Safe Passage for Children of Minnesota

Minnesota Child Fatalities from Maltreatment

2014 – 2022

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Richard Gehrman
Executive Director

Maya Karrow
Staff Attorney and
University of
St. Thomas
School of Law
Archbishop Ireland
Justice Fellow

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Executive Summary

This study of children who died in Minnesota because of maltreatment was undertaken to identify opportunities for constructive changes to the philosophy, policy, practices and management of Minnesota's public child protection and foster care programs, known together as child welfare.[1]

The project collected data and reviewed documents from Minnesota counties and courts related to 88 children who were killed between October 2014 and May 2022. The analysis by the authors was augmented by case reviews performed by fifteen Subject Matter Experts (SMEs) in six fields that regularly interface with county child protection programs. The report is presented in two sections, one focusing primarily on state and county child protection agencies, the other on the court system.

An average of two children per month were killed in Minnesota by their caregivers during the report period. Our analysis demonstrates that many of these deaths were preventable and were due to a child welfare philosophy which gave such high priority to the interests of parents and other adults in households, as well as to the goals of family preservation and reunification, that child safety and well-being were regularly compromised.

The findings from this study include:

- Fifteen cases included signs of child torture and five unambiguously met the definition of torture across three different national and state standards.
- Nearly half of children (48%) died due to actions of someone other than a biological parent, including particularly domestic partners and kinship foster parents.
- The quantitative data and case narratives we assembled raise questions for further study of whether counties may have left Black children in high risk settings more frequently and for longer periods of time than children of other races and ethnicities.
- Seven children were killed in foster care including six in kinship placements.
- Both nationally and in Minnesota over 70% of child fatalities are children under three, but a higher percentage of these children were previously known to child protection in Minnesota compared with other states.

The core mission of child welfare is to protect children, yet it frequently left them in situations where they experienced life-altering neglect, repeated physical and sexual abuse, and sometimes torture, often over long periods of time. In many cases a number of individuals in multiple institutions knew about ongoing maltreatment but failed to act.

The eleven children's stories used in this report portray a system that seems to have become inured to dangerous levels of abuse and neglect of children, the majority whom were infants and toddlers. In this regard it is important to remember that timelines for children and adults are not the same. While the system may give parents years to stop harming children, virtually every

[1] This project was made possible by funding from Kathleen Blatz and Greg Page, who supported a staff attorney through the University of St. Thomas School of Law, Archbishop Ireland Justice Fellows Program.

month that infants and toddlers continue to be traumatized by physical abuse or lack of nurturance causes further damage and often permanently diminishes their life prospects. We believe this report will demonstrate that the system's tolerance for violence against children and its lack of urgency regarding its youngest victims are out of alignment with overall community norms.

The following are a few brief examples of these children's stories. While the authors recognize that not all readers may agree with using the names of those who were killed, we believe that the child victims deserve to be remembered, and that their suffering and often unnecessary deaths may help spur a re-evaluation of current practices, and help save the lives of children in the future.

- Two-week old Anthony Herkal was killed by his father after he was served by the court with seven no- contact orders, and was charged and convicted of five domestic violence related felonies and misdemeanors. The family was also investigated twice by child protection. The final maltreatment report before Anthony's death was treated as low risk.
- Eight-year old Autumn Hallow was starved and tortured to death over a period of six months, despite frantic pleas by neighbors to local police and by her mother to the courts and child protection, each of which appeared to have sufficient information to intervene.
- Five-month old Aaliyah Goodwin was smothered to death following eight reports to child protection over seven years documenting that both parents were chronically incapacitated by drugs and unable to take care of her and her older siblings.
- Over a period of twelve years, eight year old Tayvion Davis and his siblings were sexually assaulted by four family members, beaten with hammers and belts, burned with boiling water, and deprived of food and sleep as a form of discipline, until Tayvion was locked in a garage overnight in subzero temperatures and froze to death; despite additional reports to child protection, Tayvion's siblings remained in their mother's care for five more months, and charges were not brought against her for his death a year and half later.
- Custody of six-year-old Eli Hart was returned to his mother after two inpatient psychological evaluations for delusional behavior; despite ongoing concerns expressed by the child protection caseworker and the Guardian ad Litem about her chronic mental illness, they recommended that her case be closed; nine days after the court terminated her case she killed Eli with nine shotgun blasts.
- Two-month old Eli Hentges and four-month old Kamari Gholston were both sent home with their mothers after presenting at well-baby checks with injuries which could not be self-inflicted by infants; shortly afterwards both children were killed by their mothers.
- Layla Jackson, a Black/Native American toddler was placed in kinship foster care with a relative who recorded himself screaming racial epitaphs at her and writing "loser" on her face; according to the Scott County Sheriff's Office the complexity of the child's injuries, necessitated additional examination by specialists, prolonging the autopsy results.

These and other stories, along with the quantitative data we assembled, illustrate patterns that deserve further attention, and which are analyzed in the sections below on Family Assessment and family preservation practices, and on the Court system. They include:

1. Repeated inappropriate assignment to the child protection track intended for low risk cases, known as Family Assessment.
2. Inaction in the face of chronic multitype maltreatment, i.e., chronic neglect which when allowed to continue spirals downward, often to include physical and/or sexual abuse.
3. Seemingly limitless chances in neglect cases for parents to address chronic problems.
4. Returning children home from foster care before parents have made the necessary behavioral changes.
5. Red flags that were missed or ignored by medical providers.
6. A concerning number of children killed in foster care, primarily kinship placements.
7. 12%-15% of the fatalities showed signs of or clearly were torture.
8. Children being returned home to seriously mentally ill parents.
9. Biological parents receiving substantially shorter prison sentences for killing their children than non-parents.
10. Questions that were raised by plea deals for parents.
11. Limited information-sharing and ambiguity around the responsibilities of criminal, family and juvenile courts.
12. Ineffectiveness of no-contact orders in domestic violence cases.

From a broad perspective, the causes of these shortcomings are complex. For example frontline caseworkers may lack necessary resources to do their jobs, be diverted from direct service by burdensome administrative requirements, and discouraged by attacks that blame them for the shortcomings of the system. From the viewpoint of human services as a whole, there are gaps in resources that if filled would help mitigate child maltreatment – child care, targeted home visiting, public health and mental health services to name a few. As a result any efforts to remedy the above patterns will require better equipping caseworkers to do their jobs, investments by elected officials in services, and leadership from the broader human services community.

However this report focuses primarily on the role of leaders and top managers who are directly responsible for the current philosophy and practices that contributed to the fatalities described below. These include individuals in the state Department of Human Services, county child welfare agencies, the courts, county prosecutors, local law enforcement, and Guardians ad Litem.

Our hope is that the often distressing findings from this study will encourage those involved both directly and indirectly in child welfare to make appropriate changes in their own organizational spheres, and to help raise child welfare to a high level public policy concern. The primary—and ultimate—goal should be to timely protect children from dangerous abuse and neglect that jeopardizes their safety and well-being.

The following section describes the methods used to gather the data.

Methods

The 88 child fatalities in this study occurred from October 2014 to June 2022. We selected this time period to update information from a similar project done by reporter Brandon Stahl, previously of the Star Tribune, who tracked child fatalities from 2006 to mid-2014.[2]

Eighty-six of the 88 children in our study died in Minnesota while two had child protection history here before being killed out state. We identified 75 of these cases by searching online media outlets. Eight additional cases were identified for us by Violence Free Minnesota, an association representing domestic violence programs. Counties volunteered information regarding five other fatalities that were not covered in the media.

At the start of the project, we sent letters to 30 counties where we had information from the above sources that one or more fatalities had occurred. We requested a fatality review report or reports pursuant to the Minn. Stat. 260E.35 subd. 7.[3] Under this statute, Minnesota counties are required upon request to provide a written summary of information related to child fatality cases if a person is criminally charged with having caused the fatality, or a child protection investigation resulted in a determination of maltreatment. The required disclosures include the cause and circumstances regarding the death, the result of any child mortality review, and information regarding any previous child protection reports or investigations that are pertinent to the maltreatment that led to the child fatality.[4]

The Minnesota Department of Human Services (DHS, or "the Department") maintains an ongoing inventory of child fatalities and shared with us that a total of 161 children died due to maltreatment from January 2015 through April 2022, which approximates the period of our study. We requested that the commissioner exercise her discretion in releasing mortality review data under Minn. Stat. 256.01 Subd.12 (d)[5], but this request was denied. This meant that we were unable to identify the additional children for our analysis and, as a result, could not review court records or request county fatality reports for them.

A second major source of information on the 88 fatalities known to us was court records maintained in the Minnesota Court Information System (MNCIS), which provides public access terminals in county courthouses to Juvenile, Family and Criminal Court records. Two court documents in particular provided most of the case history: Child in Need of Protection and Services (CHIPS) and Termination of Parental Rights (TPR) petitions, each of which usually include case histories provided to the court by caseworkers and Guardians ad Litem. Criminal Court records often provided us with important additional information including demographics on the perpetrator, such as race/ethnicity and their criminal history, including any history of domestic violence as indicated by domestic assault charges, and Domestic Abuse No Contact

[2] "Eric Dean: The boy they couldn't save" , Brandon Stahl, Star Tribune, September 1, 2014.
[3] Available at https://www.revisor.mn.gov/statutes/cite/260E.35
[4] Id.
[5] Minn. Stat. 256.01 Subd.12 (d). The commissioner may disclose conclusions of the review panel, but shall not disclose data that was classified as confidential or private data on decedents, under section 13.10, or private, confidential, or protected nonpublic data in the disseminating agency, except that the commissioner may disclose local social service agency data as provided in section 260E.35, on individual cases involving a fatality or near fatality of a person served by the local social service agency prior to the date of death.

Orders (DANCOs)[6]. Family Court records provided information on cases with co-occurring custody disputes, as well as regarding other protective orders including Orders for Protection (OFPs) and Harassment Restraining Orders (HROs) [7].

Because we know that child fatalities are impacted by a number of related factors, we also solicited input from fifteen Subject Matter Experts (SMEs) in six related sectors, using a model developed by the National Children's Alliance[8], which is funded by the Department of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP). These disciplines were child welfare (both from a national policy and local management perspective), domestic violence, local law enforcement, officers of the court including three Assistant County Attorneys and a retired Family Court judge, medical providers specializing in child maltreatment, and a Guardian ad Litem. Most groups had multiple members. The Guardian ad Litem and law enforcement areas had one SME each. Brief bios of the participating SMEs are included as Appendix A, with the exception that due to current active caseloads the local law enforcement and Guardian ad Litem SMEs are not identified by name. Feedback from the SME groups is included throughout the report.

The input of the SMEs was invaluable but the writing, analysis, and recommendations in this report are those of the authors. While our assessments of cases often aligned with those of the SMEs, they did not always do so. In that regard individual SMEs should not be considered to have endorsed all the contents of this report.

In response to our requests to counties we received 55 child fatality reports. Of the thirty-four cases for which we do not have a fatality review report, 21 were requested from counties but not received. Despite this we were able to include those cases in the report based on information in media reports and court records. We did not request reports for cases in which there were pending criminal charges because counties are exempt from providing them until that process is completed, or for Indian Child Welfare Act (ICWA) cases, which are handled under tribal jurisdiction and not accessible to the public.

Replies from counties varied, with some expressing interest in our project and identifying additional cases that we would otherwise not have known about. In other situations the information returned from counties was inconsistent with what appeared in the court records. One county took issue with the commonsense definition of "pertinent" to avoid providing us with required disclosures.[9] A few counties redacted all identifying information, even though this information was known to us since it was used to make the request.[10] Several counties could

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[6] There are two main avenues to protect victims of domestic violence in our system, an Order for Protection (OFP) and a Domestic Abuse No Contact Order (DANCO). An OFP is issued in family court at the request of the victim. A DANCO is issued by criminal court in response to a domestic assault charge. DANCO's are issued at the discretion of the criminal court, even over the objection of the victim of the assault. If a perpetrator violates the terms of an OFP or DANCO, they will be criminally charged with a misdemeanor, and if they continue to violate the terms of the protective order, they will be charged with a felony.

[7] A Harassment Restraining Order (HRO) is a restraining order to prevent harassment by anyone, regardless of the relationship between the victim and perpetrator. An HRO is issued in civil court.

[8] See National Children's Alliance.

[9] Beltrami County maintained that three separate child protection investigations into allegations of neglect of the foster children were not pertinent to the abuse or neglect that led to a foster child's fatality. We were however able to get the foster family's accurate child protection history through MNCIS.

[10] For example, we would request the child fatality data from a county for a child that we named and the county's response would have the child's name redacted. While this may be in compliance in a technical sense with the statute as the child's name is not explicitly listed as part of the required disclosures, it appears contrary to the intent of the statute.

not locate case records for the fatalities although they were known to the media and were in the MNCIS system. Two counties did not respond at all.[11]

The project employed four coders. Each case was coded into a spreadsheet consisting of 84 elements that correspond to a coding manual with definitions of each element and information regarding how to code the information for consistency.[12] To maintain inter-rater reliability, 30% of the cases were coded by at least two people. Coding took place from January 2022 to June 2022. We captured 55 of the elements as quantitative measures. For example, for "Race of the deceased child," 1= White, 2 =Black, 3= Asian. Nine elements were dates we collected for each case, such as "date of child fatality" or "date of first Family Assessment." Six were qualitative elements, which included the county where the death occurred, the child's name, and up to three perpetrators/participants/parents for each case. Fourteen elements were quantitative dates including "child's age at time of death" or "number of siblings."

Acknowledgements

We owe a great debt of gratitude to the SMEs for their investment of time and expertise, which helped ensure that the findings and conclusions of this report are grounded in the reality of child welfare operations. We also appreciate the review of our findings by additional colleagues listed in Appendix A. We especially wish to acknowledge the assistance of Dee Wilson, a national child welfare researcher and policy expert, who edited the document and helped ensure that our results took relevant research into account.

Limitations

The refusal by DHS to share the names of cases not reported in the media contributed to a significant limitation in our study. We obtained a substantial amount of information on 88 (55%) of child fatalities during this period. Despite the fact that this is a majority of the total group, it is possible that it is not representative of the whole in some unknown ways. In particular there is a concern that our approach may have oversampled child fatalities caused by violent maltreatment and torture, with the result that child fatalities due to neglect are underrepresented. This could potentially occur because cases of a violent nature perhaps may have been more likely to come to the attention of the media, which, as noted, was the way we initially identified most fatalities.

That said, the data and stories contained in this report stand on their own in the respect that they represent a large number of child fatalities and are sufficient to discern serious issues in the state's child protection and foster care systems.

The fact that DHS shared with us the total number of fatalities did allow us to determine that our universe of eighty-eight cases was reasonably representative of the actual rate of child fatalities for various counties. For example, 37.9% of the cases from the DHS inventory are Hennepin County cases, while 31.8% of cases included in our study are from that county. Similarly, 15.5% of the cases from the DHS inventory are Ramsey County cases, compared to 12.5% in our study.

A second significant limitation was that court records often did not include enough details about the case history to determine whether appropriate steps were taken by each of the actors

[11] Red Lake and Grant County did not respond to our requests.

[12] The coding manual is too long to include as an appendix to this report. However it is posted on our website under this report, or a link to it is provided here.

involved. In the case studies below we have attempted to point out where information gaps led to uncertainty whether different or more timely decisions may have prevented a fatality. We also excluded from this report a number of potential findings that may have been important but which we could not document fully. The lack of key information was also remarked on by the SMEs, who noted that they were often unable to determine exactly what happened at crucial steps in the child protection process. As a result they limited their feedback to comments that they felt they could make with reasonable certainty.

Statistical Analysis

The following sections summarize some of the key quantitative information collected in the course of the project.

Child Demographics

The coders collected the following demographics for each case.

Age

The age of the child at the time of death is consistent with national statistics, as seen in Exhibit 1.

The highest percentage by age group is infants, defined as less than one year of age. They account for 42% of Minnesota fatalities, compared with 45% of cases nationally. This corresponds to research that the risk of dying due to maltreatment is highest by far during the first year of life. Infants are the most vulnerable age group to abuse and maltreatment because of their physical vulnerability, total dependence on their caregivers, and inability to defend themselves or seek help. Children under the age of four, including infants, comprised 78.4% of our sample of Minnesota cases, compared to 76.3% nationally.

Exhibit 1 - Age of Child

Age at time of Death	Minnesota Fatalities	Fatalities Nationally[13]
0-11 months	42.0% (37)	45.4%
1-3 years	36.4% (32)	30.9%
4-7 years	9.1 (8)	11.2%
8-11 years	6.8% (6)	5.6%
12 and over	5.7% (5)	6.7%

Gender

Of the child fatalities included in our study, 64.8% were boys, and 35.2% were girls. Our data shows somewhat more male victims than the national average. In 2020 nationally, 890 boys (60.4%) and 584 girls (39.6%) died due to abuse or maltreatment, based on state submissions to the National Child Abuse and Neglect Data System (NCANDS).[14] The gender breakdown for all victims of abuse and neglect indicates that boys and girls are in the child protection system at nearly equal rates, 48.1% boys and 51.6% girls,[15]

[13] U.S. Department of Health and Human Services "Child Maltreatment, 2020", p. (Need a page for the chart this is in).
[14] DHHS Child Maltreatment report. Exhibit 4C page 56.
[15] DHHS Child Maltreatment report. Page 22.

indicating that boys are disproportionately killed by their caregivers, both in Minnesota and nationally. We did not have the resources or expertise to analyze the causes of this disparity; however some researchers note that boys are more likely to have disabilities in early childhood, which significantly increase the chances of death in preschool-age children generally, including in child protection[16].

