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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 5033

03/18/2024 Authored by Pinto
The bill was read for the first time and referred to the Committee on Children and Families Finance and Policy
03/25/2024 Adoption of Report: Re-referred to the Committee on Ways and Means
04/02/2024 By motion, recalled and re-referred to the Committee on Judiciary Finance and Civil Law
04/15/2024 Adoption of Report: Amended and re-referred to the Committee on Children and Families Finance and Policy
Pursuant to Joint Rule 2.03, re-referred to the Committee on Rules and Legislative Administration

A bill for an act

relating to human services; establishing a child fatality and near fatality review process and a Supreme Court council on child protection; requiring reports; appropriating money; amending Minnesota Statutes 2023 Supplement, section 256.01, subdivision 12b; proposing coding for new law in Minnesota Statutes, chapter 260E; repealing Minnesota Statutes 2022, section 256.01, subdivisions 12, 12a; Minnesota Rules, part 9560.0232, subpart 5.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2023 Supplement, section 256.01, subdivision 12b, is amended to read:

Subd. 12b. **Department of Human Services systemic critical incident review team.** (a) The commissioner may establish a Department of Human Services systemic critical incident review team to review (1) critical incidents reported as required under section 626.557 for which the Department of Human Services is responsible under section 626.5572, subdivision 13; chapter 245D; or Minnesota Rules, chapter 9544; or (2) child fatalities and near fatalities that occur in licensed facilities and are not due to natural causes. When reviewing a critical incident, the systemic critical incident review team shall identify systemic influences to the incident rather than determine the culpability of any actors involved in the incident. The systemic critical incident review may assess the entire critical incident process from the point of an entity reporting the critical incident through the ongoing case management process. Department staff shall lead and conduct the reviews and may utilize county staff as reviewers. The systemic critical incident review process may include but is not limited to:

2.1 (1) data collection about the incident and actors involved. Data may include the relevant
2.2 critical services; the service provider's policies and procedures applicable to the incident;
2.3 the community support plan as defined in section 245D.02, subdivision 4b, for the person
2.4 receiving services; or an interview of an actor involved in the critical incident or the review
2.5 of the critical incident. Actors may include:

2.6 (i) staff of the provider agency;

2.7 (ii) lead agency staff administering home and community-based services delivered by
2.8 the provider;

2.9 (iii) Department of Human Services staff with oversight of home and community-based
2.10 services;

2.11 (iv) Department of Health staff with oversight of home and community-based services;

2.12 (v) members of the community including advocates, legal representatives, health care
2.13 providers, pharmacy staff, or others with knowledge of the incident or the actors in the
2.14 incident; and

2.15 (vi) staff from the Office of the Ombudsman for Mental Health and Developmental
2.16 Disabilities and the Office of Ombudsman for Long-Term Care;

2.17 (2) systemic mapping of the critical incident. The team conducting the systemic mapping
2.18 of the incident may include any actors identified in clause (1), designated representatives
2.19 of other provider agencies, regional teams, and representatives of the local regional quality
2.20 council identified in section 256B.097; and

2.21 (3) analysis of the case for systemic influences.

2.22 Data collected by the critical incident review team shall be aggregated and provided to
2.23 regional teams, participating regional quality councils, and the commissioner. The regional
2.24 teams and quality councils shall analyze the data and make recommendations to the
2.25 commissioner regarding systemic changes that would decrease the number and severity of
2.26 critical incidents in the future or improve the quality of the home and community-based
2.27 service system.

2.28 (b) Cases selected for the systemic critical incident review process shall be selected by
2.29 a selection committee among the following critical incident categories:

2.30 (1) cases of caregiver neglect identified in section 626.5572, subdivision 17;

2.31 (2) cases involving financial exploitation identified in section 626.5572, subdivision 9;

2.32 (3) incidents identified in section 245D.02, subdivision 11;

3.1 (4) behavior interventions identified in Minnesota Rules, part 9544.0110;

3.2 (5) service terminations reported to the department in accordance with section 245D.10,
3.3 subdivision 3a; and

3.4 (6) other incidents determined by the commissioner.

