MINNESOTA CHILD FATALITIES FROM MALTREATMENT 2023-2024

January 2026

Courtney Annakin
University of St. Thomas
School of Law
Archbishop Ireland Justice Fellow

Deena McMahon
Family Therapist/Consultant

Richard Gehrman
Executive Director Emeritus

MINNESOTA CHILD FATALITIES FROM MALTREATMENT 2023-2024

January 2026

www.safepassageforchildren.org

TABLE OF CONTENTS

Executive Summary 1
Methods 4
Statistical Analysis 6
Exhibit 1: Cases with Prior Child Protection Contact 7
Exhibit 2: Cause of Child's Fatality 8
Exhibit 3: Fatalities Due to Neglect 9
Exhibit 4: Child Fatalities by Age at Time of Death 10
Exhibit 5: Child Fatalities by Race 11
Exhibit 6: Child Fatalities by Gender 12
Exhibit 7: Rural County Fatalities 12
Exhibit 8: Metropolitan County Fatalities 13
Exhibit 9: Micropolitan County Fatalities 13
Exhibit 10: Primary Responsibility for Child Fatality 14
Exhibit 11: Co-Occurrence of Child Fatalities and Domestic Violence 15
Exhibit 12: Co-Occurrence of All Child Fatalities and Substance Abuse 15
Exhibit 13: Comparison of Charging for Parent and Non-Parent Perpetrators 2023-2024 Study Period. (n=35) 16
Exhibit 14: Sentencing of Second-Degree Murder 2023-2024 Study Period (n=35) .. 16
Exhibit 15: Likelihood of Being Charged Based on Criminal Behavior 2023-2024 Study Period (n=35) 17
Case Studies 17
Zyear Bagley, 4 months old, St. Louis County 17
Thomas Pauza-Moore, 4 years old, Pine County 20
Adnan Abdullahi, 3 years old, Dakota County 22
Ahziyas Solo-Dampha, 2 years old, Freeborn County 26
Eastyn Deronjic, 3 years old, Clay County 30
Jackson Weidell, 18 months old, Ramsey County 31
Qualitative Policy Analysis 33
A Better Approach 36

Limitations 40
Conclusion 43
Acknowledgements 45
Appendix A: The Fatalities 46
Appendix B: Subject Matter Experts and Reviewers 59
Appendix C: Glossary 66

EXECUTIVE SUMMARY

This is the third Safe Passage for Children of Minnesota Report on Child Maltreatment Fatalities. It documents the cases of children who died due to maltreatment from June 1, 2023 to December 31, 2024. Although fatalities are uncommon compared to the total number of children screened in for investigation into possible maltreatment,[1] these tragic outcomes illuminate areas where improvement is needed in the child welfare system. This system includes Child Protective Services, law enforcement, the courts, mental health providers, medical providers, and legislators.

Safe Passage has now collected more than 10 years of data documenting over 200 child maltreatment fatalities, a database that allows us to examine trends over time. Among the 44 known child maltreatment fatalities covered in this report, 36 of the deceased children are identified by name.[2] The report provides objective data on the deaths, 6 case studies detailing the incidents leading up to the fatalities, an analysis of recurring system failures, and an appendix that provides brief summaries on all the known children who were killed.

The purpose of this report is not to blame individuals, but to identify practices within the child welfare system that must be changed to keep children safe.

The major findings of this third report are as follows:

- There were 44 identified fatalities during a 19-month period, which is an increase from an average of 20 fatalities per year in previous reporting periods to 28 fatalities per year in this study.
- Neglect was responsible for 63.63% of child maltreatment deaths.
- 75% of child maltreatment fatalities involved children three and younger.
- Co-occurrence of domestic violence and child maltreatment was 52.27%.
- Co-occurrence of substance abuse histories and child maltreatment was 40.9%.

---

[1] Per DCYF's *Minnesota Child Maltreatment Report, 2023*, pg. 5, There were 30,444 alleged victims involved in 23,507 completed assessments or investigations following screened-in child maltreatment reports in 2023.

[2] The unnamed children are in most of the statistics for this report. We specify when they are not included in the Statistical Analysis section.

- 20.45% of child maltreatment fatalities were caused by fentanyl exposure/ingestion.
- 50% of the families in which a child died had previously been reported to child protection, including both screened in and screened out reports. Many of these children had open child protection cases at the time of their death.
- Biological parents who kill their children are commonly not criminally charged. When biological parents are criminally convicted, they serve shorter prison sentences than others convicted of similar crimes.
- A lack of transparency in data concerning child fatalities reduces stakeholders' ability to identify weaknesses in the system and propose reforms.

The findings in this report suggest the following recommendations, which are discussed in more detail in the Statistical Analysis and Qualitative Policy Analysis sections below.

- Recognize the seriousness of neglect when considering child removals, especially as an increasing number of children are dying in homes with significant parental history of substance use disorders.
- Increase training and awareness about the signs of abuse, neglect, and torture among mandated reporters, other child welfare stakeholders, and the public, especially using TEN-4-FACESp[3] for children 4-years-old and younger.
- Allow cases to be assigned to Family Assessment only once, and never if the alleged child victim is 0-3 years of age.
- Make safety plans meaningful, measurable, and enforceable.
- Develop a systemic policy regarding domestic violence that gives priority to child safety, reduces trauma exposure, and addresses the high rate of non-compliance with domestic violence-related actions such as Orders for Protection.
- Place infants born with evidence of withdrawal from intoxicating substances on an emergency hold until a meaningful, measurable, and enforceable safety plan is in place.

[3] See the screening tool here.

- Hold parents accountable for changing behaviors that are harming children instead of reunifying families based solely on compliance with a case plan and participation in services.
- Change the current practice of frequently giving biological parents substantially shorter prison sentences than non-biologically related domestic partners.
- Consider the totality of circumstances, in decisions related to screening, removing, placing or returning children.
- Strengthen accountability for unsecured firearms, including temporary removal of children if there is no immediate remediation of the danger.
- Change policy to make voluntary Terminations of Parental Rights (TPRs) and nonvoluntary Termination of Parental Rights equally considered in Birth Match reporting.[4]
- Clarify and enforce statutory requirements that require the state and counties to make data publicly available regarding near fatalities and fatalities.
- Follow the national recommendations set forth by the National Children's Alliance to develop and support multi-disciplinary teams and Child Advocacy Centers (CACs) in response to allegations of abuse and neglect.

The Minnesota child welfare system is charged with keeping children safe. However, the number of fatalities due to neglect and physical abuse are increasing. The findings detailed in this report show that the system too often places the interests of adults ahead of children's safety. No one group of stakeholders has sufficient influence, insight, or resources to bring about change alone. The conversations required to make essential changes are as necessary as they will be challenging.

[4] A Birth Match is a mandated report of substantial child endangerment made when an infant is born to a parent who previously had an involuntary termination of parental rights, an involuntary transfer of custody, a determination of egregious harm, or a maltreatment finding involving a child's death, near fatality, or serious injury. In Minnesota, the Department of Human Services identifies these cases by matching birth records with child welfare records. Each Birth Match is treated as a new child maltreatment report that must be screened in and investigated by the local child welfare agency. Agencies must also request that the county or tribal attorney promptly file a Termination of Parental Rights (TPR) petition when a qualifying parental offense triggers a Birth Match. See DCYF's *Practice Guidelines for Family Assessment and Family Investigation*, pg. 25.

METHODS

This report covers the period from June 1, 2023 to December 31, 2024, continuing Safe Passage's studies regarding child maltreatment fatalities of Minnesota children. During this reporting period, we identified 44 children who died due to maltreatment.[5]

Our previous reports relied mainly on media coverage to quantify child maltreatment deaths, an approach that often emphasized physical abuse and overlooked fatalities caused by neglect. In this report we have largely addressed this limitation by using supplemental sources.

Non-Profit Data Collection

In addition to media sources, this report used a national online database developed by the Lives Cut Short campaign,[6] which compiles data that merge media accounts with official death records. Lives Cut Short also provided us with the death records they obtained from the Minnesota Department of Vital Records.

One case was identified from Violence Free Minnesota,[7] an association representing domestic violence programs, through their We Remember project,[8] which identifies victims killed by Intimate Partner Violence (IPV).

State Critical Incident Details Reports (CIDRs)

Another new source was the Critical Incident Details Reports (CIDRs) from the Department of Children, Youth, and Families (DCYF). These reports, which can be accessed by the public upon request under Minn. Stat. S260E.35 Subd. 7(b), provide high-level information about children who died from maltreatment in Minnesota. The data includes age, recent CPS history, the relationship of the perpetrator (i.e., biological parent) and the general cause of death (i.e., neglect). We obtained these reports for 34 of 44 children through a public data request, though it is unclear whether we received all available reports, since DCYF only produces CIDRs after investigations are completed.

---

[5] In Minnesota, child maltreatment is defined as egregious harm, neglect, physical abuse, sexual abuse, substantial child endangerment, threatened injury, mental injury, and maltreatment of a child in a facility. Minn. Stat. 260E.03 subd. 12.

[6] See Lives Cut Short

[7] See Violence Free Minnesota

[8] See We Remember. Violence Free Minnesota also recently published a report of Intimate Partner Homicides.

County Fatality Disclosures

Using the information from the sources above, we received county fatality disclosures[9] for 27 of the 41[10] disclosures requested under Minn. Stat. S260E.35 Subd. 7(b).[11] This statute requires counties to furnish fatality disclosures with the same information as CIDRs, but fatality disclosures often included information not found elsewhere, such as a family's history with voluntary services. While the disclosures were mostly consistent in format, some counties were more forthcoming than others. Issues with these disclosures are discussed later in this report.

Court Records

Another key source of information was court records maintained in the Minnesota Court Information System (MNCIS). Two types of documents provided most of the case history: Child in Need of Protection and Services (CHIPS) and Termination of Parental Rights (TPR) petitions. These documents generally include a narrative that is helpful for learning the facts of the case.

Criminal Court records often added valuable content, including incident narratives leading to a child's fatality, perpetrator criminal histories, and previous Domestic Abuse No Contact Orders (DANCOs).[12] Family Court records provided details on cases with co-occurring custody disputes and other protective orders, such as Orders for Protection (OFPs) and Harassment Restraining Orders (HROs).[13]

---

[9] These are a different document from CIDRs, even though both county fatality disclosures and CIDRs are authorized under the same statute.

[10] The remaining three children received services through their Tribes. We contacted the Tribes for similar reports, but were unsuccessful. As Tribes are sovereign nations, they are not beholden to state law.

[11] Freeborn County never responded to our request. Ramsey County only fulfilled 2/8 data requests as of 12/5/25.

[12] 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 the criminal court in response to a domestic assault criminal 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.

[13] 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.

Subject Matter Experts

Recognizing that child fatalities are influenced by many factors, we sought the perspectives of 21 Subject Matter Experts (SMEs) across 7 intersecting fields: child welfare (national policy and local management), children's mental health, law enforcement, the courts (including two Assistant County Attorneys and a retired Family Court judge), medical providers specializing in child maltreatment, Child Advocacy Centers (CACs), and Guardians *ad Litem*. Most groups included multiple members. Brief SME biographies appear in Appendix B, with the exception that, due to current active caseloads, law enforcement and Guardian *ad Litem* participants 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. Individual SMEs should not be considered to have endorsed all the contents of this report.

STATISTICAL ANALYSIS

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

Our most significant finding is the increase in child maltreatment deaths since the onset of Safe Passage for Children's Minnesota Child Fatalities project. Our current reporting period covers 44 deaths in 19 months or just under 28 children per year. This is a notable increase from our previous reports, which had around 20 children die per year from maltreatment,[14] especially since the child population in Minnesota has slightly decreased in the last five years.[15]

As noted in Limitations, there are four children who were identified by Lives Cut Short after the research period concluded that are not included in the following statistics. Two of these children died due to fentanyl ingestion and two children died from prenatal

[14] For our 2014-2022 report, DHS reported 161 child maltreatment fatalities, which is 20.125 children a year. For our 2022-2023, which covered a year, we reported 21 child maltreatment fatalities.

[15] The absolute child population remained relatively steady from 2019 (1,303,212) to 2023 (1,300,934), with a drop of 1.8%. Statistically, a commensurate drop or steady rate of fatalities would follow this trend. Per this data, child fatalities are increasing from 17 in 2019 to 32 in 2023 (1.43/100,000 to 2.46/100,000), at an increase of 53%. Administration for Children & Families Children's Bureau Child Welfare Outcomes Report Data Site, Minnesota.

substance exposure. Had these children been included, the death rate would be even higher.

Past Relationship of Family to Child Protective Services

Child Protection Services (CPS) had encounters with either the child victim or family in 50% of the cases before the child in question died, compared with just 33% in our previous report, which represents a 17% increase. However, this is a decrease from our first report, where 67% of families had previous contact before the fatality. Either way, counties may have opportunities to intervene before a fatality takes place.

Exhibit 1: Cases with Prior Child Protection Contact

Number of CPS Contacts	2023-2024 Percentage of all Fatalities (n=44)	2022-2023 Percentage of all Fatalities (n=21)	2014-2022 Percentage of all Fatalities (n=88)
1-3 contacts	31.82% (14)	14.3% (3)	37.5% (33)
4-5 contacts	11.36% (5)	4.7% (1)	12.5% (11)
6+ contacts	6.82% (3)	14.3% (3)	17.04% (15)
Total	50% (22)	33.3% (7)	67% (59)

Cause of Death

Over the decade of data collected, we have seen an increase in neglect-based deaths. In our first report, blunt force trauma was the most likely manner of death at 52%. In our second report, drug toxicity deaths, namely fentanyl toxicity, was responsible for a large proportion of child fatalities at 42.8%. As illustrated below, three manners of death– fentanyl poisoning, asphyxiation, and a fatal gunshot wound– share most maltreatment fatalities at 61.35% for this reporting period.

Drug toxicity deaths are on the decline, but still a major cause for concern. There was a 22% absolute decrease from the 2022-2023 report, but still a noted increase from our first report covering 2014-2022. The prevalence of drug related deaths is likely influenced by the rise and pervasiveness of fentanyl use. A common fact pattern is a young child finding either fentanyl or fentanyl-laced paraphernalia, and overdosing. All drug toxicity deaths were young children except for one: A 16-year-old child overdosed on fentanyl laced cocaine his mother sold him. Of note, the additional 4 cases identified from Lives Cut Short that were not included in this analysis were all related to drug toxicity. Although it is important to have empathy for parents in active addiction, the

reality is that parental drug abuse can be deadly for children. This identifies the need for practices that do not put children in danger while parents are managing their recovery from addiction.

Another major manner of death was asphyxiation. In multiple cases, parents used their preferred substance and put their child in an unsafe sleeping environment, causing that child to asphyxiate. There were two deaths where the child was purposefully suffocated and one where the child had an hours-long fatal asthma attack due to her parents' failure to refill her inhaler prescription and initiate medical intervention.

In Safe Passage's last fatality report, we wrote that a possible pattern of deadly neglect via unsecured firearms might be developing. Unfortunately, we were correct. Out of the nine known gunshot wound fatalities, four of them were due to deadly negligence, or 9% of overall maltreatment deaths. These deaths could be prevented by adults storing firearms unloaded and separated from ammunition.

