

STATE OF MAINE

—
IN THE YEAR OF OUR LORD
TWO THOUSAND AND THIRTEEN

—
H.P. 86 - L.D. 104

An Act To Amend the Laws Governing Public Records

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 1 MRSA §402, sub-§3, ¶Q, as amended by PL 2011, c. 149, §2, is further amended to read:

Q. Security plans, staffing plans, security procedures, architectural drawings or risk assessments prepared for emergency events that are prepared for or by or kept in the custody of the Department of Corrections or a county jail if there is a reasonable possibility that public release or inspection of the records would endanger the life or physical safety of any individual or disclose security plans and procedures not generally known by the general public. Information contained in records covered by this paragraph may be disclosed to state and county officials if necessary to carry out the duties of the officials, the Department of Corrections or members of the State Board of Corrections under conditions that protect the information from further disclosure; ~~and~~

Sec. 2. 1 MRSA §402, sub-§3, ¶R, as enacted by PL 2011, c. 149, §3, is amended to read:

R. Social security numbers in the possession of the Secretary of State; ~~and~~

Sec. 3. 1 MRSA §402, sub-§3, ¶S is enacted to read:

S. E-mail addresses obtained by a political subdivision of the State for the sole purpose of disseminating noninteractive notifications, updates and cancellations that are issued from the political subdivision or its elected officers to an individual or individuals that request or regularly accept these noninteractive communications.

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND THIRTEEN

H.P. 861 - L.D. 1216

An Act To Amend the Freedom of Access Act

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 1 MRSA §408-A, sub-§3, as enacted by PL 2011, c. 662, §5, is amended to read:

3. Acknowledgment; clarification; time estimate; cost estimate. The agency or official having custody or control of a public record shall acknowledge receipt of a request made according to this section within ~~a reasonable period of time~~, 5 working days of receiving the request and may request clarification concerning which public record or public records are being requested. ~~The~~ Within a reasonable time of receiving the request, the agency or official shall provide a good faith, nonbinding estimate of the time within which the agency or official will comply with the request, as well as a cost estimate as provided in subsection 9. The agency or official shall make a good faith effort to fully respond to the request within the estimated time.

Sec. 2. 1 MRSA §408-A, sub-§4, as enacted by PL 2011, c. 662, §5, is amended to read:

4. Refusals; denials. If a body or an agency or official having custody or control of any public record refuses permission to inspect or copy or abstract a public record, the body or agency or official shall provide written notice of the denial, stating the reason for the denial, within 5 working days of the receipt of the request for inspection or copying. Failure to comply with this subsection is considered failure to allow inspection or copying and is subject to appeal as provided in section 409.

Sec. 3. 1 MRSA §409, sub-§1, as amended by PL 2011, c. 559, Pt. A, §1 and c. 662, §6, is repealed and the following enacted in its place:

1. Records. Any person aggrieved by a refusal or denial to inspect or copy a record or the failure to allow the inspection or copying of a record under section 408-A may appeal the refusal, denial or failure within 30 calendar days of the receipt of the written notice of refusal, denial or failure to any Superior Court within the State as a trial de

novo. The agency or official shall file an answer within 14 calendar days. If a court, after a trial de novo, determines such refusal, denial or failure was not for just and proper cause, the court shall enter an order for disclosure. Appeals may be advanced on the docket and receive priority over other cases when the court determines that the interests of justice so require.

STATE OF MAINE

 IN THE YEAR OF OUR LORD

TWO THOUSAND AND THIRTEEN

 S.P. 566 - L.D. 1511
An Act Regarding Coordinated Access to Public Records of State Agencies**Be it enacted by the People of the State of Maine as follows:**

Sec. 1. 5 MRSA §200-I, sub-§2, ¶¶D and E, as enacted by PL 2007, c. 603, §1, are amended to read:

D. Furnish, upon request, advisory opinions regarding the interpretation of and compliance with the State's freedom of access laws to any person or public agency or official in an expeditious manner. The ombudsman may not issue an advisory opinion concerning a specific matter with respect to which a lawsuit has been filed under Title 1, chapter 13. Advisory opinions must be publicly available after distribution to the requestor and the parties involved; ~~and~~

E. Make recommendations concerning ways to improve public access to public records and proceedings; and

Sec. 2. 5 MRSA §200-I, sub-§2, ¶F is enacted to read:

F. Coordinate with the state agency public access officers the compilation of data through the development of a uniform log to facilitate record keeping and annual reporting of the number of requests for information, the average response time and the costs of processing requests.

Sec. 3. Development of centralized methods for public record requests; report. The Department of the Attorney General, with input from the Department of Administrative and Financial Services, Office of Information Technology and state agency public access officers as defined in the Maine Revised Statutes, Title 1, section 402, subsection 5, shall:

1. Review the current system used by state agencies for receiving and responding to requests for public records in accordance with Title 1, chapter 13, subchapter 1; and

2. Review the feasibility of developing a centralized system for coordinating the receipt of and response to requests to state agencies for public records in accordance with Title 1, chapter 13, subchapter 1.

A centralized system developed by the Department of the Attorney General must include a single website address, a single e-mail address and a directory for the public to use to make requests for public records of all state agencies. By January 5, 2014, the Department of the Attorney General shall submit to the Joint Standing Committee on Judiciary a report relating to the reviews under this section, including findings and recommendations and suggested statutory changes needed to implement the recommendations. The Joint Standing Committee on Judiciary may report out a bill relating to the subject matter of the report to the Second Regular Session of the 126th Legislature.

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND THIRTEEN

H.P. 250 - L.D. 345

An Act To Ensure the Confidentiality of Concealed Handgun Permit Holder Personal Information

Mandate preamble. This measure requires one or more local units of government to expand or modify activities so as to necessitate additional expenditures from local revenues but does not provide funding for at least 90% of those expenditures. Pursuant to the Constitution of Maine, Article IX, Section 21, 2/3 of all of the members elected to each House have determined it necessary to enact this measure.

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the lists of all holders of concealed handgun permits in the State, which include personal information of the permit holders such as name, full current address and often date of birth, will revert to being public on April 30, 2013; and

Whereas, the public dissemination of personal information of concealed handgun permit holders may subject a holder to possible identity theft and may put the holder's and the holder's family's well-being at risk; and

Whereas, public access to information about concealed handgun permits that does not include information that personally identifies permit holders is consistent with the underlying principles of the Freedom of Access Act relating to understanding and monitoring how the government carries out its responsibilities; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 25 MRSA §2006, as amended by PL 2011, c. 662, §15, is repealed and the following enacted in its place:

§2006. Access to information and proceedings

1. Application, refusals and collected information; proceedings. All applications for a permit to carry concealed handguns and documents made a part of the application, refusals and any information of record collected by the issuing authority during the process of ascertaining whether an applicant is of good moral character and meets the additional requirements of sections 2003 and 2005 are confidential and are not public records for the purposes of Title 1, chapter 13, subchapter 1. The applicant may waive this confidentiality by written notice to the issuing authority. All proceedings relating to the issuance, refusal, suspension or revocation of a permit to carry concealed handguns are not public proceedings under Title 1, chapter 13, unless otherwise requested by the applicant.

2. Permanent record of permit. The issuing authority shall make a permanent record of each permit to carry concealed handguns in a suitable book or file kept for that purpose. The record must include the information contained in the permit itself. The record is confidential except that the following information about each permit holder is not confidential and is a public record:

- A. The municipality of residence;
- B. The date the permit was issued; and
- C. The date the permit expires.

This subsection does not limit disclosure of confidential information for criminal justice purposes or permitting purposes to law enforcement officers and issuing authorities.

Sec. 2. Statistical information; plan; report. In order to provide meaningful statistical information about concealed handgun permits in this State, the Chief of the State Police shall prepare a plan that meets the requirements of this section. The Chief of the State Police shall submit a report to the Joint Standing Committee on Criminal Justice and Public Safety no later than January 15, 2014 that contains the plan along with any proposed implementing legislation. The Joint Standing Committee on Criminal Justice and Public Safety may report out legislation to the Second Regular Session of the 126th Legislature upon receipt of the report. The plan must include the following elements.

1. Statistical information. The plan must propose a process that results in the availability of statistical information about concealed handgun permits in this State. The information must include at a minimum the following data:

- A. About the permitting process:
 - (1) The number of permit applications;
 - (2) The number of permits issued;
 - (3) The number of applications refused or denied; and
 - (4) The number of suspensions and revocations; and
- B. About applicants and permit holders:
 - (1) Gender;

- (2) Age, in 5-year or 10-year ranges; and
- (3) Municipality or zip code of residence.

The proposal may include any additional data that may be useful in the analysis of concealed handgun permits and the issuing process, as long as personally identifying information about applicants or permit holders is not disclosed as a public record. The plan must include appropriate reporting periods.

2. Permit. The Chief of the State Police shall review the form of the permits used by issuing authorities and determine if a single model permit form would be desirable. The plan may include a model permit, which may include the integration of a photograph. The plan may recommend the use of a model permit as either advisory or mandatory for all issuing authorities.

3. Statewide information. The plan must include a process for identifying and collecting information from all issuing authorities to provide complete statewide statistical information as required in subsection 1. The Chief of the State Police shall invite issuing authorities to provide suggestions and comments. The plan may eliminate the responsibility of municipal issuing authorities to make information available to the public if the identical information is available from a central state source. The plan must provide for the public availability of statistical information and must provide for an annual report of statewide statistical information.

4. Additional information and recommendations. The Chief of the State Police may include in the report any additional information or recommendations that the chief determines may be useful to the Legislature in addressing issues concerning concealed handgun permits.

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect April 30, 2013.

APPROVED

February 19, 2013

BY GOVERNOR

CHAPTER

1

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND THIRTEEN

S.P. 214 - L.D. 576

**Resolve, To Protect Concealed Handgun Permit Information on a
Temporary Basis**

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the list of all holders of concealed handgun permits in the State is public, which includes personal information of the permit holders such as name, full current address and date of birth; and

Whereas, this resolve places a temporary moratorium on public access to such permanent records pending the Legislature's consideration of the issue; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Moratorium on access. Resolved: That, notwithstanding the Maine Revised Statutes, Title 25, section 2006, until April 30, 2013, a permanent record that is created by an issuing authority of a concealed handgun permit is confidential and may not be made available for public inspection or copying. Notwithstanding any provision of law to the contrary, this section applies to requests for information under the Freedom of Access Act that are pending on the effective date of this resolve. Notwithstanding this section, confidential information may be disclosed to law enforcement officers and issuing authorities for criminal justice and permitting purposes. After April 30, 2013, an application for a permit filed or granted on or after the effective date of this resolve and on or before April 30, 2013 will be governed by the law in effect on and after April 30, 2013; and be it further

Sec. 2. Repeal. Resolved: That this resolve is repealed on April 30, 2013.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPROVED

JUNE 18, 2013

BY GOVERNOR

CHAPTER

283

PUBLIC LAW

STATE OF MAINE

—
IN THE YEAR OF OUR LORD
TWO THOUSAND AND THIRTEEN

—
H.P. 438 - L.D. 619

**An Act To Prohibit the Sharing of Certain Personal Information by the
Department of the Secretary of State**

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 29-A MRSA §251, sub-§4 is enacted to read:

4. Confidentiality of e-mail addresses. If a person submits an e-mail address as part of the application process for a license or registration under this Title, the e-mail address is confidential and may not be disclosed to anyone outside the Department of the Secretary of State except for law enforcement officers or for purposes of court proceedings.

APPROVED

JUNE 10, 2013

BY GOVERNOR

CHAPTER

222

PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND THIRTEEN

H.P. 687 - L.D. 973

**An Act To Make Veterans' Property Tax Exemption Applications
Confidential**

Mandate preamble. This measure requires one or more local units of government to expand or modify activities so as to necessitate additional expenditures from local revenues but does not provide funding for at least 90% of those expenditures. Pursuant to the Constitution of Maine, Article IX, Section 21, 2/3 of all of the members elected to each House have determined it necessary to enact this measure.

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this legislation needs to take effect before the expiration of the 90-day period so that its provisions are in place to protect veterans as soon as possible; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 36 MRSA §653, sub-§1, ¶G, as amended by PL 1989, c. 501, Pt. Z, is further amended to read:

G. Any person who desires to secure exemption under this subsection shall make written application and file written proof of entitlement on or before the first day of April, in the year in which the exemption is first requested, with the assessors of the place in which the person resides. Notwithstanding Title 1, chapter 13, an application and proof of entitlement filed pursuant to this paragraph is confidential and may not be made available for public inspection. The assessors shall thereafter grant the exemption to any person who is so qualified and remains a resident of that place or until they are notified of reason or desire for discontinuance.

PL C. 222 p. 2

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

4.0.7

ONTP



126th MAINE LEGISLATURE

FIRST REGULAR SESSION-2013

Legislative Document

No. 19

S.P. 11

In Senate, January 15, 2013

An Act To Facilitate Access to Information by Legislators

Reference to the Committee on Judiciary suggested and ordered printed.

A handwritten signature in black ink, appearing to read 'D M Grant'.

DAREK M. GRANT
Secretary of the Senate

Presented by Senator CRAVEN of Androscoggin.

Cosponsored by Senators: LACHOWICZ of Kennebec, TUTTLE of York, Representatives:
CAREY of Lewiston, GOODE of Bangor.

4.8.8

ONTP



126th MAINE LEGISLATURE

FIRST REGULAR SESSION-2013

Legislative Document

No. 135

H.P. 110

House of Representatives, January 29, 2013

An Act To Require All Government Documents To Be Posted on the Internet

Reference to the Committee on Judiciary suggested and ordered printed.

Millicent M. MacFarland
MILLICENT M. MacFARLAND
Clerk

Presented by Representative BROOKS of Winterport.
Cosponsored by Senator GRATWICK of Penobscot and
Representatives: EVANGELOS of Friendship, FARNSWORTH of Portland, JONES of
Freedom, MORRISON of South Portland, SCHNECK of Bangor, STANLEY of Medway,
WINCHENBACH of Waldoboro.

4.D.10

1 **Be it enacted by the People of the State of Maine as follows:**

2 **Sec. 1. 1 MRSA §541, sub-§3** is enacted to read:

3 **3. Public record.** "Public record" has the same meaning as in section 402,
4 subsections 3, 3-A and 4.

5 **Sec. 2. 1 MRSA §543** is enacted to read:

6 **§543. Public records electronically available**

7 A public entity shall make all public records in the public entity's possession
8 available for viewing on a publicly accessible site on the Internet.

9 **Sec. 3. Maine Revised Statutes headnote amended; revision clause.** In the
10 Maine Revised Statutes, Title 1, chapter 14-A, in the chapter headnote, the words "notice
11 of information practices" are amended to read "information practices" and the Revisor of
12 Statutes shall implement this revision when updating, publishing or republishing the
13 statutes.

14 **SUMMARY**

15 This bill amends the laws concerning the information practices of public entities.
16 Current law defines "public entity" to include the Legislature; the Judicial Department; a
17 state agency or authority; the University of Maine System, the Maine Maritime Academy
18 and the Maine Community College System; a county, municipality or school district or
19 any regional or other political or administrative subdivision; and an advisory organization
20 established, authorized or organized by law or resolve or by executive order issued by the
21 Governor. This bill requires a public entity to make available on a publicly accessible
22 site on the Internet all public records in the possession of the public entity.

DNTP



126th MAINE LEGISLATURE

FIRST REGULAR SESSION-2013

Legislative Document

No. 495

S.P. 188

In Senate, February 19, 2013

An Act Regarding the Law Pertaining to the Confidentiality of Enhanced 9-1-1 System Information and Records

Submitted by the Department of Public Safety pursuant to Joint Rule 204.
Reference to the Committee on Energy, Utilities and Technology suggested and ordered
printed.