3.5 (c) The systemic critical incident review under this section shall not replace the process
3.6 for screening or investigating cases of alleged maltreatment of an adult under section 626.557
3.7 or of a child under chapter 260E. The department may select cases for systemic critical
3.8 incident review, under the jurisdiction of the commissioner, reported for suspected
3.9 maltreatment and closed following initial or final disposition.

3.10 (d) The proceedings and records of the review team are confidential data on individuals
3.11 or protected nonpublic data as defined in section 13.02, subdivisions 3 and 13. Data that
3.12 document a person's opinions formed as a result of the review are not subject to discovery
3.13 or introduction into evidence in a civil or criminal action against a professional, the state,
3.14 or a county agency arising out of the matters that the team is reviewing. Information,
3.15 documents, and records otherwise available from other sources are not immune from
3.16 discovery or use in a civil or criminal action solely because the information, documents,
3.17 and records were assessed or presented during proceedings of the review team. A person
3.18 who presented information before the systemic critical incident review team or who is a
3.19 member of the team shall not be prevented from testifying about matters within the person's
3.20 knowledge. In a civil or criminal proceeding, a person shall not be questioned about opinions
3.21 formed by the person as a result of the review.

3.22 (e) By October 1 of each year, the commissioner shall prepare an annual public report
3.23 containing the following information:

3.24 (1) the number of cases reviewed under each critical incident category identified in
3.25 paragraph (b) and a geographical description of where cases under each category originated;

3.26 (2) an aggregate summary of the systemic themes from the critical incidents examined
3.27 by the critical incident review team during the previous year;

3.28 (3) a synopsis of the conclusions, incident analyses, or exploratory activities taken in
3.29 regard to the critical incidents examined by the critical incident review team; and

3.30 (4) recommendations made to the commissioner regarding systemic changes that could
3.31 decrease the number and severity of critical incidents in the future or improve the quality
3.32 of the home and community-based service system.

3.33 **EFFECTIVE DATE.** This section is effective July 1, 2025.

4.1 Sec. 2. **[260E.39] CHILD FATALITY AND NEAR FATALITY REVIEW.**

4.2 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have
4.3 the meanings given.

4.4 (b) "Critical incident" means a child fatality or near fatality in which maltreatment was
4.5 a known or suspected contributing cause.

4.6 (c) "Joint review" means the critical incident review conducted by the child mortality
4.7 review panel jointly with the local review team under subdivision 4, paragraph (b).

4.8 (d) "Local review" means the local critical incident review conducted by the local review
4.9 team under subdivision 4, paragraph (c).

4.10 (e) "Local review team" means a local child mortality review team established under
4.11 subdivision 2.

4.12 (f) "Panel" means the child mortality review panel established under subdivision 3.

4.13 Subd. 2. **Local child mortality review teams.** (a) Each county shall establish a
4.14 multidisciplinary local child mortality review team and shall participate in local critical
4.15 incident reviews that are based on safety-science principles to support a culture of learning.
4.16 The local welfare agency's child protection team may serve as the local review team. The
4.17 local review team shall include but not be limited to professionals with knowledge of the
4.18 critical incident being reviewed.

4.19 (b) The local review team shall conduct reviews of critical incidents jointly with the
4.20 child mortality review panel or as otherwise required under subdivision 4, paragraph (c).

4.21 Subd. 3. **Child mortality review panel; establishment and membership.** (a) The
4.22 commissioner shall establish a child mortality review panel to review critical incidents
4.23 attributed to child maltreatment. The purpose of the panel is to identify systemic changes
4.24 to improve child safety and well-being and recommend modifications in statute, rule, policy,
4.25 and procedure.

