
Wisconsin Legislative Council

STUDY COMMITTEE MEMO



Memo No. 01

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

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

RE: Examples of Neighboring States' Laws Relating to Public Disclosure and Legislative Oversight of Critical Incidents of Child Abuse and Neglect

DATE: September 16, 2020

The Study Committee on Public Disclosure and Oversight of Child Abuse and Neglect Incidents is directed, in part, to analyze whether the requirements created by 2009 Wisconsin Act 78 provide an effective mechanism for public disclosure and legislative oversight of certain egregious incidents of child abuse or neglect. At the committee's meeting on August 27, 2020, committee members requested information on other states' laws related to the public disclosure and legislative oversight of critical incidents of child abuse and neglect.

This memo provides examples of neighboring states' laws that both require public disclosure of certain types of child abuse and neglect incidents and include specific methods for legislative oversight in those states. This memo should not be construed as an exhaustive description of these state laws.

ILLINOIS

Method of Public Disclosure

In Illinois, when a reported case of child abuse or neglect involves a child's death, or when a child's death or serious life-threatening injury involves a child whose care, custody, or guardianship has been transferred to the state, the Illinois Department of Children and Family Services must: (1) investigate or provide for an investigation of the cause of and circumstances surrounding the death or serious life-threatening injury; (2) review the investigation; and (3) prepare and issue a report that includes all of the following information:

- The cause of death or serious life-threatening injury, whether from natural or other causes.
- Any extraordinary or pertinent information concerning the circumstances of the child's death or serious life-threatening injury.
- Identification of child protective or other social services provided or actions taken regarding the child or the child's family at the time of the death or serious life-threatening injury or within the preceding five years.
- Any action or further investigation undertaken by the department since the death or serious life-threatening injury of the child.

- As appropriate, recommendations for state administrative or policy changes.
- Whether the alleged perpetrator of the abuse or neglect has been charged with committing a crime related to the report and allegation of abuse or neglect.
- A copy of any documents, files, records, books, and papers created or used in connection with the department's investigation of the death or serious life-threatening injury of the child.

If the department receives a public request for information relating to a case of child abuse or neglect involving the death or serious life-threatening injury of a child, the department's director must consult with the local state's attorney and release the report related to the case, subject to several exceptions.

Method of Legislative Oversight

Upon the completion of each report described in the previous section, and no later than six months after the date of the death or serious life-threatening injury, the department must notify certain legislative leaders, along with the legislators in whose district the death or injury occurred. In addition to such notification, the department must submit an annual cumulative report to the Governor and the Legislature incorporating cumulative data about the above reports and including appropriate findings and recommendations. These cumulative reports are also made available to the public. [325 Ill. Comp. Stat. Ann. 5/4.2.]

Child Death Review Teams¹

Illinois law provides for an Inspector General within the Department of Children and Family Services, who, among other duties, must appoint members to regional child death review teams. Very generally, an Illinois child death review team must review a child death within 90 days following completion of the department's investigation described above. The Illinois Child Death Review Teams Executive Council, consisting of the chairpersons of each of the regional child death review teams, must prepare an annual report that includes: (1) each recommendation made by a child death review team; (2) the department director's proposed schedule for implementing each recommendation; and (3) a description of the specific changes in the department's policies and procedures that have been made in response to the recommendation. The Executive Council must send its annual report to various recipients, including each member of the Legislature. [20 Ill. Comp. Stat. Ann. 515/15, 20, and 40.]

INDIANA

Method of Public Disclosure

Under Indiana law, reports of child abuse and neglect, and related records, are generally confidential. The public may have access to certain redacted information in cases regarding a child whose death or near fatality may have been the result of abuse, abandonment, or neglect. Examples of redacted information that may be provided to the public include a summary of the report, a factual description of the contents, the child's date of birth and gender, the cause of the fatality or near fatality, if it has been determined, and certain information about any contact the Indiana Department of Child Services had with the child or the child's family either before the fatality or near fatality. Public access to such information involves a procedure that is overseen by a court. [Ind. Code s. 31-33-18-1.5.]

¹ Many counties in Wisconsin have established child fatality review teams, but their operations differ among counties and are not generally governed by state statute. Note that Wisconsin law allows for disclosure of confidential reports and records to a child fatality review team recognized by a county department. [s. 48.981 (7) (a) 15., Stats.]

Access to Records by State Officials

In addition, Indiana law allows reports of child abuse and neglect, including unredacted reports and other material, to be made available to specified individuals as an exception to the general rule of confidentiality. Specifically, unredacted records may be made available to an “appropriate state or local official responsible for child protection services or legislation carrying out the official’s official functions.” In addition, such officials may have access to information contained in a child protection index, which organizes data regarding substantiated reports of child abuse and neglect, though the department may not disclose information “used in connection with the department’s activities” and must adopt rules governing the procedure for disclosing index information. [Ind. Code ss. 31-33-18 and -26.]