A handwritten signature in black ink, appearing to read 'Darek M. Grant'.

DAREK M. GRANT
Secretary of the Senate

Presented by Senator BURNS of Washington.
Cosponsored by Senator: VALENTINO of York.

A.D.12

1 **Be it enacted by the People of the State of Maine as follows:**

2 **Sec. 1. 25 MRSA §2921, sub-§4-A** is enacted to read:

3 **4-A. Emergency dispatch center.** "Emergency dispatch center" means a center that
4 dispatches emergency services in response to enhanced 9-1-1 requests for emergency
5 services.

6 **Sec. 2. 25 MRSA §2929**, as amended by PL 2011, c. 623, Pt. D, §1 and c. 662,
7 §16, is further amended to read:

8 **§2929. Confidentiality of system information and records**

9 **1. Definition.** As used in this section, "confidential information" means the
10 following information as contained in any database, report, audio recording or other such
11 record of the bureau or a public safety answering point or an emergency dispatch center
12 or as contained in any such record when in the custody of a criminal justice agency, as
13 defined in Title 16, section 611, subsection 4:

14 A. The names, addresses and telephone numbers of persons listed in E-9-1-1
15 databases;

16 B. ~~Names, addresses and telephone numbers that are~~ Customer information, as
17 described in Title 35-A, section 7501-B, that is omitted from a telephone utility
18 directory list at the request of a customer;

19 C. The name, address and telephone number of a caller to a public safety answering
20 point or emergency dispatch center; or

21 D. The name, address and telephone number of and any medical information about a
22 person receiving emergency services through the E-9-1-1 system.

23 **2. Confidentiality.** Confidential information may not be utilized for commercial
24 purposes and may not be disclosed in any manner except as follows:

25 A. A public safety answering point or an emergency dispatch center may disclose
26 confidential information to public or private safety agencies and emergency
27 responders for purposes of processing emergency calls and providing emergency
28 services;

29 B. A public safety answering point or an emergency dispatch center may disclose
30 confidential information to a ~~law enforcement officer or law enforcement~~ criminal
31 justice agency for the purpose of criminal investigations or criminal prosecutions
32 related to an E-9-1-1 call;

33 C. A public safety answering point or an emergency dispatch center may disclose
34 confidential information to designees of the bureau director for the purpose of system
35 maintenance and quality control; and

36 D. The bureau director may disclose confidential information to public safety
37 answering points, emergency dispatch centers, public or private safety agencies,

1 emergency responders or others within the E-9-1-1 system to the extent necessary to
2 implement and manage the E-9-1-1 system.

3 Confidential information that is required to be disclosed to providers of emergency
4 services and providers of emergency support services pursuant to 47 United States Code,
5 Section 222(g) remains subject to the confidentiality provisions of this section, and a
6 provider of emergency services and emergency support services that acquires such
7 confidential information pursuant to that provision of federal law may use the information
8 solely for the purposes of delivering or assisting in the delivery of emergency notification
9 services as defined in 47 United States Code, Section 222(h)(6). System databases,
10 including, but not limited to, those disclosed pursuant to 47 United States Code, Section
11 222(g), remain the property of the bureau pursuant to section 2926, subsection 6. The
12 name, address and telephone number of any person to whom any outgoing emergency
13 notification call is made using confidential information acquired pursuant to 47 United
14 States Code, Section 222(g) are confidential and may not be disclosed except as provided
15 in this section.

16 **3. Disclosure required.** The restrictions on disclosure provided under subsection 2
17 apply only to those portions of databases, reports, audio recordings or other such records
18 of the bureau ~~or~~, a public safety answering point or an emergency dispatch center that
19 contain confidential information. Other information that appears in those records and
20 other records, except information or records declared to be confidential under other law,
21 is subject to disclosure pursuant to Title 1, section 408-A. For the purposes of this
22 subsection, "information or records declared to be confidential under other law" includes,
23 but is not limited to, information or records that relate to a pending law enforcement
24 investigation or a pending criminal prosecution. Public access to such information or
25 records is governed by Title 15, Part 6 in the case of a pending investigation or
26 adjudication of a juvenile crime or by Title 16, section 614. The bureau shall develop
27 procedures to ensure protection of confidential records and information and public access
28 to other records and information. Procedures may involve developing edited copies of
29 records containing confidential information or the production of official summaries of
30 those records that contain the substance of all nonconfidential information.

31 **4. Audio recordings of E-9-1-1 calls; confidential.** Audio recordings of emergency
32 calls made to the E-9-1-1 system are confidential and may not be disclosed except as
33 provided in this subsection. Except as provided in subsection 2, information contained in
34 the audio recordings is public information and must be disclosed in transcript form in
35 accordance with subsection 3. The cost of preparing and disclosing information
36 contained in the audio recordings in transcript form is not subject to the limitation on
37 costs under Title 1, section 408-A, subsection 8. Subject to all the requirements of
38 subsection 2, the bureau ~~or~~, a public safety answering point or an emergency dispatch
39 center may disclose audio recordings of emergency calls made to the E-9-1-1 system in
40 the following circumstances:

- 41 A. To persons within the E-9-1-1 system to the extent necessary to implement and
42 manage the E-9-1-1 system;
- 43 B. To a ~~law enforcement officer or law enforcement~~ criminal justice agency, as
44 defined in Title 16, section 611, subsection 4, for the purpose of criminal
45 investigations or criminal prosecutions related to an E-9-1-1 call;

- 1 C. To designees of the bureau director for the purpose of system maintenance and
2 quality control; and
- 3 D. In accordance with an order issued on a finding of good cause by a court of
4 competent jurisdiction; and
- 5 E. To agencies or persons contracted by the bureau, a public safety answering point,
6 an emergency dispatch center or a criminal justice agency to prepare transcripts of
7 E-9-1-1 call audio recordings pursuant to this subsection.

8 Audio recordings disclosed pursuant to this subsection may not be further disclosed by
9 the agency or person receiving those recordings.

10 **5. Unlisted telephone numbers.** The name and address associated with the number
11 of a telephone company customer with an unlisted telephone number may be furnished to
12 the E-9-1-1 system for processing a request for E-9-1-1 services from that number and for
13 the provision of emergency services resulting from the request.

14 ~~**6. Penalty for disseminating information.** Knowingly disclosing confidential~~
15 ~~information in violation of subsection 2 or knowingly disclosing audio recordings of~~
16 ~~emergency calls to the E-9-1-1 system in violation of subsection 4 is a Class E crime.~~

17 **7. Penalty for disclosing or further disclosing information or records.** A person
18 may not intentionally:

- 19 A. Disclose confidential information in violation of subsection 2;
- 20 B. Disclose information or records in violation of subsection 3 if the person has
21 actual knowledge that the information or records are information or records declared
22 to be confidential under other law; or
- 23 C. Disclose or further disclose audio recordings of emergency calls to the E-9-1-1
24 system in violation of subsection 4.

25 A person who violates this subsection commits a Class E crime.

26 **SUMMARY**

27 This bill amends the law pertaining to the confidentiality of information and records
28 of the E-9-1-1 system. The bill:

- 29 1. Clarifies the types of agencies that are subject to the current law governing the
30 confidentiality of E-9-1-1 system information and records;
- 31 2. Defines the term "information or records declared to be confidential under other
32 law" by providing that the term includes, but is not limited to, information or records that
33 relate to a pending law enforcement investigation or a pending criminal prosecution;
- 34 3. Ensures that transcripts of E-9-1-1 call recordings may be accurately prepared;
- 35 4. Clarifies the types of disclosures of confidential information and records that are
36 prohibited under the law; and

4.15.15

- 1 5. Clarifies actions that constitute a violation of E-9-1-1 confidentiality requirements.

A.D.16

ONTP



126th MAINE LEGISLATURE

FIRST REGULAR SESSION-2013

Legislative Document

No. 684

H.P. 476

House of Representatives, February 26, 2013

An Act To Make Bylaws and Minutes of Board Meetings of Publicly Funded Hospitals Subject to the Freedom of Access Act

Reference to the Committee on Judiciary suggested and ordered printed.

Millicent M. MacFarland
MILLICENT M. MacFARLAND
Clerk

Presented by Representative MacDONALD of Boothbay.
Cosponsored by Representatives: BROOKS of Winterport, FARNSWORTH of Portland,
PRIEST of Brunswick, RUSSELL of Portland, SANBORN of Gorham.

4.5.17

ONTP



126th MAINE LEGISLATURE

FIRST REGULAR SESSION-2013

Legislative Document

No. 1118

H.P. 790

House of Representatives, March 21, 2013

**An Act To Amend Public Access Laws To Improve Accountability
for Public Funds by Making Public the Board Meetings of Hospitals
Receiving Significant State Funding**

(AFTER DEADLINE)

Submitted by the Department of the Attorney General pursuant to Joint Rule 205.
Reference to the Committee on Judiciary suggested and ordered printed.

Millicent M. MacFarland

MILLICENT M. MacFARLAND

Clerk

Presented by Representative PRIEST of Brunswick.
Cosponsored by Senator SAVIELLO of Franklin and
Representatives: CROCKETT of Bethel, FARNSWORTH of Portland, GOODE of Bangor,
MacDONALD of Boothbay, Senators: President ALFOND of Cumberland, CRAVEN of
Androscoggin.

4.5.19

FOA Reviews ~ Judiciary Committee ~ 126th Legislature, First Regular Session
Final

LD	COMMITTEE	SUBJECT	MEMO DATE	REVIEW DATE	REPORT DATE	RESULT	STATUTE	RESULT
160	EDU	Archaeological sites	3/13/13	3/27/13	3/28/13	Recommended change	27 §377	PL 2013, c. 89
345	JUD	Concealed handgun permits	-	4/3/13	-	Majority: no change	25 §2006	PL 2013, c. 54
532	EDU	Public library patrons records	3/25/13	4/4/13	4/4/13	No changes	27 §121	PL 2013, c. 82
549	JUD	Limitation on release of first offense Class E theft criminal record	-	4/25/13	-	No changes	15 c. 310 (§2257)	Carryover (AFA Table)
619	JUD	Release of email addresses by Bureau of Motor Vehicles	-	5/29/13	-	No changes	29-A §251, sub-§4	PL 2013, c. 283
648	IFS	External review proceedings records	5/8/13	5/15/13	5/16/13	No changes	24-A §4312, sub-§7-A	PL 2013, c. 274
973	JUD	Veterans property tax applications	-	5/13/13	-	No changes	36 §653, sub-§1, ¶G	PL 2013, c. 222
982	JUD	Gambling offset for child support – shared information	-	5/1/13	-	No changes	8 §300-B, sub-§10	PL 2013, c. 255
1016	IFW	Hide dealer licensees records of buyers and sellers	5/16/13	5/23/13	5/23/13	Recommended change	12 §12954, sub-§4-A, ¶A	PL 2013, c. 333

42

FOA Reviews ~ Judiciary Committee ~ 126th Legislature, First Regular Session
Final

LD	COMMITTEE	SUBJECT	MEMO DATE	REVIEW DATE	REPORT DATE	RESULT	STATUTE	RESULT
1019	EDU	<ul style="list-style-type: none"> Draft research and materials of Maine State Museum Personal history research and materials 	5/3/13	5/9/13	5/14/13	No changes	<ul style="list-style-type: none"> 27 §86-B, sub-§1 27 §86-B, sub-§2 	PL 2013, c. 205
1308	ENR	Product stewardship program for architectural paint	5/15/13 6/5/13	5/23/13 6/10/13	Interim: 5/31/13 Final: 6/10/13	Interim: questions Final: No changes	38 §2144, sub-§5, ¶F	PL 2013, c. 395
1334	HHS	Records of Child Advocacy Centers	5/13/13	5/23/13 6/4/13	6/5/13	No changes	22 §4019, sub-§9	PL 2013, c. 364
1335	ENR	Product Stewardship programs - model	5/15/13 6/5/13	5/23/13 6/10/13	Interim: 5/31/13 Final: 6/10/13	Interim: questions Final: No changes	38 §1776, sub-§10	PL 2013, c. 315
1373	LCRED	Polygraph examiners records	6/7/13	6/11/13	6/12/13	Recommended changes	32 §7365	PL 2013, c. 316
1437	LCRED	Reporting about physicians to the licensing board	5/22/13	5/23/13	Tabled – no report	Public records exception not included		PL 2013, c. 355
1515	CJPS	Records concerning involuntary medication of person in custody of Dept of Corrections	5/30/13	6/4/13	6/5/13	No changes	34-A §3049, sub-§3, ¶G 34-A §3049, sub-§4	Carry over (AFA Table)

FOA Reviews ~ Judiciary Committee ~ 126th Legislature, First Regular Session

Final

LD	COMMITTEE	SUBJECT	MEMO DATE	REVIEW DATE	REPORT DATE	RESULT	STATUTE	RESULT
1519	IFS	Four provisions: <ul style="list-style-type: none"> • Records confidential from national organizations • Holding company information • Insurer's own risk and solvency assessment • Protected valuation information re insurance co. reservers 	5/21/13	5/23/13	5/28/13	No changes	<ul style="list-style-type: none"> • 24-A §216, sub-§5 • 24-A §222, sub-§13-A, ¶E • 24-A §423-F • 24-A §962 	PL c. 238

G:\COMMITTEES\JUD\FOA Exception review\126th\FOA reviews in 2013.docx (7/19/2013 4:07:00 PM)

Maine Revised Statute Title 22, Chapter 1684: SENTINEL EVENTS
REPORTING

Table of Contents

Subtitle 6. FACILITIES FOR CHILDREN AND ADULTS

Error! Bookmark not defined.

Section 8751. SENTINEL EVENT REPORTING.....	2
Section 8752. DEFINITIONS	2
Section 8753. MANDATORY REPORTING OF SENTINEL EVENTS	3
Section 8753-A. STANDARDIZED PROCEDURE	4
Section 8754. DIVISION DUTIES	5
Section 8755. COMPLIANCE	6
Section 8756. RULEMAKING	7

7.19.13

22 §8751. SENTINEL EVENT REPORTING

There is established under this chapter a system for reporting sentinel events for the purpose of improving the quality of health care and increasing patient safety. [2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF).]

SECTION HISTORY

2001, c. 678, §1 (NEW). 2001, c. 678, §3 (AFF).

22 §8752. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF).]

1. Division. "Division" means the Department of Health and Human Services, Division of Licensing and Regulatory Services.

[2009, c. 358, §1 (AMD) .]

2. Health care facility. "Health care facility" or "facility" means a state institution as defined under Title 34-B, chapter 1 or a health care facility licensed by the division, except that it does not include a facility licensed as a nursing facility or licensed under chapter 1664. "Health care facility" includes a general and specialty hospital, an ambulatory surgical facility, an end-stage renal disease facility and an intermediate care facility for persons with intellectual disabilities or other developmental disabilities.

[2011, c. 542, Pt. A, §48 (AMD) .]

2-A. Immediate jeopardy. "Immediate jeopardy" means a situation in which the provider's noncompliance with one or more conditions of participation in the federal Medicare program has caused, or is likely to cause, serious injury, harm or impairment to or death of a patient.

[2009, c. 358, §1 (NEW) .]

3. Major permanent loss of function. "Major permanent loss of function" means sensory, motor, physiological or intellectual impairment that was not present at the time of admission and requires continued treatment or imposes persistent major restrictions in activities of daily living.

[2009, c. 358, §1 (AMD) .]

3-A. Near miss. "Near miss" means an event or situation that did not produce patient injury, but only because of chance, which may include, but is not limited to, robustness of the patient or a fortuitous, timely intervention.