4.26 (b) The panel shall consist of:

4.27 (1) the commissioner of children, youth, and families, or a designee;

4.28 (2) the commissioner of human services, or a designee;

4.29 (3) the commissioner of health, or a designee;

4.30 (4) the commissioner of education, or a designee;

4.31 (5) a judge, appointed by the Minnesota judicial branch; and

5.1 (6) other members appointed by the governor, including but not limited to:

5.2 (i) a physician who is a medical examiner;

5.3 (ii) a physician who is a child abuse specialist pediatrician;

5.4 (iii) a county attorney who works on child protection cases;

5.5 (iv) two current child protection supervisors for local welfare agencies, each of whom
5.6 has previous experience as a frontline child protection worker;

5.7 (v) a current local welfare agency director who has previous experience as a frontline
5.8 child protection worker or supervisor;

5.9 (vi) two current child protection supervisors or directors for Tribal child welfare agencies,
5.10 each of whom has previous experience as a frontline child protection worker or supervisor;

5.11 (vii) a county public health worker; and

5.12 (viii) a member representing law enforcement.

5.13 (c) The governor shall designate one member as chair of the panel from the members
5.14 listed in paragraph (b), clauses (5) and (6).

5.15 (d) Members of the panel shall serve terms of four years for an unlimited number of
5.16 terms. A member of the panel may be removed by the authority responsible for appointing
5.17 the member.

5.18 (e) The commissioner shall employ an executive director for the panel to:

5.19 (1) provide administrative support to the panel and the chair, including providing the
5.20 panel with critical incident notices submitted by local welfare agencies;

5.21 (2) compile and synthesize information for the panel;

5.22 (3) draft recommendations and reports for the panel's final approval; and

5.23 (4) conduct or otherwise direct training and consultation under subdivision 7.

5.24 Subd. 4. **Critical incident review process.** (a) A local welfare agency that has determined
5.25 that maltreatment was the cause of or a contributing factor in a critical incident must notify
5.26 the commissioner and the executive director of the panel within three business days of
5.27 making the determination.

5.28 (b) The panel shall conduct a joint review with the local review team for:

6.1 (1) any critical incident relating to a family, child, or caregiver involved in a local welfare
6.2 agency family assessment or investigation within the 12 months preceding the critical
6.3 incident;

6.4 (2) a critical incident the governor or commissioner directs the panel to review; and

6.5 (3) any other critical incident the panel chooses for review.

6.6 (c) The local review team must review all critical incident cases not subject to joint
6.7 review under paragraph (b).

6.8 (d) Within 120 days of initiating a joint review or local review of a critical incident,
6.9 except as provided under paragraph (h), the panel or local review team shall complete the
6.10 joint review or local review and compile a report. The report must include any systemic
6.11 learnings that may increase child safety and well-being and may include policy or practice
6.12 considerations for systems changes that may improve child well-being and safety.

6.13 (e) A local review team must provide its report following a local review to the panel
6.14 within three business days after the report is complete. After receiving the local review team
6.15 report, the panel may conduct a further joint review.

6.16 (f) Following the panel's joint review or after receiving a local review team report, the
6.17 panel may make recommendations to any state or local agency, branch of government, or
6.18 system partner to improve child safety and well-being.

6.19 (g) The commissioner shall conduct additional information gathering as requested by
6.20 the panel or the local review team. The commissioner must conduct information gathering
6.21 for all cases for which the panel requests assistance. The commissioner shall compile a
6.22 summary report for each critical incident for which information gathering is conducted and
6.23 provide the report to the panel and the local welfare agency that reported the critical incident.

6.24 (h) If the panel or local review team requests information gathering from the
6.25 commissioner, the panel or local review team may conduct the joint review or local review
6.26 and compile its report under paragraph (d) after receiving the commissioner's summary
6.27 information gathering report. The timeline for a local or joint review under paragraph (d)
6.28 may be extended if the panel or local review team requests additional information gathering
6.29 to complete their review. If the local review team extends the timeline for its review and
6.30 report, the local welfare agency must notify the executive director of the panel of the
6.31 extension and the expected completion date.

6.32 (i) The review of any critical incident shall proceed as specified in this section, regardless
6.33 of the status of any pending litigation or other active investigation.

