Safe Passage for Children of Minnesota

Minnesota Child Fatalities from Maltreatment

Update: 2022 – 2023

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Executive Summary

This report on child fatalities due to maltreatment in Minnesota examines 19 cases involving 21 children who were identified since the initial Safe Passage for Children report on this topic, published in February 2023.[1,2]

Positive organizational advances include that Hennepin County, the state's largest child welfare agency, has made substantial improvements in its child welfare programs, including significant investments in staff, administrative infrastructure, and preventive services.[3] Also, the state Department of Human Services ("the Department") is, as of this writing, poised to issue comprehensive and well-crafted new guidelines for recruiting, training, and supervising foster and kinship care providers.[4]

Encouraging developments regarding outcomes include that the proportion of cases with prior child protection history was lower for this period, there were fewer murders by domestic partners, and there were no deaths in kinship foster care. We hope our earlier report may have inspired counties to be more cautious about risks in these types of cases. However, there were instances in which the problems that we identified in our previous report recurred. These include leaving children in situations of high risk and continued abuse over long periods, torture, overuse of Family Assessment - the child protection track for low-risk cases – and returning children from out-of-home care without addressing the issues that caused them to be removed.

We believe the concerning patterns persist because of a philosophy that assigns high priority to the rights of parents and caregivers while giving children's best interests inadequate weight. This approach is not supported by research or historical professional practices, as this and our earlier report show. It is an imbalance that urgently needs to be corrected by returning to a child-centric approach that appropriately reflects the child protection and foster care mission.

Current Status of Child Welfare Programs

Follow-up by the Department and Minnesota counties to the recommendations by the 2015 Governor's Task Force on the Protection of Children has been mixed. The Department and counties agreed to some changes, such as using Multi-Disciplinary Teams (MDTs) and reviews by County Attorneys of cases where parents have not cooperated with caseworkers. However, it is unknown whether these have been implemented consistently. On the other hand, these agencies rejected a number of major recommendations, including to reduce the use of Family Assessment,[5] and to stop giving advance notice of the initial child protection worker's visit. The

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[1] Gehrman, R., & Karrow, M. (2023, February). *Minnesota Child Fatalities from Maltreatment 2014 – 2022.* Safe Passage for Children of Minnesota.

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

[3] A detailed description of Hennepin County's initiatives will be published shortly on the Safe Passage website at safepassageforchildren.org. It will be titled Archbishop Ireland Justice Fellowship Report: Hennepin County Implementation of Stipulation and Settlement Agreement *T.F., et al v. Hennepin County, et al.*

[4] Follow the progress of these guidelines at the Department's website, *Developing Child Foster Care Licensing Guidelines*.

[5] See the section entitled "The Future of our two track Child Protection System" on p. 12 of the *Governor's Task Force on the Protection of Children Final Report and Recommendations* (2015) which states, "it is clear that

Task Force also recommended ending the practice of interviewing children in front of adults during the initial child protection assessment. The Department's Best Practices Guidelines[6] continue to allow this practice, though it is no longer permitted in cases alleging sexual abuse or substantial child endangerment, and the Department recommends that children be interviewed separately from adults at some point during the process. We encourage the Department and counties to fully implement the Task Force recommendation by requiring that children be interviewed prior to the adults during the initial child protection visit.[7]

Currently, we are hopeful that the Department and counties will respond positively to the recently completed series on child fatalities by the *Star Tribune*,[8] which echoes a number of previous similar media investigations.[9] Also, this and our initial report have spurred action at a national level. We hope that this will prompt new interest in our recommendations in Minnesota.

Moving forward, we encourage elected officials to carefully evaluate needs at the county level before determining where more resources are needed. For example, from past conversations with Department officials, we understand that approximately 400 additional caseworkers were added statewide to the system following the 2015 Task Force. As a result, while there is an overall shortage of social workers in Minnesota, it may be that staffing is not the greatest need in every county. Instead, an assessment may find that addressing gaps in core services such as mental health and Substance Use Disorder (SUD) treatment is more urgent in some areas. We believe investments in prevention and early intervention services will be essential across the state.

We wish to highlight two administrative investments that would improve outcomes. First is establishing statewide standards for each step in the child welfare process. This would directly address equity issues, improve trust in the system, and help end practices that leave children for long periods in the kinds of high-risk and abusive situations described in our reports. Second, we believe modernizing SSIS, the Department's computer system, should become a top priority. In addition to reducing worker frustration, it would effectively reduce caseloads by increasing caseworker capacity. We described other important administrative initiatives in our earlier report and recap them in the Conclusions and Recommendations section below.

Political Context

Child welfare critics have alleged that the system removes children inappropriately, particularly from BIPOC families. Current efforts to keep children with their families, even in high-risk cases, have been explained as a way to address these inequities. However, we believe this approach

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Minnesota's use of family assessment is beyond that of other states and beyond what the statute allows."

[6] See Minnesota's Best Practices for Family Assessment and Family Investigation 2023 pp. 9-10 for language which fails to specifically address this concern.

[7] See Task Force recommendation 32, p. 14, "Interview children first and prior to contact with parent/legal guardian whenever possible."

[8] Meitrodt, J., Van Berkel, J., Webster, M. J., & Serres, C. (2023, November 3). In Harm's Way: How Minnesota's child protection system exposes kids to more abuse, neglect. (2023, November 16). In Harm's Way: 'Friendly' approach to child protection fails Minnesota families, leads to more abuse. (2023, December 1). In Harm's Way: Minnesota's system for helping parents with addiction is full of holes. Kids pay the price. (2023, December 17) In Harm's Way: Hennepin County reduced repeat abuse of kids. Are there lessons for the rest of Minnesota? *Star Tribune.*

[9] Stahl, B., Lagos, A. J., & Eckert, S. (2023, May 18). KARE 11 Investigates: Red flags ignored, warnings disregarded, a boy murdered. *KARE 11;* Rasmussen, E. (2021, August 12). A Pattern of Abuse: Investigation reveals warning signs long before 8-year-old's murder. *KSTP News.*

has caused policymakers to implement practices that, at times, work against their own goals. For example, in this update, African American children continued to be killed disproportionately over and above their already disproportionate representation in the system. This same disparity also newly emerged in this period for Native American children. While further research is needed, the question is whether counties may be leaving Black and Native American children in high-risk situations while they are removing white children to other settings in similar circumstances.

We believe an approach grounded in research would lead to different policies. It would take into account, for example, that thirteen states have ended or scaled back programs like Family Assessment because of high fatalities.[10] It would also consider that poverty is the most significant driver of child maltreatment,[11] and it would recognize that neglect, rather than being less serious than abuse, is the largest primary cause of child fatalities.[12]

Overview of this Report

The structure of this report is first to describe developments for the current period, illustrated by statistical charts. Subsequently, we present stories of individual children to illustrate policies and practices that continue contributing to child fatalities and identify where changes in practices and new resources can better protect children.

In this year's update, we added an analysis of four near-fatalities because the Minnesota statute requires reports on these cases equally with fatalities. These cases are not included in the statistical data but are presented to help broaden our understanding of current patterns.

As in the initial report, our policy is to name the children who were killed. We believe this is important as a way to honor and remember them. We also believe this is appropriate because confidentiality considerations that were once a concern no longer apply due to the child's death. In addition, disclosure issues are somewhat moot since the media have already made the victim's stories public. Conversely, our policy is not to identify parents, other family members, or perpetrators even when they may already have been described in the media to avoid additional trauma to siblings and adult family members who did not cause the child's death.

We do not identify the victim by name in near-fatalities since the child is still alive.