Exhibit 2: Cause of Child's Fatality

Cause of Death	2023-2024 Report Period (n=44)	2022-2023 Report Period (n=21)	2014-2022 Report Period (n=88)
Fentanyl poisoning	20.45% (9)	42.8% (9)	1.1% (1)
Other drug toxicity	2.27% (1)		2.3% (2)
Blunt force trauma	11.36% (5)	19% (4)	52.3% (50)
Drowning	4.54% (2)	14.2% (3)	5.8% (5)
Asphyxiation	20.45% (9)	4.8% (1)	17% (14)
Gunshot wound	20.45% (9)	4.8% (1)	8% (7)
Malnutrition		4.8% (1)	
Medical neglect	2.27% (1)	4.8% (1)	
Sepsis	2.27% (1)		3.4% (3)
Stab wound	2.27% (1)		3.4% (3)
Hypo/hyperthermia			2.3% (2)
Fire	2.27% (1)		1.1% (1)
Complications due to neglect	2.27% (1)		
Unknown[16]	9.09% (4)	4.8% (1)	3.4% (3)

[16] Three of these are unknown children who died from neglect. The fourth is Wings Thao, whose death was undetermined, but indications are that he died due to unsafe sleeping.

Neglect

Twenty-eight fatalities, or 63.63%, died due to the neglectful actions of their care takers. This is an increase from our original report, where only 25% of deaths were caused by neglect.[17] Nationally, neglect is responsible for around 70% of child maltreatment deaths, with the U.S. Department of Health and Human Services (DHHS) reporting that neglect was responsible for 78% of child maltreatment fatalities.[18] Although we are constrained by the limitations of this report described below, the data strongly indicates that the minimization of neglect has negatively impacted the number of children left in unsafe situations.

Exhibit 3: Fatalities Due to Neglect		
2023-2024 Report Period (n=44)	**2022-2023 Report Period (n=21)**	**2014-2022 Report Period (n=88)**
Percentage of All Fatalities	Percentage of All Fatalities	Percentage of All Fatalities
63.63% (n=28)	61.9% (n=13)	26.13% (n=23)

Age

As in previous reports, children three and under are the most vulnerable due to their total dependence on caregivers and their inability to defend themselves or seek help. In this report, 33 of the 44 fatalities, or 75%, were children 3 years old and under, which is consistent with national data that show similar age demographics.[19] In this report, almost half of the overall fatalities were children 1-3 years old, and one third were less than a year old. This is an increase from our previous report in which 66.6% of fatalities were children three and under but is commensurate with our first report that had 78.4% of fatalities being children 3 years and under. As shown below, the number of deaths occurring in 1-3 years old has increased from past reports. A possible explanation is the rise of deaths that require a child to be mobile: fentanyl toxicity deaths and self-inflicted gunshot wound deaths. There was a wide range of ages represented in this report, with our oldest child being 16 years old and our youngest child being 19 days old.

[17] This number is probably low due to our first report relying wholly on media reports (which likely overreport physical abuse deaths) and only identifying 88/161, or 55%, of the child fatalities. However, it still speaks to how neglect is seen as a lesser evil in comparison to physical or sexual abuse.

[18] DHHS *Child Maltreatment 2023*, p. 59.

[19] DHHS *Child Maltreatment 2023*, “Children <1 year old died from abuse and neglect at more than three times the rate of children who were 1 year old.” p. 58.

Exhibit 4: Child Fatalities by Age at Time of Death			
Child's Age	**Percentage of all Fatalities (n=44)**	**2022-2023 Report Period (n=21)**	**2014-2022 Report Period (n=88)**
0-11 months	34.09% (15)	33.3% (7)	42.04% (37)
1-3 years	40.90% (18)	33.3% (7)	36.36% (32)
4-5 years	4.54% (2)	14.3 (3)	3.41% (3)
6-7 years	6.81% (3)	19.1 (4)	5.68% (5)
8+ years	13.63% (6)	0% (0)	12.5% (11)

Race

It is well established that Black, Native American, and mixed-race children are disproportionately represented in Minnesota's child welfare system.[20] In this report period, Native American children died at almost double their child protection representation rate. Fortunately, fewer Black and multi-racial children died due to maltreatment this report period, but they are still overrepresented in maltreatment fatalities. In contrast, white children represent almost half of the children in the child welfare system, but only 22% of fatalities. We need to continue to apply diligence to identify and remedy factors reflected in these unbalanced outcomes.

As shown below, there was a large increase in children whose race is unknown since the 2022-2023 report. As stated in Limitations, a lack of transparency from counties and DCYF is partially responsible for this information that is unavailable, along with court records commonly lacking the race/ethnicity of the parties. This is problematic since basic demographic information, especially for children in the child protection system, should be captured routinely.

[20] DCYF *Minnesota Child Maltreatment Report, 2023,* pg. 5.

Exhibit 5: Child Fatalities by Race					
Race	**2023-2024 Report Period (n=44)**	**2022-2023 Report Period (n=21)**	**2014-2022 Report Period (n=88)**	**Percentage in Child Protection Overall[21]**	**Percentage in Child Population[22]**
White	22.73% (10)	19.1% (4)	23.9% (21)	48.9%	65.2%
Black	20.45% (9)	28.6% (6)	26.1% (23)	16.9%	11.3%
Asian	2.27% (1)	14.2% (3)	3.4% (3)	2.8%	6.6%
Latino	2.27% (1)	0 (0)	2.3% (2)	11.9%	10.0%
Native American	13.64% (6)	14.2% (3)	6.8% (6)	7.2%	1.3%
Two or More Races	15.9% (7)	19.1% (4)	13.7% (12)	19%	5.4%
Unknown	22.73% (10)	4.8% (1)	23.9% (21)	5.2%	0.0%

Gender

Of the child fatalities in this period, 32 out of 44, or 72.72%, were boys. We reported a similar breakdown of the biological sex of victims in our first report, with boys accounting for 64.8% of victims. In 2023 nationally, 942 boys (58.7%) and 657 girls (40.9%) died due to maltreatment.[23] Considering both girls and boys enter the system at around the same rates,[24] boys are being disproportionately killed by their caretakers. There is some research that hypothesizes that the disparity is due to boys being more likely to experience prematurity, disease, injuries, and disabilities, increasing the difficulty of parenting them.[25]

---

[21] DCYF *Minnesota Child Maltreatment Report, 2022,* p. 20.

[22] Administration for Children & Families Children's Bureau Child Welfare Outcomes Report Data Site, Minnesota.

[23] DHHS *Child Maltreatment 2023*, p. 58.

[24] DHHS *Child Maltreatment 2023*, p. 45

[25] See Dee Wilson's Sounding Board: *The Gender Difference in Child Maltreatment Fatalities.*

Exhibit 6: Child Fatalities by Gender			
	2023-2024 Reporting Period (n=44)	**2022-2023 Reporting Period (n=21)**	**2014-2022 Reporting Period (n= 88)**
Female	27.27% (12)	Not reported	35.2% (n=31)
Male	72.72% (32)	Not reported	64.8% (n=57)

Fatalities by County

As shown in the charts below, Hennepin County has had an increase in maltreatment deaths in this reporting period, jumping from 0.33 fatalities per month in the last report, to 0.47 fatalities per month. Ramsey County continues to have an increase in maltreatment deaths in comparison to the first report. In the first report, covering 8 years, there were 0.12 fatalities per month, but in the last two reports there were 0.58 fatalities per month and 0.47 fatalities per month, respectively. Rural counties had an increase in fatalities from our 2022-2023 report, but the results are similar to those identified in the 2014-2022 report.

Exhibit 7: Rural County Fatalities			
County	**2023-2024 Report Period**	**2022-2023 Report Period**	**2014-2022 Report Period**
Morrison		1	
Red Lake			2
Itasca			2
Aitkin			1
Pine	1		1
Cottonwood			1
Kanabec			1
Hubbard			1
Renville			1
Clearwater	1		
Lyon	1		
Martin	1		
Nobles	1		
Total in Rural Counties	5 (11.36%)	1 (5%)	10 (11.4%)

Exhibit 8: Metropolitan County Fatalities			
County	**2023-2024 Report Period**	**2022-2023 Report Period**	**2014-2022 Report Period**
Ramsey	8 (avg. 0.42/month)	7 (avg. 0.58/month)	11 (avg. 0.12/month)
Hennepin	9 (avg. 0.47/month)	4 (avg. 0.33/month)	28 (avg. 0.30/month)
Anoka		1	4
Benton		1	1
Dakota	2	1	4
Olmsted		1	3
St. Louis	3		5
Washington	1		3
Scott			2
Blue Earth			3
Sherburne	1		2
Stearns	4		1
Carlton			1
Isanti			1
Clay	1		1
Carver	1		
Wright	2		
Total	32 (72.73%)	15 (71%)	70 (79.5%)

Exhibit 9: Micropolitan[26] County Fatalities			
County	**2023-2024 Report Period**	**2022-2023 Report Period**	**2014-2022 Report Period**
Beltrami	2	2	1
Cass	1	1	1
Goodhue		1	1
Otter Tail	2	1	2
Wilkin			1
Mower			2
Chippewa	1		
Freeborn	1		
Total	7 (15.9%)	5 (24%)	8 (9.1%)

[26] 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.

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

The overwhelming majority of fatalities are due to the biological parents (86.36%), with mothers being primarily responsible for 50% of the deaths in this report period. In turn, there was a notable decrease in the mother's significant other as the primary perpetrator since the first report. In our 2014-2022 report, the mother's significant other was the primary perpetrator in 23.9% of child maltreatment fatalities. As shown below, the mother's significant other was responsible for only 6.81% of deaths. Similarly, there were no foster care related deaths this reporting period, versus 9.1% of the 2014-2022 fatalities being due to foster care maltreatment.

Exhibit 10: Primary Responsibility for Child Fatality

Person Primarily Responsible	2023-2024 Percentage (n=44)	2022-2023 Percentage (n=21)	2014-2022 Percentage (n=88)
Mother	50% (22)	52.4% (11)	27% (24)
Father	22.73% (10)	38% (8)	22.7% (20)
Biological Parent	13.63% (6)[27]	4.8% (1 both parents)	2.2% (2)
Foster Parent	0% (0)	0% (0)	6.81% (6)
Mother's significant other	6.81% (3)	4.8% (1)	23.9% (21)
Father of other child in the family	2.27% (1)	0% (0)	3.4% (3)
Other family member	2.27% (1)	0% (0)	6.7% (6)
Caretaker	2.27% (1)	0% (0)	6.81% (6)

Domestic Violence

Domestic Violence (DV), also known as Intimate Partner Violence (IPV), continues to be closely intertwined with child maltreatment deaths. Even if they are not eyewitnesses, children experience deep emotional trauma when one of their caretakers is a victim of

[27] This is the designation on CIDRs for unidentified children. We were unable to determine which parent is responsible, we just know at least one of them is.

abuse.[28] Unfortunately, current practice screens out DV/IPV calls when the child is not in the room, not physically harmed, nor expected to intervene.[29]

An important aspect of DV/IPV is the lack of accountability for the abusers. In this research period, we found that, out of 9 primary perpetrators, 4 had violated their DANCOs, or 44.44%. Considering how underreported DV/IPV is,[30] it is likely that violations are more prevalent than the data shows.

Exhibit 11: Co-Occurrence of Child Fatalities and Domestic Violence		
2023-2024 Report	**2022-2023 Report**	**2014-2022 Report**
Percentage of All Fatalities (n=44)	Percentage of All Fatalities (n=21)	Percentage of All Fatalities (n=88)
52.27% (23)	52% (n=11)	28% (n=25)

Substance Use

As shown in Exhibit 2 above, the presence of substance abuse among caretakers continues to directly account for a large proportion of child maltreatment deaths. In addition, substance abuse is a significant contributing factor in additional fatalities. As mentioned above, the opioid epidemic and the rise of fentanyl are most likely responsible for the high level of co-occurrence.

Exhibit 12: Co-Occurrence of All Child Fatalities and Substance Abuse		
2023-2024 (n=44)	**2022-2024 (n=21)**	**2014-2022 (n=88)**
40.9% (18)	42.8 % (9)	3.4 % (3)

[28] Andrew M. Campbell, Shannon L. Thompson, The emotional maltreatment of children in domestically violent homes: Identifying gaps in education and addressing common misconceptions: The risk of harm to children in domestically violent homes mandates a well-coordinated response, Child Abuse & Neglect, Volume 48, 2015, Pages 39-49.

[29] From DCYF's Minnesota Child Maltreatment Intake, Screening, And Response Path Guidelines, "In most cases, children must be involved in or otherwise situated in a location that puts them at risk of injury during incidents of domestic violence. Children witnessing or being exposed to domestic violence against a parent or caregiver is not by itself sufficient to screen in as child maltreatment. Mere exposure to acts of domestic violence committed against children's parent/caregiver does not constitute child maltreatment." pg. 70

[30] Lohani et al., Underreporting of intimate partner violence against women: An important public mental health implication, Eagles Talking About Public Health, Georgia Southern University College of Public Health, Fall 2021.

The Court System

In our first fatality study, we reported that parent-perpetrators were getting shorter sentences than non-parent perpetrators. In this period, we found that parents are less likely to get charged at all. When parents are charged and convicted, they serve less time on average by almost two years**.**

Exhibit 13: Comparison of Charging for Parent and Non-Parent Perpetrators 2023-2024 Study Period. (n=35)			
Perpetrator	**Charged With a Crime**	**Was Not Charged**	**Died During Incident**
Mothers (n=20)	60% (12)	35% (7)	5% (1)
Fathers (n=9)	33.3% (3)	44.4% (4)	22.2% (2)
Non-parents (n=6)	100% (6)	0	0

Exhibit 14: Sentencing of Second-Degree Murder 2023-2024 Study Period (n=35)[31]	
	Average Sentence
Parent	248 months (20.66 years)
Non-parent	270 months (22.5 years)
Difference	**22 months (1.83 years)**

Accountability for Deaths due to Neglect

Most perpetrators of fatal neglect were not charged or held legally accountable for the child's death. Perpetrators of physical abuse are charged at a much greater rate at 76.92%, whereas perpetrators of neglect are charged at a rate of 39.28%.

[31] In these statistics, there are 44 total children. However, there were three sets of siblings and six children where the perpetrator was unclear to us. In turn, n=35 for this chart.

Exhibit 15: Likelihood of Being Charged Based on Criminal Behavior 2023-2024 Study Period (n=35)	
Physical Abuse	**76.92% (26)**
Neglect	**39.28% (9)**

CASE STUDIES

The following six case studies illustrate the concerning fact patterns we have discovered through data and records collected and explored in the above section. Using these case studies, we highlight problematic practices and recommend changes to improve the system. These cases are not anecdotal. They illustrate how the system treats children based on chronic problems documented in hundreds of case studies gathered over the past decade. These case studies are the lived experiences of real children who died because the people, the policies, and the practices designed to keep them safe failed.

