be included in discussions related to statute or rule promulgation relative to autopsy procedures.

4) Social service agencies or reservations should be notified by the Department of Human Services regarding procedures and notifications which pertain to the Minnesota Child Mortality Review Panel.

5) The panel recommends that local agencies employ a bilingual worker to aide in investigations involving the Hispanic families.

6) The panel recommends that the Department of Human Services examine the implementation of the Indian Child Welfare Act to determine:

- If the act created confusion as to whether there is equal protection for Native American children.
- Whether implementation of the act is achieving what it was intended to accomplish?

7) The panel recommends continued efforts to develop media materials on a statewide basis which would inform the Hmong community about relevant health issues and the child abuse reporting act.

VIII. INFANT DEATH INVESTIGATIONS GUIDELINES

- There is no standard operating procedure for the investigation of infant deaths. Statewide there is a considerable degree of variance between counties and jurisdictions. The Minnesota Department of Health developed infant death investigation guidelines as a result of Department of Human Service sponsored legislation in 1989. This legislation was prompted by the panel's recognition of inconsistencies in death investigations throughout the state. In the spring of 1993, the guidelines were finalized after a one year pilot period.

INFANT DEATH INVESTIGATION GUIDELINES RECOMMENDATION:

1) The panel recommends that at the next opportunity the Department of Human Services should amend the Child Protection Rule to include a requirement that completed Infant Death Investigation Guidelines be reviewed at each local mortality review.

IX. OTHER RECOMMENDATIONS:

1) The panel recommends that the Department of Corrections make parenting education available in correctional facilities for men.

2) Because we cannot assume that all parents have the necessary skills to be effective parents, the panel recommends that parenting education be considered in all policy and direct service decisions.

APPENDICES

APPENDIX I

Appendix I contains information derived directly from death certificates received by the Minnesota Department of Health.

CHILD DEATHS IN CASES REVIEWED				
#	AGE	SEX	MANNER OF DEATH	RACE
1	44 minutes	F	Undetermined	Native American/Black
2	24 days	F	Probable Natural	Black
3	28 days	F	Homicide	Black
4	1 month 3 days	F	Natural (Possible SIDS)	White
5	1 month 4 days	M	Accident	White
6	1 month 5 days	M	Accident	Black
7	1 month 11 days	M	Natural	White
8	1 month 13 days	F	Natural (SIDS)	Native American
9	1 month 19 days	F	Undetermined	Native American
10	2 months 4 days	F	Not indicated/deferred	White
11	2 months 17 days	F	Natural (SIDS)	White
12	2 months 23 days	F	Natural (SIDS)	Native American
13	2 months 23 days	F	Homicide	White
14	3 months	M	Accident	Black
15	3 months 16 days	M	Natural (SIDS)	White
16	3 months 18 days	M	Undetermined	Native American
17	4 months 2 days	M	Undetermined	Black/White
18	4 months 5 days	M	Natural	Native American
19	4 months 14 days	M	Homicide	White
20	4 months 21 days	M	Natural (SIDS)	White
21	5 months 11 days	F	Undetermined	Mulatto
22	6 months 1 day	F	Natural	Black
23	6 months 26 days	M	Homicide	Black
24	9 months 20 days	F	Homicide	White
25	10 months 26 days	M	Accident	White
26	1 year	F	Homicide	Hmong (Southeast Asian)
27	1 year	F	Homicide	Black

CHILD DEATHS IN CASES REVIEWED				
#	AGE	SEX	MANNER OF DEATH	RACE
28	1 year	F	Natural	Native American
29	1 year	F	Homicide	White
30	1 year	M	Accident	White
31	1 year 2 months	M	Homicide	White
32	1 year 8 months	M	Natural	Hispanic/Mexican
33	2 years	F	Not indicated	White
34	2 years	M	Accident	Black
35	3 years	M	Accident	White
36	4 years	M	Homicide	White/Native American
37	5 years	M	Accident	White
38	11 years	F	Natural	White
39	13 years	M	Accident	White
40	14 years	F	Suicide	White
41	15 years	F	Accident	Native American

APPENDIX II

CHILD MORTALITY REVIEW PANEL

Junie Svenson, Infant Mortality Consultant
Minnesota Department of Health

Ann Ahlstrom, Senior Attorney
Hennepin County Attorney's Office

Glenda Bode, Medical Review Coordinator
Ombudsman Office for Mental Health and Retardation

Judith Brumfield
Ramsey County Human Services

Patrick Carolan, M. D.
Minneapolis Children's Medical Center

Julia Rosekrans, M.D.
Mayo Clinic

James Christiansen, Program Manager
Hennepin County Community Services

Barbara Max, R.N.
Sibley County Public Health

Janice Ophoven, M.D.
St. Paul Children's Hospital

Garry Peterson, M.D.
Hennepin County Coroner

William Klumpp, Assistant Attorney General
Minnesota Attorney General's Office

Joel Kohout, Special Agent
Bureau of Criminal Apprehension

Carolyn Levitt, Director
Midwest Children's Resource Center

Carolyn McKay, Commissioner
Minneapolis Health Department

Philip Peterson, Director
Kanabec County Family Services

Tom Gray
Department of Education

Department of Human Services Staff

Cynthia Turnure, Director
Chemical Dependency Program Division

Erin Sullivan Sutton, Supervisor
Early Intervention and Child Protective Services
Family and Children's Services Division

Stephen Vonderharr, Coordinator
Early Intervention and Child Protective Services
Family and Children's Services Division

Denise Revels Robinson, Director
Family and Children's Services Division

Inta Sellars, Consultant
Early Intervention and Child Protective Services
Family and Children's Services Division

Sue Stoterau, Advisor
Early Intervention and Child Protective Services
Family and Children's Services Division

FORMER PANEL MEMBERS WHO PARTICIPATED DURING THE REVIEW OF SOME OF THE CASES

Dara Ceaser, Social Worker
Minneapolis Public Schools

Daniel Broughton, M. D.
Mayo Clinic

Jane Koch, Medical Review Coordinator
Ombudsman Office for Mental Health and Retardation

Department of Human Services Staff

Janet Wiig, Former Assistant Commissioner
Minnesota Department of Human Services

Ruth Grunke, Former Advisor
Early Intervention and Child Protective Services
Family and Children's Services Division

Lori Holmes, Former Consultant
Early Intervention and Child Protective S Services
Family and Children's Services Division