7.1 Subd. 5. **Critical incident reviews; data practices and immunity.** (a) In conducting
7.2 reviews, the panel, the local review team, and the commissioner shall have access to not
7.3 public data under chapter 13 maintained by state agencies, statewide systems, or political
7.4 subdivisions that are related to the child's critical incident or circumstances surrounding the
7.5 care of the child. The panel, the local review team, and the commissioner shall also have
7.6 access to records of private hospitals as necessary to carry out the duties prescribed by this
7.7 section. A state agency, statewide system, or political subdivision shall provide the data
7.8 upon request from the commissioner. Not public data may be shared with members of the
7.9 panel, a local review team, or the commissioner in connection with an individual case.

7.10 (b) Notwithstanding the data's classification in the possession of any other agency, data
7.11 acquired by a local review team, the panel, or the commissioner in the exercise of their
7.12 duties are protected nonpublic or confidential data as defined in section 13.02 but may be
7.13 disclosed as necessary to carry out the duties of the review team, panel, or commissioner.
7.14 The data are not subject to subpoena or discovery.

7.15 (c) The commissioner shall disclose information regarding a critical incident upon request
7.16 but shall not disclose data classified as confidential or private data on decedents under
7.17 section 13.10 or private, confidential, or protected nonpublic data in the disseminating
7.18 agency, except that the commissioner may disclose local social services agency data as
7.19 provided in section 260E.35 on individual cases involving a critical incident with a person
7.20 served by the local social services agency prior to the date of the critical incident.

7.21 (d) A person attending a local review team or child mortality review panel meeting shall
7.22 not disclose what transpired at the meeting except to carry out the purposes of the local
7.23 review team or panel. The commissioner shall not disclose what transpired during the
7.24 information gathering process except to carry out the duties of the commissioner. The
7.25 proceedings and records of the local review team, the panel, and the commissioner are
7.26 protected nonpublic data as defined in section 13.02, subdivision 13, and are not subject to
7.27 discovery or introduction into evidence in a civil or criminal action. Information, documents,
7.28 and records otherwise available from other sources are not immune from discovery or use
7.29 in a civil or criminal action solely because they were presented during proceedings of the
7.30 local review team, the panel, or the commissioner.

7.31 (e) A person who presented information before the local review team, the panel, or the
7.32 commissioner or who is a member of the local review team or the panel, or an employee
7.33 conducting information gathering as designated by the commissioner, shall not be prevented
7.34 from testifying about matters within the person's knowledge. However, in a civil or criminal
7.35 proceeding, a person may not be questioned about the person's presentation of information

8.1 to the local review team, the panel, or the commissioner, or about the information reviewed
8.2 or discussed during a critical incident review or the information gathering process, any
8.3 conclusions drawn or recommendations made related to information gathering or a critical
8.4 incident review, or opinions formed by the person as a result of the panel or review team
8.5 meetings.

8.6 (f) A person who presented information before the local review team, the panel, or the
8.7 commissioner, or who is a member of the local review team or the panel, or an employee
8.8 conducting information gathering as designated by the commissioner, is immune from any
8.9 civil or criminal liability that might otherwise result from the person's presentation or
8.10 statements if the person was acting in good faith and assisting with information gathering
8.11 or in a critical incident review under this section.

8.12 Subd. 6. **Child mortality review panel; annual report.** Beginning December 15, 2026,
8.13 and on or before December 15 annually thereafter, the commissioner shall publish a report
8.14 of the child mortality review panel. The report shall include, but not be limited to
8.15 de-identified summary data on the number of critical incidents reported to the panel, the
8.16 number of critical incidents reviewed by the panel and local review teams, and systemic
8.17 learnings identified by the panel or local review teams during the period covered by the
8.18 report. The report shall also include recommendations on improving the child protection
8.19 system, including modifications to statutes, rules, policies, and procedures. The panel may
8.20 make recommendations to the legislature or any state or local agency at any time outside
8.21 of the annual report.

8.22 Subd. 7. **Local welfare agency critical incident review training.** The commissioner
8.23 shall provide training and support to local review teams and the panel to assist with local
8.24 or joint review processes and procedures. The commissioner shall also provide consultation
8.25 to local review teams and the panel conducting local or joint reviews pursuant to this section.

8.26 Subd. 8. **Culture of learning and improvement.** Local review teams and the panel
8.27 shall advance and support a culture of learning and improvement within Minnesota's child
8.28 welfare system.

8.29 **EFFECTIVE DATE.** This section is effective July 1, 2025.

8.30 Sec. 3. **SUPREME COURT COUNCIL ON CHILD PROTECTION.**

8.31 Subdivision 1. **Establishment.** The chief justice of the supreme court is invited to
8.32 establish a Supreme Court Council on Child Protection as part of Minnesota's Court
8.33 Improvement Program, the Children's Justice Initiative, authorized under Public Law

9.1 116-260, Division CC, title III, section 305, of the Consolidated Appropriations Act of
9.2 2021, to develop a comprehensive blueprint to improve Minnesota's child protection system.

9.3 Subd. 2. **Membership.** The council must consist of the following members:

9.4 (1) the chief justice of the supreme court or a designee;

9.5 (2) at least one representative of the executive branch, appointed by the governor;

9.6 (3) two members of the legislature, one appointed by the speaker of the house or the
9.7 senate majority leader and one appointed by the minority leader of the house of
9.8 representatives or senate minority leader;

9.9 (4) members representing Indian Tribes, appointed by the executive board of the
9.10 Minnesota Indian Affairs Council;

9.11 (5) professionals, including law enforcement officers, with substantial experience
9.12 responding to reports of child maltreatment, appointed by the chief justice of the supreme
9.13 court;

9.14 (6) professionals with experience providing child protective services, foster care, adoption
9.15 services, and postpermanency services, appointed by the chief justice of the supreme court;

9.16 (7) legal professionals and guardians ad litem with significant experience in juvenile
9.17 protection matters, appointed by the chief justice of the supreme court;

9.18 (8) educational professionals, including professionals with experience in early childhood
9.19 education and providing educational services to children with disabilities, appointed by the
9.20 chief justice of the supreme court;

9.21 (9) professionals from nonprofit community organizations with experience providing
9.22 services and supports to children, parents, and relatives involved in child maltreatment and
9.23 juvenile protection matters, appointed by the chief justice of the supreme court;

9.24 (10) professionals with expertise on childhood trauma and adverse childhood experiences,
9.25 appointed by the chief justice of the supreme court;

9.26 (11) professionals with expertise providing services to persons with disabilities involved
9.27 with the child protection system, appointed by the chief justice of the supreme court; and

9.28 (12) persons with lived experience as a parent or child involved with the child protection
9.29 system, appointed by the chief justice of the supreme court.

9.30 Subd. 3. **Organization and administration.** (a) The council is governed by Minnesota
9.31 Statutes, section 15.059, except that subdivision 6 does not apply. The state court

10.1 administrator must provide the council with staff support, office and meeting space, and
10.2 access to office equipment and services.

10.3 (b) Council members serve at the pleasure of the appointing authority. The chief justice
10.4 of the supreme court must select a chair from among the members. The council may select
10.5 other officers, subcommittees, and work groups as it deems necessary.

10.6 Subd. 4. **Meetings.** (a) The council must meet at the call of the chair.

10.7 (b) The chair must convene the council's first meeting, which must occur by September
10.8 15, 2024.

10.9 Subd. 5. **Duties.** The council must develop a comprehensive blueprint that addresses all
10.10 aspects of the child protection system by:

10.11 (1) reviewing policies, laws, practices, latest research, and data related to children in the
10.12 child protection system;

10.13 (2) gathering information through surveys or focus groups, including consultation with
10.14 individuals who have lived experience with the child protection system; and

10.15 (3) making recommendations for improvements in policies and law that improve outcomes
10.16 for children.