Zyear Bagley, 4 months old, St. Louis County

DOB: 03/01/2023 DOD: 07/16/2023

Issues illustrated by this child's history:

- **Death by asphyxiation due to unsafe sleeping**
- **Children remained in the custody of their family when patently unsafe for children under 4 years old**
- **Excessive use of Family Assessment and voluntary services**
- **Lack of referral to Family Investigations considering case details**
- **Failure by local law enforcement to ensure children's safety**

On July 16, 2023, 4 month old Zyear Bagley was found deceased after his mother fell asleep with him in her arms while under the influence of methamphetamine; his father was also in the same bed. In the aftermath, police noted that the home was in disarray.

Starting in April 2012, Zyear's mother had at least 30 contacts with CPS due to her drug use. There were reports of negligent supervision, the children being present at a drug

bust, and educational neglect for one of Zyear's siblings. In this decade-long period, Zyear's mother was repeatedly offered services and consistently disengaged with them. The children were temporarily removed once from their mother's custody. Multiple SMEs commented on the lack of action by the St. Louis County Department of Public Health and Human Services (SLCDPHHS) given this extensive history.

Starting in September 2014, Zyear's father also had a myriad of contacts with multiple agencies due to his drug use, physical abuse of his children, and the tumultuous relationship he had with his then wife. There were reports of him shoving his child, causing a large bruise, providing his child with cannabis, and teaching his 8 year old and 11 year old children how to operate firearms and motor vehicles. Two cases were closed with a note of high risk for further maltreatment. One Children's Mental Health SME counted 84 total contacts with social services between the two families' cases. Per the fatality disclosure from St. Louis County, from January 2021 to Zyear's death, the families had, in the aggregate,[32] eight reports screened in for Family Assessment and two reports screened in for a Family Investigation, with SLCDPHHS in almost constant contact with the families leading up to Zyear's birth.

On February 14, 2023, SLCDPHHS had a safety meeting with Zyear's parents in preparation for Zyear's birth, with the agency assuming that Zyear would remain in the hospital due to withdrawal. During this meeting, it was determined that the safety plan during the birth for both families was for the eldest two children to watch the younger five children, with the father checking in on them intermittently. The father's children were 11, 8, 4, and 3 years old and the mother's children were 13, 11, and 10 years old. At the end of the meeting, Zyear's mother admitted to SLCDPHHS that she had used methamphetamine two days prior.

On March 1, 2023, Zyear was born with gabapentin, methadone, and clonazepam in his system and was in the NICU for two weeks for withdrawal treatment. Zyear's mother also tested positive for benzodiazepines and methadone at the time of the birth. A methamphetamine-laced needle was found in the parents' possession during labor and the mother was asking if she could leave the hospital prematurely. Both parents left the hospital early the following morning, but did not go to check on their children. The following weekend, the parents were escorted from the hospital for problematic behavior.

Zyear's father violated the safety plan by failing to check in with the seven children at home. As a result, the children were placed on a police hold. Zyear's mother's three

---

[32] Zyear is his parents only shared child; all other children are from previous relationships. Zyear's mother had custody of him, so Zyear is mentioned in the mother's CHIPS petition filed after the death.

children were returned after the police hold, while the father's children spent multiple weeks with a family member. County workers held multiple safety meetings with Zyear's parents in the two weeks Zyear was in the hospital. The new safety plan for Zyear's mother's family was for Zyear's mother's sister to supervise Zyear and the mother's children when Zyear's mother had cravings to use. Zyear was released into his mother's custody soon after. The safety plan for Zyear's father was sobriety monitoring, daily check-ins from family and housing managers, and frequent check-ins with SLCDPHHS. In May 2023, Zyear's father's children were put into foster care due to his violent behavior and the "deplorable condition" of his home.[33] Despite this, two weeks later, the county wrote that "there were no current concerns for [Zyear's father] being in a sole caregiving role for Zyear."

In the two days leading up to Zyear's death, multiple reports were called into the county for Zyear's mother's behavior. She was observed driving under the influence with her children in the car, almost hitting someone, and dancing in the middle of a busy roadway with her children on the side of the road. When law enforcement arrived to speak with Zyear's mother at Gimaajii,[34] the affordable housing program where the family was staying, staff told them that she was disruptive in common areas, apparently using narcotics, and had dropped Zyear on the tile floor of the lobby.[35] Zyear's mother refused to answer the police officer's questions, seemed to be actively on narcotics, and did not allow police into her apartment. Later that day, police were called again to de-escalate an argument between Zyear's parents. Police spoke to Zyear's mother, then left the scene. Despite repeated calls in the two days before Zyear's death, the police did not successfully perform a welfare check on the baby, which was flagged as problematic by our Child Welfare Operations SME.

The fight escalated after the police left. Building staff separated the parents and put the mother into a conference room with the building staff looking after Zyear. The mother was unable to keep still and was flailing her arms, weaving her head, and folding herself forward. She wanted to go back to her apartment under protest from the building staff; they relented after Zyear's 11 year old sibling returned home and said he would call his 13 year old brother and watch the baby until the brother got home. Zyear died that night.

---

[33] Although both parents lived in the same housing program, we are assuming the father lived in a separate apartment.

[34] Gimaajii-Mino-Bimaadizimin, meaning "we are, all of us together, beginning a good life," offers sliding scale housing to otherwise homeless Native American people in Duluth, Minnesota.

[35] To our knowledge, 911 was not called after this incident nor did Zyear receive medical attention.

In the CHIPS petition for Zyear's siblings after the death, the county writes that both parents were still in active addiction, and that Zyear's mother had been only marginally cooperative with them. While the county removed the father's children, it took several months to remove the surviving children of the mother. After a year-long CHIPS case, Zyear's mother's children were returned to their mother, with SLCDPHHS "cautiously" recommending the case to close, even though they still had concerns about the mother's substance use and stability. At the end of the research period, Zyear's mother was not charged with a crime.

The family was offered many services over many years, including case management, family support services, mental health services, and food vouchers, among others. Both parents would vacillate in cooperating with SLCDPHHS and were inconsistent in their cooperation with urine toxicology screening. Our Child Advocacy Center SMEs wrote that, at a minimum, the county should use a family friend or respite care to watch the children. After Zyear's birth, he was discharged to his parents when it was obviously unsafe, with our Guardian ad Litem SME writing that there were numerous red flags in connection with Zyear's mother's behavior at the time of Zyear's birth, including having a methamphetamine-laced needle in the hospital room. There were many missed opportunities for Zyear and his siblings to be protected by CPS, the courts, and law enforcement.

Thomas Pauza-Moore, 4 years old, Pine County

DOB: 08/27/2019 DOD: 08/27/2023

Issues illustrated by this child's history:

- **Self-inflicted gunshot wound from an unsecured firearm**
- **At least two reports of neglect before the fatality**
- **Lesser criminal sentences for biological parents**
- **History of domestic violence by the father**

On August 8, 2023, first responders answered a call which alleged that four year old Thomas Pauza-Moore shot himself in the head with an unsecured firearm in his father's bedroom. Thomas died at the scene, where police spotted a semi-automatic pistol on top of an unlocked gun safe. Inside the gun safe, police found various kinds of ammunition. In an interview with police, Thomas' father stated that he was downstairs playing video games while Thomas was watching movies on his father's phone upstairs in the bedroom. Thomas' father said Thomas most likely knocked over the gun safe, a

problem that had occurred previously. The autopsy confirmed that a gunshot wound to the head was the cause of death.

In the criminal complaint, police mention that the floors and counters of the home were dirty, there were holes in the sheetrock, and that alcohol containers were on the kitchen counter and desk. Along with the unlocked gun safe, police found an unloaded semi-automatic rifle and a loaded pump shotgun in a closet accessible to Thomas.

Two days after the death, police talked to Thomas' mother, who was recently separated from Thomas' father. She stated that Thomas' father commonly left unsecured firearms around the home and that she had previously told him to secure them out of their children's reach. Despite this, Thomas' mother did not request sole custody of her children in the parents' divorce proceedings, which were filed a few days before Thomas' death and granted two months later. At the time of writing, both parents share physical and legal custody of Thomas' younger sibling. In the CHIPS petition for Thomas' younger sibling after Thomas' death, Thomas' mother reported that she was worried about her ability to financially support her child without Thomas' father's help and expressed a desire for the younger sibling to have a continued relationship with the father.

Thomas' father was charged with two counts of Second-Degree Manslaughter, one count of Child Endangerment by Firearm Access, and one count of Negligent Storage of Firearms. He pleaded guilty to Child Endangerment and received 150 days in jail, staggered in two parts. Thomas' father served the first 90 days and then filed with the court to have the second sentence forgiven. At the time of writing, the court order is not in Minnesota Court Information System (MNCIS) and there are no further entries into MNCIS; it appears his second sentence was forgiven.

Thomas' family had multiple contacts with Pine County Health and Human Services (PCHHS) before Thomas' death. In March 2020, in response to a well-child visit, Thomas' primary care provider reported that Thomas' family was overfeeding Thomas. After that report until at least late 2021, Thomas' family was working with Pine County Public Health Family Home Visiting (PCPHFHV), a voluntary program that helps support families with young children. Thomas' mother was also receiving individual therapy. In July 2021, Thomas' family was referred to the Parent Support Outreach Program (PSOP)[36] in response to a report of domestic violence between Thomas' parents whereby Thomas' mother was physically assaulted by Thomas' father in front of

[36] Minnesota's Parent Support Outreach Program (PSOP) is an early intervention program that provides short-term voluntary support for at-risk children and families identified through screened out child maltreatment reports, community, or self-referrals.

Thomas. Thomas' family did not engage in PSOP. In October 2021, there was a report of negligent supervision by Thomas' father. He was asleep when he was supposed to be watching the children[37] which was discovered by a public health worker who visited the home. Thomas' mother was not concerned about the two children, saying that Thomas' father would be able to hear them if they needed anything. Thomas' family did not receive more services in response to the report.

Thomas' family history shows Thomas' father is an unsafe caregiver, exhibiting a pattern of neglectful supervision and domestic violence. Pine County had multiple opportunities to recognize and address these concerns before Thomas' death. For example, loaded firearms may have been visible during home visits. After the July 2021 report, PSOP was offered to the family, but they did not engage. One Legal SME suggested that proactive follow-up with families in such situations could help prevent future tragedies. Similarly, after the report of negligent supervision, both CAC and Children's Mental Health SMEs identified the county's lack of intervention as a missed opportunity to provide Thomas' father with additional services, education, and support before circumstances worsened.

As a victim of domestic abuse, Thomas' mother was seemingly unable to identify that her husband was dangerous for their children. Multiple SMEs commented that the county should have recognized that Thomas' mother needed support in managing or escaping the relationship, especially since she was financially dependent on Thomas' father.

Our Children's Mental Health SMEs wrote that a voluntary offer of services following a domestic violence incidence would not likely be effective given Thomas' family dynamics. Families who have serious domestic violence problems are not good candidates for voluntary programs because the perpetrator is not likely to utilize services and the victims are not able to insist that they do so. A mandatory case plan with court ordered services would potentially go farther to ensure safety.

Adnan Abdullahi, 3 years old, Dakota County

DOB: 02/07/2020 - DOD: 07/17/2023

Issues illustrated by this child's history:

[37] Contradictions in the case file: the CHIPS petition states that he had been asleep since 5am, so around 7.5 hours. The fatality disclosure from the county said the father would set an alarm to wake up and check on them every couple of hours. At the time, Thomas was 2-years-old and his sibling was 6-months-old.

- **Child Torture**
- **Medical Neglect**
- **Lack of documentation by county officials leading to poor transparency**
- **Deficient medical care with lack of appropriate documentation**
- **Malnourished children unreported to the county**

On June 4, 2023, first responders answered a call for 3 year old Adnan Abdullahi who suffered a cardiac arrest at an Eden Prairie park. Paramedics immediately noticed that this child was malnourished, with visible ribs, swollen joints, and poor limb development. Adnan was also dehydrated and had missing and broken teeth. Once Adnan arrived at a local hospital, a CT scan revealed a loss of brain volume, which doctors associated with malnourishment. Adnan died about six weeks after this incident from anoxic encephalopathy due to resuscitated cardiopulmonary arrest.[38] Malnutrition and multiple infections were contributing factors to his death. Adnan weighed 25 pounds at the time of his autopsy, which is less than the 1st percentile for his age.

Adnan's mother told first responders that he had been sick for about a week and had not been eating for the past two days. She brought her children to the beach so that Adnan could "sweat out" his illness. Adnan's mother admitted to investigators that she did not bring her children to their well care visits because she was "too busy." Per Adnan's father, "she had a history of not taking the children to the doctors or obtaining medical care when they were sick." Adnan's mother told the same investigators that, even though Adnan was three years old, he did not say anything more than simple words.

Almost immediately, medical professionals flagged that Adnan's mother's story did not match the severity of Adnan's symptoms. Adnan's mother also interfered with Adnan's medical treatment at the hospital. She was caught tampering with his medical equipment to the point where she was once physically removed from a medical device, manipulating Adnan's jaw, causing his teeth to clamp down on his tongue, and pushing on Adnan's chest, airway, and throat area. This happened multiple times before she was restricted to supervised visits.

Police were contacted to investigate the status of Adnan's siblings. They learned Adnan's mother was the sole caretaker of her five children after their father, from whom

[38] Also known as hypoxic-ischemic brain injury, this occurs when the brain experiences a complete or near complete lack of oxygen, which then causes brain damage.

she was separated, left the country to care for an ailing parent in February 2023. Adnan's siblings described their homelife later through their father: Their mother would force them to vomit by putting her fingers down their throats, put objects down their throat as a form of medication, and told them that doctors are bad people who kill their patients.

Adnan's siblings were also malnourished, with their June 9, 2023, medical records showing a Body Mass Index (BMI) of less than 0.15% with 2 children identified BMIs at < 0.01%.[39] The Medical SMEs wrote that the Physician's Assistant examining Adnan's siblings did not appropriately document or address their malnutrition. The weight, height, and BMI are recorded for Adnan's siblings, and the BMI for each is well below normal for age on standardized growth charts. It is notable that many children of Somali heritage are tall and slender, yet BMIs at these low percentiles are markedly abnormal and reflect poor nutritional status. The medical records do not include details of a physical exam or any interpretation of the children's health beyond "Well Child Care" for all the children and ear infection and ear wax impaction in individual children. The provider fails to address the low BMIs as a concern for malnutrition, compare the information to previous growth curves, or document a plan of action. They also failed to address the lack of growth as a possible medical concern or consider the possibilities of abuse or neglect in a differential diagnosis. At the time of writing, the Physician's Assistant who evaluated Adnan's siblings is under investigation by the Minnesota Board of Medical Practice. Adnan's father returned to the United States after Adnan's hospitalization and all the siblings were placed in his care on June 24, 2023.

Documentation by the investigating county and courts was minimal because decisions about the surviving children were made as part of divorce proceedings and Orders for Protection (OFP) rather than the usual process of Child Protection Services opening a neglect or abuse case following a fatality. Adnan's father filed for divorce in September 2023 and filed multiple Orders for Protection (OFPs) against Adnan's mother, with one succeeding on March 1, 2024. In that OFP petition, Adnan's father alleged that Adnan's mother would lock the children in rooms for up to 13 hours, withhold food and water from them, force the eldest sibling to hold other children down during the abuse, and physically abuse the children to "get the evil out of them." Adnan's mother would feed the children coffee and candy to keep them awake and "hyper" for school, even though it's reported that Adnan would get sick due to the caffeine. Adnan's father wrote that Adnan's mother ignored Adnan's symptoms leading up to his hospitalization and made Adnan gag by forcing water down his throat.

