

SAFE PASSAGE FOR CHILDREN OF MINNESOTA

Child Fatalities Report
Secretaries' Innovation Group
July 11, 2023



Safe Passage Model: Connect Volunteers with their Elected Officials

They are
constituents

They speak
from the heart



Purpose of the report

Understand how child welfare philosophy and practices contribute to child fatalities

Advocate for change

Fatalities Report Findings

Many of these deaths were preventable



But policies gave preference to interests of caregivers, goal of family preservation –

above all else



Result: child safety and well-being were compromised

Fatalities Report Findings

Mission of child welfare
is to protect children

But children left in
situations of physical
and sexual abuse – and
sometimes torture –
often over long periods

Too many professionals
often knew about
ongoing maltreatment,
but failed to act



How did we get to the point where child safety and well-being are lower priority than parent's rights and family preservation at all costs?

And... what do we do about it?



**What strategies can we develop
for getting people to work across
disciplines?**



Mismatches

System values not aligned with community

Relevant stakeholders not engaged

Parents get years to address issues – children need protection in their first 1,000 days



The Team

Archbishop Ireland Justice Fellow UST law school

Four reader/coders

Trusted Advisors

Subject Matter Experts (SMEs)



Where we got the information

88 fatalities
identified in
media reports

Fatality reports
from counties

Juvenile, family
& criminal
court records

How could fatalities be made more visible in your state? What information is accessible?