[2009, c. 358, §1 (NEW) .]

3-B. Root cause analysis. "Root cause analysis" means a structured process for identifying the causal or contributing factors underlying adverse events. The root cause analysis follows a predefined protocol for identifying these specific factors in causal categories.

[2009, c. 358, §1 (NEW) .]

4. Sentinel event.

[2009, c. 358, §1 (RP) .]

4-A. Sentinel event. "Sentinel event" means:

A. An unanticipated death, or patient transfer to another health care facility, unrelated to the natural course of the patient's illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility; [2009, c. 358, §1 (NEW).]

B. A major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility that is present at the time of the discharge of the patient. If within 2 weeks of discharge from the facility, evidence is discovered that the major loss of function was not permanent, the health care facility is not required to submit a report pursuant to section 8753, subsection 2; [2009, c. 358, §1 (NEW).]

C. An unanticipated perinatal death or major permanent loss of function in an infant with a birth weight over 2,500 grams that is unrelated to the natural course of the infant's or mother's illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility; and [2009, c. 358, §1 (NEW).]

D. Other serious and preventable events as identified by a nationally recognized quality forum and determined in rules adopted by the department pursuant to section 8756. [2009, c. 358, §1 (NEW).]

[2009, c. 358, §1 (NEW) .]

SECTION HISTORY

RR 2001, c. 2, §A37 (COR). RR 2001, c. 2, §A38 (AFF). 2001, c. 678, §1 (NEW). 2001, c. 678, §3 (AFF). 2007, c. 324, §17 (REV). 2009, c. 358, §1 (AMD). 2011, c. 542, Pt. A, §48 (AMD).

22 §8753. MANDATORY REPORTING OF SENTINEL EVENTS

A health care facility shall notify the division whenever a sentinel event has occurred, as provided in this chapter. [2009, c. 358, §2 (AMD).]

1. Notification. A health care facility shall notify the division of a sentinel event by the next business day after the event occurred or the next business day after the facility discovers that the event occurred. The notification must include the date and time of notification, the name of the health care facility and the type of sentinel event pursuant to section 8752, subsection 4-A.

[2009, c. 358, §2 (AMD) .]

2. Reporting. The health care facility shall file a written report no later than 45 days following the notification of the occurrence of a sentinel event pursuant to subsection 1. The written report must be signed by the chief executive officer of the facility and must contain the following information:

A. Facility name and address; [2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF).]

B. Name, title and phone number of the contact person for the facility; [2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF).]

C. The date and time of the sentinel event; [2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF).]

D. The type of sentinel event and a brief description of the sentinel event; and [2009, c. 358, §2 (AMD).]

E. [2009, c. 358, §2 (RP).]

F. [2009, c. 358, §2 (RP).]

G. [2009, c. 358, §2 (RP) .]

H. A thorough and credible root cause analysis. A root cause analysis is thorough and credible only in accordance with the following.

(1) A thorough root cause analysis must include: a determination of the human and other factors most directly associated with the sentinel event and the processes and systems related to its occurrence; an analysis of the underlying systems and processes to determine where redesign might reduce risk; an inquiry into all areas appropriate to the specific type of event; an identification of risk points and their potential contributions to the event; a determination of potential improvement in processes or systems that would tend to decrease the likelihood of such an event in the future or a determination, after analysis, that no such improvement opportunities exist; an action plan that identifies changes that can be implemented to reduce risks or formulates a rationale for not undertaking such changes; and, where improvement actions are planned, an identification of who is responsible for implementation, when the action will be implemented and how the effectiveness of the action will be evaluated.

(2) A credible root cause analysis must include participation by the leadership of the health care facility and by the individuals most closely involved in the processes and systems under review, is internally consistent without contradictions or unanswered questions, provides an explanation for all findings, including those identified as "not applicable" or "no problem," and includes the consideration of any relevant literature.

(3) The root cause analysis submitted to the division may exclude protected professional competence review information pursuant to the Maine Health Security Act. [2009, c. 358, §2 (NEW) .]

[2009, c. 358, §2 (AMD) .]

3. Cooperation. A health care facility that has filed a notification or a report of the occurrence of a sentinel event under this section shall cooperate with the division as necessary for the division to fulfill its duties under section 8754.

[2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF) .]

4. Immunity. A person who in good faith reports a near miss, a suspected sentinel event or a sentinel event or provides a root cause analysis pursuant to this chapter is immune from any civil or criminal liability for the act of reporting or participating in the review by the division. "Good faith" does not include instances when a false report is made and the person reporting knows the report is false. This subsection may not be construed to bar civil or criminal action regarding perjury or regarding the sentinel event that led to the report.

[2009, c. 358, §2 (AMD) .]

5. Near miss notification. A health care facility may notify the division of the occurrence of a near miss. Should a facility report a near miss, the notification must include the date and time of notification, the name of the health care facility and the type of event or situation pursuant to section 8752, subsection 4-A that is related to the near miss.

[2009, c. 358, §2 (NEW) .]

SECTION HISTORY

2001, c. 678, §1 (NEW). 2001, c. 678, §3 (AFF). 2009, c. 358, §2 (AMD).

22 §8753-A. STANDARDIZED PROCEDURE

A health care facility shall have a written standardized procedure for the identification of sentinel events. The division shall develop the standardized reporting and notification procedures by adoption of routine

technical rules under Title 5, chapter 375, subchapter 2-A. [2009, c. 358, §3 (NEW) .]

SECTION HISTORY

2009, c. 358, §3 (NEW) .

22 §8754. DIVISION DUTIES

The division has the following duties under this chapter. [2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF) .]

1. Initial review; other action. Upon receipt of a notification or report of a sentinel event, the division shall complete an initial review and may take such other action as the division determines to be appropriate under applicable rules and within the jurisdiction of the division. Upon receipt of a notification or report of a suspected sentinel event the division shall determine whether the event constitutes a sentinel event and complete an initial review and may take such other action as the division determines to be appropriate under applicable rules and within the jurisdiction of the division. The division may conduct on-site reviews of medical records and may retain the services of consultants when necessary to the division.

A. The division may conduct on-site visits to health care facilities to determine compliance with this chapter. [2009, c. 358, §4 (NEW) .]

B. Division personnel responsible for sentinel event oversight shall report to the division's licensing section only incidences of immediate jeopardy and each condition of participation in the federal Medicare program related to the immediate jeopardy for which the provider is out of compliance. [2009, c. 358, §4 (NEW) .]

[2009, c. 358, §4 (AMD) .]

2. Procedures. The division shall adopt procedures for the reporting, reviewing and handling of information regarding sentinel events. The procedures must provide for electronic submission of notifications and reports.

[2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF) .]

3. Confidentiality. Notifications and reports filed pursuant to this chapter and all information collected or developed as a result of the filing and proceedings pertaining to the filing, regardless of format, are confidential and privileged information.

A. Privileged and confidential information under this subsection is not:

- (1) Subject to public access under Title 1, chapter 13, except for data developed from the reports that do not identify or permit identification of the health care facility;
- (2) Subject to discovery, subpoena or other means of legal compulsion for its release to any person or entity; or
- (3) Admissible as evidence in any civil, criminal, judicial or administrative proceeding. [2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF) .]

B. The transfer of any information to which this chapter applies by a health care facility to the division or to a national organization that accredits health care facilities may not be treated as a waiver of any privilege or protection established under this chapter or other laws of this State. [2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF) .]

C. The division shall take appropriate measures to protect the security of any information to which this chapter applies. [2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF) .]

D. This section may not be construed to limit other privileges that are available under federal law or other laws of this State that provide for greater peer review or confidentiality protections than the peer

review and confidentiality protections provided for in this subsection. [2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF).]

E. For the purposes of this subsection, "privileged and confidential information" does not include:

- (1) Any final administrative action;
- (2) Information independently received pursuant to a 3rd-party complaint investigation conducted pursuant to department rules; or
- (3) Information designated as confidential under rules and laws of this State. [2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF).]

This subsection does not affect the obligations of the department relating to federal law.

[2009, c. 358, §5 (AMD) .]

4. Report. The division shall submit an annual report by February 1st each year to the Legislature, health care facilities and the public that includes summary data of the number and types of sentinel events of the prior calendar year by type of health care facility, rates of change and other analyses and an outline of areas to be addressed for the upcoming year.

[2009, c. 358, §6 (AMD) .]

SECTION HISTORY

2001, c. 678, §1 (NEW). 2001, c. 678, §3 (AFF). 2009, c. 358, §§4-6 (AMD) .

22 §8755. COMPLIANCE

1. Oversight. The division shall place primary emphasis on ensuring effective corrective action by the facility.

[2009, c. 358, §7 (NEW) .]

2. Penalties. When the division determines that a health care facility failed to report a sentinel event pursuant to this chapter, the health care facility is subject to a penalty imposed in conformance with Title 5, chapter 375, subchapter 4 and payable to the State of not more than \$10,000 per violation. If the facility in good faith notified the division of a suspected sentinel event and the division later determines it is a sentinel event, the facility is not subject to a penalty for that event. Funds collected pursuant to this section must be deposited in a dedicated special revenue account to be used to support sentinel event reporting and education.

[2009, c. 358, §7 (NEW) .]

3. Administrative hearing and appeal. To contest the imposition of a penalty under this section, a health care facility must submit to the division a written request for an administrative hearing within 10 days of notice of imposition of a penalty pursuant to this section. Judicial appeal must be in accordance with Title 5, chapter 375, subchapter 7.

[2009, c. 358, §7 (NEW) .]

4. Injunction. Notwithstanding any other remedies provided by law, the Office of the Attorney General may seek an injunction to require compliance with the provisions of this chapter.

[2009, c. 358, §7 (NEW) .]

5. Enforcement. The Office of the Attorney General may file a complaint with the District Court seeking injunctive relief for violations of this chapter.

[2009, c. 358, §7 (NEW) .]

SECTION HISTORY

2001, c. 678, §1 (NEW). 2001, c. 678, §3 (AFF). 2009, c. 358, §7 (RPR).

22 §8756. RULEMAKING

The department shall adopt rules to implement this chapter. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [2001, c. 678, §1 (NEW); 2001, c. 678, §3 (AFF).]

SECTION HISTORY

2001, c. 678, §1 (NEW). 2001, c. 678, §3 (AFF).

The State of Maine claims a copyright in its codified statutes. If you intend to republish this material, we require that you include the following disclaimer in your publication:

All copyrights and other rights to statutory text are reserved by the State of Maine. The text included in this publication reflects changes made through the Second Regular Session of the 125th Maine Legislature, is current through September 1, 2012, and is subject to change without notice. It is a version that has not been officially certified by the Secretary of State. Refer to the Maine Revised Statutes Annotated and supplements for certified text.

The Office of the Revisor of Statutes also requests that you send us one copy of any statutory publication you may produce. Our goal is not to restrict publishing activity, but to keep track of who is publishing what, to identify any needless duplication and to preserve the State's copyright rights.

PLEASE NOTE: The Revisor's Office cannot perform research for or provide legal advice or interpretation of Maine law to the public. If you need legal assistance, please contact a qualified attorney.

RTK
AC

Excerpt from Jan 2013 Report

proposes a new provision in Title 20-A which specifically protects the release of email addresses as well as other personal information about a parent that may be collected by a school.

The Subcommittee worked through each aspect of the draft but in the end was significantly divided on whether to recommend the entire draft legislation to the Advisory Committee. The members recognized that there were a number of issues still unresolved, and the extent of the problem is unclear. The Subcommittee agreed to postpone any action on the draft legislation and requested that the Public Access Ombudsman research the issue, collect information and report back to the Subcommittee next year.

Consider creating drafting templates for exceptions to the Freedom of Access Act access requirements

The Subcommittee developed draft templates for drafting specific confidentiality provisions concerning records provided by individuals and businesses to governmental agencies. Bill Norbert of the Finance Authority of Maine had provided suggested additions for clarification as to what information submitted by an applicant would be public.

The Subcommittee agreed to recommend to the Advisory Committee that the templates be used as guidance for drafting new statutes.

See discussion of Advisory Committee recommendations in Section VI.

Public Records Exceptions Subcommittee. The Public Records Exception Subcommittee's focus is to participate in the review and evaluation of public records exceptions, both existing and those proposed in new legislation; to examine inconsistencies in statutory language and to propose clarifying standard language. Shenna Bellows is the chair of the subcommittee and the following serve as members: Perry Antone, Percy Brown, AJ Higgins and Linda Pistner.

During 2012, the Public Records Exception Subcommittee held five meetings: July 16, August 8, September 13, November 8 and November 15.

→ Title 22, section 8754, reporting of sentinel events

The Subcommittee reviewed its previous work on the confidentiality of sentinel events reporting from 2011 and reviewed a copy of the most recent report submitted by the Department of Health and Human Services. Some members of the Subcommittee expressed support for repealing the confidentiality provisions completely, although it was acknowledged that it would cause a lot of concern and require a public hearing and thorough discussion involving many people. Other members agreed that a thorough process would be required, suggesting that either the full Advisory Committee or the Judiciary Committee of the Legislature could host that process.

Katherine Lybrand, the Advisory Committee's Law School Extern, presented to the Subcommittee a memo she had prepared describing other states' sentinel events reporting programs and the availability of information collected through those processes. Ms. Lybrand noted that a lot of states do include names of hospitals and information about the sentinel events

that were reported. Some state reports include comparisons among hospitals, as well as proposals or actions for improvement.

The Subcommittee received a written memorandum provided by the Maine Hospital Association, the Maine Medical Association, the Maine Osteopathic Association and the Medical Mutual Insurance Company of Maine that expressed their strong opposition to any changes in the confidentiality provision. In remarks to the Subcommittee, Jeff Austin of the Maine Hospital Association stressed that the quality of care in Maine is very high and that a great deal of information about quality of care that is already publicly available. Mr. Austin said that removing the confidentiality provision would have a significant chilling effect on the interest of hospitals to work with other groups on legislation, because the association would not be able to trust that compromises would hold. Mr. Austin said that robust sentinel event reporting is not necessarily an indication of poor care. Sentinel events reporting covers rare events; a better indicator of potential problems is the quality of routine care. Mr. Austin noted that the purpose of the reporting statute is not to inform the public but to improve care.

The Subcommittee also received comments from two quality care managers for local hospitals, who explained the importance of confidentiality in the sentinel event reporting process. They felt it has taken years to develop the "no blame" culture which allows everyone involved to be completely candid and allows the discovery of the causes of unexpected outcomes. Sometimes human errors are forced by system problems: was it a system error vs. a conscious deviation from the standard of care? Competence issues can be dealt with and are reported to hospital boards. The hospitals are transparent about quality indicators; information is readily available on two public websites: www.GetBetterMaine.org and www.HospitalCompare.hhs.gov. Both stressed that the quality data available on the websites are more specific and more useful than sentinel events reports.

A representative of the Department of Health and Human Services also told the Subcommittee that DHHS greatly values the confidentiality provided in current law. If an immediate risk exists, information is turned over to the licensing personnel who can take action quickly. It is also important to have follow up plans – need to know what to do, and who will do what when specific events do occur. The "no blame" philosophy underlying the current law is really important.

The Subcommittee members tentatively agreed that full disclosure of all information provided to DHHS through the sentinel events reporting program would most likely be counter-productive. The challenge is to find what information is helpful to people in making informed health care decisions. Ms. Bellows said transparency is an important factor in increasing public trust, and Chief Antone said the hospitals must be permitted to maintain their investigative process. The members agreed to table the issue until 2013 with the understanding that more information from other states, coupled with good discussions with the hospitals and quality care professionals, will identify common ground with regard to providing useful information to the public.