We have written a summary of each child's story, which can be found in the Appendix.

Limitations

There are limits to what can be concluded from a sample of 19 cases and 21 deaths. However, these updated numbers help identify where a positive trend may be emerging and where there

[10] Piper, K. A., et. al (2019). Issues in differential response: Revisited. *Columbus, Ohio: The Center for Child Policy.* http://centerforchildpolicy.org/assets/IssuesInDifferentialResponseRevisited.pdf.
[11] Putnam-Hornstein, E., et. al (2013). Racial and ethnic disparities: A population-based examination of risk factors for involvement with Child Protective Services. *Child Abuse & Neglect*, 37(1), 42. https://doi.org/10.1016/j.chiabu.2012.08.005. Documents that once poverty is controlled for, racial disparities in the system disappear.
[12] See, for example, exhibit 4-E, which attributes 77.7% of fatalities to neglect and 42.8% to abuse. These categories overlap and indicate both types of maltreatment are causes of fatalities for some children. Maltreatment Types of Child Fatalities, 2021, p. 55. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2023). *Child Maltreatment 2021*.

are additional concerning patterns. Also, adding these children to past victims strengthens that database and creates a foundation for following trends that may develop over time.
Another limitation is that, unfortunately, the Department declined our request again this year to share the names of the child victims, even though, in our view, state statute Minn. Stat. § 260E.35 subd. 7 clearly requires the state and counties to make this information publicly available. However, as this report was being finalized, the Department did inform us of the number of child fatalities they recorded, a decision we greatly appreciated. According to their inventory, there were 26 child deaths due to maltreatment between June 1, 2022, and May 31, 2023. They cautioned that the final number may be larger because they do not count a fatality until the investigation is complete. In contrast, we identify fatalities through media reports, usually published when the child dies. We cannot know precisely where our lists of child fatalities agree without knowing the names of the victims. Nevertheless, it seems highly likely that we identified approximately 80% of deaths for this report, compared to last year when we knew about only half of the cases. As a result, this year's fatalities are more representative of the child welfare population as a whole.

Some additional limitations were due to counties' responses to our requests for fatality review reports under the statute mentioned above, which requires them to provide upon request a written summary of information related to a child fatality case 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 on any previous child protection reports or investigations that are pertinent to the maltreatment that led to the child fatality.

We requested fatality reports from eleven counties for eighteen of the twenty-one known fatalities. We did not request reports in three cases because we discovered the fatalities too late in the production of this report to include them. We received a response in some form from all the counties. However, they varied in their compliance with the statute, and some counties heavily redacted information to the point that it was difficult to understand the report.[13] Media reports and the fact that there is public access to Juvenile Court records helped overcome this gap.

Statistical Analysis

The following sections summarize key quantitative information collected during the project. This will be added to the database previously developed and will allow trends to continue to be tracked for Minnesota children who have died from maltreatment since 2014.

As mentioned, compared with the previous report, there are new instances of some practices that adversely impact children, while results are better in other areas, although again, the small sample size makes it impossible to know if either difference represents an emerging trend. We do not believe any developments are due to action by the Department because they have not made any recent relevant changes to practices.[14] Relatedly, most counties do not share changes in policy and practice, so it is impossible to know if any were made that affected these

[13] Ramsey and Hennepin County worked with us to provide the fatality reports but redacted the information so heavily that we could not identify the case. Subsequently, Hennepin County provided us with the children's initials, which made identification possible. Providing the initials may comply with the statute in a technical sense, as the child's name is not explicitly listed as part of the required disclosures, but it appears contrary to the statute's intent.
[14] See Bulletin #23-68-01. Revised Minnesota Child Maltreatment Intake, Screening, and Response Path Guidelines. (2023). Which includes a link to the Guidelines.

results. The exception is Hennepin County, which has been more transparent about changes in policies and practices in its progress updates related to the above-referenced lawsuit.

In the report for the period ending in May 2022, we made 39 recommendations for changes in policy and practice. These recommendations are still appropriate. For this report, we will not repeat each but will highlight recommendations particularly relevant to the fatalities in this reporting period. We have, however, provided a link to the earlier recommendations here**.**

Past Relationship of Family to Child Protection Services

A noteworthy development for this period was that the proportion of cases with a history of child protection involvement was less than in the previous report: 7 of the 21 cases, or 33%, compared to 59 out of 88 cases previously, or 67%. Of these, however, counties continued too often to leave children with their families throughout extensive periods where children were seriously harmed. This reinforces the need for more child-centric practices and earlier intervention, hopefully with a full array of prevention and early intervention services, to avoid potentially manageable situations that spiral downward with tragic consequences.

Exhibit 1: Cases with Prior Child Protection Contact		
Number of CPS Contacts	**Number of Fatalities**	**Percentage of all Fatalities**
1-3 contacts	3	14.3%
4-5 contacts	1	4.7%
6+ contacts	3	14.3%
Total	7	33.3%

Child Demographics

The following charts describe key child demographics from this report period.

Manner of Death

A new development since the previous report was the high percentage of fatalities caused by exposure to fentanyl. This likely substantially increased the number of child deaths overall and meant that blunt force trauma, previously the leading cause of death, became a much smaller proportion of the total.

Fentanyl poisoning accounted for nine out of the twenty-one deaths, or 43%, compared with three deaths due to drug toxicity, or 3.4%, in the earlier almost eight-year period, only one of which was fentanyl-related. Fentanyl was also a factor in two of the four near fatalities that occurred during the reporting period and one of the nine fatalities that occurred after the cutoff date for this report. These post-deadline fatalities will be analyzed in a subsequent report.

While the direct cause of the deaths in these nine children was fentanyl poisoning, four of the nine families in this report period also had significant prior child protection histories, eight had incidents of domestic violence, and eight had a history of Substance Use Disorder. Each of these suggests that the families were known to child protection or other mandated reporters and that opportunities existed for earlier and more decisive action that might have saved some of the children's lives. These numbers also suggest that these factors are interrelated and that the presence of one may indicate the presence of one or more of the others. Because of this, it

appears appropriate to recommend that maltreatment reports alleging one or more of these conditions be considered high-risk and screened in for investigation.

Exhibit 2: Child's Cause of Death			
Cause of Death	**Number of Fatalities**	**2022-2023 Report Period**	**2014-2022 Report Period**
Fentanyl poisoning	9	42.8%	1.1%
Other Drug toxicity			2.3%
Blunt force trauma	4	19%	52.3%
Drowning	3	14.2%	5.8%
Asphyxiation	1	4.8%	17%
Gunshot wound	1	4.8%	8%
Malnutrition	1	4.8%	
Medical neglect	1	4.8%	
Sepsis			3.4%
Stab wound			3.4%
Hypo/hyperthermia			2.3%
Fire			1%
Unknown	1	4.8%	3.4%

Age

As in the previous report, a majority of children killed were infants and toddlers. In this report, 14 of the 21 fatalities, or two-thirds, were three years old or younger, including seven or one-third who were one year old or younger. This is somewhat, although not substantially, lower than in the previous report, in which 78% were three years or younger, including 36.4% who were infants aged one year or less.