Race

The fact that Black, Native American, and mixed-race children are disproportionately represented in Minnesota child welfare systems and nationally is well documented.[17] As shown in Exhibit 2, while children in most demographic groups died due to maltreatment approximately in proportion to their representation in child protection system overall, Black children represented 17.8% of those with child welfare involvement but 26.1% of fatalities. On the other hand, while White children represented nearly half of the children with open child protection cases, they accounted for only 23.9% of the deaths. Exhibit 2 also illustrates the fact that race/ethnicity is not recorded in many court records and child protection fatality reports. The Analysis section below explores factors that may contribute to this disparity as well as some options for addressing it.

Exhibit 2 – Race of Child

Race of Child	Number of Fatalities	Percentage of All Fatalities	Percentage in Child Protection Overall
Black	23	26.1%	17.8%
Native	6	6.8%	7.3%
White	21	23.9%	49.9%
Mixed Race	12	13.7%	17.0%
Asian	3	3.4%	2.5%
Latina	2	2.3%	11.1%*
Unknown	21	23.9%	5.5%
TOTAL	88		

Manner of Death

As shown in Exhibit 3 below, the most common cause of death in our sample was blunt force trauma to the head or body, accounting for 52.3% of the fatalities. This is consistent with the fact that a substantial majority of child homicides and of neglect related deaths are infants and toddlers.

[16] See the Sounding Board, Dee Wilson, 12/22/2022.

[17] According to the 2020 DHS *Minnesota Child Maltreatment Report, 2020*, p. 15: "Adjusted to population rates, American Indian children were **5.2 times** more likely to be involved in completed maltreatment assessments/investigations than White children, while those who identify with two or more races were **4.6 times**, and African American children **2.6 times** more likely." (Emphasis in the original.)

Exhibit 3 - Cause of Child's Death	
Cause of Death	**Percentage (n=88)**
Blunt force trauma to the head/brain	33.0%
Blunt force trauma to the body	19.3%
Asphyxiation	17.0%
Gunshot wound	8.0%
Drowning	5.9%
Sepsis	3.4%
Intoxication/drugs in system	3.4%
Stab wound	3.4%
Hypothermia/hyperthermia	2.3%
Fire	1.1%
Undetermined	3.4%

Perpetrator Demographics – Who is responsible for the child's death?

We obtained information from criminal and juvenile court records indicating which person was charged as being primarily responsible for the death of the child. In some instances a second person was charged with a lesser crime. Exhibit 4 provides a breakdown of responsibility.

Parents – Mother and alleged/adjudicated fathers

In 52% of cases, the biological mother and/or father was the person primarily responsible for the child fatality. The mother was primarily responsible in 27% of cases while the alleged or adjudicated father was primarily responsible in 22.7% of cases. In 2.3% of cases, the father and another party were equally responsible for the child's death.

Non-parents

In 47.7% of Minnesota cases, the person primarily responsible for the child fatality was someone other than one of the child's biological parents. We were unable to find a directly comparable national statistic. The federal Department of Health and Human Services Child Abuse and Neglect Fatalities report however shows child fatalities that were perpetrated by non-parents (which includes kin and childcare providers). The 2019 report, the most recent one available during the writing of this report, shows that only 16.6% of perpetrators were non-parents and another 13.3% of perpetrators described as undefined "other relationships". These were not further explained but may refer to domestic partners. Even if both categories are included, this data would suggest that non-parents were responsible for barely 30% of fatalities nationally in 2019. In sum while our efforts at finding data to compare Minnesota numbers nationally in this regard were not conclusive, they did raise a question for further study of whether non-parents are responsible for significantly more fatalities in Minnesota than nationally, or if this apparent difference was a product of our sampling methods or some other factor.

In 23.9% of Minnesota cases, court documents identified the mother's "significant other" as responsible for the child's death. In two of these cases the mother was also charged for contributing to the fatality.

There are seven cases (8%) in which a child died while in foster care, including six in kinship foster care. Six foster care deaths resulted in criminal charges. In three of these two people were criminally charged. Foster mothers were primarily responsible for the child fatality in three cases, and foster fathers in two cases. In two of these cases, the foster mother's boyfriend was primarily responsible for the child fatality. As described below, three of these cases also involved torture or indications of torture.

There are eight cases (9.1%) in which a caregiver other than an intimate partner or foster parent was primarily responsible for the child fatality. In four cases (4.5%), the caregiver was a relative[18], and in four cases (4.5%), the caregiver was a non-relative.[19]

In twelve cases (13.6%), two people were criminally charged for the fatality. There are several other cases in which the court record indicates that charging a second person was considered but not followed through on. In three cases (3.4%), two people were held equally responsible for the child fatality, and there were primary charges and secondary charges in 10% of cases.

Exhibit 4 - Primary Responsibility for Child Fatality

Persons Primarily Responsible	Percentage
Mother	27.3%
Father	22.7%
Mother and Father equally	1.1%
Father and Stepmother equally	1.1%
Mother's significant other	23.9%
Stepfather	3.4%
Foster mothers	4.5%
Foster fathers	2.3%
Foster mother's boyfriend	2.3%
Relative caregiver	4.5%
Non-Relative caregiver	4.5%
Adoptive mother and adoptive father equally	1.1%
Other	1.1%

Relationship between Perpetrator and Child by Age at Death

The following chart includes the three highest categories of perpetrators in our study compared to the age of the child when they were killed. The chart demonstrates that cases in which a domestic partner was the perpetrator were more likely to involve older children: 87.5% were older than one year, and 25% were older than 8 years. In contrast, 75% of the children killed by bio-fathers were infants and another 20% were under three years of age. The percentage of children under three who died due to the actions of bio mothers was also high, but lower than bio fathers - 79% compared to 95%.

[18] Relative caregivers include a cousin, brother, uncle, and Godmother (related by blood).
[19] Non-relative caregivers include 2 childcare providers and 2 non-relative babysitters.

Exhibit 5 – Percent of Children Killed by Perpetrator by Age				
	Under 1 yr.	1 – 3 yrs	Over 3 yrs.	**Total**
Bio Mothers	13 (54%)	6 (25%)	5 (21%)	24
Bio Fathers	15 (75%)	4 (20%)	1 (4%)	20
Domestic Partners	3 (13%)	14 (58%)	7 (29%)	24

Living Situation

In 25 cases (28.4%), the child was living with both parents, including either adjudicated or alleged fathers at the time of the fatality. In 45 cases (51.1%), the child was living with their mother as the only biological parent, though the mother's domestic partner may also have been in the household either ongoing or sporadically. There were three cases (3.4%) of children living with their father only at the time of the fatality.

Substance Use

In 58 cases (65.9%), one or more of the parents/perpetrators had histories of substance abuse. Of the 24 cases in which the mother was primarily responsible for the child fatality, 19 (79.2%), had histories of substance abuse. Of the 21 cases in which the father was primary responsible for the child fatality, 13 (61.9% had a history of substance abuse.

Child Fatalities by County

The following chart shows the breakdown of child fatalities by Minnesota county using categories developed by the Minnesota Department of Health,[20] which breaks down counties by metropolitan, micropolitan, or rural.

Exhibit 6 - Child Fatalities by County		
Metropolitan	**Micropolitan**	**Rural**
Hennepin-- 28	Cass -- 1	Red lake –2
Ramsey -- 11	Otter Tail -- 2	Itasca – 2
St. Louis -- 5	Wilkin -- 1	Aikin -- 1
Dakota -- 4	Beltrami -- 1	Pine -- 1
Anoka -- 4	Goodhue -- 1	Cottonwood -- 1
Olmsted – 3	Mower -- 2	Kanabec -- 1
Washington -- 3		Hubbard – 1
Scott -- 2		Renville – 1
Blue Earth -- 3		
Sherburne -- 2		
Sterns -- 1		
Carlton – 1		
Benton -- 1		
Isanti -- 1		
Clay -- 1		
70 cases – 79.6%	8 cases (9.1%)	10 cases (11.4%)

[20] A Metropolitan statistical area must have at least one urbanized area of 50,000 or more residents. A Micropolitan statistical area must have at least one urbanized area of at least 10,000 or more residents, but less than 50,000 residents. https://www.health.state.mn.us/data/workforce/docs/2017cbsa.pdf

Analysis of Quantitative Results

Any strategy to improve child maltreatment outcomes must address two key quantitative findings, first that 78% child fatalities due to maltreatment are children under three years of age, and secondly that fatal outcomes are proportionately higher for Black children than all other groups and particularly compared to White children.

These two issues are closely related. There is a consensus among researchers that poverty is the most important single driver of child maltreatment. In addition, severe poverty, i.e., annual incomes less than 50% of the federal poverty standard, is associated with both serious harm to children and rates of foster care placement. As is well documented, BIPOC families (Black, Indian and Persons of Color) are more likely than Whites to be living in poverty or severe poverty. In addition, poverty is associated with elevated and disproportionate rates of child protection reports of infants in Black and American Indian families, often referred to as heightened surveillance or oversurveillance.[21] Factors such as inadequate housing or homelessness and childcare burdens associated with single parent families have a large effect on risk of child maltreatment. As a result, preventing child fatalities and reducing racial disproportionality in child welfare both depend significantly on relieving the economic strains that affect in particular Black, Native American and other BIPOC families, and on doing so as early as possible in the lives of child maltreatment victims.

An oft-cited study of California children by Emily Putnam-Hornstein, et. al. for example, found that while Black children were more than twice as likely to be involved in child protection overall, once poverty indicators such as receipt of Medicaid are adjusted for, "low SES (Socioeconomic Status) Black children were significantly *less likely* than low SES White children to be referred, substantiated, or enter foster care."[22] This supports the conclusion that attacking economic inequities that disproportionately drive BIPOC families into poverty will potentially have a significant impact on reducing child maltreatment overall as well as reducing racial disproportionality in child protection and foster care.

Poverty rates however are not the only important factor in addressing child maltreatment. Another California study by Putnam-Hornstein found that, after controlling for poverty, "A prior allegation to CPS proved to be the strongest independent risk factor for injury mortality before the age of five."[23] She found that a young child with a child protection report was 5.5 times more likely to die of intentional injury and two times more likely to die of unintentional injury than children without a child protection report during early childhood. These findings reinforce the importance of responding effectively to child maltreatment when it first emerges, particularly for young children.

The points to the fact that, as the case studies below demonstrate, strategies to mitigate poverty will not be sufficient to protect children in families in which poverty is combined with substance

[21] NIS interpretations: Race and the National Incidence Studies of Child Abuse and Neglect," by Drake, B and Jonson- Reid, M. *Children Youth and Services Review*, vol. 33 (1), pp. 16-20.
[22] Emily Putnam-Hornstein, et. al, Racial and ethnic disparities: A population-based examination of risk factors for involvement with child protective services, Child Abuse and Neglect 37, May 2012, p. 42.
[23] Emily Putnam-Hornstein, "Report of Maltreatment as a Risk Factor for Injury Death: A Prospective Birth Cohort Study", Child Maltreatment I 6 (3), 2011, pp. 163-174.

abuse, mental illness, or domestic violence, or when a young child is unusually challenging to care for due to disability or chronic illness.[24] [25]

These research findings suggest the following regarding public policy:

- The most effective single approach to reducing child maltreatment overall as well as to reduce racial disparities in child protection and foster care is to offer services to low- income families that reduce rates of poverty, such as to increase access to public benefit programs, reduce child- care burdens and meet housing needs.
- However, when poverty becomes combined in families with substance abuse, mental illness, and domestic violence, poverty-related services and income supports will not be enough to prevent serious maltreatment and child deaths; early intervention (prior to a child protection report if possible) through outreach to these families is necessary.

An encouraging development in this regard has come from a project conducted by the New York Times and Child Trends[26], which reached the unexpected conclusion that child poverty has fallen 59%'s since 1993, and that it has done so equitably across all racial and ethnic groups. The study attributed the unexpected decline to a combination of federal programs including expansion of both the Earned Income Tax Credit and child tax credit for low income families, food assistance provided by the SNAP program, the Affordable Care Act, school lunches, increased labor force participation among single mothers, increased number of persons qualifying for Supplemental Security Income, the impact of Social Security benefits for grandparents caring for their grandchildren, and other programs such as WIC and heating assistance.

This finding suggests that county casework services should prioritize helping families in or on the cusp of entering the child welfare system to gain access to these poverty-reducing federal programs. In addition, Minnesota has a state initiative, the Parent Support Outreach Program (PSOP), which offers concrete, usually financial supports to families with a recent screened-out maltreatment report. PSOP helps with needs such as rent, food, and transportation costs. Participation in the PSOP program is voluntary, and as a result it has not been effective in addressing problems that require parents' willing engagement in addressing chronic substance abuse, mental illnesses, and domestic violence. However it has diverted some families from long-term engagement in child protection, which fits with the finding that its early concrete relief from financial strains may have prevented or reduced these contributors to child maltreatment.

One reason that PSOP was effective is that program managers designed carefully worded introductory materials so that parents would not associate the services with their recently screened-out child maltreatment report. This practice illustrates the value of preventive services coming from programs which are perceived as being distinct from child protection.

As another example of this factor, several years ago the Minnesota Department of Education gave top priority for early learning scholarships to children who had open child protection cases or were in foster care, and lowered the age of eligibility from three years to birth. This was a promising approach for reaching infants and toddlers who were being maltreated, because early learning opportunities have been particularly effective in mitigating developmentally damaging

[24] Emily M. Douglas, "Testing if Social Services Prevent Fatal Child Maltreatment Among a Sample of Children Previously Known to Child Protective Services," Child Maltreatment Child Maltreatment Volume 21Issue 3: 239-249.
[25] See also Dee Wilson, "Hidden in Plain Sight: The Path Away from Child Maltreatment Fatalities," Sounding Board, April 2016.
[26] Thomson, D., Ryberg, R., Harper, K., Fuller, J., Paschall, K., Franklin, J., & Guzman, L. (2022). Lessons From Historic Decline in Child Poverty. Child Trends, 2022,. https://doi.org/10.56417/1555c6123k

toxic stress, as well as reducing the number of families reported or re-reported for maltreatment.[27] This policy was intended to support families in a way that would relieve parental stress and reduce the impact of maltreatment, particularly neglect. However the report for the latest fiscal year reported showed that only 253 child protection cases statewide accessed these scholarships, which included just 140 children under the age of three.[28] Program managers discovered that the uptake of services was low because parents perceived it as coming from child protection. As a result the impact of this promising program has been limited.[29]

Targeted Home Visiting programs have also been effective in reaching families with infants and toddlers before their entry into child protection.[30] These programs are often delivered by public health nurses or other professional or paraprofessional providers who are more readily accepted by parents than child protection workers.

These examples help underscore why it is critical that sectors closely related to the child welfare system make prevention of and early intervention into chronic maltreatment a core part of their own missions. One of our child welfare policy SMEs, Dee Wilson, suggested other concrete options to consider:

> "CPS should never be the first or only intervention in high risk families. It should become a goal of public policy to reach out to parents who need help in caring for their infant before a CPS report is made. This may include:
> - Funding public health nurse outreach to parents receiving publicly funded substance abuse or mental health services before a CPS report is received, or as soon after a report is made as possible, with an offer of voluntary safety- oriented services, e.g., respite care, free childcare, and support services for families who have a young child with a disability or chronic illness.
> - The child welfare agency's child safety framework should recognize that the children at highest risk of fatality from all causes are young children with disabilities or chronic illness whose parents or caretakers have functional impairments due to substance abuse, mental illness and/ or Domestic Violence (DV), or physical disability. CPS reports with these elements should never be screened out or assigned to FA."

Another approach recommended by Wilson is the use of multi-disciplinary case management teams, which can provide more integrated casework services, access to programs that reduce childcare burdens and housing needs, and help establish eligibility for income support programs.

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[27] There is a great deal of research on this but see for example the Chicago Longitudinal Study, Arthur J. Reynolds, Judy A. Temple et. al. Cost-Benefit Analysis of the Title I Chicago Child-Parent Center Program, Executive Summary pp 1-2 which showed a 51% reduction in maltreatment for participants.

[28] Early Learning Scholarships Scholarship Use in Minnesota – State Fiscal Year 2022, Appendix F: Statewide Child Counts by Age on September 1 and Priority Population – FY 2022, p. 29, and Beth Green et. al. "The effect of Early Head Start on child welfare system involvement: A first look at longitudinal child maltreatment outcomes", Children and Youth Services Review 42 (2014) 127–135.

[29] Conversations with Jessica Brogger Department of Human Services and Sandra Myers Minnesota Department of Education October 20, 2020.

[30] See for example See for example "Overview of Home Visitation Programs", Larry King Center for Building Children's Futures, 2011.

