STATE OF WISCONSIN

JOINT LEGISLATIVE COUNCIL

MEETING MINUTES

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

Virtual

September 23, 2020
1:00 p.m. – 4:00 p.m.

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:	Amber Otis, Staff Attorney, and Melissa Schmidt, Senior Staff Attorney.
APPEARANCES:	Noel Hengelbrok, M.Sc., and Dr. Scott J. Modell, Ph.D., Co-Founders, Collaborative Safety, LLC; Dr. Michael Cull, Associate Director, Safe Systems, University of Kentucky Center for Innovation in Population Health; Wendy Henderson, Administrator, Division of Safety and Permanence; Lisa Hankes, Section Manager, Bureau of Safety and Well-Being; and Therese Durkin, General Counsel, Office of Legal Counsel, Department of Children and Families.

APPROVAL OF THE MINUTES FROM THE AUGUST 27, 2020 MEETING

Senator Johnson moved, seconded by Representative Subeck, to approve the minutes from the August 27, 2020 meeting of the committee. The motion was approved by unanimous consent.

DESCRIPTION OF MATERIALS DISTRIBUTED

Amber Otis, Staff Attorney, Legislative Council staff, provided an overview of Memo No. 1, *Examples of Neighboring States' Laws Relating to Public Disclosure and Legislative Oversight of Child Abuse and Neglect* (September 16, 2020). Ms. Otis explained that the memo was prepared in response to questions raised at the committee's meeting on August 27, 2020, and highlighted other states' approaches, such as requiring annual cumulative reports on data or reports from certain types of child fatality panels or committees.

Melissa Schmidt, Senior Staff Attorney, Legislative Council staff, provided an overview of Memo No. 2, *Background Information on the Systems Change Review Approach Adopted and Implemented by the Department of Children and Families for Conducting Practice Reviews* (September 16, 2020). She explained that this memo contained links to information on the Department of Children and Families (DCF) website related to the implementation of Collaborative Safety's "safety science" approach to reviewing certain incidents of death, serious injury, or egregious child abuse and neglect (critical incidents) that must be reported pursuant to 2009 Wisconsin Act 78 (Act 78).

PRESENTATION BY SAFETY SCIENCE AND THE COLLABORATIVE SAFETY MODEL FOR SYSTEMIC CRITICAL INCIDENT REVIEWS

Noel Hengelbrok, M.Sc., and Dr. Scott J. Modell, Ph.D., Co-Founders, Collaborative Safety, LLC

Noel Hengelbrok and Dr. Scott Modell, Co-Founders, Collaborative Safety, LLC, presented information on Collaborative Safety and the "safety science" model for reviewing critical incidents in the child welfare system that has been adopted and implemented by DCF in its Systems Change Review. DCF's Systems Change Review is the approach used to review certain critical incidents that are reported to DCF pursuant to Act 78. A copy of their PowerPoint presentation is available on the committee's website.

Dr. Modell explained Collaborative Safety's safety science model for child welfare systems to use when reviewing critical incidents. Dr. Modell said that its safety science model is used in other safety critical industries like aviation, health care, and nuclear power. Mr. Hengelbrok explained that Collaborative Safety supports child welfare agencies to make the following three transitions: (1) from a culture of blame to accountability, which provides an understanding of how to learn and improve as an organization; (2) from applying quick fixes to understanding underlying systemic issues, which allows an agency to make meaningful change and address the real problems; and (3) from seeing employees as a problem (the first story) to seeing employees as a solution, by diving beneath the surface level descriptions of events and understanding the true sources of failure and success (the second story).

Dr. Modell then provided an overview of the Systems Change Review process that Collaborative Safety helped DCF implement in Wisconsin. The key features of the systems change review process include: (1) a human factors debriefing; (2) a systemic mapping that creates the second story; and (3) a systemic analysis of the second story. In response to questions, Dr. Modell and Mr. Hengelbrok cautioned against making policy changes based upon a single incident. They also explained that the number of substantiated cases of child abuse or neglect resulting in a child's death is not a good proxy for how well a child protective services (CPS) agency or the child welfare system is functioning. They explained that policymaking should be based upon aggregated data, rather than review of individual cases.

PRESENTATION BY THE NATIONAL PARTNERSHIP FOR CHILD SAFETY

Dr. Michael Cull, Associate Director, University of Kentucky Center for Innovation in Population Health

Dr. Michael Cull, Associate Director, Workplace Health and Safety, University of Kentucky Center for Innovation in Population Health, presented information about the National Partnership for Child Safety (NPCS). A copy of Dr. Cull's PowerPoint presentation is available on the committee's website.

Dr. Cull explained that NPCS is a quality improvement collaborative that is working to demonstrate the applicability of the safety science used in healthcare and nuclear industries to the child welfare system. NPCS currently has 19 participating jurisdictions (state and local governments), including Wisconsin; by the end of 2021, he anticipates 24 jurisdictions will be participating. He explained that NPCS is supported by Casey Family Programs, with research and technical assistance provided by the University of Kentucky.

Dr. Cull described NPCS's three interrelated strategies and the process for collecting and analyzing the data from the participating jurisdictions. The three interrelated strategies are to help jurisdictions: (1) create a systems-focused critical incident review process; (2) conduct an organizational assessment of a safety culture; and (3) give the participating jurisdictions basic tools to provide a collaborative environment. Because DCF, with the help of Collaborative Safety, has implemented safety science in its Systems Changes Review, NPCS is now working with DCF to begin sharing data.