Structure of the report

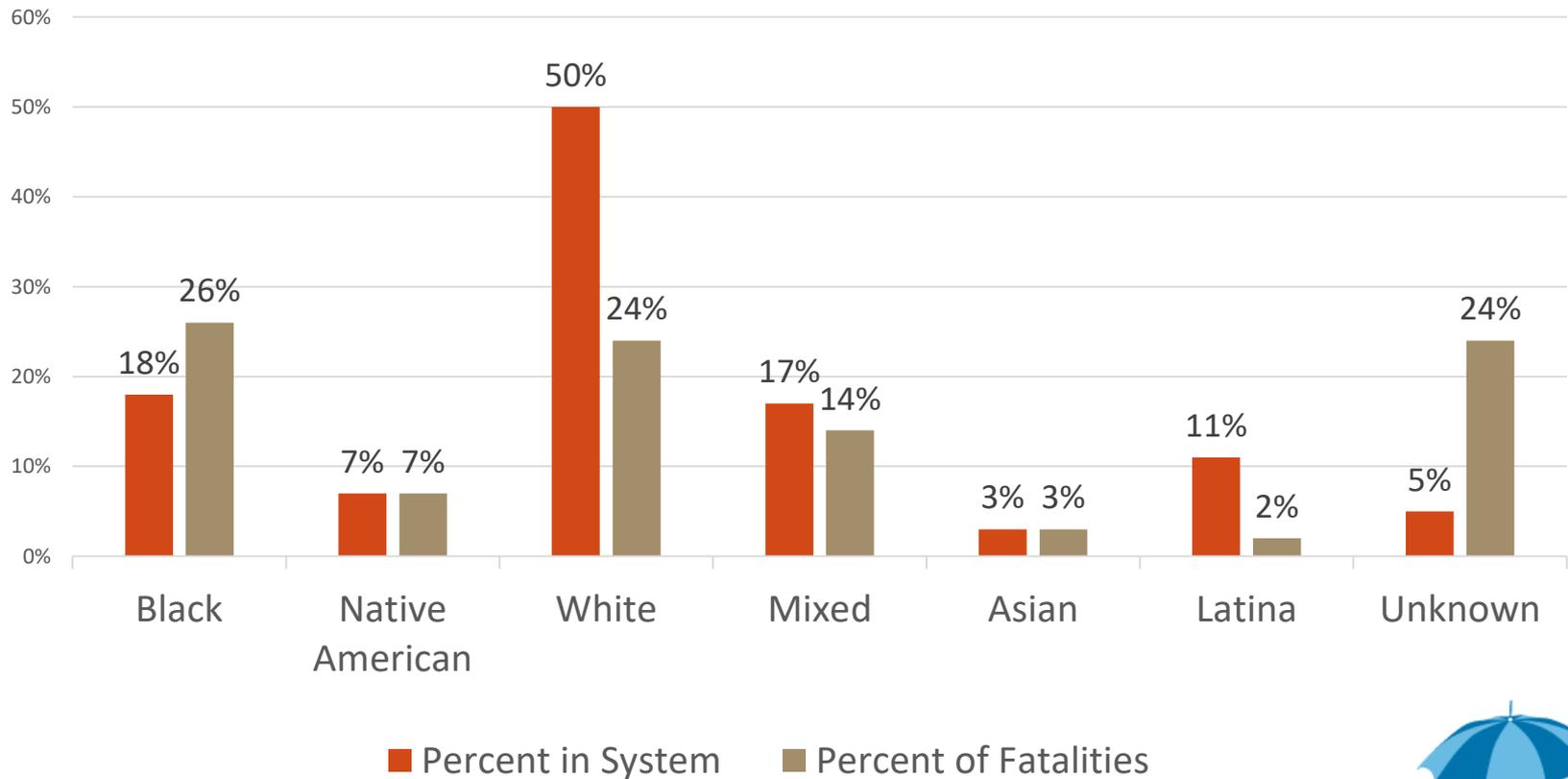
Quantitative
results

Twelve
practice
patterns

Illustrated
with children's
stories

Pattern - Racial Disparities

Minnesota Child Fatalities by Race



Patterns:

Racial Disparities

**Chronic
Multi-Type
Maltreatment**

**Premature return
from foster care**

Tayvion Davis



Pattern: Torture



Fourteen (16%) of cases with signs of torture

Autumn Hallow

Patterns:

**Ineffectiveness of
No-Contact Orders
and Safety Plans**

**Misuse of
Alternative
Response**

Anthony Herkal



Pattern:

Seemingly Unlimited Chances to Address Substance Abuse



Aaliyah Goodwin

Patterns:

Returning Children to Parents with Ongoing Mental Health Issues

Role ambiguity in courts

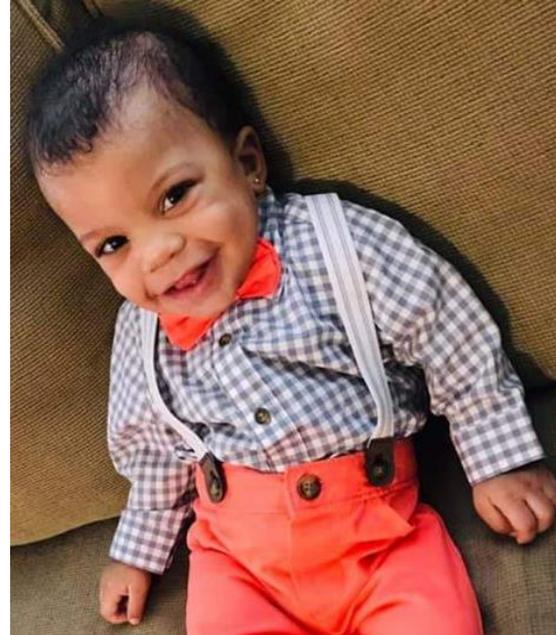
Eli Hart



Pattern:

Red Flags Missed or Ignored by Medical Providers

Eli Hentges and Kamari Gholston



Pattern:

Lack of Due Diligence in Kinship Foster Placements

6 of 7 children killed in foster care were kinship placements

Layla Mary Ann Jackson



Response – An Advocacy Agenda

Do everything
possible to
support families

But child safety
and well-being
is the priority

Policies to Prevent Entry

Relieve stress of #1
risk factor: **poverty**

Have trusted
institutions deliver
services known to
reduce maltreatment

Sometimes paying
the phone bill isn't
the right response

What advocacy strategies would work in your state?



Family Preservation/Reunification Agenda

Early learning scholarships

Targeted home visiting

Actually accessible mental
health and substance abuse
services

Child Safety Agenda

Change Philosophy!

Stop using risky engagement practices

Limit use of Alternative Response



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How could fatalities be made more visible in your state? What information is accessible?

What advocacy strategies would work in your state?

