# Wisconsin Legislative Council

## STUDY COMMITTEE MEMO

**Memo No. 03**

TO: MEMBERS OF THE STUDY COMMITTEE ON PUBLIC DISCLOSURE AND OVERSIGHT OF CHILD ABUSE AND NEGLECT INCIDENTS

FROM: Melissa Schmidt, Senior Staff Attorney, and Amber Otis, Staff Attorney

RE: Committee Options for Possible Legislation

DATE: November 11, 2020

This memo summarizes options for possible legislation that have been proposed to the Study Committee on Public Disclosure and Oversight of Child Abuse and Neglect Incidents. It reflects a preliminary list of options for changes to current law that are within the study committee's scope, as summarized by Legislative Council staff. This memo provides a basis for committee discussion on November 18, 2020, as to which legislative proposals the committee would like to review as a bill draft for consideration at its next meeting scheduled for December 10, 2020.

# PUBLIC DISCLOSURES OF AND QUARTERLY REPORTS OF SEXUAL ABUSE

## Background

Current law requires the Department of Children and Families (DCF) to prepare a quarterly report that summarizes all reports received during the previous calendar quarter of sexual abuse of a child who is placed in out-of-home care (OHC). In the fourth quarterly report, DCF must also provide information about all reports of sexual abuse received during the previous year, including whether the abuse resulted in any injury, disease, or pregnancy that is known to be directly caused by the abuse. Current law further requires DCF to transmit the quarterly reports to the Governor and the appropriate standing committees of the Legislature.

Under current law, the quarterly reports include all reports of the specified types of sexual abuse of a child placed in OHC that are received during the time in which the child is placed in OHC, regardless of when the alleged incident occurred or the relationship between the child and the alleged maltreater.

## Options

- Limit the quarterly reports to summaries of reports of sexual abuse that are alleged to have occurred while a child was placed in OHC. [See WLC: 0001/P1, relating to reports of sexual abuse of children placed in out-of-home care.]
- Limit the quarterly reports to summaries of reports of sexual abuse by an OHC provider that are alleged to have occurred while a child was placed in OHC.

# PUBLIC DISCLOSURE OF AND REPORTS OF CRITICAL INCIDENTS

## Background

State law requires DCF to publicly disclose, and provide summary reports on, certain information related to child abuse and neglect incidents that result in death or serious injury and incidents of egregious abuse or neglect (critical incident). DCF must, within two working days after receiving a report of a critical incident from a child protective services (CPS) agency, publicly disclose information specified by statute in a **two-day notification**.

Within 90 days after receiving a report of a critical incident, DCF must prepare a summary report of its review of the incident, transmit it to the Governor and to the appropriate standing committees of the Legislature, and make it available to the public. The content of this **90-day summary report** is set by statute, in that certain types of information must either be excluded or included. DCF must identify changes in policies, practices, rules, or statutes that may be needed to address issues identified in the review. Additional types of information that must be included differ depending on whether, at the time of the incident, the child was residing in the child's home or placed in OHC.

If the 90-day summary report does not contain DCF's recommendations for further changes in policies, practices, rules, or statutes that may be needed to address issues raised in the review, then DCF must prepare a final summary report and include those recommendations within six months after receiving a report of a critical incident. This report, commonly referred to as the **six-month summary report**, must be made publicly available and transmitted to the Governor and the appropriate legislative standing committees.

DCF is required to prepare and publicly disclose the two-day notification and summary reports described above, regardless of whether a CPS agency has investigated the critical incident and determined that child abuse or neglect has occurred.

## Options

- Require DCF to publicly disclose and prepare summary reports for only those critical incidents in which a CPS agency has conducted an investigation and determined that child abuse or neglect occurred. [See WLC: 0002/P1, relating to limiting the public disclosure of incidents of death, serious injury, or egregious abuse or neglect of a child to incidents of substantiated child abuse or neglect.]
- Limit the information that DCF must include in a summary report to information that is pertinent to the child abuse or neglect that led to the critical incident. [See WLC: 0003/P1, relating to limiting the public disclosure of information to that pertinent to the child abuse or neglect.]
- Require DCF to report aggregated data of critical incidents, either in DCF's annual *Child Abuse and Neglect Report* (*CAN Report*) or in another separate report that is either prepared annually or at another interval, such as the report proposed under "Reports Containing Aggregated Data of Critical Incidents" on page 4 of this memo.
- Eliminate the requirements for a two-day notification and six-month summary report; limit the critical incidents for which DCF must prepare 90-day summary reports to incidents in which the CPS agency determined the child abuse or neglect occurred; and narrow the content of the 90-day summary reports to contain the following information:
    - Scope of the review and the identities of any other agencies with which DCF cooperated.
    - Date of the incident.

