#08-68-02

Bulletin

January 25, 2008

Minnesota Department of Human Services P.O. Box 64941 St. Paul, MN 55164-0941

OF INTEREST TO

- County directors
- County child protection or social services supervisors and staff
- County attorneys
- County child mortality review coordinators
- Law enforcement
- Tribal social services

ACTION/DUE DATE

Report child deaths and near fatalities to a state child mortality review coordinator.

Complete a local review of child deaths and near fatalities, and send review reports to a state child mortality review coordinator.

Complete a record search requested by state child mortality review coordinator.

EXPIRATION DATE

January 25, 2010

Update of County Procedures and Responsibilities Regarding Child Mortality and Near-fatality Reviews

TOPIC

County child mortality and near-fatality review process.

PURPOSE

Provide guidance for counties regarding child mortality and near-fatality reviews.

CONTACT

Child mortality review consultants:
Southern region (see page 10)
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SIGNED

CHARLES E. JOHNSON
Assistant Commissioner
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PURPOSE AND OVERVIEW

Minnesota Statutes, section 256.01, subdivision 12, established the state's child mortality review in 1989. The law gave the commissioner of the Minnesota Department of Human Services responsibility for creating a process to review deaths of children and to require local mortality reviews. The commissioner set forth requirements for local Child Mortality Review Teams in Minnesota Rules, part 9560.0232, subpart 5. The statute was amended in 1998 to require reviews of near-fatalities.

The goal of Minnesota's child mortality review process is to reduce the number of children who die or are seriously injured as a result of maltreatment, or as a result of circumstances where maltreatment is a contributing factor. The local review process employs a multi-disciplinary team to study cases to discern as much as possible about the factors that contribute to deaths or near-fatalities of children. Upon completion of a review, the local Child Mortality Review Team makes recommendations to improve the child protection system by identifying gaps in the provision of services and training, and by recommending modifications of practice, policy or law.

The department consulted with the National Maternal and Child Health Center for Child Death Review to refine Minnesota's child mortality review process so that it is more effective at identifying areas that will improve child safety. The current process is a partnership between county and state agencies based on national guidelines for best practice in completing reviews, encouraging local teams to conduct thorough child mortality reviews. The local reviews are based on relevant documentation, which can be acquired under law during the investigation and review, to better understand the services or intervention provided by social services, law enforcement, and medical professionals prior to the child's death.

The state Child Mortality Review Panel studies all reports of local mortality reviews and compiles the data on an aggregate level. The perspectives learned from a greater number of local reviews results in stronger recommendations supported by data from multiple cases with similar issues. It is expected that this approach will ultimately result in a more effective system of protecting children.

LOCAL CHILD MORTALITY REVIEWS

Counties should ensure that deaths or near-fatalities requiring a child protection investigation and child mortality review are not overlooked. The basic requirements for county social services agencies regarding child mortality and near-fatality reviews are found in Minnesota Statutes section 236.01, subdivision 12 and Minnesota Rules, part 9560.0232. Essential steps in conducting a local child mortality review include:

- Notifying the department of all child deaths and near-fatalities meeting the criteria for review.
- Obtaining relevant reports, including law enforcement investigation, autopsy, medical, and other reports necessary for a comprehensive review

- Completing a local child mortality review for each eligible case. The local Child Protection Team is permitted to serve as the Child Mortality Review Team for this purpose
- Sending a report of the review to a state child mortality review coordinator for review by the state Child Mortality Review Panel and for data collection
- Completing a record search regarding death certificates sent by the department to determine if all eligible deaths have been reviewed.

LOCAL REVIEW CRITERIA

A local child mortality review must be conducted when:

- The death of a child resulted from **maltreatment or suspected maltreatment**
- A child has experienced **near-fatal child maltreatment**
  Near- fatalities are defined in Minnesota Statutes, section 626.556, subdivision 11d, as cases in which a physician determines that a child is in serious or critical condition as the result of sickness or injury caused by suspected abuse, neglect or maltreatment.
- The death or incident leading to a death or near-fatal injury occurred in a **facility licensed by the department** (including child care, foster care, shelter care, group homes and residential treatment facilities) when the manner of death is not classified as natural on the death certificate.