Exhibit 3: Child's Age at the Time of Death		
Child's Age	**Number of Fatalities**	**Percentage of all Fatalities**
0-11 months	7	33.3%
1-3 years	7	33.3%
4-5 years	3	14.3%
6-7 years	4	19.1%

Race

For this reporting period, while Black children comprise 7.6% of the population statewide, they include 17% of child protection cases and 28.6% of fatalities. Native American children, who comprise 1.4% of the statewide population, represent 7.2% of child protection cases and 14.2% of fatalities. In contrast, white children comprise 82.6% of the population statewide but only 49% of the child protection caseload and 19% of fatalities. As stated above, these numbers represent a second level of disparity: Black and Native American children are already disproportionately represented in the system and are additionally more likely to be killed than children of other racial and ethnic groups who are with them in child protection and foster care. Fatalities for other racial and ethnic groups are more proportional to their presence in the child protection

system. Again, this raises the question of whether counties are leaving Black and Native American children in settings where they experience continuous abuse and extreme risk while removing white children from similar situations.[15]

Exhibit 4: Child's Race		
Race	**Number of Fatalities**	**Percentage of all Fatalities**
Black	6	28.6%
White	4	19.1%
Mixed Race	4	19.1%
Asian	3	14.2%
Native	3	14.2%
Unknown	1	4.8%

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

One significant finding in the earlier report was that nearly half of children were killed by someone other than their biological parents. During this period, only one child out of 21, or 4.8%, was killed by an unrelated caregiver. This is in part because of the role that fentanyl deaths played, almost all of which were caused by children getting access to one or both of their parents' drugs. We hope this indicates that counties are responding more urgently to cases where a non-biological parent is a known threat to the child.

Exhibit 5: Percentage of Children Killed by Perpetrator by Age				
Relationship to Child	**Child's Age**			**Total**
	Under 1 yr. old	1-3 yrs. old	4 yrs. old and older	
Bio. Mothers	3	4	4	11 (52.4%)
Adjudicated/ Assumed Fathers	3	2	3	8 (38%)
Both Bio. Parents		1		1 (4.8%)
Mother's Significant Other		1		1 (4.8%)

Domestic Violence

There was a notable increase in the proportion of cases where domestic violence played a role. In eleven, or 52%, of 21 child fatality cases in this update, one or both parents or partners had a history of domestic violence. This compares with 28.4% percent in the previous report. A section below is dedicated to exploring this development in more detail.

Exhibit 6: Co-Occurrence of Child Maltreatment and Domestic Violence			
2022 – 2023 Report Period		**2014 – 2022 Report Period**	
Number of Fatalities	Percentage of All Fatalities	Number of Fatalities	Percentage of All Fatalities
11	52%	25	28%

[15] Minnesota Children and Family Services. (2023). (rep.). *Minnesota's Child Maltreatment Report, 2021.* (pp. 19–23). https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5408N-ENG.

Torture and Absence of Multi-Type Maltreatment

In the previous report, 16% of cases involved torture or significant elements of torture. For this report period, there were two clear instances of torture, which were not included in the statistics because neither ended in a fatality. In addition, six of 21 children who were killed, or 29%, experienced elements of torture. These developments indicate that torture is an ongoing concern. This also is the subject of additional analysis in the final section of this report.

We were encouraged that there were no clear examples in this period of chronic multitype maltreatment, a pattern noted in previous years. This is a type of maltreatment that may begin with a relatively manageable level of neglect but deteriorates over time to include physical and/or sexual abuse and sometimes torture. It is also characterized by an erosion of social norms, for example, leaving an infant or toddler alone for hours or days at a time, and may include harsh or non-nurturing parenting practices. Child welfare expert Dee Wilson provides a helpful analysis of this syndrome in the blog *Sounding Board*.[16]

The following page provides a breakdown of child deaths by county.

[16] Wilson, D., & Sebastian, T. (2022, December 22). Mitigating the effects of adverse childhood experiences in chronic multitype maltreatment. *The Sounding Board*. https://imprintnews.org/child-welfare-2/sounding-board-mitigating-aces-multitype-maltreatment/237007

Child Fatalities by County

As seen in the chart below, there was a significant increase in Ramsey County cases. While they previously accounted for eleven cases over eight years, they had seven in the past year. Hennepin County's rate of fatalities, on the other hand, remained about the same, as they averaged around 3.5 fatalities each year between 2014 and 2022 and had four fatalities this past year. Deaths in Micropolitan Counties (see definition in the footnote below) more than doubled, while Rural Counties maintained a similar rate of fatalities. While it is encouraging that Rural Counties had fewer fatalities, it is unclear if this is a trend due to the small sample size.

Exhibit 7: Child Fatalities by County[17]

Metropolitan			Micropolitan			Rural		
County	**2022-2023 Report Period**	**2014-2022 Report Period**	**County**	**2022-2023 Report Period**	**2014-2022 Report Period**	**County**	**2022-2023 Report Period**	**2014-2022 Report Period**
Ramsey	7	11	Beltrami	2	1	Morrison	1	
Hennepin	4	28	Cass	1	1	Red Lake		2
Anoka	1	4	Goodhue	1	1	Itasca		2
Benton	1	1	Otter Tail	1	2	Aitkin		1
Dakota	1	4	Wilkin		1	Pine		1
Olmsted	1	3	Mower		2	Cottonwood		1
St. Louis		5				Kanabec		1
Washington		3				Hubbard		1
Scott		2				Renville		1
Blue Earth		3						
Sherburne		2						
Sterns		1						
Carlton		1						
Isanti		1						
Clay		1						
Total	15 (71%)	70 (79.5%)		5 (24%)	8 (9.1%)		1 (5%)	10 (11.4%)

[17] 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

Practice Patterns

The following sections illustrate concerning patterns that have persisted since the last report.

Derric Fulks, Jr., 3 years old, Ramsey County
Patterns:

- **Repeated inappropriate assignment to Family Assessment**
- **Multiple chances to address chronic problems**
- **A Black child being subjected to abuse and high risk over a long period**
- **History of domestic assault**

On December 15, 2021, Derric Fulks Jr., three years old, was brought to the hospital after he was found unresponsive in his mother's car by his grandmother. Emergency responders unsuccessfully attempted to revive Derric. When interviewed by the police, Derric's mother appeared to be under the influence of alcohol and potentially other substances. The mother speculated that Derric had eaten something from the car's floor. Autopsy results concluded that he died from a fentanyl overdose.

Derric's family has a long history of involvement with child protection, including three Family Assessments and three investigations. No services were offered for any of the cases opened. Findings in the supposedly low-risk Family Assessment cases included physical abuse of Derric by his mother and prenatal drug exposure for Derric and two other siblings. Two investigations resulted in findings of maltreatment, which were the abuse of Derric by the father of his siblings and a finding related to a drug raid at which Derric and his siblings were present. This story[18] about Derric by former *Star Tribune* reporter Chris Serres reported additional incidents not reflected in the county fatality report or court documents. These included an incident at daycare where the mother was reported for beating an older sibling in the street outside the facility and a second incident where Derric arrived at the center with a sizeable gash under his eye, which he said was done by "Daddy." The father of three of Derric's siblings was also convicted of domestic assault on his mother shortly before he was born.

In the newspaper article, the maternal grandmother was quoted saying that she would have taken Derric and his siblings in had she known about the abuse. "My baby grandson did not need to die," she said. "When you have a kid who's witnessed a drug raid, you would expect follow-up services." Among other concerns, this raises the question of how local child protection agencies decide when to communicate with and involve kin in their cases.

Derric's surviving siblings were taken into care by his grandmother. She describes that all of the children are suffering from trauma by witnessing Derric's death. She also said that at the time of the article, no one from the County or state had interviewed her about Derric's death or updated her. No one has been charged in Derric's death.

[18] Serres, C. (2023, April 30). Minneapolis toddler's death triggers fresh concerns about child protection. *Star Tribune*. https://www.startribune.com/minneapolis-abuse-maltreatment-child-protection-hennepin-ramsey-fentanyl-death-foster-care/600271341/.