- Whether the incident occurred in the child's home or in OHC placement.
- Age, gender, and race or ethnicity of the child.
- Findings on which the CPS agency bases its determination that a critical incident occurred, including any material circumstances leading to the critical incident.
- A summary of any actions taken by the CPS agency.
- Any special needs of the child.
- Description of any previous CPS reports or investigations that are pertinent to the child abuse or neglect that led to the critical incident, and the results and summary of services provided to the child or the child's family at the time of the critical incident.
- If the child was placed in OHC at the time of the critical incident, the licensing history of the OHC placement, including the type of license held by the operator of the placement.

# ANNUAL HEARING BY LEGISLATIVE STANDING COMMITTEES

## Background

Current law requires the appropriate standing committees of the Legislature to do all of the following: review all summary reports on critical incidents and all quarterly reports regarding sexual abuse of children placed in OHC; conduct a public hearing on those reports at least annually; and submit recommendations to DCF regarding those reports.

## Options

- Require an annual hearing on one or more of the following:
  - DCF's *CAN Report*.
  - Aggregated and trend data about critical incidents, to be included in DCF's *CAN Report*.
  - Information regarding DCF's system change reviews, described under "County System Change Reviews" on pages 4 and 5 of this memo.
  - A new annual report from DCF providing aggregated information and analysis on various types of information, as described under "Reports Containing Aggregated Data of Critical Incidents" on page 4 of this memo.
  - Annual reports from citizen review panels, as described under "Citizen Review Panels" on pages 5 and 6 of this memo.
  - Data from local child death review (CDR) teams regarding a child's death caused by child abuse and neglect, as described under "Child Death Review Teams" on page 6 of this memo.
  - Reports received from the CDR State Advisory Council, as described under "Child Death Review Teams" on page 6 of this memo.
- Repeal the requirement that the appropriate legislative standing committees conduct an annual hearing on the individual summary reports on critical incidents.
- Authorize the appropriate legislative standing committees to convene under closed session, upon a majority vote of the committee, to review confidential case information related to DCF's summary reports on critical incidents. For this option, the committee may wish to consider the following:
  - Whether to require committee members to sign confidentiality agreements, because a governmental body's authority to convene in closed session relates only to the open meeting requirement; the authority to convene in closed session does not have an effect on the treatment of the content of the closed session.

- Whether to specify, as required under federal Child Abuse Prevention and Treatment Act (CAPTA), that a member of the legislative committee, as an authorized recipient of otherwise confidential CPS information, is generally bound by confidentiality restrictions and prohibited from any re-disclosure of the information provided.

# REPORTS CONTAINING AGGREGATED DATA OF CRITICAL INCIDENTS

## Background

Current law does not specifically require DCF to aggregate the information that it provides in a summary report on a critical incident.

## Options

- Require DCF to do all of the following: (1) prepare an annual report that aggregates all 90-day summary reports and critical incident trends, over a three-year period; (2) transmit the report to the Governor and the appropriate standing committees of the Legislature; and (3) include all of the following in the report:
  - The child's demographic information.
  - The location of the child when the incident occurred and whether the child was residing in the home or placed in OHC at the time of the incident.
  - Information about any changes to the services or interventions provided to the child or the child's family, and recommendations made by DCF to the CPS agency in its review of the critical incident.
  - Narrative information regarding any systemic issues identified during a systems change review, if applicable, along with information about both of the following: (1) interventions or changes that the CPS agency made as a result of the review; and (2) recommendations made by DCF or the CPS agency to the Legislature.
  - Recommendations related to safety improvements that were submitted to DCF by either a citizen review panel or a CDR team, as described under "Citizen Review Panels" and "Child Death Review Teams" on pages 5 and 6 of this memo.
- Require DCF to prepare a report that contains a five-year retrospective review of critical incident data, including the following information:
  - Socioeconomic and demographic information about the child and the child's family (e.g., financial stress, housing instability, educational attainment, race, age, number of parents in the home, mental health, disability).
  - CPS employee information (e.g., information about CPS employee caseload, stress, length of service, policy, training, supervision).
  - CPS agency systemic issues identified (e.g., failure to properly report, lack of communication with the family, lack of statutory authority to intervene).
  - Data from a citizen review panel and a CDR team, if applicable, as described under "Citizen Review Panels" and "Child Death Review Teams" on pages 5 and 6 of this memo.

# COUNTY SYSTEMS CHANGE REVIEWS

## Background

Multiple investigations occur when a CPS agency receives a report of suspected child abuse or neglect that results in a critical incident. For example, the CPS agency screens and investigates whether child

abuse or neglect has occurred or is likely to occur. The CPS agency also conducts an internal investigation after certain events occur.