A local review is also required when:

- The **manner of death** was classified on the death certificate as one of the following:
  - homicide
  - suicide
  - accident
  - cannot be determined
  - natural with a diagnosis of Sudden Infant Death Syndrome (also known as SIDS, Sudden Unexpected Death in Infancy, Sudden Unexpected Infant Death)

  and:
  - The child or any member of the child's family **received social services or an assessment** from the local social services agency at the time of the death or within one year prior to the death.

If county staff is uncertain whether a death or near-fatality meets the eligibility criteria, they should call or e-mail one of the state child mortality review coordinators listed on the front of this bulletin.

CHILD PROTECTION ASSESSMENTS OR INVESTIGATIONS

It is imperative that the child protection system accurately identify and review all child deaths or near-fatalities where maltreatment may be a contributing factor. Having accurate statewide data on children who have died as a result of child maltreatment is an important factor in assessing the quality of child protection services. Data collected in the local and state child mortality

reviews will help to identify patterns of abuse, and can be used to advocate for supports that are essential to delivering more effective child protection services. Recommendations from the reviews will help to shape policy and practice standards on the state and local level.

If the death or near-fatality resulted in a child protection investigation or Family Assessment, a local mortality review may need to be completed, even if the determination is that no maltreatment occurred.

In cases that involve the death of a child, law enforcement investigative reports may be used to learn the facts of the case, and to determine whether child maltreatment occurred. The child protection investigation may also be conducted jointly with the law enforcement agency.

Assessment or investigation of child deaths and near-fatalities and the subsequent reviews will help to:

- Assess the overall effectiveness of the child welfare system and develop changes in policy and resources at the state level to reduce the number of fatal or near-fatal cases of child maltreatment.
- Identify training needs for social workers or mandated reporters.
- Assess the adequacy of resources at the community level to identify high risk families or provide effective intervention to reduce risk of harm to children.
- Provide documentation in the Social Services Information System regarding determinations of maltreatment to provide essential history if the offender or other adults in the case are involved in another child maltreatment allegation in the future. The documented history will be available if an offender lives with another family, has children with a different partner, applies for a day care or foster care license, or is a household member of an applicant for a child care or foster care license.

Some deaths or near fatalities requiring a child protection assessment or investigation and a local child mortality review should not be overlooked. The following are examples of such circumstances:

- Cases where the first known incident of maltreatment results in a child's death.
- Cases where maltreatment is suspected as a contributing factor in a child's death, whether or not the family is currently open to child protection services.
- Cases where the only child in the family sustains a fatal injury or dies as a result of neglect. Although there are no children remaining in the home needing protective services, the severity of the abuse or neglect must be documented by making a maltreatment determination. Some offenders or parents who failed to protect their child from an abusive partner may have another child or move into the home of a family member or friend with children.
- Cases in which a child is murdered by a parent or adult caretaker, before the adult commits suicide. Murder of a child is the most severe form of child abuse and should be documented as abuse in the child protection system. Much can be learned during the child mortality review about the patterns of adult behaviors, and the delivery of mental health services in such cases.

- Cases deemed accidents by law enforcement or the medical examiner where lack of appropriate supervision or other caregiver neglect may have contributed to the death or near-fatality.
- Cases in which the county does not know of the suspected maltreatment contributing to the death or near-fatality until after the law enforcement investigation is completed and closed.
- Cases in which there was no law enforcement investigation or report to child protection at the time of the incident, but the case is identified through the death certificate and social services record check.

COUNTY PROCEDURES

1. Notice to the department

County social services agencies must notify the department within 48 hours, (excluding weekends and holidays), of a child's death or near-fatality meeting the criteria for review. To report a death or near-fatality, the local agency may call a state child mortality review coordinator and leave a message with pertinent information regarding the case. The information should include:

- child's name
- date of birth
- date of incident leading to the death or near-fatality
- circumstances of the child's death or near-fatality
- county of residence
- name and phone number of the county contact person
- discuss the need for technical assistance in preparing or conducting the local review.

Within one week, the county must complete form SSIS-80 and send it to the child mortality review coordinator at the Minnesota Department of Human Services using the contact information on the front of this bulletin. A copy of the revised form SSIS-80 is Attachment A; directions for locating the form in SSIS are in Attachment B.

To ensure that children's deaths and near-fatalities are reported to the department, counties may need to inform their social services staff of the requirement to report the child's death or near-fatalities to their local child mortality review coordinator, child protection supervisor, or other staff members with responsibility for local reviews. It may be necessary to provide them with the definition of a near-fatality.