Sentinel Events
RTK AC 2011 recap

Public Records Exceptions Subcommittee
September 29, 2011

54 22 MRSA §8754: *sentinel events*

Renee Guigard, Assistant Attorney General, engaged in a lengthy discussion with the Subcommittee members. She explained the sentinel events reporting program and explained the purpose of the complete confidentiality of the reports to the Sentinel Events Team within DHHS. "Sentinel events" are serious medical errors and must be reported by hospitals; failure to report may result in a fine of up to \$10,000 imposed by DHHS. The purpose of the reporting is to identify individual and systemic problems and to ensure the errors do not occur again. The only situation in which the confidential information is released is when it is determined the information indicates immediate jeopardy, in which case the Sentinel Events Team reports to the DHHS licensing office. The Department submits a report to the Legislature every year. DHHS is concerned that if the reports are not kept confidential, the hospitals will not report the occurrence of sentinel events, "near misses" or other instances which may or may not be sentinel events.

Sentinel event information reported to DHHS is not released to anyone, including law enforcement and family members of affected patients. Patients or their personal representatives may be able to receive specific information from the hospitals themselves, or from other sources. Information about the imposition of fines is not available. The licensing function carried out by DHHS is handled by a completely different office and there is no overlap or sharing of information (except in the case of immediate jeopardy).

Ms. Bellows was concerned that members of the public do not have information about possibly underperforming hospitals, and information that would be useful in making medical and economic decision is not available. Perry Antone understood both sides: there is an accountability factor and if the information is made public, events would not be reported; but after an investigation, there should be some information available that helps people make medical decisions. AJ Higgins mentioned that if people had known about the long-standing problems at Downeast Community Hospital, maybe they would have made different medical decisions. Linda Pistner agreed that people should have information and pointed out that the need to provide that information is addressed by the Maine Quality Forum that is part of Dirigo Health.

The Subcommittee voted to ask the full Advisory Committee for advice on how to proceed with the review and evaluation of the sentinel events confidentiality provisions.

November 17, 2011

54 22 MRSA §8754: *sentinel events*

At the Subcommittee's invitation, representatives from the Department of Health and Human Services, Maine Hospital Association and Maine Medical Mutual Insurance

Sentinel Events
RTK AC 2011 recap

Company provided their recommendation that the Subcommittee make no changes to current law. Mr. Austin explained that the current law works well; without the confidentiality provision, he believes that health care providers and professionals would be reluctant to report sentinel events to the detriment of patients. Mr. Austin explained that an injured patient or the patient's attorney would have access to the underlying facts associated with the patient's care through their medical records and other internal documents of a hospital as part of the legal process. Kevin Wells of the Department of Health and Human Services agreed with Mr. Austin that the statute should not be changed; the current law strikes the right balance between the public's right to know and open communication between hospitals and the department. Mr. Wells also pointed out that not all state laws relating to medical errors have a confidentiality statute like Maine; he believes the confidentiality provision makes the Maine law stronger.

Ms. Bellows and Mr. Brown expressed concerns that, under the current law, members of the public may not have enough information about underperforming hospitals; patients should have access to the best care possible.

Due to time constraints, the Subcommittee tabled the exception and asked staff to review other states laws for the next meeting.

December 8, 2012

54 22 MRSA §8754: *sentinel events*

The Subcommittee continued its discussion of Title 22, section 8754 relating to sentinel events. Staff reviewed sentinel events laws in other states and reported that, of the 27 states other than Maine that require reporting of sentinel events, 15 states make those reports confidential. Representatives from the Maine Hospital Association and the Department of Health and Human Services reiterated their prior recommendation that the Subcommittee make no changes to current law. It is their belief that the current law works well; without the confidentiality provision, health care providers and professionals would be reluctant to report sentinel events to the detriment of patients. Ms. Pistner reminded the Subcommittee that the provision does not deprive an individual patient from initiating a lawsuit or from accessing their own medical records relating to the event. Mr. Brown continued to raise his concern that, under the current law, members of the public may not have enough information about underperforming hospitals; patients should have access to the best care possible. AJ Higgins stated that the public should be made aware of these events, but recognizes the need for give and take between hospitals and the State to ensure reporting. Mr. Higgins asked whether there might be some middle ground: could hospitals be required to annually report their sentinel events? The Maine Hospital Association expressed some concern that individual hospital reporting may affect an individual's medical privacy, especially in smaller communities. Mr. Brown suggested that the Subcommittee consider tabling the exception so further discussion can take place.

Sentinel Events
RTK AC 2011 recap

The Subcommittee voted 4-0 to make no change to Title 22, section 8754 at this time and to recommend that the Advisory Committee continue its review of the provision in 2012.

Right to Know Advisory Committee

December 8, 2011

Exception 54. The Subcommittee had discussed the complete confidentiality provided by the statute with regard to the reporting of “sentinel events” by hospitals and other providers to the Department of Health and Human Services. Ms. Pistner identified the tension that exists between helping hospitals to improve and giving consumers the information they need to make intelligent choices about which hospital to utilize. The Subcommittee did not recommend statutory changes with the understanding that the subject matter would be taken up again when the Subcommittee reconvenes in 2012; the Subcommittee can then explore the balance in more depth and determine if the public’s need for information can be satisfied without undermining the value of the Sentinel events program.

The Advisory Committee voted 14-0 to carry over Exception 54, to continue the discussion of Title 22, section 8754 in 2012.

G:\STUDIES 2012\Right to Know Advisory Committee\Existing Public Records Exceptions Review\Sentinel events summary.docx
(7/6/2012 2:07:00 PM)

To: Right To Know Advisory Committee - Exemption Review Sub-Committee

**From: Maine Hospital Association, Maine Medical Association, Maine Osteopathic Association,
Medical Mutual Insurance Company of Maine**

Date: September 14, 2012

Re: Sentinel Event Confidentiality (Title 22 MRSA §8754)

Thank you for accepting these comments from MHA, MMA, MOA and Medical Mutual on your review of the confidentiality of sentinel event records in the possession of the Department of Health and Human Services (DHHS).

When the Exemption Review Sub-Committee sought input on this exemption (in 2010), MHA and others opposed changes to the exemption. We are unaware of any comment, provided either in writing or at a meeting of the Sub-Committee, which supported making any changes to the statute.

We believe the fact that your process produced no call for changes is evidence that the program is working as intended. Following are several other reasons not to change the confidentiality for sentinel event records.

1. **Removing confidentiality is bad policy.** The legislatively declared purpose of the Sentinel Event program (22 MRSA §8751-8756) is to improve performance: *"There is established under this chapter a system for reporting sentinel events for the purpose of improving the quality of health care and increasing patient safety."* Transparency and keeping the public informed are valid public purposes. However, they are not the purpose of the sentinel event statute and program.

The purpose of a sentinel event program is to improve quality. It works by making sure health care providers fully understand "what happened" and, with the help of DHHS, make changes to policies and practices where necessary to prevent similar events from happening again. Both the process of doing a root cause analyses and the results of that analyses drive health care quality improvement. In order for sentinel event systems to succeed, confidentiality is essential. The internal sentinel event systems must have full staff acceptance that the process is not about ascribing blame or shame associated with the event. Public reporting of these internal reviews will have a significant chilling effect on discovering all of the events as well as the facts that are necessary to understand the events.

2. **Confidentiality was critical to the enactment of the sentinel event law .** When the statute was enacted 10 years ago, it went through a lengthy legislative process. It was heard in April 2001, strongly opposed as drafted by many organizations,(including the above signers), and held-over until the next session where it was substantially amended and finally enacted in April 2002. ***The original bill did not have a confidentiality provision and that was a prime focus of our opposition.*** The bill was all but dead as originally proposed. It was only after confidentiality

was added that it got broader support and enactment. Removal of confidentiality is patently unfair because it undoes an important legislative compromise without which the program probably never would have existed.

3. **There is publicly available information about hospital quality.** Members of the RTKAC may not be aware of the burgeoning availability of hospital quality data. The leading collector and disseminator of the quality of care provided in hospitals in the U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services (CMS). CMS maintains a publicly available website called "Hospital Compare" where data about dozens of quality metrics are available, by hospital name. While no system is perfect, this data set provides a much more comprehensive picture about the care provided at hospital facilities. In addition, private organizations both use the CMS data to create score cards and they supplement the CMS data with additional information they gather. Groups ranging from the Maine Health Management Coalition to Consumer Reports collect and disseminate data about health care quality. The amount and accessibility of the data is growing each year.

Attached is a matrix developed by MHA that shows most of the publicly available hospital-specific data that may be used to evaluate the quality and safety of care. The first column lists each quality metric, with the National Quality Forum reference number in most cases which provides the national definition of each metric. The top horizontal row defines whether the metric is collected at the state or federal level. CMS collects or calculates hospital-specific measures in 9 different programs. "MQF/MHDO" is the Maine Quality Forum/Maine Health Data Organization, which mandates the collection of certain hospital quality and safety data under Chapter 270. "MHMC" is the Maine Health Management Coalition which posts additional hospital-specific data on their publicly available web site. This is the data used in the state employees' hospital tiering program.

Not only is the raw data available publicly, but increasingly, groups are taking the data and putting them into more user-friendly scorecards and ranking systems such as you see at Consumer Reports.

4. **Hospitals are not public/government entities.** The foundation of the argument about the "public's right to know" seems misplaced in reference to hospitals. The purpose of the FOA Act is to provide transparency into what **government** is doing. There is obviously public curiosity and interest in many private organizations but the FOA Act does not apply to private organizations. As best we understand the arguments in favor of repealing the confidentiality those arguments are rooted in the desire for the public to know what is going on in hospitals, not in the desire to know what is going on at DHHS. The annual DHHS sentinel event report no doubt satisfies the public interest in understanding what DHHS is doing. Expanding the FOA Act, in effect, provide the public access to the internal documents of private organizations is simply inappropriate.

5. **Sentinel Events may be a misleading metric.** More reports at a particular facility do not necessarily mean more problems or poorer quality; this may be misleading indicia. A higher level of reporting may simply be a reflection of a more robust reporting culture at a particular hospital – which would be good for patient safety.

6. **Other States include confidentiality protections.** The federal DHHS Office of the Inspector General issued a report in 2008 on state reporting systems for hospital adverse events which found that **25 of 26 states with sentinel event programs provide confidentiality.**¹ (This is not inconsistent with the staff memo that found fewer state confidentiality provisions. Staff indicated that they found a confidentiality provisions included in the sentinel event statute in 15 states. They noted that confidentiality could have still been provided somewhere else in each states' statutes.)

7. **Several accountability measures are available.** There are plenty of accountability measures available to patients and their families who experience sentinel events, with a varying degree of transparency. These measures include: filing complaints directly with providers; filing complaints with professional licensing boards; filing complaints with DHHS facilities licensing; private tort litigation; and, patients going to the press/social media.

8. **The process to release sentinel event information will be difficult and expensive.** The state may not override the patient confidentiality provisions in federal laws such as HIPAA. Accordingly, before DHHS would be able to release sentinel event records, someone would have to redact the sentinel event records to prevent any personally identifying information or other such privacy related information from being disclosed.

Conclusion

The challenge you face in reviewing every single exemption ever enacted is daunting. The fact that you have a process to conduct the review is great and essential to doing a good job. The process revealed no objections to confidentiality and there are several persuasive reasons to keep the provision intact. The subcommittee needs to trust the process and not dramatically disrupt an important program grounded in improving health care quality.

MHA staff regrets not being able to attend this meeting in person. We take this issue quite seriously and are more than happy to meet with you to discuss this further.

¹ U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: State Reporting Systems* (2008), p. 13.

To: Public Records Exception Subcommittee
From: Katie Lybrand
Right to Know Advisory Committee Extern, Fall 2012
Date: November 7, 2012
Re: Comparison of states' sentinel events reporting and confidentiality provisions

I. Introduction

I conducted a nationwide statutory survey of state sentinel events reporting laws looking for trends in how states treat information of sentinel events. Overall, I found that most states, like Maine, have provisions deeming the information provided by facilities in sentinel events reporting to be confidential. However, states varied on the type of information they contain in their publicly available annual reports.

I did not thoroughly examine state definitions of sentinel or adverse events, but for purposes of this memo, you may assume that all states surveyed contain roughly similar definitions to Maine's, excerpted below.

22 M.R.S.A. § 8752 (4): "Sentinel event" means

- A. An unanticipated death, or patient transfer to another health care facility, unrelated to the natural course of the patient's illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility;
- B. A major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility that is present at the time of the discharge of the patient.
- C. An unanticipated perinatal death or major permanent loss of function in an infant with a birth weight over 2,500 grams that is unrelated to the natural course of the infant's or mother's illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility; and
- D. Other serious and preventable events as identified by a nationally recognized quality forum and determined in rules adopted by the department pursuant to section 8756.

I have tried to organize this memo into an "at a glance" format, but if anyone would like further information, I am more than happy to share my research with citations to all of the state statutes and more detailed information.

II. States' Sentinel Events Reporting At a Glance

Number of states with mandatory reporting provisions:

21. California, Connecticut, Florida, Illinois, Kansas, Maine, Massachusetts, Minnesota, Nevada, New Hampshire, New York, Pennsylvania¹, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, and Wyoming. The District of Columbia also requires reporting.

Number of states with voluntary reporting provisions:

3. Indiana, Michigan, and Oregon.

Where do states make these reports?

All states require facilities to report to some division of the Department of Health. Massachusetts requires reporting to the Department of Health and to the Betsy Lehman Center, a state run center dedicated to “patient safety and medical error reduction.” Facilities in New York may also report to the Department of Health’s Patient Safety Center, in addition to facilities’ mandatory reports to the Department.

How many states require that the information provided to the reviewing body is to remain confidential?

All states, with the exception of Florida and California, and a few other states, such as South Carolina, with unclear statutes, explicitly provide that all information provided to the reviewing body by the medical facility is confidential.

California requires the reviewing body to post information from the outcomes of investigations of adverse events on the state’s website. Patient and staff identity are protected, but all other information contained in the reports is accessible.

South Carolina’s statute merely states that patient privacy must be protected but does not elaborate further on confidentiality. South Dakota’s statute contains no reference to confidentiality. Florida presents an interesting case, which I’ve discussed below.

The case of Florida

Florida passed a constitutional amendment stating that “patients have a right to have access to any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident.” Fla. Const. art. X, § 25. The only limit to the information accessible to patients is that patient identity must be protected and other federal privacy restrictions observed.

However, in January of this year, the Supreme Court of Florida held the main implementing statutes of the provision unconstitutional because they attempted to impermissibly limit the scope of a constitutional provision. *West Florida Regional Medical Center, Inc. v. See*, 79 So.3d 1 (Fla. 2012). Therefore, I am not sure where the law stands in Florida currently, but it would seem that the broad language of the constitutional provision is the current governing language, which

¹ Pennsylvania also requires reporting of so called “near misses.” Near miss includes situations that did not result in patient injury or death, but only because of chance. *See* 40 P.S. § 1303.302; 28 Pa. Code § 51.3.

would mean that no records, other than those containing patient information, that relate to an adverse event are to be confidential.

What information is contained in the reports issued by the reviewing body (includes states with voluntary reporting)?

Although almost all of the states with mandatory reporting of sentinel events require the information to be kept confidential, the states vary on the information about the event they reveal in their publicly available reports.

Twelve states specifically state that the report is to include identifying information about the hospital, the type of event, and may contain background information about the event, rates of change, patient population, the facility's compliance history, and a comparison among facilities of similar size and type. Many of these states also require the report to contain summaries of the root cause analyses and corrective action plans provided by the facilities.

Four states, including Maine, do not place any identifying information, such as naming the facilities beyond designations such as "psychiatric hospital" or "general hospital," into their reports.