Dr. Cull also discussed certain jurisdictions participating in NPCS and implementing safety that operate, like Wisconsin, a state-run and county-implemented child welfare system. Specifically, Dr. Cull highlighted the following jurisdictions: Los Angeles County, California; Franklin County, Ohio; Maryland; and Connecticut.

Dr. Cull also warned against learning about a child welfare system based upon one event. He stated that a child may die even when good child welfare casework occurs, and that good outcomes may be achieved for a child even when bad casework occurs. In response to questions, Dr. Cull explained that NPCS will not have a dataset that is representative of all child fatalities. Rather, the focus is to learn about, and improve, the child welfare system. He said that the child welfare system can benefit from using a safety science response to a critical incident because turn-over and burn-out are high in this workforce.

SUMMARY OF RECOMMENDATIONS BY THE DEPARTMENT OF CHILDREN AND FAMILIES

Wendy Henderson, Administrator, Division of Safety and Permanence; Therese Durkin, General Counsel, Office of Legal Counsel; and Lisa Hankes, Section Manager, Bureau of Safety and Well-Being

Wendy Henderson, Administrator of DCF's Division of Safety and Permanence, presented DCF's proposed recommendations for revisions to Act 78. A copy of DCF's proposed revisions and PowerPoint presentation are available on the committee's website.

Ms. Henderson began her presentation with a brief overview of the pre-service training that is required of all CPS workers in Wisconsin. This training includes education on trauma-informed practices and how to apply the safety science model approach to uncovering the "second story" when engaging the family.

Ms. Henderson then reviewed DCF's three proposed revisions to the hearings conducted by the Legislature and the information disclosed in public notifications. The first recommendation is to combine the Annual Child Abuse and Neglect (CAN) report and the Act 78 hearings. Under this recommendation, the Legislature would not be required to hold an annual hearing on each individual incident that must be publicly disclosed under Act 78. Rather, the Legislature would hold an annual hearing on the CAN report and general information about incidents that qualify for public disclosure under Act 78.

The second recommendation discussed by Ms. Henderson is to redefine incidents of child abuse and neglect that require public disclosure. Specifically, DCF recommends redefining critical incidents that require public notification to only include critical incidents that are linked to substantiated child abuse or neglect. She explained that the determination regarding whether the critical incident would qualify for public disclosure would not be made until the local CPS agency's initial assessment is complete. Ms. Henderson explained that this change would ensure that only those cases where it has been determined that maltreatment occurred in a case of a child death, serious injury, or egregious incident are reported publicly. In response to questions, Ms. Henderson explained that roughly 25 percent of the incidents publicly disclosed pursuant to Act 78 are unsubstantiated cases of child abuse or neglect.

The third recommendation described by Ms. Henderson is to limit the information that is publicly disclosed to include only individuals and information that is pertinent to the critical incident. Ms. Henderson explained that the information publicly disclosed should be narrowed to only include information about: (1) the child who was the subject of the critical incident; (2) that child's parents and siblings in the home at the time of the incident; (3) the alleged maltreaters; and (4) other caregivers or case participants who are pertinent to the critical incident. Ms. Henderson explained that under this recommendation, the information disclosed would be limited to the information that describes previous reports or child abuse and neglect allegations that are pertinent to the maltreatment that lead to a child's death or near death. In response to questions about how DCF would define what information is pertinent to the critical incident, Ms. Henderson stated that DCF would work with Legislative Council staff to create draft language for the committee's review.

DISCUSSION OF COMMITTEE ASSIGNMENT

Committee members generally discussed DCF's recommendations and how to make the legislative hearing on reports prepared pursuant to Act 78 more meaningful. In response to questions about adding information to the CAN report, Ms. Henderson raised concerns about amending the statutes in a way that is too prescriptive regarding the types of data that should be in the CAN report. She explained that under DCF's first recommendation, these annual committee hearings are opportunities to have conversations and build a partnership between DCF and the Legislature related to current issues facing the child welfare system.

Committee members then discussed how the Legislature could review aggregated data. In response to questions, Ms. Otis reminded that Memo No. 1 contains examples from neighboring states on how aggregated data is reported and reviewed by the Legislature. She highlighted Illinois and Indiana as examples of alternative approaches to Act 78's requirement that standing committees review annually each individual incident's summary reports.

Committee members also discussed child death review teams and citizen review panels. Committee members discussed the types of fatalities reviewed by these different bodies. In response to questions

raised, Ms. Otis stated that Legislative Council staff would provide follow-up information to committee members about these two bodies.

PLANS FOR FUTURE MEETINGS

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

Chair Snyder informed the committee that the goal of the next meeting will be to review and discuss legislative ideas that could be prepared as bill drafts for the committee's review at its December meeting. He requested committee members submit their own recommendations to Legislative Council staff by Friday, October 9, 2020, and directed Ms. Schmidt and Ms. Otis to compile these recommendations, including recommendations made by invited speakers during the August and September meetings, in a memo for the committee's review at its next meeting.

ADJOURNMENT

The meeting adjourned at 4:00 p.m.

[The preceding is a summary of the September 23, 2020 meeting of the Study Committee on Public Disclosure and Oversight of Child Abuse and Neglect Incidents, which was recorded by WisconsinEye. The video recording is available in the WisconsinEye archives.]

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