2. Local child mortality review

The local Child Mortality Review Team must review each case that meets the review criteria within 60 days of the death or near-fatality. The local Child Protection Team is permitted to serve as the local Child Mortality Review Team. The team shall involve community professionals with responsibility for serving or protecting children, or with knowledge of the family, for the purpose of assessing the services provided and making recommendations for changes.

3. Multiple counties and/or tribes provided services

For a comprehensive review, it is essential that all counties that have provided services to a family participate fully in the review. The best practice recommendation when multiple counties/tribes have provided services to a family prior to the death or near-fatal injury are the following:

- Notify the counties that provided services to the family of the death or near-fatality
- Confer with the counties involved and determine which one had the most significant involvement with the family and that county should host the review
- Prepare a summary of the services provided and the family's progress by each of the counties involved
- Submit each county's case summary along with social services records, police reports, medical records and other relevant documents to the host county prior to the local review
- Incorporate the case summaries into one composite case summary prepared by the host county
- Invite tribal social services to participate in the local review
- Review the case with all involved counties participating in the local review meeting
- Develop recommendations that address issues relevant to each of the agencies that provided services to the family in one report of the child mortality review.

4. Access to nonpublic data

Under Minnesota Rules, part 9560.0232, subpart 5, item C, the commissioner has authorized the local Child Mortality Review Panel to, "have access to not public data maintained by the state agencies, statewide systems or political subdivisions that are related to a child's death or circumstances surrounding the care of the child." County staff members who are assigned to coordinate local reviews, have the authority to obtain the law enforcement investigative reports, autopsy records, coroner or medical examiner investigative data, hospital, public health, or other medical records of the child; hospital and other medical records of the child's parents that relate to prenatal care; and other social services agency records for use in the local review.

5. Delay of local review

The local review may be delayed if an assessment or investigation remains active, or a criminal or civil court action is pending. If a review is delayed, a state child mortality review coordinator should be informed.

6. County report of the local review

Within 30 days of completing the local review, the county must send a report of the review to a state child mortality review coordinator.

The report must include the name of the county that conducted the local child mortality review, date of the review, child's name, date of birth and death, and include case findings, conclusions, recommendations, and the role or job title of review participants.

Report **findings** shall include statements of fact:

- Providing information relevant to the case under review.
- Accounting for the agency's activities regarding the items listed on the report format (see Attachment C), under the heading Social Services History.

  The information includes a list of all child protection reports received, whether each of those reports was assigned for assessment or investigation, the outcome of the assessment or investigation, the services provided, and the outcome of the services or intervention.
- Identifying circumstances or constraints which may have caused the agency to follow a non-standard protocol.
- Describing information from other institutions or agencies (such as law enforcement, hospital records, probation, etc) which were not included in the local social services agency's case record.
- Providing other information the local agency deems important to a full understanding of the events in the case.

Conclusions are judgments supported by factual information from the findings. Appropriate conclusions should not just be statements indicating that the local social service agency's actions conformed to law, rule or local procedure, or indicating that services or case management activities appropriately responded to the needs of the family and emerging danger.

Recommendations include any suggestions for change in:

- county-level practice, policies, or training
- coordination with other agencies
- public education and/or prevention efforts that may be necessary
- Minnesota statutes, Minnesota rules, training and resources.

In addition, the county must submit copies of the law enforcement investigative report, autopsy report, and other reports used in the local review, to a state child mortality review coordinator. When available, a copy of the "Minnesota Infant Death Investigation Guide," used for deaths of children up to 24 months, should be included.

7. Records search

The department will send copies of the child death certificates for all children who died in the county to the local child mortality review coordinator, child protection supervisor, or other assigned staff. A "Report of Records Search" form will be included to request that a record search be completed. Upon receipt of the death certificate, the social service agency must search its information system to determine if the child/family was involved with the agency (e.g., open for assessment or services related to child protection, other child welfare, chemical dependency, mental health, etc.), during the year prior to the death. The agency should provide the information requested on the form and return it to a state child mortality review coordinator within two weeks.

The record search will assist state coordinators to determine if all deaths meeting the review criteria have been reviewed. If it is determined that a death meets the review criteria, and a local review has not been held, the local agency should conduct a local review or indicate on the form the reason that the review is pending.