It is important to acknowledge that the approaches suggested here are not consistent with a common narrative that child welfare is a "family policing system" which separates parents, particularly BIPOC parents, unjustly from their children, is unable to distinguish poverty from neglect, and needlessly traumatizes children by removing them to foster care.[31] In contrast, here we describe steps that can be taken to safely reduce entry into child protection and the need for foster placements, but still advocate for reserving foster care as an option because in some instances it is necessary to preserve the life of the child.

Recommendations Related to Quantitative Findings*

1. Revise risk assessment instruments to give high risk scores in cases where infants and toddlers live with bio fathers and where older children live with domestic partners.
2. Significantly expand the state PSOP program.
3. Increase state investments in programs and services that have a documented ability to reduce child maltreatment, including Early Learning Scholarships and targeted home visiting.
4. Consider implementing multidisciplinary teams, and focus casework overall on ensuring that families have access to as many poverty reducing programs as they qualify for.
5. Develop partnerships between child protection and professions that are trusted by parents such as public health, PSOP, mental health, and domestic violence, to connect them more successfully to programs and services that reduce maltreatment.

* Recommendations from the end of each section of this report are collected in Appendix D.

Child Welfare Policy, Practice and Philosophy in Minnesota

We believe that our data combined with the analysis of case studies below will demonstrate that the philosophy currently guiding child welfare in Minnesota has contributed to many of the fatalities analyzed in this report.

To better understand this claim, it may be helpful to provide some context regarding the use of the Family Assessment model in child protection, and the overall emphasis on keeping bio families intact or returning children to their parents as soon as possible after an out-of-home placement, even when the setting is unsafe.

Family Assessment

Family Assessment (FA), is a major emphasis in Minnesota child welfare practice. It is an alternative to the traditional child welfare response to maltreatment reports, which is to investigate allegations for every screened-in CPS report. Minnesota is one of 34 states that initially adopted this approach, which is usually known as Differential Response (DR) or Alternative Response (AR), although some have since modified or ended it.[32] We use Alternative Response, or AR, in this report to designate this approach generically.

[31] For a concise overview of this dominant narrative see for example Marie Cohen, The Child Welfare Monitor, "Book Review: A Place Called Home: a needed antidote to the dominant narrative" January 17,2023.

[32] Piper, Kathryn A., et al. "Issues in differential response: Revisited." *Columbus, Ohio: The Center for Child Policy. http://centerforchildpolicy. org/assets/Issues in Differential Response Revisited. pdf* (2019).

Alternative Response emerged during the early 2000's as an effort to engage parents by developing a supportive, "family friendly" relationship with child protection rather than investigative approaches which some AR proponents alleged was inherently adversarial.[33]

In Minnesota, the Department of Human Services promoted the initial legislation authorizing FA in 2000 based on a commitment that it would be used for 20% to 30% of the lowest risk cases.[34] By 2015 however, more than 70% of screened in reports were being assigned to FA.[35] This development was noted by the 2015 Governor's Task Force on the Abuse of Children, which stated in its Final Report that "it is clear that Minnesota's use of family assessment is beyond that of other states and beyond what the statute allows" [36], and it recommended that "the types of cases in the family assessment track be narrowed".[37] However the most recent statewide report in 2020 indicated that 62% of child protection reports continue to be assigned to FA.

The original Guidelines for Family Assessment from DHS provided criteria to help caseworkers determine when a case was inappropriate for FA [38]. We have provided the list of these criteria in Appendix B. We asked the SMEs and coders to apply them to the cases they reviewed to identify which, if any, cases were assigned to FA inconsistent with the Guidelines. Their feedback was that the overwhelming majority of FA assignments were incompatible with them, usually in multiple ways. As a result, we did not include a statistical analysis of their feedback, rather we illustrated their findings by applying the DHS criteria to one case below, that of Sophia O'Neill.

In our view, as well as that of the 2015 Task Force, Minnesota's approach to AR promotes a number of practices that hinder the ability of child protection caseworkers to assess child safety, and therefore to protect children. These practices include giving caregivers advance notice of the initial child protection caseworker visit, and interviewing children in the presence of caregivers. Fact-finding protocols are also inadequate: while the new Minnesota Child Welfare Training Academy currently provides some curriculum on fact-finding, we have not found any DHS directive that requires its use or recommends a standard protocol.

Other unsafe practices include that caregivers are assured at the outset that there will be no finding whether maltreatment occurred, before any information is known. In addition, the preferred FA practice historically has been for caseworkers not to document what they discovered in the case record, including whether they believe maltreatment occurred, or to identify the child victim or the perpetrator. This obviously limits the ability of caseworkers to see dangerous patterns over time. Recently, state law was changed to require caseworkers to

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As of 2014, 22 states and the District of Columbia had implemented DR programs statewide, and six more states had implemented the program in individual regions or counties. Six additional states were considering or planning to implement DR (Hahn, 2016). By 2018, twelve states that had tried DR reform had discontinued the program, suspended it, or had elected not to expand it statewide, including West Virginia, New Mexico, Florida, Texas, Illinois, Oregon, Delaware, Arizona, Alaska, Washington, Louisiana, and New York. Of these, Florida, Texas, Washington, Oregon, and Arizona, were considering re-implementing DR statewide or were piloting DR regionally.

[33] Ronald C. Hughes, Judith S. Rycus, Stacey M. Saunders-Adams, Laura K. Hughes, and Kelli N. Hughes, "Issues in Differential Response", Research on Social Work Practice, OnlineFirst Version of Record - Jan 9, 2013

[34] Based on a conversation with the chief Senate author of the legislation, former Senator Jane Ranum.

[35] DHS "Child Maltreatment Report, 2020", p. 20.

[36] Minnesota Governor's Task Force on the Protection of Children Final Report p. 12.

[37] Ibid., p. 13.

[38] Minnesota Department of Human Services GUIDELINES FOR ALTERNATIVE RESPONSE TO REPORTS OF CHILD MALTREATMENT, Bulletin #00-68-4, April 4, 2000.

document their findings in the case record. However, this does not include specifying whether maltreatment was found or to identify the victim and perpetrator.

Another result of the FA philosophy was that Minnesota's screen-in rate has historically been much lower than the national average. Changes in statute in 2015 required the Department to develop statewide screening standards which resulted an increase in screened-in reports from 28% to 43%. This however is still well below the average for states which in most years is at or near 60%.

Administrative Consequences of Practice Changes

While Safe Passage for Children has advocated that these practices be changed, we are mindful that doing so may have workload implications. As a result we believe that an outside expert should be employed to analyze whether additional resources will be needed to implement these and other changes recommended in this report. The potential for adding new requirements without corresponding resources was illustrated by the 2015 review of the Hennepin County child protection program by Casey Family Programs, which pointed out that changes intended to strengthen investigations may have the opposite effect if the workforce isn't large enough to absorb the additional workload.[39]

Related to this, implementing or modifying good practices requires training. Several years ago the legislature approved the Child Welfare Training Academy, which had been recommended by the above-mentioned 2015 Task Force. However they failed to fully fund it. While the Department of Human Services and the University of Minnesota Center for the Advanced Study of Child Welfare (CASCW) partnered to develop the Academy, which includes a state-of-the-art facility that uses the best available training techniques, it is constrained in fully supporting the child welfare mission because does not yet have the intended budget.

One promising avenue to pursue regarding workload is the replacement or redesign of the Department's Social Services Information System, or SSIS. It difficult to identify caseworker time spent on SSIS because the statistics derived from it embed time spent on the computer into each type of casework activity, such as intake and investigation. However in our conversations over a number of years with caseworkers and managers both in Minnesota and other states, staff have consistently estimated that workers spend over 50% of their time entering information into SSIS. This has been recognized as a priority for the Minnesota Association of County Social Services Administrators (MACSSA) which is advocating for improvements in SSIS as part of a legislative package on modernization of DHS technology.[40]

A project to redesign this system would likely free up a considerable amount of caseworker time, virtually all of which could go directly to increased casework services. This would effectively increase workforce capacity without adding staff. It should be noted that part of a redesign would likely include recommendations to reduce documentation requirements and unnecessary steps in the investigation process, which would no doubt be welcomed by caseworkers and also reduce incentives to track cases to FA on the basis that they are less time-consuming than investigations.

[39] Assessment of Hennepin County Children and Family Services' (CFS) Children and Family Services' (CFS) Intake System, Casey Family Programs, June 2015.
[40] See the MACSSA Position Statement for 2023.

Another potentially helpful administrative resource specifically regarding child fatalities is the Department's Collaborative Safety Initiative (CSI), which has been operational since 2019 [41]. CSI applies quality improvement techniques used in the airline and hospital industries to fatality reviews. Typically such methods avoid blaming individual workers or counties for errors but instead identify systemic problems and recommend changes accordingly. Based on our experience with such projects we would expect that CSI would by now have identified some obvious contributors to child fatalities and made appropriate recommendations, for example to end the use of FA for infants and toddlers. However such changes have not yet been reflected in practice changes documented in the Department's periodic updates to their Guidelines.

Family Assessment Philosophy Applied to Open Child Protection Cases

Once child protection cases are open for ongoing child protection services, the effects of the overuse or misuse of Family Assessment are compounded by a similarly "family-friendly" philosophy that leaves children with their biological parents as long as possible and reunifies them as quickly as possible, in many cases regardless of whether the risks to the children have changed.

The impact of the family preservation philosophy is particularly important in considering the disproportionate rate of Black child fatalities documented earlier. We did not have the resources or expertise to analyze the reasons for this additional disparity. However the statistics in combination with our reading of court records has raised the question for us of whether Minnesota child welfare agencies may have tended to leave Black children in more high-risk situations for longer periods of time than children of other races and ethnicities. We recommend that the state agency engage an outside consultant with the necessary expertise to analyze this this occurrence and make any appropriate recommendations.

Recommendations Family Assessment and Family Preservation Philosophy

6. Reinstate the practice of limiting the use of FA to 20% - 30% low risk cases.
7. Reinstate the Department's original 2000 Guidelines to clarify cases that are not appropriate to assign to FA.
8. Engage outside experts to:
    - Analyze whether changes are needed to screening practices
    - Analyze the differential rate of child fatalities for Black children and make appropriate recommendations
9. Fully fund the Child Welfare Training Academy.
10. Fund a redesign of the Department's SSIS computer system.
11. Change FA practices described above that hinder caseworkers' ability to find information necessary to keep children safe, including:
    - End advance notice of the initial child protection visit
    - Interview children separately from and prior to adults
    - Mandate fact-finding in all assessments and investigations
    - Require FA case notes say if maltreatment occurred and if so who were the victim and perpetrator.
12. Determine if any additional resources will be needed to make recommended practice changes and if so include them in the state budget.

[41] See the DHS webpage Culture of Safety for the Minnesota plan, and the Collaborative Safety website for a view of the methodology and other states' implementation.

Combined Impact of Family Assessment and Family Preservation Practices

As indicated in the Executive Summary, our analysis revealed a number of patterns where Family Assessment combined with ongoing casework practices gave undue weight to family preservation and reunification and resulted in harm to children:

- Repeated inappropriate assignment to Family Assessment.
- Inaction in the face of chronic multitype maltreatment, i.e., chronic neglect that deteriorates over time into physical abuse and/or sexual abuse or torture.
- Neglect cases with seemingly limitless chances for parents to address chronic problems, exacerbated by ineffective safety planning.
- Returning children from foster care before parents have made the necessary behavioral changes.
- Red flags that were missed or ignored by medical providers.
- Concerning number of children killed in foster care, especially kinship placements.
- Alarming number of cases (12%-15%) that had signs of or clearly were torture.
- Children returned to parents with serious mental illness

We use each of the case summaries in the following sections to illustrate one of these patterns, although many exemplify a number of them. A summary of the SME comments is also provided for each section.

Repeated Inappropriate Assignment to Family Assessment

Out of the fifty-nine cases with Minnesota child protection history, thirty-one had at least one Family Assessment prior to the fatality. However, this number is likely higher because the court records did not consistently indicate to which track past cases were assigned. The families in our study had a range of one to six Family Assessments prior to the fatality event. Sixteen of the fifty-nine cases (27.1%) had two or more Family Assessments, and there were three or more Family Assessments in eight cases (13.6%). There may also have been previous maltreatment reports that were screened out, but neither court documents or county reports consistently recorded this information. We believe it is self-evident that the repeated use of FA in chronically referred families is inconsistent with the policy that FA be used only in low-risk cases. An alternative practice would be one used in past years by Illinois, which allows a case to be assigned to AR only one time.[42]

Viewed from another perspective, 20 of the 59 fatality cases with Minnesota child protection history were never investigated by child protection services. The following cases of Lylah Koob and Sophia O'Neill represent a number of other child maltreatment deaths that might have been prevented through conscientious investigations, rather than the repeated, risky use of FA.

Lylah Koob, Goodhue County

In November 2018, two-year-old Lylah Koob was killed while in the care of her mother's boyfriend, who became frustrated with the child after she vomited, and subsequently admitted to shaking her. Lylah's autopsy revealed she had sustained a subdural hematoma (bleeding on the brain) as well as significant acute injuries behind both eyes. Lylah's 4-year-old brother was interviewed during the investigation and reported that the boyfriend hit Lylah on the face after she threw up.

[42] 89 IL Admin Cod § 300.45

Prior to the child's death, seven reports were made to child protection, five of which were assigned to Family Assessment, one of which was screened out, and one which was recorded as an investigation, though an investigation was never actually done but rather the case was closed without services. Child protection reports contained allegations of physical abuse, sexual abuse, and unhygienic and unsafe conditions, including rotten food, garbage, drugs, alcohol, and sharp objects accessible to children throughout the home. A Family Assessment was conducted just 20 days before the fatality following a report that the mother and boyfriend were hitting the children with objects and dragging them by their hair. This assessment was closed with no services recommended or provided.

Sophia O'Neill, Hennepin County

Sophia O'Neill was two years old when she was killed by her mother's boyfriend, who had been watching Sophia while her mother was at work. In his interview with police, the boyfriend described his frustration with attempting to get Sophia to stop crying, and said he just "snapped on her". The boyfriend said he put her in a corner and kicked her in the back, which he demonstrated using a doll. When police asked how hard he kicked the child he said "…it was bad. It was hard." An hour or two later when Sophia was still crying, the boyfriend demonstrated how he laid Sophia face down on the floor and stomped on her back.

Following her death, child protection completed an investigation and made maltreatment findings of physical abuse and sexual abuse of the deceased child by her mother's boyfriend, as well as a finding of neglect against the child's mother for failure to protect the child.

While attempting to resuscitate Sophia, doctors noted bruising on several areas of her body including her arms, back and abdomen. A CT scan showed that Sophia suffered significant non-accidental trauma including a left kidney split in half, right kidney hematoma, a pancreas split in two, eight acute rib fractures and at least one healing rib fracture, a collapsed lung, deep bruising to her scalp, and lacerations to her stomach, small intestine, and liver. Given the child's age and the fact that serious injuries were inflicted on her over time, it seems that a medical provider might have had the opportunity to observe them at some point, perhaps during a well-baby or well-child visit, or a trip to an Emergency Department. However there was no information in the court records to indicate if this occurred.

Prior to the fatality child protection received four maltreatment reports related to Sophia, three of which were opened for FA. One of the Family Assessments was in response to a report that Sophia's mother had a car accident with Sophia in the car, and the mother was charged with DWI. The final FA conducted on the family prior to the fatality was in response to a report of physical abuse of Sophia by the boyfriend. In that instance Sophia's biological father created a video showing two bruises on her cheek and records Sophia saying that the boyfriend had punched her in the face. The disposition of this Family Assessment was development of a safety plan requiring the mother to keep the boyfriend away from the infant, which she failed to do. The record does not indicate whether this safety plan was monitored, and in any event it appears to have included only one of several issues that needed to be addressed.

As mentioned previously, coders and SMEs were asked to apply the Department's 2000 FA Guidelines to each case, but that they were applied so infrequently that we chose not to describe them for each instance. Instead we use this case to demonstrate a common situation in which criteria from the Guidelines should have prevented this and similar reports from being assigned to Family Assessment. They include:

- The maltreatment alleged is criminally chargeable.
- There is a potential for serious physical, emotional, or psychological harm.

- The frequency, similarity, or recency of past reports warrants a traditional investigation.
- The child is unable to protect herself for reasons such as age or disability.
- The parent/legal guardian is incapacitated due to active use of dangerous substances.
- The parent/legal guardian does not have friends or relatives that can help care for the child.

SME comments:

"The mother was able to continue leaving a 2 year old child with her abuser. Since the services were only screened in for assessment and voluntary services, there was no oversight of mom and no safety net for Sophia. It's important to note that the case was closed less than a month after being screened in against the boyfriend." – GAL SME

Recommendations on Appropriate Assignments to Family Assessment

13. Allow cases to be assigned to FA only once and never if the alleged child victim is 0-3 years of age.
14. Implement a "no screen out" policy for maltreatment reports of infants and toddlers ages 0-3, when the child maltreatment report comes from a mandated reporter.