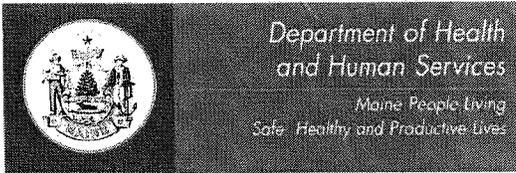
Seven states are unclear about the information that should be in the report, stating things like the report must "analyze" the past year's sentinel events and "make recommendations for improvement."

Interesting provisions

The review process of sentinel events in Illinois is interesting. The facility is required to report to the Department of Health. The Department then conducts a review and issues a report on the event. Next, the Health Care Event Reporting Advisory Committee reviews the recommendations contained in the Department's report at a public hearing. The Committee contains nine members, all appointed by the Department of Health. Membership must include one representative from hospitals, one individual representing ambulatory surgical treatment centers, and one representing physicians. The remaining members must include others with experience in "system based quality improvement and safety" and at least one public member. The statutes are not clear about what the Committee does after it reviews the Department's report, other than making recommendations on the list of reportable events.

Utah's statutes also contain a provision that allows the Department of Health to establish a multi-disciplinary advisory panel to assist it in carrying out the review process. If the Department establishes such a panel, its members must include representatives from facilities that are required to report under the statute.

In Vermont, hospitals are also required to submit "community reports" to the Department of Health and these reports are public. These reports must include measures of quality and patient safety, including comparisons to national standards. I have not examined these reports, but they may also involve discussions of sentinel events.



Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax (207) 287-3005
TTY Users: Dial 711 (Maine Relay)

May 2, 2013

Senator Margaret M. Craven, Chair
Representative Richard R. Farnsworth, Chair
Members of the Joint Standing Committee on Health and Human Services
#100 State House Station
Augusta, ME 04333-0100

Dear Senator McCormick, Representative Strang Burgess, and Members of the Joint Standing Committee on Health and Human Services:

The Sentinel Events Reporting statute (22 M.R.S.A. §8754) directs the Department of Health and Human Services to submit an annual report to the Legislature, health care facilities and the public that includes summary data of the number and types of sentinel events of the prior calendar year. Attached is the Sentinel Events Report for calendar year 2012.

If you have any questions or would like further information, please feel free to contact Kenneth Albert, Director of the Division of Licensing and Regulatory Services at 287-6664.

Sincerely,

Mary C. Mayhew
Commissioner

MCM/klv

Attachment

5.A
Report

Sentinel Events

2012

Annual Report to the Maine State Legislature



Department of Health and Human Services
Division of Licensing and Regulatory Services

Maine People Living Safe, Healthy and Productive Lives

Sentinel Event Annual Report prepared by:

The Division of Licensing and Regulatory Services
Department of Health and Human Services
41 Anthony Avenue
11 State House Station
Augusta, ME 04333-0011

For further information please contact:

Joseph Katchick, RN
Public Health Nurse Supervisor
(207)287-9300 or joseph.katchick@maine.gov

Kenneth Albert, RN, Esq.
Director, Division of Licensing and Regulatory Services
(207) 287- 9300 or kenneth.albert@maine.gov

Table of Contents

<u>Executive Summary</u>	4
<u>Background</u>	5
<u>Sentinel Events Historically Reported</u>	8
<u>Sentinel Events Reported in 2012</u>	11
<u>Conclusions</u>	13
<u>Appendix A</u>	15

This report may be found on the internet at:

http://www.maine.gov/dhhs/dlrs/medical_facilities/sentinelevents/home.html

The Maine Sentinel Event Reporting Statute may be found on the internet at:

<http://www.mainelegislature.org/legis/statutes/22/title22ch1684sec0.html>

The Rules Governing the Reporting of Sentinel Events may be found on the internet at:

<http://www.maine.gov/sos/cec/rules/10/144/144c114.doc>

Executive Summary

In 2002, Maine enacted Public Law 2001, Chapter 678 establishing a mandatory sentinel event reporting system. Since 2004 Maine Hospitals, Ambulatory Surgical Centers, End-Stage Renal Disease Facilities/Units, and Intermediate Care Facilities for Individuals with Intellectual Disabilities have been required to report whenever a serious, unexpected and preventable event, or medical error, known as a Sentinel Event, occurs. These events include unanticipated patient deaths, falls with serious injury, serious medication errors, patient suicide, surgery on the wrong body part, or an error resulting in a major loss of function. In 2012, 146 such cases were reported to the Maine Division of Licensing and Regulatory Services. The law further requires an annual report to the Legislature and public.

The number of cases reported, in and of itself, is not the most important information to focus on in this report. It is the lessons that are learned and the changes that are made as a result of these events that result in a safer environment for future patients.

In 2009, the statute requiring sentinel event reporting was amended to include new reporting requirements. Highlights of those changes include adoption of the National Quality Forum list of Serious Reportable Events and enhancements to the sentinel event definition to reduce ambiguity. Additionally, facilities are required to have standardized processes for the detection and reporting of all sentinel events.

In 2012, the most prevalent type of event reported was unanticipated death. Falls with significant injury, unanticipated transfers, pressure ulcers and retained foreign objects round out the top-five most reported adverse events.

Every facility is required to conduct an in-depth analysis after every sentinel event. The facility gathers a Root Cause Analysis team and launches a review of why the event occurred, and what steps will be undertaken to prevent a recurrence. The Sentinel Event Team and facility staff will share findings to stimulate discussion in an effort to identify opportunities for system improvements. The final report is sent to the Division within 45 days of discovery of the sentinel event. The Sentinel Event Team analyzes all events for statewide trends and features. Results are then shared in the Sentinel Event Annual Report.

The Maine program has been enriched by our active participation in the National Quality Forum (NQF) and the Agency for Healthcare Research and Quality (AHRQ). The NQF and the AHRQ bring together the 27 states, including the District of Columbia, with mandatory sentinel event reporting requirements to collaborate in a national dialogue on priorities and goals to improve patient safety by preventing adverse events in healthcare.

Background

This report is submitted in accordance with Maine law (22 M.R.S.A. §§8751-8756) that requires the Division of Licensing and Regulatory Services (the Division) to annually report to the Legislature, health care facilities, and the public on the aggregate number and type of sentinel events for the prior calendar year; including rates of change, causative factors, and activities to strengthen patient safety in Maine. This report is designed to:

- Build awareness of Maine's sentinel event reporting requirements and the follow-up process used by facilities and the State when events occur
- Provide aggregate information on the number and nature of sentinel events reported
- Identify patterns and make recommendations to improve the quality and safety of patient care
- Describe efforts to address under-reporting and enhance the role of sentinel event reporting in improving patient safety

Definition of Sentinel Event

Sentinel events are outcomes determined to be unrelated to the natural course of the patient's illness or underlying condition, or proper treatment of that illness or underlying condition. The law further characterizes sentinel events as:

- Unanticipated death
- A major permanent loss of function that is not present when the patient is admitted to the health-care facility
- Surgery on the wrong patient or wrong body part
- Hemolytic transfusion reaction involving administration of blood or blood products having blood group incompatibilities
- Patient suicide or attempted suicide resulting in serious disability
- Infant abduction or discharge to the wrong family
- Rape of a patient
- Unintended retention of a foreign object
- Patient death or serious disability associated with a fall
- Death or significant injury of a patient or a staff member resulting from a physical assault

In 2010, the entire list of the National Quality Forum (NQF) Serious Reportable List was formally adopted as part of the statutory changes. NQF serious events are structured around six categories: surgical, product or device, patient protection, care management, environmental, and potential criminal.

National Quality Forum

The National Quality Forum (NQF) is a national, consensus-driven private-public partnership aimed at developing common approaches to identification of events that are serious in nature and have been determined to be largely preventable. (National Quality Forum, 2002)¹ Sometimes referred to as "never events," the NQF list increasingly has become the basis for states' mandatory reporting system. (Rosenthal, 2007)² The list of NQF serious events is intended to capture events that are clearly identifiable and measurable, largely preventable, and of interest to the public and other stakeholders. Comparability of definitions enhances clarity about what must be reported and provides benchmarks for comparing experiences across states.

Reporting Requirements

Facilities must notify the Division within one business day of discovering an event. Through a confidential telephone exchange of information, the Sentinel Event Team determines whether the incident conforms to the statutory definition of a sentinel event. Upon confirmation that the event must be reported, the facility is required to submit a brief description of the incident via a restricted fax to the Division. A facility that knowingly violates any provision of the requirements is subject to a civil penalty.

Within 45 days of discovering a reportable event, the facility is required to share a written report with the State and the facility's quality improvement committee describing key elements of the event, the circumstances surrounding its occurrence, the actions taken or proposed to prevent its recurrence, methods for communicating the event, and planned risk reduction actions.

The Sentinel Event Team may conduct an onsite review at each facility reporting a sentinel event to assess the incident and to ensure that all relevant factors are considered in the development of an action plan. The on-site review occurs shortly after the incident is first reported so that findings can be incorporated into the facility's action plan. The facility's Chief Executive Officer (CEO) is briefed during this time by the Sentinel Event Team to assure his/her active engagement in understanding factors leading to the event and plans for mitigating its recurrence. The entire medical record of the patient is reviewed during the site visit to identify contributing factors that may have gone unnoticed and have affected the outcome before, during, and after an event. This process provides an independent assessment that augments the facility's own internal review of the incident.

¹ National Quality Forum. (2002). Serious reportable events in healthcare: A consensus report. Washington, DC: The National Quality Forum.

² Rosenthal, J. & Takach, M. (December 2007). 2007 guide to state adverse event reporting systems. (State Health Policy Survey Report, Vol. 1, No. 1). Portland, ME: National Academy for State Health Policy.
http://www.nashp.org/Files/shpsurveyreport_adverse2007.pdf

Throughout their review of a sentinel event, the Sentinel Event Team studies relevant standards of care and evidence-based research to help inform their review of the facility's response to an event. Depending on the nature of the event, content experts may also be consulted to expand understanding of the possible system failures or other factors that may have contributed to a sentinel event.

Upon receipt of the facility's full written report, the Sentinel Event Team confirms that direct causal factors have been examined by the facility and that corrective actions are appropriate, comprehensive, and implemented. If the report is accepted, a letter attesting to that fact is sent to the facility's CEO. Should more information be required, a letter requesting specific details is sent to the Risk Manager with a copy to the CEO. When this report is complete, a final approval letter is sent to the facility. Should it be necessary, the Sentinel Event Team may visit the facility to follow-up on the implementation of the action plan. A flow chart diagramming the sentinel event case review process can be found in Appendix A.

Database Implementation

In 2012, the Sentinel Event Program implemented the revised Sentinel Event Database to gather and track data. Information collected on sentinel events and their reviews are entered into this confidential database which provides an updated management system for all reports coming into the program. This database generates multi-level reporting, allowing for more efficient trend tracking, and is a step forward in electronic record keeping.

Confidentiality Provisions

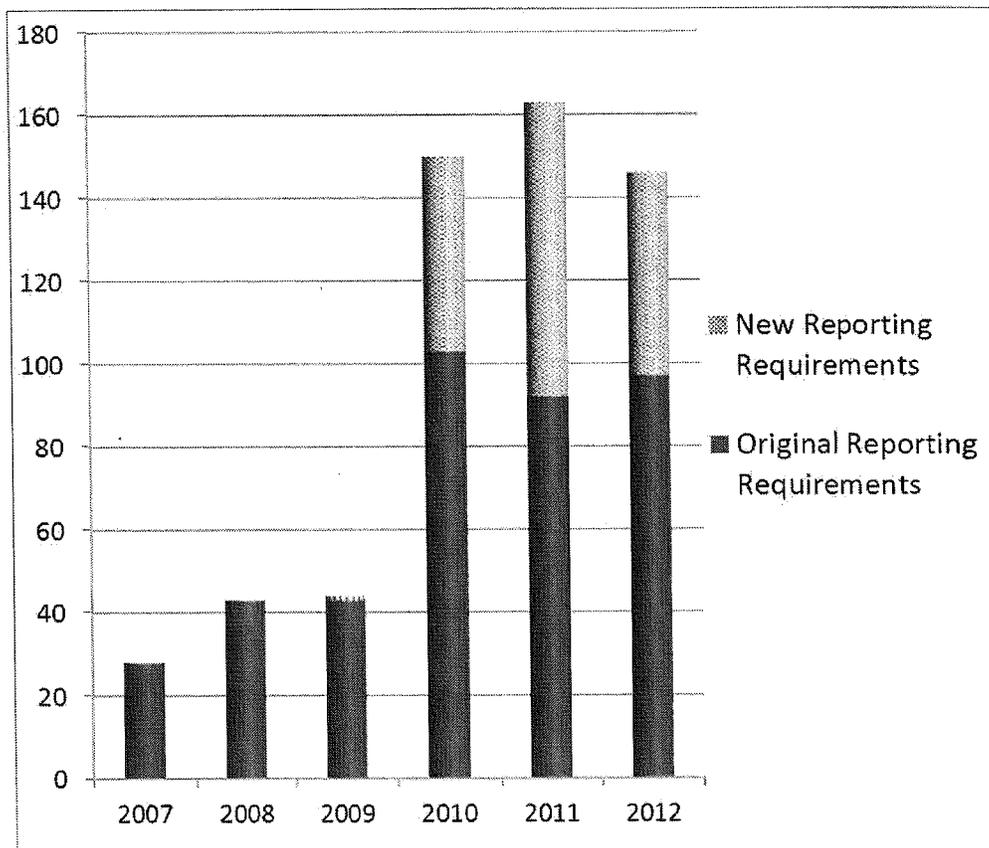
By law, all sentinel event information submitted to the Division is considered privileged and confidential. No information about facilities or providers is discoverable or made public. A firewall is maintained between the sentinel event program and the survey unit that regulates facility licensing within the State. The Sentinel Event Team is responsible for reviewing the initial reported event, conducting on-site reviews, ensuring that all contributing factors to an event are identified, and that action plans are appropriate and implemented. The Sentinel Event Team is permitted to share information with the licensing team if it determines that a sentinel event represents immediate jeopardy to the public. The information shared is limited to the Conditions of Participation for the Medicare and Medicaid certification program that was impacted by the event. This ensures that the immediate jeopardy can be investigated and separate and public corrections be made to avoid harm to the public.

Sentinel Events Historically Reported

A total of 651 sentinel events have been reported to the Division since the initiation of the program in 2004. Following focused efforts to ensure that all facilities had a heightened awareness and full understanding of the reporting requirements, reporting began to increase in 2008.

