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]