Wisconsin Department of Children and Families

Governor Tony Evers
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dcf.wisconsin.gov

TO: Chair Snyder and Members of the Legislative Council Study Committee on Public Disclosure and Oversight of Child Abuse and Neglect Incidents

FROM: Wendy Henderson, Administrator, Division of Safety and Permanence, Department of Children and Families

Amanda Merkwae, Legislative Advisor, Department of Children and Families

DATE: August 27, 2020

SUBJECT: DCF Testimony Regarding Public Disclosure Requirements Under Act 78

The Department of Children and Families extends its thanks to the Study Committee for the opportunity to provide testimony related to public disclosure requirements under Act 78. Our DCF team for the meeting is:

- Wendy Henderson, Administrator, Division of Safety and Permanence
- Amanda Merkwae, Legislative Advisor
- Lisa Hankes, Manager, Child Welfare Program & Policy Section, Bureau of Safety and Well-Being
- Therese Durkin, General Counsel, Office of Legal Counsel
- Devon Syrjanen, Director, Bureau of Compliance, Research and Analytics

On behalf of DCF, we appreciate the interest of the committee to explore ways in which we can better understand the very tragic and often highly complex situations that are subject to public disclosure under Act 78. The children, families, and child welfare agencies involved in these most tragic incidents will be in forefront of our minds, as we discuss what might be learned from these circumstances. It is in these situations that we see both the trauma experienced by the children and their families, as well as the significant secondary trauma experienced within local child welfare agencies receiving these child protective service reports for these families and to the DCF staff who carry out the Act 78 notification, reporting, and review processes. All of us at the state and local levels are continuously seeking to learn from these very heartbreaking events.

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Child Protective Service Overview

To make sure we are starting with the same understanding of the core components of the CPS process during which cases are identified that are subject to Public Disclosure requirements, I will provide you with a brief overview of the CPS process for a screened-in case.

- The CPS agency **receives a report** of suspected abuse/neglect and determines within 24 hours whether the information gathered from the reporter constitutes suspected child maltreatment as defined under state statute. If so, the report is screened in.
- At the same time, for a screened in CPS report, the agency staff **determines the response time**: either the same-day, or within 24 to 48 hours, or five days. The response time indicates how quickly a child welfare worker must see the child and family and is generally indicative of the severity of the allegation (the quicker the response time, the more serious the allegation of abuse or neglect).
- This begins the child welfare agency's investigation, otherwise known as the **Initial Assessment (IA)**.
- During the course of the IA period, if the CPS professional determines any child in the family home is **not safe**, the development and implementation of a **safety plan is required**. Consistent with state and federal law and policy, CPS intervention to address child safety concerns should be as follows:
  - Serving the child(ren) in the family home if possible.
  - If services and supports cannot be marshalled to safely serve the child(ren) in the family home, placement with a relative should be prioritized.
  - Placement of a child with a person or in a place not known to the child(ren) is used as a last resort.
- At the conclusion of an IA, the CPS professional must make two key decisions: 1) a maltreatment determination for each allegation of abuse or neglect and 2) a determination of next steps with the family which might include opening the case for ongoing services with the CPS agency or closing the case and referring the family to other non-CPS agency services or community-based services, or closing the case with no further interventions or referrals.

Of course, there is a lot more work happening throughout this assessment process, but that is a thumbnail of the CPS Initial Assessment process.

Child Protective Services and Act 78 Context

As we begin to dig into the procedural details completed by various county and DCF staff to carry out the public disclosure requirements for Act 78 incidents, it is important to understand that critical incidents occur in a very, very small subset of particularly complex and very tragic cases. As such, these specific cases are not representative of the larger population of children and families for which local agencies are carrying out their CPS responsibilities. To best illustrate this important point, please consider the following information (see Attachment 1):

There are about 1.3M children in the state of Wisconsin.

