I am Grant John Gorton (go by John). I am a retired US Navy Nuclear Submarine Officer, retired Department of Defense contractor in Navy ship design, and semi-retired farmer. I no longer milk cows, but operate a diversified Beef, cash crop, and custom field work operation in partnership with two sons. I am a certified lay servant in the Methodist Church, and along with about 20 other volunteers I run the Sheldon Methodist Church Food Shelf. I am active in the Franklin County Community Partnership (serving on the Executive Leadership Team), the Franklin/Grand Isle Hunger Council, the Franklin County Food Shelf Alliance, the Franklin County Building Bright Futures Council, and the Farm to Early Childhood Coalition.

I am her today to testify in support of Bill H265. My family has had two significant interactions with DCF. One was very positive and one was a nightmare. I feel these two contrasting experiences offer a unique perspective to the value of the Office of Child Advocate.

First the good. My family has struggled for 12 years dealing with a daughter in law experiencing serious mental health issues. The 12 years have been a roller coaster of times when we hoped she was on the verge of recovery, only to have her suffer another psychotic breakdown. There have been dozens of calls to 911 with police intervention, dozens of visits to the emergency room, out patient work by NCSS and Howard Center, and in patient stays at just about every psychiatric care facility readily available. Our son steadfastly refused to give up on her and my wife and I supported him, dealing with whatever we had to deal with for 8 years. Then they had a baby girl. For about two years things were a little calmer but starting about two years ago, she became increasingly volatile, with more frequent and unpredictable psychotic episodes. It became clearer and clearer to my wife, myself, and our son that the child could not continue to be exposed to the toxic and traumatic environment created by her mother's mental health issues. We contacted DCF and there were safety plans developed with my wife and I taking increasing child care roles and our farm house becoming the safe haven for our granddaughter. Over the course of the last year there have been three serious events where criminal charges were filed and she was sent in patient. The first time, the DCF safety plan was revised requiring contact between mother and daughter be supervised by my wife, our son, or the other grandmother who had flown in from Colorado to assist. After the second incident it was revised to further restrict contact to third party supervised visits at All About Kids in St Albans. After the third incident, based on discussions with DCF, our son filed for separation and obtained RFA protection for his daughter with DCF in control of any contact between mother and daughter. DCF has held out the "carrot" that if she would get herself seriously into recovery mode they would initiate supervised visitation, but she has not and has had no contact with her daughter since the incident in October. It was a very disheartening experience that we and our son did not want to make to basically "abandon" her. We avoided the decision as long as we could, but eventually my son and us had to choose between supporting his wife or caring for his daughter to prevent her from having to be taken into DCF custody and placed in foster care. Two weeks ago DCF closed our case with All About Kids being in control of any visitation between Mother and daughter subject to her meeting some strict behavioral conditions.

What are the take-aways from this experience:

1. There was regular communication between our family and the DCF case worker. Weekly or more frequently, phone calls, emails, multiple face to face visits to our farm house and our son's house. In addition, the case worker communicated with other care providers and the police to ensure she had full and accurate information.

2. We trusted the DCF social worker to spend the time required to take all the information, make an accurate assessment of the situation, and provide an appropriate safety plan.
3. The DCF social worker trusted us to provide her accurate information, to execute the safety plan, and to communicate any issues to her.

At the request of her supervisor, to be used in her personal performance evaluation, my son submitted an email expressing our gratitude for the case managers work with our family navigating this complex and very challenging case. She exhibited a superb level of professionalism, compassion, and competence . It would have been nice to have the Office of Child Advocate to also provide this very positive feedback to.