DATA PRIVACY

Minnesota Statutes, section 256.01, subdivision 12, states that information acquired by the local Child Mortality Review Team in the exercise of its duties is protected nonpublic data or confidential data, but may be disclosed as necessary to carry out the purposes of the review. Local Child Mortality Review Team members, or anyone attending the local child mortality review, must not disclose what transpired during the meeting except to carry out the purposes of the review.

The proceedings and records of the local review team are protected nonpublic data, not subject to subpoena or discovery, and may not be introduced into evidence in a civil or criminal action against a professional or agency. Information, documents, and records otherwise available from other sources, are not immune from discovery or use in a civil or criminal action solely because they were presented during child mortality review proceedings. A person who presented information before the review panel, or who is a member of the review panel, must not be prevented from testifying on matters about which they have knowledge, but the person cannot be questioned about the information they presented at the mortality review panel, or the opinions formed by the person as a result of the child mortality review.

CRITERIA FOR PUBLIC DISCLOSURE

Generally, the commissioner of the Department of Human Services cannot disclose to the public information that would be classified as confidential or private data by the Minnesota Government Data Practices Act. This includes much of the data collected or maintained by a Child Mortality Review Panel.

However, in accordance with Minnesota Statutes, section 256.01, subdivision 12, the commissioner **may** disclose:

- Conclusions of the child mortality review, and
- Local social services agency data under the provisions in Minnesota Statutes, section 626.556, subdivision 11d, if that agency provided services to the family prior to the date of the child's death or near-fatality, **and**
  - A person was criminally charged with having caused the child's death or near-fatality, **or**
  - The county attorney certifies that the individual would have been charged with having caused the child's death or near-fatality, except for that person's death.

Minnesota Statutes, section 626.556, subdivision 11d, **requires** that the local social services agency disclose upon request, the findings and information related to a child's death or near fatality **only** under one of the following conditions:

- An individual is criminally charged with having caused the child's death or near-fatality, **or**
- A county attorney certifies that the individual would have been charged with having caused the child's death or near-fatality, except for that person's death.

A public agency or its employees acting in good faith in disclosing or declining to disclose information under this section are immune from civil or criminal liability that might otherwise be incurred or imposed for that action.

Information to be disclosed

If disclosure is required under Minnesota Statutes, section 626.556, subdivision 11d, the findings and information disclosed consists of a written summary that is limited to the following information that the agency is able to provide:

- The dates, outcomes and results of any actions taken or social services provided.
- The results of any review of the state Child Mortality Review Panel, a local Child Mortality Review Panel, a local community child protection team, or any public agency.
- The confirmation of receipt of all reports of suspected child abuse, neglect, or maltreatment, regardless of whether the reports were accepted for assessment.
- The confirmation that child protection assessments/investigations were completed on the reports, the results of the assessments/investigations, a description of the most recent assessment/investigation, the services provided, and a statement of the agency's determination.

The public does **not** have access to:

- Private data in the custody of the state or local social services agency
- Records or content of any psychiatric, psychological or therapeutic evaluations
- Information that would reveal the identities of people who provided information related to suspected abuse, neglect or maltreatment of the child.

A person who requests public information, but is denied, may apply to the appropriate court for an order compelling disclosure of all or part of the findings and information from the public agency.

STATE CHILD MORTALITY REVIEW PANEL

The state's multi-disciplinary Child Mortality Review Panel is comprised of professionals with responsibility for serving or protecting children. The members are appointed by the commissioner of the Minnesota Department of Human Services and are considered to be "agents of the welfare system" as defined by the Minnesota Government Data Practices Act, Minnesota Statutes, section 13.46, subdivision 2(a)(4).

The state Child Mortality Review Panel will examine the information submitted by the county and the aggregate data on all child deaths and near-fatalities. The state panel will make

recommendations to the state and county agencies for improving the child protection system, including modifications in statute, rule, policy and procedure.

A report of the state review will be prepared for the commissioner. The department may request that the report's recommendations be considered by the local social services agencies and other appropriate agencies or associations suggesting ways to improve the system that protects children.

State child mortality review consultants

Two consultants have responsibility for coordinating the child mortality work through-out the state. Each consultant is responsible for approximately half of the counties in the state. For technical assistance regarding cases that require a local child mortality review, contact the consultant responsible for the county as listed below.