Statewide Child Fatality Review Committee

Indiana law provides for a statewide child fatality review committee, which consists of members appointed by the Governor from various disciplines, all of whom must sign confidentiality statements. Among other duties, the statewide child fatality review committee must submit to Indiana’s legislative council, Governor, and other state entities an annual report that includes the following information:

- A summary of the data collected and reviewed by the statewide child fatality review committee in the previous calendar year.
- Trends and patterns that have been identified by the statewide child fatality review committee concerning deaths of children in Indiana.
- Recommended actions or resources to prevent future child fatalities in Indiana.

[Ind. Code s. 16-49-3 and -4.]

MICHIGAN

Method of Public Disclosure

In Michigan, written reports of suspected child abuse or neglect, and related documents or photographs, are confidential records. However, the director of the Department of Health and Human Services may release specified information, upon written request, if the director makes certain findings. Specifically, the director must find there is clear and convincing evidence either that release of the specified information is in the best interest of the child to whom the specified information relates or, if release is not in the child’s best interest, at least one of the following conditions is met:

- Release is in the best interest of a member of the child’s family or of an individual who resides in the same home in which the child resides.
- Release clarifies actions taken by the department on a specific case.
- The report or record containing the specified information concerns a child who has died or concerns a member of that child’s family.
- All or part of the report or record containing the specified information is publicly disclosed in a judicial proceeding.

- A child abuse or neglect complaint or investigation to which the report or record containing the specified information relates has been part of the subject matter of a published or broadcast media story.
- The report or record containing the specified information concerns a substantiated report of sexual abuse, serious injury, or life-threatening harm involving the child or a sibling of the child.

[Mich. Comp. Laws s. 722.627d.]

Method of Legislative Oversight

In addition to a procedure allowing for public disclosure in certain circumstances, Michigan law allows such confidential records to be available to specified recipients, including “a standing or select committee or appropriations subcommittee of either house of the legislature having jurisdiction over child protective services matters,” subject to a provision specific to legislative review, described below.

[Mich. Comp. Laws s. 722.627.]

The department may not provide confidential information to a committee unless the committee members agree by an affirmative supermajority vote that the information is “essential for the protection of Michigan children or for legislative oversight of the protective services program and that the confidential information will only be considered at a closed session of the committee.” If the committee votes to consider the information at a closed session, any tape recording, camera, or other electronic equipment for documenting the proceedings may not be permitted in the closed session. In addition, attendance at the closed session must be limited to committee members, other members of the Legislature, and legislative staff at the discretion of the chairperson, as well as department staff designated by the director. [Mich. Comp. Laws s. 722.627a.]

Advisory Committee Reports

Michigan law also requires the department to establish a multiagency, multidisciplinary advisory committee to identify and make recommendations on policy and statutory changes pertaining to child fatalities and to guide statewide prevention, education, and training efforts. Among other duties, the advisory committee prepares an annual report on child fatalities reviewed during the previous calendar year, in part based on information provided by local child fatality review teams. While the information contained in the report is public information, the department must ensure publication of the report and transmit a copy to the Governor and to the legislative standing committees with jurisdiction over matters pertaining to child protection. [Mich. Comp. Laws. s. 722.627b.]

MINNESOTA

Method of Public Disclosure

In Minnesota, a child protective services agency is required to disclose to the public, upon request, findings and information related to a child fatality or near fatality if: (1) a person is criminally charged with having caused the child fatality or near fatality; (2) a county attorney certifies that a person would have been charged with having caused the child fatality or near fatality but for that person’s death; or (3) a child protection investigation resulted in a determination of child abuse or neglect. If public disclosure is warranted, specific information must be disclosed, such as the causes and circumstances regarding the incident, the child’s age and gender, the results of any investigations, and the results of any review by the state child mortality review panel, a local child mortality review panel, a local community child protection team, or any public agency. [Minn. Stat. s. 626.556 (11d).]

Method of Legislative Oversight

Beyond the process for public disclosure, Minnesota requires that all records concerning individuals maintained by a local welfare agency or agency responsible for assessing or investigating the report be considered private data on individuals. However, Minnesota's law expressly states that, upon request, the data on individuals must be released to the legislative auditor in order for the auditor to fulfill the auditor's duties. In Minnesota, this appears to be the only mechanism by which the statutes expressly authorize the Legislature to exercise oversight of these types of records. [Minn. Stat. s. 626.556 (11).]

Child Mortality Review Panel

Minnesota law also requires the Commissioner of Human Services to establish a child mortality review panel to review near fatalities and deaths of children in Minnesota, including deaths attributed to maltreatment or in which maltreatment may be a contributing cause. The panel's purpose is to make recommendations to the state and to county agencies for improving the child protection system, including modifications in statute, rule, policy, and procedure. One of the panel's duties is to receive summary reports from a Minnesota Department of Health Services child fatality and near fatality review team, which is tasked with reviewing child fatalities and near fatalities from the point of a mandated reporter reporting the alleged maltreatment through the ongoing case management process. [Minn. Stat. s. 256.01 (12) and (12a).]

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