



STATE OF WISCONSIN  
**JOINT LEGISLATIVE COUNCIL**

# **MEETING MINUTES**

## **STUDY COMMITTEE ON PUBLIC DISCLOSURE AND OVERSIGHT OF CHILD ABUSE AND NEGLECT INCIDENTS**

Virtual

August 27, 2020  
1:00 p.m. – 3:50 p.m.

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### **CALL TO ORDER AND ROLL CALL**

Chair Snyder called the meeting to order and a quorum was present.

**COMMITTEE MEMBERS PRESENT:** Rep. Patrick Snyder, Chair; Sen. Kathy Bernier, Vice Chair; Sens. André Jacque and LaTonya Johnson; Rep. Lisa Subeck; and Public Members Diane Cable, Emily Coddington, Susan Conwell, Tim Easker, Jermaine Reed, and Lisa Roberts.

**COUNCIL STAFF PRESENT:** Anne Sappenfield, Director; Amber Otis, Staff Attorney; Melissa Schmidt, Senior Staff Attorney; and Tracey Young, Administrative Assistant.

**APPEARANCES:** Amanda Merkwae, Legislative Advisor; Wendy Henderson, Administrator, Division of Safety and Permanence; Lisa Hanks, Section Manager, Bureau of Safety and Well-Being; Therese Durkin, General Counsel, Office of Legal Counsel; and Devon Syrjanen, Director, Bureau of Compliance, Research, and Analytics, Department of Children and Families; and Vicki Tylka, Tri-Chair, Children, Youth and Families Policy Advisory Committee, Wisconsin County Human Service Association; and Director, Department of Social Services, Marathon County.

## OPENING REMARKS

Anne Sappenfield, Director of the Legislative Council staff, welcomed committee members and thanked them for their service. She remarked upon the history of the Legislative Council and the procedures followed throughout the study committee process.

## INTRODUCTION OF COMMITTEE MEMBERS

Chair Snyder introduced himself and welcomed the committee members. At the invitation of the chair, committee members introduced themselves and provided brief explanations of their backgrounds and interest in the committee's topic.

## PRESENTATION BY LEGISLATIVE COUNCIL COMMITTEE STAFF

Melissa Schmidt, Senior Staff Attorney, and Amber Otis, Staff Attorney, provided an overview of information provided in Legislative Council Staff Brief 2020-01, [\*Study Committee on Public Disclosure and Oversight of Child Abuse and Neglect Incidents\*](#) (August 20, 2020). A copy of their PowerPoint presentation is available on the committee's [website](#).

Ms. Schmidt began the presentation with an overview of the child protective services (CPS) system in Wisconsin, to provide context for the types of disclosures and reports required by 2009 Wisconsin Act 78. Next, Ms. Otis summarized federal and state laws governing public disclosure of critical child abuse and neglect incidents. Specifically, Ms. Otis identified the minimum requirements for grant funds under the federal Child Abuse Protection and Treatment Act (CAPTA) and described the procedures for and content of the two types of reports required under state law, specifically Act 78. Ms. Otis also described Act 78's requirements for legislative oversight of certain reports. Finally, Ms. Schmidt highlighted the federal and state laws requiring confidentiality of child abuse and neglect records and further described other types of information, beyond that required by Act 78, that the Department of Children and Families (DCF) currently collects and publishes in annual reports or online data dashboards.

## PRESENTATION BY DEPARTMENT OF CHILDREN AND FAMILIES

**Amanda Merkwae, Legislative Advisor; Wendy Henderson, Administrator, Division of Safety and Permanence; Lisa Hanks, Section Manager, Bureau of Safety and Well-Being; Therese Durkin, General Counsel, Office of Legal Counsel; and Devon Syrjanen, Director, Bureau of Compliance, Research, and Analytics**

Amanda Merkwae, Legislative Advisor, introduced the panel of DCF staff presenting to the committee. DCF's written testimony and PowerPoint slides are available on the committee's [website](#).

First, Wendy Henderson, Administrator of DCF's Division of Safety and Permanence, thanked the committee for the opportunity to provide testimony and for the members' interest in the tragic and complex cases that are subject to public disclosure under Act 78. Ms. Henderson began the presentation with a brief overview of the CPS process for a screened-in case of reported child abuse or neglect. She noted that the cases prompting Act 78's requirements are a very small subset of cases in the CPS system and provided various statistics on the number of referrals to the CPS system as compared to the number of cases triggering Act 78's requirements.

Ms. Henderson described the two types of reports that DCF is required to prepare and transmit to the Governor and the Legislature under Act 78. First, she addressed the quarterly and annual reports of alleged sexual abuse of children residing in out-of-home care. For this type of report, she noted that these incidents may include sexual abuse that occurred at any point in the child's life, not just when residing in out-of-home care. She also highlighted various statistics regarding this type of report for 2019.

Ms. Henderson then described the second type of report required under Act 78, which relates to CPS reports involving a death of a child, an egregious incident of child maltreatment or serious injury, or suspected death by suicide for a child placed outside the home under the Children's Code or Juvenile Justice Code. Specifically, she identified the three steps that must occur under Act 78 for these types of cases: (1) a local CPS agency must notify DCF within two working days of determining that the CPS agency has reason to suspect that an incident of death, serious injury, or egregious abuse or neglect has occurred; (2) DCF staff must, within two working days, determine whether Act 78 applies and, if it does, notify the public and disclose whether DCF will conduct a review and the scope of that review; and (3) DCF must prepare a 90-day summary report, based either on a summary or practice review of the case, and make the report publicly available and transmit the report to the Legislature.