DCF also conducts an investigation when it receives a report from a CPS agency that a critical incident has occurred. Incidents for which CPS has provided significant or current intervention receive a "practice review," referred to as the "systems change review."

DCF's systems change review includes a human factors debriefing of CPS professionals and supervisors, followed by a mapping session of the human factors involved in the incident. The mapping session, in part, creates a visual representation of the system and its influences. Using the systems analysis tool developed by Collaborative Safety, LLC, the mapping is converted into the "second story." The second story incorporates influences and details that are typically not included in the case file, to reflect the system's influences and constraints pertinent to the work of CPS professionals. [DCF, Systems Change Review: 2018-2019 Results, pages 4 and 23.]

## Options

- Create a process by which DCF provides technical assistance to CPS agencies in replacing their internal review process for critical incidents with a process similar to DCF's systems change review.
- Create a grant program that provides financial assistance to CPS agencies seeking to replace their internal review process for critical incidents with a process similar to DCF's systems change review.
- Create a process by which DCF may conduct a systems change review of any incident of child abuse and neglect, upon the request of the CPS agency that investigated the incident.
- Create a grant program that provides funding for CPS agencies to implement changes that are identified in the systems change review process.
- Require regional and statewide evaluations of issues identified in a systems change review and create a strategic implementation plan for responding to those issues.

# CITIZEN REVIEW PANELS

## Background

Current state law does not govern citizen review panels. However, citizen review panels exist in Wisconsin by virtue of CAPTA. Each panel, comprised of volunteer members, must evaluate the extent to which the state is fulfilling its child protection responsibilities in accordance with the state CAPTA plan by: examining the policies, procedures, and practices of state and local child protection agencies; and reviewing specific cases, where appropriate. Panels are specifically authorized to review child fatalities and near fatalities.

Each panel must report annually on its activities and recommendations to improve both the state and local CPS systems. Within six months, DCF must respond in writing and describe whether or how the state will incorporate the panel's recommendations, where appropriate, to make measurable progress in improving the state and local CPS systems.

CAPTA provides a state with the flexibility to implement citizen review panels in a way that best meets its needs. Wisconsin currently has eight citizen review panels. Each panel's activities vary widely, as do the length and content of each panel's annual report.

## Options

- Require any citizen review panel established in this state to send its annual report to the appropriate legislative standing committees for review at an annual hearing.
- Require any citizen review panel established in this state to send its annual report to DCF for DCF's analysis, which must be included in a new type of annual report that is sent to the appropriate legislative standing committees, as described under "Reports Containing Aggregated Data of Critical Incidents" on page 4 of this memo.
- Create a new state statute governing citizen review panels to specify certain uniform duties and annual reporting requirements, and require that panels' annual reports be subject to an annual hearing by the appropriate legislative standing committees.

# CHILD DEATH REVIEW TEAMS

## Background

In Wisconsin, over 50 counties have voluntarily organized CDR teams, in the absence of any governing state statute. Local CDR teams receive assistance from the Children's Health Alliance of Wisconsin's (CHAW) Keeping Kids Alive in Wisconsin program, which is funded, in part, by the Maternal and Child Health Title V block grant administered by the Department of Health Services (DHS).

According to CHAW, CDR teams review all sudden and unexpected child deaths, including those resulting from accidents, homicides, SIDS, suicides, or child abuse and neglect. CDR teams include members from various disciplines who meet regularly and complete a data form for each death, using information from each member's agency records that describe the agency's role in the incident, investigation, or services provided to the family.

The CDR State Advisory Council, technically housed within DHS, advises the Keeping Kids Alive program and fulfills various functions, including: helping develop local CDR teams; identifying training needs; reviewing child deaths either upon request by a local CDR team or when a county has not established its own CDR team; educating the public; and providing information to the Legislature, state agencies, and local communities.

## Options

- Require a CDR team that is voluntarily organized by a county to send specified data from its review of a child's death caused that is by child abuse or neglect to the appropriate legislative standing committees.
- Require a CDR team that is voluntarily organized by a county to send data related to its review of a child's death caused by child abuse or neglect to DCF and require DCF to analyze this data in a new type of annual report provided to the appropriate legislative standing committees, as described under "Reports Containing Aggregated Data of Critical Incidents" on page 4 of this memo.
- Codify current practice by creating a statute establishing a CDR program within DHS, a CDR State Advisory Council, and local CDR teams to conduct child death reviews; and require that: (1) the CDR State Advisory Council report annually to the appropriate legislative standing committees; and (2) those committees conduct an annual hearing to review the newly created report.

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