Vermont Citizen's Advisory Board
Child Death Review Report

November 7, 2014

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Child Death Review Report – Executive Summary
November 7, 2014

In the spring of 2014 two children who had been removed from their homes by the Department for Children and Families (DCF) due to abuse died due to severe injuries, shortly after being reunited with their families. In response to these tragic deaths, Governor Shumlin authorized the Vermont Citizen's Advisory Board (VCAB) to conduct a review of both cases to determine:

- Did child protection workers at DCF and other involved agencies follow existing policies and procedures?
- Are the existing policies and procedures adequate?
- What other observations may be offered – errors or misjudgments, areas in need of improvement?

VCAB conducted a thorough review of documentation from both cases and concluded that our current systems, including child welfare, law enforcement, courts and community-based services, failed to protect both children. VCAB found that existing policies and procedures were not followed throughout the system and not just at the Vermont Department for Children and Families, and that policies and procedures throughout the system were not adequate. VCAB findings provide a range of observations about areas in need of improvement, providing specific recommendations in each of the following areas:

- Training and evaluation of child protection system professionals
- Policies and practices of child protection system professionals
- Communications and information sharing between professionals throughout the child protection system
- Courts and statutes
- Staffing and contracting
- Child safety and ongoing risk to children

VCAB intends that implementation of the recommendations will improve the child protection system to promote the safety and well-being of Vermont's children.

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INTRODUCTION

1. The Vermont Citizen's Advisory Board (VCAB) established in December, 1995, serves to:
   - Examine policies, practices and procedures of the state's child protection agency, and where appropriate, review specific cases to evaluate the extent to which the agency is discharging its responsibilities, and
   - Provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families throughout Vermont.

2. A child who had been removed from her home by the Department for Children and Families (DCF) due to abuse 2014 died due to severe injuries in February 2014, shortly after being reunited with her mother. In response to this tragic event, Governor Shumlin authorized the Vermont Citizen's Advisory Board (VCAB) to conduct a review to address the following key questions:

   - Did child protection workers at DCF and other involved agencies follow existing policies and procedures?

   - Are the existing policies and procedures adequate?

   - What other observations may be offered – errors or misjudgments, areas in need of improvement?

   At the governor's request VCAB expanded its membership in response to the Governor's authorization. Additional members included a retired judge, state legislators, pediatricians, a law enforcement officer, and a Special Investigations Unit investigator. In addition, the governor requested that in order to conduct an independent case review, VCAB members who are state employees recuse themselves from this review. Therefore, state employee members of VCAB were not included on the case review panel.

   VCAB is an empaneled multi-disciplinary team under the provisions of 33VSA4917; the expanded membership was included in the empanelment.

3. In April 2014 there was a second child death involving a child who had been in DCF custody and returned to his family. The governor asked VCAB to include a review of this case in its work as well.

4. VCAB Case Review Panel Orientation
   On May 9, 2014, at the request of the VCAB co-Chairs, DCF staff provided the expanded VCAB membership with a web-based orientation to DCF policies and practices. This orientation included information on:

   - Overview of DCF Family Services responsibilities
   - Brief comparison of VT to national data – rates of entry into DCF custody
   - Required steps for investigating severe physical abuse

- How children come into DCF custody
- Monitoring progress involving DCF and the Courts
- Planning for permanence
- Reunification process
- DCF social workers' caseload and supervision
- Role of the multi-disciplinary team

5. Case Review Process

   On June 6, 2014, after the VCAB had been given the final authority to go forward with its review, a web-based orientation to the first child death case, DS, was held.

   Prior to this session, VCAB members received a confidential binder of materials regarding the DS case. During the webinar, DCF staff reviewed the binder materials with VCAB members and responded to members' questions. A binder of materials on the second child death, PG, was provided to VCAB members in July. (At the end of the review process, binders were returned to DCF and have been accounted for and destroyed.)

   VCAB has met in-person to review the DS case and the PG case, five times (June 11, July 1, July 16, August 26, and September 22). VCAB members have asked DCF staff a number of questions and received answers during open discussion time; VCAB has then moved into Executive Session to discuss members' observations and emerging recommendations, which fell into the following categories:

   - Training and evaluation of child protection system professionals
   - Practices of child protection system professionals
   - Custody and reunification policies and practices
   - Communications and information sharing between professionals throughout the child protection system
   - Courts and statutes
   - Staffing and contracting
   - Child safety and ongoing risk of serious physical abuse

CASE REVIEW MATERIALS

VCAB members received binders of materials with regard to both DS and PG. The following describes these materials.

DS Case Materials

Materials included in the binder for DS were:

- Timeline of Case History and Genogram identifying family members and relationships
- DCF Family Services Critical Incident Review drafted May 27, 2014
- Intake Reports (including investigation reports from June 2011 and February 2013)
- Report from Vermont Children's Hospital
- Rutland Police Department Report
- Structured Decision Making Assessment of Danger and Safety – February 2013
- Vermont Superior Court Docket Sheets
- Family Court Orders
- Family Court Transcripts
- Placement history
- Residential Licensing and Special Investigations Licensing documents (kinship care family)
- DCF Family Services Case Notes
- DCF Family Services Case Plans (May 2013, August 2013, January 2014)
- Commissioner's Registry Review Unit Appeal and Expungement Notification Letter (December 2013)
- Child and Family Services Eckerd Family Time Coaching Notes
- DOC Case Notes
- Reach Up Case Notes
- Det. Sgt. Albert E. Abdelnour's affidavit regarding murder charge
- DCF Family Services Policies (drawn from Family Services Policy Manual)

In addition, VCAB members later received the case narrative notes of Det. Lt. James Cruise from his review, which was conducted to determine if there had been any action or inaction on the part of any public official that would rise to the level of Criminal Neglect in the provision of services to DS.

Subsequently two members of VCAB were provided, and reviewed the recorded interviews of several of the witnesses interviewed by Lt. Cruise during his investigation, and then reported a summary of their findings to the VCAB panel. Additionally, VCAB authorized one of its members to conduct further inquiry on behalf of VCAB. Additional information was obtained from Mr. Nick Ruggerio, DCF Registry Review Unit, and Mr. Kevin Klamm, Deputy State's Attorney for Rutland County.

PG Case Materials

Materials in the PG binder included:

- Timeline of Case History and Genogram identifying family members and relationships
- DCF Family Services Critical Incident Review drafted June 19, 2014
- Intake and Child Safety Intervention Documents from May 2013 Family Assessment
- DCF Family Services Case Notes

- Structured Decision Making Assessment of Danger and Safety – May 2013
- Vermont Superior Court Docket Sheets
- Juvenile Court Orders
- Juvenile Court Transcripts
- DCF Disposition Case Plan
- Easter Seals Notes/Documents
- Placement History and Residential Licensing and Special Investigations Licensing Documents (kinship placement)
- DOC Case Notes
- Reach Up Case Notes
- Lund Treatment Notes from August 2013
- Fletcher Allen Health Care Written Report from Dr. Aaron Burley from April 2, 2014
- Criminal Affidavit

In addition, VCAB members later received the case narrative notes of Det. Lt. James Cruise from his review, which was conducted to determine if there had been any action or inaction on the part of any public official that would rise to the level of Criminal Neglect in the investigation regarding the case of PG up until the time of his death.