Recommendations Related to Pattern Illustrated by Derric Fulks, Jr.

1. Reinstate the policy of limiting the use of Family Assessment to the 20% - 30% of cases identified as low-risk.
2. Allow cases to be assigned to Family Assessment only once and never if the alleged child victim is 0-3 years of age.
3. Engage outside experts to analyze the disproportionate rate of child fatalities for Black and Native American children and make appropriate recommendations.
4. Assume any cases with a combination of SUD, domestic violence, and/or prior child protection history are also at high risk for exposure to fentanyl, and screen them in for an investigation.
5. DHS should consider a public relations campaign to increase awareness of the dangers of leaving fentanyl and other deadly drugs where children have access to them.

Zyair Glapion, 3 months old, Hennepin County
Patterns:

- **Returning children home from foster care before parents have made necessary behavioral changes**
- **Numerous chances to address chronic abuse, neglect, and SUD while children continue to be at risk and suffer ongoing abuse and neglect**
- **Lenient sentencing for biological parents**
- **History of domestic assault**

On January 20, 2022, officers responded to a report of a baby not breathing in St. Louis Park, Minnesota. According to the child's mother, she had put the three older children to bed around 8:00 or 8:30 p.m. She then took two "benzos" that she did not have a prescription for to help her sleep. She stated that she remembered placing Zyair on the bed beside her. Zyair's mother woke up in the morning and noticed Zyair lying on the bed with his face covered. He was not moving, and she called the police. She denied using any other substances the prior evening. The medical examiner's findings indicate that Zyair died from positional asphyxiation.

Zyair's three siblings were in four out-of-home placements for over 900 days during the six years of their mother's involvement with child protection. The primary issue was the mother's repeated inability to address her addiction to meth for longer than it took to regain custody of her children. However, her history also included three arrests for DWI, including at least one with three children in the car. Other issues documented by the County were neglect – failure to provide shelter free of environmental hazards, failure to ensure the children's education, physical abuse by the mother who beat the oldest child with closed fists, domestic abuse by two of the other sibling's three fathers, possession of firearms by two of the fathers, and domestic abuse by a boyfriend of the mother. In addition, the record indicates that the mother had an inpatient mental health stay, which raises a previously documented question of whether there was coordination or planning between the mental health facility and child protection. There was one county petition to terminate the mother's parental rights. However, the trial ended with the children being returned to the mother again, and the child protection case was closed.

In our earlier report, we documented leniency towards biological parents who were responsible for their child’s death compared to perpetrators who were not related to the victim. In this update, only one non-biological parent was responsible for killing a child, so comparisons were not possible. However, the sentence for Zyair's mother, who was convicted of second-degree

manslaughter, reflects earlier findings in that it was a significant downward departure from guidelines, which called for her to serve a minimum of two-thirds of the four-year sentence. She ultimately served 30 days of an 80-day sentence in a workhouse, followed by home monitoring and a four-year sentence that was stayed pending successful completion of a five-year probation period. The court document required for a judge to explain a downward departure, called a departure report, indicated that she was provided this lesser sentence because she was "amenable to probation" and "shows remorse/accepts responsibility."

Recommendations Related to Pattern Illustrated Zyair Glapion

6. Develop 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.
    - Use a higher standard for returning infants and toddlers because they are defenseless against assaults or developmentally debilitating neglect.
7. Develop statewide standards regarding chronic abuse and 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.
8. The Minnesota Judicial Council should ensure that all sentencing reports involving upward and downward departures from guidelines comply with the requirement that the reasons for departures be stated in the court record.

D-Angelo Pitchford, 3 years old, Olmsted County
Pattern: Red flags that were missed or ignored by medical providers

D-Angelo Pitchford's father took him to the doctor on a day when he was not feeling well. When the father got home from work, D-Angelo had a stomachache and vomited. His father then took him to the Emergency Department at Olmsted Medical Center. After several hours, the father became impatient with the wait and told staff he was going home. Hospital staff explained that D-Angelo's white blood cell count was high and that he could die. They then had Pitchford's father sign paperwork acknowledging that he was taking the child home against medical advice. The boy died shortly after that due to complications of a paraduodenal hernia, a condition that would have been seen on an x-ray and would have required immediate surgery.

We shared court documents with two medical experts who noted that when D-Angelo presented at the hospital, he was dehydrated to the point that he was lethargic and had electrolyte disturbance significant enough for them to warn the father about heart or kidney problems. Other serious warning signs included that they were unable to place an IV to rehydrate him. The fact that the medical staff required the boy's father to acknowledge their warnings in writing indicates that they understood the degree of risk to the boy, yet they did not act to protect him. In the court complaint, a doctor said he did not think they could intervene because they did not have a definitive diagnosis, but according to our experts, that is not the standard. The issue was that they had enough information to know he was at extreme risk without immediate intervention and had options to protect the boy, including asking local police to put an emergency hold on him so they could keep him in the hospital or, at a minimum, make a report to child protection.

The fact that the hospital providers may not have been knowledgeable about their options or knew but failed to carry out their responsibility as mandated reporters resulted in the child's death within hours. There is also a concern whether the primary care provider who examined D-Angelo earlier in the day exercised reasonable care in examining the boy. However, there is insufficient information in the record to answer that question.

Olmsted County opened an investigation following D-Angelo's death and determined that there was no maltreatment on the part of the father, even though his actions appear to clearly meet the statutory criteria for neglect.[19] In contrast to the County's stance, the father is currently charged and awaiting trial for manslaughter. The mother is suing Olmsted Medical Center and the physician for Wrongful Death.

Related to this, in the previous report, we were able to identify instances where medical providers documented injuries in infants who were too young to be self-inflicted, for example, by rolling off a bed. We did not have examples in this group where the court record explicitly documented this issue. However, in a number of the deaths in this update, children had been physically abused over extended periods, and several autopsies showed old and healing injuries. The question again arises whether these children had been seen by medical providers who either failed to recognize or failed to report injuries to child protection, or if they did report, whether the county agency either screened them out or did not mention them in their reports to the court. What the Olmsted County Medical Center response and these other circumstances indicate once again is, first, the importance of having primary care and Emergency Department providers, in particular, receive training on identifying child maltreatment and what steps to take when it is discovered. Secondly, these patterns indicate the need to hold medical providers accountable when they leave children at high risk of severe harm or death. As recommended previously, this should include mandatory training as part of their licensing requirements to keep medical providers' knowledge of their child protection responsibilities current. In addition, child protection agencies should also treat cases referred by medical providers as high-risk and screen in such referrals for investigation.

Recommendations Related to Pattern Illustrated by D-Angelo Pitchford

9. Licensing bodies for physicians and advanced practice medical providers should explore how best to ensure that providers are knowledgeable about the physical manifestations of child abuse, their options for actions when they encounter maltreatment, and their responsibilities as mandated reporters.
10. Hospitals and medical associations develop protocols to clarify providers' responsibilities as mandated reporters.

Aldina Sulejmani, 3 months old, Otter Tail County
Pattern: Children Killed in Foster Care

Aldina, her twin sister, and three older siblings were placed in two separate foster homes due to their parent's ongoing and untreated SUD. Aldina died in a non-kinship placement where she was placed with her twin. The fatality report does not clearly identify the cause of death but

[19] Per Minn. Stat. § 609.378, neglect or endangerment of a child is defined as "A parent, legal guardian, or caretaker who willfully deprives a child of necessary food, clothing, shelter, health care, or supervision appropriate to the child's age when the parent, guardian, or caretaker is reasonably able to make the necessary provisions and the deprivation harms or is likely to substantially harm the child's physical, mental, or emotional health."

ascribes it to "unsafe sleeping practices," which suggests that the cause was positional asphyxiation.

