Attachment C

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.