Inaction Related to Chronic Multitype Maltreatment

The role that repeated use of FA played in enabling chronic multitype maltreatment was shown in our analysis of Juvenile Court case records, which indicated that 71.6% of child fatalities had a history with child protection.[43] These included two with prior history in another state, and seven who had histories in Minnesota plus one or more other states. There is no federal or state report with data to compare with this metric. However, the 2016 federal Commission to Eliminate Child Abuse and Neglect Fatalities estimated that half of families and one third of children who die due to abuse or neglect are "involved families known to child protection."[44] While one data point is not a sufficient basis for drawing conclusions, this raises the question for additional study of whether Minnesota child welfare agencies may be leaving significantly more children than other states in families with multiple child protection reports.

The far-reaching impact of chronic neglect and chronic maltreatment, or chronic multitype maltreatment as it is referred to here, was detailed by one of our SMEs as a lack of commonly accepted parenting practices:

> "Characteristics of chronic neglect and chronic multitype maltreatment include an erosion of social norms around parenting. For example, it is commonly agreed that preschool age children need to be supervised all the time, but in chronically neglectful families it may become common to leave an infant, toddler or elementary school age

[43] In 59, or 67%, of the 88 cases in our study the family had prior Minnesota history with child protection. In addition, two families were involved with child protection in other states, which is often discoverable by caseworkers, and one Criminal Court case record indicated the parents' involvement with child protection, but that information was not present in the Juvenile Court documents. One child also died while in the care of his adoptive parents, formerly his foster parents. These sources bring the total to 63 cases, or 71.6%

[44] Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities", Commission to Eliminate Child Abuse and Neglect Fatalities, p. 111, footnote 101 : "A number of studies indicate that anywhere from a third to half of child maltreatment fatalities involved families known to CPS. See, for example, Grimm, B. (2007). Child deaths from abuse or neglect. *Youth Law News*, *XXVIII*. National Center for Youth Law. Retrieved from http://youthlaw.org/publication/child-deaths-from-abuse-and-neglect. See also Dexheimer, E., & Ball, A. (2015, January 11). Missed signs, fatal consequences: Part 1: In many cases, families already on state's radar."

child alone for hours or even days at a time. Harsh or non-nurturing parenting practices also frequently accompany chronic neglect and multitype maltreatment. Over time, other types of maltreatment may become added to neglect, including physical and/or sexual abuse. Chronic maltreatment is exacerbated by poverty, particularly deep poverty, i.e., families with incomes less than half of the federal poverty income standard [45]…. Early intervention is particularly important because once neglect becomes chronic it is intractable and cannot be easily corrected by poverty related services or brief therapy or skill- based parenting programs."[46]

Tayvion Davis, Hennepin County

The case of Tayvion Davis exemplifies chronic multitype maltreatment and how the child welfare system responded to it.

In 2006, prior to his birth, Tayvion's mother and two other adult relatives held down and beat a child who was later one of Tayvion's siblings. The mother was convicted of malicious punishment of a child. From this time until Tayvion's death in 2018 at age eight, at least ten known subsequent child protection reports were made alleging physical abuse, sexual abuse and neglect.

The family's child protection history included an incident in 2015 in which Tayvion and two of his siblings were involved in a car accident. The mother refused treatment for the children and removed them from the hospital against medical advice. The county responded by assigning the case to Family Assessment. Court records also document that over these years the children were hit on the hands with a hammer, beaten with a metal rod, whipped with a belt, burned with boiling water or chemicals, threated with death if they talked about the abuse, deprived of food and sleep as punishments, and were continuously exposed to household hazards including accessible guns. As with the case of Sophia O'Neill, the question arises whether some medical providers other than the specialist noted below may have noticed injuries in these children over this lengthy period of time and should have reported them, however there is no information to clarify this in the court records.

During 2015 there were four separate allegations of sexual abuse against Tayvion and/or his siblings with four separate perpetrators in a span of nine months, including a juvenile relative, the oldest sibling, a cousin, and an unrelated male. Maltreatment determinations were made against three of the four perpetrators. The oldest sibling was moved out of home during the investigation, but the court ordered that child to be returned home over the objection of the local department. The father of the children knew about the sexual abuse, and, according to the court record, told the children he would break their arms and legs if they told anyone about it.

Tayvion and his siblings were examined by a physician certified in pediatric child maltreatment, regarding the cases of sexual abuse. It appears that despite the 2015 and 2016 assessments by this specialist the county did not remove the children or take other actions to protect them.

Early in 2018, Tayvion's mother forced him to spend the night in the garage in below-zero temperatures. He froze to death on February 1, 2018.

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[45] See for example the Law Insider dictionary for a description of this metric. *Statesman* (Austin, TX). Retrieved from http://projects.statesman.com/news/cps-missed-signs/missteps.html.

[46] *Sounding Board*, Dee Wilson, published in The Imprint December 22, 2022.

While the proximate cause of Tayvion's death was freezing, the physician who performed the autopsy noted extensive linear and looped injuries and scars on him, which were present in the December 2015 evaluation, but were more prominent at the time of his death, indicating ongoing physical abuse. It was later confirmed that the mother frequently whipped the children with a belt. There were also linear scars on Tayvion's genitals at the time of his death, which were not noted in prior evaluations. These observations suggest that the physical abuse not only continued but perhaps devolved into torture after the child maltreatment specialist documented the earlier injuries.

Tayvion's siblings were placed on a police hold after the fatality but were returned to their mother's care several days later for an additional five months, during which time the mother was the subject of several additional CPS reports. It was not until after they were removed that the siblings shared with their foster parents that Tayvion was deliberately locked in the garage. This ultimately led to murder charges against the mother more than a year and a half after his death.

The case of Tayvion Davis illustrates not only chronic multitype abuse, but also a number of the other patterns discovered during this study, including overuse of Family Assessment, returning surviving siblings to a situation where safety concerns have not been addressed, poor oversight of open child protection cases, ignoring evaluations from medical providers, and unrecognized child torture.

SME comments:
While SMEs did not always agree in their assessment of cases, there was a consensus regarding Tayvion that many opportunities were missed to intervene and protect both him and his siblings. Examples of their input are:

> *"Many professionals charged with protecting children instead exposed them to torture and ongoing misery." – Medical SME*
>
> *"It is obvious to me that there were so many opportunities for interventions that could have and should have occurred so many years earlier" – Court officer SME*
>
> *The children should have been removed from the home. Why was more attention not paid to the significant record and patterns of abuse throughout the entire family unit. Were background checks done? Was supervised visitation ever a starting place with dad? Who was observing mom with the children? There were no safety nets for these kids… and every time they spoke up, they were returned to harm. – GAL SME*
>
> *It is nearly impossible that the incidents reported were the only incidents that should have risen to CPS investigations. Based on frequency alone this family should have been given some type of priority status in the CPS and LE system. This is a case in which if the two entities were not working together, they should have been. That information sharing isn't done regularly. The information flow goes mostly from LE to CPS and almost never in reverse until there is specific investigation. It would be great to get this changed but data privacy laws will not allow that. – Law Enforcement SME*

Chronic Multi-Type Maltreatment Recommendations

15. DHS engage an outside expert to determine if more Minnesota families with child fatalities are known to child protection than nationally and make appropriate recommendations.
16. DHS reach out to entities involved in Tayvion Davis and similar cases, including counties, representatives of local law enforcement agencies, courts, and prosecutors to initiate a review of policies and practices that enable chronic multitype maltreatment to occur, and make appropriate changes.
17. The Department work with the CWTA to develop mandatory training for caseworkers to recognize and respond appropriately to chronic multitype maltreatment.

Neglect Cases with Many Chances for Parents to Address Chronic Problems, Combined with Ineffective Safety Planning

While many of the child fatalities in our study resulted from physical abuse, torture, or multitype maltreatment, some deaths were primarily due to neglect. As indicated earlier, neglect cases may be underrepresented in our sample but are not, as is often portrayed, less serious than abuse. As the following story of Aaliyah Goodwin illustrates, issues such as substance abuse, domestic violence, and mental illness frequently endanger the life and life prospects of children yet, as is often remarked to us by Guardians ad Litem, grandparents, foster parents, medical providers, and others who engage with child protection, current practices give parents "chance after chance after chance" to correct these problems until the child is so developmentally damaged or traumatized they are unlikely to live a normal life, or in some cases are dead.

Exacerbating this process was a lack of consistency in monitoring safety plans. We are aware that safety planning is a significant tool used by counties in ongoing open child protection cases, and on a number of occasions court records referred to safety plans. However the specifics of those plans were not described in the court records or fatality reports that we reviewed, which limited our ability to understand how they were being implemented. In the cases where safety plans were referenced however we were sometimes able to determine that they were not followed up on by caseworkers.

Aaliyah Goodwin, Kanabec and St. Louis County

Aaliyah Goodwin died from positional asphyxia in January 2022. Aaliyah was only five months old at the time of her death, but from the period 2015 to 2022 there had been eight reports to child protection for two older siblings regarding the parents' excessive substance abuse. Overall during the period of 2015-2021 four safety plans were noted in the court records, the oldest sibling was placed in foster care and returned home twice, the mother was charged with nine drug-related offenses and convicted of five, and the father was similarly charged seven times with two convictions. Because of the parents' hostile and threatening behavior, law enforcement accompanied social workers during meetings with the family.

The case history includes that in March 2015, a report was received that the mother had been using drugs and leaving the oldest sibling, a boy, unattended, and both parents were charged and convicted for drug possession. This report was assigned to Family Assessment and a safety plan was developed. Several months later, officers went to the family home to arrest the

mother on an active warrant. The home was described as being in deplorable condition, and officers could not locate food or diapers for the child. A police protective hold was obtained and both parents were arrested. The father was charged with three counts of drug possession and one count of neglect of a child, but these charges were ultimately dismissed. The case was again assigned to Family Assessment. A plan was developed that the boy would be placed in voluntary relative foster care, though it was discovered shortly thereafter that that relative had given the child to another relative who was living at the parents' apartment. They also discovered that the mother had left treatment so may have been living there as well. The child was then put on a police hold, placed with a third relative, and a CHIPS petition was filed. The older child remained in placement for a year.

The Family Assessment plans included drug assessment and treatment. During two periods both parents were compliant with the treatment plan and had the older sibling returned to their care, but relapsed with similar incidents in 2016 and 2019.

In 2019 there were two additional reports to child protection including one for the grandmother's use of methamphetamine while driving with the child. The investigation concluded with maltreatment determinations for neglect against both parents. A second child was born shortly thereafter. Again in late 2021 a Family Assessment was opened for inadequate supervision due to a report that the oldest child was brought to school by a stranger, and went to a neighbor's house daily for food. A second report, which was screened out, alleged that the mother appeared to be too high on drugs to prepare a meal and dropped the third child, Aaliyah, then three months old, on the ground.

In January 2022, the county opened another Family Assessment due to a report of domestic violence between the parents. A social worker met with the family and the mother agreed to do a chemical use assessment. Three days after this meeting, the mother was found passed out on the couch after using drugs and alcohol. Five month-old Aaliyah was squashed between the couch and her mother, and declared deceased shortly thereafter.

Chronic Neglect Recommendations

18. DHS establish statewide mandatory guidelines regarding chronic neglect that limit the number of opportunities parents have to address drug use, chronic mental illness, domestic violence or similar problems that make them incapable of nurturing their children and keeping them safe. Tolerance for severe neglect should be particularly limited and time-sensitive regarding infants and toddlers because of their urgent developmental needs.

Returning Children Before the Biological Home is Safe

Twenty-three, or 26% of the children in our sample had been previously removed from the home before being reunified with caregivers prior to death. In many of these situations, including those of Aaliyah Goodwin and the siblings of Tayvion Davis described above, reunification occurred despite obvious red flags that children would continue to be in danger. These cases illustrate the results of a philosophy that values family preservation over the safety of children. The story of Kamari Gholston illustrates how this practice affects infants, who are particularly defenseless.

Kamari Gholston, Hennepin County

In October 2020, four-month-old Kamari Gholston's mother brought him to the doctor. A medical examination revealed a fracture dislocation on the victim's elbow, a healing laceration under the victim's lip, additional fractures of the victim's left wrist and right ankle, and probable fractures to the victim's ribs, left ankle, right wrist, and right knee. The infant needed surgery for the elbow injury, and a skeletal survey revealed multiple additional fractures. The child's immediate injuries were addressed but the infant was released to go home with the mother without following the protocol to first receive clearance from child protection. The mother was subsequently charged with felony malicious punishment of a child and third-degree assault. After the investigation, Kamari and his twin sister were placed on a health and welfare hold and resided in foster care, though the mother's older child remained in her care. In February 2021, the court ordered that Kamari and his twin sister be placed on a trial home visit with their mother just two months after the children were adjudicated as CHIPS. The mother was reported to be engaged with and compliant in her case plan, but the court record provided no details. Eight weeks later, Kamari died due to suffocation.

The autopsy revealed that while his death was a result of smothering or suffocation, Kamari also had injuries consistent with physical abuse, including contusions on his face and bruises on the front and back of the infant's torso. Investigators interviewed Kamari's 10-year-old sibling, who reported the mother frequently choked the infant and covered him up when he cried. The charges against the mother regarding the October 2020 incident were still pending at the time of the child's death.

SME Comments:
The medical SMEs in particular were critical of decisions in this case:

> *"The initial ED examiner acted inappropriately when they discharged Kamari to his mother's care on the initial examination knowing that his arm was fractured and that the fracture was highly specific for child physical abuse. If they were unaware that this type of fracture in a baby was specific for abuse their education was lacking." – Medical SME*

> *"Family preservation appears to be prioritized over child safety in this case. Returning twin infants, one with multiple fractures, home to their abuser in a few months is high risk. – Medical SME."*

Recommendations for Returning Children from Placements

19. Develop mandatory statewide guidelines for when to return children from out of home care that includes:
    a. Requiring parents to demonstrate that they have addressed the issues that caused the children to be removed prior to trial home visits or reunification.
    b. Requiring counties to use of an appropriate safety assessment tool for assessing reunifications.
    c. Employing a higher standard for returning infants and toddlers because they are defenseless against assaults or developmentally debilitating neglect.

Red Flags Missed or Ignored by Medical Providers

Appendix C includes a protocol provided by our medical SMEs for providers to follow when children present with injuries.

There were just four cases in our sample such as that of Kamari Gholston where court records specifically documented that medical providers missed indicators of abuse or failed to follow up properly with child protection. However there were other cases where abuse occurred over a long period of time, raising a question of whether providers may have missed or ignored abuse during routine exams. Sophia O'Neill and Tayvion Davis are examples of this along with other children's stories not written up in this report. The following story of Eli Arispe Hentges further illustrates this issue.

Eli Arispe Hentges, Isanti County

Two-month-old Eli died by blunt force trauma while in the care of his mother in April 2017. The infant's autopsy revealed two skull fractures, as well as healing rib fractures and multiple bruises on the infant's head. The mother admitted to throwing the infant against the wall out of frustration, resulting in the fatal injury.

Medical records obtained during the investigation revealed that during a well-baby check on March 30, 2017, the doctor noticed a rash on Eli's arms, chest, head, and upper back. In addition, there were two darker bruise marks on Eli's left arm. The mother informed the doctor that they were from puppies running around that may have stepped on Eli's arm, which is not a credible explanation. This well-baby check occurred just six days before Eli was killed.

Using the protocol in Appendix C, the medical SME's who reviewed this case indicated that the provider who saw Eli should have:

- Performed a full body medical exam including radiological imaging.
- Made calls to child protection and local law enforcement while the parent was still at the provider's facility, to determine if transportation to another facility or an emergency hold were appropriate.
- Observed and documented parent's behavior including her interaction with the child, her reaction to the child's injury and to having her version of the injury challenged.
- Not discharge of the victim to the suspected abuser unless directed to do so by child protection and law enforcement officials.

The subsequent county fatality review reported that there was no public record of child protection involvement. However, at the time of Eli's birth, both parents were homeless and the mother had been discharged from the hospital to live with her former foster mother. During the investigation, it was learned that both parents were using alcohol and drugs, and text messages revealed patterns of domestic violence between them.

Additionally, the criminal complaint states that the infant rolled out of bed during his first month of life, apparently at the home of the foster mother. Infants cannot roll over at that age, thus this explanation also is not credible. If the former foster mother suspected abuse or neglect by the mother, she had the necessary knowledge and experience to report it to child protection.

In summary, the lack of prior child protection history did not mean that nothing could have been done to prevent Eli's death. The medical provider and former foster mother had information sufficient to make a report to child protection but failed to do so.

SME Comments:

> "If the child's fall was over a meter in height and especially if it was onto a hard surface, it would merit a medical evaluation…. Eli remained in the (foster) home after the head injury and the bruised forearm were identified without any reports to child protection for further evaluation or follow up to initiate safety checks. Further evaluation and referral to child protection and law enforcement at the 6-week medical visit could possibly have saved the child's life." – Medical SME

> "Medical staff should be aware that infants who are not independently mobile rarely sustain any bruises… Acceptance of an unlikely explanation for infant bruising without further consultation with a child abuse expert is not acceptable medical care." – Medical SME

> "Hospital protocols for assessing newborn risk prior to birth discharge may need updating and review. Access by hospital staff to the juvenile records for high-risk mothers should be considered. Young mothers who have experienced difficult childhoods and/or teen years deserve special care and concern for the stressors that new motherhood will bring. Offering and encouraging acceptance of programming to support the new family is societally important for raising happy, healthy, and well-adjusted children. Eli and his mother would have benefitted from this assistance." – Medical SME

Recommendations Regarding Medical Providers

20. Require mandatory training for medical providers as part of licensing requirements including:
    a. How to identify injuries that are diagnostic or likely predictors of physical abuse
    b. Required procedures for reporting physical abuse at the time the parent and child are still with the provider
21. Hospital and medical associations develop protocols to hold medical providers accountable for fulfilling their responsibility as mandated reporters.