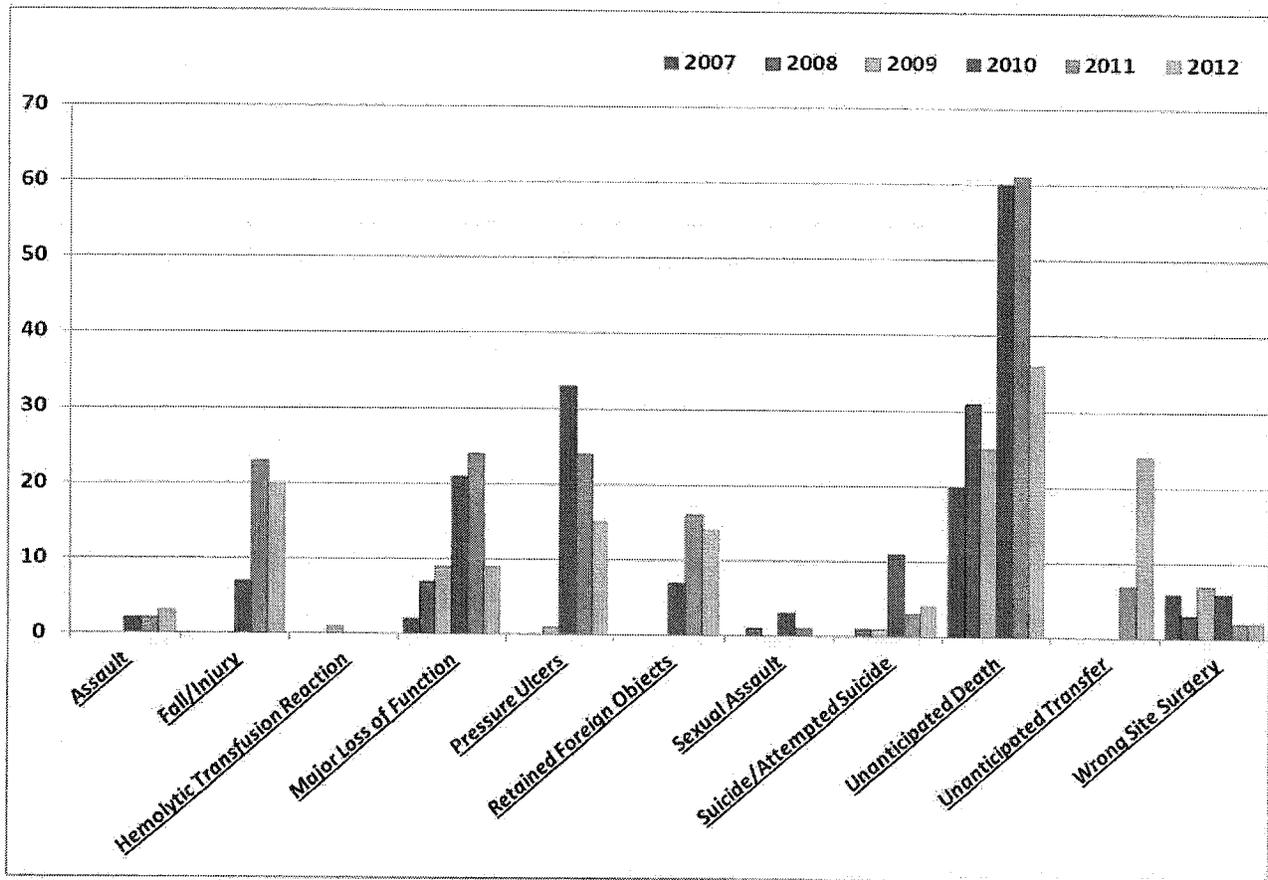
In 2010, a dramatic increase in sentinel event reporting occurred and continued through 2012. This spike in reports reflects a greater appreciation of the requirements and changes in the statutory requirements. There is also a growing awareness of the benefit of increased transparency with an emphasis on establishing a 'blame free' culture and a focus on systems improvements and reduction of the likelihood of a recurrence.

Table 1. Sentinel Events Reported, by Year, 2007-2012



Sentinel events reported during the period from 2004-2006 averaged approximately 25 sentinel events annually.

Table 2. Sentinel Events Reported, by Category, 2007-2012



	2007	2008	2009	2010	2011	2012
Assault	0	0	0	2	2	3
Fall/Injury*	0	0	0	7	23	26
Hemolytic Transfusion Reaction	0	0	1	0	0	0
Major Loss of Function	2	7	9	21	24	9
Pressure Ulcers*	0	0	1	33	24	15
Retained Foreign Objects*	0	0	0	7	16	14
Sexual Assault	0	1	0	3	1	0
Suicide/Attempted Suicide	0	1	1	11	3	4
Unanticipated Death	20	31	25	60	61	36
Unanticipated Transfer	0	0	0	0	7	24
Wrong Site Surgery	6	3	7	6	2	2

*Indicates new reporting requirements added to category 2010

During the 9 years of reporting sentinel events, hospitals have steadily increased participation in the program. By 2006, only 61% of all Maine hospitals had reported a sentinel event. By the end of 2010, 100% of the 41 acute care hospitals in Maine had reported at least one sentinel event. In 2012, there was a slight decline in the number of reporting facilities.

Table 3. Sentinel Events Reporting vs. Non-reporting Hospitals, 2012



	2007		2008		2009		2010		2011		2012	
	No.	%										
Reporting Hospitals	32	78%	33	80%	38	93%	41	100%	37	90%	34	83%
Non-reporting Hospitals	9	22%	8	20%	3	7%	0	0%	4	10%	7	17%
Total	41	100%	41	100%	41	100%	41	100%	41	100%	41	100%

Sentinel Events Reported in 2012

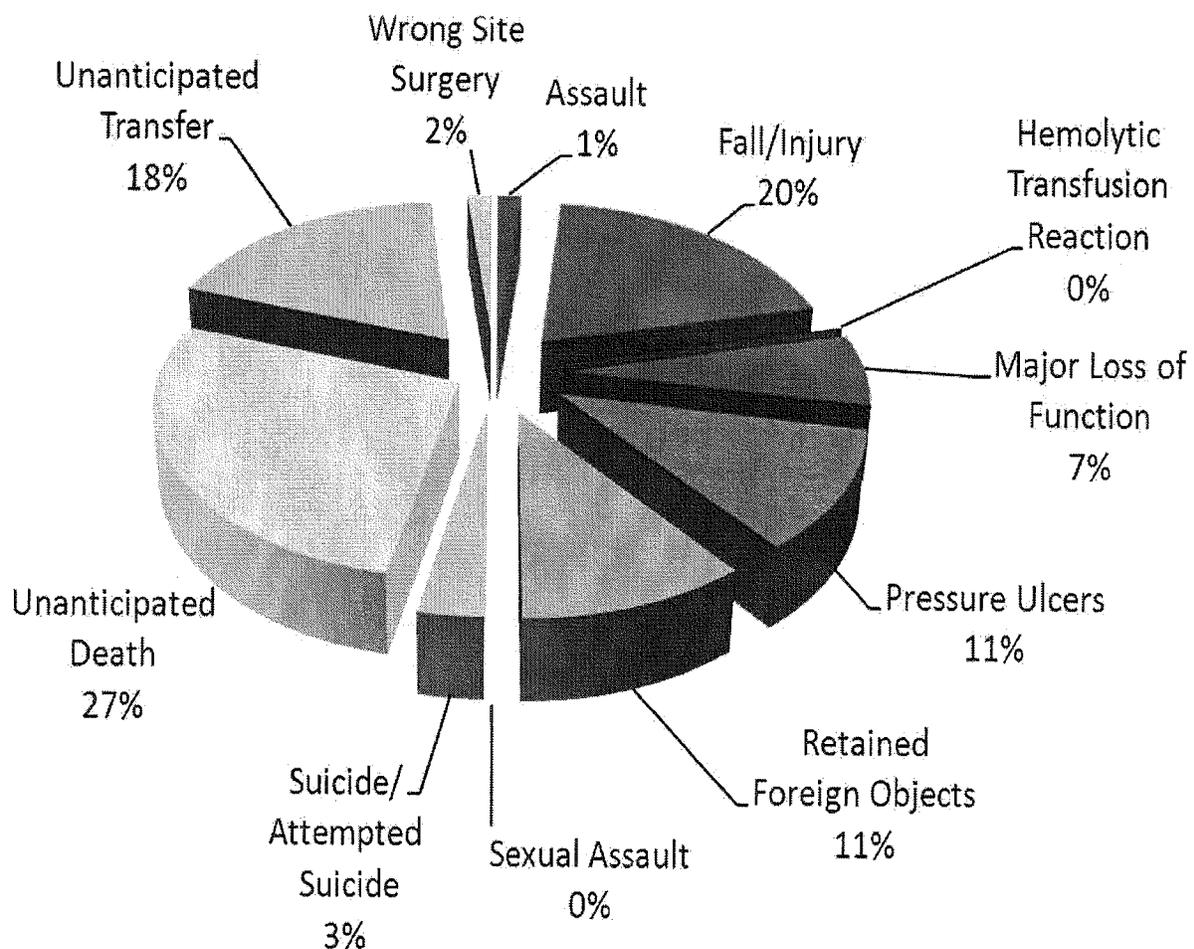
NUMBER OF SENTINEL EVENTS REPORTED IN 2012

There were 146 sentinel events reported in 2012. This is a slight decrease over the 163 reported events in 2011.

CATEGORY OF SENTINEL EVENTS

Table 4 indicates sentinel events by category in 2012. Unanticipated deaths were reported in the majority of cases at 36 (27%). Fall with Injury was the second leading event at 26 (20%) following by unanticipated transfer the third leading event at 24 (18%).

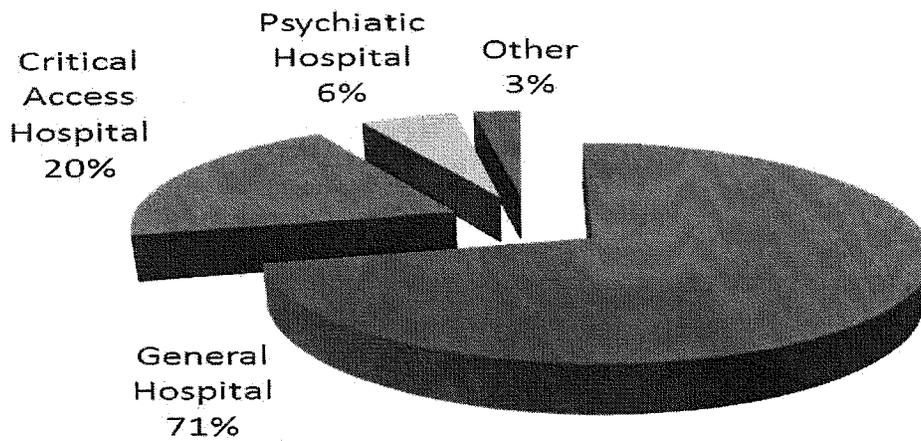
Table 4. Sentinel Events Reported, by Category of Event, 2012



TYPE OF FACILITIES REPORTING SENTINEL EVENTS IN 2012

In 2012, general hospitals represented 71% of the facilities that reported to the sentinel event program. Critical Access Hospitals accounted for 20% and Psychiatric hospitals represented 6%, while ESRD (dialysis) facilities, Ambulatory Surgical Centers and ICF/ID facilities reported 3% of cases.

Table 5. Sentinel Events Reported, by Facility Type, 2012



REPORTING VERSUS NON-REPORTING HOSPITALS, 2012

As illustrated below, 83% of the 41 hospitals had reported a sentinel event to the Division for review in 2012.

Table 6. Reporting Vs. Non-Reporting Hospitals, 2012

34 ■ Reporting Hospitals **7** ■ Non-reporting Hospitals



Conclusion

Maine's sentinel event reporting system focuses on identifying and deterring serious, preventable incidents. Mandatory reporting is the primary tool for the State to hold facilities accountable for disclosing that an event has occurred and that appropriate action has been taken to remedy the situation. The system was designed to learn from mistakes, not punish individual practitioners or providers.

To be effective, the system requires the participation of all hospitals and other reporting entities. Only by understanding the full scope of the problem can strategies be developed to improve patient safety throughout the State.

Program Goals for 2013

During 2013, the sentinel events program will work closely with hospitals and others to strengthen the reliability of reporting. To achieve this, the sentinel events program will do the following:

- Implement the updated 2011 National Quality Forum List of Serious Reportable Events
- Continue to utilize data from Maine Health Data Processing Center's all-payer claims database (APCD) to augment a review of events being reported
- Continue to perform on-site visits with hospitals and other facilities. This may include a review of documents to determine compliance with the Rules Governing the Reporting of Sentinel Events
- Continue to assess the adequacy of a facility's internal systems for detecting and reporting events
- Continue to analyze complaint data to determine if a situation reported as a complaint is a reportable sentinel event

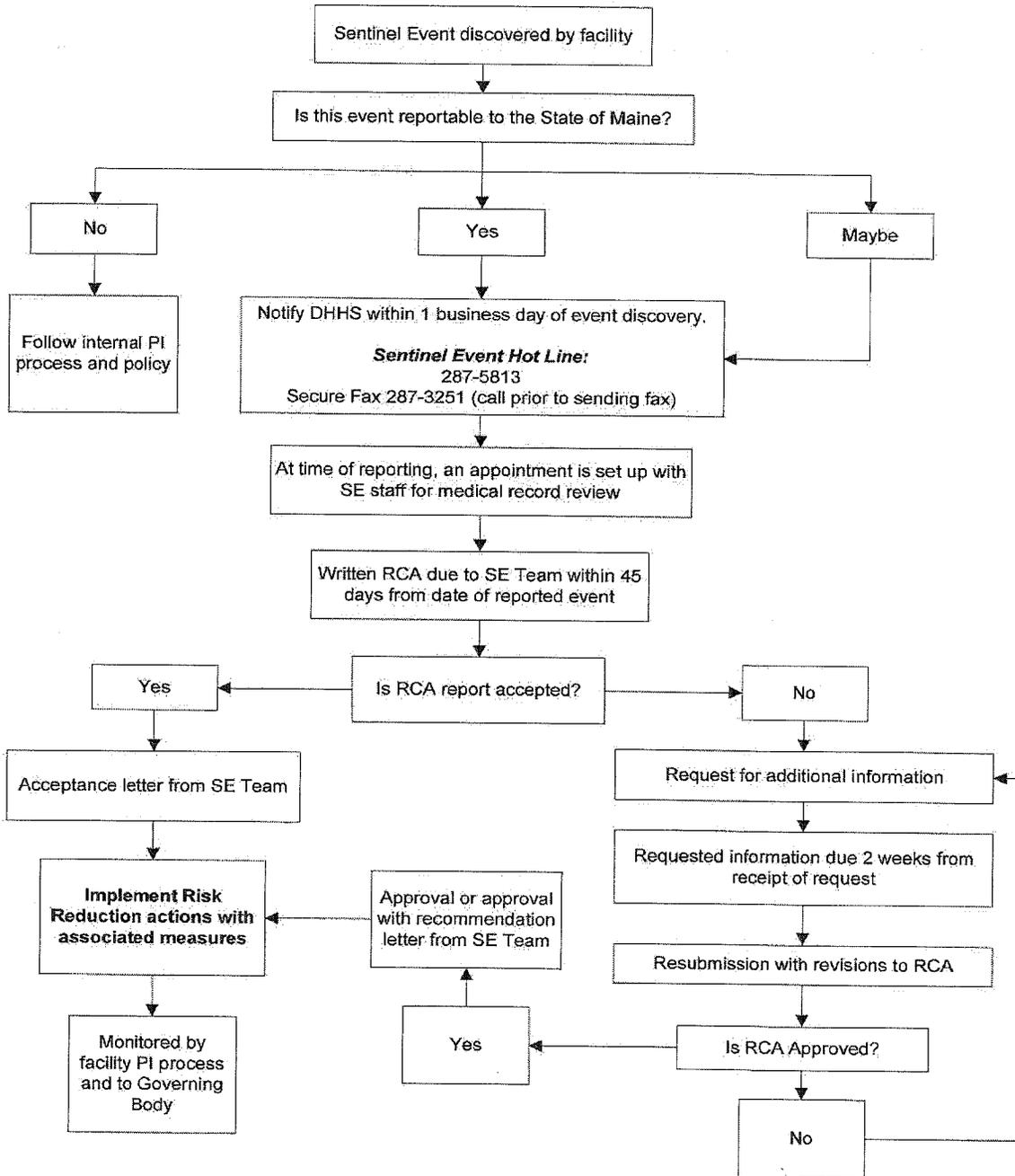
To achieve its goals, the Sentinel Events Program will continue to maintain ongoing communications with Maine hospitals, other licensed facilities and stakeholders regarding reporting requirements and lessons that can be learned to prevent events from being repeated. The Sentinel Events Program is committed to maintaining a non-punitive environment that allows for a collaborative approach for identifying serious adverse events and working toward joint solutions for reducing their occurrence.