According to the Otter Tail County Human Services Department fatality report, they investigated the matter jointly with local law enforcement and made an initial finding of maltreatment due to neglect by the foster parents. A reconsideration was requested, but the report did not indicate by whom. To avoid a conflict of interest, the County asked the Beltrami County Human Services Department and County Attorney to review their decision. As a result, the final disposition was to reverse the initial finding of maltreatment and to recommend that the situation be addressed as a licensing action related to safe sleeping practices through the State Department of Human Services Licensing Division.

This was the second placement for Aldina and her twin. In addition, her three older siblings were placed with relatives and then moved to a non-kinship placement because the relatives continued to allow the biological parents to have access to them, contrary to the case plan. This suggests inadequate due diligence in recruiting the kinship placement but also that the County responded appropriately when the providers failed to follow the case plan.

In the previous report, eight foster children died over eight years, all but one of whom was in kinship care. Aldina Sulejmani was not a kinship placement and was the only instance of foster care death in the current group of fatalities. Given the sample size, it is difficult to know if the lack of kinship foster care deaths indicates improved diligence on the part of counties, but we hope this pattern continues in future years.

This case repeats concerns identified previously regarding the quality of recruitment, training, and supervision for foster care, both kinship and non-relative. It additionally raises questions about whether accountability for child safety is insufficiently stringent for licensed foster care homes. As mentioned earlier, the Department is about to release excellent new standards in this area, and we hope they will help address these problems.

Recommendations Related to Patterns Illustrated by Aldina Sulejmani

11. Diligently implement the new statewide standards for recruiting, licensing, training, and supervising out-of-home placements.
12. Establish a policy that fatalities in foster care placements be addressed with the same standards as other child fatalities.
13. Failing to implement basic skills that foster parents have been trained in, such as safe sleeping practices, should be grounds for, at minimum, terminating their licenses.

Torture Cases and ones with Elements of Torture

As indicated, one non-fatality case and one near-fatality case met the full definition of torture discovered in the previous report. In both instances, both parents were charged by prosecutors with torture and other felonies, including malicious punishment of a child. In one of these instances, as well as two others with elements of torture, there may not have been any way for child protection, law enforcement, or other mandated reporters to know about the abuse. This elevates the importance of training mandated reporters of signs of torture so that if children do come into contact with them, their plight will be noticed.

In one situation, the parents locked their four children in cages not big enough for them to stand up in for 13-14 hours a day, denied them food and water, beat them regularly, bound their hands with duct tape, and denied them use of a bathroom. In the other, according to the criminal charges, a mother repeatedly withdrew blood from her three children, ages 8, 10, and 11, then took them to medical providers for a diagnosis. She also isolated and tortured them, terrorized them, and put them in casts and neck braces despite not having broken bones. This mother had 18 screened-in child protection cases since 2007 and had her custody terminated for two other older children.

These developments continue to highlight the need for policies that classify cases with these features as high risk, as well as for training child protection workers in signs of torture.

A link is provided here to the three standards we consulted in evaluating cases for torture or elements of torture.

None of the fatalities this year unambiguously included one key element defining torture, namely a prolonged effort to dehumanize and break the will of the child. While this did appear to be the perpetrator's intent in several instances, these criteria were difficult to establish clearly because the children were infants. As a result, torture markers such as binding the child or putting them in a confined space and depriving them of food and water did not always clearly apply.

While it is good that no children experienced most or all of the elements of torture during the reporting period, the following incidents and the two that occurred after the cutoff date for this report indicate that concerns about torture persist.

> **Jamari Hne, 17 months old, Ramsey County:** The perpetrator made one 4-minute and two shorter videos of himself beating the semi-conscious child while she was strapped in her car seat, including focusing in on her wounds. He also burned her in a bathtub until her skin peeled off. In addition, an autopsy showed old healing injuries. This illustrates elements of torture, such as binding a child while harming them and repeated abuse that causes serious injuries. Jamari's mother was apparently only living with the perpetrator for a few weeks, however, and Jamari was a young toddler, which ruled out a prolonged effort to dehumanize and control the child. The mother had no child protection history, and there was no record of domestic violence, so there was not an obvious way that authorities might have known about and intervened in the situation other than the possibility that the healing wounds indicated that another perpetrator may have harmed the child. In that event, it is possible that medical providers or the mother might have observed the wounds and failed to make a report to child protection.
>
> **Kaiden Rathke, 5 months old, Anoka County:** The infant's father repeatedly suffocated the child until he became unconscious to "get him to sleep," then revived him. Kaiden's mother shared these incidents with the police, but not until after he died. This case fits the criteria of severe and repeated physical abuse in a depraved manner and attempting to gain control over the individual. However, some other criteria may not apply given the child's young age. The father is currently being held on bail and is charged with unpremeditated murder in the 2nd degree with intent.
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> **Jewel Fineday, "Miikawaddizimikinaakikezens," meaning "Beautiful Turtle Girl," 7 years old, Beltrami County:** Jewel Fineday was a Native American girl subject to the Indian Child Welfare Act (ICWA). As a result, the fatality was charged in federal court,

and minimal information was available. However, what is public is that she died from starvation and a severe lice infection, which suggests that she was tortured over a long period. Jewel's father and grandmother have been charged with felony child neglect. This case raises the question of whether new mechanisms are needed to make ICWA cases as transparent as those managed by counties, for example, by making court records available and requiring tribes to issue a fatality report.

Recommendations Related to Cases with Elements of Torture

14. The Child Welfare Training Academy (CWTA) should train child welfare workers and mandated reporters to recognize signs of torture.
15. Tribes should consider modifying their practices to make ICWA cases more transparent and to increase agency accountability.

The following sections analyze other trends, but we did not illustrate them with additional case stories. Regarding domestic assault, the issues are described above in the cases of Derric Fulks, Jr., and Zyair Glapion, as well as in a number of the other children who died, described in the Appendix. The pattern of deadly neglect described below discusses fatalities that occurred after the cutoff date, and we did not write summaries of cases that occurred after that time.

The Relationship Between Domestic Violence and Child Fatalities

As described above, in twelve, or 57%, of 21 child fatality cases in this update, one or both parents or partners had a history of domestic violence. This compares with 28.4% percent in the previous report. This attention-getting proportion indicates the need to consider how current policies and practices around domestic violence are affecting child safety and well-being.

Of these cases, four involved domestic violence in the presence of children that were identified in Criminal Court records but not reflected in reports from the county social services agency to the Juvenile Court. This means either that the local law enforcement agency did not report the incidents to child protection as required by law, or that the local child protection agency received reports but did not screen them in, or that they screened them in but did not document domestic abuse as one of the allegations.

Of cases that should have been reported to or screened in by child protection, we did not include three additional cases in which the county records are not clear about whether the domestic violence may have occurred with a different partner not involved in the child protection report. In the remaining four cases, the record shows that domestic violence did, in fact, occur with a different partner. In either of these circumstances, domestic violence may legitimately not have been included as a factor in deciding whether to screen in the maltreatment report. However, once the case was screened in for other reasons, child protection would have been able to check criminal records and consider domestic violence in assessing the risk level and deciding to assign the case to investigation rather than Family Assessment.

This set of problems is within the ability of county and law enforcement managers to fix by updating policies and manuals, reinforcing statutory reporting requirements through training and supervision, and developing consistent protocols for information exchange between child protection and local law enforcement.

