SENATE
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S.F. No. 4877

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03/13/2024		Introduction and first reading
		Referred to Health and Human Services

A bill for an act

relating to child protection; modifying membership and requirements for the child mortality review panel; modifying the review process for child fatalities and near fatalities related to maltreatment; modifying the Department of Human Services child systemic critical incident review team requirements; establishing the critical incident public information portal; 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 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 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:

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

(i) staff of the provider agency;

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

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

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

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

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

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

(3) analysis of the case for systemic influences.

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

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

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

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

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

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

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

(6) other incidents determined by the commissioner.

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

(d) The proceedings and records of the review team are confidential data on individuals or protected nonpublic data as defined in section 13.02, subdivisions 3 and 13. Data that document a person's opinions formed as a result of the review 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 that 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 the information, documents, and records were assessed or presented during proceedings of the review team. A person who presented information before the systemic critical incident 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 opinions formed by the person as a result of the review.

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

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

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

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

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

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

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

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given:

(1) "critical incident" means a child fatality or near fatality that is attributed to maltreatment or in which maltreatment is a suspected contributing cause;

(2) "joint review" means the critical incident review conducted by the child mortality review panel jointly with the local review team under subdivision 4, paragraph (b);

(3) "local review" means the local critical incident review conducted by the local review team under subdivision 4, paragraph (d);

(4) "local review team" means a local child mortality review team established under subdivision 2; and

(5) "panel" means the child mortality review panel established under subdivision 3.

Subd. 2. **Local child mortality review teams.** (a) Each county shall establish a multidisciplinary local child mortality review team and shall participate in local critical incident reviews. The local welfare agency's child protection team may serve as the local review team. The local review team shall include but not be limited to professionals with knowledge of the critical incident being reviewed.

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

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

(b) The panel shall consist of:

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

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

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

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

(i) a physician who is a medical examiner;

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

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

(iv) a current frontline child protection worker for a local welfare agency;

(v) a current child protection supervisor for a local welfare agency, who has previous experience as a frontline child protection worker;

(vi) a county public health worker; and

(vii) a member representing law enforcement.

(c) The governor shall designate one member as chair of the panel from the members listed in paragraph (b), clauses (3) and (4).

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

(e) The commissioner shall employ an executive director for the panel to provide administrative support to the panel and the chair, compile and synthesize information for the panel, draft recommendations and reports for the panel's final approval, and conduct or otherwise direct training and consultation under subdivision 7.

Subd. 4. **Critical incident review process.** (a) When a critical incident occurs, the local welfare agency must report the critical incident to the executive director of the panel within 24 hours of when the local welfare agency receives notification of the critical incident. The local welfare agency must submit information and documentation related to the reported critical incident to the panel pursuant to guidance from the panel and continue to promptly provide such information and documentation to the panel as the critical incident investigation proceeds.

(b) The panel shall screen each critical incident reported by a local welfare agency under paragraph (a). The panel shall conduct a joint review with the local review team for:

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

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

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

(c) Within 120 days of initiating the joint review of a critical incident, except as provided under paragraph (h), the panel shall complete the joint review and compile a report. The report must:

(1) identify factors that led to the critical incident; and

(2) identify changes in policy or practice that would have reduced the likelihood of the critical incident occurring.

(d) All critical incidents not screened by the panel for joint review under paragraph (b) shall be referred to the local review team for a local critical incident review. The local review team shall complete its local review and report its findings and recommendations to the panel no later than 120 days from the notice of the critical incident. The local review team report must:

(1) identify factors that led to the critical incident; and

(2) identify changes in policy or practice that would have reduced the likelihood of the critical incident occurring.

(e) After receiving the local review team report, the panel may conduct a further review.

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

(g) The commissioner shall establish a child systemic critical incident review team that shall conduct additional fact gathering as requested by the panel. The commissioner must ensure that the child systemic critical incident review team conducts fact gathering for all cases for which the panel requests assistance. The child systemic critical incident review team shall compile a summary fact-finding report for each critical incident for which fact gathering is conducted and provide the report to the panel and the local welfare agency that reported the critical incident.