- In 2018 local CPS agencies, including the Division of Milwaukee Child Protective Services (DMCPS), received a total of 81,633 referrals from reporters alleging maltreatment of children.
- 28,124 of these reports (34.5%) were screened in for an Initial Assessment.
- 12.8% of screened-in maltreatment allegations were substantiated. These substantiated allegations involved 4,971 unique child victims.
- In 2018, as in previous years, the most prevalent type of child maltreatment was neglect rather than physical, sexual, or emotional abuse. In 2018, neglect accounted for 65.2% of the substantiated maltreatment allegations.
- When zeroing in a bit deeper on 2018, 43 of the 94 Act 78 cases were qualified due to a suspected child maltreatment death of which, very tragically, 26 of these children’s deaths were ultimately substantiated as being caused by child maltreatment. (1.3M children, 5K child victims of abuse and/or neglect, 94 Act 78 cases, 43 Act 78 cases due to suspected child maltreatment, 26 substantiated child maltreatment deaths)

Under 2009 Wisconsin Act 78, DCF is required to provide quarterly and annual reports of alleged sexual abuse of children residing in out-of-home care placement as well as specified information for CPS reports that involve a **death**, **egregious incident of child maltreatment**, or **serious injury** as determined by a physician due to suspected child maltreatment, or a **suspected death by suicide for a child that has been placed outside the home under the Children’s Code or Youth Justice Code.** We would like to provide additional details regarding these requirements.

Quarterly and Annual Reports of Alleged Sexual Abuse of Children Residing in Out-of-Home Care Placement

- The reports include information on incidents of suspected sexual abuse to children residing in out-of-home care. These incidents include sexual abuse that occurred at any point in the child/youth's life, not just when residing in out-of-home care.
- The annual report also includes additional information regarding any injury, disease, or pregnancy resulting from these abuse cases.
- Wisconsin child welfare agencies screened in and investigated 197 reported incidents of suspected sexual abuse to 176 children residing in out-of-home care during 2019. Of the 166 reported incidents where the maltreatment determination was made during 2019, 139 were unsubstantiated while 27 of the reported incidents were substantiated.

Child Death, Serious Injuries, and Egregious Incident Reports

The Act 78 public disclosure process begins when a local CPS agency receives a report or discovers during the course of an IA or ongoing CPS services that there is reason to suspect that an incident of death or serious injury or an incident of egregious abuse or neglect has occurred. At that point, the local CPS agency has two (2) working days to provide notification of the incident to DCF using functionality within the state's information system, eWiSACWIS. Then, DCF staff have two (2) working days after receiving the information to determine if the case qualifies as an Act 78 case. If so, DCF must make the required disclosers and decide whether a review should be conducted and the scope of any review (DCF completes either a Summary Review or Practice Review). A summary review involves examining the documented case history in eWiSACWIS related to the children and their family, who were identified in the notification, in order to complete the information required for the 90-day summary. If the case was open at the time of the incident or has had recent contact through Access or Initial Assessment, DCF conducts an additional review, which is called a Practice Review. We will provide a more detailed description of the Practice Review in a few minutes. Once these decisions regarding qualification and review type are made, the notification is finalized and posted to the Public Disclosure website.

Using the Act 78 procedures chart (see Attachment 2), we will walk through the steps used by DCF staff to complete the subsequent reports that are issued to the legislative clerks and published on the DCF Public Disclosure website.

To get a sense of the frequency with which each of these procedures and corresponding tasks take place (e.g. review eWiSACWIS documentation, drafting Notifications or Reports, reviewing, editing and routing Reports, performing outreach and communications with key stakeholders, e.g. local CPS agency staff, District Attorneys, recording and tracking status of Notification and Report routing and completion, issuing and publishing Notifications and Reports to the website and legislative clerks), please consider the counts for Notifications and Reports over the last three years:

- The annual number of notices of potential Act 78 critical incidents sent to DCF by local CPS agencies is about 140 Notifications per year.
- Of these notices, we qualified an average of 100 per year as being subject to Act 78, i.e., about 70% are qualified to be critical incidents subject to Act 78 requirements.
- Of the cases that are qualified, a subset are not confirmed to be a result of child maltreatment, a concern which DCF will return to in a future committee meeting.
- As mentioned previously, a Summary Review is completed for all qualified Act 78 critical incidents and a Practice Review is completed for an average of 27% of these cases as well.
- In total, including Notifications, Summary Review and Practice Review Reports, i.e., 90-Day and 6-Month Reports, an annual average of 223 total documents were published to the DCF Public Disclosure website.