Children Killed in Kinship Foster Care

According to the DHS Child Welfare Data Dashboard, child placements with relatives in Minnesota has increased from 47% in 2015 to 63% in 2021. This has generally been hailed as a positive development since it addresses the objectives of keeping children within their communities and cultures, as well as maintaining ties to the extended family, which is thought to reduce the trauma of being removed from the biological parents.

However, this study found that 7 of the 88 fatalities (8%) occurred in foster care. Of these, six were kinship foster care placements. A review of the case records in these fatalities suggests a lack of due diligence in deciding whether a kinship placement would ensure the safety and well-being of the child.

Related to this issue, a 2019 study by the Hennepin County Citizens Review Panel (CRP) documented multiple shortcomings in the kinship foster care decision-making process. Among other conclusions, the study asserted that:

> "…the decision as to where to place the child is often based more on which kin is first located rather than how well the home can meet the child's needs. Several kin caregivers commented on feeling under pressure to take the child and that they really didn't understand the responsibility they were assuming. Furthermore, workers reported that once a child is placed in a home, there is great reluctance to remove that child, even if another placement option is found that would clearly be better for the child."[47]

Further, the CRP found that kinship care providers frequently said they received too little support from the County. Correspondingly, kinship foster care caseworkers complained that they often do not have much information regarding the children they are being asked to place. The CRP also concluded "… there does not seem to be much of a shared, formalized knowledge base that is shared across the whole team, leaving individual workers having to rely largely on their own expertise." [48]

This report describes practices indicating that the likelihood that a child will be placed in a safer and more nurturing setting than the one they are being removed is not assured. Added to this are political pressures to keep children within family and community. This pattern of decisions appears to be driven by organizational needs and political considerations rather than the best interests of the child. While placing children within their extended family and community whenever possible is clearly a good overall objective, the story of Layla Mary Ann Jackson illustrates the consequences of giving these considerations priority of the child's safety.

Layla Jackson, Scott County/Hennepin County

Layla Jackson was a 17-month-old Native American/Black infant who was killed by her foster father in 2018. Her autopsy revealed extensive subdural hemorrhages and severe brain injury, as well as extensive bruising on her buttocks.

The biological mother's parental rights were terminated for Layla and her older brother, and the siblings were placed in a kinship foster placement in April 2018. The children were under the legal and physical custody of Hennepin County, but Scott County was responsible for the licensing procedure of the foster parents.

After Layla was killed, details emerged that should have precluded Layla and her brother from being placed with these foster parents. They stated on licensing forms that neither of them had any criminal convictions, had never been arrested, and never abused drugs or alcohol. However a background check would have shown that the foster father had convictions for DWI, theft, and possession of drug paraphernalia, and the foster mother was convicted twice of disorderly conduct. Additionally, a social worker who toured their home noted that firearms and ammunition were accessible to children. Records show they were asked to lock them up, but another tour two months later found that firearms were still not locked away. On the day of Layla's death the foster father told law enforcement that he never wanted or agreed to have the foster children come stay with them. The foster parents were never trained, licensed or vetted.

Once the children were placed with the foster parents, additional warning signs were ignored in both counties. Scott County received a licensing referral from Hennepin County in June 2018, at which time the children had been in the foster home for two months. A Scott County licensor scheduled a meeting for July 2018; however, the foster mother canceled this meeting. The meeting took place the following week, but only the foster mother was in attendance. They

[47] Hennepin County Child Protection Citizen Review Panel (CRP), 2019 Annual Report, pp. 15 – 16.
[48] Ibid p. 14.

scheduled a follow up meeting which both foster parents were supposed to attend, but again the foster mother canceled it. The licensor was unable to contact the foster parents until late August 2018, at which point she expressed concern to the child welfare agency that the family was not taking the necessary steps to complete the licensing process.

In July 2018, the foster mother contacted Hennepin County child protection saying that they could no longer provide foster care for the older brother because he threatened to drown himself and to lie to intentionally get the foster parents in trouble. Later that same day, the foster mother texted the foster father, "you better pray we don't lose our daughter," and "stop hitting him," and "please just ignore him." The next day the foster mother again contacted a Hennepin County child protection caseworker and said that she refused to have the brother around her other children. She stated, "no one can force me to continue care, he isn't my child." The brother was removed from the foster care home on July 13, 2018.

Court records describe the foster father as being verbally and physically abusive towards Layla. He sent his wife a video of him screaming "White power" at her, writing "loser" on her face in magic marker, and calling the child a racial slur and a mongoloid. Layla's older brother reported being slammed into the floor and said that the foster father would throw Layla into her crib. The record does not state how much of this information was known to caseworkers at the time these events were occurring. However, the children's biological mother reported that the brother told her the foster father hit him on the head and kicked him and that he did not want the foster children in the home. The biological mother reported that "she and Hennepin County did not pay attention to that at the time because they thought he may have been fabricating those stories because he did not want to be with them."

SME Comment:

> *"A lot of red flags that should have popped up from just doing a basic criminal history check. Foster father had prior DWI's, foster mother had possession charges. From a best practice perspective, this should have been a deal breaker for immediately placing the children there." – Child Welfare SMEs*

Recommendations Related to Kinship Care

22. Ensure that the mandatory licensing guidelines currently being developed by DHS apply to both traditional and kinship foster care placements.
23. Implement statewide the recommendations of the Hennepin County Citizens Review Panel regarding kinship foster care including to:
    a. Establish communication protocols between the various workers involved with a kinship placement.
    b. Provide support for kinship caregivers including help to fulfill licensing requirements, and financial resources.
    c. Ensure that children are placed with the best kinship option rather than simply the first relative to respond

Of the seven cases in which a child died while in foster care, three involved torture or elements of torture, a pattern that is described in the following section.

Child Torture

In reviewing these child fatalities, we noted a number of cases in which children were treated in a particularly cruel manner over an extended period of time. Coders were asked to note any cases that included signs of potential torture. To assist them in making this determination, we provided the following definitions.

1. Minn. Stat. § 609.3775 defines torture as "The intentional infliction of extreme mental anguish, or extreme psychological or physical abuse, when committed in an especially depraved manner."

2. The National Center for Child Abuse Statistics and Policy: "Child torture includes a combination of two or more cruel and inhuman treatments for protracted periods of time, which may include:
   - intentionally starving the child
   - binding or restraining the child
   - repeatedly physically or sexually abusing the child,
   - exposing the child to extreme temperatures without adequate clothing,
   - locking the child in closets or other small spaces,
   - forcing the child to eat excrement, or have sexual contact with animals, or
   - forcing the child into stress positions, or other regimens intended to break the child's will resulting in prolonged suffering permanent disfigurement/dysfunction, or death."

3. The Knox Standard[49] defines child torture as:
   - At least two physical assaults, occurring over at least two incidents or a single extended incident, which would cause prolonged physical pain, emotional distress, bodily injury, or death, and,
   - At least two elements of psychological abuse such as isolation, intimidation, emotional/psychological maltreatment, terrorizing, spurning, or deprivation inflicted by the child's caretaker(s),
   - Neglect is usually present, and manifests as failure to seek appropriate care for injuries and/or malnutrition resulting in prolonged emotional distress, pain and suffering, bodily injury/disfigurement, permanent bodily dysfunction, and/or death.

Using these criteria, the coders identified 14 cases which they designated as involving torture or had indicators of torture.

The public policy child welfare SME Dee Wilson provided the following additional context:

> "Torture is characterized by systematically depriving children of both food and water, binding children and/or forcing them to stay in confined spaces for hours or days at a time, the use of humiliation and sexual abuse to dehumanize a child and break the child's will, repeated extreme physical abuse leading to permanent disfiguration or physical dysfunction or death, complicity in the plan of torture by both parents and (sometimes) siblings, medical neglect due to prolonged denial of medical attention even when a child is in obvious pain. Torture differs from battered child syndrome, which typically involves assaulting a child impulsively

[49] Barbara L. Knox et. al., "Child Torture as a Form of Child Abuse, Journal of Child and Adolescent Trauma, 2014, p. 10

to keep them from crying. In addition, children who are tortured are frequently older children rather than infants and toddlers."[50]

We consulted Wilson as well as another child torture expert, pediatrician Dr. Kenneth Feldman, to review the cases flagged by our coders. Wilson responded that all but one of the cases met the definition of torture. Feldman compared each case to the above definitions including the Knox article, of which he is a co-author [51]. He concluded that 12 of the 14 cases met the National Center standard, that all cases met the Minnesota and Knox criteria for the physical abuse, but that there was insufficient information in a number of cases to evaluate whether they met the psychological criteria for torture. He judged that three of the 14 cases at minimum met all criteria for torture across all standards, and others may have met the criteria had more information been available regarding the presence of psychological abuse. Our consensus conclusion was that five cases met the criteria for torture.

A number of cases which either had signs of or which were conclusively child torture have been described in previous sections: Tayvion Davis, Kamari Gholston, Layla Jackson, and Sophia O'Neill. The story of Autumn Hallow is recounted here.

Autumn Hallow, Sherburne County

In August 2020, eight-year-old Autumn Hallow's rigid body was found partially submerged in the bathtub. Officers noted the child's body to be extremely frail and thin, she had lacerations and bruising on her face, and partial hair loss. Autumn's cause of death was listed as asphyxia and blunt force trauma. She had multiple puncture wounds on her head, hemorrhaging in the abdomen, scattered subdural hemorrhages, and contusions to the hands and hips. Autumn's father and stepmother were charged and convicted of second-degree unintentional murder.

The investigation revealed that Autumn's father and stepmother frequently bound her up in a sleeping bag, at times with her hands tied behind her back with a belt, and left her alone in a room as punishment, sometimes overnight. They starved her over a period of six months, and at the time of her death she weighed only 45 pounds.

In 2017 Autumn's mother attempted to petition the family court for an Order for Protection for her and her children against Autumn's stepmother. The petition detailed how Autumn's brother came home from a weekend with his father and stepmother covered in bruises. Autumn told her mother that the stepmother had hit him. She reported the incident to the police and took her son to the doctor who documented his injuries. She reported this to child protection, and it was screened in for a Family Assessment. The case was subsequently closed for lack of evidence. The court denied the OFP request on the grounds the petition failed to allege immediate and present danger to the children.

Although the mother shared 50/50 custody with the father, at the time of Autumn's death the mother had not seen her daughter for over six months. During the period that Autumn was being tortured in 2020 the mother attempted to enforce the custody order by petitioning the family court, pleading that Autumns father was intentionally withholding Autumn from her, and that he was falsely claiming concerns over COVID-19. Her motion was denied, in part because the mother did not have legal counsel so had failed to properly serve the father. However, the court

[50] Personal conversation with Dee Wilson November 2022.
[51] "Child Torture as a Form of Child Abuse", Barbara L. Knox, Suzanne P. Starling, Kenneth W. Feldman, Nancy D. Kellogg, Lori D. Frasier and Suzanna L. Tiapula, Journal of Child and Adolescent Trauma, 2014.

also reasoned that COVID-19 was a valid justification for disrupting parenting time agreements. Because of the ongoing COVID-19 pandemic, there was no hearing on the matter.

The court had the option of holding a Zoom custody hearing, which was being used by district courts at that point in the pandemic, to at least lay eyes on Autumn. The judge might also have simply been able to refer her to a court employee to help her cure the flaw in her petition.

In addition, according to media reports the Elk River Police Department responded to 31 calls about Autumn when she was in the custody of her father and stepmother. Concerned neighbors made recordings of the child screaming which they provided to the police. However, the father never agreed to allow the police see Autumn in person. It is possible that the police requested but were denied a court order to give them access to the child. The court documents do not have this information, though it seems unlikely that under the circumstances a judge would deny such a request. Instead the police settled for observing Autumn waving from the balcony.

Following the 2017 incident there were five other reports made to CPS. At one point the child protection caseworker determined that Autumn's younger brother should stay with the mother, but Autumn should remain with her father and stepmother. The documented past injuries to the brother should have been sufficient reason to at minimum do an in-person check on Autumn. However, according to an investigative reporting series done on this case[52], the mother stated "I said that (the father and stepmother) aren't answering the door for law enforcement and the intake worker kind of chuckled and said that if they won't answer the door for police then they're not going to answer the door for them. She said she would look into it and I never heard back."

Overall the Autumn Hallow case presents a picture of rather chilling indifference by all the authorities involved to the screams of a child and the pleas of an increasingly distraught mother.

We were unable to determine if the incidence of torture is higher in Minnesota than other states. In consultation with the experts, we did determine that there is no research on whether it has become more common in child protection recent years and no national database documenting the extent of child torture. Regardless of the frequency of these cases, it seems clear that increased attention needs to be paid to them.

SME Comments:

> *"Based on the information provided…the decision of the judicial officer to dismiss the Petition for an OFP filed in November 2017 is questionable. There appears to be sufficient evidence to support the granting of the OFP. However, the judge's decision did not provide any reasons other than allegations not proven. Another critically important piece of missing information is the actions of child protection after the referral regarding the allegations contained in the OFP petition. This was the first known incident of possible abuse of a child in the home where mother's two children shared 50-50 parenting time with the father." – Court Officer SME*
>
> *"Decision to have the brother stay with mom while Autumn has to stay with dad is concerning. What is the impact of treating the children differently – unknown with the*

[52] Eric Rasmussen and Ana Lastra "A Mother's Plea: Death of 8-year-old exposes 'system failure' and need for change, advocates say", KSTP Channel 5 News, January 10, 2022.

information provided but something to consider. How does that decision impact a child's thoughts about disclosure in the future or possibly recanting…What does this mean for the child who did not disclose abuse – will that child then bear the brunt of abuse because the other child is no longer "available"? – Court Officer SME

Recommendations Regarding Child Torture

24. State law should clearly define torture in a way that makes it actionable by counties and gives psychological torture equal weight to physical and sexual abuse.
25. A finding of torture should be grounds for immediately pursuing Termination of Parental Rights as well as criminal prosecution.
26. The CWTA should train child welfare workers to recognize signs of torture.
27. Train mandated reporters to recognize torture and hold them accountable for reporting it.
28. Associations representing local law enforcement agencies and child protection officials should work together on standard protocols for when law enforcement should insist on seeing a child in person, and develop statewide protocols for communications between local law enforcement and county child protection agencies.

Children Returned to Parents with Serious Mental Illnesses

Of the twenty- four cases in which the mother was primarily responsible for the child fatality, seven, or 29%, of the mothers had significant mental health concerns. These included psychosis, having been found incompetent to stand trial, or having been civilly committed. This pattern is illustrated in the death of six-year-old Eli Hart.

Eli Hart, Hennepin and Dakota County

Eli Hart's mother had a history of mental health problems. She killed him with as many as nine shotgun blasts to his head and torso nine days after he was returned home without a safety plan.

Prior to his death, Eli's mother had five reports to child protection which led to three Family Assessments and two investigations. A Family Assessment report in October 2020 raised concerns whether the mother was sufficiently stable to care for the child. She was delusional when she was admitted to the hospital on a hold for a psychological evaluation, while the child was placed on a 72-hour health and welfare hold. The home was in disarray, including a flooded bathroom, eggs broken and smeared throughout house, and food in various stages of decay. The child was found naked and the social worker was unable to locate shoes or other clothing other than pajamas. The child, who had developmental delays, was not wearing his hearing aids.

Three months later, child protection received a report that the mother was again hearing voices telling her to kill herself. The mother was placed on another hold for a psychological evaluation. Eli was again placed on a 72-hour health and welfare hold and placed in non-relative foster care, and a CHIPS petition was filed.

As described in the criminal section below, the mother's mental health condition remained a concern throughout the year that Eli was in foster care and during a trial home visit. Additionally in an attempt to keep Eli's father from obtaining partial or full custody, the mother filed four

OFPs against the father. This was despite multiple reports from the social worker and the GAL that the father's interaction with the child was positive, and that the child was happier and more stable during their visits. Over time, it became clear from the case narrative and court documents that the mother's allegations were unfounded.

While Eli's mental and emotional well-being in his mother's care was of concern to the juvenile court, both the social worker and GAL ultimately recommended reunification with the mother, stating that they had no concerns for Eli's physical well-being in her care. Nevertheless, in the final social worker report which recommended that custody be returned to the mother and that jurisdiction be terminated, the worker reported that the mother had not consistently attended therapy, and that the mother's mental health provider and she agreed to mutually terminate the relationship. The report stated that the mother was allegedly looking for a new therapist, but the social worker was unaware if the mother had found one. The record also showed that during the first months of the mother's case plan, she did not attend therapy and only minimally met with her mental health worker. Her mental health care providers expressed concern to the social worker that the mother lacked insight into her mental illness and behavior.

After Eli's mother shot him, she was pulled over because the car she was driving was riding on a wheel rim and its back window was shot out. Officers observed blood in the vehicle and blood on the defendants' hair, but she was released from the scene. They discovered Eli's body in the trunk shortly afterwards.

