

## 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	<input type="checkbox"/> Pending
<input type="checkbox"/> Homicide	<input type="checkbox"/> Undetermined
<input type="checkbox"/> Suicide	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Accident	
<input type="checkbox"/> SIDS	
How did the death, or near death, happen?	

Is the death, or near death, attributed to intra familial child maltreatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the incident leading to the death, or near death, occur in a licensed facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of facility:	
<input type="checkbox"/> Family Day Care	<input type="checkbox"/> Center Based Day Care
<input type="checkbox"/> Foster Care	<input type="checkbox"/> Group Home
<input type="checkbox"/> Residential Treatment Program	<input type="checkbox"/> Chemical Dependency Treatment Program
<input type="checkbox"/> Residential Program for the Developmentally Disabled	<input type="checkbox"/> Other, specify:
Was there a child maltreatment investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What were the findings of the child maltreatment investigation?	
<input type="checkbox"/> Maltreatment determined - parents responsible	
<input type="checkbox"/> Maltreatment determined - facility responsible	
<input type="checkbox"/> Maltreatment determined - facility staff responsible	
<input type="checkbox"/> Maltreatment determined - other responsible	
Specify:	
<input type="checkbox"/> Maltreatment not determined	
<input type="checkbox"/> Pending	

Was a social services case open at the time of death, or near death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the county ever provided social services to any member of the family? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list the social service programs open, the recipients, and the dates:	
<input type="checkbox"/> Child Protection	From date: ____/____/____ To date: ____/____/____
Recipient name:	Relationship:
Recipient name:	Relationship:
<input type="checkbox"/> Child Welfare	From date: ____/____/____ To date: ____/____/____
Recipient name:	Relationship:
Recipient name:	Relationship:
<input type="checkbox"/> Chemical Dependency	From date: ____/____/____ To date: ____/____/____
Recipient name:	Relationship:
Recipient name:	Relationship:
<input type="checkbox"/> Adult Mental Health	From date: ____/____/____ To date: ____/____/____
Recipient name:	Relationship:
Recipient name:	Relationship:
<input type="checkbox"/> Child Mental Health	From date: ____/____/____ To date: ____/____/____
Recipient name:	Relationship:
Recipient name:	Relationship:
<input type="checkbox"/> Other, specify:	From date: ____/____/____ To date: ____/____/____
Recipient name:	Relationship:
Recipient name:	Relationship:

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