(h) If the panel requests fact gathering by the child systemic critical incident review team, the panel may conduct the joint review and compile its report under paragraph (c) after receiving the child systemic critical incident review team's summary report.

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

Subd. 5. **Critical incident reviews; data practices and immunity.** (a) In conducting reviews, the panel, the local review team, the child systemic critical incident review team, and the commissioner shall have access to not public data under chapter 13 maintained by state agencies, statewide systems, or political subdivisions that are related to the child's critical incident or circumstances surrounding the care of the child. The panel, the local review team, the child systemic critical incident review team, and the commissioner shall

also have access to records of private hospitals as necessary to carry out the duties prescribed by this section. A state agency, statewide system, or political subdivision shall provide the data upon request from the commissioner. Not public data may be shared with members of the panel, a local review team, or the child systemic critical incident review team in connection with an individual case.

(b) Notwithstanding the data's classification in the possession of any other agency, data acquired by a local review team, the panel, or the child systemic critical incident review team 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 team or panel. The data is not subject to subpoena or discovery.

(c) The commissioner shall disclose the information listed under subdivision 8 regarding a critical incident upon request 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 critical incident with a person served by the local social service agency prior to the date of the critical incident.

(d) A person attending a local review team or child mortality review panel meeting shall not disclose what transpired at the meeting except to carry out the purposes of the local review team or child mortality review panel. A member of the child systemic critical incident review team shall not disclose what transpired during its fact gathering process except to carry out the duties of the child systemic critical incident review team. The proceedings and records of the local review team, the panel, and the child systemic critical incident 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. 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 local review team, the panel, or the child systemic critical incident review team.

(e) A person who presented information before the local review team, the panel, or the child systemic critical incident review team or who is a member of the local review team, the panel, or the child systemic critical incident review team shall not be prevented from testifying about matters within the person's knowledge. However, in a civil or criminal proceeding, a person may not be questioned about the person's presentation of information to the local review team, the panel, or the child systemic critical incident review team, or

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

(f) A person who presented information before the local review team, the panel, or the child systemic critical incident review team or who is a member of the local review team, the panel, or the child systemic critical incident review team is immune from any civil or criminal liability that might otherwise result from the person's presentation or statements if the person was acting in good faith and assisting in a critical incident review or fact gathering under this section.

Subd. 6. **Child mortality review panel; annual report.** Beginning December 15, 2026, and on or before December 15 annually thereafter, the commissioner shall publish a report of the child mortality review panel. The report shall include de-identified summary data on cases reviewed and conclusions made by the panel in the preceding year, and recommendations on improving the child protection system, including modifications in statute, rule, policy, and procedure. The panel may make recommendations to the legislature or any state or local agency at any time, outside of its annual report.

Subd. 7. **Local welfare agency critical incident review training.** The commissioner shall provide training and support to local review teams to assist with local review processes and procedures. The commissioner shall also provide consultation to local review teams conducting local reviews pursuant to this section.

Subd. 8. **Critical incident public information portal.** The commissioner shall develop and maintain a critical incident public information portal to be publicly available on the commissioner's website. The portal shall provide real-time information and periodic updates on the status of the review of the critical incident. Publicly available information on the portal must include only:

(1) the county where the critical incident occurred, and the county of the child's residence, if different;

(2) the date of the critical incident;

(3) the date on which the county received notification of the critical incident;

(4) the child's age;

(5) the child's sex;

(6) whether the critical incident was a fatality or a near fatality;

(7) the type of review initiated in response to the critical incident and the status of the review;

(8) whether a criminal investigation related to the critical incident is pending or completed; and

(9) whether criminal charges have been filed related to the critical incident.

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

Sec. 3. **REPEALER.**

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

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

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.