While there are gaps in the case records, it appears both that mental health professionals may have released a seriously mentally ill mother without coordinating with child protection, knowing that she was not capable of caring for a young child, and that the child protection agency ignored the obvious serious risk of leaving Eli with her. In addition, this case illustrates the excessive and unsafe use of Family Assessment, the failure to monitor open child protection cases, lack of appropriate actions taken by local law enforcement, and a lack of communication and role clarity between family and juvenile courts. The issues related to the courts regarding Eli's case are explored in additional detail in the second section of this report on criminal court.

Input from SMEs raised concerns about the child being returned to the mother despite the lack of any significant change in the home situation, persistent concerns over mother's chronic mental health problems, and the lack of safety planning.

SME Comments:

> *"While a person should be able to access mental health care without worrying about losing her children, severity of the mother's mental illness indicates the need for criteria to determine when it is safe for a child to be reunified with a parent suffering from a mental illness." – DV SMEs*
>
> *"Juvenile Court does not have the authority to decide the custody issues, i.e., whether the child is better off with one parent rather than the other, but only whether the child is safe with the parent who has custody at the time of the CHIPs action. If the CPS or foster care caseworker can't demonstrate otherwise, the default decision is that the child is safe. This case illustrates that the ways in which the roles of the courts are defined sometimes prevents judicial officers from making decisions supported by the evidence available to them." – Child Welfare SMEs*

"The decision to not file a CHIPS petition [during the first inpatient evaluation] and have the child at home under court ordered protective supervision with requirements that must be met is questionable as in the best interests of the safety and welfare of the child. That decision proved to be unwise when approximately 3 months later the mother is resisting therapy sessions twice a week as set out and mother had yet to complete a psychological evaluation." – Courts SME

Recommendations for Communications between Child Protection, the Courts, and Mental Health Agencies

29. The Department and the courts should strengthen guidelines such that seriously mentally ill parents are not returned home to care for children, especially young ones. Children should either be placed in a safe environment or the setting should be closely supervised such as with a live-in aide or other "set of eyes" until the parent's mental health improves sufficiently that they can care for the child or children safely.
30. The Department and counties should reach out to mental health stakeholders at their respective levels to clarify roles and establish protocols for ongoing communication, particularly around discharge planning.

Child Fatality Issues Related to the Court System

The second main section of this report explores a number of patterns regarding child fatalities that relate primarily to the court system rather than to child welfare. These patterns relate to the investigation, charging, sentencing, and supervision of perpetrators:

- Parents received substantially shorter sentences than non-parents.
- Unique characteristics of evidence in child maltreatment cases may lead to advantageous plea deals for parents.
- Poor communication and lack of role clarity among criminal, juvenile, and family courts contributed to child fatalities.
- No-contact orders in cases of domestic violence were ineffective.

We believe our findings raise a number of policy and practice issues related to local law enforcement, prosecutors, and the judiciary. However, making recommendations for change is more difficult for these institutions than in the child welfare arena. In the case of prosecutors and law enforcement, many decisions to not follow up on potential crimes against children are made internally, with no record of the relevant deliberations. Regarding the courts, the public has historically had limited input into the inner workings of this system. As a result, this section of the report is limited to raising questions suggested by the quantitative data and by particular cases, and to encourage the relevant leaders to explore them, whether they be the County Attorneys, the Minnesota Judicial Council, the Children's Justice Initiative, or another appropriate entity.

Differences in Sentencing between Parents and Non-Parents

The 88 child fatalities in our study resulted in criminal charges against 94 perpetrators, 72 of whom were sentenced for crimes related to the fatality. These included first degree murder, second degree intentional and unintentional murder, first-and second-degree manslaughter,

aiding an offender, child endangerment, and neglect of a child.[53] As Exhibit 7 shows, the average sentence for non-parents overall is substantially higher than for parents, with a difference of 82.1 months. This difference is greater between women. The difference between nonparent females convicted for their role in a child's death compared to convicted mothers is 112.8 months, whereas the average difference for males is 44.3 months. The average sentence is higher for nonparents in every category except males convicted of second-degree murder where the sentence for fathers averaged 305.5 months compared to 290.4 months for non-parent males.

Exhibit 7 - Average Length of Sentences for Child Fatalities (Months)			
	Overall Average	Average Male	Average Female
Parents (34)	169.1	215.7	110.1
Non parents (38)	251.2	260.0	222.9
Difference (Months)	82.1	44.3	112.8

We probed more deeply into one category of convictions, second degree manslaughter, to explore how they fit with the Minnesota Sentencing Guidelines. Of the 20 convictions for this charge, twelve were the biological parent of the child, and eight were not. Of the twelve parents, only one received an upward departure from the Guidelines, six received stayed sentences which represent downward departures, and five received sentences within the Minnesota Sentencing Guidelines, with an average sentence of 48.8 months. In comparison, of the eight non-parents convicted for second degree manslaughter, none received a downward departure and seven were sentenced within the Minnesota sentencing guidelines, with an average sentence of 63.6 months. Some defendants were sentenced to incarceration in a local facility or given credit for time spent in jail prior to the case being resolved in court. [54]

Exhibit 8 - Sentences for Second Degree Manslaughter				
	Parents		Non-Parents	
	Number	Avg. Mo.	Number	Avg. Mo.
Sentence Within Guidelines	5	48.8	7	63.6
Downward Departure	6	Stayed sentence	0	N.A.
Upward Departure	1	78	1	114

It is beyond the scope of this report and expertise of the authors to analyze why there were differences in lengths of sentences and departures from the Guidelines. It may be possible, for example, that nonparents on average had higher criminal history scores, or there may be different evidentiary challenges in the two types of cases that would be unknown outside the prosecutor's office, and which would affect plea deals.

[53] 92 individuals were criminally charged for their role in the child fatality, 72 that have been sentenced, and 18 that are pending. There were 2 cases in which charges were dropped.

[54] In addition to a stayed prison term, the court also addresses local confinement that is independent from the stayed prison sentence. Of the six parents that received a stayed sentence for second degree manslaughter, one was given 65 days of local confinement, with credit for 65 days already served in jail (0 days to serve); two were given 180 days of local confinement, which could be served on home detention/electronic monitoring or work release if eligible; one was given 90 days of local confinement; one was given 182 days of local confinement that could be served on work release if eligible; and one was given 365 days of local confinement, though this sentence reflects a plea negotiation for a separate domestic assault charge the defendant plead guilty to in which his sentences run concurrently.

However reviewing the courts' justification for departures provides some useful context. When a defendant receives a downward departure, the court is required to issue a departure report that lists the reasons why it is appropriate. All seven criminal defendants in our study who received a downward departure at sentencing were a biological parent of the deceased child. In four of these cases a reason for the downward departure was that the defendant "shows remorse/accepts responsibility."[55] This suggests that the court in these cases perhaps was more inclined to use remorse as a mitigating factor at sentencing for parent offenders compared to non-parent offenders. There is some relevant literature that addresses this[56], with some scholars pointing out remorse used as a mitigating factor at sentencing can be intimately tied to the parent's perceived suffering in the loss of their child. These authors contend that some members of the judiciary, along with society in general, believe that when a parent contributes to the death of a child, that loss is punishment in and of itself, and additional suffering imposed by the criminal justice system is unjust.[57] There are other factors that could contribute to this discrepancy, such as the reluctance documented earlier of the child welfare system to break up a family unit, as incarceration inevitably does.[58]

These examples raise a question whether these factors are widely used considerations by Minnesota courts. We recommend this as a topic for further study by an institution with the necessary expertise to explore it fully.

Unique Evidentiary Issues and Plea Deals for Parents

The unique characteristics of child fatality cases can also present unique evidentiary issues that could contribute to the differences in criminal justice outcomes for these cases. For one, child abuse and maltreatment typically occur in the children's homes, which may often eliminate outsider eyewitness testimony.[59] Because of this, successful prosecution is often dependent on surviving family members, who may be unwilling to testify against the offender. Surviving siblings that may have witnessed the abuse may lack competency to testify. In addition, fatal abuse of children is often inflicted with the hands, which eliminates the possibility of identifying the perpetrator with fingerprints or DNA evidence.[60] This is important because prosecution often must rely heavily on medical evidence. In cases where these factors lead to problems with evidence, prosecutors may have to rely on plea negotiations in order to secure a conviction.

As with all criminal cases, the majority of child fatality cases in our analysis were resolved though plea negotiations, meaning the parent or perpetrator admitted their guilt in exchange for having other charges dismissed or receiving a lighter sentence than otherwise proscribed.

Eighty-nine percent of defendants in our study plead guilty. Of these, 21 plead guilty to a lesser charge in exchange for more severe charges to be dismissed. This includes seven defendants

[55] Out of the seven criminal defendants that received a downward departure, "shows remorse/accepts responsibility" was used as a reason for the departure for four of the defendants. Two of the downward departures did not include a departure report.

[56] See Jennifer M. Collins, Lady Madonna, Children at Your Feet: The Criminal Justice System's Romanticization of the Parent-Child Relationship, 93 Iowa L. Rev. 131, 133 (2007); Jennifer M. Collins, Crime and Parenthood: The Uneasy Case for Prosecuting Negligent Parents, 100 Nw. U.L. Rev. 807, 848 (2006); Cynthia Godsoe, Redrawing the Boundaries of Relational Crime, 69 Ala. L. Rev. 169, 178 (2017)

[57] See Collins at 807; see also Jeffrie Murphy, Mercy and Legal Justice, in Crime and Punishment: Philosophic Explorations 454, 457.

[58] Collins at 846.

[59] Collins at 153.

[60] Collins at 153-154

who were initially charged with first degree murder but plead guilty to a lesser offense, such as 2nd degree unintentional murder or 1st degree manslaughter. There are different types of plea negotiations used in our sample, including 12 criminal defendants who plead guilty pursuant to a Norgaard[61] or Alford plea.

Alford pleas in particular present issues in child fatality cases. An Alford plea allows a criminal defendant to enter a guilty plea while maintaining her or his innocence.[62] A defendant typically enters an Alford plea by conceding there is enough evidence for a conviction if the case were to go to trial. Alford pleas can be advantageous for prosecutors in securing a conviction in cases where the evidence may be lacking, and advantageous for criminal defendants who want to avoid admitting guilt. However, critics of Alford pleas argue that they are inappropriate where the victim's ability to recover from the crime depends on the defendant's acknowledgement that he or she did in fact commit the crime as charged, such as cases involving sexual assault and molestation.[63] Hennepin County does not accept Alford pleas in criminal cases generally, including for child abuse felonies, although this is not binding on judges, and our case reviews indicated that this policy is not in place in all counties.

While the victims in child fatality cases are not alive to realize the benefits of a defendant admitting their guilt, the ability of surviving family members to feel that justice has been done is similarly hindered by a criminal proceeding that concludes with the defendant maintaining his or her innocence. The recent successful civil lawsuits by the surviving relatives of Arianna Hunziker and Kendrea Johnson against a county and, in one case, a medical provider, were widely covered in the media, and are Minnesota examples of survivors' need to hold negligent parties responsible for children's deaths.

Alford pleas can also present issues at the sentencing stage for states such as Minnesota that use remorse as a mitigating factor.[64] A defendant may receive a lighter sentence if he or she expresses remorse or regret in committing the act. But by definition Alford defendants lack remorse, as they refuse to admit to committing the offense they have been accused of.[65] Therefore logically a defendant who chooses to enter an Alford plea should not benefit from a remorse assessment at sentencing. However this is not always the case. In the Dakota County case of Vaida Grass for example, the mother was charged with two counts of 2nd degree manslaughter for her role in the death of her five-month-old baby. She plead guilty to second degree manslaughter pursuant to an Alford plea and was given a stayed sentence of 58 months, which is a downward departure from the Minnesota Sentencing guidelines. The departure report lists "accepts responsibility/shows remorse" as a mitigating factor for the downward departure.

To address the unique challenges posed by child fatality cases, several states have implemented special laws, referred to as "homicide by child abuse" statutes which recognize the need for additional protection for children.[66] These statutes eliminate the intent to kill

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[61] A *Norgaard* Plea is a procedure that governs situations where a defendant wants to enter a plea of guilty but is unable to recall facts due to intoxication or amnesia. In a Norgaard plea, the defendant does not make a claim he is innocent.

[62] North Carolina v. Alford, 400 U.S. 25 (1970).

[63] Claire L. Molesworth, Knowledge Versus Acknowledgment: Rethinking the Alford Plea in Sexual Assault Cases, 6 Seattle J. for Soc. Just. 907, 909 (2008)

[64] Id.

[65] Id.

[66] *See* S.C. CODE ANN. § 16-3-85 (2003); as cited in Brigid Benincasa, Protecting Our Children: A Reformation of South Carolina's Homicide by Child Abuse Laws, 65 S.C. L. Rev. 735, 742 (2014).

requirement for situations in which a child's death results from abuse. They also take prior instances of abuse into account.[67]

For example, under Delaware's framework[68], a person is guilty of murder by abuse or neglect in the second degree when, with criminal negligence, the person causes the death of a child: (1) through an act of abuse and/or neglect of such child; or (2) when the person has engaged in a previous pattern of abuse and/or neglect of such child.

If Minnesota had a statute similar to the Delaware homicide by child abuse statute, it is possible that some cases in our study may have had different outcomes. Regarding the Kamari Gholston case described earlier, for example, the mother plead guilty and was convicted of second-degree manslaughter under a set of facts establishing that she put the infant in an unsafe sleeping position. She received a sentence of 41 months, or 3.4 years. Based on the court records, the facts that the mother frequently abused Kamari and his 10-year-old brother were not reflected in the sentence. Further, the mother's pending charge for felony malicious punishment of a child was dismissed as part of her plea deal. The Delaware framework would have required these factors to be considered, and it is possible that the mother could have been charged with a higher level crime and received a longer sentence, although this cannot be known for certain without further analysis.

Recommendations Evidentiary Issues and Plea Deals:

31. Independent research is needed to understand the reasons for differences in sentencing and plea deals between parent and non-parents. This may be appropriate for the Minnesota Sentencing Guidelines Commission, the County Attorney's Association, the state legislature, or individual County Attorneys.
32. An appropriate entity such as the County Attorney's Association or individual County Attorneys should work with state legislators to explore whether homicide by child abuse statutes used in other states would be useful in charging child abuse cases in Minnesota.
33. The Minnesota Judicial Council should ensure that all sentencing reports involving upward and downward departures comply with the requirement that the reasons for departures be stated in the court record.

Inconsistent Mandates and Protocols among the Courts

Our analysis of child fatalities in Minnesota revealed that conflicting mandates and the lack of protocols for communicating about cases that are active in multiple courts has at times put children at risk. The following cases illustrate conflicts related to; 1) prenatal substance abuse, 2) lack of coordination around decisions related to custody that co-occur with child maltreatment, and 3) domestic violence.

Conflicting Mandates - Prenatal Substance Abuse: Avery Lundeen Hennepin County

Avery Lundeen was born alive but died shortly thereafter as a result of complications from her mother's use of alcohol during pregnancy. The mother reported that on December 30, 2018, she drank one liter of whiskey, felt contractions, then passed out. When she woke up, she found

[67] Id.

[68] Del. Code Ann. tit. 11, § 633

Avery with the umbilical cord wrapped around her neck. Prior to Avery's birth and death, there were six reports to child protection related to the mother's excessive alcohol abuse. For example a relative reported earlier that the mother passed out with her two young children unattended and screaming. This report was assigned to Family Assessment. The other reports were for mothers' alcohol use during pregnancy, which were all ruled out by reason of unborn child. The mother had been civilly committed for chemical dependency on three prior occasions. Because the infant was born alive at 33 weeks' gestation, the mother was charged and convicted of 2nd degree manslaughter.

In Minnesota, prenatal exposure to alcohol is included in the statutory definition of neglect,[69] which indicates that the legislature considers substance use during pregnancy a serious child protection risk. Mandated reporters are required by law to report a mother who is using substances during her pregnancy to a local welfare agency.[70] However the statutory requirements for mandated reports recently changed to exempt medical providers from the mandated reporting requirements if they are providing prenatal care or other health care services to the pregnant woman, though providers are still required to make a report if the pregnant woman declines care.[71]

In seeming tension with this law, DHS guidelines require that reports received on unborn children should be documented and screened out with the reason of "unborn child."[72] DHS guidelines also indicate that if a mother is abusing substances during pregnancy the county should do an assessment, not as Family Assessment or investigation but through some other vehicle such as PSOP or as a child welfare case – a category which the Guidelines do not clearly define – or an evaluation by a substance abuse provider, which the caseworker may not have authority to procure. It should also be noted that PSOP is a voluntary program hence likely not an appropriate vehicle for an involuntary assessment. If appropriate, the mother should then be offered voluntary services and if those services are declined, the county child protection agency is required to consult with the county attorney regarding civil commitment.[73] This indicates that there is a theoretical but not very easy to implement path for child protection to get a mother civilly committed if ongoing substance abuse is more likely than not to put the health or life of the unborn child in jeopardy. However, while our sample included a number of cases in which mothers were seriously abusing drugs or alcohol during pregnancy, none of them indicated any efforts to protect the unborn child by seeking a civil commitment.