Now the ugly. Seven years ago another of our sons got into an argument with his wife and during the incident she slipped and fell on the wooden deck of their house with their then 2 year old daughter in her arms. Our son moved over to the farm house with us to provide some separation while they sorted out their future. Three days later she called police and there ensued a criminal case. DCF was called and on Friday afternoon at 4 PM a DCF social worker drove from St Albans to the hinter land of Fairfield to complete an investigation before she could go home. Care to guess how thorough that investigation was?? She spoke with our son for a few minutes on the phone, spent half an hour or so questioning his wife and left. On Monday she again spoke briefly with his wife. She never said anything about what she was doing with the information she was collecting and provided no report to any of us. Hearing nothing for several weeks, we all assumed nothing would come of it. After two months our son received a letter in the mail informing him he had been "substantiated" was placed on the Child Protection Registry at Level one (which we later learned was the most severe). We had never heard of substantiation or the child protection registry and had no clue what information had been used to make the determination. We had to request the "administrative review" in order to even learn that our son was substantiated for "Risk of Harm". Without going into nauseating detail we went thru a "neutral and independent review", a "Fair Hearing", and a hearing before the Human Services Board.

Everyone in the process made us feel we had no right to question DCF's claims and that pointing out errors and contradictions in DCF claims was being abusive to the DCF social worker. In the interest of transparency, a moment of historical context. These events occurred in 2014 – substantiation in January, review in May, hearings in late fall. In February/March of 2014 two children who had been the subject of DCF cases but were not in DCF custody died at the hands of their parents. DCF was under intense scrutiny and pressure about their protection of children. We fully understood that our claim of DCF being way too heavy handed about this incident was not going to be very well accepted at the reviews/appeals.

What are the take-aways from this experience:

1. There was basically no communication between our family and the DCF case worker. We had no clue what DCF was doing till it was done.
2. We didn't trusted the DCF social worker. It was very disconcerting to sit in a hearing and have the DCF social worker blatantly lie under oath looking at us with a smirk on her face.
3. Despite a public proclamation during this time by the then Commissioner of DCF that "the review/fair hearing process protects families from capricious action by DCF", we found the opposite. The DCF social worker provided ample evidence at the Fair Hearing that she was willing to say whatever she needed to say to support a substantiation without regard to its

accuracy or truthfulness. The Independent Reviewer, the Fair Hearing Officer, and even the Human Services Board went out of their way to ignore evidence they didn't want to acknowledge, misrepresent information they couldn't ignore, and provably outright lie to avoid being critical of DCF. They all frequently, both verbally and in writing, contradicted their on verbal and written statements. Pinocchio's nose got so long it filled the room but they just pretended it didn't even exist. Just like the rioters at the Capitol on 6 January, they did it brazenly and openly, unafraid if being held accountable.

4. As a naval officer who served on nuclear armed ships for several years, operating under a sworn obligation that given a lawful order by the President of the United States thru the National Command Authority I would launch nuclear weapons against other human beings to protect my Country, I was very upset that I could not defend my own family from my own State. No family should have to endure what my family did, but I had nowhere to turn. The Advocate Office could have provided that.

How are these experiences relevant to Bill H265

These two experiences were not driven good or bad thru legal representation issues. It was the systemic functioning**/**malfunctioning that defined them. This is the heart of the advocacy value. The Advocate can't and shouldn't "change the determination". But what the Advocate needs to be able to do is three fold:

1. Collect feedback on cases to identify **systemic** <u>failures</u> and <u>successes</u> and then move those into system change processes which enhance successes and reduce failures.
2. Be able to sort out between cases where a complaint is simple "dissatisfaction with the determination" and cases where systemic failures raise questions about the validity of the determination.
3. In cases where the determination is of questionable validity due to systemic failure, the advocate needs to be able to force the case back into a "re-determination" which uses due process (maybe the determination will change, maybe it won't - the advocate doesn't decide that, the process does).

Right now there is no mechanism for the collection and analysis of feedback so "system improvement" is impossible.

As currently stated the three non-legislative member groups listed to nominate members of the Oversight Committee all have significant conflicts of interest because they all rely on DCF/AHS for funding. Oversight Committee members must be independent of any organization receiving funding from the agencies to be overseen.

An office by itself is only half of the solution, the other half is a reformed Child and Parent legal representation system. Otherwise, the Office will be dealing with nothing but a tsunami of complaints about ineffective representation and DCF will never be held accountable.

Grant John Gorton