10.17 Subd. 6. **Reports.** By January 15, 2025, the Supreme Court Council on Child Protection
10.18 must submit a progress report on the council's duties under subdivision 5 to the governor,
10.19 the chief justice of the supreme court, and the chairs and ranking minority members of the
10.20 legislative committees with jurisdiction over child protection. By January 15, 2026, the
10.21 council must submit its final report to the governor, the chief justice of the supreme court,
10.22 and the chairs and ranking minority members of the legislative committees with jurisdiction
10.23 over child protection, detailing the comprehensive blueprint developed under subdivision
10.24 5.

10.25 Subd. 7. **Expiration.** The Supreme Court Council on Child Protection expires upon the
10.26 submission of its final report under subdivision 6.

10.27 Sec. 4. **APPROPRIATION; SUPREME COURT COUNCIL ON CHILD**
10.28 **PROTECTION.**

10.29 $800,000 in fiscal year 2025 is appropriated from the general fund to the supreme court
10.30 for the establishment and administration of the Supreme Court Council on Child Protection.
10.31 This is a onetime appropriation and is available until June 30, 2026.

11.1 Sec. 5. **REPEALER.**

11.2 (a) Minnesota Statutes 2022, section 256.01, subdivisions 12 and 12a, are repealed.

11.3 (b) Minnesota Rules, part 9560.0232, subpart 5, is repealed.

11.4 **EFFECTIVE DATE.** This section is effective July 1, 2025.

256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

Subd. 12. **Child mortality review panel.** (a) The commissioner shall establish a child mortality review panel to review deaths of children in Minnesota, including deaths attributed to maltreatment or in which maltreatment may be a contributing cause and to review near fatalities as defined in section 260E.35. The commissioners of health, education, and public safety and the attorney general shall each designate a representative to the child mortality review panel. Other panel members shall be appointed by the commissioner, including a board-certified pathologist and a physician who is a coroner or a medical examiner. The purpose of the panel shall be to make recommendations to the state and to county agencies for improving the child protection system, including modifications in statute, rule, policy, and procedure.

(b) The commissioner may require a county agency to establish a local child mortality review panel. The commissioner may establish procedures for conducting local reviews and may require that all professionals with knowledge of a child mortality case participate in the local review. In this section, "professional" means a person licensed to perform or a person performing a specific service in the child protective service system. "Professional" includes law enforcement personnel, social service agency attorneys, educators, and social service, health care, and mental health care providers.

(c) If the commissioner of human services has reason to believe that a child's death was caused by maltreatment or that maltreatment was a contributing cause, the commissioner has access to not public data under chapter 13 maintained by state agencies, statewide systems, or political subdivisions that are related to the child's death or circumstances surrounding the care of the child. The commissioner shall also have access to records of private hospitals as necessary to carry out the duties prescribed by this section. Access to data under this paragraph is limited to police investigative data; autopsy records and 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 parent that relate to prenatal care; and records created by social service agencies that provided services to the child or family within three years preceding the child's death. A state agency, statewide system, or political subdivision shall provide the data upon request of the commissioner. Not public data may be shared with members of the state or local child mortality review panel in connection with an individual case.

(d) Notwithstanding the data's classification in the possession of any other agency, data acquired by a local or state child mortality review panel in the exercise of its duties is protected nonpublic or confidential data as defined in section 13.02, but may be disclosed as necessary to carry out the purposes of the review panel. The data is not subject to subpoena or discovery. The commissioner may disclose conclusions of the review panel, but shall not disclose data that was classified as confidential or private data on decedents, under section 13.10, or private, confidential, or protected nonpublic data in the disseminating agency, except that the commissioner may disclose local social service agency data as provided in section 260E.35, on individual cases involving a fatality or near fatality of a person served by the local social service agency prior to the date of death.

(e) A person attending a child mortality review panel meeting shall not disclose what transpired at the meeting, except to carry out the purposes of the mortality review panel. The proceedings and records of the mortality review panel are protected nonpublic data as defined in section 13.02, subdivision 13, and are not subject to discovery or introduction into evidence in a civil or criminal action against a professional, the state or a county agency, arising out of the matters the panel is reviewing. 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 proceedings of the review panel. A person who presented information before the review panel or who is a member of the panel shall not be prevented from testifying about matters within the person's knowledge. However, in a civil or criminal proceeding a person shall not be questioned about the person's presentation of information to the review panel or opinions formed by the person as a result of the review meetings.

