



To: Members of the Legislative Council Study Committee on Public Disclosure and Oversight of Child Abuse and Neglect

From: Karen Ordinars, Executive Director
Children's Health Alliance of Wisconsin

Re: Study Committee Options for Possible Legislation

Date: November 17, 2020

Children's Health Alliance of Wisconsin (Alliance) is a statewide organization affiliated with Children's Wisconsin, and works closely with the Department of Health Services (DHS) as a contract agency under the Maternal Child Health Program in the Division of Public Health. We appreciate the Study Committee's work on Act 78 and the ties it may have to child death review (CDR) overall. More than 15 years ago, the Alliance partnered with DHS to build Wisconsin's comprehensive CDR system and continues to provide technical assistance to all local county teams across Wisconsin. We would like to provide the following comments on the draft recommendations being considered by the Study Committee that we believe impact CDR:

Page 3 Options for Annual Hearings: The Alliance provides technical assistance to the State CDR Advisory Council on behalf of DHS and currently presents the annual Sudden Unexpected Infant Death (SUID) report to the Advisory Council. This report could be easily shared at an annual hearing on Act 78. However, requiring data to be reported from 50 individual CDR teams across the state would be quite challenging and not feasible. Since CDR is voluntary, the quality or completion of data significantly varies from county to county. Also, while our case reporting system does capture CPS history, a team's ability to obtain that data is spotty and depends on cooperation and access at the local level. Another factor to consider is the timing of case reviews at the local level. Many teams do not review a case until months after the death, and purposely place a hold on cases where charges or other legal issues are pending.

Page 6 Options for Child Death Review Teams and requirement for CDR teams to submit data: As stated above, the data reported by the 50 county teams varies significantly and oftentimes teams are either unable to gather that information, or are missing pieces of it. Death reviews concerning abuse and neglect are unlikely to be reviewed by a CDR team in a timeframe that meets the requirements of the Department of Children and Families (DCF). In addition, not all teams review all deaths. At a minimum, each team is encouraged to review all infant and child deaths where the coroner or medical examiner investigated and signed the death certificate, but this can vary based on capacity and needs in the community. Any data reported would not provide a complete and adequate representation what is taking place statewide.

An alternate recommendation you may wish to consider is to request the State CDR Advisory Council to provide DCF with an annual summary of local CDR team findings related to abuse and neglect deaths, and



system change or prevention recommendations from local teams. This report would most likely be delegated to the Alliance to prepare on behalf of the Advisory Council.

Page 6 Option to codify in statute the CDR program at DHS and require annual reporting requirements:

The Alliance supports this recommendation and believes the establishment of a state statute on fatality review would provide for more clarity and consistency across all counties, particularly in data collection. While we need to continue to recognize the volunteer nature of CDR teams, having clear support and guidance from the legislature would allow us to make great strides in the prevention of child deaths.

We wish to thank the Committee for including CDR in your discussions and review of Act 78. Please let me know if we can be of further assistance as you finalize your recommendations.