An issue with less clear-cut solutions is how child protection should evaluate risk in situations where there is a history of domestic violence. Based simply on the number of fatality cases in which domestic violence co-occurs, it seems reasonable to require that maltreatment reports in which one or both partners have a history of domestic violence be considered high risk and should be screened in and assigned to an investigation rather than a Family Assessment, even if there is not a current case between the partners. Once open, child protection should continue to work with the parents around effective safety planning, including making sure that domestic violence programs and mental health providers continue to be engaged. Local law enforcement should commit to working with child protection staff to better enforce the different types of no-contact orders.[20,21] Child protection and law enforcement should also reflect a low tolerance for any form of family violence once a case is active and prioritize getting children to a safe place if the abuser continues to pose a threat to them and the non-offending parent.

Recommendations Domestic Violence No-Contact Orders

16. Change policies to designate cases with a history of domestic violence on the part of one or both partners as high risk and automatically assign them to an investigation.
17. Develop consistent statewide communication protocols between local law enforcement and county child protection agencies so that domestic violence is reported and violations of no-contact orders are consistently followed up on.
18. Law enforcement leaders, the courts, prosecutors, and parole/probation programs should convene to discuss practical measures for addressing the high rate of non-compliance with no-contact orders.

Potentially Emerging Pattern of Deadly Neglect

A new issue that merits watching in the coming year is what we are calling deadly neglect. This includes three fatalities that occurred after the cutoff for this reporting period, which involved leaving loaded handguns in a residence or vehicle where children could reach them. This resulted in one three-year-old shooting himself. In that case, charges were filed against the father, including second-degree manslaughter, child endangerment, and negligent storage of firearms. In a second gunshot case, a four-year-old found a loaded gun in his father's truck and shot his two-year-old brother to death. The father has been charged with two counts of second-degree manslaughter, one count of child endangerment, and one count of negligent storage of a firearm. In a third such incident, a 7-year-old shot and seriously injured his 9-year-old brother with a loaded gun accessible in the house. The latest media report at the time of this report was that the incident was being investigated. However, the story did not say whether charges were being considered.

[20] As described in the earlier report, 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 victim's request. A DANCO is issued by criminal court in response to a domestic assault charge. DANCOs 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. If they continue to violate the terms of the protective order, they will be charged with a felony.

[21] An additional option to protect victims of domestic violence is a Harassment Restraining Order (HRO), which 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.

In an additional case of deadly neglect, a parent with a history of domestic abuse and a violent felony allowed a four-year-old to drive a full-size ATV on an open road, where it tipped over and killed him. Although a child younger than ten is not legally allowed to drive an ATV on public land, the father was not criminally charged, and no child protection investigation was opened.[22]

We propose that these types of neglect are no different than leaving deadly narcotics where children can reach them. They deserve further attention and discussion about changes to public policy that will better protect children.

Recommendations Related to Patterns of Deadly Neglect

19. DHS should consider a public relations campaign to increase awareness of the dangers of leaving guns and ammunition where children have access to them, as well as allowing children to operate motorized vehicles.
20. Screen all fatalities caused by deadly neglect as child protection investigations that lead to findings and case actions consistent with other fatalities caused by caregivers.
21. Encourage law enforcement to apply existing laws to prosecute deadly neglect consistently.

Conclusions and Recommendations

The recently renewed interest in child protection and foster care by the Governor and the Legislative Task Force on Child Protection provides a fresh opportunity to address the issues identified in this report and the investigative reporting described above. We encourage elected officials and their staff to give this effort the same meticulous attention that characterized the 2015 Task Force. In this regard, we recommend exploring several administrative and program initiatives.

Making administrative improvements will require that the Department establish several baselines, including a survey to assess current caseload sizes throughout the state and identify gaps in core services needed for case plans, particularly mental health and SUD treatment.

Additional surveys of counties will be needed to determine which of the practices agreed to in 2015 have been implemented. These include statewide implementation of 24/7 response to child maltreatment reports, Multi-Disciplinary Teams, and reviews by County Attorneys of non-compliant cases prior to closing.

As mentioned, the most significant administrative return on investment would almost certainly come from modernizing the Department's computer system, known as SSIS, which, by numerous accounts over the years, absorbs over 50% of caseworkers' time. This could reduce or potentially eliminate the need for more staffing. Again, consistent improvements will depend on having statewide standards for all steps in the child protection/foster care service continuum.

[22] According to the Minnesota DNR website, it is legal for a child under ten to operate a Class 1 ATV on private land with the owner's permission. However, the rider must be 12 years old to operate on public land. Anyone under 15 is prohibited from operating a Class 2 ATV, which "have a total width greater than 50 inches but no more than 65 inches from outside of tire rim to outside of tire rim." (Minn. Stat. § 84.9256). It is unclear what size ATV the child was driving.

From a program perspective, we do not wish to repeat the analysis from our previous report here,[23] but in brief, the most effective ways to reduce child maltreatment overall, as well as to reduce racial disparities, are to provide resources that reduce poverty, and to provide prevention and early intervention services. In this regard, we recommend substantial increases in the state's Parent Support Outreach Program (PSOP), which addresses immediate poverty issues and provides preventive services to help keep families from entering the child protection system. Other effective preventive services include, particularly, early learning scholarships and targeted home visiting.

Regarding poverty reduction, caseworkers' responsibilities should allow them to help families access public benefits programs that they are eligible for and connect them to services that directly ease economic burdens, such as childcare and housing.

Efforts such as these can minimize child maltreatment but, even if done optimally, will not eliminate it. When issues such as SUD, mental illness, and domestic violence occur, poverty-related support and preventive services will not always be sufficient to prevent serious maltreatment of children. Our joint commitment should always be to manage the child welfare system as well as possible, support the people doing this difficult work, and keep children safe.

[23] See pp. 12-15 of our above-referenced report, *Minnesota Child Fatalities from Maltreatment 2014 – 2022*, for a more detailed analysis of the relationship between poverty and child maltreatment.

Appendix:
Case Summaries 2022-2023

Fatalities

The following tells the stories of the children who were killed during this report period.

Ashton Michael Littlewolf, 9-months-old, Cass County
June 13, 2021 – March 12, 2022
There is not much information on this case as there are no criminal charges specifically for the fatality; however, information in the subsequent CHIPS case for Ashton's siblings states that Ashton Littlewolf, nine months old, died of fentanyl exposure.

Ashton's family had a long history of involvement with child protection prior to his death. His mother additionally had multiple drug-related and assault charges. His sibling's father also had several drug and domestic assault charges. This demonstrates that the family and the risk to the children were well known to child protection.

Oaklee Hirsch, 6-years-old, Hennepin County
August 15, 2015 – May 27, 2022
On May 27, 2022, police officers responded to an overdose call. When they arrived, they observed Oaklee Hirsch, six years old, not breathing and seizing. Life-saving measures were attempted, but Oaklee passed away at the scene.

Officers spoke to Oaklee's mother, who advised that she woke up to find Oaklee, who had slept in her bed, not breathing, and he had vomited. When Officers spoke with Oaklee's father, he advised that he saw a dollar bill around Oaklee's mouth and believed there may have been drug residue on the bill. He had also given Oaklee Narcan, but it did not revive him. When speaking with the Officers in more depth, Oaklee's mother admitted to using fentanyl, which she thought was heroin, within the 48 hours prior. She stated that she had no idea how Oaklee had died besides chewing on the dollar bill that was used for narcotics. Oaklee's grandmother advised that he sometimes chewed on newspaper and sometimes swallowed it. Oaklee's cause of death was confirmed to be acute fentanyl toxicity.