Northern region
Sue Krinkie (651) 431-4697

Aitkin
Anoka
Becker
Beltrami
Benton
Carleton
Cass
Chisago
Clay
Clearwater
Cook
Crow Wing
Douglas
Grant
Hennepin
Hubbard
Isanti
Itasca
(Northern region continued)
Kanabec
Kittson
Koochiching
Lake
Lake of the Woods
Mahnomen
Marshall
Mille Lacs
Morrison

Southern region
Ruth Clinard (651) 431-4696

Big Stone
Blue Earth
Brown
Carver
Chippewa
Cottonwood
Dakota
Dodge
Fairbault/Martin
Fillmore
Freeborn
Goodhue
Houston
Jackson
Kandiyohi
Lac Qui Parle
LeSueur
Lincoln/Lyon/Murray
(Southern region continued)
McLeod
Meeker
Mower
Nicollet
Nobles
Olmsted
Pipestone
Ramsey
Redwood

Norman
Otter Tail
Pennington
Pine
Polk
Pope
Red Lake
Roseau
St. Louis
Sherburne
Stearns
Stevens
Todd
Traverse
Wadena
Wilkin
Wright
Renville
Rice
Rock
Scott
Sibley
Steele
Swift
Wabasha
Waseca
Washington
Watonwan
Winona
Yellow Medicine

Special Needs

This information is available in other forms to people with disabilities by contacting us at (651) 431-4671 (voice), or through the Minnesota Relay Service at 711 or (800) 627-3529 (TDD), or (877) 627-3848 (speech-to-speech relay service).

Attachment A

CHILD MORTALITY LOG
Send this information to DHS to Ruth Clinard, Child Mortality Review Coordinator at **Ruth.A.Clinard@state.mn.us**
Or
Child Safety and Permanency Division
PO Box 64943
St. Paul, MN 55164-0943
Confidentiality must be maintained by sending this through the regular mail or state/county e-mail with secure encryption and the following e-mail suffix: **[sender's name]@co.[county name].mn.us**

County making this report:
[County]

☐ Death
☐ Near death
Date of death, or near death: ___/___/____
Date received: ___/___/____

Child's name	[Child_Name]	DOB:[Child_DOB]	SSN # [Child_SSN]
Case name	[WgName]	Workgroup Number: [WgNumber]	
Mother's name	[ParCst1Name]		
Father's name	[ParCst2Name]		
Date the agency became aware of death, or near death			
Date of this report			

Hospital where child was treated for the fatal, or near fatal injury:	
Hospitals with additional information:	
Law enforcement agency that investigated the death, or near death:	
Other law enforcement agencies with information on the family:	

Manner of death
☐ Homicide
☐ Suicide
☐ Accident
☐ SIDS
☐ Pending
☐ Undetermined
☐ Other, specify:

How did the death, or near death, happen?

Is the death, or near death, attributed to intra familial child maltreatment?	☐ Yes ☐ No
Did the incident leading to the death, or near death, occur in a licensed facility?	☐ Yes ☐ No

Type of facility:

☐ Family Day Care	☐ Center Based Day Care
☐ Foster Care	☐ Group Home
☐ Residential Treatment Program	☐ Chemical Dependency Treatment Program
☐ Residential Program for the Developmentally Disabled	☐ Other, specify:

Was there a child maltreatment investigation?	☐ Yes ☐ No

What were the findings of the child maltreatment investigation?

- ☐ Maltreatment determined - parents responsible
- ☐ Maltreatment determined - facility responsible
- ☐ Maltreatment determined - facility staff responsible
- ☐ Maltreatment determined - other responsible
  Specify:
- ☐ Maltreatment not determined
- ☐ Pending

Was a social services case open at the time of death, or near death?	☐ Yes ☐ No
Has the county ever provided social services to any member of the family?	☐ Yes ☐ No

If yes, list the social service programs open, the recipients, and the dates:

☐ Child Protection	From date: ___/___/____	To date: ___/___/____
Recipient name:	Relationship:	
Recipient name:	Relationship:	
☐ Child Welfare	From date: ___/___/____	To date: ___/___/____
Recipient name:	Relationship:	
Recipient name:	Relationship:	
☐ Chemical Dependency	From date: ___/___/____	To date: ___/___/____
Recipient name:	Relationship:	
Recipient name:	Relationship:	
☐ Adult Mental Health	From date: ___/___/____	To date: ___/___/____
Recipient name:	Relationship:	
Recipient name:	Relationship:	
☐ Child Mental Health	From date: ___/___/____	To date: ___/___/____
Recipient name:	Relationship:	
Recipient name:	Relationship:	
☐ Other, specify:	From date: ___/___/____	To date: ___/___/____
Recipient name:	Relationship:	
Recipient name:	Relationship:	