[39] The average BMI is 18-25%.

In his divorce petition, Adnan's father wrote that there was a current safety plan through Dakota County Child Protective Services (DCCPS), but there was no active CPS case since Adnan's father chose to file for divorce instead.[40] Since there was not a proceeding filed by DCCPS, the decision-making process and the agreed-on safety plan by Dakota County is unclear. In the divorce judgment, the Court awarded sole legal and physical custody to Adnan's father but relied on Adnan's parents to privately file Terminations of Parental Rights petitions: Adnan's father against Adnan's mother and Adnan's mother against herself. This allowed Adnan's mother to present her side of the story in which she alleged that she was falsely accused of neglect, her children were being coached by their father, and, because of this, she became mentally unwell and unable to take care of her children. Her request for a termination of Parental Rights (TPR) was denied by the court. Adnan's father filed his own TPR petition alleging facts like the eventual criminal complaint. At the end of the research period, this proceeding was still ongoing, so it is unclear whether Adnan's mother's parental rights have been terminated.

Almost all SMEs who reviewed this case identified how inappropriate the proceedings were, with one of our Child Advocacy Center SMEs asking, "How is it possible for a divorce to supersede a child protection proceeding?" One of the Children's Mental Health SMEs wrote that, in their experience, child protection matters take precedence over family court matters; if there is a "safe" parent, the agency must ensure that the children are properly protected by this parent.

While it was clear that Adnan's mother abused and tortured Adnan, we were unsure of the accuracy of some details since their source was Adnan's father, someone who could have a possible bias in his recounting. Adnan's mother was eventually charged with one count of Second-Degree Manslaughter, four counts of Child Endangerment, and one count of Harassment on July 8, 2025, two years after the death of her child. We relied on this criminal complaint to establish a timeline and case narrative for Adnan, but actions taken by DCCPS are still unclear. Considering the severity of the situation, DCCPS's decision not to pursue proceedings for the remaining siblings undermines the interim safety for Adnan's siblings until the findings of the divorce and custody matters are resolved. A safer solution would have been for the county to immediately file a CHIPS petition so that they could oversee the wellbeing of the children during the divorce proceedings.

[40] There is no consistent standard for safety planning; it is on a case-by-case basis using the discretion of the agency. In turn, DCCPS allowed the "safe" parent to file for divorce and did not file a proceeding.

We have previously written about the prevalence of child torture, using three standards that emphasize the depravity of a caretaker's actions.[41] In Minnesota, child torture is defined as "the intentional infliction of extreme mental anguish, or extreme psychological or physical abuse, when committed in an especially depraved manner."[42] According to reports, over the course of several months, Adnan and his four siblings were subjected to starvation, isolation, and choking by their mother, leaving all of them severely underweight and with exceptionally low BMIs. Although all of Adnan's siblings were enrolled in school, Dakota County reported in its fatality disclosure that no prior reports of maltreatment were received concerning Adnan's siblings before Adnan's death. This raises concerns about whether school staff and/or clinic personnel reported to child protection and illustrates the need for better training of all professionals involved on the signs of abuse and neglect.

Ahziyas Solo-Dampha, 2 years old, Freeborn County

DOB: 04/21/2021 - DOD: 07/26/2023

Issues illustrated by this child's history:

- **Physical abuse causing the child's death**
- **Pattern of violence by the perpetrator**
- **A Birth Match was screened out due to a Termination of Parental Rights (TPR) being "voluntary"**
- **Domestic violence**

On July 6, 2023, police responded to multiple calls about an unresponsive child. When they arrived on the scene, first responders found 2 year old Ahziyas Solo-Dampha unresponsive and began life-saving measures. Ahziyas' mother was at work and received an alarming message from her boyfriend of a year, who was watching Ahziyas and his 12 week old sibling.[43] He explained that Ahziyas fell down the stairs and injured himself. After Ahziyas' mother asked for photos multiple times, her boyfriend sent a photo of an unresponsive Ahziyas with bruises on his face and blood on his lips. By the time Ahziyas' mother returned home, her boyfriend had barricaded himself inside the

[41] Read the standards here.

[42] Minn. Stat. 609.3775 subd. 1.

[43] Ahziyas' sibling is the couple's only joint child; Ahziyas was from the mother's previous relationship.

apartment. Ahziyas' mother forced her way into the home, saw her child unresponsive, and called the police.

Upon police arrival, Ahziyas' mother's boyfriend fled the scene with Ahziyas' sibling. Police detained him nine blocks away. With significant bruising around Ahziyas' sibling's neck noted, the sibling's age of vulnerability, and a suspicion for child physical abuse, Aziyah's sibling was transferred to the hospital for a physical examination. Ahziyas' sibling's right eye was swollen, there was bruising on various parts of his body, and he had bite marks on his right knee and left hand. Further medical examination of Ahziyas' sibling revealed over 17 broken ribs in various stages of healing. Some ribs were broken in more than one place.

Ahziyas was pronounced dead within two hours of the original 911 call. His autopsy revealed injuries to his head and abdomen: rib fractures, a liver laceration, a transected pancreas, contusions throughout the face and neck, multiple subgaleal hemorrhages, and hematomas. The cause of death was listed as multiple blunt force injuries and Ahziyas' death was ruled a homicide.

Ahziyas' mother's boyfriend was arrested, charged with Second Degree Murder and Assault in the Third Degree, and ordered to have no contact with Ahziyas' mother and his sibling. In the days after Ahziyas' death, Ahziyas' mother's boyfriend made or received multiple phone calls while in jail from his mother and sister where he admitted to punching Ahziyas in the head multiple times and kicking him in the side. Ahziyas' mother's boyfriend was released on bail a week later. In September 2023, he pleaded guilty to both charges and was sentenced to 25 years for Ahziyas' murder and a concurrent 32 months for Ahziyas' sibling's physical abuse.

In an interview with Ahziyas' mother, it was revealed that her boyfriend was physically abusive towards Ahziyas' mother and was "heavy handed" with the children. She reported previous episodes where her boyfriend used more force than necessary. The physical abuse intensified when Ahziyas' sibling was born, causing Ahziyas' mother to leave the state with the children a couple weeks before Ahziyas' death. She returned home when her boyfriend texted her that he would leave her alone. He did not leave her alone. Four days before Ahziyas' death, Ahziyas' mother's boyfriend stomped on Ahziyas' mother's right shoulder before dragging her into the apartment where he continued assaulting her. She went to the Emergency Room for treatment and told them she fell; shoulder bruising was evident during her interview. Even after this, Ahziyas' mother's boyfriend was allowed to watch the children four times a week for around five hours at a time.

Ahziyas' mother blamed her boyfriend's methamphetamine use for the domestic abuse she experienced, stating that they got into an argument about the drug use the day before Ahziyas' death. Ahziyas' mother stated that, when her boyfriend uses methamphetamine, she attempts to have her family members watch the children, since her boyfriend is the most violent when effects of the drug are waning. It was reported that Ahziyas was wary of his mother's boyfriend and that multiple family members talked to Ahziyas' mother about her boyfriend's treatment of the children. Ahziyas' mother said, "I should have known something would happen," in the aftermath of Ahziyas' death. Despite those remarks, Ahziyas' mother stated she never noticed any abuse or red flags of abuse by her boyfriend during the same interview.

Ahziyas' mother's boyfriend had a history of violence. In 2019, he beat the mother of his other children so badly that her spleen ruptured, requiring emergency surgery. In the child protection investigation pertaining to that incident, Ahziyas' mother's boyfriend did not show a willingness to change his violent behavior. In 2020, he signed a Consent to Adopt for his child from a previous relationship after learning that the Freeborn County Department of Human Services (FCDHS) was filing a Termination of Parental Rights (TPR) for failing to demonstrate a willingness to follow the case plan and change his violent behavior.[44] In 2022, his parental rights were voluntarily terminated for another child due to his unwillingness to follow his second child's case plan and his continued violent behavior. During this time, Ahziyas' mother's boyfriend violated two of his three DANCOs.

When Ahziyas' younger sibling was born, FCDHS received a Birth Match, meaning that, because of previous documented history, Ahziyas' and his sibling were considered at risk of harm or danger, and CPS involvement was warranted. The case intake was initiated for Ahziyas' mother's boyfriend due to his previous TPR,[45] but the case was screened out for "not meeting criteria" since the TPR was voluntary and Ahziyas' mother's boyfriend was reportedly not living with Ahziyas' mother and Ahziyas.

Ahziyas' death was not Ahziyas' mother's first contact with CPS. In March 2022, a Family Assessment was opened after a domestic altercation between Ahziyas' mother

---

[44] Contradictions in the case file: In an October 2023 court filing from the Freeborn County Department of Human Services, it is reported that the mother's boyfriend had a TPR from May 2020. However, in the December 2023 Freeborn County TPR Petition for the mother's boyfriend that was filed after Ahziyas' death, it is reported that the boyfriend signed a Consent to Adopt for the same child.

[45] From DCYF's *Practice Guidelines for Family Assessment and Family Investigation*, pg. 25: "Agencies can consider past *voluntary* termination of parental rights or *voluntary* transfer of physical and legal custody as a threatened injury report. However, this is not considered a Birth Match report, therefore, if screened in, a Family Assessment or Family Investigation may be initiated, depending on the nature of a current report." (emphasis added).

and Ahziyas' biological father. Ahziyas' mother was holding Ahziyas when Ahziyas' father assaulted her. During the assessment, a DANCO was put into place for Ahziyas' mother, but she soon wanted the DANCO lifted. She was offered community resources and the case was closed late May 2022. After Ahziyas' death, a CHIPS case was opened for Ahziyas' surviving sibling. Ahziyas' sibling was placed in foster care until Trial Home Visits (THV) began the following month. The THV was stopped after the county learned that Ahziyas' mother was in contact with her boyfriend, for whom there was a DANCO in place, and was allowing unsafe individuals into her home. A year after Ahziyas' death, Ahziyas' mother had a third child with a second boyfriend. A Family Assessment was opened because of Ahziyas' mother's multiple maltreatment determinations received for Ahziyas' death. The new child's father had a history of domestic violence and was eventually sentenced to prison for domestic assault in another matter. Eventually Ahziyas' mother received returned custody of Ahziyas' sibling, and both cases were closed early 2025. Ahziyas' mother's boyfriend's parental rights were terminated for Ahziyas' sibling in February 2025.

Evidence shows that Ahziyas' mother's boyfriend was not a safe parent or partner. He ignored the many opportunities he was offered to address his violent and dangerous behaviors. These behaviors led to Ahziyas' death and the violent assault of Ahziyas' mother and sibling.

When Ahziyas' new sibling was born and Ahziyas' mother's boyfriend's birth match was triggered, FCDHS had opportunities to mitigate the harm before Ahziyas' death. The termination of parental rights is a serious process, not taken lightly by the courts, and usually results from significant parental abuse and/or neglect. It is common for parents to agree to "voluntary" TPRs because the parent is told that a decision by the court for an involuntary TPR is imminent. Ahziyas' mother's boyfriend's previous TPR was due to his violent behavior, so that alone is a reason for more aggressive action by the child welfare system. If nothing else, the authorities should have realized that Ahziyas' mother's boyfriend would have unsupervised access to his own child, even if he didn't live with Ahziyas, his mother, and Ahziyas' infant sibling.

Ahziyas' mother made a series of poor decisions that put her children at risk. Her boyfriend's violence sent her to the hospital. Her baby had broken ribs healing at different stages; it is likely Ahziyas' sibling was visibly in pain with common care provided for an infant because of these injuries. Multiple family members spoke with Ahziyas' mother about her boyfriend's behavior and were willing to help. Ahziyas' mother crossed state lines to escape her abusive relationship yet returned later. After all of this, she allowed her boyfriend to have unsupervised contact with her young children. Even in the aftermath of Ahziyas' death, Ahziyas' mother continued to have contact with

her son's killer by breaching the DANCO put in place for her protection. Once her boyfriend was incarcerated, she immediately began a relationship with another man who eventually went to prison for domestic assault. Despite offers for services to ensure her and her children's safety, she chose not to act. Child safety cannot be voluntary. When a parent is unable to identify safety concerns, the system is obliged to do so.

Eastyn Deronjic, 3 years old, Clay County

DOB: 01/19/2021 - DOD: 03/18/2024

Issues illustrated by this child's history:

- **Blunt force injuries from physical abuse causing death**
- **Family members in contact with an injured child and failing to report to medical providers, police or Child Protection Services**
- **Caretakers delaying medical attention for a gravely ill child**
- **Informal living situations as a complicating factor**

On March 18, 2024, first responders responded to a call for an unresponsive toddler, 3 year old Eastyn Deronjic. At the scene, it was reported that the toddler drank some water and started coughing and gagging before becoming unresponsive. Eastyn died less than two hours later. Officers on the scene noted that Eastyn was heavily bruised on his face and body. His autopsy outlined 28 blunt force injuries. Eastyn died from peritonitis due to a bowel perforation from one of these injuries.

Eastyn and his younger sibling lived with his mother's friend, Caretaker 1, and Caretaker 1's significant other, Caretaker 2, in an unofficial arrangement that was in effect for over a year. Leading up to his death, Eastyn was very ill, with Caretaker 1 saying he was vomiting, struggling to breath, and having diarrhea starting two days before his death. On the night of his death, Caretaker 2 suggested taking Eastyn to the hospital after getting advice from her mother. Caretaker 1 refused, saying Eastyn was fine. Instead of taking Eastyn to the hospital, Caretaker 1 took Caretaker 2 to the hospital because she fell ill from cannabis use. Caretaker 1's mother was watching Eastyn and his sibling when Eastyn became unresponsive.

Both Caretakers were charged with second degree murder for Eastyn's death. Caretaker 1 pleaded guilty to second degree murder and was sentenced to 240 months in prison, which is an upward durational departure for sentencing. At the time of writing, Caretaker 2 is awaiting trial.

Leading to Eastyn's death, multiple adults either witnessed Caretaker 1 assault Eastyn or saw bruising on his body. Caretaker 2 witnessed Eastyn suffer physical abuse by Caretaker 1 at least once, even standing in front of Eastyn to prevent the assault and was assaulted in his place. Eastyn's mother saw bruising on her child during past visits, but accepted the explanation that Eastyn was clumsy. She even defended Caretaker 1 when two of her friends expressed worry about Eastyn's safety. Eastyn's paternal grandparents visited with him frequently and reported that they saw bruising on his stomach, legs, and back a week before his death. When they asked about it, Caretaker 1 said Eastyn fell off his bike. Caretaker 1's mother told police that she saw Caretaker 1 scream at, slap, flick, and spank Eastyn. She also noticed a black bruise on Eastyn's genitals less than a week before his death and was told this was due to Eastyn falling off his bike. In the CHIPS petition filed for Eastyn's younger sibling after Eastyn's death, multiple photographs of Eastyn and his sibling with bruises on them were given to the county. In the fatality disclosure from Clay County, it stated that there were no reports of maltreatment made to Clay County in the 12 months prior to Eastyn's death.

