TO:	**Legislative Council Study Committee on Public Disclosure and Oversight of Child Abuse & Neglect Incidents**
FROM:	**Jodi Bloch, Director, State & Local Government Relations**
DATE:	**Tuesday, November 17, 2020**
RE:	**Comments on Department of Children & Family Recommendations to Committee**

Chairman Snyder & Members of the Committee,

As many of you know, Children's is the state's only independent health care system dedicated solely to the health and well-being of children. We serve children and families in every county across the state, and care for every part of a child's health. In addition to our highly ranked pediatric hospital and clinical care, we also offer community health education, family preservation and support programs, child advocacy centers, foster care and adoption services, and much more to support and enhance the health and well-being of Wisconsin kids and families.

Included in the Wisconsin Legislative Council Study Committee Memo No. 03, "Committee Options for Possible Legislation", are options for reports containing aggregated data of critical incidents. Learning from Act 78 cases is critically important, particularly with a focus on identifying prevention opportunities. We believe aggregated data will have a limited, though potentially insightful, value in this effort, however we defer to the Department of Children and Families as they have more informed knowledge about the data that would be accessible and the utility of that information in helping develop a prevention plan.

Children's has long believed that a much more robust analysis of a subset of Act 78 cases would be highly valuable in developing strategies for prevention. In particular, this examination would focus its lens on which other systems interacted with the child prior to egregious injury or death. If, for example, a large percentage of cases involved children with previous sentinel injuries or if law enforcement had engaged with the family previously due to domestic violence, these analyses would illuminate areas of focus for the various systems to help prevent child injuries and deaths. This type of study would be well served to focus on infants, since developmentally infants are a vulnerable population at risk for maltreatment, severe injuries and death. A research study of this magnitude would undoubtedly be valuable, however it would require commissioning an outside, third party researcher and would need to be adequately funded.

Lastly, with respect to Child Death Review team data analysis, the limited quantity of local team data on child death caused by child abuse and neglect does not allow for a robust and meaningful analysis by the Department of Children and Families. Alternatively, the recommendation could instead be that the State Advisory Council is required to provide the Department of Children & Families with an annual summary of local Child Death Review team findings related to child abuse and neglect deaths with systems change and/or prevention recommendations.

Thank you for exploring ways to improve the reporting process and consider more robust ways the data may be used to help focus on preventing harm and improving the lives of Wisconsin's kids and families. If you have any questions or would like to discuss further, please feel free to contact me via email at jbloch@chw.org or 608-217-9508.

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Kids deserve the **best.**