On the criminal court side, there are nine Minnesota statutes criminalizing injuries and/or death of an unborn child.[74] All of these however relate to someone other than the mother harming the fetus. Under certain circumstances the criminal court may prosecute the mother after the child is born, as was done in Avery Lundeen's case. However, this is clearly not helpful in protecting the child.

In Lundeen's case, despite multiple reports regarding the mother's excessive ongoing alcohol use, as well as the success in obtaining prior civil commitments, both law enforcement and child protection failed to seek a civil commitment in the months leading up to the fatality. It is not known whether child protection consulted with the County Attorney on this matter. It seems

[69] Minn. Stat. 260E.03, subd. 15 (5)
[70] Minn. Stat. 260E.31, subd. 1
[71] Minn. Stat. 260E.31, subd. 2
[72] See Revised Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines, pg. 31.
[73] See Minnesota's Best Practice Guide for Responding to Prenatal Exposure to Substance Use, pg. 18.
[74] Minn. Stat. 609.2661; Minn. Stat. 609.2662; Minn. Stat. 609.2663; Minn. Stat. 609.2664; Minn. Stat. 609.2665; Minn. Stat. 609.267; Minn. Stat. 609.2671; Minn. Stat. 609.2672; Minn. Stat. 609.268

evident that the appropriate step for all entities would have been to pursue a civil commitment and potentially enable the fetus to be born alive, not wait until she was dead, then prosecute. Taking no action led to an outcome unfavorable to all parties involved: a child died, the mother was criminally charged and convicted, and the mother lost custody of her other two children.

Juvenile and Family Courts at Cross Purposes Regarding Custody and Child Protection: Eli Hart, Dakota County

As described in an earlier section, the case of Eli Hart revolved around the perceived inability of family court to make a custody determination until juvenile court determined whether Eli was safe with his mother. When Eli's father filed for custody, family court placed the custody action on inactive status while they waited for the juvenile proceedings to conclude.

While under CHIPS jurisdiction, the mother continued to present concerning behaviors. She had eight traffic-related convictions including for speeding and careless driving, and was also charged with theft of pharmaceutical drugs. In contrast the juvenile record repeatedly described parenting by Eli's father in a positive light. After Eli was under juvenile court jurisdiction for over a year, there was a CHIPS review hearing to address terminating jurisdiction on the matter, a decision resting on whether Eli would be safe in his mother's care. During that hearing, the GAL took the unusual position of disagreeing with the social worker and did not recommend reunification. This delayed closing the case by a month, at which time the GAL, while still listing the same concerns about the mother, agreed with the social worker and the courts to reunify Eli with his mother. While her motives for changing her recommendation were not specified in the court record, the context suggests that this may have been done under pressure, not because the GAL and caseworker thought that Eli would be safe with his mother but so that the custody case could proceed. Nine days later Eli was dead.

It is our understanding that Court Rules already allow cases to be heard by one judge when family and juvenile court proceedings overlap, but that revised rules might be needed for this to occur between districts.

Input from the Assistant County Attorney SMEs included the observation that child protection law treats placement with a non-custodial parent the same as placement with non-relative foster care: there must be an effort to reunify.

> *"The result was that the father's custody case was on hold because of the child protection case. This raises the question of whether the law should be more flexible to allow for custody cases to proceed in certain situations."- County Attorney SMEs.*

The guardian *ad litem* SME added this perspective:

> *"It's unfortunate this strategy - reunification over the best interest of the child - is the only mechanism within the courts. It is well known (at least in my experience) that the county will close cases even when there are still safety concerns. The "hope" that the other parent will continue in family court is the only 'plan'. – GAL SME*

Recommendations for Integrating Custody and Child Protection Decisions:

34. DHS modify its Guidelines to offer practical options for caseworkers to obtain a substance abuse assessment, and mandate that county child welfare agencies consult with the County Attorney regarding possible civil commitment of a pregnant woman who is known to be using drugs and alcohol to the extent that failing to restrain from doing so is more likely that not to put the health or life of the unborn child in jeopardy.
35. The Minnesota Judicial Council, the Children's Justice Initiative, or another appropriate entity should study the efficacy of changing Family Court and Juvenile Court Rules to permit allowing only one judge to handle a circumstance in where there is a family court custody case and a juvenile child protection case being heard at the same time in different judicial districts, and encourage using it more often, as appropriate, when both cases are in the same district.

Domestic Violence and the Ineffectiveness of No-Contact orders

As detailed in an earlier section, domestic violence co-occurred with child maltreatment in 25, or 28.4% of the cases in our study. In nineteen, or 21.6% of all cases included in the study, the perpetrator responsible for the child fatality had at least one prior domestic violence-related charge. For the 25 domestic violence-related child fatality cases, 44% had a prior domestic violence related charges and 44% had at least one no contact order in place (including DANCO, OFP, or HRO)[75] prior to the fatality event. The following case narrative demonstrates a pattern we found repeatedly, which was that protective orders often had little impact on deterring perpetrators and victims from continued contact.

Children living in families with domestic violence are at increased risk for physical abuse and other forms of child maltreatment.[76] A recent study explored the role of domestic violence in child homicide cases.[77] It defined domestic violence-related child fatalities in two ways: where the perpetrator also kills or attempts to kill the intimate partner; and where intimate partner conflict precedes the fatality, including divorce, separation, and custody issues. Using these categories, we categorized 25 (28.4%) of child fatality cases as co-occurring with domestic violence. There were 7 cases in which the child was killed along with the mother, or the child was killed while attempting to intervene during an assault on the mother.

Minnesota child protection practices do not favor the interests of the child in domestic violence situation. A child's witnessing of or exposure to domestic violence against a parent or caregiver

[75] As noted earlier, there are two main avenues to protect victims of domestic violence in our system, an Order for Protection (OFP) and a Domestic Abuse No Contact Order (DANCO). An OFP is issued in family court at the request of the victim. A DANCO is issued by criminal court in response to a domestic assault charge. DANCO's are issued at the discretion of the criminal court, even over the objection of the victim of the assault. If a perpetrator violates the terms of an OFP or DANCO, they will be criminally charged with a misdemeanor, and if they continue to violate the terms of the protective order, they will be charged with a felony.

[76] Lyons VH, Adhia A, Moe CA, Kernic MA, Schiller M, Bowen A, Rivara FP, Rowhani-Rahbar A. Risk Factors for Child Death During an Intimate Partner Homicide: A Case-Control Study. Child Maltreat. 2021 Nov;26(4):356-362. doi: 10.1177/1077559520983901. Epub 2020 Dec 30. PMID: 33375835; PMCID: PMC8243381.

[77] Adhia A, Austin SB, Fitzmaurice GM, Hemenway D. The Role of Intimate Partner Violence in Homicides of Children Aged 2-14 Years. Am J Prev Med. 2019 Jan;56(1):38-46. doi: 10.1016/j.amepre.2018.08.028. Epub 2018 Nov 8. PMID: 30416031.

is not by itself sufficient to screen in as child maltreatment.[78] Instead, "a child must be involved in or otherwise situated in a location that puts them at risk during incidents of domestic violence"[79] to trigger a child protection response. In addition, according to DHS best practices guidelines, every effort should be made to keep children safely in the care of abused parents/caregivers.[80] This pressure to keep children with their mothers was evident in our analysis of domestic violence related child fatalities, even in situations in which the mother demonstrated she was unable to leave her abusive partner and also unwilling or unable to protect her child. The following case narrative illustrates how county agencies, law enforcement, the court and other institutions often dealt with reports of domestic violence.

Anthony Herkal, Dakota County

Two-week-old Anthony Herkal died in August 2018 as a result of physical abuse by his father. The family had five prior reports to child protection, including two Family Assessments and three investigations. Two investigations were for incidents of domestic violence between the biological mother and father with the children present. Both of these investigations resulted in findings of maltreatment against the father.

During one 13 month period the father was charged and convicted of gross misdemeanor interference with an emergency call [81], two misdemeanors for violation of an Order for Protection (OFP), and two felonies for violation of a DANCO. In total the record notes at least 7 DANCOs issued in criminal court, one HRO which was dismissed when neither party appeared at the court hearing, and one OFP which the mother subsequently requested be withdrawn.

The first of these domestic incidents occurred in February 2016 which resulted in three misdemeanor charges and a DANCO, which the father subsequently violated. The child protection assessment determined that maltreatment occurred, but the fatality report indicated that services were not needed because the mother got a no-contact order against the father. There is no indication in the court records whether the mother actually got the order or whether the caseworker attempted to confirm that. The agency did complete safety planning with the mother, which required the mother to not allow the father back into the home or have contact with the baby, but there is no indication that this was followed up on.

In one subsequent instance where maltreatment was substantiated the county determined that services were not needed because the father was doing well on probation. Recommendations in safety plans included that the mother did not allow the father back into the home, she seek counseling for herself, and stay at a domestic abuse shelter for her safety. The court record reflects that little if any of this was implemented.

In January 2018, child protection received another report alleging the father had injured the oldest child. It was again assigned to Family Assessment. As noted, this option should be reserved for low-risk cases, yet child protection consulted with the County Attorney's office due to a high rating on the Structured Decision Making Assessment, which is a tool routinely used by child protection workers to assess risk. The father signed a safety plan which stated no physical discipline or holds would be utilized. This again was not effectively monitored.

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[78] See Minnesota's Best Practice Response to the Co-occurrence of Child Maltreatment and Domestic Violence. https://www.tn.gov/content/dam/tn/dcs/documents/training/cwresources/dv/MN_DV_Best_Practice_Response.pdf

[79] See Revised Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines. Pg 66.

[80] Id.

[81] Emergency telephone calls/communications – Interrupt, interfere, impede, disrupt 911 call:

Following the fatality, the TPR petition stated incorrectly that the agency only learned that the father was threatening and controlling of mother during the investigation into Anthony's death.

In this and other fatality cases we reviewed the mother apparently willingly let the abuser back into the home and attempted to withdraw OFPs, so it would have been appropriate for child protection to take action to protect the children. However in other situations mothers may cooperate with child protection and prosecutors, and do everything they can personally to keep the abuser at bay, but are still not able to deter him. As domestic violence advocates know, in such situations there are no easy solutions.

However difficult these situations are to address, we think a starting point is to have a greater sense of urgency about the safety of children. It would help for example if law enforcement, the courts, prosecutors, and probation and parole officers adopted - if not a zero tolerance policy - at least a much lower level of tolerance for physical assaults on children and violations of no-contact orders. This could include bringing criminal charges more readily when children are injured rather than just having a child protection finding of maltreatment, and sentencing the abuser to jail time after, for example, the first DANCO violation rather than the fourth or fifth. For child protection, a policy of not using Family Assessment for domestic violence cases would give caseworkers additional leverage, including potentially bringing a CHIPS petition and requiring supervised visits for the abuser. In general more diligence is clearly needed in monitoring safety plans. Our SMEs suggested that child protection adopt the use of lethality assessments, which are employed by domestic violence programs to assess the level of risk posed by the abuser. Another useful practice would be to follow up to see if the mother actually did get an OFP as agreed to in a safety plan.

It is important however for both child protection and domestic violence programs to recognize that, regardless of the level of the mother's cooperation, at certain point a line is crossed and it becomes imperative to move children to a safe place. There are often options short of foster care, such as sending children temporarily to stay with a relative, or making the (admittedly also high-risk) move to go to a shelter. Clearly these are not easy decisions to make, but they are necessary to give appropriate weight to the interests of the child, and hopefully can be a cooperative effort between the mother, the caseworker, and the domestic violence advocate.

> *"Had CPS been involved, there would have likely been a requirement for supervised visitation with the father. Since they were never screened for CHIPS, there were no avenues to advocate for the best interests of the child. Sure, CMH (the county's Children's Mental Health program) was involved, however their focus was on services for Child 1 specifically (another sibling), not the whole family and their best interests. I'm still curious why it was referred to that track when physical abuse with root cause". – GAL SME*

> *"Lethality assessments are used in domestic violence cases to assess the seriousness of the abusive partner. What was the role of lethality assessments here and are they applicable to children? If so surely they would be applicable in the child protection context" – DV SME*

Recommendations Domestic Violence No-Contact Orders:

36. Leaders of law enforcement, the courts, prosecutors, and parole/probation programs should convene to discuss practical measures for lowering the tolerance level for child injuries and violation of no-contact orders.
37. DHS establish a guideline that if a parent voluntarily and repeatedly allows an abuser back into the home child protection must consult with the County Attorney on the filing of a CHIPS petition for failure to protect.
38. DHS establish a guideline that if a parent or custodian is required to get an OFP as a condition of the child remaining with them, proof of the OFP must be provided to child protection within 10 days.
39. Ensure that MNCIS has the capability to cross-report information among child protection, corrections agencies and the relevant courts to share timely information regarding violations of OFPs and DANCOs, as well as dismissals or attempted dismissals of OFPs.

Conclusions and Final Recommendations

Members of the public often express dismay and outrage to us over stories such as those recounted in this report. We infer from this that the professional norms currently guiding child protection and foster care are out of alignment with those of the broader community. We hope that leaders who are directly responsible for segments of child welfare, as well as related human services institution, will consider how to mend this rupture, and engage in a conversation about how to work across disciplines to reduce violence against children.

An important first step is to improve the ability of the public to track relevant performance measures. In this regard the Department of Human Services should:

- Make public its inventory of child maltreatment fatalities and near-fatalities.
- Report all fatalities, near-fatalities and serious maltreatment-related child injuries on its dashboard report.
- Make public the child fatality and near-fatality reports that counties are required to send the state.
- Report regularly on the Collaborative Safety Initiative.

Progress also depends on the willingness of elected officials to appropriate the resources needed to effectively protect children, and to hold institutions accountable for outcomes.
As the stories in this report illustrate, leaders from related human services sectors will also need to become directly involved in efforts to reverse this trend. We make the following suggestions for their consideration:

- As trusted professionals whom parents will invite into their homes, Public Health Nurses and home visiting caseworkers should team with county child welfare agencies to develop ways in which they might serve as point persons for helping families access preventive support services and public benefits programs that directly reduce poverty.
- Mental health programs and agencies need to evaluate their patients' ability to care for young children, and develop protocols to communicate and coordinate with child welfare, particularly around discharge planning.

- Early childhood development and childcare advocates should develop new strategies for accelerating the uptake of early learning scholarships by parents of children involved in child protection, and take as active a role as possible in interrupting toxic stress in infants and toddlers before permanent physical and developmental damage is done.
- Medical associations need to ensure that providers are knowledgeable about the indicators of child maltreatment, and hold them accountable through training and licensing requirements for carrying out their role as mandated reporters.
- Local law enforcement agencies should require that parents allow them to see children they suspect are being harmed, and also develop protocols with county child protection for sharing information.
- Domestic violence programs should take the position that being a victim of domestic assault does not exempt a parent from responsibility for protecting their children, and clarify advocates' responsibilities around ensuring that children are safe.
- Managers of Guardian ad Litem programs should renew their efforts to ensure that guardians are independent voices for children first, and members of their court and social services team second.

The erosion in professional norms that has gradually caused human services entities to tolerate the current level of neglect and physical abuse of children has developed over the course of decades. A concerted effort by a community of professionals will be required to restore standards that were once taken for granted, and to place appropriate limits on the ability of adults in a child's life to harm them.

Appendix A

Subject Matter Experts and Reviewers Who Contributed to the Project

The following are brief bios for each Subject Matter Expert who contributed to this effort.

Child Welfare

The Child Welfare SME group consisted of three individuals representing direct supervision of child protection units and a national policy expert.

Greg Gardner
Greg is a retired social worker with 40 years of public child welfare experience, 37 of which were spent in the Hennepin County Child protection system. He was a unit supervisor for 30 years in foster care, Child Protection Case Management and for the last 24 years of his career in the areas of Child Protection Screening and 24/7 Immediate Response. Greg served on several hospital and community-based Child Abuse Teams, as well as on the Hennepin County Child Abuse Team. He also functioned as the Child Protection liaison for Hennepin County with the Minneapolis, Bloomington and Richfield Police Departments.

Rick Morrissey
Rick Morrissey is a retired child protection supervisor who worked in Dakota County for 35 years. In his final position at Dakota County, he supervised the Child Protection Investigation Unit. Throughout his career he has dealt with child and family matters including but not limited to truancy, mental health, chemical issues and investigations of child maltreatment cases. He testified to the Governor's Task Force on Child Protection issues and provided advice and program enhancement ideas to the commissioner of the Department of Human Services.

Prior to working for Dakota County, Rick worked for three years in social services for St. Louis County and, prior to that, in Lake County Minn. in a County Group Home for adolescent boys.

Dee Wilson
Dee is a child welfare expert with over 40 years of experience, and formerly worked for Casey Family Programs in its Knowledge Management unit. Dee Wilson worked for the public child welfare agency in Washington State from 1978 – 2004 in a variety of positions including CPS social worker, supervisor, area administrator, training director and regional administrator. After leaving the Children's Administration in 2004, Wilson was Director of the Northwest Institute for Children and Families at the University of Washington School of Social Work from 2005 to 2008 and was director of child welfare training in the UW – School of Social Work through 2009. He participated in Casey Family Program's analysis of Hennepin County's child intake project in 2015. He co-authored an article for a 2013 edition of the journal*, Child Welfare* dedicated entirely to research on child fatalities. Dee Wilson speaks and writes on a wide range of child welfare issues including neglect, risk and safety, substance abuse and reunification, foster care outcomes, critical thinking and child welfare management. He is the author of monthly Sounding Board commentaries on child welfare subjects and issues.