Next, Lisa Hankes, Section Manager of DCF's Bureau of Safety and Well-Being, provided a detailed explanation of DCF's procedures in performing a summary or practice review of a critical incident and completing of the summary reports for the public and the Legislature. Ms. Hankes also described DCF's implementation of a data-driven and trauma-informed approach for conducting Act 78 practice reviews, based on DCF's engagement with Collaborative Safety, LLC, based in Tennessee. This new approach, referred to as the "systems change review," emphasizes system accountability, rather than individual blame, when reviewing critical incidents, by applying safety science principles from other safety critical industries such as health care, aeronautics, and nuclear energy.

Committee members posed questions to DCF regarding the following topics: the legislative history of Act 78's language requiring a report on sexual abuse of a child placed in out-of-home care; the process for "screening in," versus "screening out," a reported case of child abuse or neglect; options for informing individual legislators that Act 78 reports have been published on DCF's website; the general purpose of public disclosure, other than receipt of federal grant funds; and whether the reports are useful to DCF or CPS agencies.

## **PRESENTATION BY WISCONSIN COUNTY HUMAN SERVICE ASSOCIATION**

**Vicki Tylka, Tri-Chair, Children, Youth and Families Policy Advisory Committee, WCHSA; and Director, Department of Social Services, Marathon County**

On behalf of WCHSA, a membership organization representing Wisconsin's 72 counties, Vicki Tylka, Tri-Chair of WCHSA's Children, Youth and Families Policy Advisory Committee, provided testimony from a county's perspective on Act 78's requirements. Her written testimony is available on the committee's [website](#).

Ms. Tylka began her presentation by noting that Act 78's reporting requirements do not generally provide valuable or helpful information to CPS agencies. While she noted the benefit of consistency that comes with a state law requirement for uniform disclosure, she relayed a general concern that even the high-level summary information required may allow for public identification of the individuals involved, depending on the community. Ms. Tylka identified three ways in which CPS agencies respond

and address critical incidents, all of which provide value to the agency and support the priority of keeping families safe: (1) an internal investigation; (2) local review with partner organizations; and (3) systems change reviews with DCF at the state level.

With respect to internal investigations, Ms. Tylka noted that these may occur when the CPS agency has been involved with the family either prior to, or at the time of, the incident. She explained that in all cases, the agency will examine what happened and how the agency or other community system partners responded or could have responded, with the goal of learning how to improve as a system, rather than place blame. The agency will immediately address any identified practice concerns. Next, Ms. Tylka described the types of local partnerships that many counties employ in reviewing such incidents, such as child death review teams, law enforcement, the medical community, and other agencies serving children. Finally, with regard to state level reviews, Ms. Tylka expressed support for DCF's shift to the systems mapping process, which CPS agencies have found to be more collaborative and focused on system improvement, and less traumatizing for staff.

Finally, Ms. Tylka provided four recommendations for the committee's review. First, CPS agencies may benefit from technical assistance or grants to improve the infrastructure of local reviews and provide a more structured, collaboration review among county partners, similar to the state's systems change process. Second, the current statewide systems change process could be made available to CPS agencies that voluntarily wish to have a specific case subject to that type of review, even if that case does not meet the definition of "egregious" requiring review under Act 78. Third, additional resources, such as local grants, could help address any system-wide issues identified in local and statewide evaluations and could support the creation of a strategic implementation plan to make improvements based on systems change procedures. Finally, the committee should examine the big picture regarding the child welfare system, when evaluating the critical incidents subject to Act 78, to apply what is working well to areas in which challenges exist.

## **DISCUSSION OF COMMITTEE ASSIGNMENT**

Committee members generally discussed the policy goals of public disclosure, citing that the purpose is not only to comply with federal requirements, but also to satisfy the public's desire for information. Committee members noted the importance of providing accurate information and creating community trust in the child welfare system.

With respect to Act 78, specifically, committee members discussed Act 78's requirements for a quarterly and annual reports on sexual abuse of a child placed in out-of-home care, and whether the legislative history demonstrated any intent as to the meaning of requiring the reports in that manner. Committee members also stated that Act 78 was not intended to blame individuals but rather to provide CPS agencies and DCF the opportunity to communicate with the Legislature and provide feedback and recommendations on requested changes.

Some committee members noted that DCF rarely includes recommendations in the Act 78 summary reports, and that the Legislature is unlikely to act in the absence of any recommendations from DCF. Committee members noted the potential value of recommendations written in clear, nontechnical language, which can be easily understood by the public. Committee members also expressed interest in making the legislative oversight hearings on Act 78 reports more meaningful. To that end, committee members identified certain potential areas of interest, such as disclosing additional types of information or allowing the Legislature to conduct the Act 78 oversight hearings in closed session. However, committee members acknowledged uncertainty as to whether federal law would allow those options.

Committee members requested information on other states' approaches to complying with CAPTA's public disclosure requirements, as well as examples of how other states engage in dialogue with the legislative branch. The chair directed Legislative Council staff to research these questions and provide information to the committee for the next meeting.

### **PLANS FOR FUTURE MEETINGS**

The committee's next meeting will be held virtually on Wednesday, September 23, 2020. Once finalized, Chair Snyder will inform members of the meeting's start time. Chair Snyder also requested that committee members hold November 18 and December 10, 2020, as tentative dates for the committee's third and fourth meetings, respectively.

### **ADJOURNMENT**

The meeting adjourned at 3:50 p.m.

[The preceding is a summary of the August 27, 2020 meeting of the Study Committee on Public Disclosure and Oversight of Child Abuse and Neglect Incidents, which was recorded by WiscosnEye. The video recording is available in the WisconsinEye [archives](#).]

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