Oaklee's mother struggled with SUD and had a few domestic assault charges. However, the family did not have any prior involvement with child protection.

Oaklee's mother was convicted of 2nd-degree felony manslaughter.

Quadrillion Lee, 4-years-old; Phoenix Lee, 5-years-old; and Estella Lee, 3-years-old; Ramsey County
July 1, 2022
On July 1, 2022, the children's father died by suicide, which his wife, the children's mother, witnessed. After police investigated their father's death, the children were going to go to their grandparent's house, but their mother insisted they stay with her. Later in the evening, family members notified police that she intended to harm herself and the children. Their bodies were later found in Vadnais Lake, where she had drowned the children and then herself. The family had no known criminal history or involvement with child protection.

Steve "Owen" Meyer, 4-years-old, Morrison County
July 14, 2017 – July 12, 2022
On July 12, 2022, Steve "Owen" Meyer, four years old, was driving an ATV with a six-year-old passenger when he lost control on a gravel road and rolled the machine. The six-year-old jumped off the ATV before it flipped over, while Owen was ejected from the vehicle. Life-saving measures were attempted at the scene of the accident, but they were unsuccessful, and Owen was pronounced dead at the scene. It is unclear whether adults were nearby or supervising the four-year-old while he was driving.

The family did not have any involvement with child protection, but Steve's father had a prior conviction for domestic assault.

No criminal charges have been brought in this case.

Amonre Randolph, 7-years-old, Hennepin County
July 12, 2015 – August 17, 2022
On August 17, 2022, around 7 a.m., Amonre Randolph, a seven-year-old boy, was found unresponsive at a home in Minneapolis. After examination by police officers and emergency medical personnel, they declared Amonre deceased. According to Amonre's father, he had acted normally the day before. When he woke up the next day, he found Amonre stiff in his bedroom with a white substance around his mouth. An autopsy determined that Amonre had died of acute fentanyl toxicity.

Amonre's father has multiple domestic assault convictions, including at least one where children were present. The family had no known child protection history, but the parents were well-known to other authorities.

Amonre's father was subsequently charged with 2nd Degree Murder – Without Intent – While committing a Felony.

Ryder Compton, 17-months-old, Ramsey County
May 21, 2021 – September 4, 2022
On September 4, 2022, Ryder Compton, a one-year-old boy, died of fentanyl and heroin toxicity. It was later determined that Ryder's parents had both gotten high on heroin the day that Ryder died. His father admitted that he had placed his narcotics in a location where Ryder could reach them. He fell asleep on the floor, and when he awoke, Ryder was lying on top of him, not breathing. Ryder's parents administered Narcan before his father fled the scene. An autopsy determined that Ryder had died of combined drug toxicity, which included heroin and fentanyl.

Ryder's parents had past contact with child protection due to SUD. Ryder's mother additionally has a history of mental health struggles. Ryder's father had multiple domestic assault incidents against Ryder's mother, but it is unclear whether the children were ever present. Even though Ryder's mother had a DANCO petition filed against the father, they were living together when Ryder died.

Both of Ryder's parents have been convicted of manslaughter.

Jamari Hne, 17-months-old, Ramsey County
2021 – October 18, 2022
The perpetrator made one 4-minute and two shorter videos of himself beating a semi-conscious Jamari while she was strapped in her car seat, including focusing in on her wounds. He also

burned her in a bathtub until her skin peeled off. In addition, an autopsy showed old healing injuries. Jamari's mother was apparently only living with the perpetrator for a few weeks. Jamari's autopsy determined that her cause of death was multiple traumatic injuries due to assault, with external injuries to the face, shoulder, chest, and right forearm and internal bleeding in the brain. There were lacerations to the thymus gland, liver, and adrenal gland and fractures to the right ulna and radius.

The perpetrator had multiple prior convictions for ineligible possession of a firearm.

The perpetrator was convicted of 2nd-degree murder.

Jewel Fineday, "Miikawaddizimikinaakikezens," meaning "Beautiful Turtle Girl," 7-years-old, Beltrami County
September 24, 2015 – December 25, 2022
Jewel Fineday was a Native American girl subject to the Indian Child Welfare Act (ICWA). As a result, the fatality is charged in federal court, and minimal information is available. However, what is public is that she died from starvation and a severe lice infection, which suggests that she was tortured over a long period. Jewel's father and grandmother have been charged with felony child neglect.

We could not find any child protection history, but Jewel's father did have one incident of domestic violence against her mother. It is unclear whether any children were present during the incident.

Joshua Needham Jr., "Ogimaa binesi Niizho anaag," meaning "Chief Thunder Bird, Two Stars," 21-months-old, Beltrami County
April 13, 2021 – January 4, 2023
On December 31, 2022, Police Officers responded to a report that 18-month-old Joshua Needham Jr. was unresponsive. While they began efforts to revive Joshua, they overheard his mother inform a person on the phone that Joshua must have gotten into the trash, where there was a piece of tin foil that had previously been used to smoke fentanyl. Joshua's mother informed police officers that around 8 a.m., while she was cleaning the kitchen, Joshua had accessed the trash can and removed the tinfoil with fentanyl residue on it. She removed the tinfoil from his hands, and a short time later, Joshua collapsed in the kitchen. She administered Narcan to Joshua, and he became alert and vomited. She bathed Joshua and said he appeared fine afterwards. She never called 911 or brought Joshua to the emergency room. At around 1 p.m., Joshua became unresponsive, and then, five hours after the initial overdose, his mother called 911.

Joshua was revived at the hospital with the help of a ventilator and was transported to a Fargo hospital, where he remained in critical condition. A blood and urine sample established that he had fentanyl and meth in his system. Joshua later died on January 4, 2023, from fentanyl toxicity.

Both of Joshua's parents have DWI charges for driving while using drugs. Joshua was in the vehicle for two of these instances. It is unclear whether this was reported to child protection as court records did not indicate any child protection history.

Joshua's mother has been charged with 2nd-degree manslaughter.

Messiah O'Neal, 9-days-old, Dakota County
January 10, 2023 – January 19, 2023
On January 10, 2023, a nine-month pregnant Kyla O'Neal and her unborn child's father fought outside an Amazon warehouse in Lakeville. They were fighting because the child's father had a child with another woman while Kyla was pregnant with his child. During the fight, he shot Kyla in the neck. She was rushed to the hospital, where she was pronounced dead. The doctors performed an emergency c-section and were able to get a pulse on the baby boy, Messiah O'Neal, but he died nine days later in the hospital.

Messiah's family did not have any prior child protection involvement, but court documents do note domestic violence between his parents. His father additionally had a domestic assault case against a previous partner.

Messiah's father is currently charged with murder in the 2nd degree and is out on conditional release.

Hazel Clark, 4-months-old, Benton County
January 19, 2023
Hazel Caloni Clark, four months old, died in an apparent murder-suicide at the hands of her father in an apartment building in Sartell, Minnesota. They were found after the apartment building was on fire, which was later determined to be set intentionally.

It is unclear whether Hazel's father had any serious criminal or other legal involvement, as they had just recently moved here from North Dakota. A records search in North Dakota only showed traffic-related charges.

Koas Vilaihong, 18-months-old, Hennepin County
August 2, 2021 – February 23, 2023
On February 23, 2023, police responded to a 911 call of a baby not breathing. Koas Vilaihong, one year old, was found unresponsive. EMS attempted CPR but were unable to revive him. He was pronounced dead at the hospital.