Although there were not any mandated reporters interfacing with Eastyn due to his age and unofficial living situation, there were at least seven trusted adults who knew, or had reason to believe, that Eastyn was being physically abused. This was flagged by both our Medical and Legal SMEs. Because none of these adults called for help or assistance from police or CPS, there was no way for the child welfare system to know about or intervene in Eastyn's situation. There were missed opportunities for notifying Child Protection, medical providers, or the police that could have saved Eastyn's life.

Jackson Weidell, 18 months old, Ramsey County

DOB: 06/04/2023 DOD: 12/25/2024

Issues illustrated by this child's history:

- **Children ingesting fentanyl and dying from drug toxicity**
- **Policy of inaction by the County when children are born substance addicted**
- **Parents having numerous chances to address their substance abuse**
- **County ignoring prior voluntary Terminations of Parental Rights (TPRs)**
- **Imprudent safety plan**

- **Acceptance of parents' representation of the facts without question or verification**

On Christmas Day 2024, officers responded to a call for an unresponsive child, 18 month old Jackson Weidell. While supervising his children, Jackson's father fell asleep surrounded by the tin foil he used to smoke fentanyl while Jackson's mother was in the shower. After getting out of the shower, Jackson's mother found Jackson lying on his father's head, unresponsive. Jackson had ingested his father's fentanyl. Jackson's mother called 911 and administered Narcan. Although first responders attempted life-saving measures, Jackson died about an hour after they arrived on the scene. Jackson's autopsy concluded that fentanyl toxicity caused his death.

During the incident, police noticed a dirty home, the presence of drugs, and drug paraphernalia. Jackson's infant sibling was found in an old, dirty diaper and had a white substance on his forehead. Jackson's 4 year old sibling was found sitting on top of another piece of tin foil with fentanyl residue. Both of Jackson's siblings tested positive for fentanyl exposure later that day. Police reported that Jackson's mother seemed under the influence at the scene. A later search warrant found methamphetamine, fentanyl, drug paraphernalia, and shotgun shells in the home.

Jackson's family has a long history with child protection services due to Jackson's mother's chronic substance abuse. This includes two previous voluntary Terminations of Parental Rights (TPR) for Jackson's mother in 2018 and a maltreatment determination in 2020 due to her prenatal exposure of Jackson's older sibling to amphetamines and opiates. During the 2020 investigation, both parents received in-patient addiction treatment and experienced a period of sobriety before being reunited with Jackson's sibling.

Jackson's parents have a tumultuous relationship. From April 2022 to May 2024, Jackson's father filed four petitions for Orders for Protection (OFPs) against Jackson's mother. Jackson's mother filed one against Jackson's father. Each parent alleged that the other was emotionally abusive, physically abusive, and actively using narcotics. Jackson's mother reported that Jackson's father physically harmed her while holding Jackson's older sibling. Jackson's father reported that Jackson's mother chased him with scissors. None of these petitions resulted in issuance of an OFP since Jackson's parents seemingly reconciled each time. One of our Guardians ad Litem (GAL) SMEs wrote that Jackson's parent's fraught interpersonal history, as evidenced by multiple petitions for OFPs going both ways, should have been a red flag for Ramsey County Social Services Department (RCSSD) when researching Jackson's family, along with the multiple previous TPRs for Jackson's mother.

On December 1, 2024, RCSSD was notified that Jackson's infant sibling was born addicted to fentanyl; Jackson's mother admitted to using the day prior. RCSSD established a safety plan that made Jackson's father the gatekeeper for his wife's drug abuse. As noted by one of our Legal SMEs, this was a seemingly reckless decision considering his previous substance abuse and absent an effort to confirm his sobriety with a urine toxicology test. Jackson's mother was then not allowed unsupervised contact with the children nor allowed in the home during her drug use. Jackson's infant sibling was released from the hospital to his father's care six days before Jackson's death. The next day, RCSSD used their discretion and visited Jackson's home in a scheduled rather than an unannounced visit, which gave Jackson's parents time to present a façade of progress. RCSSD deemed it a safe environment for the children to live in. Jackson died five days later.

During her interview after Jackson's death, Jackson's mother said she lied about Jackson's father's sobriety. Both parents were in active addiction, and both parents used fentanyl Christmas morning, the day of Jackson's death. Both parents were charged with Second Degree Manslaughter. At the time of writing, Jackson's mother pled guilty and Jackson's father is awaiting trial.

Multiple SMEs– Child Welfare Research, Legal, and GAL– said RCSSD did not decide in favor of child safety. In this scenario, Jackson and his siblings should have been put into foster care, and a CHIPs petition should be filed.

QUALITATIVE POLICY ANALYSIS

Any effort to improve child safety and well-being needs to be grounded in an understanding of how the following powerful drivers of current policies and practices are negatively affecting children.

A belief that neglect is less serious than abuse

A frequently articulated belief behind recent legislative and practice changes is that most child protection cases are "just neglect," minimizing the deadly effects of neglect. This report shows that 63% of Minnesota maltreatment fatalities were categorized as neglect cases. Nationally, the annual federal Child Maltreatment report consistently shows that neglect was a significant factor in around 70% of fatality cases.[46] Even for children who survive, the effects of chronic neglect are devastating, with the National Scientific Council on the Developing Child stating that "young children who experience

[46] U.S. Department of Health and Human Services, Child Maltreatment Report *2023*, p. 59.

severe neglect… bear the burdens of a range of adverse consequences… including subsequent cognitive delays, impairments in executive functioning, and disruptions of the body's stress response."[47]

Confusion about poverty versus neglect

A similar belief is that child protection case workers unnecessarily remove children from their biological families because they are unable to distinguish between poverty and neglect. There is no data to support this concern in Minnesota, moreover, there is data demonstrating the opposite. For example, a 2021 summary of research on this issue reported that "…only a small subset of neglect referrals (perhaps one in four) are due to material needs, and those cases are only about a quarter as likely to be substantiated as other neglect cases."[48] In short, the universe of cases in which this mistake would be possible is quite small. Further, many parents who are involved with CPS or whose children are placed in foster care are in the system not due to poverty, but because they have substance use disorders, chronic mental health issues, and histories of domestic violence. In addition, guidance from the state of Minnesota is clear: "When it is determined that reports of neglect are based solely on conditions due to poverty a finding of maltreatment should not be made."[49]

Belief that removing children from their biological parents is more traumatic than living in an unsafe home

Another frequently cited reason for leaving children in or returning them to high-risk situations is that the trauma of removing a child from their family is so great that it is outweighed only by the immediate risk of being killed or seriously injured. It is true that moving children from caregivers with whom they have bonded is often traumatic, as research on multiple foster care placements shows,[50] but so is being left in the care of seriously abusive or neglectful caregivers. The Harvard Center for the Developing Child also offers "A Guide to Neglect" (2024), which provides a succinct summary of the catastrophic consequences of this form of maltreatment. In every unique case, the issue

---

[47] National Scientific Council on the Developing Child. (2012). *The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain: Working Paper 12*, pp. 2-3, http://www.developingchild.harvard.edu.

[48] Barth, et. al. "*Research to Consider While Effectively Re-Designing Child Welfare Services*", p. 6, Research on Social Work Practice, 2021, Vol. 0(0) 1–16.

[49] Minnesota Child Maltreatment Intake, Screening, and Response Path Guidelines January 2023, pp. 39-40.

[50] See Foster Care Placement Moves: Impacts on Development and Suggestions for Mitigating Risk Megan R. Gunner, Ph.D. & Faith VanMeter, M.A.

is where to strike the balance. These decisions are made more difficult because there is minimal research that specifically compares the trauma of removing children from their biological families with the trauma of leaving them in an unsafe environment.

Foster care is a worse alternative

Another common rationale for leaving children in unsafe settings is research showing that children in foster care have poorer outcomes as adults than children in the general population. However, several recent studies have shown that foster care is protective of infants and other young children. Schneiderman, et. al. studied deaths due to medical causes reported to Child Protection Services in California during a six-year period.[51] The authors state that "infants with a history of reported maltreatment died from medical causes 1.77-3.27 times more frequently (depending on the number of CPS reports) than infants not reported to CPS. Among infants reported for maltreatment, when in foster care the rate of death was roughly 50% lower. As more reports were received the associated risk (of death) increased." In short, foster care often saves lives. In addition, several studies show that a majority of people who experienced foster care believed it to be a positive experience.[52]

Reporting prenatal exposure to substance use 'criminalizes' women

Another contributing factor to child risk and fatalities is the position that medical testing for prenatal substance use and reporting positive results to child protection 'criminalizes' this behavior.[53] Although it is important to support the whole family, when possible, the focus of child protection is to protect children. Studies involving the entire populations of children in Pennsylvania and California show that most women who abuse drugs or alcohol during pregnancy end up in the child protection system within the infant's first

[51] Infant Deaths from Medical Causes After a Maltreatment Report, Janet U. Schneiderman *et. al.* PEDIATRICS Volume 148, number 3, September 2021.

[52] Dunn DM, Culhane SE, Taussig HN, Children's Appraisals of their Experiences in Out-of-Home Care, Child Youth Serv Rev. 2010 Oct 1;32(10):1324-1330; Courtney, M., Terao, S., Bost, N. (2004). Midwest Evaluation of the Adult Functioning of Former Foster Youth: Conditions of Youth Preparing to Leave State Care, Executive Summary. Chicago: Chapin Hall at the University of Chicago; Kothari BH, McBeath B, Bank L, Sorenson P, Waid J, Webb SJ. Validation of a Measure of Foster Home Integration for Foster Youth. Res Soc Work Pract. 2018 Sep 1;28(6):751-761.

[53] See the draft report of the 2024 Task Force on Pregnancy Health and Substance Use Disorder where the Task Force recommends limitations on toxicology testing and also recommends notification for collection of public health data rather than reporting to Child Protection as the baseline standard when babies are born affected by parental substance abuse or experiencing withdrawal.

year of life.[54] Policies that discourage engaging them at the time of birth miss an opportunity to mandate supportive services as early as possible and put children at risk without real benefit to the mother.

Conversely, removal to a safe setting is commonly protective of young children; Lawler et. al. found that the fatality rate for infants prenatally exposed to opioids, stimulants or alcohol was cut in half for those who experienced one or more episodes of out-of-home care, regardless of length.[55]

A BETTER APPROACH

We believe several changes in philosophy and practice, combined with state-level investments, are most likely to result in better outcomes.

Reconsider the Seriousness of Neglect

Our observations indicate that removing children from their biological families only when they are at immediate risk of harm has increased the likelihood of a child being left in a home where they are chronically neglected. As stated in the Statistical Analysis section, many child fatalities were due to fatal neglect. Even for children who survive caregiver neglect, the trauma of that experience affects them greatly.[56] To better protect vulnerable children, we must start taking neglect seriously.

Hold Parents Accountable for Their Actions

The failure to hold parents accountable for maltreating their children occurs too often. "Voluntary" Terminations of Parental Rights do not count as a Birth Match for automatic Family Investigations. Children are routinely left with or returned to parents who are unable to address their drug dependence over periods of years, resulting in ongoing severe neglect and incalculable trauma, sometimes fatally so. Others are enabled to

---

[54] See Font, *et. al.* The intersection of prenatal substance exposure and child protection: Evidence from Pennsylvania, August 2025. This study included nearly 32,000 children on Medicaid between 2015 and 2021. Among other findings it discovered that an estimated 45% of children who were involved with child protection by age three and 59% who entered foster care by age 3 had experienced prenatal substance exposure. See also Prindle, *et. al.* Prenatal substance exposure diagnosed at birth and infant involvement with child protective services, Child Abuse and Neglect, 2018. This study included over 550,000 children born in California in 2006 and found that of those diagnosed with prenatal substance exposure at birth; 61.2% were reported to CPS before age 1 and nearly one third (29.9%) were placed in foster care (emphasis added).

[55] Lawler K, et al. Archive of Disease in Childhood 2025.

[56] Monnat SM, Chandler RF. Long Term Physical Health Consequences of Adverse Childhood Experiences. Sociol Q. 2015 Sep;56(4):723-752.

keep their children after leaving deadly drugs or firearms accessible to infants and toddlers. In our current fatalities study, we found that many parents with serious and long-lasting substance abuse issues had seemingly unending opportunities to address their chemical issues without success. Parents are also less likely to be charged with a crime after neglectfully killing their child and, if they are, they serve substantially shorter sentences. These practices demonstrate a powerful preference for the rights and interests of parents at the expense of safety and well-being for children.

Manage Domestic Violence

Current state policy regarding domestic violence currently screens out reports if there is no direct maltreatment or risk of injury to the child.[57] Research shows that children who grow up in homes with violence between caretakers can be emotionally traumatized.[58] This is coupled by our case studies and other research[59] showing that Minnesota local law enforcement and courts often fail to properly follow up and manage domestic violence, thus leaving caretaker-victims and their children in danger.

Better protection of victims is possible and has been done well in other jurisdictions. As an example, in Queens County, New York, Scott Kessler, the former Chief of the Domestic Violence Bureau in the District Attorney's Office, found that victims of domestic violence often were not even aware that a restraining order had been issued against their abuser. So his office began texting restraining orders, related documents, and HIPAA waivers to be signed directly to the victims' phones. This enabled the office to collect statements from victims faster, reducing the number of withdrawn complaints. A group of police officers specifically assigned to domestic violence cases would also follow up with the victim within two days, allowing officers to make arrests of perpetrators who violated the order during follow up visits.[60] Minnesota should follow this and similar examples to make OFPs and related orders meaningful ways of protecting victims of domestic abuse.

---

[57] DCYF Child Maltreatment Intake, Screening, and Response Path Guidelines, pg. 70-71.

[58] Andrew M. Campbell, Shannon L. Thompson, The emotional maltreatment of children in domestically violent homes: Identifying gaps in education and addressing common misconceptions: The risk of harm to children in domestically violent homes mandates a well-coordinated response, Child Abuse & Neglect, Volume 48, 2015, Pages 39-49.

[59] See Global Rights for Women, An Institutional Analysis of the Minneapolis Police Response to Domestic Violence.

[60] Based on personal conversations with Scott Kessler, September 2025.

End Overuse of Family Assessments

The practice of using Family Assessments (FA) repeatedly rather than opening a compulsory child protection case remains prevalent, as seen in our case studies. Minnesota's 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.[61] Using the most recent state data, Family Assessments account for 65.5% of all cases, while Family Investigations account for 31.9% of cases.[62]

Proponents argue that Family Assessments are less adversarial, less intimidating, and invite family cooperation. While that may be true in some situations, there are cases involving child fatalities that have had multiple Family Assessments opened and then closed a few weeks later as the family chose not to cooperate. In addition, it is unclear whether counties are consistently complying with the statute that requires agencies to consult with their County Attorney prior to closing cases where parents have been uncooperative. While FA may require less time and fewer resources from the agency, they are not appropriate for chronic problems that present risks for the children, especially children three and under.