Subd. 12a. **Department of Human Services child fatality and near fatality review team.** (a) The commissioner shall establish a Department of Human Services child fatality and near fatality review team to review child fatalities and near fatalities due to child maltreatment and child fatalities and near fatalities that occur in licensed facilities and are not due to natural causes. The review team shall assess the entire child protection services process from the point of a mandated reporter reporting the alleged maltreatment through the ongoing case management process. Department staff shall lead and conduct on-site local reviews and utilize supervisors from local county and tribal child welfare agencies as peer reviewers. The review process must focus on critical elements of the case and on the involvement of the child and family with the county or tribal child welfare agency.

The review team shall identify necessary program improvement planning to address any practice issues identified and training and technical assistance needs of the local agency. Summary reports of each review shall be provided to the state child mortality review panel when completed.

(b) A member of the child fatality and near fatality review team shall not disclose what transpired during the review, except to carry out the duties of the child fatality and near fatality review team. The proceedings and records of the child fatality and near fatality review team are protected nonpublic data as defined in section 13.02, subdivision 13, and are not subject to discovery or introduction into evidence in a civil or criminal action against a professional, the state, or a county agency arising out of the matters the team is reviewing. 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 assessed or presented during proceedings of the review team. A person who presented information before the review team or who is a member of the team shall not be prevented from testifying about matters within the person's knowledge. In a civil or criminal proceeding a person shall not be questioned about the person's presentation of information to the review team or opinions formed by the person as a result of the review.

9560.0232 ADMINISTRATIVE REQUIREMENTS.

Subp. 5. **Child mortality review panel.**

A. For purposes of this subpart, "local review panel" means a local multidisciplinary child mortality review panel.

B. Under the commissioner's authority in Minnesota Statutes, section 256.01, subdivision 12, paragraph (b), each county shall establish a local review panel and shall participate on the local review panel. The local agency's child protection team may serve as the local review panel. The local review panel shall require participation by professional representatives, including professionals with knowledge of the child mortality case being reviewed.

C. The local review panel shall:

(1) have access to not public data under Minnesota Statutes, section 256.01, subdivision 12, paragraph (c), maintained by state agencies, statewide systems, or political subdivisions that are related to a child's death or circumstances surrounding the care of the child;

(2) conduct a local review of the case within 60 days of the death of a child if:

(a) the death was caused by maltreatment;

(b) the manner of death was due to sudden infant death syndrome or was other than by natural causes, and the child was a member of a family receiving social services from a local agency, a member of a family that received social services during the year before the child's death, or a member of a family that was the subject of a child protection assessment; or

(c) the death occurred in a facility licensed by the department if the manner of death was by other than natural causes; and

(3) submit a report of the review to the department within 30 days of completing subitem (2).

A review may be delayed if there is pending litigation or an active assessment or investigation.

D. Under Minnesota Statutes, section 256.01, subdivision 12, paragraph (d):

(1) data acquired by the local review panel in the exercise of its duty is protected nonpublic or confidential data as defined in Minnesota Statutes, section 13.02, but may be disclosed as necessary to carry out the purposes of the local review panel. The data is not subject to subpoena or discovery; and

(2) the commissioner may disclose conclusions of the local review panel, but shall not disclose data classified as confidential or private on decedents under Minnesota Statutes, section 13.10, or data classified as private, confidential, or protected nonpublic in the disseminating agency.

E. Persons attending the local review panel meeting, members of the local review panel, persons who presented information to the local review panel, and all data, information, documents, and records pertaining to the local review panel must comply with the requirements under Minnesota Statutes, section 256.01, subdivision 12, paragraph (e).

F. When the department notifies the local agency that a state review will be conducted under Minnesota Statutes, section 256.01, subdivision 12, paragraph (a), the local agency shall submit a copy of the social services file within five working days.