Medical Experts with Child Protection Experience

Maggie Carney
Maggie is a recently retired nurse at Children's Hospital of Minnesota and spent the last 20 years of her career working in the child abuse clinic, Midwest Children's Resource Center (MCRC), interviewing children who have experienced abuse and neglect, preparing medical reports, and testifying in court settings about the findings.

Lisa Hollensteiner
Dr. Lisa Hollensteiner, MD, is a Family Medicine Specialist and recently retired from practice with Emergency Physician's P.A. Dr. Hollensteiner has over 36 years of experience in the medical field. She was a prominent member of the 2015 Minnesota Governor's Task Force on the Protection of Children and has been active in child protection legislative, policy and legal issues since that time.

Alice Swenson
Dr. Swenson is a Child Abuse Pediatrician at the Midwest Children's Resource Center (MCRC) at Children's Hospitals and Clinics of Minnesota. Dr. Swenson had extensive experience working on child fatality cases, including providing medical evaluations on abused children, writing medical autopsy reports, and providing expert opinion in child abuse cases.

Guardian Ad Litem
Anonymous

Law Enforcement
Anonymous

Officers of the Courts

Jane Ranum
The honorable Jane Ranum is a former Fourth Judicial District judge for Hennepin County. Prior to taking the bench, Jane was an Assistant Hennepin County Attorney for 26 years, working in the child support division, juvenile prosecution division, and adult prosecution division. She also served as a Minnesota State Senator from 1991 to 2006, where she was the chief Senate author of the bill that originally authorized Family Assessment. Jane has since expressed concerns about the program straying from its original intent, and has worked on legislation and other initiatives to strengthen safeguards for child safety.

Erin Johnson
Erin Johnson is an Assistant County Attorney in the Washington County Juvenile Division. She has been with the Washington County Attorney's Office for 17 years, with a primary focus on child protection cases. Ms. Johnson is the co-chair of CHIPS Subcommittee of the Minnesota County Attorney's Association Juvenile Law Committee. She is also on the Rules Committee for the Rules of Juvenile Protection Procedure and participates in many other work groups with child protection stakeholders on policy and practice issues.

Lisa Jones
Lisa is currently in a new position but was an Assistant County Attorney in Anoka County Civil Division at the time she gave input on the case reviews.

Rebecca Church
Rebecca is an Assistant County Attorney with the Winona County Attorney's office, a position she has held for 7 years.

Domestic Violence
Violence Free Minnesota is a statewide coalition working to end relationship abuse, and has been a leading organization in domestic violence advocacy in Minnesota for 40 years. Three VFM staff members provided input for this report.

Reviewers and Commenters

Patty Moses
Patty is a retired 4th District Court Referee and former Assistant Hennepin County Attorney. As a referee, she served for five years in Juvenile Court, hearing delinquency and child protection cases, and for seven years in Family Court, hearing dissolution, child custody and domestic abuse cases. Between Court appointments Patty worked for 25 years mostly in child protection and juvenile delinquency, both as a trial attorney and division manager. She helped found the Hennepin County Domestic Abuse Service Center, was active in juvenile diversion and truancy work, as well as serving stints in Civil and Criminal Appeals in the Hennepin County Attorney Office.

Vivian Jenkins Nelsen
Vivian Jenkins Nelsen is a co-founder of the former African American Coalition on Child Protection, co-founder of INTER-RACE, a diversity think tank located at Augsburg University in Minneapolis, and a diversity consultant to numerous businesses and governmental agencies.

Dr. Kenneth W. Feldman
Kenneth Feldman, MD is a general pediatrician who divides his time between primary care pediatrics and child abuse consultation. He is a Clinical Professor of Pediatrics at the University of Washington and a member of the General Pediatric Division. Research interests have focused on childhood injuries, both unintentional and inflicted. He has authored or co-authored articles on numerous child maltreatment areas including torture.

Appendix B

GUIDELINES FOR ALTERNATIVE RESPONSE TO REPORTS OF CHILD MALTREATMENT
Family and Children's Services Division Minnesota Department of Human Services April 4, 2000

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ALTERNATIVE RESPONSE INITIAL SCREENING TOOL Attachment B-1
Screening Decision Date Report Date Case Name Workgroup #
Screened By Assigned to Supervisor Name Worker Name
STEP 1 Did the alleged maltreatment occur in any of the following settings?
o 1. A hospital licensed under Minn. Stat. §§ 144.50 to 144.58.
o 2. A correctional facility required to be licensed under Minn. Stat. § 241.021.
o 3. A residential or nonresidential program required to be licensed by the Commissioner of Human
Services under Minn. Stat. §§ 245A.01 to 245A.16.
o 4. A program serving persons with mental retardation or related conditions governed by Minn. Stat.
Ch. 245B.
o 5. An elementary, middle, or secondary school as defined in Minn. Stat. § 12A.05.
o 6. A charter school governed by Minn. Stat. § 124D.10.
o 7. The child was receiving personal care services as defined in Minn. Stat. §§ 256B.04, subd. 16, and
256B.0625, subd. 19a, from the alleged perpetrator.
o
o
Are any of the boxes in Step 1 checked? If yes, the report is *not* eligible for Alternative Response and
must be assessed or investigated using the traditional investigative model under Minn. Stat. § 626.556.
Is this report eligible for Alternative Response?
Yes (1) Go to Step 2
No (0) Must be referred for traditional investigation.
STEP 2 Does the report allege any of the following forms of substantial child endangerment?
(See Attachment B-2 for further guidance.)
o 1. Egregious harm, as defined in Minn. Stat. § 260C.007, subd. 26
o 2. Sexual abuse, as defined in Minn. Stat. § 626.556, subd. 2(a)
o 3. Abandonment under Minn. Stat. § 260C.301, subd. 2
o 4. Neglect, as defined in Minn. Stat. § 626.556, subd. 2(c), that substantially endangers the child's
physical or mental health, including a growth delay, which may be referred to as failure to thrive,
that has been diagnosed by a physician and is due to parental neglect.

o 5. Murder in the first, second, or third degree under Minn. Stat. §§ 609.185, 609.19, or 609.195
o 6. Manslaughter in the first or second degree under Minn. Stat. §§ 609.20 or 609.205
o 7. Assault in the first, second or third degree under Minn. Stat. §§ 609.221, 609.222, or 609.223
o 8. Solicitation, inducement, and promotion of prostitution under Minn. Stat. § 609.322
o 9. Criminal sexual conduct under Minn. Stat. §§ 609.342 to 609.3451
o 10. Solicitation of children to engage in sexual conduct under Minn. Stat. § 609.352
o 11. Malicious punishment/neglect/endangerment of a child under Minn. Stat. §§ 609.377 or 609.378
o 12. Use of a minor in sexual performance under Minn. Stat. § 617.246
o
o
Are any of the boxes in Step 2 checked? If yes, the report is *not* eligible for Alternative Response and
must be assessed or investigated using the traditional investigative model under Minn. Stat. § 626.556.
Is this report eligible for Alternative Response?
Yes (1) Report is presumed to be eligible for Alternative Response. Go to Step 3
No (0) Must be referred for traditional investigation

Appendix C

From the Medical SMEs for this report:

Standard Emergency Department evaluation of a fracture in a young infant includes:

History:

- A complete history of the injury to include any noted delay in seeking care, changing history, or implausible history.
- A complete history of previous injuries.
- Any patient or family history of blood or bone disease.
- Any previous involvement with child protection.
- A complete social history to include documentation of other children and adults in the house including ages and dates of birth, family residence type (single family, multi-family, apartment, condominium, homelessness), concerns for chemical dependency for caregivers or other persons residing with the family, and financial or social stressors.

Physical Examination:

- Full naked body examination including assessing for general state of health, bruising, areas of tenderness, lacerations, burns, or other injury.
- Skin examination to include genitals and anus assessing for trauma.
- Head, eyes, ears, nose, and throat exam which includes intraoral exam to assess for any lacerations and a fundoscopic examination looking for retinal hemorrhages.
- Abdominal exam to include evaluation for tenderness, distention, or rigidity.
- Extremity exam to evaluate for areas of tenderness or deformity.
- Cardiac and pulmonary examination to evaluate for possible intrathoracic injury such as unusual breathing pattern, unusual sounds noted by stethoscope.
- Musculoskeletal examination assessing for deformity, ease of movement, tenderness, or crepitus.
- Neurologic examination to assess for any neurologic abnormalities.

Radiological Imaging:

- CT Head
- CT Abdomen if liver and pancreatic enzymes are abnormal.
- Complete skeletal survey (NOT AP/Lateral “babygram”)

Laboratory:

- CBC
- PT, PTT if bruising to screen for hematologic abnormalities.
- ALT/AST/Amylase and Lipase to evaluate for internal abdominal injury.
- Consider testing for bone health at a later date.

Additional Observations and Actions:

- Call to Child Abuse Professionals for guidance in evaluation, arrange for transfer as needed.
- Observation and documentation of family interaction.
- Parent behavior with the child.
- Interaction between other family members.
- Parents' reaction to the injury.
- Parents' reaction if their history of the injury is challenged.
- Hospital Social Work consultation to assist in interviewing family, completing and filing Child Protection report.
- Notification of Child Protection Services (CPS) for verbal report as well as filing of report, developing a safety plan, and planning disposition of child as recommended.
- Notification of Law Enforcement (LE) to place an emergency hold to remove the child from the home if required.

DO NOT

- Delay reporting to CPS and LE by the treating physician especially if transfer is accepted by another treating physician.
- Discharge a patient to their abuser and/or their abuse environment unless directed by LE and/or CPS. Be certain to clearly document this direction because this scenario always entails the risk of delayed or no follow-up as well as further abuse and potential death.

Appendix D

Recommendations from Report Sections

The following recaps the recommendations from each of the sections of this report.

Recommendations Related to Quantitative Findings

1. Revise risk assessment instruments to give high risk scores in cases where infants and toddlers live with bio fathers and where older children live with domestic partners.
2. Significantly expand the state PSOP program.
3. Increase state investments in programs and services that have a documented ability to reduce child maltreatment, including Early Learning Scholarships and targeted home visiting.
4. Consider implementing multidisciplinary teams, and focus casework overall on ensuring that families have access to as many poverty reducing programs as they qualify for.
5. Develop partnerships between child protection and professions that are trusted by parents such as public health, PSOP, mental health, and domestic violence, to connect them more successfully to programs and services that reduce maltreatment.

Recommendations Regarding Family Assessment and Family Preservation Philosophy

6. Reinstate the practice of limiting the use of FA to 20% - 30% low risk cases
7. Reinstate the Department's original 2000 Guidelines for cases that are not appropriate to assign to FA.
8. Engage outside experts to:
    - Analyze whether changes are needed to screening practices
    - Analyze the differential rate of child fatalities for Black children and make appropriate recommendations
9. Fully fund the Child Welfare Training Academy.
10. Fund a redesign of the Department's SSIS computer system.
11. Change FA practices described above that hinder caseworkers' ability to find information necessary to keep children safe, including:
    - End advance notice of the initial child protection visit
    - Interview children separately from and prior to adults
    - Mandate fact-finding in all assessments and investigations
    - Require FA case notes say if maltreatment occurred and if so who were the victim and perpetrator.
12. Determine if any additional resources will be needed to make recommended practice changes and if so include them in the state budget.

Recommendations on Appropriate Assignments to Family Assessment

13. Allow cases to be assigned to FA only once and never if the alleged child victim is 0-3 years of age.
14. Implement a "no screen out" policy for maltreatment reports of infants and toddlers ages 0-3, when the child maltreatment report comes from a mandated reporter.

Chronic Multi-Type Maltreatment Recommendations

15. DHS engage an outside expert to determine if more Minnesota families with child fatalities are known to child protection than nationally and make appropriate recommendations

16. DHS reach out to entities involved in Tayvion Davis and similar cases, including counties, representatives of local law enforcement agencies, courts, and prosecutors to initiate a review policies and practices that enable chronic multitype maltreatment to occur, and make appropriate changes.
17. The Department work with the CWTA to develop mandatory training for caseworkers to recognize and respond appropriately to chronic multitype maltreatment.

Chronic Neglect Recommendations

18. DHS establish statewide mandatory guidelines regarding chronic neglect that limit the number of opportunities parents have to address drug use, chronic mental illness, domestic violence or similar problems that make them incapable of nurturing their children and keeping them safe. Tolerance for severe neglect should be particularly limited and time-sensitive regarding infants and toddlers because of their urgent developmental needs.

Recommendations for Returning Children from Placements

19. Develop mandatory statewide guidelines for when to return children from out of home care that includes:
    a. Requiring parents to demonstrate that they have addressed the issues that caused the children to be removed prior to trial home visits or reunification.
    b. Requiring counties to use of an appropriate safety assessment tool for assessing reunifications.
    c. Employing a higher standard for returning infants and toddlers because they are defenseless against assaults or developmentally debilitating neglect.

Recommendations Regarding Medical Providers

20. Require mandatory training for medical providers as part of licensing requirements including:
    a. How to identify injuries that are diagnostic or likely predictors of physical abuse
    b. Required procedures for reporting physical abuse at the time the parent and child are still with the provider
21. Hospital and medical associations develop protocols to hold medical providers accountable for fulfilling their responsibility as mandated reporters.

Recommendations Related to Kinship Care

22. Ensure that the mandatory licensing guidelines currently being developed by DHS apply to both traditional and kinship foster care placements.
23. Implement statewide the recommendations of the Hennepin County Citizens Review Panel regarding kinship foster care including to:
    a. Establish communication protocols between the various workers involved with a kinship placement.
    b. Provide support for kinship caregivers including help to fulfill licensing requirements, and financial resources.
    c. Ensure that children are placed with the best kinship option rather than simply the first relative to respond

Recommendations Regarding Child Torture

24. State law should clearly define torture in a way that makes it actionable by counties and gives psychological torture equal weight to physical and sexual abuse.
25. A finding of torture should be grounds for immediately pursuing Termination of Parental Rights as well as criminal prosecution.
26. The CWTA should train child welfare workers to recognize signs of torture.
27. Train mandated reporters to recognize torture and hold them accountable for reporting it.

28. Associations representing local law enforcement agencies and child protection officials should work together on standard protocols for when law enforcement should insist on seeing a child in person, and develop statewide protocols for communications between local law enforcement and county child protection agencies.

Recommendations for Communications among the Courts, Child Protection, and Mental Health Agencies

29. The Department and the courts should strengthen guidelines such that seriously mentally ill parents are not returned home to care for children, especially young ones. Children should either be placed in a safe environment or the setting should be closely supervised such as with a live-in aide or other "set of eyes" until the parent's mental health improves sufficiently that they can care for the child or children safely.
30. The Department and counties should reach out to mental health stakeholders at their respective levels to clarify roles and establish protocols for ongoing communication, particularly around discharge planning.

Recommendations Evidentiary Issues and Plea Deals:

31. Independent research is needed to understand the reasons for differences in sentencing and plea deals between parent and non-parents. This may be appropriate for the Minnesota Sentencing Guidelines Commission, the County Attorney's Association, the state legislature, or individual County Attorneys.
32. An appropriate entity such as the County Attorney's Association or and individual County Attorney should work with state legislators to explore whether homicide by child abuse statutes used in other states would be useful in charging child abuse cases in Minnesota.
33. The Minnesota Judicial Council ensure that all sentencing reports involving upward and downward departures comply with the requirement that the reasons for departures be stated in the court record.

Recommendations for Integrating Custody and Child Protection Decisions:

34. DHS modify its Guidelines to mandate that county child welfare agencies must consult with the County Attorney regarding possible civil commitment of a pregnant woman who is known to be using drugs and alcohol to the extent that failing to restrain from doing so is more likely that not to put the health or life of the unborn child in jeopardy.
35. The Minnesota Judicial Council, the Children's Justice Initiative, or another appropriate entity should study the efficacy of changing Family Court and Juvenile Court Rules to permit allowing only one judge to handle a circumstance in where there is a family court custody case and a juvenile child protection case being heard at the same time in different judicial districts, and encourage using it more often, as appropriate, when both cases are in the same district.

Recommendations Domestic Violence No Contact Orders:

36. Representatives of law enforcement, the courts, prosecutors, and parole/probation programs convene to discuss practical measures for lowering the tolerance level for child injuries and violation of no-contact orders.
37. DHS establish a guideline that if a parent voluntarily and repeatedly allows an abuser back into the home child protection must consult with the County Attorney on the filing of a CHIPS petition.

38. DHS establish a guideline that if a parent or custodian is required to get an OFP as a condition of the child remaining with them, proof of the OFP must be provided to child protection within 10 days.
39. Ensure that MNCIS has the capability to cross-report information among child protection, corrections agencies and the relevant courts to share timely information regarding violations of OFPs and DANCOs, as well as dismissals or attempted dismissals of OFPs.