Bill Summary

H.F. 4697

As introduced

Subject	Child Mortality Review
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Overview

The child mortality review panel, established by the commissioner of human services under section 256.01, subdivision 12, reviews child fatalities and near fatalities attributed to or possibly caused by maltreatment. County agencies are also required to review such incidents through local child mortality review panels. This bill recodifies and makes extensive changes to the child mortality review panel and child fatality and near fatality review processes.

Summary

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1	**Department of Human Services systemic critical incident review team.** Amends § 256.01, subd. 12b. Adds child fatalities or near fatalities in licensed facilities to critical incidents to be reviewed by the systemic critical incident review team. Makes this section effective July 1, 2025.
2	**Child fatality and near fatality review.** Proposes coding for § 260E.39. Outlines new process for child fatality and near fatality reviews.

Subd. 1. Definitions. Defines "critical incident;" "joint review;" "local review;" "local review team;" and "panel" for purposes of this section.

Subd. 2. Local child mortality review teams. Requires each county to establish a multidisciplinary local child mortality review team, participate in local critical incident reviews, and conduct critical incident reviews jointly with the child mortality review panel.

Subd. 3. Child mortality review panel; establishment and membership. Paragraph (a) requires the commissioner to establish a child mortality review panel to review critical incidents related to child maltreatment, identify systemic changes to improve child safety, and recommend regulatory and policy changes.

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Paragraph (b) lists the members of the panel, and paragraph (c) requires the governor to appoint a chair. Paragraph (d) specifies member terms and removal procedures. Paragraph (e) requires the commissioner to employ an executive director for the panel, to provide administrative support and perform other listed duties.

Subd. 4. Critical incident review process. Outlines the critical incident review process. Paragraph (a) requires the local welfare agency to report the critical incident within 24 hours of when the agency receives notification, and submit information and documents to the panel.

Paragraph (b) requires the panel to screen each reported critical incident and conduct a joint review with the local review team for critical incidents that meet listed criteria. Paragraph (c) requires the panel to complete the joint review and compile a report within 120 days of initiating the joint review of a critical incident; specifies what the report must include.

Paragraph (d) specifies that all critical incidents not screened by the panel for review must be referred for a local critical incident review. Requires the local review team to complete its review and report its findings and recommendations to the panel within 120 days; specifies what the report must include. Paragraph (e) allows the panel to conduct a further review after receiving the local review team report.

Paragraph (f) allows the panel to make recommendations to any state or local agency, branch of government, or system partner to improve child safety and well-being.

Paragraph (g) requires the commissioner to establish a child systemic critical incident review team to conduct additional fact gathering at the request of the panel, and compile a summary fact-finding report for each critical incident for which the team conducts fact gathering. Paragraph (h) allows the panel to conduct its joint review and compile its report after receiving this summary fact-finding report.

Paragraph (i) requires critical incident reviews to proceed as specified in this section, regardless of the status of any pending litigation or active investigations.

Subd. 5. Critical incident reviews; data practices and immunity. Outlines access to not public data for entities involved in critical incident review processes. Specifies that data acquired by an entity involved in critical incident review is protected nonpublic or confidential data, and is not subject to subpoena or

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discovery; allows disclosure as necessary to carry out the purposes of the review team or panel.

Paragraph (c) requires the commissioner to disclose specified data upon request, but with specified limitations. Paragraph (d) outlines data disclosure prohibitions for meeting attendees and team members; specifies data classification for proceedings and records of review teams and the panel. Paragraph (e) prohibits a member of a review team or the panel or a person who presented information as part of a critical incident review from being prevented from testifying about matters within the person's knowledge; prohibits such a person from being questioned about participation in a critical incident review.

Paragraph (f) provides immunity from civil or criminal liability for specified persons, if acting in good faith and assisting in a critical incident review or fact gathering.

Subd. 6. Child mortality review panel; annual report. Requires the commissioner to publish an annual report of the child mortality review panel. Specifies contents of the report.

Subd. 7. Local welfare agency critical incident review training. Requires the commissioner to provide training, support, and consultation to local review teams.

Subd. 8. Critical incident public information portal. Requires the commissioner to develop and maintain a critical incident public information portal on the commissioner's website, that provides real-time information and updates on critical incident reviews. Lists information that must be made available on the portal.

Makes this section effective July 1, 2025.

3 **Repealer.**

Repeals section 256.01, subdivisions 12 and 12a (child mortality review panel; Department of Human Services child fatality and near fatality review team), and Minnesota Rules, part 9560.0232, subpart 5 (local child mortality review panel).

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