Present at the scene were the child's mother and father. Koas's father was yelling at his mother, who responded, "I know it's my fault." During a police interview, she advised that she purchased 10-20 pills the night before that she believed were fentanyl. She advised that she took about 15 pills, put the remainder in her bra, and went to bed. Koas was in the bed next to her, and she believed he must have gotten some of the pills and ingested them. An autopsy confirmed that Koas's cause of death was fentanyl toxicity.

Koas's mother struggled with SUD, including a child protection case while pregnant with Koas because of her substance use. Additionally, Koas's father had multiple domestic violence incidents and DANCO violations with the mothers of his other children, but it is unclear if any of those incidents involved Koas's mother.

Koas's mother was charged with 2nd Degree Manslaughter and is currently out on conditional release.

Kaiden Rathke, 5-months-old, Anoka County
September 26, 2022 – March 1, 2023
Kaiden's father repeatedly suffocated him until he became unconscious to "get him to sleep" and then revived him. The Hennepin County Medical Examiner's Office released its preliminary

report. The Immediate Cause of Death was listed as multiple blunt force injuries, and the Manner of Death was homicide. Injuries found during the autopsy included subdural and subarachnoid hemorrhage, traumatic axonal injury of the brain and spinal cord, optic nerve sheath hemorrhage, scant retina hemorrhaging, and multiple acute and healing rib fractures with remote fracturing of the mid-thoracic spinal cord.

Kaiden's father has a domestic abuse conviction as well as a criminal sexual conduct case when he was a juvenile. There was no indication of child protection history in the court records.

Kaiden's father is currently being held on bail and is charged with murder in the 2nd degree - with intent - not premeditated.

Za'Maiya Travis, 7-years-old, Ramsey County
December 16, 2015 – March 31, 2023
At around 6:40 a.m. on March 31, 2023, medics and officers pronounced Za'Maiya dead on a blowup mattress in the middle of the living room. According to Za'Maiya's mother and her boyfriend, they all went to bed around 11:30 p.m. When Za'Maiya's mother woke up around 6 a.m. to wake up Za'Maiya for school, she would not wake up. Her hands were curled up and stiff, and her skin was purple. Officers obtained a search warrant and retrieved Za'Maiya's mother's wallet from her bedroom, which contained a straw with white residue. Officers also recovered a blue M30 pill from her purse. Six straws with white powder residue were recovered from the bedroom. No other drugs were found in the home. Za'Maiya's cause of death was fentanyl toxicity.

Right before her death, Za'Maiya and her family were working with child protection to transfer custody of Za'Maiya to her grandmother. There were concerns of physical abuse that Za'Maiya's school documented but failed to report until after her death. Additionally, Za'Maiya's mother struggled with SUD, and her father had domestic assault charges.

Za'Maiya's mother was charged with 2nd-degree manslaughter.

Ozzy McCutchen, 2-months-old, Goodhue County
March 24, 2023 – May 25, 2023
On May 23, 2023, two-month-old Ozzy McCutchen's mother made a 911 call because he was not breathing. Ozzy's father walked into the kitchen holding Ozzy, who was not responsive and was light blue. When the officer asked him what happened, he reported that he was feeding Ozzy when he got up briefly, and when he returned, the infant became "unresponsive."

Ozzy was transferred to a hospital, where they detected a heartbeat. They observed that he had fixed and dilated pupils during this time. A chest x-ray showed multiple bilateral rib fractures in various stages of healing as well as a healing clavicular fracture, which is highly suggestive of nonaccidental trauma. Imaging of his head and brain showed multiple areas of bleeding in the brain and documented loss of brain function and tissue indicative of an anoxic brain injury. The doctor determined that Ozzy was a victim of Abusive Head Trauma, formerly Shaken Baby Syndrome. Ozzy died on May 25, 2023.

Ozzy's mother later recorded a conversation with Ozzy's father in which he admitted to shaking Ozzy and putting his hand over his mouth, "but it wasn't like a death grip or anything."

Ozzy's family did not have any child protection involvement, but his father had multiple domestic violence cases against his mother and previous partners.

Ozzy's father is currently charged with 1st-degree manslaughter.

Near Fatalities

2-month-old girl, Micropolitan County
Summer 2022
In the Summer of 2022, a two-month-old girl was brought to the hospital for trouble breathing. Her parents reported that she had fallen during a diaper change, but the nurse practitioner at the hospital advised that her significant injuries did not align with this story. The little girl had sustained a near-fatal abusive head injury. The little girl's mother told police that she was out with her sisters when the child's father called and advised that the girl was "breathing funny and acting weird."

When police spoke to the little girl's father, he admitted shaking her around nine or ten times, dropping her, and that his actions caused her injuries. The little girl was on life support and was unlikely to survive, but she lived and is now one and a half years old.

The girl's father is currently charged with 1st-degree assault and malicious punishment of a child.

Siblings: 11-year-old boy, 10-year-old boy, and 8-year-old girl; Micropolitan County
Summer 2022
In the Spring of 2022, an investigator began working on a child maltreatment case involving three children and their mother. This investigation was triggered when one of the children was seen at the hospital for low hemoglobin numbers. During a forensic interview, the three children disclosed that their mother would withdraw blood before doctor's visits and then flush the blood down the toilet. The children also disclosed that they were often forced to wear casts and neck braces even though they did not have injuries. Besides the medically focused abuse, the children were often choked and thrown around the house and made to stand outside in the cold for a long time.

The children's mother has been charged with child torture, stalking, and theft of medical costs.

3-year-old boy, Metropolitan County
Spring 2023
In Spring 2023, police were called to a report of a three-year-old boy who was choking. Police interviewed the boy's father and stepmother, who advised that he choked on something while they were sleeping. The officer doubted this story and believed that the little boy had suffered from a drug overdose. After being advised of her rights, the stepmother admitted that they were addicted to fentanyl, had used it the night before, and then fell asleep. It was later confirmed that the boy came in contact with fentanyl, causing him to overdose. The boy survived.

The child's father and his stepmother have both been charged with controlled substance crime in the 2nd degree and endangerment of a child.

1-year-old girl, Metropolitan County
Spring 2023
In the Spring of 2023, police were dispatched for an overdose of a one-year-old girl. When officers arrived at the scene and spoke with her mother, she advised that she had a fentanyl pill

in her purse, which the girl grabbed and swallowed. When her mother noticed she could not stand or talk and kept rubbing her eyes, she called the police. The girl survived.

The girl's mother is currently charged with child endangerment and 5th-degree drug possession.

Case Involving Torture

In addition to the above near-fatality story of the three siblings (Micropolitan County, aged 8, 10, 11, Summer 2022), there was one additional torture case that included four children ages 3, 6, 7, and 10.

Siblings: 10-year-old girl, 7-year-old boy, 6-year-old boy, and 3-year-old boy; Micropolitan County
Summer 2022
In the Summer of 2022, Child Protection investigators received concerning reports about a family with four children. Included in the report were stories of cages around the children's beds, the children's father duct taping their hands and placing them in a closet, withholding food, burning the children's hands under hot water, not allowing them to use the bathroom, and not ensuring the children received medical care, which resulted in seizures for one of the children.

The mother of the family suffers from severe mental health issues and, according to court records, attempts suicide "several times a year." There was no record of previous involvement with child protection, but the mother's mental health issues indicate she was known to one or more medical providers or agencies. Prior to the torture being discovered, either local law enforcement or child protection performed a welfare check when the mother was reported as driving around with the four children, threatening to commit suicide. Once the children were removed from the home, a medical examination showed bruising on their hips and buttocks, as well as healed fractures in one of the children. Forensic interviews with the children provided additional details into their lives and the trauma they endured.

The children's father and mother are both currently charged with multiple charges related to child torture and endangerment.