



Testimony for the Children and Families Committee

Minnesota House of Representatives

March 17, 2026

Marie K. Cohen

Child Welfare Monitor

[www.childwelfaremonitor.org](http://www.childwelfaremonitor.org)

[marie@childwelfaremonitor.org](mailto:marie@childwelfaremonitor.org)

Good afternoon! My name is Marie Cohen, and I live in Washington DC. After my first career as a policy analyst and researcher, I became a social worker and served in the District of Columbia's child welfare system until 2015. Soon after leaving that job, I began writing a blog, which later became *Child Welfare Monitor* ([www.childwelfaremonitor.org](http://www.childwelfaremonitor.org)). Child Welfare Monitor takes a child-centered approach to child welfare policy, prioritizing child safety and wellbeing over all other goals. I am proud to say that the Monitor is read by some of the leading policymakers, advocates, and academics in the field. I also helped establish the Lives Cut Short project ([www.livescutshort.org](http://www.livescutshort.org)), a joint venture of the American Enterprise Institute and the University of North Carolina Chapel Hill, which is devoted to documenting child maltreatment deaths and understanding the circumstances and policy choices that contributed to them. For that project, I wrote the report *Keeping the Public in the Dark: How Federal and State Laws and Policies Prevent Meaningful Disclosure about Child Maltreatment Fatalities and Near Fatalities*.<sup>1</sup> I am currently working on my second report on child maltreatment fatalities in the District of Columbia and am dealing with the multiple redactions allowed by the District's very flawed disclosure law.

Child fatalities are the most tragic outcome of a state's failure to protect children from abuse or neglect. To prevent such fatalities, legislators, advocates, and the public must have access to timely information about the circumstances leading to child maltreatment fatalities so they can identify how the system failed and what policy and practice changes are necessary to protect children. For that reason, Congress added a section to the Child Abuse Prevention and Treatment Act (CAPTA) in 1996, requiring all states to provide assurances to the US Department of Health and Human Services that they have provisions for disclosing findings and information regarding child fatalities and near fatalities from maltreatment.

Minnesota’s current law technically complies with the CAPTA requirement but is deficient in important ways. Findings and information on child maltreatment fatalities are available only upon request, which means the public will not find out about child maltreatment deaths unless the media has written about them or relatives have spoken up. The current law allows disclosure of previous maltreatment reports, investigations and agency actions only when they are “pertinent to the maltreatment that led to the child fatality or near fatality.” But “pertinent” is not defined. In my opinion, any prior abuse or neglect is pertinent to an instance of maltreatment severe enough to cause a fatality. Defining “pertinent” narrowly allows the department to disclose only reports or investigations of maltreatment that closely resembles the abuse or neglect that led to the death. For example, the department could argue that a previous finding of neglect has nothing to do with a child death caused by abuse, but abuse and neglect are strongly related, and many families (especially chronically maltreating families) have histories of both.

HF 4408 will be an improvement over current law. I strongly support the requirement that information and findings on child maltreatment fatalities must be made publicly available on the Department of Children, Youth and Families website, eliminating requirement that this information be available only upon request. However, the bill should be amended to eliminate the language requiring the disclosure of previous maltreatment reports, investigations and agency actions only when they are “pertinent to the maltreatment that led to the child fatality or near fatality.” As I mentioned, this provision in the current law can be used to radically restrict the information that is disclosed.

Thank you for the invitation to testify and I am happy to answer any questions.

---

<sup>1</sup> See <https://www.aei.org/wp-content/uploads/2024/11/Keeping-the-Public-in-the-Dark-How-Federal-and-State-Laws-and-Policies-Prevent-Meaningful-Disclosure-About-Child-Maltreatment-Fatalities-and-Near-Fatalities.pdf?x97961>.

Testimony in support of HF 4408 to improve transparency in regard to child fatalities caused by abuse and neglect.

Co-chairs West and Kotyza-Witthuhn and members of the committee:

My name is Rich Gehrman. I am the founder and former Executive Director of Safe Passage for Children of Minnesota. I am here to speak in support of Representative Nelson's Bill to promote increased transparency around child deaths due to maltreatment. I am speaking on my own behalf, not representing legislative positions of Safe Passage for Children.

Safe Passage has produced three reports on Minnesota child fatalities due to maltreatment covering hundreds of child deaths from 2014-2025. I performed or supervised the research and writing of these reports. Based on this experience I offer the following reasons to support this bill.

First, the bill places affirmative responsibility on the state Department of Children, Youth and Families (DCYF) to post reports related to child maltreatment fatalities and near-fatalities on the Department's website, whether they were the subject of a joint review with the state panel or as a result of a local review. This is important because neither the state agency nor counties have in the past provided this information consistently or in a uniform format, despite the statutory requirement to do so. While some counties have produced reports to the public as requested, others have responded only after long delays, or produced information at a summary level too general to offer insights into the causes of the death. For its part, the state agency, despite numerous requests, has not released the reports it received from counties, nor has it shared basic information such as the total number of fatalities in a given period. The result has been gaps in understanding the scope of the problem as well as underlying reasons for maltreatment-related fatalities. This has made it difficult to understand what changes in policy and practice are needed to keep children safe.

This bill would provide increased standardization and accountability to this process.

The requirement for the child mortality review panel to provide an annual report of child fatalities should also increase public understanding of the causes of child fatalities and near-fatalities, though I would encourage the bill authors to require more specific information, because in my experience the Department has interpreted legislative requirements in a way that provides the least possible information to the public.

One friendly amendment to the bill would be to eliminate phrases allowing counties to disclose only "pertinent" past encounters with the child protection agencies. This term has been used by some counties to not disclose essential information, for example previous terminations of parental rights.