Expand Services

We recognize that expanding services may prove difficult given current federal efforts to significantly reduce support for social services. Ironically, federal audits of child welfare have repeatedly criticized Minnesota for having an inadequate "service array," meaning access to services that workers need to implement case plans.[63]

One way to expand services is to expand Minnesota's network of Child Advocacy Centers (CACs), a whole-child response to children who are abused and neglected. CACs offer a variety of services that focus on mitigating additional trauma for their clients. Forensic interviewers learn the details of the abuse first hand from the child's perspective, mental health providers offer healing for the trauma experienced, law enforcement is informed of the learned details so their investigation can begin immediately, Child Protective Services is involved in real-time and gathers appropriate family support and services, victim advocates assist with barriers caused by the

---

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

[62] DCYF *Minnesota Child Maltreatment Report, 2023*, pg. 32.

[63] Third Child and Family Services Reviews, Minnesota Final Report 2016, p. 3.

abuse,[64] and medical providers associated with the CAC offer physical examinations and medical treatment as needed. The comprehensive experience for families limits the need for multiple episodes of questioning, allows for early coordination of services and support, expedites investigations and safety plans, and facilitates mental health support and treatment as soon as possible to limit the effects of possible ongoing trauma.

More children served by the Child Advocacy Centers (CAC's) and their Multi-Disciplinary Teams (MDTs) increases the consistency of response and treatment to children at risk for abuse and neglect. This nationally recognized system, accredited by the National Children's Alliance (NCA),[65] is tasked with many national initiatives to improve the response and treatment of child abuse victims and affords each child access to the most recent improvements in response. Both Midwest Regional Children's Advocacy Center[66] and Minnesota Children's Alliance[67] are poised to assist new and developing centers for our state.

As of 2024, Minnesota houses 9 CACs: One associate/developing member, one satellite member, and seven fully accredited members.[68] A commitment is needed from DCYF and the legislature to address best practices and their availability to all of Minnesota's children.

Mandate Consistent Standards

As has been documented in our reports and elsewhere,[69] compared to other states Minnesota's state child welfare program provides an unusually low level of structure to its counties and tribes. Local values tend to shape practices and the weight given to different mandates varies. Relative searches for foster and/or adoptive families, for example, may go on for long periods of time at the expense of timelines for reaching permanency. Children may be placed in long-term foster care, only to be removed from their foster families once a distant relative is licensed, sometimes years after the child

---

[64] For example, crime victims forms, Minnesota Crime Victims Reparations Board applications, and emotional support for parents.

[65] See National Children's Alliance.

[66] See Midwest Regional Children's Advocacy Center (MRCAC), which is the 12-state Midwest office.

[67] See Minnesota Children's Alliance, which is Minnesota's chapter of the MRCAC.

[68] See a map of the United States' CACs here. Read more on the National Children's Alliance rigorous standards here.

[69] See for example the Office of the Legislative Auditor Evaluation Report: Child Protection Screening, 2012.

was removed from the home. The Best Interests Factors are well known and established by statute,[70] but how any judge may apply weight to each factor is widely disparate and overemphasizes placing children with family. Due to differences in local tax bases, resources are extremely limited in some communities, but case managers, judges, and GALs are still held to the same standards of practice as those who work in resource rich communities.

These factors lead to inconsistent practices among counties that have the potential to harm children. The legislature, DCYF, and the courts, have the authority to address the issue related to inconsistent practice and should prioritize doing so with the help of Subject Matter Experts. DCYF should produce standards for each step in the child protection and foster care service continuum. The court needs to clarify the issues described here and rebalance practices to be more child focused.

LIMITATIONS

Our research is constrained by the need to rely on public data that is limited and sometimes difficult to obtain. Although we were generally successful in identifying the deceased children and their histories, some patterns or nuances may be missing.

After completing our research, four more child fatalities were identified by Lives Cut Short, bringing the total to 48 children of maltreatment deaths in a 19-month period. These children are **not** included in the Statistical Analysis section.

- Hazel Bostwick of Ramsey County died from prenatal substance exposure in May 2024.
- Lincoln Thong of Ramsey County died from fentanyl ingestion in February 2024.
- Manal Dahir Afi of Stearns County died from prenatal substance exposure and prematurity in November 2023.
- Nada Mohamed of Hennepin County died from fentanyl ingestion in December 2024.

Transparency of Data

A persistent problem, both in this report and in our ongoing work, is the lack of transparency surrounding child maltreatment fatalities in Minnesota. Without access to

[70] Minn. Stat. 260C.212 Subd. 2.

clear information about the circumstances and system failures that lead to child maltreatment deaths, accountability and reform are difficult.

Under the federal Child Abuse Prevention and Treatment Act (CAPTA),[71] states are required to maintain a process for disclosing information about child fatalities resulting from maltreatment to ensure public transparency.[72] The federal agency overseeing this law, the Administration for Children & Families (ACF), requires states to disclose:

- Cause of and circumstances regarding the fatality or near fatality;
- Age and gender of the child;
- Information describing any previous abuse or neglect reports or investigations that are *pertinent* to the maltreatment that led to the fatality or near fatality;
- Result of any such investigations; and
- Services provided by and actions of the State on behalf of the child that are *pertinent* to the abuse or neglect that led to the fatality or near fatality.[73] (emphasis added)

The ACF mandates that "pertinent" findings and information must be disclosed and allows states to deny disclosure requests when a criminal investigation is ongoing.[74] However, ACF does not define what qualifies as "pertinent" in this context, leaving significant room for interpretation.

In Minnesota, upon request, both the county agencies and DCYF must release information if someone is criminally charged, could have been criminally charged if alive, or when maltreatment is determined.[75] DCYF's disclosure comes in the form of Critical Incident Details Reports (CIDR). The CIDR consists of a one-page, high-level summary. At the county level, comparable information is provided through county

---

[71] 42 U.S.C. 5106a(b)(2)(B)(x). This also included near-fatalities, which is outside the scope of this report.

[72] For a discussion of Congressional intent on this topic see the narrative and references on p. 15 of "State Secrecy and Child Deaths in the U.S.", 2nd Edition 2012, a joint research project by the Children's Advocacy Institute at the University of San Diego School of Law and First Star, a child welfare advocacy institute based in Washington D.C.

[73] US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "2.1A.4 CAPTA, Assurances and Requirements, Access to Child Abuse and Neglect Information, Public Disclosure," Question #8 in the Child Welfare Policy Manual.

[74] US Department of Health and Human Services, Question #8.

[75] Minn. Stat. §260E.35 subd. 7.

fatality disclosures, which are not standardized. Some counties issue detailed case reports, while others provide only brief summaries. Names are typically redacted, likely because federal law allows state and local agencies to disclose only the information they consider “pertinent.” The level of detail varied from county to county. For example, some counties would include the races of all parties, some counties would not. In some cases, parts of the family history with CPS were omitted. These inconsistencies made data collection labor-intensive and raises concerns that other material facts were omitted.

The lack of transparency and standardization of documents detailing child maltreatment deaths is alarming, especially as child maltreatment deaths continue to rise. Some states choose to be more forthcoming about child fatalities than Minnesota.[76] Although there have been recent attempts to address the lack of transparency by creating a State Child Fatality and Near Fatality Review Panel,[77] the effectiveness of those efforts is currently unknown. Until Minnesota becomes more transparent about these tragedies, the systemic issues that lead to them will persist.

Data Acquisition

The process for obtaining information about child fatalities in Minnesota through these forms is problematic.

Critical Incident Disclosure Records (CIDRs) must be requested. They are not proactively published and do not provide meaningful details. Because of their lack of information, CIDRs cannot be used alone to identify child fatalities.

After receiving DCYF’s CIDRs for 2023 and 2024, we found discrepancies. Some children identified from other sources lacked CIDRs and some otherwise unknown children had CIDRs. DCYF declined to reconcile these inconsistencies, stating that it had provided all information required by statute. DCYF also informed us that three children in the list we provided had either an incorrect date of death or incorrect

---

[76] Marie Cohen, Keeping the Public in the Dark: How Federal and State Laws and Policies Prevent Meaningful Disclosure About Child Maltreatment Fatalities and Near Fatalities, American Enterprise Institute, October 2024.

[77] On July 1, 2025, a new state process took effect establishing a State Child Fatality and Near Fatality Review Panel to examine child fatality cases and identify opportunities for systemic improvement. Beginning in December 2026, the panel is required to publish an annual report that includes de-identified summary data, the number of cases reviewed, key systemic findings, and recommendations for change. Specific details about individual children who died from maltreatment will not be disclosed. Minn. Stat. 260E.39.

county/tribal agency. This was concerning, considering we received that information from the CIDRs themselves.

County fatality disclosures suffer from similar issues of inconsistency and opacity. Each county has its own process for handling disclosure requests, and report content varies widely. The absence of a standardized form, and differing interpretations of what is "pertinent" by county attorneys, results in significant disparities. Some counties provided over 100 pages of documentation; others supplied only two pages. Both extremes technically comply with state law, but the inconsistency is concerning.

County response times varied from the same day to never. For example, Freeborn County never responded. Ramsey County failed to fulfill over half of our requests, despite repeated follow-ups, and Chippewa County charged $171 for a single report. Several counties rejected seven of our requests due to an ongoing criminal investigation. Even among cooperative counties, obtaining and tracking these reports was time-consuming. Dakota County, however, acknowledged its initial delays and pledged to improve moving forward.

After repeated requests, we received 34/44 state CIDRs and only 27/41 county fatality disclosures. Until counties are more transparent about child fatalities from maltreatment, stakeholders will be unable to effectively enact systemic change.

Lag in Data Released

Consistent with prior years, in April 2025, the total number of children who died due to maltreatment during our reporting period was requested from DCYF. In October 2025, we were told that 48 child-fatalities had a maltreatment determination during the 19-month period covered by this report. This means that an investigation into the fatality was completed and a maltreatment determination was made, not necessarily that a child died during that period. Because our request for the names of those children was denied, we cannot determine what portion of those cases are reflected in our findings. Given our 48 identified cases in 19 months, however, we assume we captured a vast majority of the 48 cases identified by DCYF.

CONCLUSION

The Safe Passage for Children of Minnesota 2023-2024 Child Fatalities from Maltreatment Report examines the cases of the 44 children killed in a 19-month period and highlights practices that endangered these children and likely put other children at risk.

- The rate at which children are killed continues to increase. In this report, there were at least 44 deaths in 19 months, or 2.3 maltreatment fatalities per month, up from a rate of approximately 1.7 per month in previous reports.
- Most children died due to neglect.
- Half of the families of deceased children had previous contact with child protective services.
- One in five of all maltreatment deaths studied were caused by fentanyl toxicity.

Attempts to discount these results as anecdotal are not addressing the realities of the situation. In this report, we documented dozens of children who overdosed, or were stabbed, assaulted, suffocated, shot, or fatally neglected. In many of these cases, abusers were given continuous opportunities to change for the better, even when evidence strongly suggested this was unlikely.

In recent years, an emphasis on parents' rights has led stakeholders to tolerate extreme levels of child maltreatment. Even after children die, the state and counties resist sharing basic facts about the fatalities, reducing accountability for any of the adults or systems that failed them.

Maltreatment deaths are a small part of the overall maltreatment problem, but examining them helps identify key areas where change would be impactful, especially with collaboration from child advocate colleagues. We must better address how parental drug addiction affects children by creating practical standards for case workers that focus on infant and toddler safety. We must hold abusers accountable for mistreating and neglecting their children. We must increase public service messaging and create actual accountability for caregivers not properly securing their firearms. We must provide training for stakeholders that give them the tools to keep children safe. Finally, we must increase state and county transparency surrounding the child welfare system, especially for fatalities and near fatalities.

At Safe Passage, maltreatment fatalities are not just tragedies, but symptoms of weaknesses plaguing the entire child welfare system. We believe our community wants children to grow up safe, happy, and healthy. To achieve that shared goal, we have a lot of work to do together. No one group has the influence, understanding, or resources to accomplish reform alone. We must forge new alliances to build a better future for vulnerable children.

ACKNOWLEDGEMENTS

We are incredibly grateful to the many people who helped contribute to this report. We owe great debt to the SMEs who donated their time and expertise. We thank Dee Wilson, who reviewed our analysis and interpretation of the research used for this report. We also thank the entire team at Lives Cut Short, especially Dr. Sarah Font and Dr. Emily Putnam-Hornstein, for their guidance, data sharing, and work as SMEs. Thank you to D.J. Tice, Maggie Carney, Lisa Hollensteiner, and Greg Gardner who helped edit the report. Lastly, we thank Justice Kathleen Blatz and Greg Page, who supported a staff attorney through the University of St. Thomas School of Law Archbishop Ireland Justice Fellow Program to conduct the research necessary to compile this report.

APPENDIX A: THE FATALITIES

The following is a short case summary for each of the 48 children that were identified during our reporting period.

The following are identified children:

Aaryan Jackson was a two-year-old from Cass County who died after his mother slammed his head into the wall in August 2023. His mother gave multiple conflicting accounts of the incident to investigators. During a later search of the home, police found blood and at least two indentations on the sheetrock of the bedroom wall consistent with the shape of a toddler's head. Aaryan's mother pleaded guilty to Second Degree Murder and is serving 210 months in prison. She had previously lost custody of three other children, with the agency recommending a Termination of Parental Rights (TPR) for the siblings before the case was moved to tribal court.

Abdullahi Adod Gelle was a seven-year-old from Hennepin County who was suffocated by his adult brother during the brother's mental health crisis in September 2023. When the brother called 911, he said that he hurt someone and that he did it "for the greater good" and that "God told me to do something to prove I'm not God." When police arrived, they found Abdullahi unresponsive and not breathing. The officer attempted live-saving measures, but Abdullahi was declared deceased at the hospital. The brother was charged with Second Degree Murder and is currently awaiting trial.

Adnan Abdullahi was a three-year-old from Dakota County who died due to his mother's torture and abuse in July 2023. Adnan was hospitalized after going into cardiac arrest with brain volume loss that the doctors associated with maltreatment; he died around six weeks later. When Adnan was in the hospital, Adnan's mother was restricted to supervised visits for interfering with Adnan's care. During the ensuing investigation, it was discovered that the mother would force Adnan and his four siblings to vomit by putting her fingers down their throat. Medical records show Adnan's siblings' BMIs were all <1%; all of the siblings were enrolled in school. However, there were no previous reports of maltreatment, according to Dakota County's fatality disclosure. Adnan's mother was eventually charged with one count of Second Degree

Manslaughter, four counts of Child Endangerment, and one count of Harassment two years after the death of her child. This proceeding is ongoing.

Ahziyas Solo-Dampha was a two-year-old from Freeborn County who was beaten to death by his mother's boyfriend in July 2023. The boyfriend had a history with CPS that led to him having a voluntary Termination of Parental Rights for one child and signing a Consent to Adopt for another. During his relationship with Ahziyas' mother, the boyfriend was "heavy-handed" with the children and assaulted the mother so violently she had to go to the ER. At the time of Ahziyas' sibling's birth, the county screened out the boyfriend's Birth Match report due to his previous TPR being voluntary and because the boyfriend was, reportedly, not living with Ahziyas and his mother. The boyfriend was convicted of Second Degree Murder for Ahziyas' death and Third Degree Assault for the sibling's abuse. He is currently serving 25 years in prison.

