WI Department of Children & Families Proposed Revisions to Act 78

Wisconsin law, 2009 Wisconsin Act 78, requires public disclosure and reporting for a small percentage of child abuse and neglect incidents that meet certain criteria as well as a suspected suicide of a child in out-of-home care. These incidents represent a narrow subset of all child abuse and neglect reports that are made to CPS and law enforcement in Wisconsin. In addition, Act 78 also requires public disclosure of information related to reports involving sexual abuse of a child placed in out-of-home care. Wisconsin's public disclosure requirements under Act 78 were enacted to inform the public and the legislature of these specific critical incidents and to comply with the federal Child Abuse Protection and Treatment Act (CAPTA) requirements specific to public disclosure of the findings or information about cases of child abuse or neglect that have resulted in child fatalities or near fatalities.

DCF is proposing the following revisions specific to hearings conducted by the legislature and information disclosed in public notifications. The recommendations can be considered in isolation, but together we believe they provide the best opportunity for public oversight of the system through sharing meaningful information and improving public hearings. Revised in this way, the Department would be able to make overarching recommendations for systems change guided by the information we gather in both our egregious incident reviews and the state oversight and continuous quality improvement efforts of the child welfare system as a whole.

Proposed Revisions

Hearings

Recommendation 1: Combine the annual Child Abuse and Neglect (CAN) and Act 78 hearings.

Currently, the annual Act 78 hearing focuses on critical incidents and does not allow for a broader review of a culmination of information regarding our child welfare system. **DCF recommends eliminating the annual Act 78 hearing and combining aggregate information into one annual Child Abuse and Neglect (CAN) hearing.** The annual hearing would continue to include information related to child abuse and neglect, as well as general information about cases that qualified for Act 78 (e.g. the number of notifications, number of cases qualified, etc.). In addition, the annual hearing would be focused on sharing combined, systems-level data and significant systems improvements and policy recommendations. Additionally, at an established, longer interval, DCF would provide longitudinal trends of aggregated information specific to cases that qualify for Act 78 which can also be discussed at the hearing.

Moving to an annual, combined hearing is consistent with the theory and principles that underpin DCF's critical incident review process. The results of critical incident reviews are most meaningful at an aggregated level and when evaluated with other relevant administrative and case review data. Considering policy and/or practice changes for each critical incident individually and independent of other critical incidents does not go far enough to improve systems learning nor does it adequately address the complexity of the child welfare system. In order to use learnings from critical incidents to effect positive change in policy and programs on a state level, it is important to look at how systems factors within and across cases affect the decision making and practice of our workforce.

As such, an annual hearing that focuses on aggregate data and systems-level improvements is the best way to identify opportunities for meaningful potential legislative changes that would support practice changes. Any recommendations derived from this aggregate review of critical incidents could also be included in the WI CAN Report.

Information Requirements

Recommendation 2: Redefine which cases require public notification.

Currently public information is posted in instances where no maltreatment has been confirmed. In cases where a child fatality or near-fatality occurs and is not linked to maltreatment, it is an unnecessary violation of the privacy of the family involved to have information about their child's tragic circumstances posted to the DCF website. **DCF recommends redefining critical incidents that require public notification to only include critical incidents that are linked to substantiated maltreatment.** A determination regarding whether the critical incident would qualify for public disclosure would not be made until the local child welfare agency's investigation (the initial assessment) is complete. This ensures that only those cases where it has been determined that maltreatment occurred in a case of a child death, serious injury, or egregious incident are reported publicly.

This modification would eliminate the unnecessary reporting of case and family information on incidents not determined to be the result of child abuse or neglect. Review of cases in which abuse or neglect was not determined to have resulted in the death or serious incident provides less valuable insight into child welfare systems-level factors than review of cases in which abuse or neglect played a part in the incident. This revision aligns with child fatality reporting in the Wisconsin Child Abuse and Neglect (CAN) Report, other child welfare jurisdictions' public disclosure policies, and CAPTA requirements.

Recommendation 3: Limit information disclosed in public notifications to pertinent information.

Currently, the information required to be disclosed in critical incident reports includes details unrelated to the critical incident. This detailed information, in any other circumstance, would be protected from disclosure under our confidentiality statutes. Additionally, it takes a significant amount of staff time to gather the necessary information via eWiSACWIS records, de-identify the information and complete the Summary Reports. **DCF recommends limiting the information required to be disclosed to include only individuals and information that is pertinent to the critical incident.** Whose information is disclosed should be narrowed to only the child who was the subject of the critical incident, that child's parents and siblings in the home at the time of the incident, alleged maltreaters, and other caregivers or case participants who are pertinent to the critical incident. Similarly, what information is disclosed should be limited to only information describing previous reports or child abuse and neglect allegations that are pertinent to the maltreatment that lead to the child death or near death. This modification would ensure that what is shared publicly only includes information that is pertinent to the critical incident. Prioritizing family confidentiality in incidents of child deaths and near deaths and focusing just on information that is pertinent to the incident is consistent with guidance from the Children's Bureau.