Act 78 Practice Review: Systems Change Review Process Overview

In 2016, DCF engaged Collaborative Safety, LLC, to support the implementation of a more data-driven and trauma-informed approach for conducting Act 78 practice reviews. This approach is referred to as the Systems Change Review (SCR) and was originally developed by the state of Tennessee. Systems Change Review was developed using principles from the field of Human Factors and System Safety Science that are the basis for other safety critical industries such as health care, aeronautics, and nuclear energy. By applying these principles to critical incidents in child welfare, this new process directs us away from trying to explain what happened by focusing on what could have happened differently; instead, we are now directing our **learning**

towards what people did do and why. Understanding why a decision made sense at the time doesn't mean the decision was right or wrong, and it doesn't remove accountability. Rather, it helps us understand how CPS professionals are functioning within our complex child welfare system by identifying influences, such as pressures or barriers that negatively impact our practice and helps us pinpoint where to focus systemic changes in order to reduce the impact of them. The SCR process is based on four main features of safety science: (1) Humans are not the cause of bad outcomes; they are the recipient. People make decisions because the decision made sense at the time, given the environment they are working in. (2) Causation is non-linear and non-proportional. In other words, bad outcomes are not necessarily the result of a singular event or decision. Instead, outcomes emerge from complex interactions, cross adaptations, and cumulative change within a complex system. (3) Review methods must study normal work and seek to understand the complex systems in which our child welfare workforce operates and the tradeoff decisions that must be made daily to help families. (4) Safety is created through changing the environment in which people work (i.e., removing barriers, adding supports, building better processes) instead of applying quick fixes intended to target frontline staff (i.e., new/more policy, retraining, reprimanding).

This collaborative review process is facilitated by DCF and includes the use of state and local agency reviewers who have completed formal SCR reviewer training requirements. The practice review applies a structured analysis process, which results in the compilation of both qualitative and quantitative information that is used to support child welfare system improvements. The SCR review process includes collaboration between the local child welfare agency, tribes, community stakeholders, DCF, and other relevant parties. Participants involved in this review and structured analysis process leave with a better understanding of how the various levels of our system influence case decision-making. Further, the unique and particular influences of each case are better understood in a broader context of all cases reviewed in order to support system improvement recommendations that are made based on patterns and trends, instead of one unique case, emphasizing the system accountability instead of individual blame. The SCR process and results of the reviews completed over the course of the SCR implementation since 2017 are routinely used to inform professional development and continuous quality improvement initiatives. More information about the Systems Change Review process and review results can be found at the following DCF website:
https://dcf.wisconsin.gov/cwportal/access-ia/act78

