Minnesota Child Fatalities from Maltreatment 2014 - 2022 Recommendations

The following recaps the recommendations from the February 2023 report.

Recommendations Related to Quantitative Findings

1. Revise risk assessment instruments to give high-risk scores in cases where infants and toddlers live with biological 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 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 programs, 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% of low-risk cases.
7. Reinstate the Department's original 2000 Guidelines for cases that are inappropriate 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 advanced 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 to 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 the Tayvion Davis case 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.

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 include:
    - Requiring parents to demonstrate that they have addressed the issues that caused the children's removal before trial home visits or reunification.
    - Requiring counties to use an appropriate safety assessment tool for assessing reunifications.
    - 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:
    - How to identify injuries that are diagnostic or likely predictors of physical abuse
    - Required procedures for reporting physical abuse at the time the parent and child are still with the provider.
21. Hospitals and medical associations develop protocols to hold medical providers accountable for fulfilling their responsibilities 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:
    - Establish communication protocols between the various workers involved with a kinship placement.
    - Provide support for kinship caregivers, including help to fulfill licensing requirements and financial resources.
    - Ensure 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 Communication 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 be placed in a safe environment, or the setting should be closely supervised, such as with a live-in aide or another "set of eyes" until the parent's mental health improves enough to 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 for Evidentiary Issues and Plea Deals:

31. Independent research is needed to understand the reasons for differences in sentencing and plea deals between parents 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 an 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 the 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 than 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 which 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 ten days.
39. Ensure that MNCIS can cross-report information among child protection, corrections agencies, and the relevant courts to share timely information regarding violations of OFPs and DANCOs and dismissals or attempted dismissals of OFPs.