The predominant goal of the Sentinel Events Program is to have a reporting system that helps facilitate the improvement of quality health care for all Maine's citizens.

Appendix A

Sentinel Event Process Flow

State of Maine Department of Health and Human Services
 Division of Licensing and Regulatory Services



Non-Discrimination Notice

The Department of Health and Human Services (DHHS) does not discriminate on the basis of disability, race, color, creed, gender, sexual orientation, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices. This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, the Maine Human Rights Act and Executive Order Regarding State of Maine Contracts for Services. Questions, concerns, complaints or requests for additional information regarding the ADA may be forwarded to the DHHS ADA Compliance/EEO Coordinators, #11 State House Station, Augusta, Maine 04333, 207-287-4289 (V), or 287-3488 (V)1-888-577-6690 (TTY). Individuals who need auxiliary aids for effective communication in program and services of DHHS are invited to make their needs and preferences known to one of the ADA Compliance/EEO Coordinators. This notice is available in alternate formats, upon request.

Public Records Exceptions Subcommittee

**Existing Public Records Exceptions, Titles 26 – 39-A
Statutes remaining after 2012 review**

Revised 7/19/2013 9:12 AM

TITLE	SECTION	SUB-SECTION	DESCRIPTION	DEPARTMENT/ AGENCY	COMMENTS	SUBCOMMITTEE RECOMMENDATIONS	ADVISORY COMMITTEE ACTION ON RECOMMENDATIONS
1	22	1696-D	Title 22, section 1696-D, relating to the identity of chemical substances in use or present at a specific location if the substance is a trade secret	<ul style="list-style-type: none"> DHHS 	<ul style="list-style-type: none"> No record of any experience No changes 	11/4/10: tabled 9/12/11: REPEAL 5-1 (LP) 9/29/11: wait for additional information 11/17/11: No change with letter to ENR and HHS – review letter 12/8/11: Approved letter	12/8/11: No change with letter to ENR and HHS 2012: Proposed amendment (LD 420)
2	22	1696-F	Title 22, section 1696-F, relating to the identity of a specific toxic or hazardous substance if the substance is a trade secret	<ul style="list-style-type: none"> DHHS 	<ul style="list-style-type: none"> No record of any experience No changes 	11/4/10: tabled 9/12/11: REPEAL 5-1 (LP) 9/29/11: wait for additional information 11/17/11: No change with letter to ENR and HHS – review letter 12/8/11: Approved letter	12/8/11: No change with letter to ENR and HHS 2012: Proposed amendment (LD 420)

Public Records Exceptions Subcommittee
Existing Public Records Exceptions, Titles 26 – 39-A
Statutes remaining after 2012 review
 Revised 7/19/2013 9:12 AM

TITLE	SECTION	SUB-SECTION	DESCRIPTION	DEPARTMENT/ AGENCY	COMMENTS	SUBCOMMITTEE RECOMMENDATIONS	ADVISORY COMMITTEE ACTION ON RECOMMENDATIONS
3	26	3	Title 26, section 3, relating to information, reports and records of the Director of Labor Standards within the Department of Labor	<ul style="list-style-type: none"> • DECD • SPO/OPM • DOL 	<ul style="list-style-type: none"> • DECD • SPO/OPM? • DOL: no more than one or 2/year; NO CHANGE 	9/13: Tabled-- discuss potential amendments with DOL 11/8: Amend; accepted draft	Propose repeal and replace (LD 420)
4	26	934	Title 26, section 934, relating to report of the State Board of Arbitration and Conciliation in labor dispute	<ul style="list-style-type: none"> • State Board of Arbitration and Conciliation 	<ul style="list-style-type: none"> • No requests • NO CHANGE 	9/13: Tabled—ask Board for input 11/8: Amend	Propose amendment (LD 420)
5	28-A	755	Title 28-A, section 755, relating to liquor licensees' business and financial records	<ul style="list-style-type: none"> • DAFS: BABLO 	<ul style="list-style-type: none"> • Not being collected now • Unresolved by Legislature in 125th • Support change but recommend NO CHANGE for now 	9/13: Tabled until 2013; Dept. legislation expected in 126 th Legislature, First Session	Tabled
6	29-A	152	Title 29-A, section 152, subsection 3, relating to the Secretary of State's data processing information files concerning motor vehicles	<ul style="list-style-type: none"> • SOS 	<ul style="list-style-type: none"> • Estimate: 12-20 times per year) • NO CHANGE – comply with Federal Driver Privacy Protection Act 	8/8: Amend	Propose amendment (LD 420)
7	29-A	257	Title 29-A, section 257, relating to the Secretary of State's motor vehicle information technology system	<ul style="list-style-type: none"> • SOS 	<ul style="list-style-type: none"> • No request • NO CHANGE 	8/8: Tabled—flag inconsistency with other provisions; ask OIT for input 9/13: Tabled 11/8: Repeal	Propose repeal (LD 420)

Public Records Exceptions Subcommittee

**Existing Public Records Exceptions, Titles 26 – 39-A
Statutes remaining after 2012 review**

Revised 7/19/2013 9:12 AM

TITLE	SECTION	SUB-SECTION	DESCRIPTION	DEPARTMENT/ AGENCY	COMMENTS	SUBCOMMITTEE RECOMMENDATIONS	ADVISORY COMMITTEE ACTION ON RECOMMENDATIONS
8	29-A	4	Title 29-A, section 517, subsection 4, relating to motor vehicle records concerning unmarked law enforcement vehicles	<ul style="list-style-type: none"> SOS 	<ul style="list-style-type: none"> Estimate: 1-2 every couple of years NO CHANGE 	8/8: Amend—strike 2 nd ¶ because same language in #12	Propose amendment (LD 420)
9	30-A	1-A	Title 30-A, section 503, subsection 1-A, relating to county personnel records concerning the use of force	<ul style="list-style-type: none"> Counties – Joe Brown and Tim Leet? 	<ul style="list-style-type: none"> Kennebec County: No requests NO CHANGES 	11/8: Tabled; ask AG for input	Tabled
10	30-A	1-A	Title 30-A, section 2702, subsection 1-A, relating to municipal personnel records concerning the use of force	<ul style="list-style-type: none"> <i>Municipalities</i> 	See # 20	11/8: Tabled; ask AG for input	Tabled
11	32		Title 32, section 2599, relating to medical staff reviews and hospital reviews – osteopathic physicians	<ul style="list-style-type: none"> Osteopathic Licensing Board 	<ul style="list-style-type: none"> 	11/8: Tabled; ask for input from Board and providers 11/15: Tabled	Tabled
12	32		Title 32, section 3296, relating to Board of Licensure in Medicine medical review committees	<ul style="list-style-type: none"> Medical Licensing Board 	<ul style="list-style-type: none"> Accusations of unprofessional conduct or incompetence if found to be without merit are damaging Investigative records include individual patient info NO CHANGE 	11/8: Tabled; ask for input from Board and providers 11/15: Tabled	Tabled

Public Records Exceptions Subcommittee

**Existing Public Records Exceptions, Titles 26 – 39-A
Statutes remaining after 2012 review**

Revised 7/19/2013 9:12 AM

TITLE	SECTION	SUB-SECTION	DESCRIPTION	DEPARTMENT/ AGENCY	COMMENTS	SUBCOMMITTEE RECOMMENDATIONS	ADVISORY COMMITTEE ACTION ON RECOMMENDATIONS
13	32	13006	Title 32, section 13006, relating to real estate grievance and professional standards committees hearings	<ul style="list-style-type: none"> Real Estate Commission 	<ul style="list-style-type: none"> No experience; applies to records of hearings held by professional trade associations NO POSITION: Why part of Real Estate Brokerage Act? 	11/8: Tabled; ask Maine Association for input; is this necessary?	Tabled
14	32	16607	Title 32, section 16607, subsection 2, relating to records obtained or filed under the Maine Securities Act	<ul style="list-style-type: none"> DPFR; Securities Regulation 	<ul style="list-style-type: none"> Seven requests: 5 denied to protect investigative records; 2 denied because only investigative records requested NO CHANGE 	11/8: Tabled; ask Office of Securities for input	Tabled
15	34-A	5210	Title 34-A, section 5210, subsection 4, relating to the State Parole Board report to the Governor	<ul style="list-style-type: none"> Dept. of Corrections 	<ul style="list-style-type: none"> Requested 2-3 times per year AMEND: clarify that applies regardless of entity advising Governor 	8/8: Tabled—ask Governor's Office for input 9/13: Tabled 11/8: Tabled	Tabled
16	35-A	1311-B	Title 35-A, section 1311-B, subsections 1, 2 and 4, relating to public utility technical operations information	<ul style="list-style-type: none"> PUC 	<ul style="list-style-type: none"> Occasional requests NO CHANGE 	11/8: Tabled; ask PUC for input	Tabled
17	35-A	1316-A	Title 35-A, section 1316-A, relating to Public Utilities Commission communications concerning utility violations	<ul style="list-style-type: none"> PUC 	<ul style="list-style-type: none"> No requests NO CHANGE 	11/8: Tabled; ask PUC for input	Tabled

Public Records Exceptions Subcommittee

**Existing Public Records Exceptions, Titles 26 – 39-A
Statutes remaining after 2012 review**

Revised 7/19/2013 9:12 AM

TITLE	SECTION	SUB-SECTION	DESCRIPTION	DEPARTMENT/ AGENCY	COMMENTS	SUBCOMMITTEE RECOMMENDATIONS	ADVISORY COMMITTEE ACTION ON RECOMMENDATIONS
18	35-A	8703	Title 35-A, section 8703, subsection 5, relating to telecommunications relay service communications	<ul style="list-style-type: none"> PUC 	<ul style="list-style-type: none"> Does not come through PUC Could be worded more clearly 	11/8: Tabled; ask PUC for input	Tabled
19	35-A	9207	Title 35-A, section 9207, subsection 1, relating to information about communications service providers	<ul style="list-style-type: none"> PUC ConnectME Authority 	<ul style="list-style-type: none"> No requests NO CHANGE 	11/8: Tabled; ask PUC for input	Tabled
20	36	575-A	Title 36, section 575-A, subsection 2, relating to forest management and harvest plan provided to Bureau of Forestry and information collected for compliance assessment for Tree Growth Tax Law	<ul style="list-style-type: none"> Dept. of Conservation Maine Revenue Services 	<p>DOC:</p> <ul style="list-style-type: none"> New, closely parallels §579 Never received a request under §579 NO CHANGES 	(added by PL 2011, c. 619) 11/8: Tabled; ask for input from Bureau of Forestry and MRS	Tabled
21	36	579	Title 36, section 579, relating to the Maine Tree Growth Tax Law concerning forest management plans	<ul style="list-style-type: none"> <i>Municipal assessors</i> Maine Revenue Services 	<p>MRS:</p> <ul style="list-style-type: none"> No position <p>MUNICIPALITIES</p> <ul style="list-style-type: none"> 14 municipalities responded Few requests 7 recommend NO CHANGE 2 recommend AMEND to allow Board of Assessors access 5 recommend that AMEND to make plans public 	11/8: Tabled; ask for input from Bureau of Forestry and MRS and municipal assessors	Tabled

Public Records Exceptions Subcommittee
Existing Public Records Exceptions, Titles 26 – 39-A
Statutes remaining after 2012 review
 Revised 7/19/2013 9:12 AM

TITLE	SECTION	SUB-SECTION	DESCRIPTION	DEPARTMENT/ AGENCY	COMMENTS	SUBCOMMITTEE RECOMMENDATIONS	ADVISORY COMMITTEE ACTION ON RECOMMENDATIONS	
22	36	1106-A	3	Title 36, section 1106-A, subsection 3, paragraph D, relating to forest management and harvest plan made available for Farm and Open Space Tax Law	<ul style="list-style-type: none"> • <i>Municipal assessors</i> • Dept. of Conservation • Maine Revenue Services 	<p>MUNICIPALITIES</p> <ul style="list-style-type: none"> • 12 municipalities responded • No requests (new law) • 6 recommend NO CHANGE • 2 recommend AMEND to allow Board of Assessors access • 4 recommend AMEND to allow public access <p>DOC:</p> <ul style="list-style-type: none"> • New, closely parallels §579 • Never received a request under §579 • No provision to review plans under this section • NO POSITION <p>MRS:</p> <ul style="list-style-type: none"> • NO POSITION 	(added by PL 2011, c. 618, §7) 11/8: Tabled; ask for input from DOC, MRS and municipal assessors	Tabled
23	37-B	708	3	Title 37-B, section 708, subsection 3, relating to documents collected or produced by the Homeland Security Advisory Council	<ul style="list-style-type: none"> • DVEM: MEMA 	11/8: Tabled; ask for more information	Tabled	

Public Records Exceptions Subcommittee

Existing Public Records Exceptions, Titles 26 – 39-A

Statutes remaining after 2012 review

Revised 7/19/2013 9:12 AM

TITLE	SECTION	SUB-SECTION	DESCRIPTION	DEPARTMENT/ AGENCY	COMMENTS	SUBCOMMITTEE RECOMMENDATIONS	ADVISORY COMMITTEE ACTION ON RECOMMENDATIONS
24	37-B	797	Title 37-B, section 797, subsection 7, relating to Department of Defense, Veterans and Emergency Management, Maine Emergency Management Agency reports of hazardous substance transportation routes	• DVEM: MEMA	<ul style="list-style-type: none"> • 1 – 2 request per year for general info • NO CHANGE 	11/8: Tabled; ask for more information	Tabled
25	38	414	Title 38, section 414, subsection 6, relating to records and reports obtained by the Board of Environmental Protection in water pollution control license application procedures	• DEP • BEP	<ul style="list-style-type: none"> • DEP: 1-2 requests per year • NO CHANGE • BEP: No need to access info in proceedings • NO POSITION; Clarify by including cross-reference to definition of trade secret? 	11/8: Tabled; ask DEP and BEP for more information	Tabled
26	38	470-D	Title 38, section 470-D, relating to individual water withdrawal reports	• DEP	<ul style="list-style-type: none"> • No requests • Information reported in aggregate • NO CHANGE 	11/8: Tabled; ask DEP for more information	Tabled
27	38	585-B	Title 38, section 585-B, subsection 6, relating to mercury reduction plans for air emission source emitting mercury	• DEP	<ul style="list-style-type: none"> • No requests by facilities to keep information confidential • REPEAL 	11/8: Amend	Propose amendment (LD 420)

Public Records Exceptions Subcommittee
Existing Public Records Exceptions, Titles 26 – 39-A
Statutes remaining after 2012 review
 Revised 7/19/2013 9:12 AM

TITLE	SECTION	SUB-SECTION	DESCRIPTION	DEPARTMENT/ AGENCY	COMMENTS	SUBCOMMITTEE RECOMMENDATIONS	ADVISORY COMMITTEE ACTION ON RECOMMENDATIONS
28	38	585-C	Title 38, section 585-C, subsection 2, relating to the hazardous air pollutant emissions inventory	• DEP	<ul style="list-style-type: none"> No requests by facilities to keep information confidential for at least 10 years REPEAL 	11/8: Amend	Propose repeal (LD 420)
29	38	1310-B	Title 38, section 1310-B, subsection 2, relating to hazardous waste information, information on mercury-added products and electronic devices and mercury reduction plans	• DEP	<ul style="list-style-type: none"> Few requests for each type of info; Concerns that electronic filing often means DEP has multiple copies of confidential information; lack of locked storage space for confidential records NO CHANGE 	11/8: Tabled; ask DEP for more information	Tabled
30	38	1610	Title 38, section 1610, subsection 6-A, paragraph F, relating to annual sales data on the number and type of computer monitors and televisions sold by the manufacturer in this State over the previous 5 years	• DEP	<ul style="list-style-type: none"> No requests Manufacturers do mark portions of annual filing as confidential and info is segregated from public files NO CHANGE 	11/8: Tabled; ask DEP for more information	Tabled