Conclusion

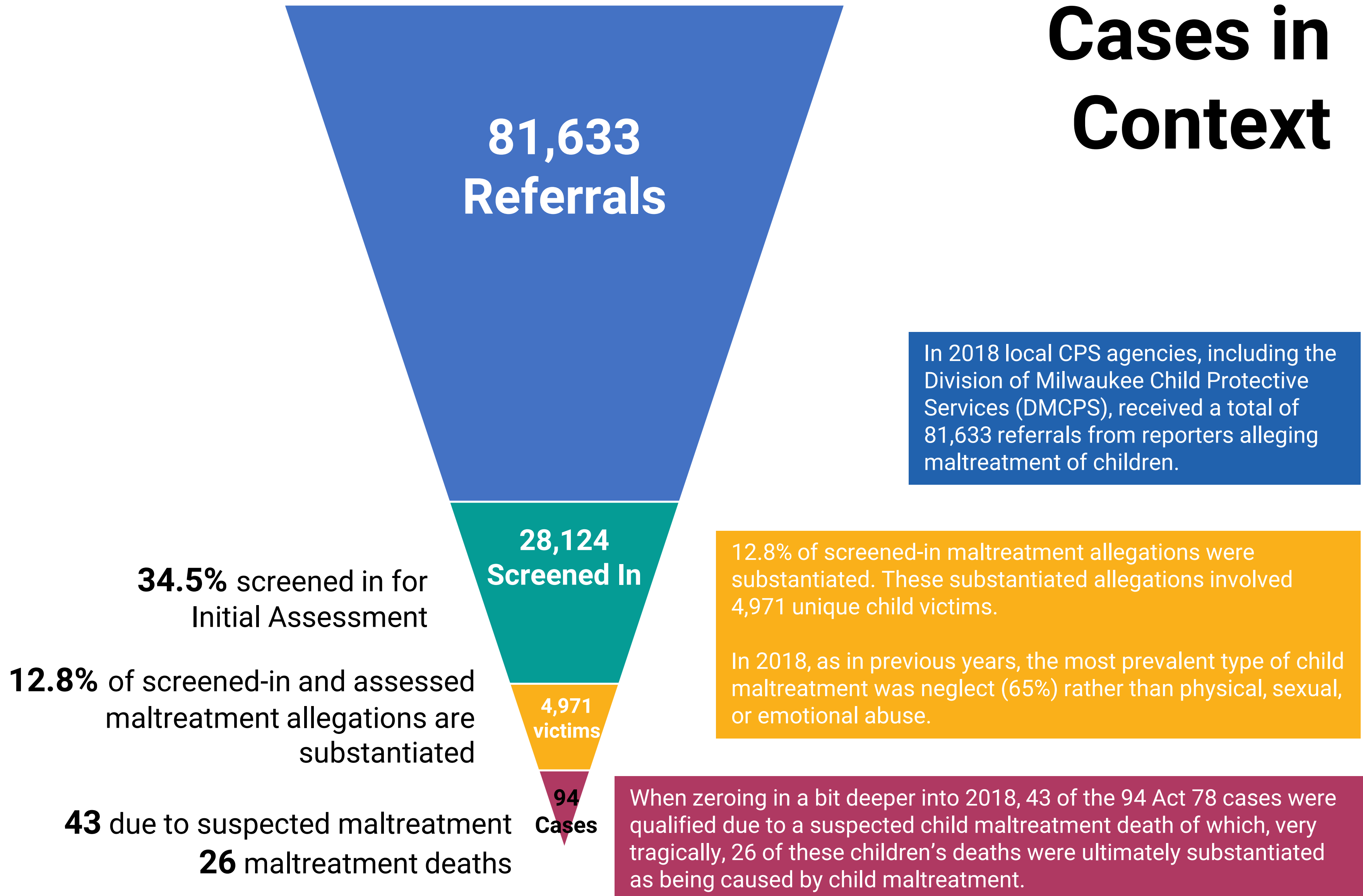
Thank you for your time. We look forward to a being part of this study committee in identifying ways our state's requirements in carrying out Public Disclosure responsibilities currently outlined in Act 78 can be best set up to inform us in finding ways to improve our local child welfare systems to help children and their families. We are happy to answer any questions from the committee now.

Wisconsin Department of Children and Families

Attachment 1

There are about 1.3M children in the state of Wisconsin.

Act 78 Cases in Context



Attachment 2

Qualification

Incident Notification
90-Day Report Only No further Review

Qualify/Disqualify

All of this is done within 2 Business Days of Incident Notification

Post Public Notification

Provide PDF to SO

(See the Back Side for "Practice Review" Additional Steps)

County Supervisor Receives Email if 90-Day I.A. is not Complete
Day 50 – 60

PPA Adv Email County Supervisor if not Completed by Day 60

90-Day Summary Report

County Agency Completes 90 Day Summary Report in Ewisacwis
60 Days from Qualification
(Ewisacwis Tickler is set for 60 days from qualification date)

BSWB 90 Day Summary Report Preparation
5 Days

Internal Routing
OLC Review
5 Days

Director
BSWB Director Edit
5 Days

Internal Routing
S.O./Communications Review
5 Days

BSWB Director Final Edits, Check Status of Criminal Charges & if Needed Finalize DA Delay Decision
ASAP

Post 90 Day Summary or Post Notice of Delay
5 Days for a Total of 90 Days or Less

Provide PDF to SO

90-Day Report Plus 6-Month Summary Report

Incident Notification
90-Day Report With Further Review
(6-Month Report)

County Review Correspondence
Same Day as Public Notification

System Change Review
(3-6 Months)

BSWB 6-Month Summary Report Prep
(6-Months)

Internal Routing Process

See Prior Page

Send for County Preview
(5 Days Prior to Posting)

Post 6-Month Summary

Provide PDF to SO