**COMMITTEE ON CHILD PROTECTION**

**TESTIMONY OF CHIEF JAMES W. BAKER**

**23 JULY 2014**

LESSONS LEARNED

I am going to present to you from the police point of view and from the standpoint of criminal investigations and cases of abuse/neglect that do not rise to the level of criminal conduct. I do not present myself as having the knowledge of daily interaction with DCF to fully understand all of the organization's functions/roles. I also have reviewed the case file of the incident involving the broken legs of Dezirae and have read Lt. Cruises' report. My involvement in this incident review is because a Rutland City Police Department Detective, assigned to the SIU in Rutland, was the case officer in the investigation of the child's leg injuries.

The overarching lesson learned from the Dezirae case is that there was a failure of checks and balances, as well as a lack of effective communication. It is the system that supports the process that needs to be closely examined in order for the process to be effective. There was no identified gatekeeper in this investigation; and that needs to change in the future.

Under the surface, there are several areas that I believe highlight lessons learned. My history with DCF operations goes back to the forerunner, SRS. There was a time, when on call case workers were direct contacts in cases of suspected abuse. Police officers and school officials knew the case workers on a first name basis. This facilitated conversations, exchange of information and all around better collaboration. At some point there was a change and the 800 number was created. In my opinion, this significant change damaged the ability to create close working relationships and enhance the best way to communicate.

There is a perceived culture about DCF that shrouds it in secrecy. The secretive nature and current level of interaction with key stakeholders leaves a sense of mistrust. That perceived mistrust fosters a lack of coordination, information sharing and feedback. My clearest example of this culture is experienced in my current role in Rutland. As the Chief of a police agency with someone assigned to an SIU I have limited access to information about cases the officer works on. There is no supervision of the officer as it pertains to criminal investigations. This fact came to the forefront in the Dezirae case.

Also, another lesson learned for me in the review of the Dezirae case is that the lack of a gatekeeper, coordination of investigation resources and the lack of ownership lead to no accountability. If several different agencies and resources have different parts of a case who is to be held accountable? Inside the Rutland City Police Department and locally with the Vermont State Police, we have started to discuss the supervision of these criminal cases worked in conjunction with DCF.

There are many good aspects of the SIU arrangements in the state, but there are some crucial structural and personnel issues that have not been resolved. One of those issues is the lack of supervision of criminal cases. In our case in Rutland, there are 3 different chains of supervision for 2 ½ investigators. This does not bring into the supervision chain the other personnel in the SIU, for example the DCF case worker who has their own chain of supervision. This is a recipe for disaster.

The issue of the failure to share information is complicated. It is understood that sensitive information about children and family dynamics need to be protected. But, the fact that a police officer who may be dealing with a family that has a parent present in a child's life, who has been deemed by DCF as an abuser, and the officer does not know this vital fact - is unacceptable on every level. There needs to be change as to how information is accessed and shared, especially with law enforcement. The feelings of mistrust and lack of cooperation/coordination are further intensified by the fact that in many cases we cannot get answers on cases that we referred to DCF.

CHANGES TO FIX

There needs to be a change in the fundamental way that DCF interacts with stakeholders. This is centered on the ability to share information. The current state of information sharing is very similar to the challenges that law enforcement faced in the pre 9/11 world. It is not easy to identify solutions, but there needs to be a shift in that information sharing. It will take time and it will require statute change as well cultural change. The best way to do this is the collocation of multidiscipline resources with a focus on protecting children.

If DCF is going to continue to investigate acts of abuse against children they need to be trained and retooled to be an investigative agency. That requires a mindset of an investigator, not the mindset of a social worker. That statement is not meant to be critical. It is a reality that to be a social worker you need to be trained as a social worker; to be an investigator you need to be trained as an investigator.

DCF needs to move beyond collecting data for statistic purposes and begin to collect data for the purposes of enhancing their ability to identify those who are the greatest threat to children, not just in a local office, but throughout the entire system. In law enforcement we "fuse" information through a central point in the state; DCF needs an operation that is similar. It is one thing to understand statistical data about the number and frequency of cases of abuse; it is another thing at the management level to know WHO the abuser is and how many times that abuser has abused.

My final suggestion is that within DCF there needs to be a trained investigative leader who is the focal leader for coordinating abuse investigations. That may require a major shift in culture in order to accept someone who, for example, comes from a law enforcement background.

STATUTE CHANGES

As stated previously, there needs to be a focus on legislative review of statutes that limit the sharing of information with law enforcement. There needs to be a balance between protecting the rights and interest of individuals and the ability to share information to protect children.

CONCLUSION

It is easy to sit and criticize the efforts of protecting children in Vermont. There is no one in the system that goes to work every day that does not want to protect children. My comments today are not meant to be over critical of individuals. It is the system that failed and it is the system that needs to be addressed.