Amir Harden was an eight-year-old from Dakota County who was shot and killed by his father after he intervened during a domestic violence incident between his parents in June 2024. That morning, the father had appeared in court for domestically assaulting the mother. Afterwards, he returned to the family home, in doing so breaching a DANCO. During the ensuing domestic violence incident, Amir intervened to protect his mother and was shot in the head and neck by his father in front of his mother and four siblings. The father fatally shot himself soon after.

Amy Lynn Modrow was a nine-year-old from Hennepin County who suffocated due to an hours-long asthma attack after her parents did not refill her inhaler prescription or take her to the hospital in February 2024. According to Hennepin County's fatality disclosure, there were four screened out reports of maltreatment between March 2020 to December 2023. Both parents pleaded guilty to Second Degree Manslaughter for her death, with the father serving 48 months in prison and the mother serving 41 months in prison.

Anisa Hassan was a three-year-old girl from Otter Tail County who was suffocated by her mother in July 2023. Her mother told police that she had placed her hand over Anisa's mouth because Anisa was crying for food. She also told investigators that she had attempted to stab Anisa earlier in the night, had previously laid on top of the child while Anisa was face down, and had bitten her cheek. Anisa's mother received a

provisional diagnosis of Schizoaffective Disorder after the death and had reportedly been prescribed neuroleptic medication in the past. Anisa and her mother lived in a shared townhome with other members of their family; there is no known history with Child Protective Services. Anisa's mother pleaded guilty to Second Degree Murder and is serving 150 months in prison.

Catherine Wilson-Jenkins was a two-year-old from Ramsey County who died due to methadone ingestion in September 2023. Catherine's mother had a long history of both drug addiction and mental health issues. Because of this, the mother had a previous involuntary Termination of Parental Rights and three Consents of Parent to Adopt. During her pregnancy with Catherine, the mother admitted to using THC. At her birth, Catherine tested positive for THC and triggered a birth match due to her mother's previous involuntary Termination of Parental Rights. However, Catherine was still sent home with her parents and adjudicated a Child in Need of Protection or Services. After two years, the CHIPS case was closed. Catherine died two months later; the circumstances surrounding her methadone ingestion are unknown. Catherine's mother was not criminally charged.

Eastyn Deronjic was a three-year-old from Clay County who died from his injuries after being beaten to death by one of his caretakers in March 2024. At the scene, officers noticed heavy bruising on his face and body. Eastyn's autopsy revealed 28 blunt force injuries, with the Medical Examiner indicating that the victim died from peritonitis caused by one of these injuries. In the months leading up to Eastyn's death, at least seven adults either saw Eastyn be physically abused or noticed Eastyn's bruising. However, none of these adults contacted CPS. The caretaker is currently serving a 240 month sentence in prison for Eastyn's death.

Elijah Casanova was an eight-year-old from Nobles County who died from a staph infection due to medical neglect by his mother in February of 2024. The mother had waited multiple days after Elijah became ill before taking him to the hospital where he died the following month. There is a long history of CPS involvement with Elijah's family due to environmental hazards in the home and possible physical abuse that caused Elijah to have a dislocated shoulder and broken clavicle. Four years before the death, the agency recommended a CHIPS petition be filed for Elijah and his sibling after a parental assessment, yet one was never filed. The mother was not criminally charged for Elijah's death.

Hazel Bostwick was a one-day-old from Ramsey County who died from prenatal substance exposure and prematurity in May 2024. Her Lives Cut Short report described her injury as "maternal methamphetamine use."

Huxlee Jones was a five-week-old from Lyon County who asphyxiated due to unsafe sleeping conditions his mother put him in while intoxicated in September 2023. The mother had an alcohol concentration of 0.17 the following morning, with police calculating the mother's BAC was between 0.294 and 0.286 the night prior. She also tested positive for THC. The mother had been offered PSOP four times in the four years prior to Huxlee's death, with three of them closing due to non-cooperation. The mother also had four Child Protection Assessments for prenatal exposure, threatened injury, and severe use of narcotics, with one being active at the time of Huxlee's death. Huxlee's mother pleaded guilty to Second Degree Manslaughter and is serving 41 months in prison.

Jackson Dropik was a five-month-old from Hennepin County who asphyxiated due to unsafe sleeping conditions his mother put him in while intoxicated in February 2024. His mother pleaded guilty to Felony Child Neglect or Endangerment and served 150 days in prison.

Jackson Forster was a three-month-old from Ramsey County who died from abusive head trauma inflicted by his father while he was blacked out from alcohol use in March 2024. CPS did not have contact with this family before the death. The father pleaded guilty to Second Degree Murder with a *Norgaard* plea[78] and is serving 128 months in prison.

Jackson Weidell was an eighteen-month-old from Ramsey County who died after ingesting his father's fentanyl on Christmas Day 2024. The family had a history due to the mother's chronic substance abuse which led to her having two previous voluntary

[78] 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 they are innocent.

Terminations of Parental Rights and a maltreatment determination. Both parents had received addiction counseling during a previous CPS investigation. The month Jackson died, the family came into contact with the county due to Jackson's sibling being born addicted to fentanyl. The county allowed the parents to keep custody of the children by creating a safety plan that assumed the father was sober. He was not; Jackson died five days after the county visited the home. Both parents were charged with Second Degree Manslaughter. The mother pleaded guilty and has yet to be sentenced and the father is currently awaiting trial.

Jacob Nephew was a fifteen-year-old from St. Louis County who was murdered by his father along with his mother, step-mother, and brother Oliver in November 2024. The father had a history of severe mental health issues, with the police previously responding to calls to the father's home. The father drove to his ex-wife's home, shot his ex-wife and Jacob, then returned home to shoot his current wife and Oliver before committing suicide.

JaJuan "Junior" Robinson was a three-year-old from Hennepin County who shot himself with an unsecured firearm after it was left on the kitchen counter by his mother's boyfriend in October 2024. The mother had previous contact with CPS. At JaJuan's birth, the mother tested positive for THC, triggering a Family Assessment that led to a safety plan and referrals for voluntary services. The same year, a Family Investigation was triggered due to a report that JaJuan's father assaulted the mother and started a fire in the apartment. The agency worked on the mother's support system, which included support from Project CHILD.[79] The mother did not receive a maltreatment determination for Jajuan's death since she was unaware her boyfriend brought a gun into the house. The boyfriend pleaded guilty to Second Degree Manslaughter, but has not yet been sentenced.

Jayceon Williams was a nine-month-old from Hennepin County who died from fentanyl and xylazine toxicity in September 2024. The circumstances of his death are unknown.

[79] Project CHILD is a voluntary program in Hennepin County for pregnant people ages 16 and older. The program can also support those already in active recovery to reduce the risk of relapse during pregnancy.

Kamora Kolako was a nineteen-day-old from Carver County who asphyxiated after her intoxicated mother co-slept with her in March 2024. The family did not have previous CPS contact, but there was a history of domestic violence between the parents, with the father being the perpetrator. Before the death, he was charged with False Imprisonment for holding Kamora's mother and sibling hostage. After the death, he was charged with Domestic Assault by Strangulation for violently sexually and physically assaulting the mother. An Order for Protection ordered the father to have no parenting time for at least two years. In the CHIPS proceedings for Kamora's sibling after the death, the mother moved homes and tested 0.0 on her random breathalyzer tests. In turn, the CHIPS case was closed. The mother was not charged with Kamora's death.

Laiken Frank was a four-year-old from Wright County who, along with his sister Solara, was shot and killed by his mother in April 2024. The mother took her children to a park and shot them in her car before committing suicide. Both the mother and Solara were deceased when police arrived and Laiken later died in the hospital from his injuries. The county fatality disclosure reported that the family did not have previous contact with CPS, but the children's CIDRs reported that there had been a screened out report of neglect three months prior.

Lincoln Thong was a ten-month-old from Ramsey County who died due to fentanyl toxicity in February 2024. His Lives Cut Short report described his injury as "ingested fentanyl."

London Lozano was a one-month-old from Chippewa County who died due to unsafe sleeping conditions and neglectful supervision from her parents in February 2024. While the adults were at the casino, London's 12-year-old sibling was left responsible for six children, including London. London's mother came back to feed and change London, then left her on a pull-out couch with five other children before returning to the casino. The next morning, London was found unresponsive, with signs of rigor mortis reported. Although her father was also present, only London's mother was criminally charged. She pleaded guilty to Gross Misdemeanor Neglect of a Child. She was sentenced to 364 days in jail to be stayed for two years while she is under probation. The family had a Family Assessment from the prior year due to a report of inadequate supervision.

Maddox Hart was a two-year-old from Washington County who died after ingesting his parents' fentanyl in July 2023. While the family was running errands, Maddox somehow ingested fentanyl in the car and became unresponsive. Instead of calling emergency services, the father went into CVS and bought Narcan. When that did not work, he then waved down passing police who began life saving measures. In a later search of the car, police found a bubble pipe, an empty canister of Narcan, and multiple pieces of tin foil with residue on them. There was a previous CHIPS petition for Maddox due to the parents' drug abuse, but both parents completed addiction counseling and "[engaged] in other necessary services," before the case was closed a year later. At the time of Maddox's death, both parents admitted they had recently relapsed. Neither parent was criminally charged.

Manal Dahir Afi was a four-month-old from Stearns County who died from prenatal drug exposure and prematurity in November 2023. His Lives Cut Short report described his injury as "small for gestational age, possible dehydration, prematurity, intrauterine methamphetamine exposure."

Mateo Harding was a seven-month-old from Hennepin County who was drowned by his mother in a hotel bathroom in February 2024. Mateo's mother had gone to Children's and reported that Mateo had naturally died at the hospital 5 days prior. Children's had no record of Mateo being admitted or dying in the hospital and promptly called the police. After being interviewed by police, Mateo's mother admitted that she had drowned him in a hotel bathtub three days prior due to his continuous cries while she was bathing. After, she texted her boyfriend, who came and unsuccessfully attempted CPR. The couple then had sexual relations before packing Mateo into a backpack and dumping his body in the hotel's dumpster. The body was never recovered. Mateo's mother pleaded guilty to Second Degree Murder and is serving 384 months in prison. The boyfriend pleaded guilty to Aiding an Offender and is serving 74 months in prison. The family had no prior CPS history.

Matthew Alshaikhnasser/Krueger was a two-year-old from Martin County who was accidentally shot by his 4-year-old brother with an unsecured firearm in October 2023. The family was leaving the home together and the mother's boyfriend had placed his firearm in the front passenger seat door pocket. When both the mother's boyfriend and Matthew's mother went back into the home, the 4-year-old got the gun and fired it at Matthew while the family was driving. Matthew died from his injuries two days later. The

family did not have previous involvement with CPS. The boyfriend pleaded guilty to Endangerment of Child by Firearm Access and was sentenced to 90 days in county jail. He was also sentenced to 18 months of prison time to be stayed for 5 years, during which he is on probation.

Mi'Vida Vorlicky was a fourteen-month-old from Ramsey County who died after ingesting tinfoil laced with fentanyl in December 2023. Her mother was experiencing drug addiction and had left tin foil with residue out where Mi'Vida could access it. Mi'Vida's father attempted CPR and her grandmother administered Narcan before first responders arrived. Mi'Vida was declared brain dead four days later. Her mother pleaded guilty to Second Degree Manslaughter and is currently serving 48 months in prison. In an interview with KARE 11,[80] Mi'Vida's mother reported that the hospital and CPS knew she was in active addiction and even put Mi'Vida in an emergency hold before allowing Mi'Vida to return home with her mother.

Nada Mohamed was a three-year-old from Hennepin County who died from fentanyl toxicity in December 2024. Her Lives Cut Short report described her injury as "ingestion of illicit drugs occurred under unknown circumstances."

Niindonis Goodman was a two-year-old from Sherburne County who died after ingesting her mother's fentanyl in May 2024. Niindonis' father had left her with her mother. When he returned, he saw Niindonis unresponsive. Police found drugs and drug paraphernalia in the apartment and Niindonis' autopsy confirmed fentanyl toxicity as her cause of death. This family had a long history of CPS involvement, with Niindonis' father losing custody of three of his children due to neglect and physical abuse and the mother losing custody of her eldest child and periodically her middle child due to her substance abuse. When Niindonis was born, her mother tested positive for amphetamine; Niindonis was placed in foster care for 55 days before being reunified with her mother. In the time between Niindonis' reunification with her mother and death, there were three reports of maltreatment, with one being actively investigated when Niindonis died. During a forensic interview after the death, Niindonis' sibling reported that Niindonis had previously ingested fentanyl, with her mother administering Narcan.

[80] *KARE 11 Investigates: Nearly 2 dozen MN babies and kids killed by fentanyl.*

Niindonis' mother pleaded guilty to Second Degree Manslaughter and is serving a 36 month sentence.

Oliver Nephew was a seven-year-old from St. Louis County who was murdered by his father along with his mother, his brother's mother, and brother Jacob in November 2024. The father had a history of severe mental health issues, with the police previously responding to calls to the father's home. The father drove to his ex-wife's home, shot his ex-wife and Jacob, then returned home to shoot his current wife and Oliver before committing suicide.

Peyton Jensen was a sixteen-year-old from Stearns County who overdosed on fentanyl-laced cocaine his mother sold him in March 2024. His father figure found him on the floor of the bathroom and attempted to wake him. When he was unsuccessful, the father figure then put a space heater next to him and went to bed. When the father figure woke up 8 hours later and saw Peyton still unresponsive, he called first responders. Peyton was announced deceased on the scene. During the investigation, police find out that Peyton was buying cocaine for him and his father figure from his mother's boyfriend through his mother. The mother had several interactions with CPS due to neglect and substance use, with many of the reports screened out or offered voluntary services. Peyton's father figure pleaded guilty to Second Degree Manslaughter and was sentenced to 48 months. Peyton's mother pleaded guilty to Second Degree Manslaughter and was sentenced to 41 months. The mother's boyfriend pleaded guilty to Second Degree Manslaughter and was sentenced to 75 months.

Reina Cooper was a fourteen-month-old from Ramsey County who died due to fentanyl toxicity in September 2023. The circumstances of her death are unknown.

Remi Stately was a six-year-old from Beltrami County who was fatally stabbed by his mother and left for dead in a house fire with his brother, Tristan, in March 2024. The mother had absconded with their sibling and fled the scene, triggering an AMBER alert. Police stopped the vehicle and found the sibling suffering from visible signs of neglect, including open sores and lesions on his face and body and rotten teeth in his mouth. The mother was federally charged with two counts of Premeditated Murder, two counts

of Murder in the Course of Committing Child Abuse, Murder in the Course of Committing Arson, and Arson. This proceeding is ongoing.

Riverlynn Vannorman was a fourteen-month-old from Stearns County who was beaten to death by her mother's boyfriend in July 2023. The boyfriend originally told the police her injuries were accidental, but that was proven untrue by the autopsy, which confirmed that Riverlynn's homicide was caused by blunt head and neck injury and asphyxial injury. The mother had previously come into contact with CPS due to using THC during her pregnancy with Riverlynn; the mother eventually disengaged with services and nothing could be done since Riverlynn was still *in utero*. Two years later, a report of a domestic violence incident between the mother and Riverlynn's father was screened out since it was not in front of the children. The boyfriend had a history of violence, which included previous child abuse, and physically assaulted Riverlynn's mother "on occasion." The boyfriend was charged with two counts of Second Degree Murder and one count of First Degree Manslaughter. This proceeding is ongoing.