The next section of this report consists of the panel's Findings, followed by a section containing the panel's Recommendations.

FINDINGS

This section describes findings that arose from the VCAB's examination of materials and information described in the previous narrative. Findings fall into six categories:

- Training and evaluation of child protection system professionals
- Policies and practices of child protection system professionals
- Communications and information sharing between professionals throughout the child protection system
- Courts and statutes
- Staffing and contracting
- Child safety and ongoing risk to children

The findings emerged from:

- Specifics of the DS case
- Specifics of the PG case
- Consideration of the overall workings of Vermont's Child Protection system.

The term "Vermont's Child Protection system" refers to those agencies, departments, organizations, services and individuals that have formal responsibilities for, or are involved in activities related to the protection of Vermont's children. These entities include:

- Vermont Department for Children and Families – Family Services Division
- Local and state law enforcement agencies
- Special Investigative Units
- Vermont Department of Corrections
- Family courts
- Prosecuting attorneys
- Defense attorneys
- Attorneys representing children and other family stakeholders
- Guardians ad Litem
- Contract service providers
- Medical providers
- Vermont Department for Children and Families – Economic Services Division

The Vermont Department for Children and Families is referred to as DCF throughout this report; in most cases the findings and recommendations referring to DCF pertain specifically to the Family Services Division.

F-1	Findings: Training and Evaluation of Child Protection System Professionals
F-1.1	**DS and PG Case Review**
F-1.1.A	DCF's policy (Policy 124) states "Safe and timely reunification is the first and primary goal for children in custody." This principle, advocated by DCF leadership, is carried out in both cases, where reunification is strongly pursued seemingly without regard to other permanence options. DCF leadership states that this perception did not reflect the department's policy which states: "Children in custody will be reunified with their parents whenever it is in their best interest." DCF policy further states "Reunification Not Required. For some children, it may be clear from the beginning that reunification with family is contrary to the child's best interest." This is a staff training issue as well as a DCF policy and practice issue.
F-1.1.B	Parents of both children had long histories of significant drug abuse. The DCF workers may have lacked training, experience and expertise working with drug abusers, and may have not recognized many of the manipulative behaviors common to many drug abusers.
F-1.1.C	The court proceedings in both cases reveal a desire to reach a quicker resolution—by returning custody to custodial parent—in an effort to achieve "permanence" or case closure, to the detriment of the children.
F-1.2	**DS Case Review**
F-1.2.A	The DCF caseworker emphasized and reiterated in the case notes her understanding that reunification was a departmental priority that was to be pursued wherever possible. While DCF leadership says this perception did not reflect the department's policy which strives for reunification when possible and when in the best interest of the child, it is clear that here that some of the information and "red flags" which may have influenced case planning were missed.
F-1.2.B	Staff did not give the seriousness of the abuse the appropriate attention. As there are relatively few substantiated "serious" physical abuse cases in Vermont, DCF staff may not have sufficient training or experience dealing with these types of cases.
F-1.2.C	Law enforcement did not follow up on the origin of DS's broken legs. Training and expertise is needed in order to ensure adequate investigation of issues such as inconsistent statements, and to pursue the possibility of criminal charges after charging DS's mother with Cruelty to a Child.
F-1.2.D	Although the DCF investigation resulted in the substantiation of DS' mother for physical abuse and medical neglect of DS, and she was convicted for Cruelty to a Child, neither DOC nor DCF, nor the court system required her to complete any kind of assessment or counseling to address the physical abuse, or her ability to protect or keep her child safe from further abuse.
F-1.2.E	In making decisions to begin visitation and then allow unsupervised parent-child contact, DCF did not account for, nor understand, the potential risk of harm this posed. Additional training regarding supervised and unsupervised parent-child contact and its implications for reunification decisions is warranted. Given the information gleaned from the DCF investigation, DCF should have communicated relevant information to all parties, and especially to the child's attorney and GAL, to allow them to assess the advisability of unsupervised parent-child contact.
F-1.3	**PG Case Review**
F-1.3.A	Medical personnel who examined the child did not have expertise in pediatric child abuse and thus were not able to identify head trauma injury. There were 3 missed opportunities to investigate this case further; medical personnel didn't address the leg fracture and history of injury.

F-1	**Findings: Training and Evaluation of Child Protection System Professionals** (continued)
F-1.4	**Child Protection System**
F-1.4.A	Due to legislative funding cuts in the past decade, DCF lost central office supervisory and quality assurance staff positions. As a result the Department does not have the capacity for robust quality control to monitor cases and apply lessons learned to policies, staff training, and resource allocation. DCF reports it is working to develop its quality control capacity.
F-1.4.B	Given the staff turnover rate of approximately 20%, there are consistently many newly hired workers who typically come with less experience than seasoned workers and therefore require training, quality supervision and regular evaluation--all of which are predicated on the availability of adequate staff resources to carry out these activities.
F-1.4.C	VCAB questioned whether and when evaluations of DCF caseworkers take place and if so how the results of caseworker evaluations are tracked. DCF replied that regardless of whether annual evaluations are conducted, the new Human Resources electronic system no longer provides timely reports on employee evaluations to DCF supervisors.
F-1.4.D	DCF did not provide information regarding the education level and training of the staff involved in the specific cases in response to VCAB's request for this information. When VCAB asked for aggregate information on training and education of all caseworkers, DCF reported that that information was not accessible. Without access to this information, concerns remain about the level of education and training of DCF Family Services caseworkers.
F-1.4.E	An incorrect perception appears to exist among casework staff, the Family Courts, and others in the system that "reunification at all costs" is the formal policy of the department, and indeed of the entire child protection system. This misinterpretation of the Juvenile Proceedings Act appears to result in incorrect assumption that reunification takes priority over the best interests of the child.
F-1.4.F	DCF Family Services workers traditionally have factored in the financial impacts of the decision to remove a child from his/her home - impacts that eventually might make it more difficult for a child to return home (ex: loss of Reach Up support, Medicaid). It appears that in the DS case this may have been a factor in the effort to reunify quickly. It may be that not all Family Services Division caseworkers are aware of ESD policy regarding economic supports for parents whose child has been removed.

F-2	**Findings: Policy and Practice Issues**
F-2.1	**DS and PG Case Review**
F-2.1.A	There were no ongoing supports or systems in place to ensure the safety of each child after reunification with their families occurred.
F-2.1.B	There were little or no contacts, or documentation of DCF contact, with a range of persons including kinship caregivers, intervention services and other providers outside of DCF, several of whom appeared to have more knowledge than the DCF worker of risks to each child's safety.
F-2.1C	In both cases, DCF's Case Plan recommended a return home/reunification without a full understanding of and accountability for the safety risks posed by DS' and PG's mothers. The casework reflected a push to achieve permanency through reunification in a manner that did not appear to adequately address these risk factors. Additionally, the other parties in the Court proceedings did not appear to challenge or question these recommendations.

F-2	**Findings: Policy and Practice Issues** (continued)
F-2.2	**DS Case Review**
F-2.2.A	The DCF case file lacked complete documentation and explanations. Furthermore the DCF file does not demonstrate that the worker accessed the extensive narrative from the Department of Corrections Probation officer who supervised mother or the facts and information learned during its own investigation. Because of the lack of documentation, it is reasonable to conclude that important information was not considered or shared with others when making important case planning decisions. While the case file includes a list of services provided to DS and her family, there was little information about any of those services.
F-2.2.B	When considering reunification, the DCF worker's documentation in the case record shows no indication that she adequately assessed or addressed the presence of the mother's boyfriend/husband (DD) in the mother's home or his involvement with the child, or the significant life events he was involved in, such as their marriage, pregnancy and new baby. It is reasonable to conclude that this important information was not considered or shared with others when making important case planning decisions, including the decision to reunify DS with her mother. The failure to adequately consider this information, or to share it with the State Attorney's office and Family Court, is a significant concern
F-2.2.C	The case record indicates that the supervised visits conducted by the DCF worker did not meet the Department's own standards.
F-2.2.D	The law enforcement investigation into DS' broken legs in 2013 was clearly insufficient. There was little to no effort undertaken to identify and hold accountable the perpetrator(s) of the two broken legs, beyond the focus on DS's mother's failure to obtain medical care. No recorded interviews were taken, no witness interviews were obtained, inconsistent statements and information that mother's then-boyfriend was present with the child was not followed up on, there was no crime scene investigation, insufficient suspect interviews or interrogations, and no charges specific to the cause of the broken legs were pursued.
F-2.2.E	DCF did not conduct an investigation or assessment in response to a report from Lund that the mother left the program against advice – which was contrary to the mother's own statement - and that she was living in an unstable and potentially unsafe situation with her young daughter.
F-2.2.F	Case notes provided by Eckerd Family Time Coaching notes were incomplete at best. Even more egregiously, DCF utilized these supervised visits as parenting education for a mother who was substantiated for abusing her child and as justification that she was following DCF recommendations.
F-2.2.G	DCF minimized and failed to follow up on concerns about mothers' mental health; this included both failing to ensure that mother completed a psychological evaluation as required by DCF itself as a part of the case plan, and failing to independently verify that mother was engaged in therapeutic services.
F-2.2.H	Based on our review of documents and relevant DCF policies provided to VCAB, it appears that DCF casework on this case fell short of complying with their own policies. Specifically, there was not adequate assessment of risk factors present, and life stressors; no communication with collateral contacts, nor with others in the child protection system; and inadequate supervisory oversight prior to the decision to reunify.
F-2.2I	There was a lack of inquiry by *all child protection system players*, particularly within the judicial process, on the crucial issue of who caused the two abusive injuries to DS, and how to best ensure her future safety by preventing future abuse.

F-2	**Findings: Policy and Practice Issues** (continued)
F-2.3	**PG Case Review**
F-2.3.A	After the mother's arrest in New Hampshire the Structured Decision Making safety assessment form was not fully completed and therefore did not reflect the level of risk. Once a case is identified as "high risk" it appears that case workers did not include all the details as they are not important to opening the case; however, those details are important throughout the case.
F-2.3.B	Reports for this mother conflicted – facts of the case indicated that the mother wasn't doing well yet Lund reported that she was doing well. A home visit noted an apparent lack of attachment between child and mother, however there was only one mention of this.
F-2.3.C	DCF did not have sufficient understanding or means to assess mother's parenting abilities outside of a residential setting, and did not have a safety plan in place to address possible substance abuse relapses.
F-2.3.D	In informing the parties to the Court proceeding of risk factors within the family, DCF did not adequately address the extent of mother's substance abuse history, nor of her mental health and/or history of interpersonal violence, including her conviction for an Aggravated Assault with a Weapon, both of which were known to DCF.
F-2.4	**Child Protection System Review**
F-2.4.A	The child welfare and Family Court systems in Vermont reflect a culture which excessively prioritizes reunification as the outcome to pursue, thus influencing practices and decisions.
F-2.4.B	DCF Policy 125 does not clearly or adequately specify the process for determining what is required for reunification to take place.
F-2.4.C	An under-funded, under-resourced system has created a culture within the court, the State's Attorney's offices and DCF that puts an emphasis on bringing resolution to and closing cases as quickly as possible, sometimes without adequate attention or review.
F-2.4.D	Because of the overwhelming caseload demands at all levels of the child protection system, cases may be closed too quickly without adequate attention and review. Better oversight, monitoring of the household, checking on collateral contacts and ensuring a safety plan in the event of any relapse or concern should have been in place for a longer period of time to ensure child safety.
F-2.4.E	DCF case workers and other involved agencies failed to follow existing policies and procedures.
F-2.4.F	Reports to DCF Centralized Intake Unit from mandated reporters and others who have reasonable cause to believe a child has been abused, neglected or is at risk of harm are often not "accepted"/opened for investigation or assessment, even when the information provided seems credible and appears to meet the statutory definitions.

F-3	Findings: Communications and Information Sharing Between Professionals Throughout the Child Protection System
F-3.1	**DS and PG Case Review**
F-3.1.A	Little or no communication and information was shared between DCF, DOC and others involved in these cases including judges, attorneys, guardians ad litem, contracted service providers, law enforcement, and medical providers. As a result, decisions were made too quickly, without the benefit of all relevant information.
F-3.2	**DS Case Review**
F-3.2.A	The DCF record lacks documentation about the frequency and content of internal communications about the case between the DCF caseworker, supervisor and District Director. Consequently, the panel finds there was a lack of communication between the case worker and her supervisor which negatively affected case planning.
F-3.2.B	This case was not referred to a multi-disciplinary team (MDT) or to the Special Investigation Unit (SIU). No standards exist for making referrals to, or communicating with the SIU.
F-3.2.C	The Registry Review Unit letter upholding the substantiation was sent to the DCF District Director and DCF Commissioner; however there was no evidence that the letter had been received and reviewed by any of these persons and there is no mechanism in place to ensure that it would have been received and reviewed, or that any of the information contained therein would be incorporated into future case planning.
F-3.2.D	Critical information, including the findings of the Registry Review process, was not conveyed to DCF workers making decisions regarding DS or to those involved in the court hearings.
F-3.2.E	There is no evidence that the information learned from DCF's initial investigation of DS's leg fractures was shared with the on-going caseworker or the other parties involved in DS's CHINS case. Because of this, it appears that others, such as DS's GAL and attorney were unaware of the role played by mom's boyfriend/husband.
F-3.3	**PG Case Review**
F-3.3.A	DCF did not share critical information about mother's substance abuse, mental health and criminal history with all parties to the CHINS proceedings, therefore the court and those making decisions about the baby's welfare were not adequately informed of the safety and risk factors.

F-4	Findings: Courts and Statutes
F-4.1	**DS and PG Case Review**
F-4.1.A	The court process does not allow kinship caregivers, who may be most familiar with the situation, to be present in all proceedings, thus potentially excluding important information pertaining to the child's safety from the court's consideration.
F-4.1.B	PG and DS were both non-verbal (pre-verbal) when they each sustained significant injuries, and were unable to explain how the injuries occurred, and who inflicted them. While qualified medical personnel were available for consult, and did consult, the information regarding the cause and mechanism of injury was not able to be fully presented to, or sufficiently considered by the Court because Vermont's Rules of Evidence do not adequately address these situations.
F-4.2	**DS Case Review**
F-4.2.A	Because the Juvenile Proceeding Act statutes mandate a hierarchical system that favors the custodial parent(s), lawyers and judges agreed to reunification in a case where there should have been a more critical analysis of the hierarchy, and of the circumstances that led to DS being taken into DCF custody. Here, this push for reunification and case closure resulted in a lack of information and inquiry as to the exact circumstances under which a 1-year old had 2 broken bones, who actually caused those injuries, and what measures were being taken to ensure her future well-being.
F-4.2.B	There appears to have been a lack of attention to and follow through on important case details by all involved with the court process. Insufficient documentation in court records makes it difficult to determine whether there was perfunctory review of case plan or if there was simply lack of documentation of a more thorough review. There was little indication in the court record or the case files of sufficient attention to this case by the Guardian ad Litem, the attorneys and the various judges involved.
F-4.4	**Child Protection System Review**
F-4.4.A	Rule 804A permits hearsay evidence in sexual abuse cases rather than requiring a child to testify. The rule does not currently apply in Human Service Board hearings; children have to testify across a table from their abuser in these situations.
F-4.4.B	Vermont law and policies do not currently provide sufficient mechanisms to address cases of serious injury to children where the perpetrator cannot be identified and the caretaker cannot reasonably explain how the injuries were caused.

F-5	**Findings: Staffing and Contracting Issues**
F-5.1	**DS and PG Case Review**
F-5.1.A	Contracted service providers worked with the mothers of both children toward building their parenting skills. The level of communication and quality of information on their progress which these programs shared with the DCF caseworkers was grossly inadequate.
F-5.1.B	Service providers may face a challenge from people with a history of drug use. Some providers—including contracted service providers, as well as those within DOC and DCF— appear to overemphasize their role in engaging and supporting their adult clients, rather than maintaining neutrality and healthy skepticism in an effort to ensure child safety.
F-5.2	**Child Protection System Review**
F-5.2.A	**DCF caseload ratios (client/worker) are well above the national best practice standard of 12 cases per social worker, which was approved by the Vermont Legislature in 2009.** ***The recent addition of 18 new positions will not fully address this issue.***
F-5.2.B	The current rate of turnover for DCF caseworkers is 20%. Staff turnover has several implications: there may be a delay in filling vacant caseworker and supervisory positions, thus increasing the caseloads of other case workers and requiring supervisors to "cover" cases in an interim basis. Staff training needs for new staff are addressed above.
F-5.2.C	Questions remain about reports which are not opened for DCF intervention, and whether this is due in part to DCF staff shortages.
F-5.2.D	**It is clear that all agencies within the child protection system are carrying caseloads that are too high, which causes workers to triage, to burnout and leave, and to cut corners in an effort to do the best they can**.

F-6	**Findings: Child Safety and Ongoing Risk to Children**
F-6.1	**Child Protection System Review**
F-6.1.A	DCF reports there have been at least 44 cases involving serious abuse since 2009. There remains a concern about the extent to which any of the findings identified in this review of the DS and PG cases are present in these 44 cases of serious child abuse, and whether any of these children are currently at risk for further abuse. *(Legislative Council is reviewing these cases for the legislature's Child Protection Committee.)*
F-6.1.B	The child protection system in Vermont does not adequately address—by policy, statute, or rule of evidence—situations of non-verbal or pre-verbal children who are victims of abuse. As a result, the perpetrator(s) are not held accountable, and the parties who are supposed to protect children are often unable to do so because the injury remains "unexplained." No one was identified in criminal court as the person who caused 2 fractured bones to D.S. and this negatively impacted decisions within the child protection system.

RECOMMENDATIONS

To address the findings the Vermont Citizen's Advisory Board developed the following recommendations.

R-1	**Recommendations: Training and Evaluation of Child Protection System Professionals**
R-1.1	DCF staff training should clearly address the staff misperception that reunification should always be pursued first and foremost. DCF should train staff to assess child safety first and foremost, and to pursue reunification only when safe and in the child's best interest. Further, staff training should specifically address situations where a child has been seriously physically abused, and should reinforce that reunification should not be pursued until the abuse has been adequately explained, addressed, and there is sufficient information to ensure that it will not be repeated.
R-1.2	Quality Assurance staffing in DCF's Central Office needs to be at full capacity.
R-1.3	In order to assess and address the training and supervision needs of caseworkers, DCF supervisors should conduct annual evaluations of caseworkers under their supervision. In addition, managerial staff should have timely access to information about whether or not annual evaluations have been conducted, and to the information contained in employees' evaluations.
R-1.4	DCF should develop clear standards to ensure that assessments of families and risk to children are complete and accurate, and then train staff to include complete and accurate information on assessments.
R-1.5	The quality of documentation in DCF case files needs to be improved. Electronic and other methods are needed to make all documentation provided by any organization and entity involved in child abuse cases less complicated to navigate and to share when appropriate.
R-1.6	Vermont should pursue all avenues to fund a dedicated, full-time specialty board certified or board eligible Child Abuse Pediatrician– responsible for providing direct care and consultation on cases of suspected child abuse, as well as for training residents, students and other medical staff in partnership with existing community-based child abuse prevention efforts.
R-1.7	The medical community, including hospitals, needs to provide specific training and support to Emergency Department physicians in recognizing and responding to injuries caused by abuse.
R-1.8	Training is critical to understanding and learning how to deal with substance abusers. VCAB supports DCF-Family Services' plan to work with national technical assistance providers to build staff competence to address the challenges resulting from increased incidence of drug abuse and addiction. Other professionals, especially program providers, should also be trained to recognize and deal effectively with substance abusers.
R-1.9	Special Investigation Unit/Multi-Disciplinary Team trainings and consultation should be mandatory for all DCF-Family Services and Law Enforcement investigators who conduct investigations and who do casework on all cases involving serious physical (and all sexual) abuse.
R-1.10	DCF case workers should have a relevant educational back ground such as a Social Work degree, preferably an MSW. DCF should define caseworker professional competencies and standards, and should ensure that caseworkers are properly trained and hold these competencies prior to being assigned cases. Investigations of serious abuse cases should be assigned to a master's level social worker with experience and training in investigation.
R-1.11	Support expansion of existing statewide research-based effective training initiatives regarding abusive head trauma (AHT). Recent efforts have resulted in a significant reduction in child fatalities due to AHT; such efforts should be expanded to include parents/caregivers of toddlers.
R-1.12	Training is necessary for *all* child protection system professionals -- DCF Family Services, Family Court, attorneys, GAL's, etc. -- on reunification and TPR policy, practice and rationale.

R-2	**Recommendations: Improve Policy and Practice**
R-2.1	**Policy and Practice: Reunification**
R-2.1A	DCF Policy 125 states "Reunification is not required: For some children, it may be clear from the beginning that reunification with family is contrary to the child's best interest. Reunification efforts are not required by either state or federal statute," and lists instances where TPR should be pursued. Policy 125 should specify that reunification is not required when the child has been the victim of serious physical abuse and there is reason to believe that the parent has caused the injury or is unwilling or unable to protect the child from the abuser. When DCF has substantiated a parent for physical abuse of their child, reunification should not be pursued until the abuse has been adequately explained, addressed, and there is sufficient information to ensure that it will not be repeated.
R-2.1B	All DCF's policies should be thoroughly reviewed to ensure a consistent and balanced approach toward reunification, one which emphasizes child safety. For example, DCF's Family Time policy (Policy 124) regarding parent-child contact states "Safe and timely reunification is the first and primary goal for children in custody." This policy should more accurately reflect Policy 125 which clarifies that "Reunification is not required" and that "Children in custody will be reunified with their parents *whenever it is in their best interest*."
R-2.1C	DCF should establish a policy standard that requires that, in cases of reunification, everyone living in the household or in a close relationship with the child's parent/guardian and having child care-taking responsibilities must be screened to assess potential child safety risks and concerns. Their role as a potential caretaker of the child(ren) must be included in the case plan. DCF policy should require that case plans must be updated when new household members start living in the home with child. Screening of household members shall include criminal records as well as the DCF Child Protection Registry.
R-2.1D	Policies and procedures should be developed to ensure that prior to a reunification, a comprehensive review of all case notes (from DOC and DCF, including Reach Up) is conducted, and that this information is included in the case plan and forwarded to the Family Court for review by the judge.
R-2.1E	When reunification is being planned, parent-child contact (visitation) between the parent and child must include supervised visits at the parent's home, and clear standards to evaluate the appropriateness of continued work towards reunification, incorporating the nature and quality of the home-based parent-child contact, should be implemented.
R-2.1F	In addition to reinstating the previously eliminated position of Permanency Planning manager, DCF should add a Reunification Manager position in the Family Services Division central office to oversee and provide guidance to caseworkers and supervisors on all cases involving a reunification plan. *Funding should be requested of and allocated by the Legislature for these positions.*
R-2.1G	When substance abuse and/or mental health issues are present, structures should be in place to consider the safety of the child if reunification is pursued, and to ensure careful monitoring if reunification occurs. VCAB supports DCF's plan to seek Technical Assistance from the National Center on Substance Abuse and Child Welfare to determine appropriate and most effective assessment tools and intervention strategies for case planning where there is a history of substance abuse, especially where reunification is being considered.

	Recommendations: Improve Policy and Practice (continued)
R-2.2	**Consistency in Policy and Practice**
R-2.2A	DCF's mission should be reviewed and updated if needed, to ensure that the safety and welfare of children is central to all decision making. In following federally mandated guidelines regarding permanency, child safety must not be compromised.
R-2.2B	Improved communication mechanisms and staff training are needed to align practices in the field with DCF Central Office policies. Quality control processes in Central office should be strengthened to ensure that policies are being implemented appropriately and that practice guidance is being followed.
R-2.3	**Standards of Practice, Protocols, Mechanisms and Tools**
R-2.3A	DCF should establish comprehensive standards for practice, should operationalize those standards through policies, protocols/procedures and practice guidance. Where standards are lacking, develop them, and should regularly monitor their utilization and effectiveness.
R-2.3B	Structured Decision Making risk assessment tools should be implemented consistently and regularly – ongoing risk assessments should be conducted throughout the life of a case to address changing situations and circumstances. All risk factors should be thoroughly documented; information from the risk assessments (not just the "risk score") should be taken into consideration for case planning, and should be shared with all parties to the court proceedings.
R-2.3C	DCF should establish more comprehensive protocols and procedures for investigations (Policy 52), to ensure that all elements that might be helpful to the investigation and to subsequent case planning are considered and documented.
R-2.3D	The quality of documentation must be improved without creating such volume and demands on workers' time that documentation best practices are impeded. Documentation must include information regarding the nature and quality of relationships between parents and their children.
R-2.3E	DCF needs to establish a clear policy and practice guidance that: values and considers any information that comes to a caseworker; enables reasonable efforts to contact collaterals and specifies who comes under that category; and identifies steps to overcome barriers to gaining information from collateral parties.
R-2.3F	DCF should update its Case Planning/Disposition Report template so that it adequately informs the parties of the concerns and issues that led to the child coming into custody, and the particular details of what has happened to address those issues. Workers need to fill out the items with specificity and more information, including providing information about substance abuse and mental health issues and criminal histories.
R-2.3G	DCF needs to create mechanisms for closely monitoring cases of child abuse and document and apply lessons learned from these cases to policy development, staff training, and allocation of resources.
R-2.3H	DCF should ensure continuous monitoring of child safety and well-being that includes conducting in-home visits, and not just "eyes-on" in court or at school. The federal standard of 1 face-to-face meeting per month between caseworker and child is inadequate to effectively evaluate how a child/family is doing and to make case plan decisions. More home visits, including *unannounced visits*, should be required when child safety is being assessed or when a child is being reunited with family.

R-2	**Recommendations: Improve Policy and Practice** (continued)
R-2.4	**Serious abuse or injury**
R-2.4A	DCF should instill a cultural sense of urgency for serious cases, including all cases involving severe physical abuse or injury and sexual abuse, to a child. Serious abuse includes, but is not limited to: death, head or internal injuries, central nervous system injury, fractures, strangulation/choking, burns as well as attempts to cause such injuries, or any act which could be considered serious bodily injury as defined under 33 VSA 1021(2).
R-2.4B	An internal review process involving consultation with Central Office should take place in all cases where the child has been seriously harmed (this Recommendation has been implemented by DCF effective March 2014).
R-2.4C	DCF should ensure that serious cases are assigned only to trained, experienced investigators and social workers and that District Supervisors routinely monitor these cases. Additionally, DCF must regularly collaborate with other members of their SIU-MDTs on these cases.
R-2.5	**Additional Policy and Practice Improvements**
R-2.5A	The Court Administrator's Office should work with DCF and other child protection system partners to create a "checklist" of issues and information that need to be addressed and discussed for every case that is going to court, to ensure that *all* relevant information is included and is provided to the State's Attorney and to the court.
R-2.5B	DCF should ensure that contracted agencies provide sufficient and appropriate information to DCF to enable the caseworker to effectively evaluate risk based on the information provided. This is particularly true for contracted agencies providing services essential to determining child safety and risk, such as residential treatment programs, supervised visitation services, and parent education services.
R-2.5C	DCF should incorporate best-practice; evidence based assessments of parent/caregiver-child attachment in case planning; and should provide practice guidance and training for staff on how to use such assessments in guiding reunification decisions.
R-2.5D	DCF should implement research-based best practices for working with families. Home visiting services provided in accordance with the standards set by the Vermont Department of Health's Maternal Child Health Division should be required for *all* new parents involved with the child welfare system, starting prior to the birth of the baby if possible.
R-2.5E	DCF should develop appropriate measures to assess child safety and healthy development as successful outcomes for children.
R-2.5F	Vermont must invest in proven effective prevention strategies such as research based parent education and support programs. Prevention efforts should focus on children and families with whom DCF is working, but also be available to all families as an effective approach to preventing serious injury and child fatality.

R-3	Recommendations: Communications and Information Sharing Between System Players
R-3.1	All cases of serious abuse shall be referred to the appropriate Special Investigation Unit and/or Multi-Disciplinary Team for review and collaboration. Any case involving a non-accidental fracture or serious injury to a child should be immediately accepted for investigation and should also include immediate collaboration with the MDT; this includes injuries caused by out- of- home perpetrators. (definition of serious injury see R.2.4)
R-3.2	DCF should seek technical assistance from Casey Family Programs or other national child welfare experts to gain knowledge about how to improve communications and information sharing among all parties, including judges, attorneys, law enforcement, DOC workers, DCF workers and supervisors, Guardians ad Litem, contract service providers, and medical providers. Technical Assistance should also help DCF identify and address barriers, and create mechanisms to govern communications between involved system players for children in crisis.
R-3.3	Protocols should be developed to ensure that findings of the Registry Review Unit (RRU) are reviewed by the caseworker on open cases and that information from the RRU is taken into account in developing the plan. Additionally, protocols must be put in place to ensure that RRU findings are sent to the caseworker, supervisor, District Director and Commissioner or his/her designee, and that those individuals review and appropriately consider the RRU's findings, and that they document such review.
R-3.4	Confidentiality issues and barriers to information sharing should be reviewed to ensure that all parties who need to share information regarding child safety may do so. 33VSA4917 should be reviewed to determine whether it adequately addresses balancing confidentiality concerns with the need for members of child protective services agencies to adequately address concerns of child safety through the open exchange of information.

R-4	Recommendations: Courts and Statutes
R-4.1	Revise Statutory language (Title 33: Section 5101) which contributes to a misunderstanding of the law's intention. Language should direct the court, in requests for custody, to carefully assess if reunification is genuinely in the child's best interests if any caretaker or household member has a history of significant abuse or criminal charges.
R-4.2	The legislature should review 33 VSA 5301(1) to consider allowing DCF personnel to submit an emergency affidavit requesting a judge take a child into custody. This review should also include 33 VSA 5308/08 considering revising the hierarchy regarding out-of-home placement.
R-4.3	Recommend the following change be made to evidentiary rebuttable presumptions: In cases where the court has found serious bodily injury to a child and reasonable medical evidence cannot *corroborate* the cause of the injury as described by the custodial parent, reunification of the child with the parent caretaker at the time of the injury is presumed to be against the best interests of the child.[1]
R-4.5	Expand Rule 804 A to permit hearsay evidence in cases with child victims of physical abuse. Additionally, the law should be changed to allow hearsay evidence in Human Service Board hearings so that child victims of physical and sexual abuse are not required to testify at HSB hearings. Rule 807 should also be expanded to allow the exception for medical evidence to include others with child development expertise and experience with the child/family to testify.
R-4.6	Implementation of the statutory provisions allowing necessary parties to be included in juvenile proceedings needs to be consistent.
R-4.7	The confidentiality statutes should be changed to permit the rapid and sensible flow of information between the professional resources charged with child protection.
R-4.8	When a child is hospitalized due to suspected intentional injury, hospitals should be allowed to implement policy that prohibits any suspected perpetrator from visiting the child.

[1] Item R-4.3 is Part Two of a proposed two-part recommendation to add evidentiary presumptions. VCAB was unable to reach consensus on Part One, thus the proposal and comments are included as an addendum to this report (p.22). VCAB suggests further review and exploration of the issues surrounding the proposed evidentiary presumptions.

R-5	Recommendations: Staffing and Contracting Issues
R-5.1	Significant funding must be provided to DCF Family Services to enable DCF staff/client ratios to meet best practices levels of an average of 12 cases per social worker. Additional specialized staffing, including Substance Abuse and mental health consultants co-located in each District Office, should be funded by the legislature to enable DCF to address this urgent need.
R-5.2	The performance and outcomes achieved by all contract parties should be regularly and thoroughly reviewed. Contracts with DCF should define what the work is, articulate clear expected outcomes and require reporting of activities and results. DCF should promptly address concerns with contractors who do meet these outcomes or provide adequate reports of activities and results, and if necessary contracts should be terminated.
R-5.3	VCAB supports DCF's plan to contract with Casey Family Programs to conduct a thorough evaluation of staffing, policy, and practice issues and to make recommendations for improvement, based on their expertise in the field of child welfare.
R-5.4	DCF should conduct a complete regular audit of how determinations are made to *not* open an investigation or assessment based on a report; whether these determinations are appropriate; timeframes for follow-up calls; and criteria in place for following-up reports. DCF should consider evaluating whether reports from physicians, schools, or others should be weighted more heavily than other reports.

R-6	Recommendations: Child Safety and Ongoing Risk to Children
R-6.1	In order to hold the perpetrator accountable, a new investigation should be initiated to determine who broke DS's legs.
R-6.2	**VCAB supports the full review by the VT Agency of Human Services Special Investigation Unit and by the legislative Child Protection Committee of the founded 44 serious abuse cases over the past five years, and any appropriate action they may take as a result of these reviews to ensure the safety of these children. Absent review by legislative committee, this panel would recommend review by an independent special prosecutor and investigative team.**
R-6.3	Establish a citizen oversight mechanism, such as an ombudsman or Office of the Child Advocate to provide ongoing oversight of DCF Family Services, the courts, GAL's and others involved in the child protection system.

ADDENDUM

VCAB considered a proposed evidentiary presumption in our recommendations. The proposed evidentiary presumption consists of two parts. The section contained in the report's recommendations, as agreed upon by VCAB, is "part two." The VCAB Case Review Panel did not reach consensus on the proposal below, which is Part One of the proposed evidentiary presumption.

The group's lack of consensus suggests to the Co-chairs the need for additional review and. We have included here the proposal, as well as a summary of arguments pro and con. We encourage further consideration of the proposal and these issues.

Proposed Evidentiary Presumptions in cases involving serious injury to children

(1) In cases where the Commissioner of the Department of Children and Families substantiates that a child has suffered serious bodily injury;

and the caretaker or parent who supervised the child at the time of the injury provides an explanation for the injury materially inconsistent with the physical evidence of injury and in conflict with competent medical opinion;

a presumption arises that the supervising caretaker or parent at the time of the injury either caused the injury or is shielding the person who caused of the injury.

(2) In cases where the court has found serious bodily injury to a child and reasonable medical evidence cannot corroborate the cause of the injury as described by the custodial parent, reunification of the child with the parent caretaker at the time of the injury is presumed to be against the best interests of the child.

Rationale for inclusion of "First Rebuttable Evidentiary Presumption"

The first presumption addresses concerns found in our review of the overemphasis on reunification despite clear evidence of unexplained child abuse. It places the Commissioner in the position of having to address affirmatively the issue of injury and not ignore it (as we saw in the DS case). Further the medical team examining a child should be aware that serious injuries to children that the caretaker cannot reasonably explain raises a legal red flag as well as a medical red flag (as we saw in the PG case).

Both presumptions are focused on the safety of the child. This first presumption would apply at the critical first Emergency Detention Hearing where decisions regarding custody, visitation and, in life threatening situations, medical decisions are considered. In DS this presumption could have changed the mechanism by which the court assessed the early fractures.

Concerns for a possible co-victim parent are noted, and is a concern for us as well. Some argue that the operant protections for these co-victims are inadequate; we do not disagree. The fact that the proposed presumption is rebuttable affords some additional protection for parents who are co-victims. Co-victims are adults for whom there are accessible opportunities to get help. But the child victim has no other opportunity for help, as we have seen in this case and in others.

Rationale of those opposed to this recommendation:

This presumption is overly broad and has implications for many cases outside of those reviewed by the panel. This presumption would apply to all legal proceedings, including criminal prosecutions, family court proceedings, and termination of parental rights proceedings. Although the stated intent of the presumption is to force the Commissioner to affirmatively address the cause of injury, it does not in fact force the Commissioner to substantiate, but rather serves to implicate a (possibly innocent) parent after the Commissioner has already determined serious physical injury.

We agree that efforts should be focused on investigating the cause of injury to children and preventing further harm, but the focus should be on ensuring that investigators – both police and social workers – are well trained in conducting investigations and are able to determine the cause and source of injury. Once the cause is determined, then the courts can step in to bring justice to the actual perpetrator. Presuming that a parent - who may themselves be a victim of abuse and terror at the hands of the other parent - is guilty of causing injury to a child simply because they cannot explain how the child was injured, does not achieve the desired outcome.

Unfortunately, we know that there is a significant overlap between domestic violence and child abuse, and that those who would batter their partner are also capable of violence toward children. Perpetrators of domestic violence too often use threats of violence or death toward the victim, children, family and friends as weapons to control a victim who is striving to protect their children. The proposed presumption puts those victims at risk of criminal prosecution, and of losing the ability to protect their children, if they cannot explain the source of injury. This risks punishing parents who are trying to be protective – and who could succeed with proper supports – and puts victims and any other children at greater risk.

Supporting Documents

Federal authorizing language for VCAB and child death review

Governor Shumlin's letter authorizing VCAB's review

Vermont Agency of Human Services Secretary Doug Racine's letter requesting VCAB's review

VCAB empanelment as Vermont Multi-Disciplinary Team, 33VSA4917

VCAB membership and additional members for case review

2.2 CAPTA, Citizen Review Panels

3. Question: What are the functions that citizen review panels must perform?

Answer: Pursuant to sections 106(c)(4)(A)(i) and (ii) of the Child Abuse Prevention and Treatment Act (CAPTA), each panel must evaluate the extent to which the State is fulfilling its child protection responsibilities in accordance with its CAPTA State plan by: (1) examining the policies, procedures and practices of State and local child protection agencies, and (2) reviewing specific cases, where appropriate. In addition, consistent with section 106(c)(4)(A)(iii) of CAPTA, a panel may examine other criteria that it considers important to ensure the protection of children, including the extent to which the State and local CPS system is coordinated with the title IV-E foster care and adoption assistance programs of the Social Security Act. This provision also authorizes the panels to review the child fatalities and near fatalities in the State.

In order to assess the impact of current procedures and practices upon children and families in the community and fulfill the above requirements, citizen review panels must provide for public outreach and comment (section 106(c)(4)(C) of CAPTA). Finally, each panel must prepare an annual report that summarizes the activities of the panel and makes recommendations to improve the CPS system at the State and local levels, and submit it to the State and the public (section 106(c)(6) of CAPTA).

- **Source/Date:** ACYF-CB-PI-99-09 (6/2/99); updated 3/22/06
- **Legal and Related References:** Child Abuse Prevention and Treatment Act (CAPTA), as amended (42 U.S.C. 5101 et seq.) - section 106(c)

4. Question: Section 106 (c)(5) of CAPTA requires States to provide citizen review panels with access to information on cases that the panel wants to review "if such information is necessary for the panel to carry out its functions". Who determines what confidential information is necessary for these functions?

Answer: The Congress intended that citizen review panels be established to evaluate the extent to which States are meeting the goals of protecting children and their responsibilities related to the State plan. In carrying out these responsibilities, it is important for the review panels to have access to confidential information, as necessary, to assist in their duties. The intent of section 106 (c)(5) was to direct States to provide the review panels with information that the panel determines is necessary to carry out these functions (Congressional Record - House, September 25, 1996, p. H11149).

- **Source/Date:** ACYF-NCCAN-PIQ-97-01 (3/4/97); updated 2/3/05
- **Legal and Related References:** Child Abuse Prevention and Treatment Act (CAPTA), as amended (42 U.S.C. 5101 et seq.) - section 106(c)(5)

5. Question: Do the confidentiality requirements in the Child Abuse Prevention and Treatment Act apply to the members of citizen review panels?

Answer: Citizen review panel members are bound by the confidentiality restrictions in section 106 (c)(4)(B)(i) of CAPTA. Specifically, members and staff of a panel may not disclose identifying information about any specific child protection case to any person or government official, and may not make public other information unless authorized by State statute to do so. Further, section 106 (c)(4)(B)(ii) of CAPTA requires States to establish civil sanctions for violations of these confidentiality restrictions. States that already have civil sanctions in place for breaches of confidentiality need not enact new legislation, so long as their existing provisions encompass the CAPTA requirements.

- **Source/Date:** ACYF-BC-PI-98-01 (1/7/98); updated 9/27/11
- **Legal and Related References:** Child Abuse Prevention and Treatment Act (CAPTA), as amended (42 U.S.C. 5101 et seq.) - section 106(c)(4)(B)

http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=70

State of Vermont
OFFICE OF THE GOVERNOR

May 14, 2014

Vermont Citizen's Advisory Board
Joseph F. Hagan, Jr., MD, FAAP,
Chair

Dear Dr. Hagan,

I greatly appreciate the decision of the Citizen's Advisory Board for Child Protective Services to thoroughly review the State's handling of the Dezirae Sheldon case. As I am sure you are aware, Vermont has experienced the tragic loss of a second baby to homicide, Peighton Geraw. I know, given your commitment to Vermont's children, that you join me in feeling anger and frustration that the adults in their lives failed to provide protection.

I write you today to urge the Board to meet as regularly and as expeditiously as possible to review both of these deaths. I understand the Board's work cannot conflict with the pending criminal investigation but a timely review will best ensure that other children benefit from the correction of any deficiencies you find or recommendations you may make. I want these investigations to be thorough, and I want you to keep asking questions until you have the answers to determine whether changes are required to protect Vermont's children.

I appreciate that you all have the commitment, experience and heart to complete this job swiftly and well. And I thank you for your service and attention to these tragic deaths.

I would appreciate it if you would share this letter with Sally Borden, your co-chair for the Shelton matter, and the other Board members as you deem advisable. I understand that Secretary Racine and members of the Agency of Human Services will be in touch to further assist in your efforts.

Sincerely,

Peter Shumlin
Governor

Cc: Douglas A. Racine, Secretary
Vermont Agency of Human
Services

-------- Original Message --------

Subject:Vermont Citizen's Advisory Board review
Date:Thu, 27 Feb 2014 20:30:03 +0000
From:Racine, Doug <doug.racine@state.vt.us>
To:'jhagan@burlingtontelecom.net'<jhagan@burlingtontelecom.net
CC:Schatz, Ken <Ken.Schatz@state.vt.us>

Dear Dr. Hagan,

I am writing to confirm my request that the Vermont Citizen's Advisory Board review the State's handling of the Dezirae Sheldon case. I sincerely appreciate the Board's willingness to address this important and challenging matter.

I know that as a Board created under Section 106 (c) of the federal Child Abuse Prevention and Treatment Act (CAPTA), the Vermont Citizen's Advisory Board has the role and responsibility to independently examine child protection policies, procedures, and practices, including where appropriate, specific cases. I am glad we will have the benefit of your expertise and experience as you review this case.

I have consulted with legislators regarding the appropriate review of this matter. They have suggested certain names to be considered as part of the group empaneled for review. Those names are John Campbell, Martha'Neary (former SA of Windsor County), and retired Judge Ben Joseph. I support your consideration of additional membership as you deem appropriate.

Also, I would appreciate an independent review that involves no state employees. Consequently, I ask that any state employees on the Board not be involved in the review of this case.

I am asking that the Board review all aspects of the handling of the Sheldon case to determine whether DCF policies and practices were appropriately followed and are adequate to ensure the safety of Vermont's children and what changes, if any, are needed to prevent similar tragedies from occurring in the future.

Please let me know if you have any questions regarding this matter. Thank you again for your service.

Sincerely,

Douglas Racine

VERMONT

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Commissioner's Office
103 South Main Street – 5 North
Waterbury, VT 05671-2980
www.dcf.vt.gov

[phone] 802-871-3385
[fax] 802-769-2064

Agency of Human Services

April 7th, 2014

Dr. Joseph Hagan
C/O Hagan, Rinehart and Connolly Pediatricians, PLLC
128 Lakeside Ave, Suite #115
Burlington, VT 05401
jhagan@burligntontelecom.net

Dear Dr. Hagan,

Please accept this letter as a formal authorization to empanel the following team as a special investigation multi-task force for the independent review of the Dezirae Sheldon case pursuant to 33 V.S.A. § 4917:

First	Last	Affiliation	First	Last	Affiliation
Stephen	Berry	Pastor	Robin	Lockerby	Foster Parent
Sally	Borden	Kidsafe VT	Sarah	Lowell	Parent
John F.	Campbell	Legislator	Kim	Magnuson	Education Specialist
Edward	Cashman	Former Judge	Patrick	Malone	Fletcher Allen Health Care
Rachel	Cohen	Fletcher Allen Health Care	Martha	Neary	The Family Place
Lynn	Granger	Kinship VT	Eliot	Nelson	Fletcher Allen Health Care
Hilda	Green	VT Children's Trust Foundation	Karyn	Patno	Fletcher Allen Health Care
Joseph	Hagan	Fletcher Allen Health Care	Jennifer	Poehlmann	VT Children's Alliance
Linda	Johnson	Prevent Child Abuse VT	Ann	Pugh	Legislator
[redacted]			Michael	Schirling	Burlington Police Chief
Ben	Joseph	Former Judge	Debra	Taylor	Rutland Supervisory Union
Sarah	Kenney	VT Network			

Thank you for your time and coordination of this important endeavor.

Sincerely,

Dave Yacovone, Commissioner
Department for Children and Families
Agency of Human Services

VERMONT

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Agency of Human Services

May 28th, 2014

Dr. Joseph Hagan
C/O Hagan, Rinehart and Connolly Pediatricians, PLLC
128 Lakeside Ave, Suite #115
Burlington, VT 05401
jhagan@burligntontelecom.net

Dear Dr. Hagan,

Please accept this letter as a formal authorization to empanel the following team as a special investigation multi-task force for the independent review of the Peighton Geraw case pursuant to 33 V.S.A. § 4917:

First	Last	Affiliation	First	Last	Affiliation
Stephen	Berry	Pastor	Robin	Lockerby	Foster Parent
Sally	Borden	Kidsafe VT	Sarah	Lowell	Parent
John F.	Campbell	Legislator	Kim	Magnuson	Education Specialist
Edward	Cashman	Former Judge	Patrick	Malone	Fletcher Allen Health Care
Rachel	Cohen	Fletcher Allen Health Care	Martha	Neary	The Family Place
Lynn	Granger	Kinship VT	Eliot	Nelson	Fletcher Allen Health Care
Hilda	Green	VT Children's Trust Foundation	Karyn	Patno	Fletcher Allen Health Care
Joseph	Hagan	Fletcher Allen Health Care	Jennifer	Poehlmann	VT Children's Alliance
Linda	Johnson	Prevent Child Abuse VT	Ann	Pugh	Legislator
Ben	Joseph	Former Judge	Debra	Taylor	Rutland Supervisory Union
Sarah	Kenney	VT Network			

Thank you for your time and coordination of this important endeavor.

Sincerely,

Dave Yacovone, Commissioner
Department for Children and Families
Agency of Human Services