Public Records Exceptions Subcommittee

**Existing Public Records Exceptions, Titles 26 – 39-A
Statutes remaining after 2012 review**

Revised 7/19/2013 9:12 AM

TITLE	SECTION	SUB-SECTION	DESCRIPTION	DEPARTMENT/ AGENCY	COMMENTS	SUBCOMMITTEE RECOMMENDATIONS	ADVISORY COMMITTEE ACTION ON RECOMMENDATIONS
31	38	1661-A	4 Title 38, section 1661-A, subsection 4, relating to information submitted to the Department of Environmental Protection concerning mercury-added products	• DEP	<ul style="list-style-type: none"> • 2 requests made for confidential info • DEP followed process in § 1310-B, sub-§ 2 and requested info was able to be provided or summarized info provided • NO CHANGE 	11/8: Tabled; ask DEP for more information	Tabled
32	38	2307-A	1, 5 Title 38, section 2307-A, subsections 1 and 5, relating to information submitted to the Department of Environmental Protection concerning toxics use and hazardous waste reduction (REPEALED 7/1/12)	• DEP	<ul style="list-style-type: none"> • Only 1 request • Replaced by new statute; rules pending to implement confidentiality provision (38 MRSA § 2324, sub-§3) • CONTINUE; NO CHANGE 	11/8: Tabled; ask DEP for more information	Tabled
33	39-A	153	5 Title 39-A, section 153, subsection 5, relating to the Workers' Compensation Board abuse investigation unit	• Workers' Compensation Board	<ul style="list-style-type: none"> • Average of 6 times per year • NO CHANGE 	11/8: Amend; but HOLD for review in 2013	Tabled
34	39-A	153	9 Title 39-A, section 153, subsection 9, relating to the Workers' Compensation Board audit working papers	• Workers' Compensation Board	<ul style="list-style-type: none"> • No requests • NO CHANGE 	11/8: Tabled; ask WCB for more information	Tabled

Public Records Exceptions Subcommittee
Existing Public Records Exceptions, Titles 26 – 39-A
Statutes remaining after 2012 review
 Revised 7/19/2013 9:12 AM

TITLE	SECTION	SUB-SECTION	DESCRIPTION	DEPARTMENT/ AGENCY	COMMENTS	SUBCOMMITTEE RECOMMENDATIONS	ADVISORY COMMITTEE ACTION ON RECOMMENDATIONS	
35	39-A	355-B	11	Title 39-A, section 355-B, subsection 11, relating to records and proceedings of the Workers' Compensation Supplemental Benefits Oversight Committee concerning individual claims	<ul style="list-style-type: none"> Workers' Compensation Board 	<ul style="list-style-type: none"> No requests NO CHANGE 	11/8: Tabled; ask WCB for more information	Tabled
36	39-A	403	3	Title 39-A, section 403, subsection 3, relating to workers' compensation self-insurers proof of solvency and financial ability to pay	<ul style="list-style-type: none"> BOI 	<ul style="list-style-type: none"> No requests NO CHANGE 	11/8: Tabled; ask BOI for more information	Tabled
37	39-A	403	15	Title 39-A, section 403, subsection 15, relating to records of workers' compensation self-insurers	<ul style="list-style-type: none"> BOI 	<ul style="list-style-type: none"> Requests are rare NO CHANGE 	11/8: Tabled; ask BOI for more information	Tabled
38	39-A	409		Title 39-A, section 409, relating to workers' compensation information filed by insurers concerning the assessment for expenses of administering self-insurers' workers' compensation program	<ul style="list-style-type: none"> BOI 	<ul style="list-style-type: none"> No requests AMEND; clarify that already included within § 403, sub-§ 15 exception 	11/8: Tabled; ask BOI for more information	Tabled

G:\STUDIES 2013\Right to Know Advisory Committee\Existing Public Records Exceptions Review\Chart - to start 2013.docx (7/19/2013 9:28:00 AM)

Hon. David R. Hastings III, Chair
Hon. Joan M. Nass
Perry Antone
Shenna Bellows
Percy L. Brown, Jr
Michael Cianchette
Richard Flewelling
Mary Ann Lynch



A. J. Higgins
Mal Leary
William Logan
Judy Meyer
Kelly Morgan
Linda Pistner
Harry Pringle
Mike Violette

STATE OF MAINE
RIGHT TO KNOW ADVISORY COMMITTEE

November 15, 2012

Brian MacMaster, Chair, Board of Trustees
Maine Criminal Justice Academy
15 Oak Grove Road
Vassalboro, Maine 04989

Dear Mr. MacMaster:

The Right to Know Advisory Committee requests that the Board of Trustees consider establishing a model encryption policy for radio transmissions by law enforcement agencies and first responders that reflects current practices.

As you may know, the Right to Know Advisory Committee was created by the Legislature as a permanent advisory council with oversight authority and responsibility for a broad range of activities associated with the purposes and principles underlying Maine's freedom of access laws. Recently, the Maine Freedom of Information Coalition informed us of its concern that public safety agencies and first responders may begin encrypting radio transmissions that are not currently encrypted as part of the federally mandated switch from an analogue to a digital radio system.

As part of our work on this matter, we established the Encryption Subcommittee to study the issue and report its findings and recommendations to us. The Subcommittee was composed of Linda Pistner, chair (Office of the Attorney General), Rep. Joan Nass, Perry Antone (representing law enforcement interests), Joe Brown (representing county or regional interests), Mike Cianchette (representing State Government interests), AJ Higgins (representing broadcasting interests), Mal Leary (representing a statewide coalition of advocates of freedom of access), and Judy Meyer (representing newspaper publishers).

The Encryption Subcommittee held two meetings this summer and heard testimony from the Maine Freedom of Information Coalition, Maine Association of Broadcasters, and the Department of Public Safety. After considerable discussion, the Subcommittee made the following recommendations to us: 1) That no changes be made to existing law regarding the encryption of radio transmissions by public safety agencies and first responders; and 2) That we send a letter to the Board of Trustees of the Maine Criminal Justice Academy asking that it consider creating a model encryption policy for consideration by local law enforcement agencies.

G.A.1

The Advisory Committee has adopted those recommendations and this letter is our formal request that you consider establishing a model encryption policy that reflects current practices for consideration by local law enforcement agencies. We also request that you please inform us of any decisions or actions taken pursuant to this letter.

Thank you for your consideration of our requests.

Sincerely,

A handwritten signature in cursive script that reads "Dave Hastings". The signature is written in black ink on a white background.

Senator David Hastings III
Chair

cc: Suzanne Goucher, MFOIC

G.A.2

BOARD OF TRUSTEES MAINE CRIMINAL JUSTICE ACADEMY

December 6, 2012

Senator David Hastings III, Chair
Right to Know Advisory Committee
Maine State Legislature
13 State House Station
Augusta, ME 04333-0013

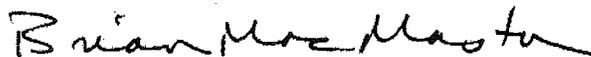
Dear Senator Hastings:

My apologies for the late response to your letter of November 15, 2012, but, for whatever reason, I only received the letter a couple of days ago.

The Board of Trustees of the Maine Criminal Justice Academy does not formulate model policies for law enforcement. The Board is charged by the Legislature with developing standards for law enforcement policies mandated by the Legislature. It is then the responsibility of each law enforcement agency in the State to develop its own policy that, at a minimum, incorporates the standards promulgated by the Board. The Board has no statutory authority to promulgate standards for policies other than those mandated by the Legislature.

Model policies for law enforcement are developed and disseminated by the Maine Chiefs of Police Association as a service to its membership. Such is the case with the mandated policies. The Association develops model policies that incorporate the Board-promulgated standards. The Association also develops other (non-mandated) model policies for its membership. Accordingly, it may be prudent to invite the Association to develop a model policy on encryption for radio transmissions. To that end, I have taken the liberty of forwarding your letter to the Board of Directors of the Association.

Sincerely,



BRIAN MACMASTER
Chair
Board of Trustees

Hon. David R. Hastings III, Chair
Hon. Joan M. Nass
Perry Antone
Shenna Bellows
Percy L. Brown, Jr
Michael Cianchette
Richard Flewelling
Mary Ann Lynch



A. J. Higgins
Mal Leary
William Logan
Judy Meyer
Kelly Morgan
Linda Pistner
Harry Pringle
Mike Violette

STATE OF MAINE
RIGHT TO KNOW ADVISORY COMMITTEE

November 15, 2012

Brenda Kielty
Public Access Ombudsman
Department of Attorney General
6 State House Station
Augusta, Maine 04333-0006

Dear Ms. Kielty:

Earlier this year, the Advisory Committee received a letter from Rep. Mary Nelson concerning the confidentiality of parent email addresses collected by schools. The issue arose from a request made to the Falmouth School Department for the home email addresses of all parents of students in the Falmouth school system. For Rep. Nelson and others, the request raised serious concerns about privacy for students, parents and their families. Because parent email addresses are maintained as part of student education records and are provided by parents to allow them to access other confidential student records, the Falmouth School Department believes they are confidential under the Federal Family Educational Rights and Privacy Act (FERPA). However, since the issue was not clear as a matter of State law, Rep. Nelson asked the Advisory Committee to consider whether our statutes should be clarified to protect the confidentiality of parent email addresses.

The Advisory Committee agreed to review Rep. Nelson's request and referred the issue to the Legislative Subcommittee for further consideration. The Legislative Subcommittee met 3 times to discuss the issue. Subcommittee members considered whether email addresses are confidential under federal law, whether State law should be changed and what practical problems might result from redacting email addresses from otherwise public documents. While the Subcommittee did consider draft legislation, the members were not able to make a unanimous recommendation on the proposal. As a result, the Subcommittee recommended that no changes be made in the statute, but agreed to revisit the issue after gathering information about whether the issue is a widespread concern or if this is an issue for one school system. Although we understand that Rep. Nelson may propose legislative changes to the 126th Legislature, the Advisory Committee supported the Subcommittee's recommendations. Shenna Bellows abstained from the Advisory Committee's vote because the ACLU of Maine is likely to support any legislation proposed by Rep. Nelson.

We are writing to ask if you could assist the Advisory Committee in this effort by surveying school departments throughout the State and gathering information about any complaints or

Ombudsman Letter
November 15, 2012

concerns brought to your attention related to the confidentiality of parent email addresses. We ask that you submit your findings, and any recommendations you may have, to the Advisory Committee by July 1, 2013 so we may consider them as part of our 2013 activities.

Thank you for your time and attention to this matter. Please feel free to contact staff, Peggy Reinsch or Colleen McCarthy Reid, if you have questions. They can be reached at the Office of Policy and Legal Analysis at 287-1670.

Sincerely,

A handwritten signature in black ink that reads "Dave Hastings". The signature is written in a cursive style with a large, prominent "D" at the beginning.

The Honorable David R. Hastings III
Chair, Right to Know Advisory Committee

cc. Rep. Mary Pennell Nelson

STEPHEN WAGNER

92 Forest Avenue
Portland, Maine 04101
207-664-3742
stephen.w.wagner@maine.edu

EDUCATION

University of Maine School of Law, Portland, Maine

J.D. Candidate, degree expected May 2015

- Class Rank: Top Quintile; Dean's List

College of the Atlantic, Bar Harbor, Maine

B.A., Human Ecology, 2011

- First recipient of the Partridge Foundation's Trans-Atlantic Partnership Award.
- College of the Atlantic official nominee for Moriss K. Udall Scholarship.
- Member of the Student Activities Committee; coordinated a sub-committee's charter revision.
- Founder and President of a student political group.

SELECTED WORK & VOLUNTEER EXPERIENCE

Maine Citizens for Clean Energy, Bar Harbor, Maine

Hancock County Election Day Coordinator, October - November 2011

- Organized thirty volunteers to gather signatures for a citizen initiative regarding clean energy standards in Maine.

College of the Atlantic, Bar Harbor, Maine

Researcher, Hancock County Firewood Project (half-time, National Science Foundation Grant), January - July 2011

- Explored the implications and feasibility of expanding wood-based heat in Hancock County, Maine.
- Conducted over 100 ethnographic interviews with county residents.
- Developed and authored the guiding document for the "Neighborhood Forests Initiative," an ambitious community development effort encouraging communal use of small, private woodlands.

Slow Food USA, Brooklyn, New York

Programs and Campaigns Intern, September - December 2011

- Represented the organization to coalition partners for food safety and child nutrition campaigns.
- Authored talking points, internal research documents, and press statements for U.S. Department of Agriculture/Department of Justice anti-trust hearings.
- Coordinated a series of internal 2012 farm bill research sessions.

Salt i Groten, Ytre Lygra, Norway

Volunteer, World Wide Opportunities on Organic Farms, Summer 2010

- Lived and worked full-time (50 hours per week) on an isolated organic farm specializing in vegetable production for retail and restaurants.
- Continued to work remotely for the Organic Research Centre.

Organic Research Centre, Newbury, United Kingdom

Policy Intern, March - June 2010 (and remotely, June - August, 2010)

- Researched, proposed and co-authored published articles on alternative legal scenarios for the expanded commercial use of the Research Centre's composite-cross wheat population project.
- Presented on behalf of the Trans-Atlantic Partnership to board members and donors at the Research Centre's 30th anniversary event.
- Lectured on international intellectual property rights regime and UK seed registration laws to class of visiting students from American and European universities.

Various other full and part-time positions to acquire experience and help finance education include: carpentry assistant, winery staff, research assistant, dairy farm apprentice, political campaign organizer/coordinator, grounds crew, and food service.

Proposed ideas for discussion

1. "Abuse" of the Freedom of Access Act (FOAA);
2. Whether restrictions should be placed on requesters;
3. Whether government records containing "personal information" that is protected under 10 MRSA Chapter 210-B, *Notice of Risk to Personal Data*, also ought to be protected from public disclosure;
4. Whether the Maine Revised Statutes also ought to be reviewed at regular intervals to determine whether currently publicly accessible records ought to instead be protected from public disclosure due to personal privacy-related concerns;
5. Whether the payment in advance threshold of 1 MRSA § 408-A(10) ought to be lowered, at least in some cases;
6. As a matter of transparency, whether persons making FOA requests should be able to do so anonymously;
7. In light of the United States Supreme Court's recent decision in *McBurney v. Young*, 569 U.S. ____ (2013), whether the FOAA ought to be clarified to state that it is available for use by Maine citizens/residents as a means to access Maine, county, and municipal government records and proceedings;
8. Whether the FOAA ought to be able to be used as an additional tool of discovery when a formal adjudicatory proceedings is already pending;
9. Whether the FOAA ought to focus solely on the public accessibility of records, and not on the public accessibility of information;
10. As a matter of clarification of policy, whether the exceptions listed in the definition of "public records" are intended to be permissive or mandatory;
11. Whether the law needs to be made clearer that public employees' date of birth information is not subject to public disclosure;
12. Whether FOAA requests made for commercial purposes ought to be subject to the fee restrictions of 1 MRSA § 408-A(8);
13. Whether a formal, standardized policy ought to be developed governing the storage, retention, and disposition of government emails;
14. Whether government records containing personal information about private citizens ought to be generally protected from public disclosure;
15. The unintended, adverse impacts of the FOAA (for example, on the preservation of historical information and on the efficiency of communications in government).