Rudy Sweere was a three-year-old from Otter Tail County who fatally shot himself with an unsecured firearm in December 2024. The father was home with the children, heard a noise, and found Rudy in a pool of blood in the master bedroom, where two loaded and unlocked guns were in the nightstand. Rudy's 5-year-old sibling was also in the bedroom. Rudy died while enroute to the hospital. The family did not have previous contact with CPS and the father was not criminally charged.

Solara Frank was a nine-year-old from Wright County who, along with her brother Laiken, was shot and killed by her mother in April 2024. The mother took her children to a park and shot them in her car before committing suicide. Both the mother and Solara were deceased when police arrived and Laiken later died in the hospital from his injuries. The county fatality disclosure reported that the family did not have previous contact with CPS, but the children's CIDRs reported that there had been a screened out report of neglect three months prior.

Thomas Pauza-Moore was a three-year-old from Pine County who shot himself with his father's unsecured semi-automatic pistol in August 2023. His family had previous contact with CPS due to the domestic violence between his parents and the neglectful supervision by his father. Thomas' mother, who was recently separated from Thomas'

father, said that she had previously told her husband to secure the guns in the home, but did not file for sole custody of her child after the death. Thomas' father pleaded guilty to Second Degree Manslaughter and was sentenced to 150 days in jail, to be staggered into two parts. The father served 90 days; his second sentence was likely forgiven. Both of Thomas' parents currently share physical and legal custody of Thomas' younger sibling.

Tristan Stately was a five-year-old from Beltrami County who was stabbed by his mother and died in a house fire with his brother, Remi, in March 2024. The mother had absconded with their sibling and fled the scene, triggering an AMBER alert. Police stopped the vehicle and found the sibling suffering from visible signs of neglect, including open sores and lesions on his face and body and rotten teeth in his mouth. The mother was federally charged with two counts of Premeditated Murder, two counts of Murder in the Course of Committing Child Abuse, Murder in the Course of Committing Arson, and Arson. This proceeding is ongoing.

Wings Thao was a five-month-old from Hennepin County who most likely asphyxiated due to unsafe sleeping in October 2023. The mother was at work and the father was responsible for watching their four children. Wings was found unresponsive with his siblings on an adult bed with loose clothing and adult bedding. However, the fatality disclosure from the county reports that the Manner of Death and Cause of Death are undetermined. This family had a history with CPS due to the father's negligent supervision and addiction to alcohol, leading to an investigation where the county learned that the parents co-slept with Wings' older siblings. After the parents followed their case plan, this case was closed. The father was not charged for Wings' death.

Zyear Bagley was a four-month-old from St. Louis County who died due to unsafe co-sleeping with his intoxicated parents in July 2023. In combination, his parents had over 80 contacts with CPS in the decade leading up to his birth. Two weeks before his birth, Zyear's mother admitted to the agency that she had used methamphetamine two days prior. Zyear was born with gabapentin, methadone, and clonazepam in his system. After two weeks in the NICU, Zyear was released into his mother's custody. Police and CPS were contacted multiple times in the two days leading up to Zyear's death for the mother's apparent substance use, but Zyear was left in her custody. Neither parent was charged for Zyear's death.

The following are unidentified children:

An unknown baby boy from Stearns County was killed due to neglect by a biological parent in August 2023. The family had one previous report that was screened out two months before the death. Per the fatality disclosure, the perpetrator was criminally charged.

An unknown baby boy from Hennepin County died due to fentanyl toxicity in September 2023. The fatality disclosure from the county reports that the circumstances are unclear, but there were two maltreatment determinations made for the death. Per the fatality disclosure from the county, the family had multiple interactions with CPS before the child was born due to negligent supervision and the mother's unwillingness to work with the agency. This led to the child's older sibling being removed from the home multiple times.

An unknown baby girl from Ramsey County died due to fentanyl toxicity in September 2023. In the fatality disclosure from the county, it is reported that the child's home was "completely trashed and had moldy food all over the place and dog feces throughout the home." However, the county reports that social services were not provided to the family in the year prior to the fatality.

An unknown three-month-old from Stearns County asphyxiated due to unsafe sleeping conditions in November 2023. The fatality disclosure from the county reports that there were no previous reports of maltreatment. PSOP and public health services were being provided at the time of the child's fatality.

An unknown eight-year-old from Hennepin County was murdered by her mother, put into a tote bag, and dumped at a dumpster in an industrial park in December 2023. The mother had told her friend that she had disciplined her child and had gone too far. When she returned home, the unknown girl was dead. The mother waited five days before putting her daughter's corpse into a tote and placed the tote in an industrial park dumpster. There were two previous reports to CPS. The first report was an investigation

at the time of the victim's birth due to the mother triggering a Birth Match; what caused the Birth Match is unknown. The second report was for physical abuse by an unknown offender that was screened in for an investigation. The investigator was unable to locate the family. The mother was charged with First Degree Murder, three counts of Child Abuse, Abandonment or Concealment of a Dead Body, and Tampering with Physical Evidence for her daughter's death. She is currently awaiting trial.

An unknown baby boy from Ramsey County died due to neglect by a biological parent in March 2024. The child's CIDR reports the family had one previous Family Assessment that was finalized 9 months before the child's death.

An unknown baby boy from Ramsey County died due to neglect by a biological parent in July 2024. The child's CIDR reports the family did not have any pertinent prior history.

An unknown two-year-old from Clearwater County drowned in an unattended residential pool in July 2024. The county reported in their fatality disclosure that the family did not have previous reports to CPS before the death.

APPENDIX B: SUBJECT MATTER EXPERTS AND REVIEWERS

The following are brief biographies for each Subject Matter Expert and reviewer who contributed to this effort.

Child Welfare

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. He is a board member of Safe Passage for Children.

Sarah Font

Dr. Sarah Font, PhD, is a professor at the Brown School at Washington University in St. Louis and an interdisciplinary researcher examining the impacts of the child welfare system and the criminal and juvenile legal systems on children and families. Her research primarily involves partnerships with state and local public agencies and the use of linked administrative data to inform agencies' strengths, challenges, and priorities for reform. She is the Co-Principal Investigator of Lives Cut Short, a joint project of the American Enterprise Institute and UNC Chapel Hill that identifies and investigates child maltreatment deaths nationally.

Emily Putnam-Hornstein

Dr. Emily Putnam-Hornstein, PhD, is the John A. Tate Distinguished Professor for Children in Need at the School of Social Work at the University of North Carolina at Chapel Hill and faculty co-director of the Children's Data Network. For nearly two

decades, Putnam-Hornstein has partnered with public agencies to carry out applied research to inform child welfare policy and practice. Her analysis of large-scale, linked administrative data has provided insight into where scarce resources may be most effectively targeted and informs understanding of maltreated children within a broader, population-based context. She is the Principal Investigator of Lives Cut Short, a joint project of the American Enterprise Institute and UNC Chapel Hill that identifies and investigates child maltreatment deaths nationally.

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 the 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. Dee is a contributing editor for this report.

Child Mental Health

Deena McMahon

Deena McMahon is a family and attachment therapist in private practice. She is often consulted as an expert witness on contentious child welfare cases. She also serves as consultant to numerous state and county child protection agencies, adoption agencies, and parent support groups. Her clinical focus is on adoption dynamics and the trauma of disrupted attachment. She does forensic parenting assessments, attachment and sibling assessments, and attachment therapy. She has been working with families and children for over 43 years and has developed expertise in the areas of childhood

trauma, childhood sexual abuse, grief and loss, family violence, transracial placements, and ICWA cases.

Brandon Jones

Brandon Jones, M.A., CPPM, is the Executive Director of the Minnesota Association for Children's Mental Health (MACMH), where he leverages extensive experience in consulting, mental health, and leadership development. His expertise spans Adverse Childhood Experiences (ACEs), historical and intergenerational trauma, social and emotional intelligence (EQ), leadership development, and the Intercultural Development Inventory (IDI). Brandon holds a B.A. in Sociology from the University of Minnesota, a master's degree in Community Psychology from Metropolitan State University, and a master's degree in Psychotherapy (Marriage and Family Therapy) from Adler Graduate School. As a 2013 Bush Foundation Leadership Fellow, he has demonstrated a commitment to impactful leadership and community transformation.

Medical Experts

Maggie Carney

Maggie is a 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. She is a board member of Safe Passage for Children.

Lisa Hollensteiner

Dr. Lisa Hollensteiner, MD, is a retired Emergency Department physician with over 36 years experience in the medical field, primarily through the Emergency Physicians Professional Association. She has had board certification in both Emergency Medicine and Family Practice. 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. She is currently the Safe Passage for Children Board Chair.

Marjorie Hogan

Dr. Marjorie “Margie” Hogan, MD, is a retired pediatrician with more than 40 years of experience, mostly working at Hennepin County Medical Center. Dr. Hogan has expertise in the fields of Child Maltreatment and Adolescent Health. She is married to Dr. David Griffin, also a pediatrician, and they lovingly share four adult children and four granddaughters.

Roger Sheldon

Dr. Roger Sheldon, MD, is the Emeritus Professor of Pediatrics in the Neonatal-Perinatal Medicine Division at the College of Medicine, University of Oklahoma. In addition to his responsibilities in neonatal intensive care, he was Medical Director of the MediFlight infant transport service, the Oklahoma Infant Transition Program, the Sooner NIDCAP Training Center, and the Oklahoma Areawide Services Information System (OASIS). He retired in 2010 and moved to Minneapolis with his wife to be near their daughter and family. At the University of Minnesota, he has been involved in neonatal care, the Advanced Careers Initiative of the Department of Sociology, and as the volunteer coordinator of the Encore Volunteers at the Earl E. Bakken Medical Devices Center. He is a member of the American Academy of Pediatrics and Doctors for Early Childhood.

Austin Schatzman

Dr. Austin Schatzman, DO is a third year medical fellow in the field of Child Abuse Pediatrics at the University of Minnesota. His fellowship includes training at the Center for Safe and Healthy Children at M Health Fairview, Midwest Children’s Resource Center at Children’s Minnesota, medical consults at Hennepin County Medical Center, and time with the Hennepin County Medical Examiner’s Office. His fellowship research interests include injuries to hospitalized children, quality improvement centered on the hospital workup of child abuse, and pediatric resident burnout and resilience. He graduated from the Philadelphia College of Osteopathic Medicine as a Doctor of Osteopathic Medicine and subsequently completed his general pediatrics residency at Lehigh Valley Health Network in Allentown, Pennsylvania prior to moving to Minnesota for fellowship.

Guardian Ad Litem

Anonymous

Law Enforcement

Anonymous

Officers of the Court

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 the 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.

Patty Moses

Patty Moses 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.

Jennifer Christensen

Jennifer Christensen is the Carver County Juvenile Division Manager. She has been with the Carver County Attorney’s Office for 17 years, handling a variety of cases for the

division. Christensen is a member of the Carver County Children’s Justice Initiative, the Carver County Child Mortality Review Board, the Carver County Child Protection Consultation Team, the Carver County Child Protection Investigations Team, and the Minnesota County Attorney’s Association Juvenile Law Committee for both Delinquency and Child Protection. She also consults with and provides advice to law enforcement and other county agencies.

Child Advocacy Centers

Cornerhouse

Based in Minneapolis, CornerHouse was founded in 1989 as Minnesota’s first Children’s Advocacy Center to address a critical need for a safe, child-friendly environment where children could disclose abuse and receive support. CornerHouse's mission is to partner with families, communities, and systems who are entrusted with the safety of children, youth, and vulnerable adults to reduce trauma and end abuse. To achieve its mission, Cornerhouse programming includes forensic interviews, family support and advocacy, mental health services, and training. Multiple members, including the Executive Director Christy Shannon, were SMEs for this project.

Rebecca Foell

Rebecca Foell, LICSW, has dedicated her career to working with children and families impacted by trauma. She has provided outpatient mental health services, victim advocacy, crisis support, and has most recently focused on program development. Rebecca is currently the Program Coordinator for the Otto Bremer Trust Center for Safe and Healthy Children, working with the multidisciplinary team to address issues related to child abuse and neglect through direct service, research, prevention, and education.

Journalists

Doug "D.J." Tice

D.J. Tice has been a writer, editor and publisher in Twin Cities journalism for decades. He was previously an editor at Corporate Report Minnesota and Twin Cities magazines, editor and publisher at the Twin Cities Reader, and an editorial writer and columnist for the St. Paul Pioneer Press. From 2003-2009, he was the Star Tribune's state political editor, directing coverage of the Legislature, state government, the Minnesota congressional delegation, and elections. After that, he was the Star Tribune's commentary editor through early 2024. He is the author of two books of popular history. His collection of ordinary Minnesotans' memories, Minnesota's Twentieth Century, published by the University of Minnesota Press, was awarded the Minnesota Book Award for history in 2000. He is a board member of Safe Passage for Children and a contributing editor for this report.

APPENDIX C: GLOSSARY

The following terms are acronyms commonly used in this report, along with a brief description of the acronym itself:

CAC: Child Advocacy Center.

These are child-focused centers that perform forensic interviews of children, which provide information admissible as evidence in court. CACs also offer direct client services to victims of abuse.

CHIPS: Child in Need of Protection or Services.

Child in Need of Protection or Services actions are court cases that involve the health, safety and welfare of children.

CIDR: Critical Incident Details Report.

This is the fatality disclosure the Department of Children, Youth, and Families must produce under Minn. Stat. §260E.35 subd. 7.

CPS: Child Protection Services.

An umbrella term for the social services agencies working in child protection matters.

DANCO: Domestic Abuse No Contact Order.

A Domestic Abuse No Contact Order is issued by the criminal court in response to a domestic assault criminal charge. DANCO's are issued at the discretion of the criminal court, even over the objection of the victim of the assault. If violated, the perpetrator can be criminally charged.

DCYF: The Department of Children, Youth, and Families.

This is the state department responsible for managing Minnesota's child welfare system.

DHS: The Department of Human Services

The state department that was responsible for Minnesota's child welfare system throughout part of the case history for many of the children in this report. DCYF was spun off from DHS on July 1, 2024.

GAL: Guardian ad litem.

These are paid or volunteer professionals who are trained to independently investigate and advocate for the child in a court proceeding.

OFP: Order For Protection.

An Order For Protection is a way to protect victims of domestic violence in our system and is issued in family court at the request of the victim. If violated, the perpetrator can be criminally charged.

PSOP: Parent Support Outreach Program.

Minnesota's Parent Support Outreach Program is an early intervention program that provides short-term voluntary support for at-risk children and families identified through screened out child maltreatment reports, community, or self-referrals.

SME: Subject Matter Expert.

These are professionals working on the frontlines of the child welfare system who advised on this report.

TPR: Termination of Parental Rights

This is a legal process in which the parent-child relationship is legally severed by the court.