Person making this report: [SocialWorkerName]	
Title: [SocialWorkerTitle]	Phone: [SocialWorkerPhone]

Attachment B

Instructions to Locate the Child Mortality/Near Fatality Log (SSIS-80)

To locate the Child Mortality/Near-fatality Log form, also known as SSIS-80 in the Social Services Information System, use the following steps:

- Enter the SSIS system (can use any case name)
- Right click on the **Chronology** folder
- Select **New Document** from the drop down box
- Select **Document Category**
- Select **State: Child Protective Services**
- Select **Document Name**
- Select **Child Mortality Log** click to open the form

The form can be completed in a case that has been closed, in the event that a death occurs after a case was closed.

For additional assistance, contact the county SSIS coordinator or mentor. If necessary, the coordinator or mentor can contact the SSIS-Helpdesk for additional direction.

Minnesota Child Mortality and Near Fatality Review

Guide for the Local Child Mortality/Near-fatality Review and Format for Local Review Report

The commissioner of the Minnesota Department of Human Services established procedures for local child mortality reviews in the Child Mortality Review Panel administrative Rule 9560.0232, subpart 5, to review deaths and near-fatalities, including those attributed to maltreatment, or where maltreatment may be a contributing cause. The procedures include a requirement that the local review team meet to examine the cases and to submit a report of the review to the Department.

Purpose of the guide

This guide is designed with a dual purpose; to outline the local Child Mortality Review Team discussion during the local review meetings, and to provide a format for the written report of the review. Local review teams should discuss all documentation from the law enforcement investigation, full autopsy report, social services records, medical history, and any other relevant reports. The discussion of the facts related to the child's death from the perspective of the different disciplines represented on the local review team will generate the issues, findings, and recommendations to improve practice and policy in the child protection system. Recommendations for improvement in the child protection system may be made for any of the agencies that work in collaboration to protect children. Recommendations may be directed at both the state and local level.

Public Disclosure

All reports should be clearly written so they will be easily understood by someone not familiar with the county that created the report. Do not use abbreviations or acronyms. Individuals mentioned in the report should be identified by their role in the case (for example, the child-care provider, county attorney, absent parent, etc.) to ensure accurate understanding of the report.

Report Requirements

Minimally, all local child mortality review reports should include the following information:

County information

- Name of the county that conducted the local child mortality review
- Date of the local review.

Child's identifying information

- Child's name
- Birth date
- Date of incident causing near-fatal injury or condition

- Date of death
- City/county of residence
- City/county of death or near-fatal injury.

Sources of information
List all reports or supporting documentation used to inform the local review panel of the facts of the case. The list should minimally include the county social services records, law enforcement investigative reports, autopsy report and coroner or medical examiner investigation reports. If available, include the infant death investigation report, medical records, public health records, or other documents collected during the investigation relevant to the review of the child's death or near fatality.

Background information
Provide a brief summary of the circumstances surrounding the child's death or near-fatality. Explain what is known about how the child died or sustained the near-fatal injury or condition, and the relationship between the child and the person caring for the child when the incident occurred. Indicate if the death or near-fatality happened in a licensed or non-licensed child care facility. Include any relevant information about the caretaker's emotional health, developmental level, chemical use, or criminal history that might be factors that contributed to the situation. Include the cause and manner of death from the death certificate.

Social services history
Review of the relevant social services history is imperative to understanding the case and to conducting a thorough local and state child mortality review. The history should be part of the discussion during the case review, analysis and when determining recommendations.

Briefly summarize any services provided by the local social services agency or by a private agency under contract with the social services agency to the child or family prior to the child's death or near-fatal injury. Describe what was learned during the investigation conducted after the child's death.

The Child Mortality Review Team may discuss psychiatric and psychological conditions or therapeutic services information for the purpose of developing findings, conclusions and recommendations. However, the report written for public disclosure cannot include release of psychiatric, psychological or therapeutic evaluations, or the disclosure of information that would reveal the identity of the person who provided information related to suspected child maltreatment.

The Social Services History section of this report format was developed to include the information required in the statute regarding disclosure of findings and information. The notes written in italics under each bullet are suggestions for information that should be considered for that purpose.

- **Confirmation of the receipt of all reports accepted or not accepted by the local agency for assessment or investigation of suspected child maltreatment.**
  - *Date each child protection report was made and nature of allegation*
  - *Whether each report was assigned for a traditional investigation, Family Assessment response, or was screened out.*

- **Confirmation that investigations were conducted, the results of the investigations, a description of the most recent assessment or investigation and services rendered, and a statement of the basis for the agency's determination.**
  - *Describe the maltreatment determination for traditional investigation cases*
  - *Indicate whether services were provided following a family assessment response*

- **Provide the dates, outcomes/results of any actions taken or services rendered.**
  - *Indicate the child protection case status at the time of the child's death or near-fatal injury*
  - *Indicate whether services were needed following child protection investigation or family assessment of maltreatment allegations*
  - *Briefly summarize the services provided, the progress made, and the dates that services were initiated and concluded*
  - *Indicate whether a Child in Need of Protection or Services (CHIPS) petition was filed, and the dates the case was open in Juvenile Court*
  - *Indicate if criminal charges were filed, the dates, and charges that were filed, as well as outcomes.*

- **The results of any review by the local child protection team or any public agency.**
  - *Indicate recommendations for investigation/assessments or services developed by the local Child Protection Team prior to the death or near- fatality, and recommendations made by any public agency. (The results of the local child mortality review will be included in the "Results" and "Recommendations" section of this report.)*

Review of autopsy report

Provide a brief summary of the autopsy findings. If a second opinion of the child's cause and manner of death was obtained based on the autopsy report, provide information about the reason for the second opinion. If known, indicate who requested the second opinion (defense attorney, county attorney, coroner, or physician). Include a copy of the second opinion report along with the autopsy report.

Review of law enforcement investigation
Summarize the law enforcement investigation of the death or near-fatality. For children up to 24 months of age, use of the "Minnesota Infant Death Investigation Guidelines" is encouraged which can be a helpful tool to assess the circumstances preceding the death. If the investigation resulted in the filing of criminal charges, indicate what charges were filed and the dates and outcomes of the criminal charges.

Review of medical history
Summarize significant medical information about the victim of the fatality or near-fatality. Was there prior medical history that indicated previous injuries or suspicious injuries? Had there been prior medical intervention that addressed the condition (such as evaluation for poor weight gain or respiratory condition that may have been aggravated by the care the child received in their home)? Were statements made to medical staff inconsistent with the mechanism of injury or inconsistent with what was stated to the law enforcement investigator or child protection worker during the investigation?

Results of the local Child Mortality Review Panel
The results of the local child mortality review must include the local team's findings and conclusions, as well as recommendations for improvements in local or state laws, rules, training and procedures.

The **findings** are statements of facts relevant to the case under review that:

- Accounts for the agency's activities regarding the items listed in the Social Services History section (above)
- Identifies circumstances or constraints which may have caused the agency to follow a non-standard protocol
- Describes information from other institutions or agencies that was not present in the local social services agency's case record
- Provides other information the local agency deems important for a full understanding of the events in the case.

Conclusions are drawn from the facts collected and reviewed by the panel to explore how to improve the system at both the state and local levels. The goal of this process is to learn from the comprehensive local review to prevent a future death or serious injury to a child. This is accomplished by:

- Exploring how agencies communicated and coordinated services provided and examining if there were areas that should be strengthened
- Analyzing whether existing policies created a barrier to effective intervention
- Examining whether the agencies involved in providing services conformed to law, rule or local procedures
- Assessing whether the services provided were appropriate for the needs of the family

Recommendations for improvements in local or state laws, rules, training or procedures should be a direct result of the conclusions made during the local review. Recommendations may identify prevention efforts that can be implemented locally or statewide.

Use of Local Child Mortality Review Reports

The report of the local child mortality review is used by the state Mortality Review Panel to identify patterns and trends in cases throughout the state that involve child deaths or near-fatalities. The report is used to collect data that is compiled on an aggregate basis. The data is analyzed to identify patterns that indicate the need for improvements in the child protection system, and also used to support recommendations made to Department administration or the state legislature.

Documentation Used to Inform the Local Review Team

When submitting the local child mortality review report, the county must also include copies of the reports or written documentation used to inform the local child mortality review team. Documents can include law enforcement investigative reports, autopsy report, social services documentation, medical records, and all other reports used in the local review. When available, a copy of the "Minnesota Infant Death Investigation Form," should also be included.