Senator ..... moves to amend S.F. No. 4877 as follows:

Delete everything after the enacting clause and insert:

"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 or of a child under chapter 260E. 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 in which maltreatment was a known or 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 (c);

(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 that are based on safety science principles to support a culture of learning. 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 (c).

Subd. 3. **Child mortality review panel; establishment and membership.** (a) The commissioner shall establish a child mortality review panel to review critical incidents attributed 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) the commissioner of health, or a designee;

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

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

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

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

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

(vii) a county public health worker; and

(viii) 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 (5) and (6).

(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, including providing the panel with critical incident notices submitted by local welfare agencies; 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) A local welfare agency that has determined that maltreatment was the cause of or a contributing factor in a critical incident must notify the commissioner of children, youth, and families and the executive director of the panel within three business days of making the determination.

(b) 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 or commissioner directs the panel to review; and

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

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

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

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

(f) Following the panel's joint review or after 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 conduct additional information gathering as requested by the panel or the local review team. The commissioner must conduct information gathering for all cases for which the panel requests assistance. The commissioner shall compile a summary report for each critical incident for which information gathering is conducted and provide the report to the panel and the local welfare agency that reported the critical incident.

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

(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, 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, 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 commissioner 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 commissioner in the exercise of their duties is protected nonpublic or confidential data as defined in section 13.02 but may be disclosed as necessary to carry out the duties of the review team, panel, or commissioner. The data is not subject to subpoena or discovery.

(c) The commissioner shall disclose information 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 panel. The commissioner shall not disclose what transpired during its information gathering process except to carry out the duties of the commissioner. The proceedings and records of the local review team, the panel, and the commissioner 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 commissioner.

(e) A person who presented information before the local review team, the panel, or the commissioner or who is a member of the local review team or the panel, or an employee conducting information gathering as designated by the commissioner, 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 commissioner, or about the information reviewed or discussed during a critical incident review or the information gathering process, any conclusions drawn or recommendations made related to information gathering or a critical incident review, 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 commissioner, or who is a member of the local review team or the panel, or an employee conducting information gathering as designated by the commissioner, 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 with information gathering or in a critical incident review 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, but not be limited to de-identified summary data on the number of critical incidents reported to the panel, the number of critical incidents reviewed by the panel and local review teams, and systemic

learnings identified by the panel or local review teams, during the period covered by the report. The report shall also include recommendations on improving the child protection system, including modifications to 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 and the panel to assist with local or joint review processes and procedures. The commissioner shall also provide consultation to local review teams and the panel conducting local or joint reviews pursuant to this section.

Subd. 8. **Culture of learning and improvement.** The local review teams and panel shall advance and support a culture of learning and improvement within Minnesota's child welfare system.

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."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly