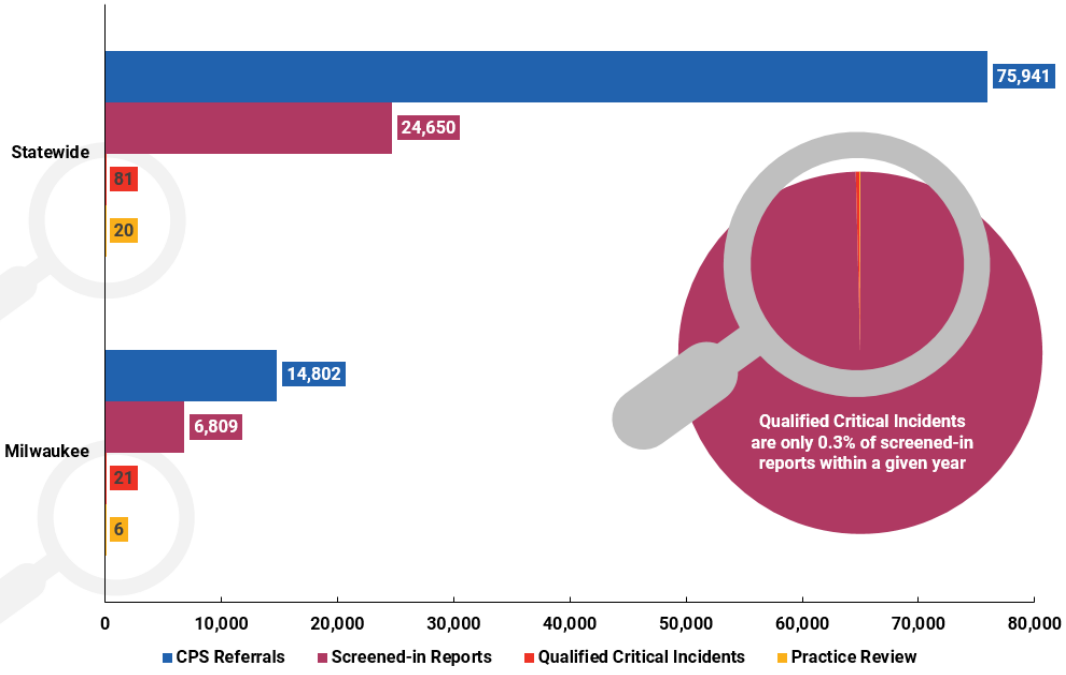
Act 78 Critical Incidents: Data and Trends

2021 Wisconsin Act 148 requires the Department of Children and Families (DCF) to provide additional reporting on critical incidents annually starting on January 1, 2023. This additional reporting is required to include certain information related to Act 78 qualified critical incidents. The following data includes all critical incidents that were posted on DCF's Public Disclosure website (https://dcf.wisconsin.gov/cps/incidents) between January 2018 and December 2022.

It is important to understand these incidents in the context of all reports received by our child welfare system. From 2018 - 2022 Wisconsin received an average of about **76,000** reports of alleged maltreatment per year and on average, **25,000** of these were screened-in for investigation. Qualified critical incidents comprised a small number of these reports, accounting for only **0.3%** of all screened-in reports over the 5-year period.

Average Taken from 2018-2022



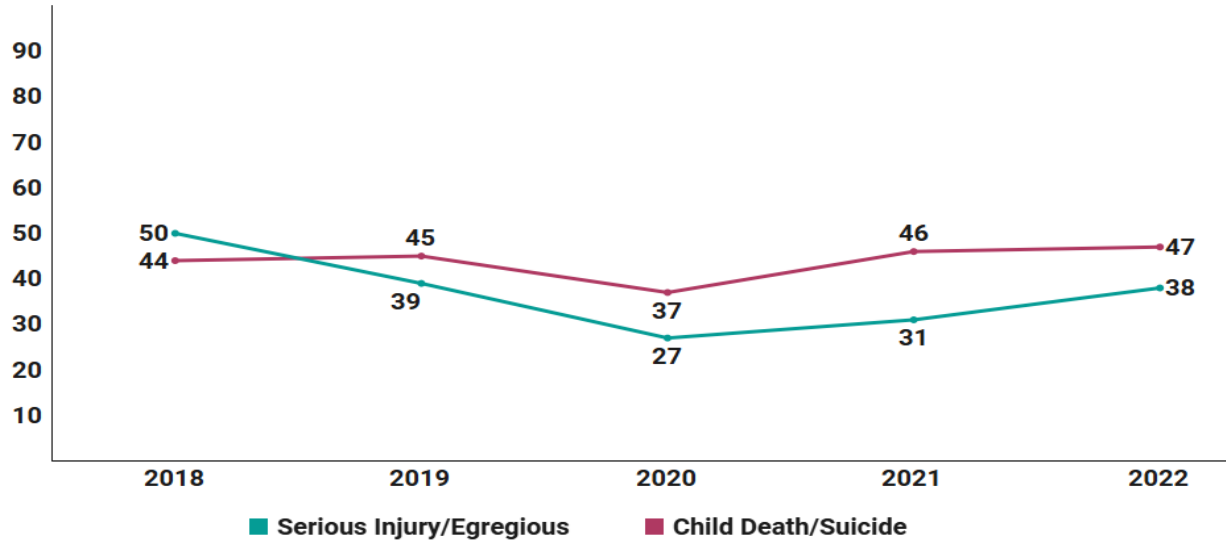
All Qualified Critical Incidents: Aggregate Data & Trends

Critical Incident Types

Under statute, "incident of death or serious injury" means an incident in which a child has died or been placed in serious or critical condition, as determined by a physician, because of suspected abuse or neglect reported under Chapter 48 or in which a child who has been placed

outside the home by a court order under Chapter 48 or Chapter 938 is suspected to have committed suicide. “Incident of egregious abuse or neglect” is defined by statute to mean an incident of suspected abuse or neglect that has been reported under Chapter 48, other than an incident of death or serious injury, involving significant violence, torture, multiple victims, the use of inappropriate or cruel restraints, exposure of a child to a dangerous situation, or other similar, aggravated circumstances. Incident type is different from, and doesn’t correspond to, any maltreatment type or determination. For purposes of tracking and reporting, DCF groups critical incidents into four separate categories: 1) child death, 2) serious injury, 3) egregious incident, and 4) suspected suicide of a child placed into out-of-home care. In some, but not all, of these critical incidents there was a determination of substantiated maltreatment. Child deaths made up **54%** of all critical incidents, while all others accounted for **46%** over the cumulative 2018–2022 timeframe as presented in the chart below.

Critical Incidents by Year[1]



Characteristics of Children

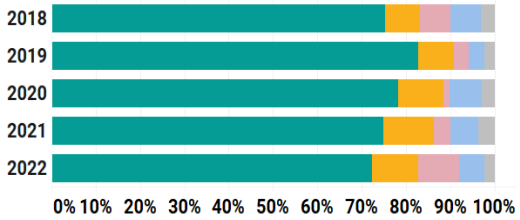
For purposes of looking at age and gender, cumulative data was used for the years of 2018 - 2022. For those years, of the **404** critical incidents, there were **424** unique children (multiple children can be included as part of an incident). **73% (309)** of these 424 children were in the

[1] Last year, we retrieved the Act 78 data using the "Publication date". We are now using "Date of Notification (DON)" as of this year. As a result, there is a small difference in the data from the previous year.

Balance of State, and the remaining **27% (115)** were in Milwaukee. Broken down by gender, males accounted for **58%** of children and females the remaining **42%**.

As noted in the chart below, **52%** of the children were under 1 year old and **77%** were age 3 and under. When broken down by incident type, children under 1 accounted for **47%** of all child deaths, **61%** of serious injuries, and **51%** of egregious incidents.

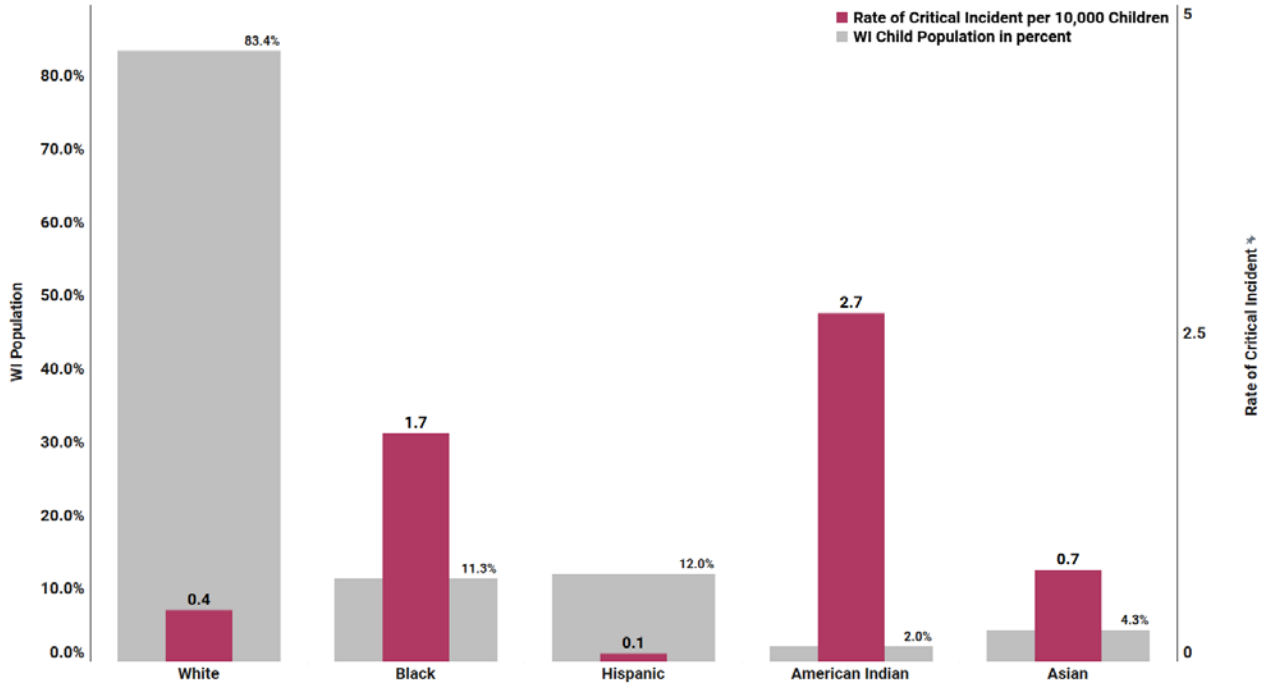
Children's Age by Year



	0-3	4-7	8-11	12-15	16 +	Grand To..
2018	76(75%)	8(8%)	7(7%)	7(7%)	3(3%)	101(100%)
2019	72(83%)	7(8%)	3(3%)	3(3%)	2(2%)	87(100%)
2020	54(78%)	7(10%)	1(1%)	5(7%)	2(3%)	69(100%)
2021	60(75%)	9(11%)	3(4%)	5(6%)	3(4%)	80(100%)
2022	63(72%)	9(10%)	8(9%)	5(6%)	2(2%)	87(100%)
Grand Total	325(77%)	40(9%)	22(5%)	25(6%)	12(3%)	424(100%)

As with other areas of our child welfare system, racial disparities stand out in the data for qualified critical incidents across the state. For context, white children account for **62%** of screened-in reports for this period and **55%** of critical incidents for this same period, which is significantly lower when compared to their percentage of Wisconsin's population of children under 18 (**83%**). In comparison, Black and African American children comprise **11%** of the population, but account for **30%** of screened-in reports and **33%** of critical incidents. When we consider the children's ethnicity, we find that, of the 424 distinct children who had critical incidents, **9%** identify as Hispanic. Hispanic children account for **12%** of screened-in reports and **12%** of Wisconsin's population chart. When viewing the rates of critical incidents by race in comparison to Wisconsin child population, it is clear the disparity of these incidents occurs both in proportion and frequency.

Average Critical Incident rate by WI Child Population and Race



Practice Reviews: Aggregate Data & Trends

Practice Review Overview

For qualified critical incidents where the family has an open case or recent involvement in the child welfare system, a practice review is conducted. This involves a comprehensive and thorough review of practice and decision making within the most recent year prior to the date of the critical incident. The primary purpose of the practice review is to provide a structured learning process which is an essential component to the state's continuous quality improvement efforts.

The information in the following table provides the number of critical incidents qualified for practice reviews in the context of broader critical incidents. Over the five-year period, the number of practice reviews has remained constant and on average accounts for 25% of the qualified critical incidents.

Year	Number of Notifications	Number of Qualified Incidents	Number of Summary Reviews	Number of Practice Reviews
2018	132	94	62	32
2019	128	84	66	18

2020	88	64	49	15
2021	96	77	57	20
2022	126	85	69	16
Total	**570**	**404**	**303**	**101**

Nationally, children under the age of three account for the largest group of child victims of both abuse and neglect and critical incidents. According to the U.S. Department of Health & Human Services, **66.2** percent of child fatalities in 2021were children who were younger than 3 years and close to half (**45.6%)** of child fatalities were children who were younger than 1 year (https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2021.pdf).

These trends are similar in Wisconsin. As referenced in Figure 14 of the 2021 CAN Report, children ages 3 or under accounted for the largest age group of child victims. Additionally, as seen earlier in this report, children ages 3 years and under experience critical incidents at a higher rate than other age groups and **82%** of the practice reviews involved children between the ages of 0-3 years. The average age of children involved in a critical incident with a practice review was 2.5 years, which is comparable to the average age of children for all critical incidents, which is 2.6 years.

Wisconsin data specific to child maltreatment fatalities in 2021 indicates that **73%** of the deaths were children ages three or under and **46.2%** of the deaths were children under age one. These national and state level findings reflect the fact that children under 3 years are most vulnerable to maltreatment as they depend on others for their health and safety, and their ability to either verbalize or clearly articulate maltreatment is not yet developed.

Practice Review Findings

The practice reviews allow for review of practice and decision making. The CPS practice areas that are the focus of the practice review process include: Access, Initial Assessment, and Ongoing Case Management. The information provided here includes data gathered from practice reviews between 2019-2021. During this timeframe, Initial Assessment was the most frequently studied area of practice. More specifically, safety assessment and planning practices received the greatest amount of attention during these reviews.

The practice reviews are conducted to further understand the environment in which practice and decisions occur. Systemic factors and influences that impact CPS practice and decision making were identified and analyzed. This comprehensive understanding of both the practice and systemic considerations contributes to information necessary to identify, address and implement system-level improvements more adequately and meaningfully.

Based on the practice review data and analyses completed to date, the areas where CPS practice is strong includes the following:

- Local CPS professionals are able to obtain and/or synthesize the relevant information needed to inform their assessments.
- In general, case practice documentation is consistently completed, and case records have complete information per state documentation requirements.
- Local CPS agency supervisors are providing effective support and communication within their teams.

The analyses completed to date also identified specific practice and system-level opportunities for potential improvement.

- Continued focus on efforts to ensure that assessment, planning and decision making is done in an objective and equitable manner.
- Continue to review and revise state standards/policy in order to provide clarity of practice expectations and to better support consistency in practice and decision-making.
- Provide additional guidance that supports effective communication, collaboration and, where applicable, teaming between local agencies and community partners on child welfare cases.

Given that in **32%** of the practice reviews, the identified caregiver in the home was grappling with a serious substance use concern that impacted their parenting at the time of the incident, each of the system-level opportunities identified above should also consider the impact of and responses to substance misuse. Substance use issues in child welfare is a national focus as it continues to be a significant factor in families. The dynamics of substance use have changed over the last decade in the type of substances being used, exposure to children, and impacts on child safety. There is a need, at the national level and here in Wisconsin, to put additional thought into a strategy in which we serve families where substance use is affecting child safety and how to ensure access and availability to supportive alcohol and drug use programming and treatment.

Improvement Opportunities

It is important to note that practice and policy changes are not made based on critical incidents alone because these cases make up an extremely small proportion of all CPS reports (see page 1 of this report). The learnings from these practice reviews are used in conjunction with other data and analysis to gain a more robust and complete picture of systemic factors that represent strengths and needs, and identify potential improvement opportunities at the local and state levels.

At the local level, as indicated in the 6-month summary reports, agencies are working towards specific practice improvements based on their assessment of and response to a critical incident. An example of one such locally driven action relates to improvement of teaming practices to enhance collaboration and communication with other local providers in order to better support children and their families. Another example is an agency implementing efforts to provide staff with additional training opportunities to enhance safety assessment practices.

At the state level, the Division of Safety and Permanence attends to continuous quality improvement efforts that are inclusive of learnings from Act 78 practice reviews. In 2022, several local child welfare agencies participated in a Plan, Do, Study, Act (PDSA) Collaborative regarding identifying and engaging non-custodial parents. Improvement opportunities in this area of practice were identified as a key learning from the Act 78 practice reviews. Agencies participating in the PDSA collaborative developed and implemented specific improvement strategies related to non-custodial parent identification and engagement, which when proved successful at the local levels, are being shared with other local agencies. At the conclusion of the PDSA Collaborative, the Continued Quality Improvement Advisory Committee will identify improvement strategies that will improve non-custodial parent related policy and trainings. More can be learned about the PDSA Collaborative on the Wisconsin Child Welfare Professional Development System (WCWPDS) website (https://wcwpds.wisc.edu/organizational-development/organizational-process-improvement/plan-do-study-act-pdsa-collaborative/). The next PDSA Collaborative topic, scheduled to be introduced in 2024, will be focused on better supporting a professional collaboration between child protective service and mental health and substance use treatment providers.

Some improvement areas identified in the practice reviews require system level supports and are also outlined as recommendations in the 2021 Child Abuse and Neglect Report (https://dcf.wisconsin.gov/files/cwportal/reports/pdf/can.pdf). These system-level needs include strengthening efforts and resources related to the recruitment, retention, and well-being of our child protective service professionals to better ensure consistency in practice and engagement with children and their families. Another consistently identified system-level need relates to working together to ensure accessibility and availability of supports and resources outside of the child protective service system, so children and their families have their needs met before crisis occurs.

DCF continues to partner with the Children's Health Alliance Child Death Review Team and the National Partnership for Child Safety in order to understand how the themes presenting in Wisconsin reviews compare to national data and trends. Collaborating with these key stakeholders and attending to advocacy efforts at the national level is necessary to identify and provide needed resources and services, and to improve outcomes for children and families served in Wisconsin's child protective service system.